Using an emergency response infrastructure to help women who experience gender-based violence in Gujarat, India

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Problem  Many women who experience gender-based violence may never seek any formal help because they do not feel safe or confident that they will receive help if they try.

Approach  A public–private–academic partnership in Gujarat, India, established a toll-free telephone helpline – called 181 Abhayam – for women experiencing gender-based violence. The partnership used existing emergency response service infrastructure to link women to phone counselling, nongovernmental organizations (NGOs) and government programmes.

Local setting  In India, the lifetime prevalence of gender-based violence is 37.2%, but less than 1% of women will ever seek help beyond their family or friends. Before implementation of the helpline, there were no toll-free helplines or centralized coordinating systems for government programmes, NGOs and emergency response services.

Relevant changes  In February 2014, the helpline was launched across Gujarat. In the first 10 months, the helpline assisted 9767 individuals, of which 8654 identified themselves as women. Of all calls, 79% (7694) required an intervention by phone or in person on the day they called and 43% (4190) of calls were by or for women experiencing violence.

Lessons learnt  Despite previous data that showed women experiencing gender-based violence rarely sought help from formal sources, women in Gujarat did use the helpline for concerns across the spectrum of gender-based violence. However, for evaluating the impact of the helpline, the operational definitions of concern categories need to be further clarified. The initial triage system for incoming calls was advantageous for handling high call volumes, but may have contributed to dropped calls.

Introduction  Globally, over one-third of all women will experience gender-based violence in their lifetime.1 Such violence includes any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, which includes coercion or arbitrary deprivation of liberty:2 Gender-based violence may be perpetrated by current or former partners, strangers, acquaintances or family members. Women who experience such violence may experience physical and mental health problems across their lifetime,3 including an increased risk of sexually transmitted infections,4 depression and anxiety,5 giving birth to low-birthweight infants,6 and hypertension.7 While governments and nongovernmental organizations (NGOs) work to build support services and the legal infrastructure to prevent and to confront gender-based violence, women often do not seek out or cannot connect to these resources.

In India, there is a 37.2% lifetime prevalence of gender-based violence among women.8 Only 31.5% of these women will ever report gender-based violence to anyone, and less than 1% will report it to a formal source, such as the police or a physician.9 This is below the low global average of 7% of women reporting gender-based violence to any formal source.10

In January 2013, the Indian Department of Telecommunications released the toll-free phone number 181 across India, and mandated that every state government develop infrastructure for this number that would address the needs of women experiencing gender-based violence. This paper describes a multisectoral collaboration in the state of Gujarat, India, that has met this mandate by creating a toll-free helpline called 181 Abhayam.

Approach  The Indian Administrative Service Secretary for Gujarat, Anju Sharma, who was also the state head of the Women and Child Development Department, brought together key collaborators across sectors to establish the helpline. For ensuring the effectiveness of the interventions and for creating accountability, the secretary enlisted the Government of Gujarat Home Department, which is responsible for the police. The secretary recruited the GVK Emergency Management Research Institute to be responsible for the implementation and operations of the helpline. The institute is the largest provider of free emergency medical services in India, covering 15 states. It operates as a public–private, not-for-profit partnership with each state’s government. The secretary also invited the Tata Institute of Social Sciences, which has a history of gender-based violence research, to provide technical expertise for helpline protocols.

The collaborators created a shared vision: any woman, irrespective of caste, religion, class, ability, age, sexual or political orientation, educational or economic status, would be able and empowered to seek and receive emergency services anywhere, at any time. Their mission – paid for by the Government of Gujarat – was to provide a coordinated, effective and timely multi-agency response that offered quality mental health, social, and legal services. They agreed upon a target group that reached beyond the traditional definition of gender-based violence: women in distress, which includes any woman who has or is experiencing psychological, emotional, financial, and/or social crisis or physical harassment. Here, crisis is defined as when a woman’s sense of self or safety is likely to be compromised.

