Testing the integration of gender-based violence screening and response in routine health services in Nigeria

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Introduction

- Studies across the world have demonstrated that intimate partner violence (IPV) is associated with poor reproductive and maternal health outcomes, including male partner/family opposition to family planning (FP) use (i.e., reproductive coercion).

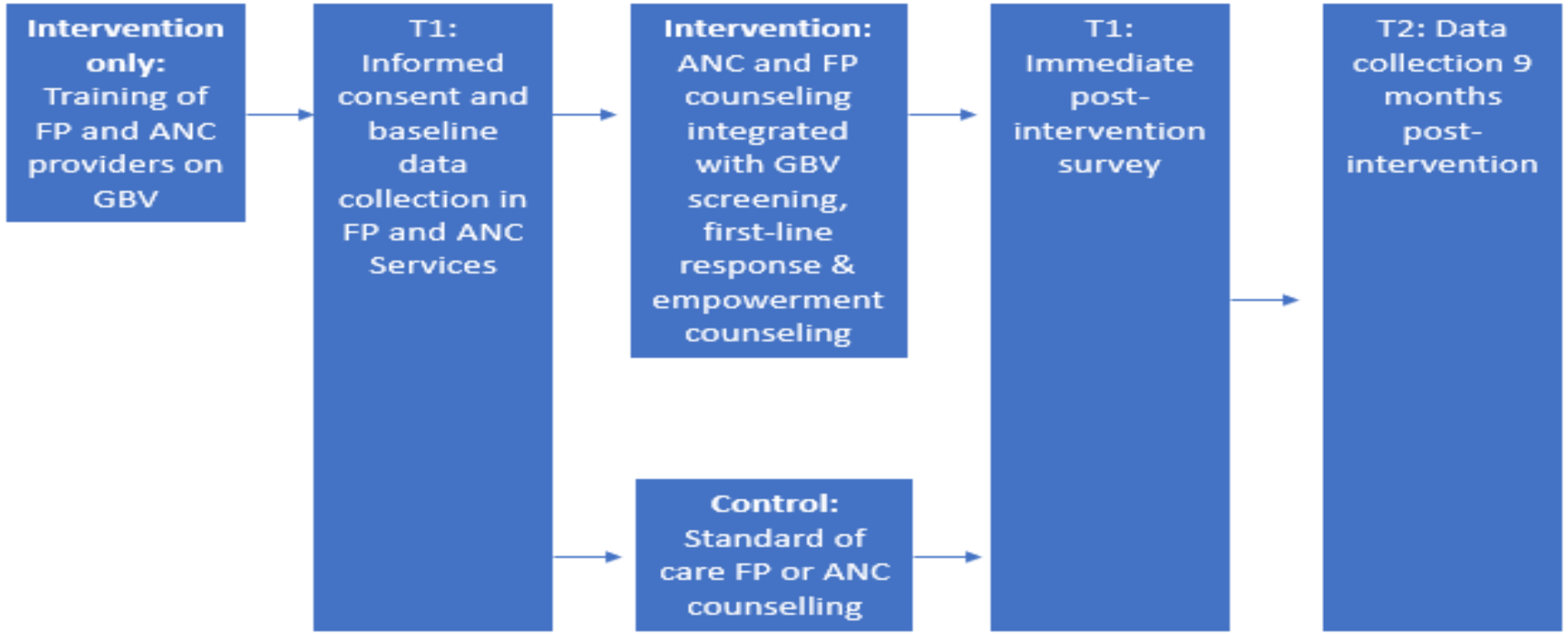
- In Nigeria, 36% women have experienced violence by their husband/partner becoming a clinical problem of epidemic proportions as well as a gross violation of women's human rights and bodily autonomy, yet, 45% of these women never sought help.

- RC, a phenomenon that involves interference with a woman's autonomous decision-making around contraceptive use and pregnancy decisions, is highly correlated with IPV, particularly when such interference is meted by a partner.

