Cehat

Annual Report

2025 - 2026



Cehat
CENTRE FOR ENQUIRY INTO HEALTH AND ALLIED THEMES

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1. Research

a. Deepening health system response for VAW/G

The project aims to deepen CEHAT's existing work with the health system to ensure a gender sensitive and comprehensive healthcare response and quality of care to survivors of Violence against Women/Girls (VAW/G). The work focuses on demonstrating feminist crisis intervention services to survivors through 'Dilaasa' centres in 12 public hospitals in Mumbai, in the form of psychosocial counselling, safety planning, medico-legal support, multi-stakeholder coordination and referrals to needs-based services. Monitoring of the services through regular visits and meetings as well as capacity building of health care providers (HCPs) and the Dilaasa teams to ensure effective service provision is also undertaken.

I. Presentation at Maharashtra Mahila Arogya Hakk Parishad

The team presented its experiences on the challenges faced by adolescents and young women in accessing sexual and reproductive health care such as the restrictions on their reproductive autonomy, the fear and biases of the healthcare providers, the extra-legal requirements imposed by the hospitals, the contradictions between the laws and the social stigma surrounding it. The programme was attended by women's rights activists and organisations from across Maharashtra.





II. Paper Presentation at National Conference on Restorative Justice



During the National Restorative Justice Week in November, CEHAT colleagues participated and presented a paper on "Institutionalising Restorative Approaches within Health-System Responses to GBV" at the National Conference on Reimagining Justice: Exploring Restorative Approaches in the Indian Context organised by Enfold Proactive Health Trust, Christ (Deemed to be) University, Counsel to Secure Justice, and Ashiyana Communities Foundation in Bengaluru. The presentation examined gendered harms historically produced through medical practices and highlighted how initiatives such as Dilaasa and the Comprehensive Health Systems Response to Sexual Violence are advancing survivor-centred, restorative models of care.

b. Mainstreaming Gender in Medical Education in India

I. Upscaling Gender in medical education (GME) project

The previous year, CEHAT received a Design Phase Grant to develop a systems-change strategy for mainstreaming gender in undergraduate medical education. During the year, CEHAT completed the design phase and submitted the final systems-change prospectus. Drawing on evidence generated through CEHAT's implementation experience and consultations with medical educators and experts, the prospectus outlines a roadmap for strengthening gender integration within undergraduate medical education.



The systems-change strategy is organised around five interconnected areas: 1. understanding the structural barriers that continue to make medical education gender-blind; 2. articulating a vision for a gender-responsive medical education system; 3. identifying pathways for institutional and policy change through faculty development, curriculum reform and 4. stakeholder engagement; strengthening CEHAT's organisational readiness to support scale-up; and 5. developing a learning, monitoring and evaluation framework to document outcomes and guide implementation. The prospectus will inform the next phase of the initiative as CEHAT works towards expanding Gender in Medical Education across institutions and states.

II. Pre-post study at Pramukhswami Medical College, Karamsad

CEHAT initiated a collaborative research study with Pramukhswami Medical College (PSMC), Karamsad, Gujarat to evaluate the implementation of gender-integrated undergraduate medical education. The study adopts a pre-post design to assess changes in medical students' knowledge, attitudes and perceptions following gender-integrated teaching across five disciplines: Community Medicine, Obstetrics and Gynaecology, Internal Medicine, Psychiatry, and Forensic Medicine and Toxicology.



Building on CEHAT's earlier evaluation of Gender in Medical Education in Maharashtra, the study follows students over one academic year using a validated assessment tool developed by CEHAT. The findings will provide evidence on the implementation of gender-integrated teaching within undergraduate medical education.

III. Outcome Harvesting Evaluation

After more than a decade of implementing the Gender in Medical Education (GME) initiative across multiple institutions, CEHAT initiated an Outcome Harvesting evaluation to systematically document the changes emerging from the programme and understand how these changes occurred. Outcome Harvesting is a qualitative evaluation approach that identifies significant changes in behaviour, practices, institutional processes and policies, and then works backwards to examine how the programme contributed to these outcomes. It is particularly

useful for evaluating complex interventions where change is gradual, non-linear and influenced by multiple actors.

The evaluation seeks to understand changes in teaching practices, clinical care, institutional processes and policy engagement among medical educators trained through the GME initiative. Using qualitative interviews, documentation review and survey findings, the study will document outcomes across medical colleges and identify the enabling factors and challenges that have shaped implementation. The findings will help strengthen the GME programme, inform future scale-up, and generate evidence on pathways for integrating gender into medical education.

c. Scaling up health system response to and prevention of domestic violence in Aurangabad, Maharashtra: A randomised control trial

Violence against women is a serious public health issue, and gender inequality concern. The World Health Organization's Clinical and Policy Guidelines on Responding to Intimate Partner Violence and Sexual Violence against Women (2013) recommend the integration of violence response into primary healthcare systems. However, there is limited evidence from low- and middle-income country settings on how such integration can be achieved effectively, especially at the primary healthcare level and through the engagement of community health workers (CHWs) in prevention. This is a collaborative project between CEHAT and MASUM, with CEHAT serving as a research partner overseeing research activities and MASUM leading the intervention component & technical support from World Health Organization (WHO) & George Washington University (GWU). Project aims to strengthen the health system's response to and prevention of VAW in Maharashtra, India, by embedding WHO-recommended practices into primary healthcare services. Various research activities including a formative research, baseline cross-sectional survey, baseline knowledge, attitude and practice survey of health worker and baseline facility readiness was carried out.

