Lessons in Adaptation of a Clinical Intervention to Address Reproductive Coercion and Violence Across Five Countries

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What We'll Discuss

1. **Background** – Reproductive Coercion is GBV
2. **ARCHES Adaptation** – Aims and Objectives
3. **FRAME Methodology** at the Centre
4. **Adaptation Study Findings**
5. **Recommendations** for Future Adaptations

BACKGROUND

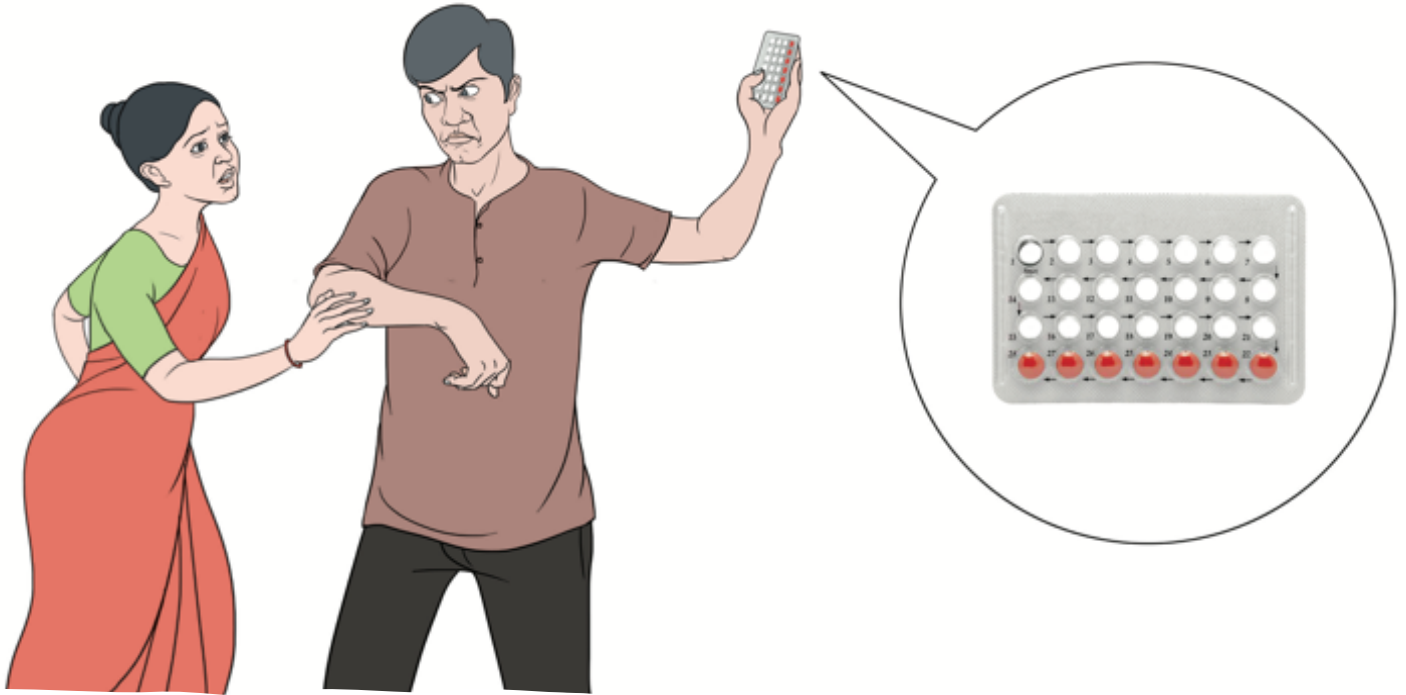
Reproductive Coercion is Gender-based Violence

Reproductive Coercion (RC)

RC is 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.**

- Prevalence in FP settings ranges from **10%** in Bangladesh to **42%** in Kenya.

