

# Not just hotlines and mobile phones: GBV Service provision during COVID-19

By Dorcas Erskine<sup>1</sup>

This note provides a few ideas to a challenging problem of reaching survivors who cannot easily access phone-based GBV support. It is very much a living document given the evolving nature of the pandemic and may be adapted as more evidence, insights and lessons become available. It is intended to spark conversation in the hope that additional contributions and innovations from others will result.

## Introduction

As countries across the globe struggle to manage the COVID-19 pandemic, concerns are being raised about the effect of the pandemic on Gender Based Violence (GBV) in all countries affected by the COVID-19 pandemic. A few of these concerns include:

## Pandemic control measures are increasing vulnerability to GBV

Extended quarantine, and other physical distancing measures enacted to manage the pandemic, are feared to have increased vulnerability to GBV<sup>2</sup>. Pre-existing gender inequalities and harmful norms, have combined with an increased exposure to abusers at home and economic shocks to create a potent mix for violence to thrive. An increase in reported incidents of intimate partner violence, have been reported in almost all countries affected by the pandemic.

## Investment in GBV support services

Questions remain as to whether governments in their national COVID-19 strategies have considered the allocation of adequate resources for women and girls fleeing violence – including those who may be seeking alternative safe shelter away from home. Many GBV service providers found securing resources pre-pandemic challenging. With the public health crisis necessitating increased investment in healthcare, there is a risk that funding for GBV life-saving support (including clinical management of rape, reproductive health and shelter services) - may be deprioritized<sup>3</sup> or diverted, at a time when they are most needed. Additionally, fear of infection, and rising public demand for medical care, may potentially make accessing GBV support services (where they are integrated and are permitted to operate) in a healthcare setting difficult.

## Purpose of the brief

This note sets out a number of alternative entry points for providing survivors with **non-phone, low/no tech** options to alert trustworthy stakeholders of their need for GBV services given the restrictions on movement as a result of COVID-19. It also provides ideas for linking such 'alert systems' with remote GBV support providers. Consideration is also given to other ways mobile phones can be used to support survivors - who do own, or have access to mobile phones, but cannot use them to dial, chat or text for support because of abuser surveillance. **'No-dial or chat'** phone options that can operate even when offline are outlined here as a resource for those contexts where it is applicable and appropriate. The note will also provide suggestions of where GBV support services can be safely integrated, beyond traditional integration points such as healthcare settings.

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<sup>2</sup> Fraser E, VAWG Helpdesk, Impact of COVID-19 pandemic on violence against women and girls March 2020

<sup>3</sup> CARE, Gender implications of COVID-19 outbreaks in development and humanitarian settings, Policy Brief, March 2020

## GBV services lack necessary permissions to operate

A combination of pandemic restrictions and a lack of recognition that GBV services are essential services that must be integrated into actors' responses, or permitted to operate as a standalone service;- has meant most GBV services have, or will have to, suspend face to face services. These issues present GBV service providers with an acute, two-fold problem: **how to know survivors** need help, including those in imminent danger of injury and harm; and **how to get support to survivors** if services are disrupted? Most services are transitioning to phone, internet, or SMS based services to address both problems. This includes ultimately making adjustments to deliver slimmed down, GBV Case Management services - such as facilitating referrals to healthcare and other providers that are permitted to operate, offering emotional support and undertaking enhanced safety planning with survivors. These solutions however do not work for all survivors.

## How to reach survivors who have no access to a mobile phone?

The increasing heavy reliance on the use of phone, internet and email services, raises a number of concerns and dilemmas. Such modalities depend on a number of safety conditions that pandemic control measures may be closing off for survivors – including, waiting to be by themselves to seek help from a hotline, secretly seeking support from friends/ community members, or seeking support from specialist services. While mobile phone ownership and access has increased globally, particularly in low income settings, women are still less likely than men to own a phone. It is estimated that there are 443 million “unconnected”<sup>4</sup> adult women in the world. Figures for adolescent girls in some contexts are likely to be much higher. Adolescent girls, including those with disabilities face particular risks and vulnerabilities for which phone/internet/SMS based services alone may not be able to address.<sup>5</sup> Additionally, insufficient attention has been given to the fact that even if survivors have access to a phone, they may find using them, in a situation of confinement and close monitoring by abusers at home, challenging and very unsafe. This is an issue that a number of service providers in some contexts are beginning to highlight. While there has been considerable media attention to a surge in calls received by crisis lines in various parts of the world, some providers are also reporting a dramatic drop in calls- raising fears that survivors in need are not able to safely call for help and support.<sup>6</sup> Additionally, not all hotlines services are free to dial- making having sufficient phone credit necessary to make such calls - a key barrier for the economically insecure.

