

ARCHES India

Intervening in Public and Private Family Planning Systems with Facility- and Community-based Providers in Gwalior, Madhya Pradesh

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The Center on Gender Equity and Health (GEH) at UC San Diego has partnered with the International Planned Parenthood Foundation (IPPF), Family Planning Association of India (FPAI), and Sambodhi to adapt an evidence-based model, ARCHES (Addressing Reproductive Coercion in Health Settings), designed to increase the agency of women to achieve their reproductive goals in the face of violence and coercion from male partners and family members, to the Indian context in Gwalior, Madhya Pradesh. A memorandum of understanding was also established with the Ministry of Health and Family Welfare in Madhya Pradesh.

The project will include adaptation, implementation, and pilot testing of ARCHES in both public health facilities (Government of Madhya Pradesh) and private (Family Planning Association of India) family planning service delivery settings for women of reproductive age (18 to 49 years old) seeking family planning services.



Young Women's group from Bilheti Village

ARCHES | Overview

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). ARCHES supports women's rights to universal counseling, women-centered care, and agency of women to achieve reproductive goals and respond to experiences of violence how they wish.

ARCHES as a facility-based model has been tested in cluster randomized controlled trial in the United States, Kenya, and Bangladesh in public and private settings. Results across studies show increased reproductive agency, increased agency to respond to violence experiences and reduced violence, and increased quality of care.¹⁻⁵

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**

In India, reproductive coercion rates range from 3.9% to 12% in Uttar Pradesh.^{6,7} Broader estimates on its prevalence and associated health outcomes are not yet available. However, existing evidence indicates high levels of intimate partner violence, with one in three Indian women reporting physical, sexual, or emotional partner violence in their lifetime.^{8,9} In Madhya Pradesh, where this study is conducted, the prevalence is even higher, with approximately two in five women experiencing such abuse.^{8,9}

Contraceptive discontinuation is also widespread.¹⁰ While many women cite the desire to have a child as a reason, research suggests that decisions about the number and timing of children are often influenced by male partners and family members.^{11,12} Despite child marriage being illegal, many women in India marry before age 18, further limiting their reproductive agency.¹³ Social pressures also push many women to conceive early in marriage to demonstrate fertility.

Background



Clinical Context

Most women's first point of contact with the health care system in India usually occurs in the community. Additionally, some methods (implant, hormonal IUD) are currently only available in private facilities. To reach women where they are seeking care and provide the full range of contraceptive methods, ARCHES is being simultaneously adapted, implemented, and tested in both public (*Government of Gwalior, India*) and private family planning systems (*Family Planning Association of India*) where both facility-based (ANMs, counselors) and community-based providers (ASHAs) will be trained to implement the approach.



PHC, Utila, Gwalior



Phulbagh FPAI Clinic

The ARCHES India adaptation aims to support women and girls of reproductive age in addressing violence and achieving their reproductive goals. It targets barriers at both the interpersonal level (e.g., reproductive coercion, violence) and provider level (e.g., awareness, biases). Through initial development and pilot testing, we aim to position the model for a future effectiveness-implementation trial and broader scaling in India.

Aims



Increase providers agency to provide high-quality, comprehensive family planning counseling



Increase women's agency to achieve their reproductive goals in the face of violence and coercion