I. Baseline Data Collection

During the reporting period, CEHAT made substantial progress in generating evidence to strengthen the health system response to violence against women through baseline research.

We completed a large cross-sectional survey among 12,459 women attending 35 primary health facilities across intervention and control blocks to estimate the prevalence of violence against women and health-seeking patterns. Team also carried out data cleaning, source verification and preliminary analyses of this data to compile a baseline report.

A pre and post-test survey of knowledge, attitude and practice survey was carried out with ASHA workers in two intervention and two control blocks. A total of 979 pre-tests (Intervention=547, Control= 432) and 542 post-tests was completed by CHWs. Thus, a total of 542 CHWs completed pre- and post-tests in intervention blocks. The entry of this data was carried out in OpenClinica as this survey was entirely administered through paper-based forms. The data was matched with physical logs to address any discrepancies. The team also developed a digital system in OpenClinica for routine entry of health facility register data and generated quarterly analyses of violence-related cases registered in participating health

facilities. The data from the health facility registers is routinely analysed and shared with MASUM team to facilitate ongoing monitoring of the intervention.

Based on all the baseline research activities, an internal baseline report was compiled and presented in a webinar organised by George Washington University. We also developed a protocol paper based on the project, which was submitted to BMC Health Services Research.

d. Building stronger evidence on gender-based violence towards young girls and women at the grassroots level in India

The project was focused on strengthening grassroots organisations' capacity to document, manage, and analyse service-related data on gender-based violence (GBV). By doing so, the initiative aimed to generate evidence that could inform interventions, amplify survivors' voices, and influence systemic responses to young girls' and women's vulnerabilities in India.



CEHAT's work with grassroots organisations including Association for Advocacy and Legal Initiatives Trust (AALI), Rajsamand Jan Vikas Sansthan (RJVS), Sahjani Shiksha Kendra (SSK), Nazariya, Jagori, Equidiversity Foundation, Vishakha and Anandi was focused on building their capacity to maintain and analyse their service data effectively. All eight organisations from this cohort actively work with girls and women across their life cycle and in different capacities, from education and leadership building to VAW interventions and legal aid. By building the research capacities of these grassroots organisations to organise and analyse their service data, the initiative helped strengthen on-field interventions with girls and women. For instance, the data from EDF showed that child marriage/early marriage continued to pose a structural risk that increased vulnerability to domestic violence. At the same time, analysis of their records highlighted the need to revisit their interventions strategies with respect to young girls and women. This was especially true in cases of choice or partner, child marriage and human trafficking. In the districts of West Bengal where EDF works trafficking and child marriage are a grave issue. But often, in cases of choice of partner and elopement, often get reported by parents' and families as child marriage or trafficking cases. The EDF team is working on re-evaluating how they distinguish these cases and provide appropriate support to young girls across these situations, including how they engage with the natal family exercising control over girls' choice, freedom and mobility.

RJVS found that survivors from traditional marriage practices like Nata Pratha, Ata-Sata, or child marriage often take longer than three years to report violence. This indicated that organisations must work towards developing comprehensive intervention strategies that recognise the continuum of violence, with changing perpetrators, ranging from natal family pressures and control to violence within marital households. Organisations also record data on age, gender, caste, religion, sexuality, forms of violence, help-seeking behaviour, etc. to better guide how they intervene in VAW cases. When organisations organised and analysed these

data points, crucial information on the intersectional nature of violence and vulnerabilities also emerged. The key learnings from this evidence can help organisations develop an intersectional approach to their work with girls and young women. At the same time, organisations are filling a key evidence gap by providing nuanced and contextual information on the nature of violence and the (in)formal redressal mechanisms accessed by girls and women. As in the case of SSK, which closely documented 'compromise' in cases of VAW. Their factsheet highlighted the realities of navigating compromise between families, sometimes facilitating settlements for women's immediate safety and survival, while in other grievous cases of murder and rape, resisting pressure for compromise and supporting survivors and their families in seeking justice.



e. Mapping Gender-based Violence in Public Spaces

This year, CEHAT completed a 3-year exploratory study aimed at mapping the evolving landscape of civil society interventions addressing gender-based violence (GBV) in Public Spaces in India. It approached public spaces as dynamic and lived spaces, where violence co-exists with mobility, work, habitation, leisure and socio-cultural participation. Violence becomes a tool for social control, changing the way these spaces are experienced, used, and accessed, especially by marginalised groups. Women, girls, transqueer persons and differently abled persons often bear the double burden of GBV in public spaces and structural exclusions, impacting their ability to fully participate in public life through education, healthcare, gainful employment, political action, etc.





It was against this background, that the study captured the experiential knowledge of civil society organisations and synthesised the range of grassroots strategies used to address this issue. We adopted a multi-stage research methodology, where data emerging from one stage of the research guided the methods and analysis of the next stage of the study.

Thirty-one organisations contributed to this research. They completed a written questionnaire and participated in a two-day participatory workshop to share nuanced information about their interventions. Four participatory workshops were conducted between May-June 2025, and each workshop represented a unique but interlinked dimension to addressing the issue. The four dimensions of

work include: improving infrastructure, transforming gender norms, promoting livelihoods and strengthening response. Contributing organisations shared their expertise on building interventions that address multidimensional risks that increase vulnerability to violence in public, as well as the protective strategies and activities they use to mitigate these risks. The CEHAT research team presented the findings using the Social-Ecological Model, examining how risks and protective factors interact across individual, relational, community, and societal levels. Validation meetings were held with the contributors to triangulate and confirm the findings.



The final report ***And Still We Walk*** was launched at a dissemination meeting in March 2026, where the contributing organisations were joined by peers, academics, researchers and development practitioners' working to end gender-based violence.