## Not all GBV providers have the resources to transition to phone based support

A lack of funds and hardware are also barriers for a number of GBV providers. Simply not all can afford to transition or have the infrastructure to do so. Additionally, issues of confidentiality are paramount. Due to restrictions in movement, calls will most likely in many cases have to be managed from a caseworkers' home where privacy and confidentiality cannot be assured. This is particularly an issue for caseworkers who are refugees themselves and reside in camp settings. The net effect will be much reduced availability of services just when they are needed the most by GBV survivors in confinement. It is becoming clear that an over-reliance on any one system of support for reaching GBV survivors, is a strategy that must be avoided at all costs. The establishment of hotlines, internet, SMS services, and/the migration of GBV from face to face to remote mobile phone solutions are an important solution that must continue and see investment. These modalities however must not be the only service modality or be seen as a be-all solution. Alternative solutions must be found to safely complement hotline/remote services and to expand provision to survivors, who, for whatever reason, cannot access services delivered through the aforementioned means. It is also

### Enhanced safety planning

Regardless of the model(s) chosen in each context, it is clear that service providers will need to urgently update safety planning processes with survivors. Enhanced focus on managing personal safety during a period of potential prolonged confinement is essential. Attention to topics on keeping safe during a situation of escalation, creating safe zones in the home, avoiding being in rooms with weapons etc. in particular –are an urgent priority.

<sup>4</sup> CARE & IRC, Global Rapid Gender Analysis for COVID-19, March, 2020

<sup>5</sup> Please see upcoming UNICEF and IRC Guidance on GBV programme adaptation for Adolescent girls. See also Pearce E, GBV Helpdesk report Disability Considerations in GBV Programming during the COVID-19 Pandemic, March 2020

<sup>6</sup> <https://www.cnn.com/2020/03/31/new-york-coronavirus-domestic-violence-programs-see-decline-as-disease-spreads.html> see also <https://www.nytimes.com/2020/04/17/nyregion/new-york-city-domestic-violence-coronavirus.html> Conversations with practitioners in some low income settings for this brief also noted this trend in some services.

essential, in line with interagency guidelines that GBV service providers are considered as providing an essential and life-saving service that must continue throughout the course of the pandemic. Providers must be given the necessary protective equipment, integration support, and resources needed in order to deliver such services wherever possible.

## Emerging solutions and alternative options

Some of the models described in this note are emerging due to the pandemic, but others are not in fact, new. They are drawn from existing services – including those pioneered by local women’s organizations and human rights activists in operation, pre-pandemic, in various high and low-income settings. Lessons can also be drawn from other sectors like commercial and security operations – including those seeking to keep lone workers safe in hostile environments. **Nonetheless, it is important to accept that as yet, there is not one clear or easy solution that will work for all survivors, in all contexts.** Additionally, a system that enables a survivor to alert others for support without a follow up service to respond to that need, is of limited, or no utility. Both aspects

### Risk of perpetrator backlash

Any system adopted will inherently include risks of perpetrator backlash for survivors. This is particularly true if survivors are seeking urgent support to prevent imminent physical injury and may require security support. Given the challenges in some contexts of access to trusted security actors and the limited ability of such actors to provide on-going security (such services are likely to be stretched during the pandemic); the risk of perpetrator backlash and the ability to manage such backlash should be carefully considered when designing an alert and support model.

are needed - a safe system of alert and the existence of services themselves, that should be permitted to operate in some remote or integrated form at the very least. The first stage of ensuring survivors can access support, is to design a system and process through which they can safely request help without their abusers knowing, and that is not dependent on their ability to own a phone. As mentioned such alert systems must be linked to GBV service provision. Some emerging field solutions include:

