

ARCHES (Addressing Reproductive Coercion in Health Settings):

A Scalable Approach to Support Women's Reproductive Agency and Reduce GBV

August 2024



Purpose

This slide deck was created as a stand-alone product to provide an overview of the *ARCHES (Addressing Reproductive Coercion in Health Settings)* approach. It highlights the approach's effectiveness, feasibility and scalability across multiple regions to guide and support the expansion and scaling of this brief model across low- and middle-income countries (LMICs).

The goal of ARCHES is to support reproductive agency, improve quality of care, and reduce gender-based violence (GBV) among women and girls globally.

Acknowledgements

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ARCHES Donors

- Bill & Melinda Gates Foundation
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ARCHES Partners

- Population Council
- Kenya Ministry of Health
- IPPF and Member Associations
 - Mexfam, FPAI, FHOK
- Ipas, Ipas Bangladesh, Ipas DRC, Ipas Indonesia, Ipas Bolivia
- Jhpiego

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Section One

UNDERSTANDING ARCHES

Understanding Reproductive Coercion

What is reproductive coercion?

Reproductive coercion (RC) describes behaviors by a male partner or family member(s) designed to interfere with women's and girls' family planning (FP) use or pregnancy decisions.^{1,2} RC is a distinct form of gender-based violence (GBV) that often co-occurs with intimate partner violence (IPV).³ In population-based surveys from sub-Saharan Africa and South Asia, 3-20% of women report experiencing reproductive coercion (RC) in the past year.^{4,5} Studies among women seeking health services consistently find high prevalence rates (e.g., 42% in our most recent study).⁶

Forms of reproductive coercion include:



Pregnancy Coercion: Forcing or pressuring a woman or girl to become pregnant and/or discontinue contraceptive use against her will; OR to use contraceptives or be sterilized to prevent pregnancy against her will.



Contraceptive Sabotage: Deliberately hiding, withholding, destroying, or removing FP methods against a woman's will or preventing her from seeking care for FP or otherwise blocking access to FP.

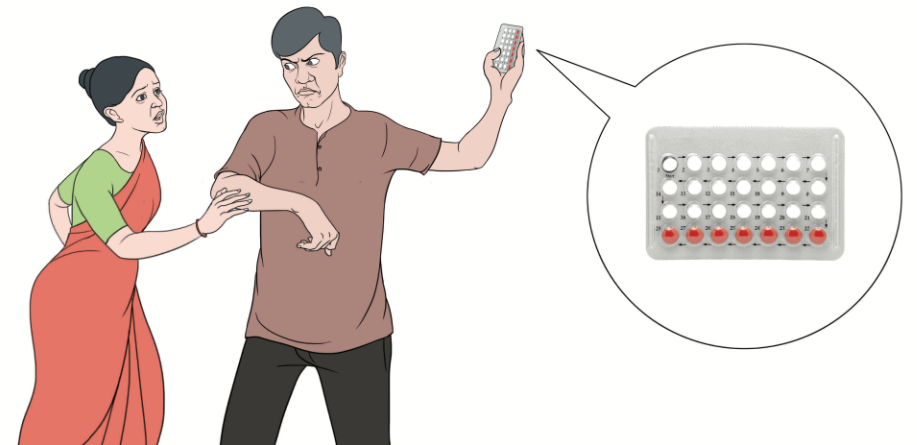


Abortion Coercion: Forcing or pressuring a woman to terminate or continue a pregnancy against her will, or impeding access to safe abortion services.

Impacts of reproductive coercion

RC is associated with poor health outcomes:

- 4.7 times more likely to report experiencing unintended pregnancy⁴
- 8.0 times more likely to report experiencing intimate partner violence⁷



Understanding ARCHES

What is ARCHES?

The ARCHES approach consists of three core elements that are readily integrated into existing FP counseling models and demonstrated to support women's reproductive agency, reduce GBV and improve quality of care. ARCHES elements are integrated into a single counseling session and take minimal time to deliver (less than two minutes in the most recent study).

Universal, rights-based, woman-centered care

ARCHES prioritizes the unique needs, preferences, and experiences of women and supports their rights to:



Universal Counseling: The receipt of comprehensive, accurate, unbiased education and support including information to assist them to cope with RC/IPV, regardless of disclosure of RC/IPV.



Reproductive Autonomy: Emphasis on women's right to control FP decisions independently, including the decision to use FP without partner or family knowledge.



High Quality, Woman-centered Care: The receipt of high-quality, respectful, confidential, person-centered reproductive health care, free from bias or coercion.

ARCHES Core Elements

1

Counseling and screening for RC, including strategies for using FP methods discreetly to reduce male partner or family member interference in FP use.