2. Training and Education

a. Training of Trainers (ToT) at Pramukhswami Medical College, Karamsad

CEHAT entered into a Memorandum of Understanding (MoU) with Bhaikaka University, Karamsad to pilot the Gender in Medical Education initiative at Pramukhswami Medical College. The collaboration aims to integrate gender into undergraduate medical education through faculty development, curriculum review, development of teaching – learning and assessment methods, research, documentation and dissemination. The partnership also includes a pre-post evaluation to assess changes in students' knowledge, attitudes and perceptions following gender-integrated teaching.



As part of this collaboration, CEHAT organised a three-day Training of Trainers (ToT) programme from 24–26 June 2025 for 37 faculty members from pre-clinical, para-clinical and clinical departments. The programme introduced faculty to concepts of gender and health, intersectionality, gender-based violence, ethics, disability and inclusive healthcare, and approaches for integrating gender into undergraduate teaching. Participants developed discipline-specific lesson plans aligned with the Competency-Based Medical Education (CBME) curriculum for implementation within their departments.

b. Continuing Medical Education Workshop on Integrating Gender in Medical Education

CEHAT, in collaboration with the Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sevagram, organised a three-day Continuing Medical Education (CME) workshop in Mumbai on Integrating Gender in Medical Education, from 6–8 February 2026. Twenty-two medical educators from institutions across the country participated in the workshop.

The workshop explored gender as a social determinant of health and discussed themes including intersectionality, gender-based violence, healthcare for sexual and gender-diverse communities, ethics, family planning, and integration of gender within AETCOM and the Competency-Based Medical Education curriculum. Interactive teaching methods, case discussions and lesson planning exercises enabled participants to develop approaches for integrating gender into undergraduate teaching.

c. Training of Field Investigators



We organised a one-day closure meeting with field investigators who conducted a cross-sectional survey. In this meeting, the field investigators shared their experiences and learning from the field.

d. Capacity Building of grassroot organisations on Violence against young women & girls

CEHAT continued its engagement with the existing cohort of seven organisations i.e. Jagori, Nazariya, SSK (Sahjani Shiksha Kendra), RJVS (Rajsamand Jan Vikas Sansthan), Vishakha, AALI (Association for Advocacy and Legal Initiatives Trust), and ANANDI. Following earlier workshops on data validation, data entry and data cleaning, CEHAT continued to provide handholding support through regular virtual meetings to address their questions, test the MIS sheets, and troubleshoot any data entry challenges. Feedback was incorporated through continuous revisions and refinements to the MIS. During this period, CEHAT also expanded the cohort to include the Equidiversity Foundation (EDF) based in West Bengal. A three-member team from EDF's intervention and research unit was invited to Mumbai for a workshop focused on streamlining their intake and documentation formats, and to discuss data validation and data cleaning processes.



In December 2025, all eight organisations participated in an intensive 2-day workshop on data analysis and research writing. Here, the focus was data interpretation and presentation of findings using the revised data sets and MIS sheets developed and maintained by organisations. Using participatory methods, the workshops focused on identifying research topics, the framework of analysis, describing the research methodology, and contextualising and presenting the findings.

e. Workshops on Monitoring Methods for Domestic Violence Interventions

Over the past few years, CEHAT has worked to strengthen the intra-sectoral capacity for GBV data collection and management. Our work focuses on developing an accessible and inclusive methodology for data management, MIS development and standardisation of data entry at the organisation level. The outcome has been the improved organisational resources and commitment towards evidence building on contextual trends and effective strategies to address GBV across diverse grassroots contexts. To this effect CEHAT participated in the AMAN Network, a national level network of feminist organisations, working to end domestic violence. A validation meeting was held with AMAN members to support the revision and refinement of the Standard Operating Procedures (SOP) for maintaining service data on DV and GBV at large. In addition, a consensus-building workshop with 23 AMAN organisations facilitated alignment on a set of common minimum indicators of change at the survivor, community, health system, and justice system levels. Together, these efforts lay the foundation for more standardised, comparable, and actionable GBV data systems, which strengthen the sector's ability to generate evidence, design interventions and support policy engagement.

f. Capacity Building of Muktha Teams

The Muktha counsellors were trained by the Samvidhaan Fellows under the Nyaaya initiative for skill building of counsellors around the laws and legal rights of survivors of violence.

g. Training of Trainers under Muktha initiative



Due to large scale transfers of health care providers in the department, most of the trained doctors and nurses in each of these five hospitals had moved out. To establish Muktha therefore we had to conduct a second round of Training of Trainers (ToT). The first three days of the five-day ToT was conducted at Arogya Soudha in February 2026 for over 35 healthcare providers.

h. Training of Health Care Providers (HCPs) on recognising and responding to VAW/G





CEHAT conducts periodic trainings for HCPs across 12 peripheral hospitals in Mumbai which have Dilaasa crisis centres for survivors of violence. Given the frequent transfer of HCPs across hospitals, continuous induction of new staff into clinical identification of violence against women and children (VAW/G) and appropriate referral pathways, is crucial. In the period between April 2025 and March 2026, 14 orientation trainings were conducted across 12 hospitals (including 3 maternity homes). The trainings aim to equip HCPs—including doctors, nurses, and other medical staff—with the knowledge and skills to recognise clinical signs and health consequences of violence. Other components include psychological first aid using the WHO-LIVES framework, and an introduction to the services provided by Dilaasa centres. 4 of the 10 trainings was on comprehensive health system response to survivors of sexual violence, including proper medico-legal examination and documentation according to the guidelines by the Ministry of Health and Family Welfare (MoHFW). In total, 344 HCPs participated in these trainings. Some of these HCPs have now started co-facilitating trainings in their hospitals and also proactively sensitising other hospital staff towards VAW/G, ensuring regular training and participation from others.