Study Aim:

To pilot and assess the effectiveness of integrating first-line response to GBV, particularly IPV, sexual violence and RC, within family planning (FP) and antenatal care (ANC) services at public health facilities in Ebonyi and Sokoto states in Nigeria.

Study Design



Study design: Quasi-experimental, matched-pair, cluster-controlled design with parallel treatment/control groups assigned in a 1:1 allocation ratio based on location, facility type, average number of new FP and ANC users

Study Setting: 20 intervention and 20 control sites with functional antenatal care and family planning units that provided at least three modern family planning methods.

Inclusion Criteria for Participants (n=1760)

Health Facility Eligibility

If they have functional ANC and FP units

Can provide at least 3 modern family planning methods and one long-acting reversible contraceptive (LARC).

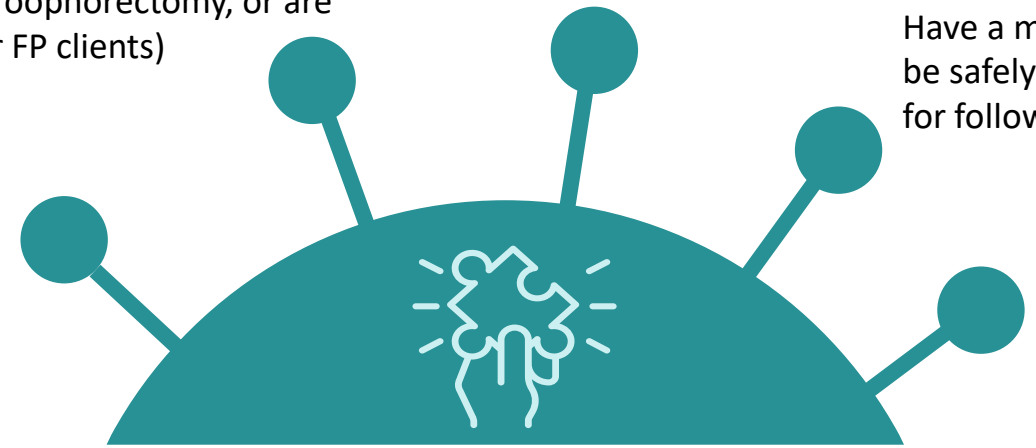
Client Eligibility:

Women who believe they are able to conceive (i.e. who have not undergone a tubal ligation, hysterectomy, or oophorectomy, or are menopausal) (for FP clients)

Have a male partner they currently have sex with

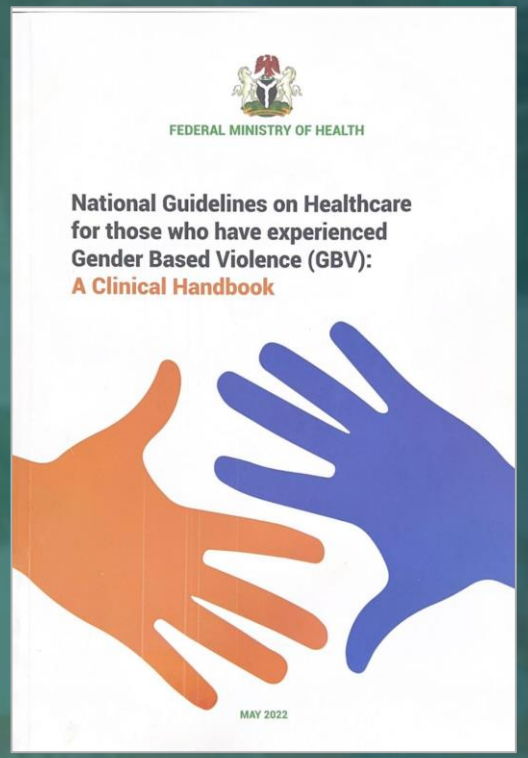
Have a mobile phone that can be safely used for re-contacting for follow-up surveys