2

Counseling and screening for IPV without pressure to disclose, including supportive, respectful, validating responses and offers of linkage to support services for those who choose to disclose.

3

Offer of an easily-concealable mini-booklet with information on FP methods, RC/IPV, and local IPV support services for personal use or for sharing with family, friends/groups or partners.

Increased
Reproductive
Agency
+
Decreased
GBV

Where has ARCHES been adapted and implemented?



2009-2015 ARCHES initial development and testing via two randomized control trials in the **United States**



2016 First clinical adaptation to an LMIC context in **Nairobi, Kenya**



2018-2023 Adaptations in **Mexico, Nigeria, and Bangladesh** (including abortion and humanitarian settings); Gov't of **Kenya** initiates national scaling efforts



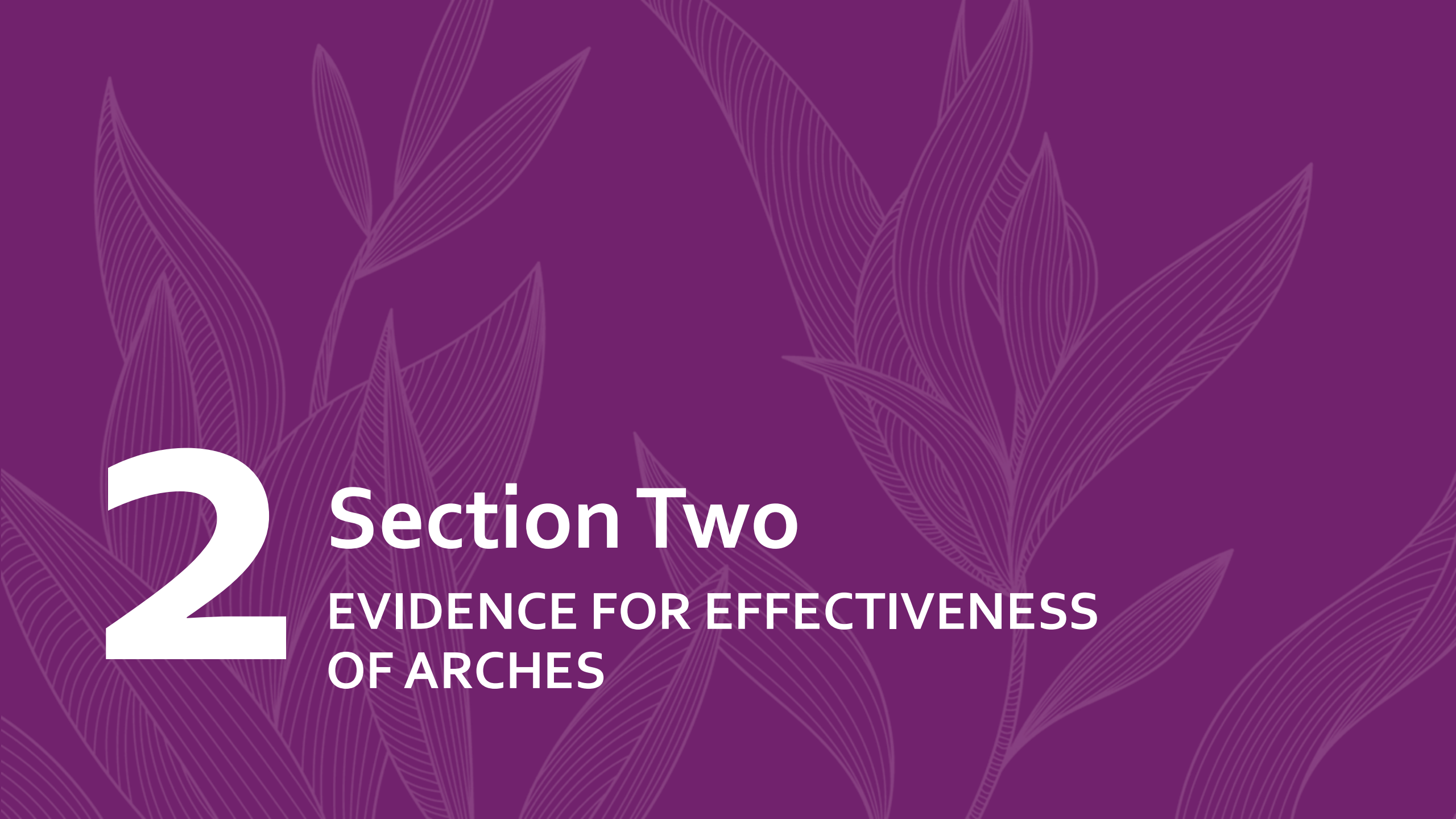
2024 First adaptation outside of the health system (community-based women's economic empowerment groups in **Kenya**); adaptations initiated in **India, Bolivia** and **Indonesia**