i. Monitoring Committee Meetings



The Monitoring Committee Meetings (MCMs) create a space for the HCPs and the Dilaasa teams to discuss the response of the hospital to cases of VAW/G and assess the quality of care provided. The committee at each hospital comprises of doctors and nurses from key departments as well as the Dilaasa and CEHAT teams. CEHAT also conducts a review of the medico-legal examination of sexual violence proformas in consultation with the HCPs to understand any gaps in the protocols or documentation and suggest ways to address them. CEHAT facilitated 2 MCMs across 2 hospitals in this period. These meetings have enabled the hospitals to bring about changes in their procedures and practice.

Examples of issues that emerged from MCMs:

1. During an MCM, the HCPs raised a question about whether it is the hospital's responsibility to present the child before the Child Welfare Committee and keep them admitted until it happens. It was clarified that it is the police's responsibility to do the same and the hospital can discharge the survivor if she is medically fit and safe at home.
2. The HCPs at one of the hospitals shared that they had confusion and queries around the technicalities of sample collections in cases of sexual violence. Based on this, the CEHAT team arranged a meeting between the senior doctors of the gynaecology department and the Forensic Science Laboratory (FSL) where their questions were addressed.

j. Capacity building of Dilaasa teams through case presentations



Regular case presentations are conducted as a capacity building exercise for the Dilaasa teams, with the objective of monitoring the quality of services provided and facilitating a peer learning process. The teams share their experiences and challenges while dealing with cases of VAW/G and receive inputs from their peers, facilitators and external resource persons. Ideas, suggestions and best intervention practices are generated through the discussion. 6 case presentations were conducted during this period across themes such as 1. Challenges with hospital procedures, 2. Understanding neurological disabilities and addressing challenges related to sexual, physical and emotional abuse to support legal process, 3. Successful Cases, Homeless and Runaway Women/Girls, 4. Technology-facilitated Gender-Based Violence.

Examples of case presentation discussions:

1. During the Case Presentation on Responding to Attempted Suicides, a question was raised about how to handle confidentiality when working with children in POCSO cases. Counsellors noted the dilemma: we often reassure a child that "we won't tell anyone", yet the law mandates reporting. The suggested approach was to change the counselling dialogue. Instead of giving assurances that may later be violated, counsellors should say: "You can trust me, and this is a safe space. I will do my best to support you.
2. Counsellors shared challenges faced by the doctors while conducting medical examinations of survivors of sexual violence, especially children who have some form of neurological disability and are not able to communicate the abuse. The experts from Urmi Foundation shared their Sensory Friendly Medical Kits for such survivors and explained the process of eliciting history using the sensory tools such as dolls, kinesthetic sand, sound balls, visual cards (story cards), finger puppets and so on. The major takeaways were the use of reinforcement as the base for behaviour management, sensory integration using the tools and giving step-by-step instructions using short sentences.






k. Capacity Building Session on Medico-Legal Response to Sexual Violence

Members from the CEHAT team presented its health-systems intervention at a workshop on "Sexual Violence and Legal Framework" organised by Urja Trust and the Department of Women and Child Development, engaging stakeholders such as Protection Officers, ASHA and Anganwadi workers, and social workers. The session focused on recognising health consequences of violence, identifying clinical indicators, understanding medico-legal responsibilities, and ensuring survivors' rights within health-system interactions.

l. Exposure visit by Kutch Mahila Vikas Sangathan

As part of CEHAT's knowledge-sharing and capacity-building efforts, the Dilaasa Centre at K.B. Bhabha Hospital, Bandra hosted an exposure visit for 12 grassroots social workers from Kutch Mahila Vikas Sangathan (KMVS), Gujarat, on 9 February 2026. The visit provided an opportunity for the KMVS team to understand the BMC–NHM Dilaasa model as a hospital-based response to violence against women, highlighting the critical role of public health facilities in the early identification, support, and referral of



survivors of domestic and sexual violence. The interaction facilitated an exchange of experiences on institutional responses to violence against women and explored the relevance of integrating similar approaches within community-based support systems.

3. Intervention and Service Provision

a. Psycho-social interventions at Dilaasa centres

CEHAT plays an important role in assisting Dilaasa counsellors in Mumbai as well as counsellors in sites where the Dilaasa initiative is being replicated. The team provides technical guidance on feminist and crisis counselling methods, sharing practical strategies through case-based interventions and ongoing mentoring. CEHAT is also engaged in direct service provision in one of the oldest Dilaasa centres. In addition, the team also assists in challenging cases handled by the other Dilaasa centres. This often requires on-site support, where CEHAT team members work alongside Dilaasa counsellors to navigate particularly sensitive or challenging situations.