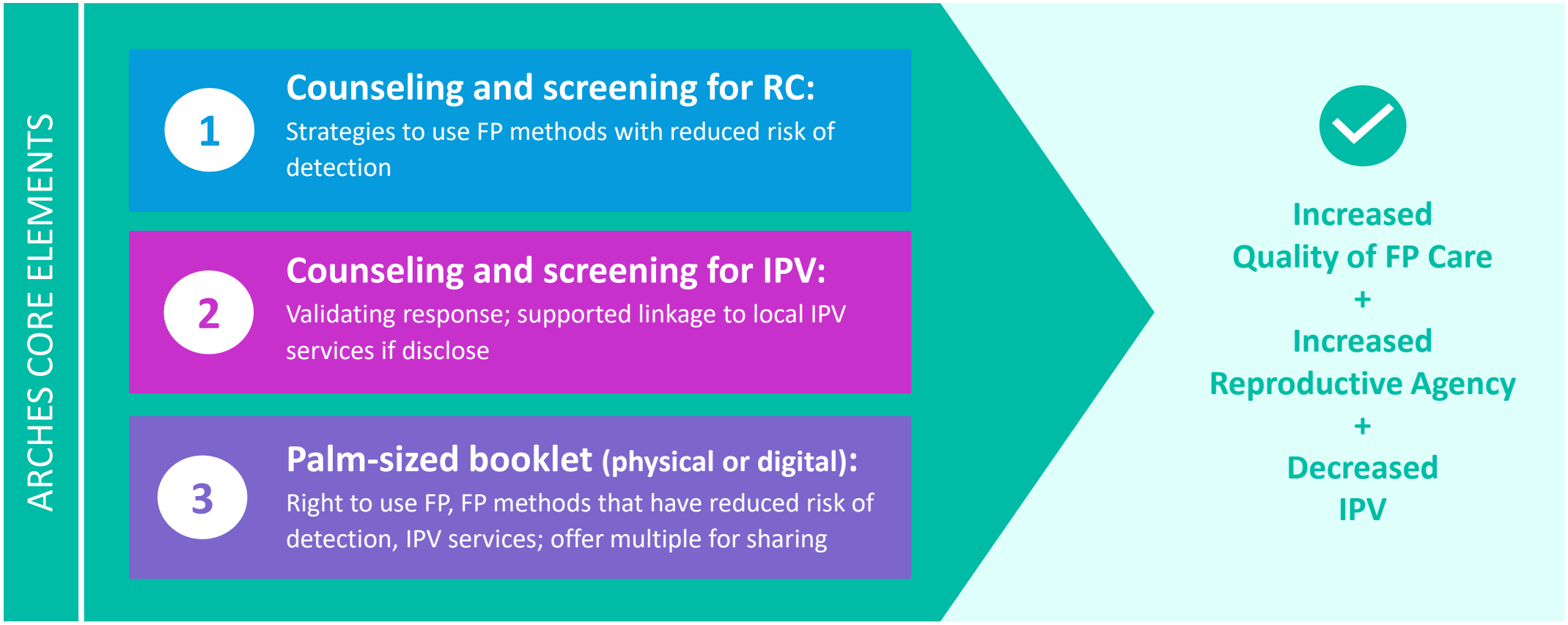
- Women experiencing RC are:
  - **4.7 x** more likely to report recent unintended pregnancy.
  - **8.0 x** more likely to report experiencing intimate partner violence.



The ARCHES Approach

Scalable by Design

The ARCHES approach consists of three core elements that are readily integrated into existing FP counseling models and are delivered by existing staff. These elements are integrated into a *single counseling session* and take *minimal time to deliver.*



ARCHES ADAPTATION

Aims and Objectives

A.D.A.P.T

A **Assess** context

D **Design** adaptation approach

A **Adapt** programme

P **Pilot** and refine adapted programme

T **Targeted** implementation and evaluation of the adapted programme

Goal: increase fit and maintain fidelity

Core Components of Adaptation

Retain these core components during a program adaptation:

- **Fidelity** - degree to which a program is implemented as intended by the original developers
- **Fit** - how closely the program is tailored to the context in which adaptation occurs
- **Local partner's experience** – move beyond structural changes to meaningful change in relation to norms, values, beliefs…