ARCHES has been adapted, implemented, and rigorously evaluated across a range of LMIC and care contexts.*

	Nairobi, Kenya ^{8,9} 	Bangladesh ¹⁰ 	Uasin Gishu, Kenya ¹¹ 
TIMEFRAME	2018-2019	2019-2021	2023-2024
STUDY DESIGN	Cluster-controlled	Cluster-randomized	Cluster-randomized
FOLLOW-UP PERIOD	6 months	12 months	6 months
SAMPLE AND SITES	659 FP clients in 6 urban, private-sector clinics	2685 abortion clients in 6 urban, private-sector clinics	3920 FP clients in 24 urban and rural, public-sector clinics
FP COUNSELING MODEL	GATHER (Greet, Ask, Tell, Talk, Help, Explain, Return)	GATHER	BCS+ (Balanced Counseling Strategy Plus) via a mobile app
PROVIDER TRAINING	3-day, stand-alone training	3-day, stand-alone training	3-hour training integrated into MOH standard 6-day FP training
PARTNERS	FHOK, IPPF, Population Council Kenya, GEH-UCSD	Ipas Bangladesh, Ipas, RHSTEP, BAPSA, GEH-UCSD	Kenya MOH, Population Council Kenya, GEH-UCSD

*ARCHES was also adapted, implemented, and tested in Nigeria by Jhpiego in partnership with the Nigeria MOH with GEH assistance in 2021-2023.

The background of the slide is a solid purple color with a subtle, repeating pattern of stylized, elongated leaves or feathers in a lighter shade of purple. The pattern is oriented diagonally, creating a sense of movement and texture.

2

Section Two

**EVIDENCE FOR EFFECTIVENESS
OF ARCHES**



KEY FINDING | ARCHES increases women's agency to reach their reproductive goals.

Evidence from global adaptations of ARCHES supports that this simple, low-resource approach is effective in increasing women's agency to:

- Recognize and increase confidence that they **CAN** use contraceptive methods regardless of opposition from partners or family.
- **ACT** on their decisions to use FP to prevent pregnancy (including discreet FP use).
- **RESIST** coercion regarding their FP decisions.

Among women seeking FP care:



ARCHES increases women's self-efficacy (i.e., confidence) to use FP methods in the face of opposition from male partners, including self-efficacy to use FP discreetly vs. controls.



ARCHES increases FP method uptake and FP use overall by 5-13% vs. controls.



ARCHES reduces incident pregnancy by 44%-126% vs. controls.



KEY FINDING | ARCHES increases women's agency to reach their reproductive goals.

	Nairobi, Kenya 	Bangladesh 	Uasin Gishu, Kenya 
Self-efficacy to use FP methods in the face of RC	No effect on self-efficacy	16.5% relative increase in feeling “very confident” they could use a FP method even if a male partner or family member tried to interfere (ARCHES: 64% at baseline to 75% at exit; control: 48% at baseline to 48% at exit, $p<.0001$)	3.3% relative increase in feeling “very confident” they could use a FP method even if a male partner or family member tried to interfere (ARCHES: 71% at baseline to 76% at exit; control: 73% at baseline to 76% at exit, $p<.05$)
FP method use	12.8% relative increase in FP uptake (86% ARCHES, 75% control, $p<.001$)	6.6% relative increase in FP use at 3-month follow-up (90% ARCHES, 84% control, $p<.0001$), an effect which was sustained at 12-month follow-up	4.5% relative increase in FP uptake among clients receiving full ARCHES implementation (88% ARCHES, 84% control, $p<.01$)
Pregnancy	125.9% relative decrease in incident pregnancy at 6-month follow-up (4% ARCHES, 9% control, $p<.001$)	43.7% relative decrease in incident pregnancy at 12-month follow-up (7% ARCHES, 10% control, $p<.05$)	No effect on incident pregnancy at 6-month follow-up



KEY FINDING | ARCHES increases women's agency to reach their reproductive goals.

*"Previously, I could not have used that method. It was after the provider talked to me [about discreet methods] that I opted for that method. **Had he not talked to me and given me the injection, I would most likely be pregnant currently or with another child.**"*

- ARCHES client, Nairobi, Kenya

"The usefulness [of ARCHES counseling] is... knowing about different [contraceptive] methods... Women can have their wish; their wish is valued."

