Addressing reproductive coercion and intimate partner violence: Evidence from two ARCHES trials

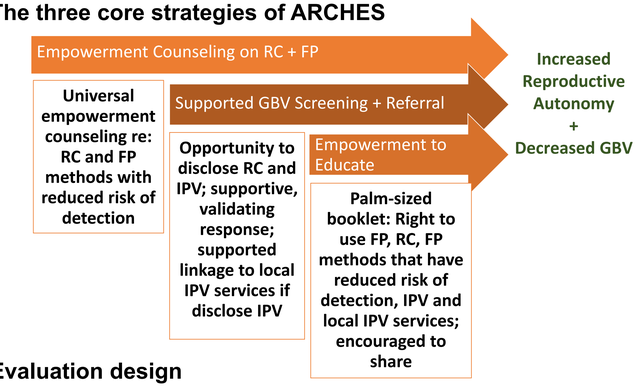
Authors: Jay Silverman, Erin Pearson, Jasmine Uysal, Nicole Johns, Wilson Liambila, Dipika Paul, Jamie Menzel, Mohammad Abdul Hannan Shakhider, Rabeya Akter Konika, Seri Wendoh, Chi-Chi Undie

INTRODUCTION

- Reproductive coercion (RC) is a form of gender-based violence (GBV) comprised of behaviors that interfere with family planning (FP) use or pregnancy decisions[1].
- RC and intimate partner violence (IPV) negatively impact women's health and well-being and increase risk of unintended pregnancy[2].
- The ARCHES (Addressing Reproductive Coercion in Health Settings) intervention trains health providers to counsel, screen, and provide support for RC and IPV during routine clinic visits.
- This study tested the effectiveness of the ARCHES intervention, adapted for use with FP clients in Nairobi, Kenya and abortion clients in urban Bangladesh, in increasing modern FP use and reducing RC, IPV, and incident pregnancy.

METHODS

- The three core strategies of ARCHES



- Evaluation design

	Urban Kenya	Urban Bangladesh
Design	Matched-control	Cluster-randomized trial
Study sites	6 family planning clinics	6 abortion clinics
Sample size	659 family planning clients	2686 abortion clients
Data collection	Baseline, exit, 3 / 6-month follow-up surveys (87% retained) Qualitative interviews with clients and providers	Baseline, exit, 3 / 12-month follow-up surveys (94% retained) Qualitative interviews with clients and providers
Data analysis	**Intent-to-treat approach** **Logistic mixed effects models** adjusted for baseline differences in socio-demographics and for within-group variance of clusters and repeated observations overtime - Odds ratios for follow-up only analyses - Odds ratios for ratios for difference-in-difference analyses over time	

CONCLUSION

ARCHES is scalable and adaptable
- Implemented with high fidelity
- Feasible and acceptable to clients and providers in diverse contexts
- Resulted in high rates of RC and IPV disclosure within intervention clinics

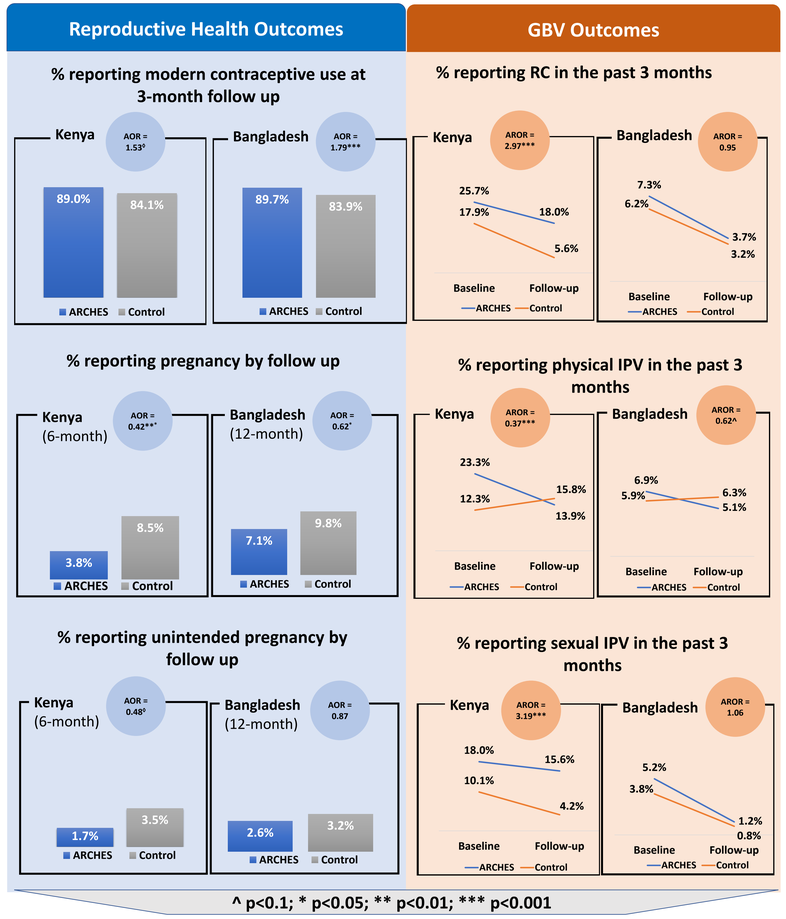
ARCHES increased reproductive agency
- Increased use of modern FP
- Decreased incident pregnancy and possibly decreased unintended pregnancy

ARCHES decreased reporting of physical IPV
- Decreased reporting of physical IPV
- Increased awareness of IPV services

Mixed results on RC and sexual IPV reporting
- Decreased reporting of RC and sexual IPV in both arms
- In Kenya, decreases were significantly greater among controls providing standard contraceptive care

RESULTS

Implementation and acceptability
- Each ARCHES element was implemented with >85% of clients in both Kenya and Bangladesh
- >80% of clients reporting RC on survey disclosed to their provider (both countries)
- 82% of clients reporting IPV on the survey disclosed to their provider in Kenya and 55% disclosed in Bangladesh



1. Tarzia L, Hegarty K. A conceptual re-evaluation of reproductive coercion: centring intent, fear and control. Reprod Health. 2021 Dec;18(1):87.
2. Silverman JG, Raj A. Intimate Partner Violence and Reproductive Coercion: Global Barriers to Women's Reproductive Control. PLoS Med. 2014 Sep 16;11(9):e1001723.