The Dilaasa teams handled more than 2000 new cases of domestic violence and sexual violence in the given year. Additionally, they conducted routine follow ups with survivors of ongoing cases and reached out to more than 20,000 women and girls through screening, health talks, and IEC material to encourage them to seek support services and linking them to resources.

b. CEHAT 24x7 Gender-Based Violence Helpline



CEHAT counsellors received more than 600 calls from April 2025 to March 2026 on the 24x7 helpline. The callers included survivors facing domestic violence or sexual violence or their family members, health care providers, and social workers/counsellors from other organisations. Few of the calls were from survivors in a crisis situation and requiring urgent support. Most of the other calls were regarding reporting a case of violence and queries on police not filing complaints of the abuse. Other reasons included survivors seeking legal advice for their ongoing case in the court, abuser getting bail and a fear of re-occurrence of violence from him. Calls from health care providers were primarily related to medical examination; documentation related to medical procedures; and questions about advanced pregnancies and legal recourse for survivors, especially past the legal 24-week period. Other organisations contacted the helpline mainly for referral support to Dilaasa centres. The round the clock helpline service has been of use to survivors as well as HCPs as stated by the number of calls received.

c. Psycho-social interventions at Muktha crisis centre, Bengaluru

A total of 10,778 women and children were identified as survivors of violence, since its inception in 2022 till March 2026. 3761 women and children were referred and supported by the Muktha centre during this period.

4. Engagement with Stakeholders

a. Gender in Medical Education Short Film Series

Recognising the need for creative approaches to strengthen discussions on gender in medical education, CEHAT initiated the development of a series of short films based on the Gender in Medical Education (GME) initiative. The films aim to complement existing teaching modules by using stories and everyday clinical situations to facilitate conversations on gender, ethics and patient care within medical education.

CEHAT partnered with Agents of Ishq (AOI), a digital media platform that creates content on gender, sexuality and relationships, to conceptualise and develop the film series. As part of the creative process, the AOI team participated in a GME training workshop to understand the content, pedagogical approach, target audience and discussions that emerge during the trainings. This was followed by a series of collaborative meetings between the CEHAT and AOI teams to identify key themes, develop story ideas, prepare treatment notes and draft scripts based on the GME modules and the experiences of medical educators.

Adapting teaching modules into short films required an iterative process of script writing, review and revision to ensure that the films remained pedagogically relevant while also being engaging and accessible to a wider audience. The process involved multiple rounds of discussions between the creative and technical teams to balance medical accuracy, gender perspectives and storytelling. Following script finalisation, preparations for production and filming were initiated. The six films explore themes including gender as a social determinant of health, sexual and gender identity, contraception and medical termination of pregnancy, adolescent sexual and reproductive health and rights, violence against women, and gender and mental health.

b. Putting knowledge into practice

During the year, CEHAT actively engaged in and knowledge translation activities to strengthen the health system response to violence against women. Baseline findings from the project were presented at the funders Annual Planning Meeting and disseminated through an internal webinar involving consortium partners, facilitating discussion on key research findings and their implications for programme implementation. Evidence generated through the health facility readiness assessment was shared with MASUM to support the development of Standard Operating Procedures for responding to survivors of violence in primary healthcare settings. CEHAT also participated in bilateral coordination meetings with MASUM and the What Works II, contributing to discussions on the project's theory of change, implementation strategy, governance mechanisms, partner roles, and approaches to maintaining intervention fidelity. Research findings were continuously used to refine training content, monitoring systems, and intervention delivery. In addition, CEHAT engaged with senior officials in the Government of Maharashtra, including the Health Secretary, for the integration of an indicator on violence against women within the state Health Management Information System (HMIS), with the aim of strengthening routine reporting, monitoring, and evidence-informed planning for health system responses to gender-based violence.

c. Session at the Sixth Pre-Budget Consultation of the Feminist Policy Collective



CEHAT team presented their reflections on gender-based violence and the implementation of the PWDV Act over two decades at the national dissemination event organised by SAHAJ and the Feminist Policy Collective. The presentation critically analysed India's policy response over the past decade and underscored the importance of participatory investment in GBV prevention and response, inclusive legal frameworks, fidelity to evidence based practices, and strengthening data systems beyond administrative sources.

d. International Women's Day Celebration



Guided by the spirit of International Women's Day 2026 and the call to advance the rights, dignity, and agency of every woman and girl, the Dilaasa teams marked 8th March 2026 through a range of activities across the 12 public hospitals in Mumbai. Healthcare providers, survivors, and hospital staff came together for awareness sessions, interactive games, street plays, health talks, and celebrations that reaffirmed the collective responsibility of the health system in creating spaces where women are heard, believed, and supported. The activities celebrated not only women's resilience but also the compassion and commitment of healthcare providers who stand alongside survivors in their journey towards safety and healing.

CEHAT also celebrated the occasion with the Dilaasa teams, creating a space for them to pause, connect, and step away from the demands of their routine work. The celebration included activities focused on burnout prevention and self-care, fun games, and a small token of appreciation as an expression of gratitude for their unwavering commitment to their work.





e. International Day for the Elimination of Violence Against Women and 16 Days of Activism against Gender-Based Violence

In observance of the International Day for the Elimination of Violence Against Women on 25 November 2025, the Dilaasa teams aligned their activities with the theme of "UNiTE to End Digital Violence against All Women and Girls." As technology becomes increasingly embedded in everyday life, digital forms of violence are emerging as rapidly growing yet often under-recognised manifestations of gender-based violence. Limited awareness among survivors, communities, and service providers frequently results in these experiences going unrecognised and unaddressed. Against this backdrop, Dilaasa reinforced the critical role of the health system in identifying and responding to violence in all its forms.