Abstract: in العربية, 中文, Français, Русский and Español at the end of each article.
To inform the direction of the helpline, the GVK Emergency Management Research Institute conducted a survey across three cities in which they intended to pilot services. Together, these cities had a total population of 4,661,804 women in 2011. The survey included 8,935 participants (93%; 8,269 women). Overall, 43% (3,821) had experienced at least one type of harassment: 51% (4,520) verbal harassment, 27% (2,378) physical assault, 17% (1,529) sexual assault and 27% (2,438) stalking. The majority of respondents did not call the police when experiencing harassment (80%; 7,146) and almost all respondents (95%; 8,511) wanted an additional agency for gender-based violence-related support. Moreover, participants desired a range of services, such as counselling, police-assisted rescue and legal aid.

The helpline’s central operations were based in the GVK Emergency Management Research Institute’s call centre. The collaborators recruited women with education and experience in social work to become response officers for the helpline. To prepare response officers to answer calls and respond to callers’ concerns, the collaborators jointly developed a month long training course. After successful training, a team of 32 female response officers were hired to keep the helpline staffed 24 hours a day, seven days a week.

The collaborators developed specific protocols for the response officer when answering calls. First, response officers triage calls. The protocols outline specific actions based on (i) the call’s concern; (ii) the caller’s safety and the urgency of the concern; and (iii) the parameters of established governmental and NGO resources. Second, if the caller’s needs cannot be quickly met or if the call is emergent, then the call is transferred to a counsellor. Counsellors are the same aforementioned response officers, but acting in a specific role wherein they have more time to provide in-depth counselling and interventions to the woman calling. Response officers and counsellors, each independently classify every caller’s primary concern according to a predefined list of 55 concerns.

Response officers use the infrastructure of the call centre to connect women via phone directly to NGOs and governmental partners. Using the call centre technology, they are able to stay on the line with the caller to ensure that women obtain the help they need. Occasionally, response officers are unable to connect women to appropriate resources. If this occurs when a woman is in an emergent circumstance, then they may use escalation protocols. These protocols involve state level officers, within the home department and the women and child development department, who ensure that women receive the help they need.

In two of the cities and one district the helpline piloted rescue services. The rescue services consisted of a specifically designated van, driver, female police constable from the home department and a field response officer from the helpline. The team provided on-site counselling, mediation and rescue services. Via the helpline, callers could either directly ask for on-scene rescue services or counsellors could recommend the service to the caller.

All services, whether provided on the phone or in the field, are explained by response officers and counsellors and they require a caller’s verbal informed consent to proceed. A woman’s right to privacy is paramount throughout the process. Data from calls are stored on a central server, only accessible by helpline staff.

Outcome

The helpline was launched on 4 February 2014. A review of its first 10 months of operation demonstrated that the helpline reached women in distress. During this period, it received 9,767 calls. Most callers identified themselves as women (8,654). Many were married (5,161) and 5,479 called on their own behalf. The median age was 30 years (interquartile range: 24–38). Although the helpline targeted women, men made 364 calls on behalf of others and 304 calls on their own behalf; 301 did not identify who they were calling for. The caller’s primary concern, as classified by the response officer and the counsellor independent of each other, fell into one of six major categories: violence against women; sexual vulnerability; mental health; sexual, reproductive and family health; information; and others (Fig. 1). Overall, 79% (7,694) of calls required an intervention beyond information alone (Table 1).

Despite limited poster advertisements, the helpline received calls from all districts in Gujarat. The highest call volume (7,245) came from the five most urban districts in Gujarat, while the lowest call volume (194) came from the six most rural districts. There could be several reasons for this, including a lack of marketing and less dense signage in more rural areas. Telephone coverage has not been a major obstacle in rural locations for GVK Emergency Management Research Institute’s emergency medical service operations, which uses the same infrastructure.

In March 2015, using the existing emergency response infrastructure, rescue services were expanded across Gujarat with 43 vans. An additional 110 response officers were hired to staff the expansion. In the subsequent nine months, helpline call volume increased, resulting in 73,238 helpline calls. Since the launch, the
helped by extending the length of the call and adding a call transfer. An estimated 727 calls were dropped in transfers between response officers and counsellors. Once staffing better matches call volume, the helpline plans to move away from the current triage system to decrease the number of dropped calls.