**Adapting existing physical safe spaces for women and girls into GBV phone booth stations** where phone-based case management support can be given. This may be the most minimally disruptive and cost-effective solution for both providers and survivors in some settings. This model is being enacted by an INGO in North East Nigeria. Existing safe spaces have been equipped with a series of simply constructed private, phone booths/stalls where survivors can call GBV case workers who are on standby at set times and receive support. Infection Prevention Control (IPC) protocols including social distancing policies are enacted - with only 5 survivors permitted in the centre at any one time. There are no staff physically present- only one safe space volunteer available to help with any technological issues and to ensure hygiene management of the mobile phones in the booth. This solution is reliant on providers having; (1) the space to

requisition in the first place, (2) permissions from authorities permitting the service to operate, and if replicated elsewhere, (3) consideration around the scope of movement restrictions that may hinder survivors’ ability to access the centre. If the latter two factors are a barrier; particularly if a GBV provider’s safe space is outside the permitted distance limits for movement set by national authorities; consideration can be given to scoping whether it is possible to place such ‘phone booth’ services in or near, other premises that are permitted to operate (see more on this later in the note). In any case, coordinating opening times of the service with times survivors are likely, or permitted (if there are curfews in place or if they are under close surveillance by abusers) to be out of their homes shopping for food, or queuing for distributions (e.g. in some camp settings) etc. will be necessary.

**Create entry points and systems survivors can access or can signal a need for support** – a number of solutions are emerging to provide entry points for survivors to signal they need support. Such solutions must also include safeguards to ensure that support can be activated without abusers being aware. Emerging approaches are taking two forms:

### Be aware

Any system adopted will require careful planning of the alert system and its dissemination/promotion. An approach that balances reaching the largest number of survivors, against the risk of perpetrators being able to use knowledge of system to hinder survivor access to it.

- 1. GBV Service Integration** – a general women and girls’ helpdesk is set up in permitted areas or open services - e.g. pharmacies, grocery shops/food markets/food distribution points/ water pump stations etc. where survivors can alert outreach GBV workers for support; or if privacy and security can be assured at or near the premises, access direct crisis GBV support and referrals from GBV providers at the premises.
- 2. Survivors can activate an ‘alert chain’ for support at permitted premises.** This is a popular solution proposed by governments and some women’s rights organizations in high income countries (e.g. Spain and France). In this model, a survivor can approach a proprietor of the selected arena - e.g. pharmacist, shop assistant/shopkeeper/ grocer, and make a request for assistance through disclosure or a code word - which in turn signals to the proprietor that a referral for expert support and protection should be made to a GBV service provider or police services if the survivor is in imminent danger. While in use in high income settings, the principles may be transferable in some low income and humanitarian settings, but it requires some form of ongoing GBV support infrastructure to be in place to be effective. See box 1 for an example of how this perhaps could work in a humanitarian setting. Well mapped entry points and relationships with trusted community stakeholders who are permitted to operate during the pandemic are essential. Table 1 outlines a number of the key questions that must be considered, resources needed and limitations to consider.

**Box 1. Low tech signal alerts – what could this look like in a humanitarian/low income setting?  
E.g. Refugee settings**

An alert object (e.g. a coloured cloth) could be included in dignity kits that women and girls receive if distributions are continuing. They are told during distribution of kits that wearing the cloth on their person, when they access an alert premises or service, will activate an alert for support. E.g. if they are waiting in a food distribution line, water pump etc. and have cloth visible on their person, a referral by a provider managing the service they are accessing, can be made to GBV support services - i.e. if services are not already integrated at premises. If food distributions are operated through voucher schemes redeemable at independent retailers; wherever possible in such premises attempts should be made to include the presence of women and girls help desks where GBV outreach workers can directly interact with survivors. However, if not possible, a phone booth system for support can be established within the premises (or nearby). If a retailer is assessed as trustworthy, privacy can be assured, and inserting a booth is not an option, such retailers can be provided with a phone linked to GBV providers to give to survivors wearing alert objects. In this way, arrangements can be made between the survivor and service about the most appropriate means to safely, and privately, provide support at a time and place convenient and safe for the survivor. This could include encouraging survivors to access face to face services wherever they may still be situated (e.g. in healthcare setting, or other entry points), or connecting survivors to a key community worker/women’s organisation that may hold a ‘community phone’ from which phone based GBV services can be delivered in a safe location the survivor can access when next permitted to venture outside home.

**Key questions**

1. What is my service signal alert? If time permits prior consultation with women and girls is always best to decide a suitable alert.
2. If it is an object, how will it be distributed and its purpose communicated (safely) to women? – In the example above alert object is a coloured cloth, distributed through camp dignity kits distributions or food distribution (if single sex) or at water pump stations. In other non-camp or higher income contexts, general ‘free give aways’ – at a women and girls helpdesk pharmacy etc.