-ARCHES client, Bangladesh

“

*I used to follow what my husband and mother-in-law wanted blindly...I used to abide to their wishes to give birth. When she [the provider] **made me aware that there were family planning methods that I can use without someone knowing really helped me...like the three months injectable that I could use without anyone noticing. I think that they [providers] should continue giving information to all the other women.***

– ARCHES client, Uasin Gishu, Kenya

”



KEY FINDING | ARCHES increases women's agency to address IPV and reduces IPV.

Evidence from global adaptations provides support that ARCHES, delivered by existing providers with minimal added time, is effective in increasing women's agency to:

- Recognize that they **CAN** access support services for their experiences of IPV.
- **ACT** to seek support for IPV, if they choose.
- **RESIST** and reduce IPV that they are experiencing in their relationships.

Among women seeking FP care:



ARCHES increases women's awareness of IPV support services by 11-193% vs. controls.



ARCHES reduces subsequent experiences of intimate partner violence by 21-69% vs. controls.



KEY FINDING | ARCHES increases women's agency to address IPV and reduces IPV.

	Nairobi, Kenya	Bangladesh	Uasin Gishu, Kenya
Awareness of IPV support services	10.6% relative increase in awareness of IPV support services (ARCHES: 65% at baseline to 88% at 3-month follow-up; control: 53% at baseline to 66% at 3-month follow-up, $p < .02$), an effect which was sustained at 6-month follow-up	192.8% relative increase in awareness of IPV support services (ARCHES: 22% at baseline to 71% at 3-month follow-up; control: 25% at baseline to 31% at 3-month follow-up, $p < .0001$), an effect which was sustained at 12-month follow-up	15.2% relative increase in awareness of IPV support services (ARCHES: 30% at baseline to 58% at 6-month follow-up; control: 20% at baseline to 36% at 6-month follow-up, $p < .001$) among sites without a pre-existing IPV intervention
IPV experiences	69.0% relative decrease in recent physical IPV (ARCHES: 23% at baseline to 14% at 6-month follow-up; control: 12% at baseline to 16% at 6-month follow-up, $p < .01$)	21.4% relative decrease in recent physical and sexual IPV (ARCHES: 10% at baseline to 5% at 12-month follow-up; control: 8% at baseline to 6% at 12-month follow-up, $p = 0.03$)	27.0% relative decrease in recent physical IPV (ARCHES: 12% at baseline to 8% at 6-month follow-up; control: 9% at baseline to 9% at 6-month follow-up, $p = 0.02$) 43.6% relative decrease in recent emotional IPV (ARCHES: 16% at baseline to 12% at 6-month follow-up; control: 13% at baseline to 15% at 6-month follow-up, $p < .0001$)



KEY FINDING | ARCHES increases women's agency to seek support for IPV and reduces IPV.

*"I felt very good because the provider gave me counsel and advise that I had not known earlier so next time if am in the same problem, I know where to start, where to go for help. **The provider told me about these people that help women that are experiencing violence. That you can go there for counselling on what to do.** He just told me that they help the women that are experiencing violence as a result of using family planning...I just liked it. **I know where to go to next time in the event that the same happens.**"*

- ARCHES client, Nairobi, Kenya

*"I once had a client who was experiencing violence. **So after giving her, her preferred contraceptive choice, she opened up on what she was going through. Then I called MSF. But first I asked the client if she really wanted to talk to somebody.** Then she said it's okay, because she was even thinking of leaving that marriage anyway. **But my part was not to encourage her to leave but just to give her information and show her that it was her right to be in a safe place.**"*

- ARCHES trained provider, Nairobi, Kenya

"If he [my husband] tells me something now, (laughs) I'll show him the number [in the mini-booklet] and say, 'I'll call to these numbers and say that you are abusing me.' Then he says, (laughs) 'I won't say anything anymore'."

-ARCHES client, Bangladesh



KEY FINDING | ARCHES increases person-centered quality of care regarding family planning.

Evidence from global adaptations of ARCHES supports that **training existing FP providers on the ARCHES elements increases the person-centered quality of care** that women receive and increases providers self-efficacy and ability to offer high-quality FP care.

Providing such high-quality care leads to greater trust and sense of safety among women, increasing the likelihood that they will choose to disclose experiences of RC and IPV in this setting.

Among women seeking FP care:



ARCHES improves person-centered quality of FP counseling by 37% and increases private counseling by 51% vs. controls.



ARCHES leads to high rates of disclosure of RC and IPV to providers (>50%) and improves detection of RC and IPV cases by 64-199% vs. controls.



ARCHES increases provider self-efficacy to provide high quality, person-centered care by 15-26% from pre to post training, an effect which was sustained at 6-month follow-up in Uasin Gishu.



KEY FINDING | ARCHES increases person-centered quality of care regarding family planning.