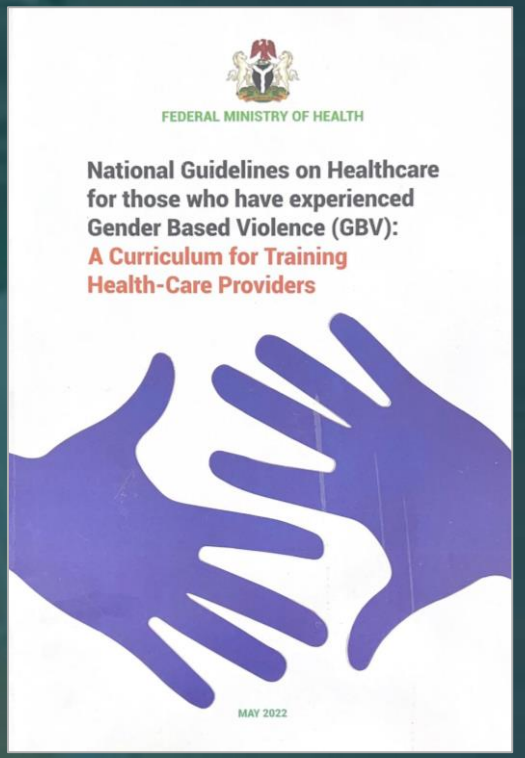
Women of reproductive age (18 to 49 years) seeking FP or ANC services at study sites



Do not have any accompanying male partners or family members aged 5 or above present

Intervention Design





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Intervention: Provider-driven GBV first-line response and reproductive empowerment counseling intervention

Screen

We integrated a combination of LIVES+ARCHES intervention into ANC and FP services: Introduced routine client screening for GBV, including intimate partner violence, sexual violence, and reproductive coercion using a standardized screening form, in FP and ANC services

First Line Response

For individuals who disclosed GBV, First-line response—empathetic counseling, including LIVES, safety planning, empowerment counseling and referral to other non-clinical services using a referral directory. counselling sessions lasted between 15 to 20 minutes.

IEC

Regardless of disclosure of GBV, counseling and information, education and communication (IEC) on IPV, including reproductive coercion, and FP options were provided to both FP and ANC clients.

In control facilities, posters also highlighted GBV as a violation of rights and GBV services available

Guided by protocols and on-going mento

Conduct GBV first-line response intervention only when you can speak to the client alone

GREET THE CLIENT, ASSURE CONFIDENTALITY AND AUDIO-VISUAL PRIVACY

SCRIPT: *"I'm really glad you came in today. May I know the purpose of your visit? Before we get started, I want you to know that violence is common in people's lives. Related to this, we routinely ask certain questions. The information you provide will better enable us to provide you with the necessary care. Everything you tell me will be kept confidential. I will not tell anyone; unless you tell me to do so."*

Ask client the purpose of her visit: ANC, FP or other?

TALK TO HER ABOUT REPRODUCTIVE COERCION (RC)

SCRIPT: *"Unfortunately, many women have a difficult time using family planning with their partners, so we ask these questions of all our clients."*

For ANC clients: Ask

Did you want this pregnancy? Or was it forced by your partner? If forced, has your current partner ever made it difficult for you to get or to use family planning (e.g. destroy, take away, or hide your contraception) in the past?

For FP clients: Ask

Are you currently being pressured or forced by your husband/male partner or family member to stop using family planning or to become pregnant, against your wishes?

> RC PRESENT

SCRIPT: *"Thank you for sharing this with me, I know these situations can be difficult to talk about. You have the right to be in control of your reproductive choices, no matter your situation. We can help and give you information and strategies to help you make the right FP decisions for yourself."*

ANC Clients: Help her in the care and safety she needs during pregnancy and childbirth and plan for postpartum contraceptive method options.