Next steps

This paper demonstrates the feasibility of a multisectoral collaboration to leverage existing resources to connect women to available gender-based violence services. More work is needed to demonstrate the impact of 181 Abhayam on women’s ability to obtain services they are connected with, as well as the longer-term impact on their own health and behaviours. The collaborators are working to strengthen their follow-up process to be able to track outcomes, such as successful linkages to services and women’s experience with the helpline. This data will guide efforts to improve and expand services offered across the social service and public health sectors.

The key components of the 181 Abhayam model exist in at least the 15 Indian states where the GVK Emergency Management Research Institute operates, including the same emergency response infrastructure, state-level women and child development departments and home departments. The states also have the same national mandate to staff a 181 helpline. As in Gujarat, states will need a central leader who can bring this infrastructure and key stakeholders together to create a shared vision and to launch a multisectoral model that helps women who experience gender-based violence.

Competing interests: None declared.
Utilisation d'une infrastructure de réponse d'urgence pour venir en aide aux femmes victimes de violences sexistes dans le Gujarat, en Inde

Problème Nombre de femmes victimes de violences sexistes ne cherchent aucune aide formelle, car elles ne se sentent pas suffisamment en sécurité ou ne sont pas sûres que leur démarche leur permettra réellement d'obtenir de l'aide.

Approche Dans le Gujarat, en Inde, un partenariat entre les secteurs public, privé et universitaire a instauré un numéro d'appel gratuit baptisé 181 Abhayam — un service d'assistance téléphonique gratuit pour femmes victimes de violences sexistes. Ce partenariat s'est basé sur une infrastructure existante de réponse d'urgence pour mettre en lien les femmes avec un service d'assistance par téléphone, les organisations non gouvernementales (ONG) et les programmes gouvernementaux.

Environnement local En Inde, la prévalence sur la vie entière des violences à l'égard des femmes est de 37,2 %. Or, moins de 1 % des femmes cherchent à obtenir de l'aide en dehors du cercle de leur famille ou de leurs amis. Avant l'instauration de ce service téléphonique, il n'existait aucun numéro d'appel gratuit ni aucun système centralisé de coordination pour les programmes gouvernementaux, les ONG et les services de réponse d'urgence.

Changes signifiants Cette ligne téléphonique a été lancée en février 2014 dans l'état du Gujarat. Au cours des 10 premiers mois, ce service d'assistance téléphonique a été en aide à 9 767 personnes, dont 8 654 femmes. Sur la totalité des appels, 79 % (7 694) ont nécessité une intervention par téléphone ou en personne le jour de l'appel, et 43 % des appels (4 190) ont été réalisés par ou pour des femmes victimes de violences.

Leçons tirées Même si les données jusqu'alors disponibles montrent que les femmes victimes de violences sexistes ne cherchent que rarement de l'aide auprès d'interlocuteurs officiels, dans le Gujarat, les femmes ont réellement utilisé cette ligne téléphonique pour évoquer un grand nombre de problèmes, sur tout le spectre des violences faites aux femmes. Néanmoins, pour évaluer l'impact de cette ligne téléphonique, les définitions effectives des catégories de problèmes doivent être clarifiées. Le système de triage initial des appels entrants a été bénéfique pour traiter de gros volumes d'appels, mais il a peut-être contribué à la coupure de certaines communications.
Резюме
Использование инфраструктуры службы чрезвычайного реагирования для помощи женщинам, подвергающимся гендерному насилию, в штате Гуджарат, Индия

Проблема Многие женщины, подвергающиеся гендерному насилию, никогда не обращаются за какой-либо организованной помощью, поскольку не чувствуют себя в безопасности или не уверены, что получат помощь, если попытаются обратиться за ней.