Throughout the 16 Days of Activism against Gender-Based Violence, Dilaasa teams extended the campaign beyond hospitals through community outreach and intersectoral engagement. Awareness programmes at schools, colleges, police stations, NGOs, maternity homes, health posts and aanganwadis reinforced the message that preventing violence requires informed communities, responsive institutions, and collective action to ensure that women and girls are safe, supported, and empowered in both physical and digital spaces.

f. World Suicide Prevention Day



World Suicide Prevention Day, observed on 10 September 2025, provided an opportunity for Dilaasa teams to strengthen awareness around the links between violence and suicidal behaviour. Building on the ongoing 2024–2026 World Suicide Prevention Day theme, *"Changing the Narrative on Suicide,"* and its call to action, *"Start the Conversation,"* the teams emphasised the importance of recognising warning signs, encouraging timely support, and creating safe spaces for conversations around suicide prevention and violence against women.



g. World Mental Health Day

On World Mental Health Day, Dilaasa teams organised many creative activities across hospitals to promote conversations on mental well-being among patients and healthcare providers. The observance highlighted the often-overlooked mental health consequences of violence against women, while reinforcing the health sector's role in early identification and support. Recognising that the well-being of healthcare providers is equally vital, the teams also encouraged staff to acknowledge signs of stress and burnout, prioritise self-care, and seek support without stigma, fostering a culture of compassion and resilience within healthcare settings.

h. National Consultation on Access to Abortion

In April 2026, CEHAT participated in a consultation on the *Impact of Medical Boards on Access to Abortion Services*, organised by Jindal Global Law School. Conducted in a clinic format, the consultation brought together researchers, lawyers, and practitioners to discuss research findings, legal and ethical issues, implementation challenges, and recommendations for developing Standard Operating Procedures (SOPs) for medical boards. CEHAT contributed intervention-based insights highlighting how defensive practices by healthcare providers can delay access to abortion, resulting in pregnant persons being referred to courts and medical boards. We also emphasised that medical boards often adopt a moralistic approach to late-term abortions, inadequately consider the psychological and material consequences of continuing a pregnancy, and increasingly frame the health of the pregnant person and the foetus as competing interests.

i. Annual AMAN Network Meeting

CEHAT team attended the annual AMAN network meeting in Hyderabad, contributing insights on emerging concerns such as natal family violence and technology-facilitated violence. The team shared experiences from hospital-based crisis interventions, illustrating how these forms of violence manifest in clinical settings and how Dilaasa teams respond.





j. Short Film on Dilaasa

CEHAT, with support from the Brihanmumbai Municipal Corporation (BMC), is currently producing a short film on Dilaasa. The film follows the journey of a survivor of domestic violence illustrating how compassionate, survivor-centred healthcare can create opportunities for women to disclose violence, access support, and reclaim their lives. It highlights the critical role of healthcare providers in identifying and responding to gender-based violence, while showcasing the Dilaasa model as an effective, health system-based response to violence against women.



5. Documentation and Publication

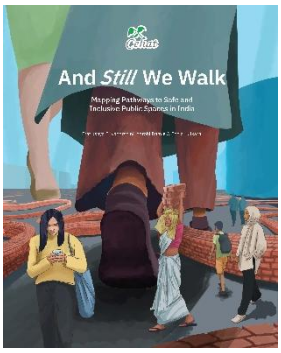
a. Evidence on Violence against Women & Girls



Following the writing workshop, eight organisations tabulated their data sets and organised their findings in a factsheet on several different aspects of VAW. The frontline researchers from each organisation presented their evidence in the form of published factsheets at a dissemination event held in March 2026 in Mumbai. The factsheets are available at this link.

b. And Still We Walk

And ***Still We Walk*** maps civil society efforts to address gender-based violence (GBV) in public spaces across India. Available on the CEHAT website, the report brings together the experiences and grassroots learnings of 31 organisations working on this issue.



Using the internationally recognised Social-Ecological Model (SEM), the report identifies key risk factors that contribute to GBV in public spaces and the protective strategies developed by organisations to address them. These risks and strategies are mapped across the four levels of the SEM—individual, relationship, community, and societal—and organised around four interconnected dimensions of work namely improving infrastructure, transforming gender norms, promoting livelihoods, and strengthening institutional response.

The report aims to serve as a practical resource for organisations, helping them design, strengthen, and monitor programmes to prevent and respond to GBV in public spaces.

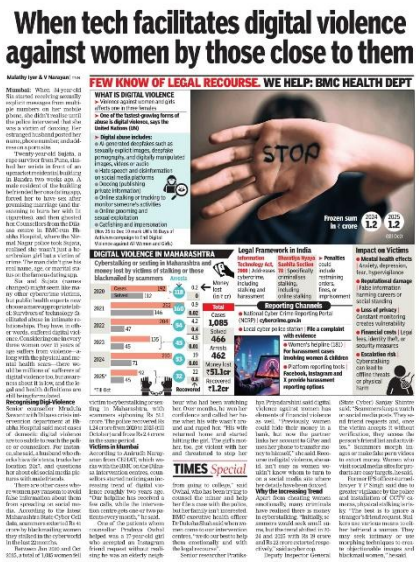
c. Article on challenges faced by young women in accessing MTP in The Leaflet



The post delves into the ethical complexities surrounding adolescent girls' access to reproductive healthcare in India, especially within cases of consensual relationships. It sheds light on the practical challenges arising from legal mandates and societal stigmas, which often prioritise legal compliance over the wellbeing and autonomy of adolescents.

d. Article on technology-facilitated gender-based violence and Dilaasa (The Times of India)

How intimate partner violence has shifted online and everyday technology is used to surveil, control, and extort women including experiences of Dilaasa and CEHAT.



When tech facilitates digital violence against women by those close to them

FEW KNOW OF LEGAL RECOURSE. WE HELP: BMC HEALTH DEPT

Mumbai: When 14-year-old Ria started receiving gradually escalated messages from multiple numbers on her mobile phone, she didn't realise until the police intervened that she was a victim of cyberstalking. Her estranged husband posted her name, phone number, and addresses on a porn site.