FP Clients: Offer full range of methods. Counsel her about methods that can be used privately and help client choose method of her choice. If unprotected intercourse within 72 hrs provide ECPs and PEP.

> RC NOT PRESENT

SCRIPT: *"I am glad to hear that you are not experiencing any of these issues in your relationship today. If your situation ever changes, I want to assure you that you have a safe space here to talk about these issues and receive help."*

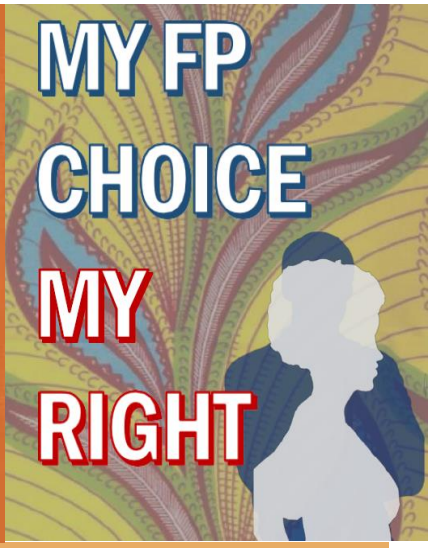
ANC Client: Provide routine ANC and PPFP

FP Client: Offer full range of methods. Counsel her about methods that can be used privately and help client choose method of her choice.

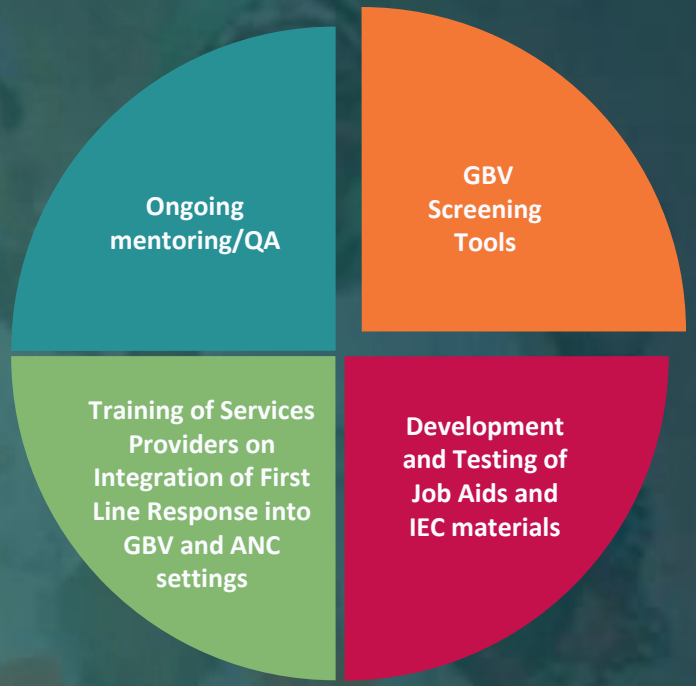
> IF RC PRESENT: TELL HER ABOUT FP METHODS THAT CAN BE USED PRIVATELY

SCRIPT: *"We have found that many women have difficulty using FP due to their partners or family. To help our clients make an informed choice we provide information about how to use FP methods privately."*