	Nairobi, Kenya 	Bangladesh 	Uasin Gishu, Kenya 
Quality of FP care	Not measured	51.3% higher proportion of clients counseled privately (99% ARCHES, 65% control, $p<.0001$)	37.3% higher person-centered quality of care score* (45.1 ARCHES, 39.2 control, $p<.0001$)
Detection of RC and IPV cases [†]	76.3% of RC cases were detected 74.3% of IPV cases were detected	188.4% higher RC detection rate (80% ARCHES, 2% control, $p<.0001$) 198.6% higher IPV detection rate (55% ARCHES, 0.2% control, $p<.0001$)	63.8% higher RC detection rate (62% ARCHES, 32% control, $p<.0001$) 147.8% higher IPV detection rate (60% ARCHES, 8% control, $p<.0001$)
Self-efficacy to provide FP counseling**	25.7% increase in provider self-efficacy score pre to post training (pre 4.39, post 5.93, $p<.0001$)	Not measured	15.3% increase in provider self-efficacy score pre to post training, sustained at 6-month follow-up (pre 19.0, post 22.7, 6-month follow-up 23.1, $p<.0001$)

[†] RC and IPV detection not measured in the control group for Nairobi study.

* Interpersonal Quality of Family Planning (IQFP) scale (range: 11-55) includes 11 items such as “The FP provider took your preferences seriously” and “The FP provider gave you enough information to make the best decision about your FP method”. Clients in ARCHES facilities were consistently more likely to report their FP provider was “very good” or “excellent” on each of the 11 IQFP items.

** Provider self-efficacy score to delivery comprehensive FP counseling (range: 0-6 Nairobi, 0-24 Uasin Gishu) includes 6-8 items such as “How confident do you feel talking to a woman about RC?” and “How confident do you feel responding appropriately a woman or girl who tells you she is experiencing abuse from a male partner?”. After providers were trained in ARCHES, they were significantly more likely to report being “very confident” or “extremely confident” on each of the provider self-efficacy items in both Nairobi and Uasin Gishu.



KEY FINDING | ARCHES increases person-centered quality of family planning care.

"The main thing is the environment. If I can create a good environment so that they feel comfortable to talk, they get the feeling that the information will be kept confidential, they will have more satisfaction."

- ARCHES trained provider, Bangladesh

"I felt good when the provider told me how to hide my method because when you go to most of these other hospitals, they are just quick to insert the method but offer no encouragement...I was touched. For example; after inserting the implant on me, he told me how to keep it hidden. Now, no one at home knows that am using it, unless I tell them. I liked the encouragement the provider gave me with that information."

-ARCHES client, Nairobi, Kenya



***It has boosted my confidence.** I used to think that family planning should be discussed by the couple, and they settle for one method of family planning. **But in this case after training, I realized that it doesn't necessarily have to be both of them and the person with the greater percentage of choice of the method lies with the person taking the method.** So, for me the training has affected me positively and has even boosted my confidence in offering the services. Sometimes back when we were in school, they used to tell us that "you are not supposed to offer family planning services without consent from both partners". But now with this, it's the right of the person who is taking the method.*

-ARCHES trained provider, Nairobi, Kenya



ARCHES Elements Are Acceptable to Providers and Clients

“There is no other platform to get this information from....with ARCHES, while counselling on family planning, one can come with reproductive coercion and IPV and they will get information on the same. I think ARCHES is handling this better.”

- ARCHES trained provider, Nairobi, Kenya

*If a man insists on having a child, you can use a method secretly for some time and stop using it when you feel you are ready to have a baby. So, it was important to me because **the doctor gave me knowledge** and I learned when to use that knowledge.*

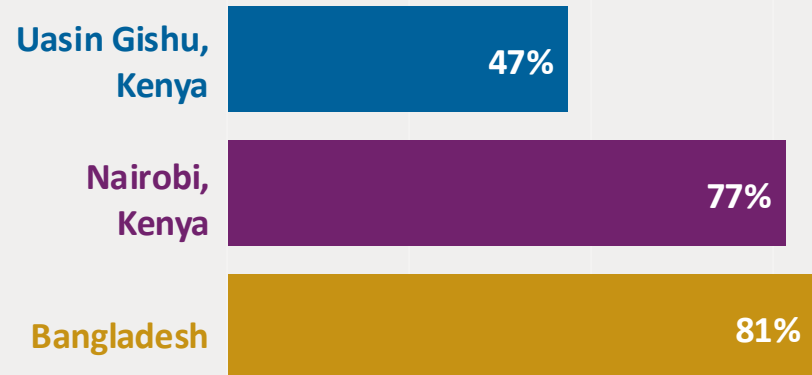
-ARCHES client, Nairobi, Kenya

Learning from Adapting ARCHES for Scale

ARCHES Fidelity and Scaling

The primary objective of the adaptation in Uasin Gishu county in Kenya was to develop a model that could be implemented at scale. To avoid the need for a standalone ARCHES training, three hours of training on ARCHES was integrated into the Kenya MOH's standard six-day FP training. However, this abbreviated training, even with intense post-training mentorship, resulted in reduced implementation fidelity - 47% of FP clients in Uasin Gishu received all ARCHES elements compared to ~80% of clients in previous adaptations. **Development and testing of scalable training models (e.g., digital) is required.**

