



ARCHES Kenya

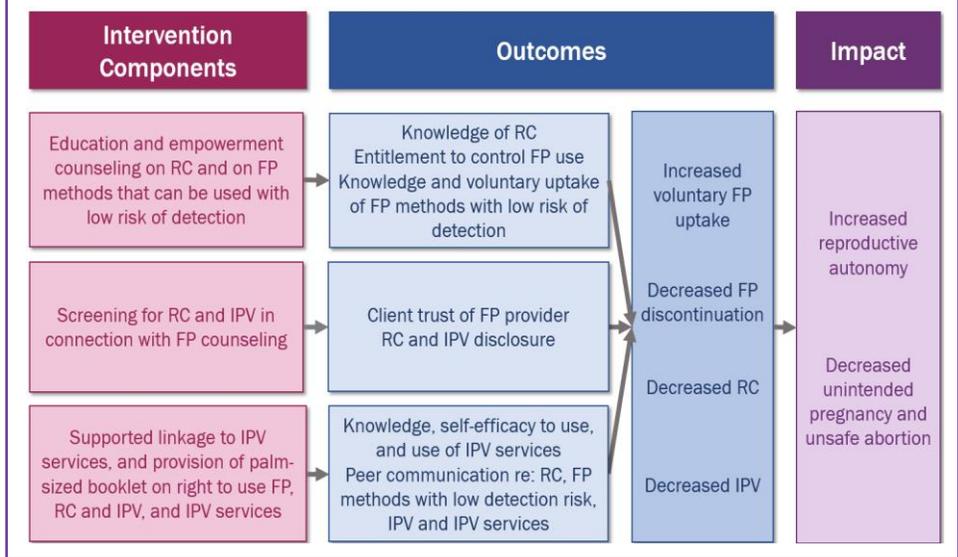
Promoting reproductive autonomy for women and girls by addressing gender-based violence within routine family planning counseling

BACKGROUND

Intimate partner violence (IPV) and reproductive coercion (RC; behaviors of male partners or family members that reduce female autonomy regarding pregnancy decisions or family planning use) are two prevalent forms of gender-based violence (GBV) consistently associated with poor reproductive outcomes among women and girls.¹⁻⁵ Despite World Health Organization (WHO) recommendations that identification and support of GBV survivors be integrated into reproductive health services, few effective models have been identified in low to middle income countries.^{6,7}

ARCHES (Addressing Reproductive Coercion in Health Settings) is a brief program delivered within routine family planning (FP) counseling, and demonstrated to reduce RC and IPV and increase reproductive autonomy among women and girls (see Figure 1), based on evidence from two U.S. randomized controlled trials involving >4000 female FP clients.⁸⁻¹⁰ The Center on Gender Equity and Health (GEH) at UCSD and our partners are now adapting and evaluating ARCHES in multiple low and middle income countries. **ARCHES Kenya** is the first such adaptation, and is being evaluated via cluster-controlled trial in six community-based clinics across Nairobi. ARCHES Kenya is being conducted by GEH in partnership with the International Planned Parenthood Federation (IPPF), Population Council and Family Health Options Kenya (FHOK), and is funded by the Bill and Melinda Gates Foundation.

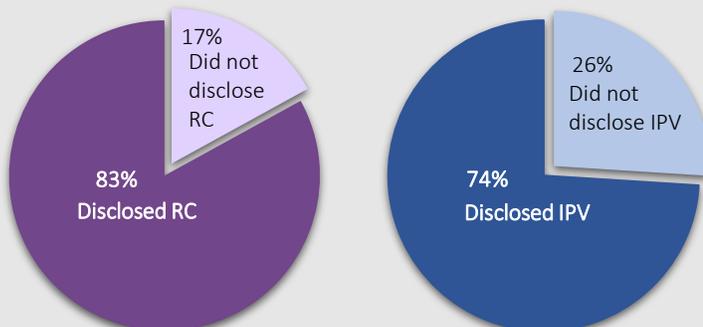
Figure 1: The ARCHES theoretical model



FINDINGS FROM ARCHES KENYA TO DATE

At baseline, among women and girls ages 15-49 years who received FP services (N = 657), more than 1 in 3 (37%) reported experiencing RC; 55% reported physical or sexual IPV, and 65% reported ever having an unintended pregnancy. Women who reported RC had nearly 3x the odds of reporting unintended pregnancy compared to women who had not reported RC (AOR 2.7, 95% CI 1.9-3.9) highlighting the importance of reproductive autonomy to women’s health. After receiving the single-visit intervention, over 95% of FP clients perceived the ARCHES counseling and education on FP methods that can be used with a low risk of detection to be helpful. Notably, more than 80% of FP clients who had experienced RC and 70% of clients who had experienced IPV subsequently disclosed these experiences to an ARCHES-trained provider upon being screened (see Figure 2); these are far higher rates of disclosure than observed in evaluations of other clinical models seeking to identify and support GBV survivors. As important, most all FP clients disclosing RC or IPV reported that providers’ responses to disclosure made them feel supported, safe, and understood (98-99%). Of clients offered the ARCHES Kenya “My FP Choice, My Right” mini-booklet,