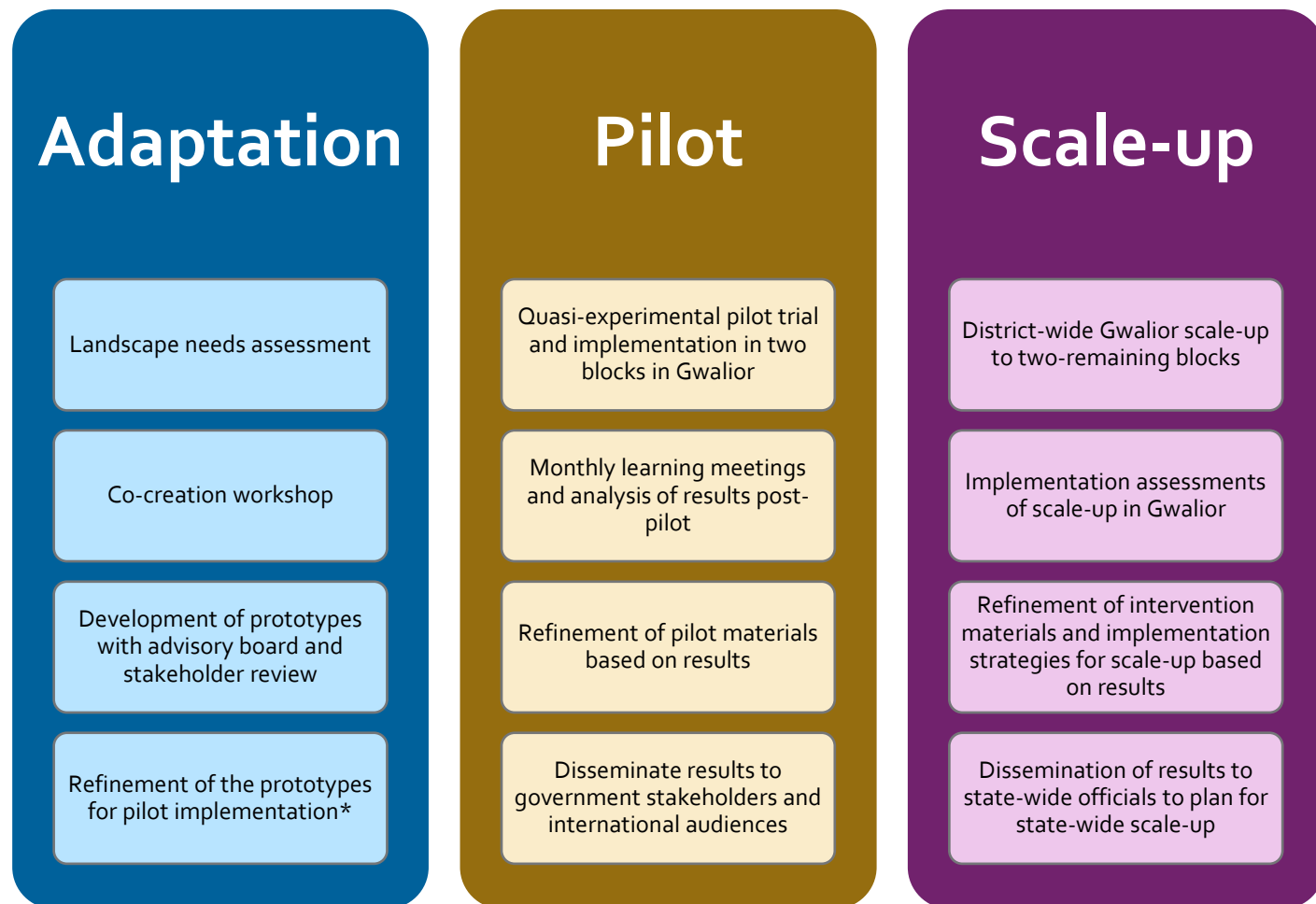


Increase women's agency to respond to violence experiences



Poise ARCHES for regional scale-up in Gwalior and Madhya Pradesh

Project Overview



The project, which began in April 2024, was designed to be completed in several phases including a rapid landscape needs assessment, a participatory co-creation process with multi-level stakeholders based on findings from the needs assessment, testing implementation of the approach in a pilot trial, and scaling district wide with implementation assessments to prepare for regional scale-up.

The project was paused at the end of January 2025 at the end of the adaptation phase due to lapse in funding after the pilot training-of-trainers with public and private providers.

The team is currently mobilizing resources to complete this work and position this approach for expansion in India.

* Project paused here after initial pilot training-of-trainers

Needs Assessment Highlights

Focus-group discussions and semi-structured interviews with women and family planning providers were completed along with facility-checklists to understand the cultural and structural environment for implementation. This information was used during the adaptation and co-creation process to ensure a strong fit to the Indian context. Common themes from the landscape needs assessment included:

- **RC by male partners/in-laws is common**, severe, and limits agency
- **Low-parity women are restricted** in mobility and autonomy, particularly as many are married young
- **Discreet FP use is hindered** by low awareness and support
- **Providers hold problematic attitudes** on women's agency
- **System constraints** include high workloads and low privacy and fear of backlash from the community