ARCHES FIDELITY RATES: % of clients receiving all core ARCHES elements



Factors impacting implementation of a scalable ARCHES model in Uasin Gishu, Kenya:



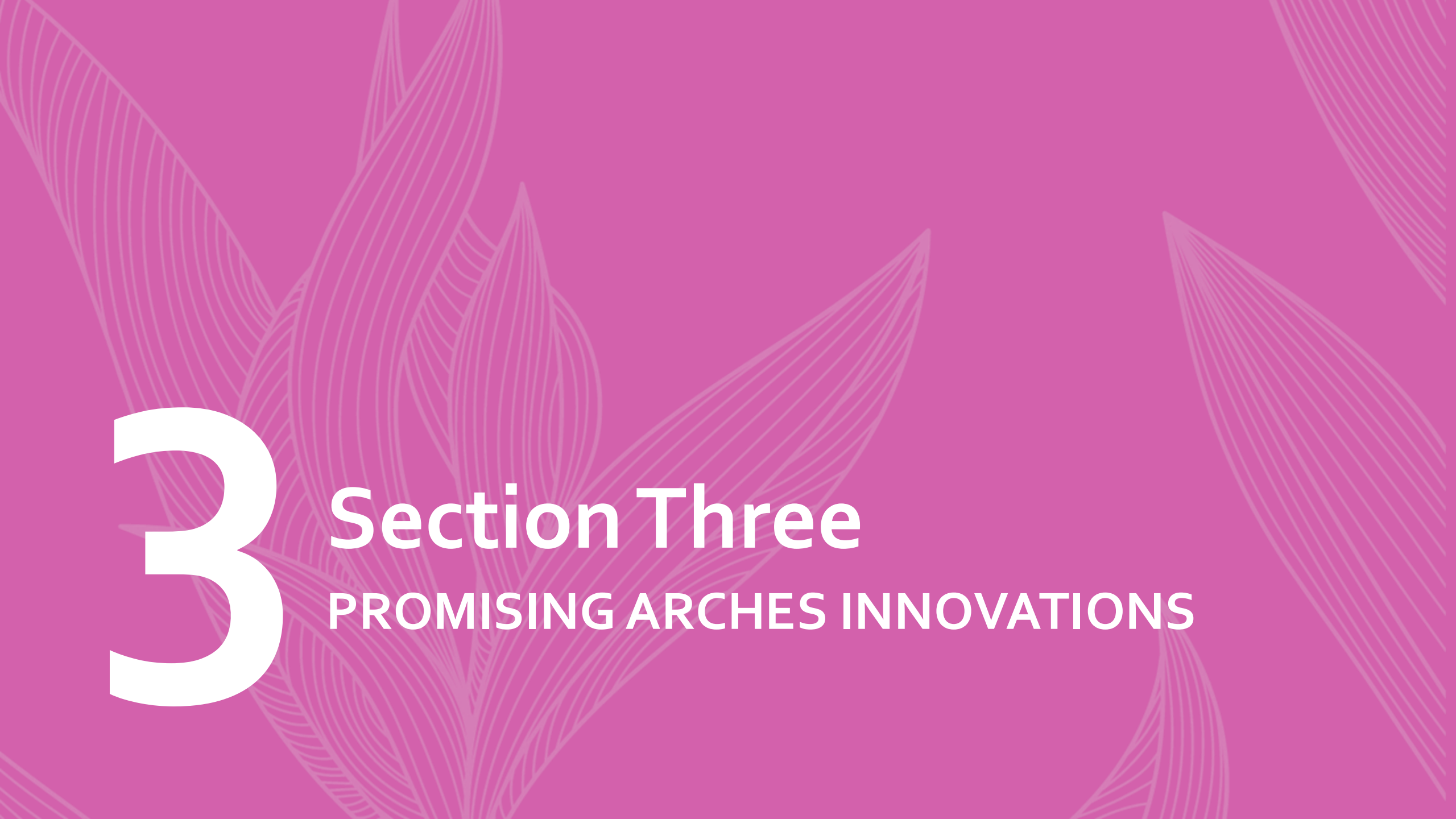
High-Intensity Mentorship: Minimal training on ARCHES elements led to the need for high-intensity mentorship to jumpstart implementation



Mobile Application: Use of a mobile application increased provider fidelity to the ARCHES approach



Client Volume: High client load reduced faithful implementation; effect likely compounded by utilization of full BCS+ protocols (requires 25 minutes)

The background is a solid pink color. Overlaid on this are several stylized, white line-art leaves. The leaves are elongated and pointed, with fine lines radiating from the base to the tip, giving them a feather-like or palm-like appearance. They are arranged in a way that some are in the foreground and others are behind, creating a sense of depth.