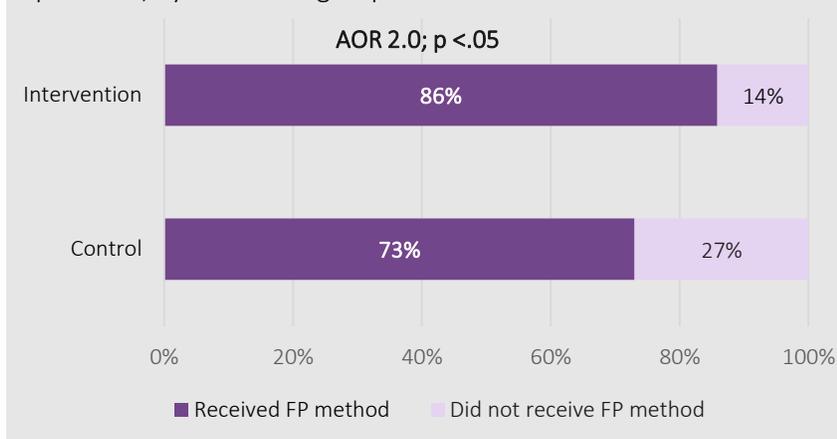
Figure 2: Disclosure of RC and IPV to an ARCHES trained provider among FP clients seeking care from intervention clinics



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97% took the booklet, and over 85% reported intending to share this information with female friends and family members. Demonstrating the impact of ARCHES provider training, women and girls seen at ARCHES intervention clinics were 75% less likely than those seen in controls to report that their provider “made them feel uncomfortable or treated them badly for using or wanting to use FP,” (AOR 0.25, 95% CI 0.1-0.8). Most importantly, women and girls receiving ARCHES were 2x as likely to receive an FP method during their visit than clients visiting control clinics (AOR 2.0, 95% CI 1.1-3.5, see Figure 3). The positive effects of ARCHES on provider behavior and FP method uptake extend to adolescent girls and young women (age 15-24 years), those most vulnerable to both GBV and unintended pregnancy. Providers delivering ARCHES described the model as highly relevant to their clients, and expressed increased confidence in their ability to meet clients’ needs based on their training and implementation of ARCHES (see Box 1). In interviews, women experiencing RC described how the interaction with an ARCHES provider helped them to use FP successfully and to realize their reproductive rights (see Box 2).

Figure 3: FP Uptake among ARCHES Kenya participants immediately post-visit, by treatment group



CONCLUSIONS

The ARCHES model is a brief, sustainable and scalable approach that may be highly relevant to FP practice globally. Adaptation in Kenya was found to be feasible and highly acceptable to FP clients and providers, and results indicate increased contraceptive uptake, high levels of disclosure of RC and IPV, and reduced provider maltreatment. Subsequent 3 and 6 month follow-up data from the current trial in Kenya will clarify the efficacy of ARCHES to improve the reproductive health and autonomy of women and girls, and to reduce RC and IPV. GEH, in partnership with Ipas, is also adapting ARCHES to the contexts of post-abortion care in Dhaka, Bangladesh (funded by Society of Family Planning), and family planning services for adolescents in Tijuana, Mexico (funded by NIH). Results of evaluations of these trials will inform replication and scaling of the ARCHES model in other low and middle-income contexts.

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Box 1: FP provider experience with ARCHES

Before the ARCHES training, I did not have the skills of intervening or counseling [women] on how to use family planning privately. I [now] have the skills to handle different clients, with different challenges that they face from their husbands in the uptake of family planning. I feel good delivering ARCHES because I am able to help empower someone who was unable to use family planning services [previously]. – FP Provider, FHOK, Nairobi

Box 2: FP client experience with ARCHES

Before [ARCHES], I could not use any [FP] method. It was after the provider talked to me that I opted for that method [injection]. Had he not talked to me, I would most likely be pregnant currently or with another child. The provider also told me if a man is abusive towards me I have rights as a woman. I do not have to let a man know that I am going for family planning; it is my right. These teachings are very important. Through them I have come to understand that I have my own rights and I know more FP methods than I did before. –FP client, FHOK Nairobi

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