"The husband did not care if they kept having more children. The children came free [with sex]. He still did not allow her to use anything [contraceptive]. Poor girl, she used to take it [OCPs] from us secretly, but her husband would throw it away. She even came by our homes to take the pills. Even if we gave it, he would throw it away." - Facility-based provider

"They start asking about children within the first six months of marriage. That even the neighbors had a wedding at the same time. The mother-in-law taunts the daughter-in-law that she [the neighbor] has got a kid, why don't you?" - Women's group member

"If the neighbors or their family members find out we helped her with family planning, they will reprimand us [ASHAs] that you are trying to break our family." - ASHA

Co-creation Highlights

The team learned valuable lessons during the adaptation and co-creation process that are relevant to future efforts to adapt ARCHES in new settings. Below are the highlights of transferable lessons learned.



Fidelity – The core components of ARCHES were retained but adapted to the local context by making language culturally acceptable, incorporating visuals for low-literacy populations, using a story format, and simplifying training materials.



Fit – A needs assessment provided a deeper understanding of the local context, revealing common provider misconceptions and privacy challenges that were addressed in intervention design and provider training.



Local partner's experience – The intervention was co-created with local partners, ensuring their involvement in designing the ARCHES model and shaping its community component.



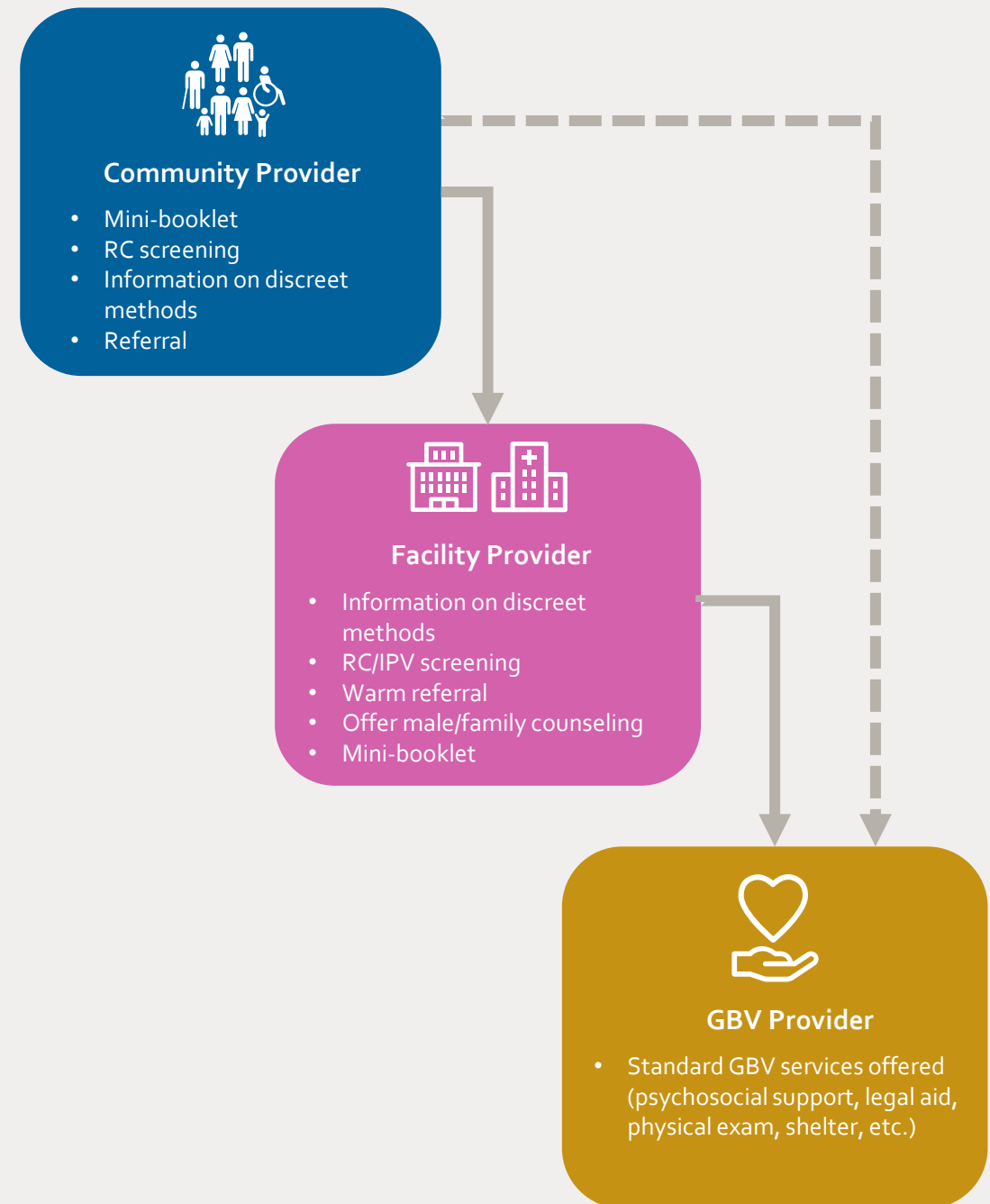
Women's Group Participant, Morar

Multi-level ARCHES India Model

The co-creation process, including a co-design workshop with diverse stakeholders and tailored validation meetings, led to a comprehensive, multi-level model for ARCHES delivery.

In this model, women first engage with the health system through a community-based provider (ASHA), who provides basic information and RC screening. ASHAs then refer women to facility-based providers, especially for modern contraceptive methods beyond pills or condoms. At the facility, women receive thorough screening for reproductive coercion and intimate partner violence as part of standard family planning services, with referrals for further GBV care available at both levels.

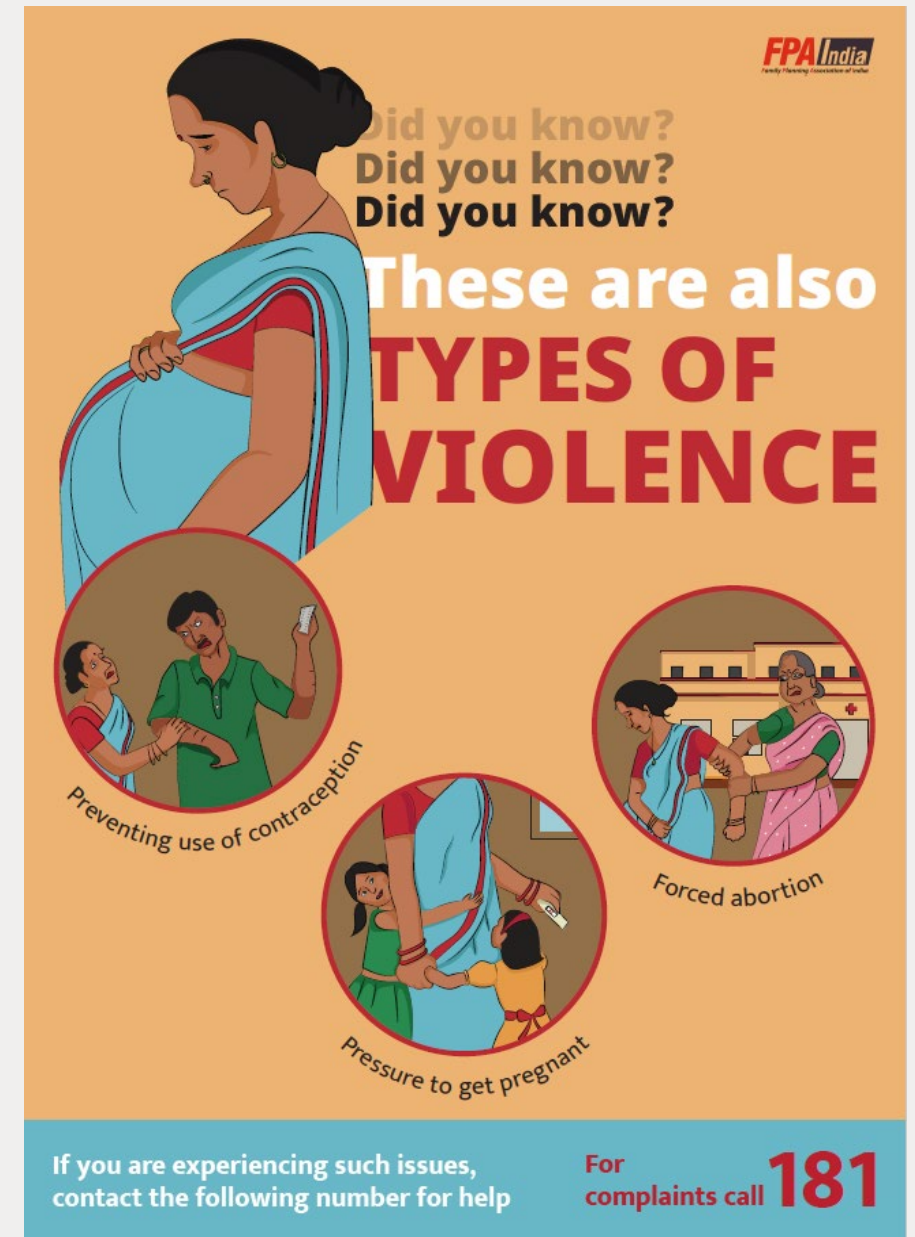
During co-creation, participants highlighted that community-based providers may not be in a safe position to screen for intimate partner violence. Thus, formal screening is conducted at facilities where privacy is assured, while ASHAs are trained to respond sensitively and refer women as needed.