Twenty-year-old Sapna, a rape survivor from Pune, also had no idea that a fake Instagram account created in Bhadra two weeks ago. A male resident of the locality had revealed her cross-dressing. Forced her to have sex after promising marriage (and the morning to harm her with 31 injections), and then ghosted her. Counsellors on the Dilaasa centre in BMC-run Bhagwati Hospital in Kandivali and Nagar police took Sapna's complaint she wasn't just a lovelorn girl but a victim of crime. The man didn't grow his real name, age, or marital status on the famous dating app.

Ria and Sapna (names changed) might seem like many other cybercrime victims, but public health experts now see technology-facilitated gender violence (TFGBV) and digitally facilitated abuse in intimate relationships. They have, in other words, suffered similar violence. Considering how in every three women over 15 years of age suffers from violence—a long with the physical and mental health scars—there would be millions of sufferers of TFGBV. Yet, hardly anyone knows about it is low, and the legal and health difficulties are still being worked out.

Recognising Digi-Violence

Senior counsellor Shraddha Sawant with Dilaasa crisis intervention department at Bhabha Hospital said most cases of domestic digital violence survivors unable to reach the police. "Many victims, like Ria, don't even realise what's happening to them. Initially, a husband who checks his wife's texts, tracks her location, logs, and questions her about old social media pictures with male friends.

There are other cases where women are unaware to avoid false information about them from spreading on social media. According to the latest data, women under 30 are the victims by blackmailing women they wished in the cybercrime in the last 22 months.

Between Jan 2021 and Oct 2025, a total of 1,085 women fell victim to cyberstalking scams, ling in Maharashtra, with scammers siphoning Rs 51.1 crore. The police recovered Rs 1.24 crore from 2020 to 2025 (till October) and froze Rs 1.2 crore in the cases reported.

Seeking Assistance

According to Ashwini Nayagaonkar from CEHAT, which runs the helpline, as well as the intervention centres, consultants started noticing an increasing trend of digital violence roughly two years ago. "Our helpline has received a few calls, while the intervention centres get one or two per month. Now, we get 10 to 15 calls.

One of the cyclones whose counsellor Pradnya Dabral helped was a 17-year-old girl who accepted an Instagram friend request without realising he was an elderly neighbour who had been watching her. Over months, he won her confidence and called her home when his wife wasn't around and raped her. His wife returned home and started hitting the girl. The girl's mother, the girl's mother with her, contacted to stop her son. Unable to stop her from going to college," said Dabral, who has been trying to contact the minor and help her files a case with the police, but her family isn't interested.

Dr Tulsi Bhatt, head of the Centre for Excellence in Forensic Sciences, said cyberstalking is the most common form of digital violence against women. "Perpetrators could be anyone, from a former partner to a stranger who gains access to personal information. Victims may not even realise they are being tracked until real-world incidents occur."

Deputy Inspector General (State Cyber) Sanjay Shintre said, "Scammers lure girls with social media posts. They send friend requests and, once the victim accepts it without verification, they access the person's friend list and start chatting with them. Sometimes, they agree to make like-minded videos to extort money. Women who visit social media sites for purchases are easy targets, he said.

Former DCP Aleem Kurwai, lawyer Y P Singh said due to greater vigilance by the police and installation of CCTV cameras, physical stalking is on the decline, but cyberstalking is on the rise. "The best is to ignore a stranger's friend request. We have had various cases in which her believed a woman. They may seek intimacy or use morphing techniques to create digitally manipulated images and blackmail women," he said.

TIMES Special

DIGITAL VIOLENCE IN MAHARASHTRA

Cyberstalking or sexting in Maharashtra and money lost by victims of stalking or those blackmailed by scammers

Legal Framework in India

Information Technology Act, 2000 | Addresses cybercrime, including stalking and harassment

Bharatiya Nyaya Sanhita Section 78 | Specifically criminalises stalking, including online stalking

Penalties could include restraining orders, fines, or imprisonment

Reporting Channels

National Cyber Crime Reporting Portal (NCRP) | cybercrime.gov.in

Local cyber police station | File a complaint with evidence

Women's helpline (181)

For harassment cases involving women & children

Platform reporting tools | Facebook, Instagram and X provide harassment reporting options

Impact on Victims

Mental health effects | Anxiety, depression, fear, hypervigilance

Reputational damage | False information harming careers or social standing

Loss of privacy | Constant monitoring creates vulnerability

Financial costs | Legal fees, identity theft, or security measures

Escalation risk | Cyberstalking can lead to offline threats or physical harm

CEHAT Staff as on 31st March 2026

Sr. No.	Name	Male / Female	Designation	Period
1	Aarohi Damle	Female	Sr. Research Associates	16.03.2023 – till date
2	Ajinkya Deshmukh	Male	Sr. Research Associates	03.05.2021 – till date
3	Amruta Bavadekar	Female	Director	01.07.2024 – till date
4	Anirudh Narayanan	Male	Research Associates	01.08.2024 – till date
5	Ashwini Chougule	Female	Sr. Research Associates	09.05.2022 – till date
6	Heena Sinha	Female	Research Associates	02.04.2024 – till date
7	Jiti Chathamala	Female	Sr. Research Associates	22.09.2025 – till date
8	Mohd. Uruj Anwar Shaikh	Male	Research Associates	10.10.2024 – till date
9	Pradnya Jadhav	Female	Sr. Research Officer	03.11.2025 – till date
10	Pramila P. Naik	Female	Sr. Administrative Officer	09.10.2000 – till date
11	Pratikshya Priyadarshini	Female	Research Officer	01.03.2023 – till date
12	Rajeeta G. Chavan	Female	Research Associates	27.07.2009 – till date
13	Sanjida Arora	Female	Sr. Research Officer	04.07.2014 – till date
14	Shobha Kamble	Female	Office Assistant	14.12.1999 – till date
15	Sudhakar Manjrekar	Male	Office Assistant	15.11.2000 – till date
16	Swati S. Pereira	Female	Junior Administrative Officer	16.07.2015 – till date
17	Uvika Durani	Female	Sr. Research Associates	18.03.2024 to 09.01.2026
18	Yogita Shivankar	Female	Administrative Assistant	01.03.2023 – till date

