Community-Based GBV Response in Remote Tribal Contexts

Before designing a response, understand the landscape. In Odisha, the official crime rate against women stands at 103.3 per 100,000 — above the national average of 66.4. NFHS-5 data shows 29.3% of married women in Odisha have experienced spousal violence. During COVID-19 lockdown...

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B practice-note Social Justice & Tribal Welfare

Published: April 2026 · Last reviewed: April 2026

Those are the reported and documented figures. The actual prevalence is substantially higher. Under-reporting in tribal communities happens for layered reasons: fear of family stigma; distrust of police who historically treated tribal complainants dismissively or actively dissuaded complaints; cultural frameworks that normalise certain forms of violence as domestic matters; practical inaccessibility of reporting mechanisms; and the economic dependence that makes leaving or reporting financially catastrophic for many women.

A cross-sectional study of GBV among adolescents in central India found tribal adolescents facing particularly high GBV risk — and specifically noted that GBV among tribal youth was more prevalent in workplaces and institutions than at home, meaning the public/community sphere is not safe even where home might be perceived as protection. This matters for how community response systems are designed: they need to address violence in community, agricultural, and institutional settings, not only intimate partner violence.

The design implication: Do not base your programme's need assessment on official crime statistics. Conduct your own community-level assessment — through women's groups, trusted women leaders, AWWs and ASHAs — to understand the actual texture of violence in the specific communities where you work. The official data will almost always undercount.

Why Formal Systems Don't Reach Remote Tribal Communities

Understanding the specific barriers is the starting point for designing around them.

Geographic distance: The nearest One Stop Centre in most Odisha districts is at the district headquarters. For a woman in an interior block of Malkangiri or Nabarangpur, that is a full day's journey. Accessing it requires: transport money she may not have; permission from the person

who may be the cause of her complaint; knowledge that the OSC exists; and the willingness to navigate a bureaucratic institution in a language she may not speak fluently.

Language: Most formal legal and support systems operate in Odia. Police stations, courts, and legal aid offices conduct their work in Odia. For tribal women speaking Gondi, Kharia, Bonda, or Kui, the language barrier is not a minor inconvenience — it is a structural exclusion from the entire formal protection system.

Police distrust: Multiple studies and field reports document tribal women's experiences of police dismissing domestic violence complaints as "family matters," attempting reconciliation rather than documentation, or — in some documented cases — actively colluding with perpetrators who have community or political connections. A woman who has experienced this response, or knows others who have, will not report to police again.

Documentation requirements: Filing an FIR, accessing legal aid, and pursuing cases through the Protection of Women from Domestic Violence Act all require documentation: Aadhaar, ration card, marriage certificate, medical evidence. Many tribal women in remote areas lack the specific documents required, have never interacted with legal processes, and need support navigating systems that were not designed for them.

Stigma and communal norms: In many tribal communities, reporting violence — particularly sexual violence — is understood as bringing shame on the family, not on the perpetrator. Women who report face the additional burden of social ostracism on top of whatever violence they have already experienced.

The CYSD Model: What Was Built and What It Produced

The most documented community-based GBV response model in tribal Odisha comes from CYSD's work in Boipariguda block of Koraput district, implemented during and after COVID-19 when the physical inaccessibility of formal services was at its most acute.

The core design elements, which are directly transferable:

Element 1: Male and female volunteers from within the community

CYSD recruited both male and female volunteers as "Sexual and Gender-Based Violence Warriors." This was deliberate and important. Programmes that recruit only women as GBV responders face a structural limitation: the norms they are challenging are held by the whole community, including men. A male volunteer who understands GBV and who intervenes in his peer network produces norm change that a female-only programme cannot.

The volunteer role was clear and bounded: identify situations of potential violence, provide first-line support to survivors, connect survivors to appropriate referral pathways, and attend regular

training and review meetings.

Key design principle: Volunteers are not counsellors. They are not legal advisors. They are trusted community members who know who in their social network needs support, and who know the pathways that exist to provide it. Training them beyond this — into clinical counselling, legal advocacy — is beyond what community volunteers can sustainably deliver and creates false expectations.

Element 2: Grassroots helpdesks rather than remote services

CYSD established helpdesks at the gram panchayat or block level — physical points where community members could access information, report situations, and be connected to appropriate support. These helpdesks were not managed by NGO staff from outside; they were operated by trained community volunteers who lived in the communities they served.