ARCHES India Implementation Toolkit

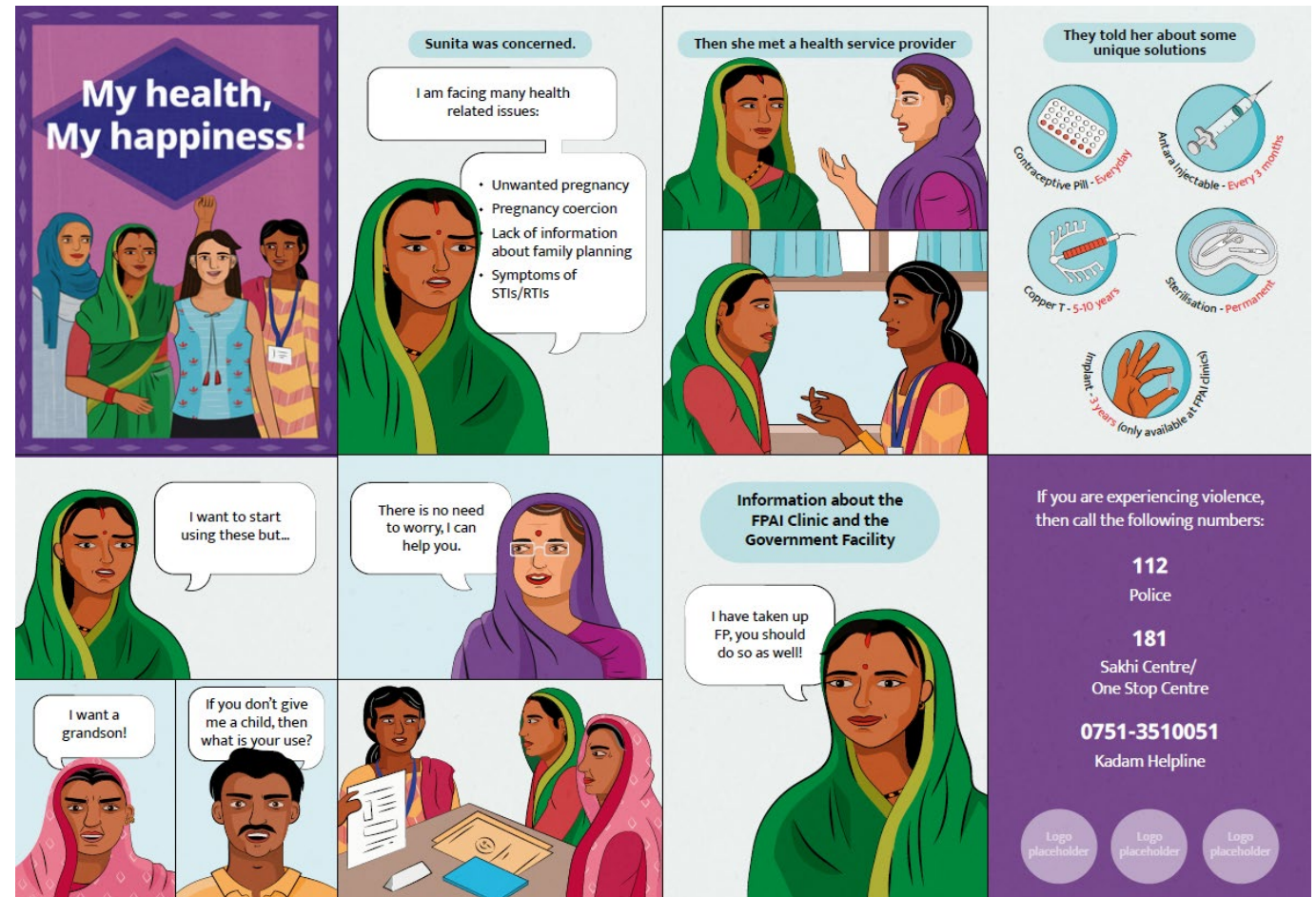
To implement the ARCHES model in Gwalior, India, an implementation toolkit was developed to support trainer and provider training, service delivery, and client education. The toolkit will be refined based on pilot results through a continuous learning process, including monthly meetings. Initial materials developed include:

- **3-day training-of-trainers; 2-day cascade provider training** with training manuals for facilitators and providers and slides
- **Mini educational booklet** with visual story-based approach
- **Four client education posters** on referrals, right to privacy, provider harassment, and reproductive coercion
- **Provider/client-facing flipbook** with images and text to guide both facility- and community-based providers through the counseling session
- **Provider-facing 1-pager job-aid**



ARCHES India Booklet

The ARCHES India mini educational booklet uses a story-based approach to engage women and accommodate low literacy levels. It follows Sunita, a woman facing reproductive health challenges, including coercion and intimate partner violence. She receives guidance from an ASHA and an ANM at a facility, who inform her about effective family planning methods and support her choices. The booklet concludes with referral contacts for both violence and family planning services.



Pilot Training-of-Trainers

In January 2025, project partners convened to complete a three-day pilot training-of-trainers. The team trained 15 government providers, including supervisors of facility- and community-based providers, medical officers, community health officers, and government trainers in selected ARCHES implementation areas. Additionally, 10 supervisors, facility managers, and outreach workers from Family Health Options Kenya, Gwailor participated.

Participants found the ARCHES content valuable and relevant to their roles, particularly in emphasizing best practices that prioritize women's family planning needs over external pressures from family or the community.

Several adaptations emerged from the training, including reordering early activities on values clarification, reproductive coercion, and intimate partner violence, as well as adjusting session durations to fit within the three-day format.