Подход В рамках партнерства между государственными, частными и академическими учреждениями в штате Гуджарат, Индия, была создана специальная линия под названием «181 Abhayam» (181 Абхайам) для предоставления информации и оказания помощи женщинам, подвергающимся гендерному насилию, с бесплатным телефонным номером. Партнерство использовало существующую инфраструктуру службы чрезвычайного реагирования в качестве промежуточного звена между женщинами и службами телефонного консультирования, неправительственными организациями (НПО) и государственными программами.

Местные условия В Индии гендерному насилию подвергаются 37,2% женщин, но менее 1% из них обращается за помощью к кому-либо вне своего близкого окружения (членов семьи или друзей). До внедрения специальной линии отсутствовали какие-либо подобные службы с бесплатным телефонным номером или централизованные системы координации для государственных программ, НПО и службы чрезвычайного реагирования.

Осуществленные перемены В феврале 2014 года была запущена специальная линия для предоставления информации и оказания помощи во всем штате Гуджарат. В первые 10 месяцев благодаря этой специальной линии была оказана помощь 9767 лицам, 8654 из которых были женщинами. 79% (7694) из числа всех звонивших потребовалось вмешательство по телефону или личная встреча в день звонка, в 43% (4190) случаев звонки были совершены женщинами, подвергающимися насилию, или от их имени.

Выводы Хотя полученные ранее данные свидетельствовали о том, что женщины, подвергающиеся гендерному насилию, редко обращаются за помощью к официальные органы, жительницы штата Гуджарат в действительности использовали специальную телефонную линию для решения разнообразных проблем, связанных с гендерным насилием. Тем не менее для оценки влияния специальной линии для предоставления информации и оказания помощи необходимо дополнительно уточнить рабочие определения категорий проблем. Первоначальная система фильтрации входящих звонков позволила успешно обрабатывать значительные объемы звонков, но также могла привести к увеличению числа сброшенных вызовов.

References
1. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and nonpartner sexual violence. Geneva: World Health Organization, 2013.
2. Declaration on the elimination of violence against women. New York: UN General Assembly, 1993.
3. Campbell JC. Health consequences of intimate partner violence. Lancet. 2002 Apr 13;359(9314):1331–6. doi: http://dx.doi.org/10.1016/S0140-6736(02)08336-8 PMID: 11965295.
4. Sugg N. Intimate partner violence: prevalence, health consequences, and intervention. Med Clin North Am. 2015 May;99(3):629–49. doi: http://dx.doi.org/10.1016/j.mcna.2015.01.012 PMID: 25841604.
5. Weiss HA, Patel V, West B, Peeling RW, Kirkwood BR, Mabey D. Spousal sexual violence and poverty are risk factors for sexually transmitted infections in women: a longitudinal study of women in Goa, India. Sex Transm Infect. 2008 Apr;84(2):133–9. doi: http://dx.doi.org/10.1136/sti.2007.026039 PMID: 17942576.
6. Murphy CC, Schei B, Myhr TL, Du Mont J. Abuse: a risk factor for low birth weight? A systematic review and meta-analysis. CMAJ. 2001 May 29;164(11):1567–72. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&st_uid=11402794&dopt=Abstract PMID: 11402794.
7. Devries KM, Mak J, Bachrchi LJ, Child JC, Falder G, Petzold M, et al. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. PLoS Med. 2013;10(5):e1001439. doi: http://dx.doi.org/10.1371/journal.pmed.1001439 PMID: 23671407.
8. Coker AL, Davis KE, Arias I, Desai S, Sanderson M, Brandt HM, et al. Physical and mental health effects of intimate partner violence for men and women. Am J Prev Med. 2002 Nov;23(4):260–8. doi: http://dx.doi.org/10.1016/S0749-3797(02)00514-7 PMID: 12406480.
9. National Family Health Survey (NFHS-3), 2005–06: India [volume 1]. Mumbai: International Institute for Population Sciences (IIPS) and Macro International, 2007.
10. Palermo T, Black J, Peterman A. Tip of the iceberg: reporting and gender-based violence in developing countries. Am J Epidemiol. 2014 Mar 1;179(5):602–12. doi: http://dx.doi.org/10.1093/aje/kwt295 PMID: 24335278.