Addressing reproductive coercion and intimate partner violence: Evidence from ARCHES

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Reproductive Coercion Defined

Form of gender-based violence (GBV) comprised of behaviors by a male partner or family members that reduce women’s and girl’s reproductive autonomy by interfering with contraceptive access or use, or pregnancy decisions

- 10%-37% prevalence across LMICs
- Associated with physical and sexual intimate partner violence
Forms of Reproductive Coercion

- Contraceptive Sabotage
- Pregnancy Threats
- Pregnancy & Abortion Coercion
ARCHES: Addressing Reproductive Coercion in Health Settings

1. Universal Right’s-based Counseling on RC + FP methods with reduced risk of detection
2. Opportunity to Disclose RC/IPV+ Referral: warm, supportive, validating response; supported linkage to local IPV services if disclose IPV
3. Rights-based Palm-Sized Booklet: Right to use RC, FP methods that have reduced risk of detection, IPV services; encouraged to share

Increased Reproductive Autonomy + Decreased GBV
ARCHES: Adaptations in Kenya and Bangladesh

- First adaptations of ARCHES to LMIC contexts
- Participatory process with providers, local partners, stakeholders
- 3-day training of providers (nurses and counselors)
- High rates of implementation in the absence of incentives

<table>
<thead>
<tr>
<th>ARCHES element</th>
<th>Kenya</th>
<th>Bangladesh</th>
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<tbody>
<tr>
<td>Counseling on FP methods with low risk of partner detection</td>
<td>87%</td>
<td>90%</td>
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<tr>
<td>Screening for RC</td>
<td>90%</td>
<td>91%</td>
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<tr>
<td>Screening for IPV</td>
<td>91%</td>
<td>90%</td>
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<tr>
<td>Offering rights-based booklet</td>
<td>94%</td>
<td>98%</td>
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Rate of Implementation of Each Intervention Element (Client Reports)
ARCHES:
Kenya & Bangladesh Evaluations

<table>
<thead>
<tr>
<th></th>
<th>Urban Kenya</th>
<th>Urban Bangladesh</th>
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<tbody>
<tr>
<td><strong>Design</strong></td>
<td>Matched-control</td>
<td>Cluster-randomized</td>
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<tr>
<td><strong>Study sites</strong></td>
<td>6 family planning clinics</td>
<td>6 abortion clinics</td>
</tr>
<tr>
<td><strong>Sample size</strong></td>
<td>659 family planning clients</td>
<td>2686 abortion clients</td>
</tr>
<tr>
<td><strong>Data collection</strong></td>
<td>• Baseline, exit, 3- and 6-month follow-up surveys (87% retained)</td>
<td>• Baseline, exit, 3- and 12-month follow-up surveys (94% retained)</td>
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<tr>
<td></td>
<td>• Qualitative interviews with clients and providers</td>
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<tr>
<td><strong>Data analysis</strong></td>
<td><strong>Intent-to-treat approach</strong></td>
<td></td>
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<td></td>
<td><strong>Logistic mixed effects models</strong> adjusted for baseline differences in socio-demographics and for within-group variance of clusters and repeated observations over time</td>
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<tr>
<td></td>
<td>• Adjusted odds ratios (AOR) for follow-up only analyses</td>
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<tr>
<td></td>
<td>• Adjusted ratio of odds ratios (AROR) for difference-in-difference analyses over time</td>
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# ARCHES: Baseline Sample Characteristics

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<thead>
<tr>
<th></th>
<th>Kenya n=659</th>
<th>Bangladesh n=2686</th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>(%)</td>
</tr>
<tr>
<td>Age &lt;25</td>
<td>323 (49)</td>
<td>741 (28)</td>
</tr>
<tr>
<td>Currently married</td>
<td>429 (65)</td>
<td>2645 (98)</td>
</tr>
<tr>
<td>Lifetime RC experience</td>
<td>243 (37)</td>
<td>312 (12)</td>
</tr>
<tr>
<td>Lifetime physical IPV experience</td>
<td>313 (48)</td>
<td>1152 (43)</td>
</tr>
<tr>
<td>Lifetime sexual IPV experience</td>
<td>166 (25)</td>
<td>345 (13)</td>
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RC & IPV Disclosure in ARCHES Clinics

Clients were comfortable disclosing experiences of RC and IPV to the provider.