ANNEXURE

Publications April 2025 – March 2026

1. Journal Article:

1. Domestic violence against married women in reproductive age group - its causes and impact on their health: A facility based cross sectional study (2025) – Aswar, Nandkeshav; Kale, Kalpana; Deshmukh, Ajinkya & Bavadekar, Amruta – International Journal of Medicine and Public Health, 15(2), 1114-1120 p.
2. To understand the challenges faced by female sex workers in seeking health care in Miraj town (Maharashtra) (2025) – Kale, Kalpana; Aswar, Nandkeshav; Deshmukh, Ajinkya; Rege, Sangeeta & Bavadekar, Amruta – Indian Journal of Public Health Research and Development, 16(2), 165-170 p.
3. Determinants of male partner involvement in utilization of family planning methods: A mixed methods study (2025) – Lokare, Pushpa O.; Deshmukh, Ajinkya; Bavadekar, Amruta; Karanjekar, Vinod D. & Chaudhary, Sanjeev M. – Journal of Integrated Health Sciences, 13(1), 22-31 p.
4. Integrating gender and violence in medical education: A pedagogical intervention (2026) – Bavadekar, Amruta & Deshmukh, Ajinkya – Medico Friend Circle Bulletin (386), February 2026
5. Violence as routine: How institutional conditions shape healthcare workers (2026) – Rege, Sangeeta; Deshmukh, Ajinkya; Angeline, Nancy & Bavadekar, Amruta – Medico Friend Circle Bulletin (386), February 2026
6. Obstetric violence and respectful maternity care in India: A review of the evidence (2026) – Bavadekar, Amruta; Dasgupta, Jashodhara & Khanna, Renu – Medico Friend Circle Bulletin (386), February 2026

2. Books / Reports:

1. Feminist psychosocial intervention approaches to respond to domestic violence against women: Evolution and emerging evidence from India (2025) – Rege, Sangeeta & Bhate-Deosthali, Padma – In Psychosocial Interventions for Social Issues in Contemporary India by U. Vindhya (Ed.), Springer, pp. 61-83, ISBN: 978-981-96-6552-5
2. An analytical report on domestic violence data of Equidiversity Foundation, West Bengal (2026) – Equidiversity Foundation (EDF) & CEHAT
3. Support needs of queer and trans persons: Insights from Nazariya's helpline data (2026) – Nazariya Foundation & CEHAT
4. A step towards gender responsive Panchayat: Insights from Anandi (2026) – Anandi & CEHAT

5. सामाजिक कलंक और हिंसा के अंतर्संबंध: समुदाय के अनुभवों से उभरती समझ (2026) – Vishakha & CEHAT
6. घरेलू हिंसा के मामलों में नारी अदालत की भूमिका: राजसमन्द जन विकास संस्थान के डेटा से मिली समझ (2026) – राजसमन्द जन विकास संस्थान (RJVS) & CEHAT
7. घरेलू हिंसा और महिलाओं के स्वस्थ्य पर प्रभाव: जागोरी के केसवर्क और काउंसलिंग से सिख (2026) – Jagori & CEHAT
8. महिलाओं के खिलाफ हिंसा और समझौते की हकीकत: सहजिनि शिक्षा केंद्र के मामलों का विश्लेषण (2026) – सहजनी शिक्षा केंद्र (SSK) & CEHAT
9. महिलाओं के खिलाफ हिंसा का जीवन चक्र: आली के सेवा रिकॉर्ड से समझ (2026) – Association for Advocacy and Legal Initiatives (AALI) & CEHAT
10. And still we walk: Mapping pathways to safe and inclusive public spaces in India (2026) – Priyadarshini, Pratikshya, Damle, Aarohi & Kulkarni, Pooja – CEHAT, ISBN: 978-81-89042-95-0

3. Blogs:

a. Legal but out of reach: Medical termination of pregnancy remains arduous for India's young people (2025, July 18) – Narayanan, Anirudh & Rege, Sangeeta – The Leaflet.in

4. Media Coverage:

a. Housewives account for 51.36% of female suicides in city: Report (2025, July 20) by Mavad, Asra – Deccan Herald
b. Mumbai's healthcare system shows the public, not the private, matters (2025, September 5) by Dhagey, Jashvitha & Saraf, Nikeita – Question of Cites.org
c. कौटुंबिक हिंसा प्रतिबंधासाठी आता आशा वोर्करही सज्ज (2025, November 8) – लोकमत
d. The power of listening, the power of the LIVES approach (2025, November 19) – World Health Organization
e. Sangeeta Rege: हिंसेला चेहरा नसतो! (2025, November 30) by Kalgutkar, Sharmila – महाराष्ट्र टाइम्स
f. When tech facilitates digital violence against women by those close to them (2025, December 7) by Iyer, Malathy & Narayan, V. – The Times of India
g. कौटुंबिक हिंसाचार रोखण्यास 'आशा' कार्यकर्त्यांचा पुढाकार (2025, December 08) – लोकमत