METHOD	PROS	CONS	DISCUSSION
Injectable contraceptives (DMPA-IM or DMPA-SC provider administered)	• Does not leave any marks on the skin • No supplies to store	• Menstrual bleeding changes, including amenorrhea possible • Need to come back every 3 months	• Are you worried that your partner may track your periods? • Do you think you can come back for re-injection without fail?
Injectable contraceptives (DMPA-SC self-injected)	• Does not leave any marks on the skin	• Same as above and • Supplies could be found	• Are you worried that your partner may track your periods? • Do you have a safe space to store the device?
Implants	• Works well for several years • Usually no follow-up needed • No supplies to store	• Sometimes can be felt under the skin of the arm • May cause spotting or bleeding changes (could improve over time)	• Are you worried that your partner may track your periods?
Copper or hormonal IUD	• Remains out of sight in the uterus • Long lasting (Copper for 12 years and Hormonal between 3 and 6 years) • Usually no follow-up needed • No supplies to store	• Copper IUD may increase menstrual flow • Hormonal IUD may decrease or stop bleeding • Needs to be inserted in a facility by trained provider. • Partner may be able to feel the strings at cervix	• Are you worried that your partner may track your periods? • Are you concerned that you may have an STI?
Pills (COCs or POPs)	• Does not leave any signs • Little effect on menstrual bleeding (POPs could extend lactational amenorrhea)	• Must be taken every day • Packet of pills must be kept in safe place	• Do you have a safe place to keep the pills?
Lactational Amenorrhea Method (LAM)	• No supplies to store	• Only feasible for women within 6 months postpartum and exclusively breastfeeding • Maintain exclusive breastfeeding may be challenging without partner support	• Does your partner provide you sufficient time and support to breastfeed exclusively? • Do you have a plan for a backup method or a switch if foods are introduced to the baby?
Emergency Contraceptive pills	• Prevents unwanted pregnancy from unprotected intercourse	• Must be taken within 72 hours of unprotected intercourse.	• Do you have a safe place to keep the pills



Study Analysis and Results



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Intended Primary and Secondary Effectiveness Outcomes

Primary outcomes

- Exposure rate to intimate partner and sexual violence
- Use of modern contraceptive methods

Secondary outcomes

- Reproductive coercion (RC)
- FP self-efficacy
- Knowledge of IPV and SV related laws and services
- Self-efficacy to access IPV services
- Use of IPV services
- Safety measures used

- *"Has your current partner ever slapped you, punched you, hit or kicked you, or done anything else to hurt you physically?"*
- *"Has your current male partner ever forced you to have sex or do something sexual when you didn't want to?"*
- *"Did you receive a family planning method today from your provider?"*

% Reporting IPV or SV, RC and Modern Contraceptives in last 6 months

	% Reporting Outcome		Intervention effect
Physical or Sexual Intimate Partner Violence[a]	Baseline N (%)	Endline N (%)	β (time x intervention) (95% CI)
Comparison facilities (N=779)	54 (6.93%)	64 (8.21%)	0.54 (0.30- 0.98)*
Intervention facilities (N=754)	74 (9.81%)	58 (7.69%)	
Reproductive Coercion[a]			β (time x intervention) (95% CI)
Comparison facilities (N=784)	51 (6.51%)	66 (8.41%)	0.52 (0.29-0.96)*
Intervention facilities (N=768)	72 (9.38%)	59 (7.68%)	
Current modern contraceptive use (FP cohort only)[b]			β (time x intervention) (95% CI)
Comparison facilities (N= 366)	259 (70.68%)	321 (87.67%)	1.04 (0.82-1.32)
Intervention facilities (N= 372)	252 (67.92%)	327 (87.89%)	

1,617 women completed both baseline and the 9-month follow-up surveys (92% retention)

Transition probabilities for IPV or SV and RC

IPV		Comparison (N=779)			Intervention (N=754)	
		Endline			Endline	
	Baseline	No	Yes	Baseline	No	Yes
	No (N=725)	678 (93.5%)	47 (6.5%)	No (N=680)	655 (96.3%)	25 (3.7%)
	Yes (N=54)	37 (68.5%)	17 (31.5%)	Yes (N=74)	41 (55.4%)	33 (44.6%)
RC		**Comparison (N=784)**			**Intervention (N=768)**	
		Endline			**Endline**	
	Baseline	**No**	**Yes**	**Baseline**	**No**	**Yes**
	No (N=733)	683 (93.2%)	50 (6.8%)	No (N=696)	676 (97.1%)	20 (2.9%)
	Yes (N=51)	35 (68.6%)	16 (31.4%)	Yes (N=72)	33 (45.8%)	39 (54.2%)