3

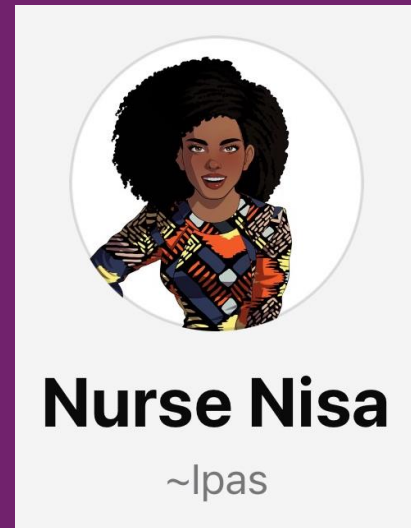
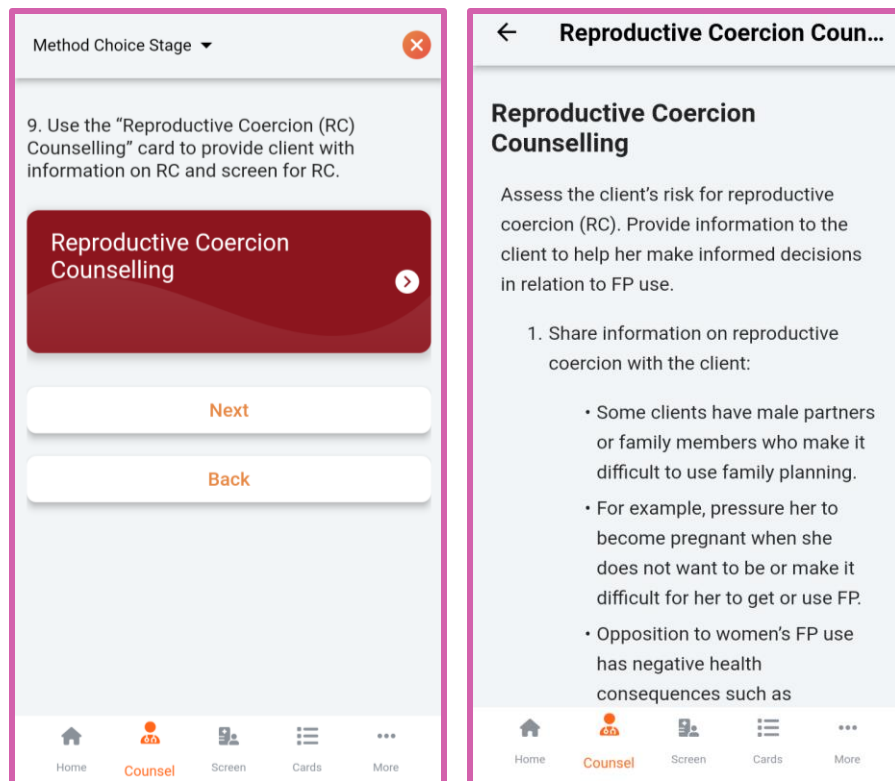
Section Three

PROMISING ARCHES INNOVATIONS

ARCHES Digital Innovations in Kenya and DRC

Uasin Gishu County, Kenya

The Kenya FP+ app guides a health provider on how to use the BCS+ algorithm with ARCHES elements integrated, improving intervention fidelity and quality of care. See Kenya FP+ app screenshots below.



Democratic Republic of Congo (DRC)

In collaboration with Ipas and Ipas DRC, ARCHES elements were integrated in the **Nurse Nisa WhatsApp-based chatbot**. Women and girls can explore the health of their relationship, including reflecting on experiences of RC and IPV. They can also explore strategies for discreet use of FP and abortion.

ARCHES in a Humanitarian Setting in Bangladesh

Cox's Bazar, Bangladesh

In collaboration with Ipas Bangladesh, ARCHES has been adapted for use with **Forcibly Displaced Myanmar Nationals seeking menstrual regulation (MR; a form of abortion care), postabortion care (PAC), or FP services** in health facilities located in refugee camps in Cox's Bazar district, Bangladesh.