Kenya
- 82.9% Disclosed RC
- 82.2% Disclosed IPV
- 17.1%
- 17.8%

Bangladesh
- 80.3% Disclosed RC
- 55.4% Disclosed IPV
- 19.7%
- 44.6%
Results:
% reporting modern contraceptive use at 3-month follow up

Kenya

89.0% 84.1%
ARCHES Control
AOR = 1.53*

Bangladesh

89.7% 83.9%
ARCHES Control
AOR = 1.79***

^ p<0.1; * p<0.05; ** p<0.01; *** p<0.001
Results:
% reporting pregnancy by follow up

Kenya (6-month)
AOR = 0.42***
ARCHES: 3.8%
Control: 8.5%

Bangladesh (12-month)
AOR = 0.62*
ARCHES: 7.1%
Control: 9.8%

^ p<0.1; * p<0.05; ** p<0.01; *** p<0.001
Results:
% reporting unintended pregnancy by follow up

Kenya (6-month)
AOR = 0.48
1.7% ARCHES
3.5% Control

Bangladesh (12-month)
AOR = 0.87
2.6% ARCHES
3.2% Control

^ p<0.1; * p<0.05; ** p<0.01; *** p<0.001
Results:

% reporting RC in the past 3 months

**Kenya**
- Baseline: 25.7%
- Follow-up: 17.9%
- AROR = 2.97***

**Bangladesh**
- Baseline: 7.3%
- Follow-up: 6.2%
- AROR = 0.95

Comparison between ARCHES and Control groups:
- Bangladesh: 3.7% vs. 3.2%
- Kenya: 5.6% vs. 18.0%

^ p<0.1; * p<0.05; ** p<0.01; *** p<0.001
Results:
% reporting sexual IPV in the past 3 months

Kenya

Baseline: 18.0% (ARCHES) vs 10.1% (Control)
Follow-up: 15.6% (ARCHES) vs 4.2% (Control)
AROR = 3.19***

Bangladesh

Baseline: 5.2% (ARCHES) vs 1.2% (Control)
Follow-up: 3.8% (ARCHES) vs 0.8% (Control)
AROR = 1.06

^ p<0.1; * p<0.05; ** p<0.01; *** p<0.001
Results:
% reporting physical IPV in the past 3 months

**Kenya**
- Baseline: 23.3%
- Follow-up: 15.8%
- AROR = 0.37***

**Bangladesh**
- Baseline: 6.9%
- Follow-up: 6.3%
- AROR = 0.62^
ARCHES increased knowledge of available IPV services.

- **Kenya**: AOR=2.5*** at 6-month follow-up
- **Bangladesh**: AOR=5.0*** at 12-month follow-up
- >50% in intervention facilities shared information on RC and IPV with others

^ p<0.1; * p<0.05; ** p<0.01; *** p<0.001
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 KENYA FP CLIENT, 22 YEARS OLD

ARCHES content is acceptable to clients and providers.
## Key Takeaways of ARCHES Results

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<th>ARCHES is adaptable and scalable</th>
<th>ARCHES increases reproductive agency</th>
<th>ARCHES decreases reporting of physical IPV</th>
<th>Mixed results on reporting of RC and sexual IPV</th>
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<tbody>
<tr>
<td>• Implemented with high fidelity</td>
<td>• Increased use of modern FP at follow up compared to controls</td>
<td>• Decreased reporting of physical IPV over time compared to controls</td>
<td>• Decreased reporting of RC and sexual IPV over time in both arms</td>
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<td>• Feasible and acceptable to clients and providers in diverse contexts</td>
<td>• Decreased incident pregnancy at follow-up, possibly unintended pregnancy, compared to controls</td>
<td>• Increased awareness of IPV services over time compared to controls</td>
<td>• In Kenya, decreases were significantly greater among controls providing standard contraceptive care</td>
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<td>• Resulted in high rates of RC and IPV disclosure at clinic</td>
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