Use of services amongst those experiencing IPV or RC at endline

Service	Comparison N (%) (N=112)	Intervention N (%) (N=84)	Chi-2 p-value
Health Services	42 (37.5%)	27 (32.7%)	0.437
Law Enforcement	14 (12.5%)	14 (16.7%)	0.409
Legal Aid	2 (1.8%)	8 (9.8%)	P<0.05
Psychosocial support	2 (1.8%)	17 (20.2%)	P<0.01
Shelter/ temporary accommodation	3 (2.7%)	15 (17.9%)	P<0.01
Economic Reintegration	0 (0.0%)	11 (13.1%)	P<0.01

Safety actions taken by survey and intervention group (n=1,617)

Safety actions (measured with Y/N)	Intervention group	Baseline (%)	Endline (%)	
Identified a safe place to go in case you need to leave your home?	Comparison	66.4%	61.7%	p<0.01
	Intervention	59.7%	65.2%	
Identified a friend or relative to whom you could seek help?	Comparison	69.8%	60.1%	P=0.055
	Intervention	65.3%	64.8%	
Set aside some things you may need, such as clothes, documents	Comparison	38.3%	28.6%	P<0.01
	Intervention	26.4%	31.4%	
Set aside funds	Comparison	37.6%	22.7%	P<0.01
	Intervention	22.8%	25.1%	
Made a plan for children	Comparison	48.4%	42.3%	P<0.01

Study Impact

01 The enhanced GBV first-line response intervention effectively reduced both intimate partner violence and reproductive coercion, marking it as the first successful single-session, clinic-based counselling intervention to do so in low-resource public health facilities.

02 The intervention was more likely to prevent IPV, both physical and sexual, as well as RC in women who had not already been exposed to it, than mitigating on-going violence in women among GBV survivors

03 The study suggests that the intervention may have served as the first exposure for many women to the idea that violence is unacceptable, potentially triggering a positive response to the availability of services or safety actions.

04 The results of the study builds evidence substantiating that efforts should be made to streamline integration of GBV first-line response into routine health services, as it can mitigate risk of violence to clients.

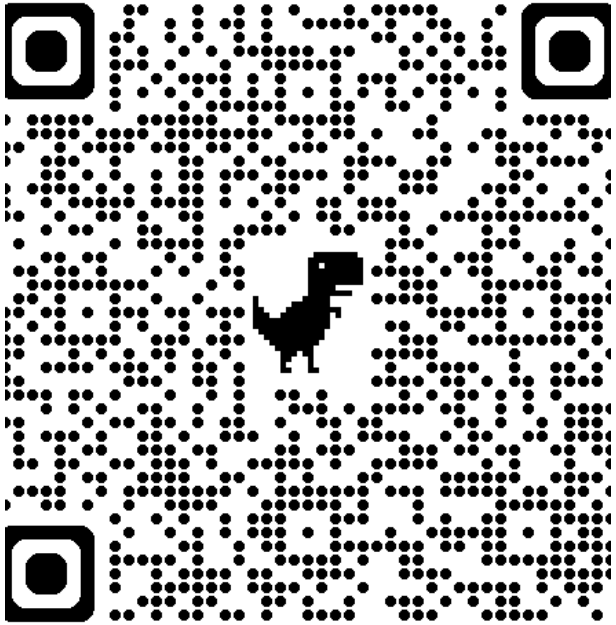
Limitations and Areas for Future Research

Key limitations:

- Did not assess exposure effect to each component of intervention
- Limited to 6 month recall period of the 9 months post-intervention
- High levels of modern contraceptive use, given FP point of service
- Did not assess client perspectives

Future research:

- Analyze effect of subcomponents
- Analyze pathways to change through further analysis and qualitative research with clients



Thank You for Listening

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