**Low or no tech alert systems**

Given the possibility of heightened surveillance, survivors with limited access to phones or those who do possess them, or those in imminent danger of injury and harm, need multiple options to alert trusted contacts, police and service providers. A number of solutions for such ‘silent/non-verbal alerts’ have been developed by women’s organisations, security operations and human rights activists over time that can perhaps be replicated and modified. These ‘alerts’ can take various forms in different contexts depending on resources, cultural norms and safety. Code words, whistles/alarms, placing innocuous objects outside the home e.g. a certain coloured cloth/bucket etc. are the mainstay of such systems. These models are intended to enable survivors to alert local women’s organisations/key community members for support. See box 1 above on how such a system could work

in a humanitarian context and box 2 below on considerations needed to design such a system when survivors are able to move to permitted points. Below, discussion is also given to how such alerts may potentially also be used by survivors in imminent danger, or those who cannot readily access even permitted service points.

## **Box 2.** Key questions to consider when adapting services and creating GBV-alert systems during COVID-19

**Where are women and girls still permitted to go and at what times?** In refugee camp settings for example, mapping of core essential actors (beyond health) and knowledge of service structure is crucial for ascertaining potential entry points. E.g.

- What, when and where are the planned distribution activities for essential goods in the camp? What water points, latrines, market places or other spaces are women/girls accessing?
- Are health services not associated with COVID-19 operating including maternal and reproductive health services that could serve as entry points?
- Are there provisions for the distributions to be single sex - so awareness of the alert system and services available communicated only to women and girls?
- Are GBV providers permitted to provide such information during distribution? If no, what ways can the system and service be communicated?
- Is it possible to provide rapid training/awareness to non GBV frontline workers still permitted to operate who are conducting distributions?
- If distributions are done through verified independent local contractors – who are these contractors and are they trustworthy (see point 2)?
- Do I have the necessary permissions to adapt my existing safe spaces into a phone booth service?
- Do I have the resources to adapt the space? Can I ask for a donor realignment to fund adaptation?

### **Who is the most trustworthy person at places where survivors can still access?**

Trustworthy attributes include persons/areas where the following can be secured or enhanced – Confidentiality, Safety and/access to security, Non-judgement, proprietor holds community/official influence and permissions to operate during pandemic etc.

### **Will GBV providers be allowed to include an outreach contact in permitted premises and/or during permitted outreach activities?**

- If so how easy will it be to disguise as a general service for women and girls? And how will the alert service be promoted? (see below for further guidance on this)
- Does my service have the necessary contacts, resources, security arrangements permissions and relationships to make a referral alert system work?
- How can I ensure the safety of my staff both from potential perpetrators and infection? E.g. through security partnerships, IPC protocols, rotation of case workers etc.

### **Which non- GBV actors will be permitted to patrol or move around the community?**

- If GBV outreach integration is not possible, will it be possible to provide rapid GBV training/awareness to such actors?
- Are such actors trustworthy (see point 2) particularly if signal alert system is known to them?
- Does my service have the necessary contacts, resources, security arrangements, permissions and relationships to make a referral alert system work with these actors?

A key feature of effective low tech alerts, is that the modality is often not widely known beyond survivors at risk and the support organisation or through 'link officials' or community members who are aware of the alert, and can alert providers of a need for support. The support organisation may itself be a GBV provider or have the capability to refer survivors to a provider. This system may be useful for providers to consider if they have survivors at high risk of injury and harm on their caseload and are concerned about their ability to access support when in active danger. When used in this particular way with high risk cases, this system can only work within the strictures of COVID-19 if; (1) trusted officials and essential 'link' services/stakeholders who are permitted to operate during the course of the pandemic are aware of the signal, (2) some form of security support (official or community based support) is available, and (3) 'link' officials that can alert the appropriate GBV and police services (if requested by a survivor). This model may be possible in a number of contexts for example where authorities have engaged women's groups and volunteers to walk through communities and disseminate messages on COVID-19. Where women's groups with known survivor centred attitudes and norms are engaged in such activities, they should be considered as primary actors to engage in the alert system. Other permitted stakeholders could include trusted

WASH and other essential service actors- and with careful, context consideration and survivor consent, security patrols and police. All will have to receive speedy training and awareness on GBV.