The helpdesk model addresses the fundamental access problem: it puts the first point of contact within walking distance, not a day's journey away. It also provides a location that doesn't require a woman to go to a police station (which many cannot or will not do) to access the system at all.

Element 3: AWW and ASHA integration

CYSD integrated Anganwadi Workers and ASHAs into the response system. These frontline workers already visit every household, already have trusted relationships in communities, and are already mandated to identify and refer cases of child marriage, domestic violence, and sexual abuse. What they lacked was clear knowledge of where to refer cases and a functional escalation pathway.

Training AWWs and ASHAs in GBV identification — not clinical assessment, but knowing which situations to flag and who to connect to — and giving them a specific escalation pathway (block helpdesk → block child protection officer → DCPU/OSC) transforms them from passive witnesses into active parts of the response system.

Element 4: Documented cases and referral tracking

The CYSD model maintained case records — not for external reporting purposes, but as a tracking tool. Did the woman who was identified as at risk get connected to the block helpdesk? Did she access any support? What happened in her situation after the initial identification?

This tracking function is critical and almost universally absent from community-based GBV programmes. Without it, "identifying cases" produces a list of women in difficult situations, not any change in their situations.

Element 5: Panchayat and block official engagement

CYSD worked with sarpanches, ward members, and block-level child and women protection

officials — not to make them the primary responders, but to ensure they understood the volunteer network and the helpdesk model, and to create the accountability structure that prevents the community response from operating in a vacuum.

When a sarpanch publicly endorses the village SGBV volunteer network, it sends a norm signal to the community. When a block official knows that the helpdesk exists and has a relationship with the volunteers, escalated cases have somewhere to go.

Step-by-Step Implementation Guide

Phase 1: Community assessment and entry (Months 1–2)

Do not begin by recruiting volunteers. Begin by understanding the GBV landscape through careful, confidential conversations with: women in SHGs and Mission Shakti groups; AWWs and ASHAs; women panchayat members; teachers at the local school; and trusted community leaders who can provide honest assessments without compromising confidentiality.

You are trying to understand: What forms of violence are most prevalent? What informal response mechanisms already exist? What are the community's norms about acceptable and unacceptable violence? Who do women turn to when they experience violence? What would make it safer or easier for women to seek support?

This assessment is not a survey. It is a series of relationships. It takes six to eight weeks done honestly, and it is the foundation on which everything else is built.

Map the formal systems. Identify: the nearest One Stop Centre and its opening hours; the Block Child Protection Officer; the local police station CWPO (Child Welfare Police Officer); the District Child Protection Unit; the nearest government shelter; and whether Childline (1098) coverage exists in the area. Document the contact details for each. You will need this for your referral pathway.

Phase 2: Volunteer recruitment and training (Months 2–3)

Selection criteria for volunteers:

- From the community, not outsiders
- Respected by both women and men — the village gossip is not your volunteer, even if she has the most information
- Willing to commit to monthly training and review meetings
- Ideally: one male and one female volunteer per 50–80 households

Training content (over three to four days, not a one-day session):

Day 1: Understanding GBV — what counts as violence, why it happens, why women don't report.

Use local scenarios, not abstract definitions. Ask volunteers to describe situations they've seen or heard about. Build from existing knowledge, don't replace it.

Day 2: Survivor-centred response — how to talk to a woman who is disclosing violence, what to say and what not to say, how to assess immediate safety needs without making assessments that require clinical training. Role play is essential — paper content is not retained.

Day 3: The referral pathway — where to go, who to call, what the helpdesk does, how to make a referral to the block protection officer, what a survivor needs to know before she goes anywhere. Go through each step concretely, not theoretically.

Day 4: Self-care and boundaries — what volunteers can and cannot do, how to protect their own wellbeing when they are regularly exposed to others' trauma, when to escalate immediately vs. when to provide ongoing support.

Critical design note: Train men and women separately for at least part of the training, then together. Men need space to discuss their own relationship to gender norms without performing for women in the room. Women need space to speak honestly about their experiences without men present. The joint sessions should happen after the separate foundational sessions have built the necessary understanding.

Phase 3: Establishing the community response structure (Month 3–4)

Set up the helpdesk. Identify a physical location — often the Anganwadi centre or a panchayat building — where volunteers are available for a few hours each week at a fixed, known time. Post the schedule publicly. Ensure volunteers have the phone numbers of block-level officials and the OSC.