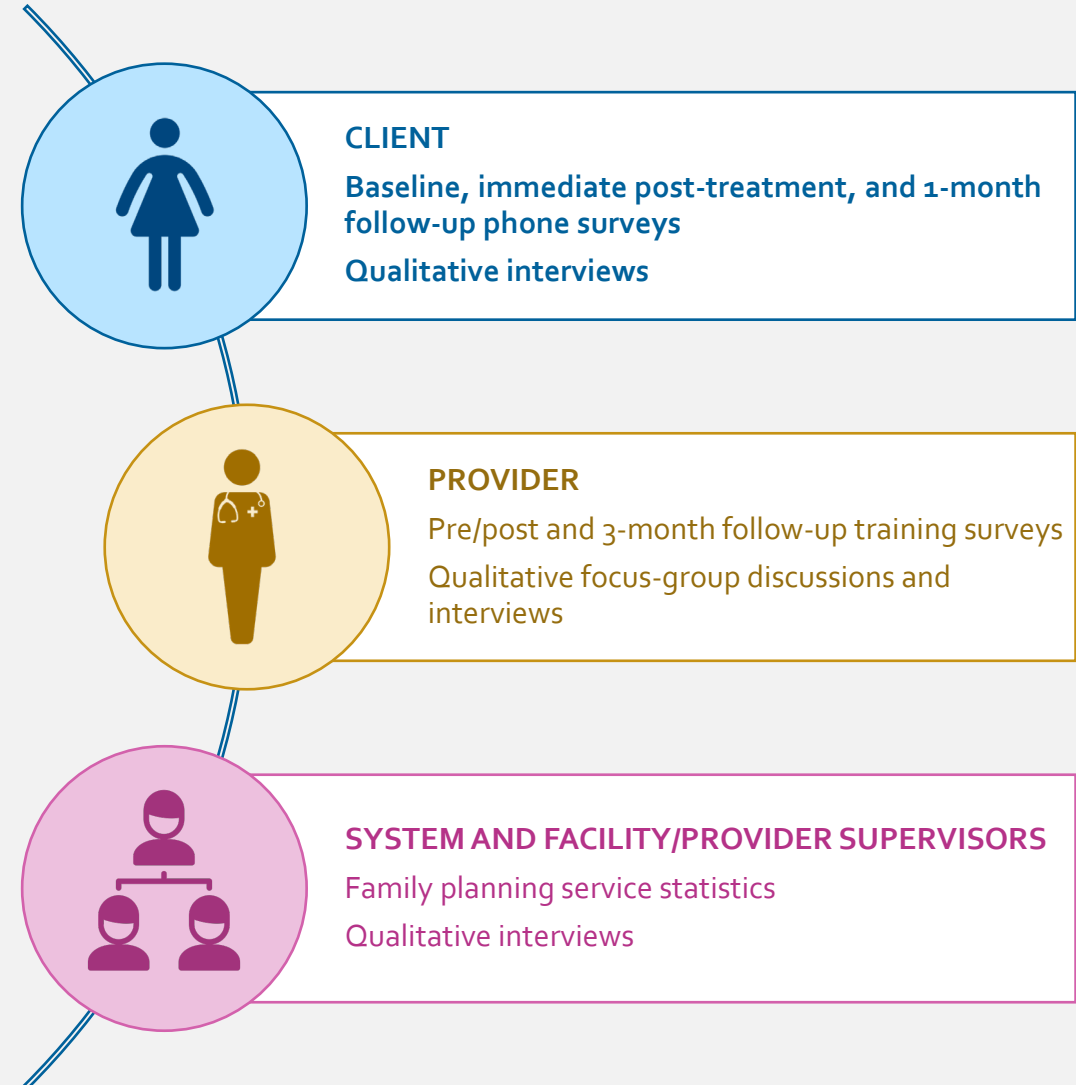
Pilot Trial | Overview

The three-month, pilot trial uses a mixed-methods design with matched-pair control groups (for public facilities) to assess ARCHES' implementation and short-term effectiveness in public and private family planning settings in India. The study plans to recruit ~825 women (650 facility-based, 175 community-based) and ~225 providers (140 facility-based, 85 community-based). Research is planned at FPAI facilities (n=2), a district hospital (n=1), government PHCs (n=2), and through community-based provider visits in 21 sub-center catchment areas. Control facilities, matched on client load and urbanicity, including one district hospital and two PHCs, will follow standard practices without ARCHES implementation for comparison.

Implementation research will evaluate acceptability, feasibility, fidelity, quality, and short-term effectiveness. Quantitative and qualitative data from clients and providers will guide refinements through two iterative learning sessions. A final round of qualitative data collection will assess how the refined package functions in practice. Findings will inform scale-up efforts and, possibly, a larger implementation-effectiveness and costing trial for potential expansion in India.

Note, the pilot trial was paused immediately after the training-of-trainers. Additional funding will be needed to complete the pilot as planned. Ethical approvals have already been obtained to complete this work.

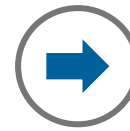
DATA COLLECTION





Future Directions

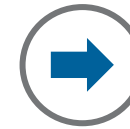
Based on the substantial investment and work accomplished to date, coupled with the high need in this context, the team has developed a set of crucial next steps to test the adaptation and position this innovative solution for expansion.



Identify additional funding to complete the first phase of work, including completing the pilot implementation, trial, refinement, and planning for district- and state-wide scale-up.



Learn about the effectiveness of the community-based adaptation, as compared to the facility-adaptation, including feasibility, acceptability, and fidelity of the approach implemented within community-based settings and connections to high-levels of care.



Consider potential adaptations of innovative strategies, such as digital technologies for training, supervision, and decision-support of frontline workers to increase fidelity, feasibility, and scalability of the approach.

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