Once 'alert referrals' are received from such stakeholders, onward GBV service provision is likely to also still be remote unless there is pre-existing integration in healthcare settings or a designated entry point. If remote services are all that can be provided, a phone device will be needed for 'link' officials/frontline workers to alert GBV providers if they observe an alert object outside a high risk survivor's home or on a survivor's person. Where the alert object is wearable and the issue is just of safe access to a phone where the survivor will be minimally observed, the 'link official' can facilitate this process by connecting the survivor with the remote GBV provider who in turn can arrange with survivor to visit an integrated service or arrange a way in which remote phone case management can be given. In terms of high risk cases where an alert object is placed outside a home as a crisis sign for support because of imminent danger, considerations will be different. This system depends on prior consent and approvals with survivors at high risk known to current service providers. The system will need the necessary security referrals, whether community based or official to support the survivor at imminent risk. Not all providers can provide such options and context specific conditions make such solutions unsafe not only for the survivor but also for 'link workers'. Careful consideration of all possible security and confidentiality aspects must be considered when designing such a system. Box 2 provides a short checklist of questions to consider.

**Safe, alternative 'high' technology driven solutions that can be used in some low income settings for women at very high risk.** In some contexts and circumstances where heightened surveillance by abusers in confinement exists, the issue may not be mobile phone ownership per se, but the ability of a survivor to use their device **to call** support services/hotline or trusted personal support systems. GBV providers should consider the use of a wide array of applications that enable survivors to use their devices (even when offline) to 'silently ask' for support without alerting abusers. Other alternatives include investment in small, discreet wearable devices which when pressed, send support alerts to pre-programmed service providers and/trusted personal contacts. An example of the former includes 'Chilla' an app designed in India which on 'hearing' a survivor scream, alerts pre-programmed trusted support services and personal contacts. Some alert systems on a phone will silently activate support signals if shaken etc. There are also a number of discrete GPS wearable devices that can operate as a more sophisticated version of traditional panic/rape alarm systems, which when pressed send a silent alert for support to the phones of providers and key contacts. These 'wearables' may be an option to distribute to a small number of survivors who are already known to providers as living in situations of high risk. As they work through GPS, these small wearable devices can work in a variety of geographical contexts and were to an extent, pioneered by the security sector to provide support to commercial firms operating in high risk environments in which their staff are at risk of attack, kidnap or accidents. Such devices have found their way into the mass market and come in various forms and relatively low price points as a result. Despite the increased affordability of such options, most programmes in low income settings, if they can still procure such items at all, would only be able to procure a few - which then perhaps should be considered for those survivors in the case load whom are known to be at potential high risk of injury and have limited options for alternative shelter or security. Additionally, given increased donor interest in investing in hotlines and distributing mobile phones during COVID-19, this solution should also where appropriate, be considered as an investment or an area of realignment for services who are looking to adapt budgeted activities to address COVID-19. Regardless of the alert model or service adaptation chosen, there are a number of key questions to consider when designing an alert system and linkages to support provision during COVID-19. These have been summarised in box 2 and Table 1.

**Table 1 below** further outlines the features, conditions and resources needed to enact each model and their limitations. Limitations including; issues of general population wealth, connectivity, pandemic control restrictions, security, donor flexibility-(in permitting support services to realign activities to resource alternative solutions); - and the ability of a GBV provider to adapt to the new operating conditions are all noted. UNICEF and IRC guidance on further adapting GBV programming to address the particular vulnerabilities of adolescent girls is also forthcoming. In addition, more detailed consideration of the needs of women and girls with disabilities can be found in the GBV Helpdesk report 'Disability Considerations in GBV Programming during the COVID-19 Pandemic' (Pearce, March 2020). This note is a living document, given the evolving nature of the pandemic, it may be adapted as more evidence relating to GBV and COVID-19 becomes available. It is intended to spark conversation in the hope that additional contributions and innovations from women's organizations, GBV practitioners and other organizations will result.