Establish a referral register. A simple notebook: date, nature of support sought, action taken, follow-up date. This is not a formal case file — it is a tracking tool for volunteers to remember what they committed to follow up on.

Run a community meeting. Not to announce the programme, but to build community understanding. Focus on: every family's daughter and sister deserves to be safe; this community has volunteers who can help when help is needed; the support is confidential. Have community leaders — male and female — speak, not only the NGO.

Phase 4: Monthly support and review (Month 4 onwards)

Monthly volunteer meetings are non-negotiable. This is where:

- Volunteers debrief the situations they have encountered (without naming individuals)
- The escalation pathway is tested and refined — are cases actually reaching the block helpdesk? Are referrals being followed up?

- New scenarios are role-played
- Volunteers' own wellbeing is checked

Do not let monthly meetings become reporting sessions. They are support and learning communities. Volunteers who feel isolated and unsupported will stop volunteering within a few months. Volunteers who feel part of a community of practice will sustain for years.

The Male Engagement Question: Why It Is Not Optional

The most common design mistake in community GBV programmes is treating it as a women's issue requiring women's response. The evidence is unambiguous: community-level GBV reduction requires changing the norms held by men and boys, not only the safety and support infrastructure for women.

The global literature on male engagement in GBV prevention is growing rapidly. The consistent finding: when men and boys can engage without fear of community backlash, they become advocates for gender equality who speak up against violence in their peer networks. But backlash — from peers who see male engagement as disloyal to male group norms — is real and must be anticipated and managed.

Practical guidance for male volunteer engagement:

- Frame participation for male volunteers in terms of family protection, not feminism. A man who speaks to his peer network about violence is protecting the women he loves — that framing is more accessible and more sustainable than abstract gender equality language in most tribal communities
- Do not expose male volunteers to ridicule from their peers by asking them to perform feminist positions in public before they have built peer consensus. Change happens in private conversations first
- Connect male volunteers to each other — solidarity within the group protects individuals from backlash

The CYSD model in Koraput found that male volunteer involvement was specifically what enabled community accountability. When a respected male community member said to another man "what you're doing to your wife is not acceptable and this community won't ignore it," the norm-changing conversation happened. That conversation cannot happen without men in the programme.

What to Measure — and What Not to Claim

Appropriate measures:

- Number of volunteers trained and actively meeting monthly (at 6 and 12 months)
- Number of cases where a volunteer connected a survivor to any form of support
- Number of referrals made to the block helpdesk, OSC, or legal aid
- Qualitative change in community discourse — do community members talk about GBV differently?

What you should not claim:

- Reduction in prevalence of domestic violence (you don't have a baseline and a control group)
- Cases "resolved" (complex situations are rarely resolved by community intervention — they are navigated)
- That your programme prevented violence (attribution is impossible in this domain)

The honest measurement framework is: did your programme reach women who previously had no access to any support? Did it create pathways that didn't exist before? Did it shift any community conversations? These are significant outcomes even if they are not quantifiable in the way donors often want.

What This Programme Cannot Do

A community-based GBV response addresses the access gap. It does not address the legal gap (which requires lawyers and courts), the shelter gap (which requires physical infrastructure), the economic gap (which requires livelihoods programmes that give women alternatives to staying in violent situations), or the structural norm gap (which requires sustained, multi-generational change in how communities understand gender).

The volunteer and helpdesk model is a first link in a chain that doesn't exist completely anywhere in tribal Odisha. Building that first link — ensuring that a woman who experiences violence has someone nearby who knows about it, cares about it, and knows what to do — is significant, real, and incomplete. Name all three of these honestly when designing, reporting, and fundraising for this work.

Related Knowledge Commons content: Women Empowerment Sector Primer (Sector 02) · Practice Note: SHG Federation Models — for the solidarity platform that community GBV response can build on · Practice Note: Entitlements Mapping — connecting GBV survivors to government schemes

Evidence Grade: B — Multi-study. This Practice Note draws on CYSD field documentation from Koraput, the SNEHA programme research (ScienceDirect 2024), IPA/J-PAL GBV evidence summaries, and the IGWG male engagement evidence base. Last reviewed: April 2026.

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Published by JaBaSu Trust. For corrections or additions: knowledge@jabasu.org