Photo Credit:
Fabeha Monir for Ipas

Engaging community health workers

This adaptation was done using a human-centered design approach that was overseen by the project's Community Advisory Group, consisting of community women, and Resource Group, which included government and camp officials and partner organizations. In addition to adapting and integrating the core ARCHES elements into clinic-based services, this adaptation also engaged community health workers (CHWs) because of the critical role they play in providing health information at the community-level.

The CHWs received a one-day training to provide women in the camps with information on FP methods, MR/PAC options and information/screening on RC and IPV during routine household visits. Referrals were offered for FP, MR/PAC, and IPV services as needed.

Impacts

An initial pre-post evaluation of this ARCHES adaptation found the following changes between baseline and exit for women receiving care:

- 62% increase in self-efficacy to use a FP method in the face of RC
- 13% increase in self-efficacy to use IPV support services
- 12% increase in attitudes less tolerant of RC

Extending ARCHES to Community Health Workers in India

Under the USAID-funded *Agency for All* project, ARCHES is currently being adapted and tested within FP services in Gwalior, Madhya Pradesh, India. Led by Family Planning Association of India (FPAI) and IPPF with support from Sambodhi and GEH-UCSD, ARCHES is being adapted to both private and public FP services. This pilot will capture learnings on the feasibility, acceptability, fidelity, and quality with which the core ARCHES elements are delivered in these contexts to inform future scale-up efforts in India.

Emerging findings from a landscape needs assessment and participatory co-creation process have identified that in this context, due to limited mobility of women and strong patriarchal social norms limiting women's reproductive agency, adaptation of ARCHES to train both facility- and community-based health workers will be essential to reach women with need for FP services and who are experiencing RC and/or IPV.



Facility-based health workers

Facility-based FP counselors and auxiliary nurse midwives will be trained to deliver the core ARCHES elements within the existing FP counseling model. Providers will offer referrals to clients who screen IPV positive to both formal IPV support services and to local women's IPV support groups (Shor Dal).



Community-based health workers

Front line health extension workers, already operating extensively in the Indian context (e.g., ASHAs and anganwadi workers), will be trained to offer the ARCHES mini-booklet to women at community-based health events and home visits. In instances where privacy can be secured, they will be trained to screen for RC/IPV and provide information on discreet use of FP methods integrated within their standard model of FP counseling. Referral to local facilities will be offered for contraceptive methods not provided by CHWs and, for women screening positive for IPV, CHWs will be trained to offer referrals to local IPV support services.

ARCHES with Women's Economic Empowerment Groups in Kenya

ARCHES + Economic Empowerment

Across ARCHES facility-based adaptations, providers and clients have strongly suggested the need for an ARCHES model that reaches women at the community level. Another unanticipated finding was that large percentages of women receiving ARCHES were choosing to share what they had learned about IPV and RC within women's economic empowerment groups (WEEGs). Additionally, women experiencing IPV identified lack of financial means as a key reason why they and other women cannot leave abusive partners. To address these needs jointly, *Jenga Dada* (which translates to “build a woman” in Kiswahili) was co-developed with WEEG members and community partners.

Jenga Dada

Jenga Dada incorporates the core ARCHES elements within programming designed to increase women's economic independence as delivered via established WEEGs (e.g., table banking groups). **The aim of Jenga Dada is to build collective agency to respond to and support WEEG members (and others) experiencing economic abuse, IPV and RC.**

Jenga Dada is delivered via eight one-hour, discussion-based modules incorporated into existing group meetings and includes content on gender roles, economic abuse, IPV, RC, FP, financial literacy, and developing life goals. It also links group members to FP providers at local health facilities (in Uasin Gishu County, providers are trained in ARCHES).

***Jenga Dada* is currently being piloted with 18 WEEGs in Uasin Gishu County, Kenya.** Findings will be used to refine the program for larger-scale implementation and evaluation.





4

Section Four

FUTURE OF ARCHES

Future of ARCHES

1

Further **expansion and scaling of ARCHES** in additional LMIC contexts:

- Strategic inclusion of opportunities for implementation learnings to continue to optimize adaptation, implementation and scaling guidance and tools.
- Include focus on utilization of CHWs and expansion to non-traditional contexts (e.g., humanitarian settings).

2

Further development of **digital innovations** to facilitate provider training, mentoring and implementation, inclusive of consideration of AI, to strengthen implementation, scalability and sustainability.

3

Development and testing of ARCHES **innovations outside of the health system** with a focus on community-based women's economic empowerment groups.

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ARCHES

EMPOWERING WOMEN TO CONTROL THEIR REPRODUCTIVE HEALTH



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