**Table 1: Alternative alert and support systems for supporting survivors of GBV**

Model	GBV Alert entry points	Signal alert systems
Description	<p>Mapping exercise to ascertain the areas/arenas in which women are most likely to access, so an alert for support and assistance can be made safely without alerting the abuser</p>	<p>'silent/non- verbal alerts' can be made to signal that a survivor requires assistance. This can be combined with the GBV alert entry point model and requires a strong GBV referral pathway. It can take various forms in different contexts depending on resources, cultural norms and safety.</p>
Examples/features of the model	<p><u>Caseworker Integration</u> – general women and girls' helpdesk in pharmacies, grocery shops/open markets where survivors can access direct support from GBV providers.</p> <p><u>Activating an alert chain for support</u> – in this model, a survivor can approach a proprietor of the arena- e.g. pharmacist, shop assistant/Shopkeeper/ grocer etc. and make a request for assistance through disclosure or a code word, or wearing a certain object (see signal alert system conditions below)- which in turn signals to the proprietor that a referral for expert support and protection should be made.</p>	<p><u>Code words, silent alarms, placing innocuous objects outside the home</u> (a cloth/bucket or wearing a colour coded cloth to a GBV entry point where support can be provided or referred)- these models are intended to enable survivors alert local women's organisations/key community members for support who often devise the alert modality. In this model, the alert modality is not widely known beyond survivors at risk and the support organisation. The support organisation may itself be a GBV provider or have the capability to refer survivors to a provider.</p> <p>Silent alert numbers –request for assistance is made by the survivor dialling a designated number that is often linked to a police/provider hotline for GBV support. No communication is needed by the survivor. Often used as an emergency service model for survivors to use in live, active abusive situation where immediate security support/'safety check in' is needed to stop the abuse and protect themselves and others from further harm and injury.</p>
Challenges	<p><u>Security</u> - alert chain model requires system and code words (if used) to be widely known to reach largest number of vulnerable survivors. However, wide dissemination not only informs survivors but potentially abusers too, about the process.</p> <p><u>Strong dependence on community stakeholders</u> - requires trust that proprietors have survivor centred attitudes and /or training/guidance can be provided at speed to ensure they do- so safety, confidentiality and other rights of the survivor are maintained.</p> <p><u>Potentially resource intensive</u> - requires investment in a referral process, structured guidance and support to stakeholders not usually versant in such issues. It may also require support and collaboration with police to ensure safety of all or investment in security support/process where official agencies may be non-existent, or trust in them may be lacking.</p>	<p><u>Resources</u> - if intended to dispatch immediate lifesaving security or prevent further injury, the silent phone system alerts require precise location tracking abilities on the survivors' phone device. Phones without this facility can be tracked but not with precise location accuracy. The silent phone alert systems linked to police services also require that security stakeholders have the ability, permissions and resources firstly, to do such tracking, and secondly, deploy rapid support in a survivor centred form. While mobile phone ownership is widespread in low income settings, and smartphone use is growing, it is not a model that will work for all women. While many signal alerts apps may be free or low cost, they do require a smartphone device. Wearable devices may be less reliant on in hand mobile devices but can be a resource intensive depending on the model chosen. Where possible and partnership exists, consideration of using existing procurement channels/ collaboration with humanitarian agencies for the rapid procurement of these devices may be an option to discuss.</p> <p><u>Trust</u> – if used to prevent physical injury the silent call system requires a high level of trust in police and security services, their data privacy processes, and ability to uphold survivor centred attitudes</p> <p><u>Scale</u> - while the community signal model may work well in within defined contexts and spaces, (and is particular valuable in remote communities or where official assistance is non-existent), without considered adaptation, it is not an option that can be widely promoted for all for reasons of security, thereby limiting the numbers of survivors that can be reached by this modality alone. Some signals/alarms may not be appropriate to use during a live act of violence in particular.</p> <p><u>Security</u> – with the silent alert number, a survivor must still be able to dial for assistance and not alert the abuser that they are doing so. A challenging feat in a situation of close monitoring by the perpetrator or in a context of live abuse.</p>

	GBV Alert entry points	Signal alert systems
Resources/conditions needed to enact model	<p><b>Caseworker Integration model</b></p> <ul style="list-style-type: none"> <li>• Best practice - helpdesks must be disguised as general support services and not advertised directly as a GBV support service.</li> <li>• Security arrangements should be in place.</li> <li>• Updated referral pathways including- emergency shelter provision/ security options should be made available wherever possible in case of survivor request and need.</li> </ul> <p><b>Activating an alert chain for support</b></p> <ul style="list-style-type: none"> <li>• Careful screening, selection, training of community proprietors</li> <li>• Clear and highly responsive GBV referral pathway must be in place- emergency shelter provision/ security options should be made available wherever possible.</li> <li>• Security arrangements should be in place in case- to protect all- investment in rapid security deployment/monitoring wherever possible.</li> <li>• Contextual risk assessment undertaken which balances need for large numbers of avenues of support included in an alert chain, against ensuring the system can uphold minimum safety and confidentiality standards.</li> <li>• Careful planning of the placement and dissemination/promotion of service that balances reaching the largest number of survivors, against risk of perpetrators being able to use knowledge of system to further hinder survivors access to it.</li> </ul>	<p><b>Silent alert systems</b></p> <ul style="list-style-type: none"> <li>• Careful screening, selection, training of police officers/other key workers managing the service.</li> <li>• Clear and highly responsive GBV referral pathway must be in place- including immediate referral to expert providers, ensuring emergency shelter provision/security options should be made available wherever possible.</li> <li>• Survivors must not be compelled to make a criminal complaint against their abuser as a conditionality for continued support if service is paired with police or official security services.</li> <li>• Careful planning of the placement and dissemination/ promotion of service that balances reaching the largest number of survivors, against risk of perpetrators being able to use knowledge of system to further hinder survivors access to it. An example may be to promote the system to women and girls when doing female only distributions of items such as food or dignity kits. This could include placing the 'alert object' in established distribution chain and/or in dignity kits.</li> <li>• Strong data protection and privacy policy and processes</li> <li>• 'Community circles'- must be established with trusted community members known to survivors 'or link officials' if using the low tech silent alarm system of placing alert objects outside the home etc. During confinement these may be members and officials permitted to move relatively freely in order to notice the alert and make referrals for support.</li> <li>• What kind of silent alert objects can I consider? If time and resources allow- this question is best answered through quick consultation with women and girls in the community.</li> <li>• Is it possible to seek permission to include GBV outreach workers in community monitoring patrols to monitor (but not enter homes) to ascertain whether signal alerts have been placed outside homes of known (to GBV provider alone) high risk survivors in particular?</li> </ul>

# Resources

## **GBV service entry points and alert systems:**

Pop-up counselling centres in grocery stores in France

<https://www.france24.com/en/20200330-france-to-put-domestic-violence-victims-in-hotels-as-numbers-soar-under-coronavirus-lockdown>

Silent solution - UK police

[https://www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/Silent\\_solution\\_guide.pdf](https://www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/Silent_solution_guide.pdf)

Mask -19

<https://www.bbc.com/news/world-europe-52216966>

Regulation exemptions enabling women to leave their homes in case of abuse

<https://www.lanacion.com.ar/sociedad/coronavirus-gobierno-exceptuo-cuarentena-personas-lgttbi-sal-gan-nid2351012>

## **GBV risk mitigation:**

Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response

<https://gbvguidelines.org/cctopic/covid-19/>

## **Resources on GBV Remote Support:**

How to Support Survivors of Gender-Based Violence When a GBV Actor Is Not Available in Your Area: A Step-by-Step Pocket Guide for Humanitarian Practitioners

<https://bit.ly/2WqrT9f>

## **Remote GBV Case Management series in the COVID-19 response**

<http://www.gbvims.com/covid-19/>

Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery

<https://bit.ly/2xKsFUe>

GBV Guidelines Resource Hub

<https://gbvguidelines.org/en/knowledgehub/covid-19>

General GBV integration Guidance

Integrating GBV interventions in humanitarian actions

<https://gbvguidelines.org/en/additional-resources/>

## **Phone and non-phone (GPS enabled) panic button systems:**

Apps - Alternative phone alert solutions that do not require dialling or opening phones

- **VithU App** - The VithU App push your power button twice to instantly send an SOS alert to contacts.
- **I'm Shakti App** - As above when power button is pressed A pre-set emergency SMS will be sent to trusted contacts alongside GPS location.
- **Shake 2 safety** - as above.
- **Chilla** - recognises screams and sends alert to trusted contacts.

## **When the use of panic button apps can cause damage if abusers are aware and/or lack of effective support infrastructure is in place:**

<https://www.duvarenglish.com/women/2019/12/16/use-of-panic-button-app-on-the-rise-among-turkish-women/>

## **Wearable panic buttons:**

Brazil city battles domestic abuse with mobile panic button

<https://edition.cnn.com/2013/11/19/world/americas/brazil-panic-buttons/index.html>

Survivor view of panic buttons

<https://www.telegraph.co.uk/women/life/duchess-cornwall-hails-magic-secret-panic-alarms-domestic-abuse/>