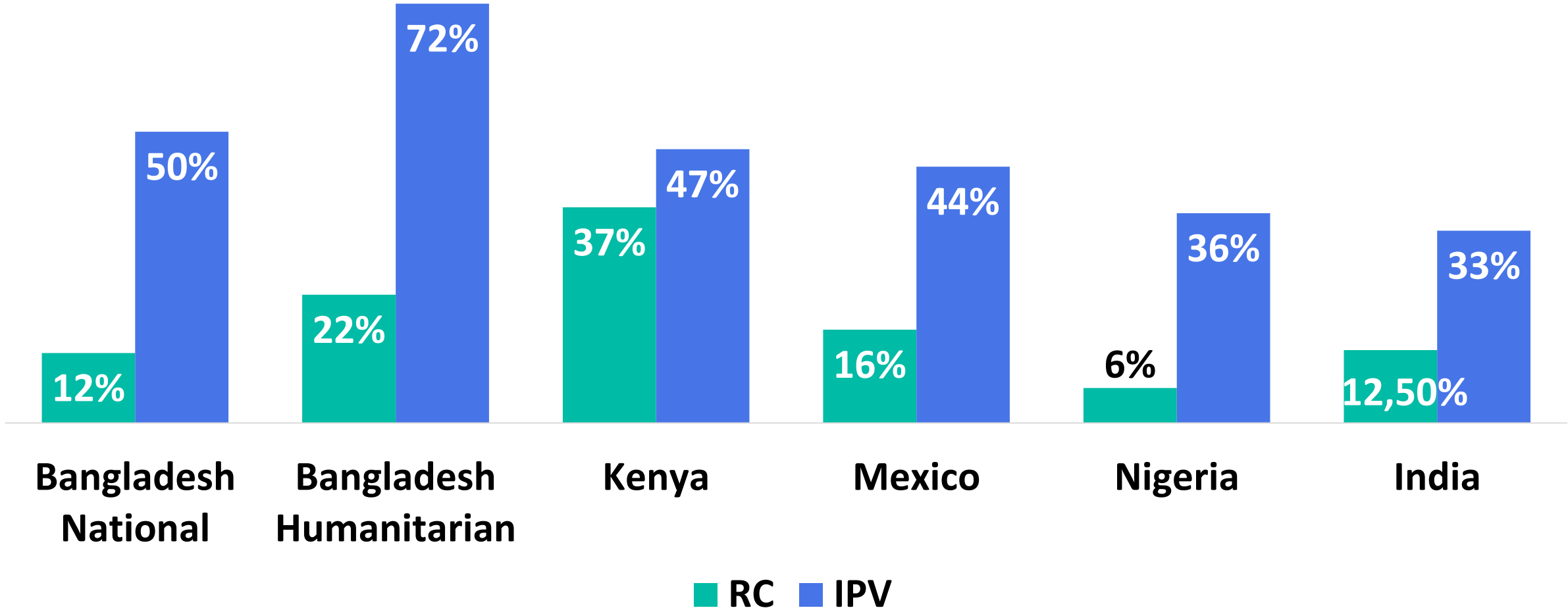
Where has ARCHES been adapted and implemented?

- **2009-2015** ARCHES initial development and testing via two randomized control trials in the **United States**
- **2016** First clinical adaptation to an LMIC context in **Nairobi, Kenya**
- **2018-2023** Adaptations in **Mexico**, **Nigeria,** and **Bangladesh** (including abortion and humanitarian settings); Gov't of **Kenya** initiates national scaling efforts
- **2024** First adaptation outside of the health system (community-based women's economic empowerment groups in **Kenya**); adaptations initiated in **India**

Setting, Population, Facilities
Across Adaptations

BANGLADESH	KENYA	MEXICO	NIGERIA	INDIA
• Women seeking abortion services in urban areas from Ipas facilities • Women seeking FP or abortion services in humanitarian setting (Cox Bazar) with Rohingya from Ipas facilites	• Women seeking FP services from IPPF facilities in Nairobi • Women seeking FP services from public facilities in one peri-urban county	Women seeking FP services from IPPF/Mexfam facilities in Mexico City	Women seeking FP and ANC services in public facilities	Women seeking FP in IPPF/FPAI private facilities and public facilities and through community-based outreach in Madya Pradesh National: 32%

RC and IPV Baseline Prevalence
Across Country Contexts

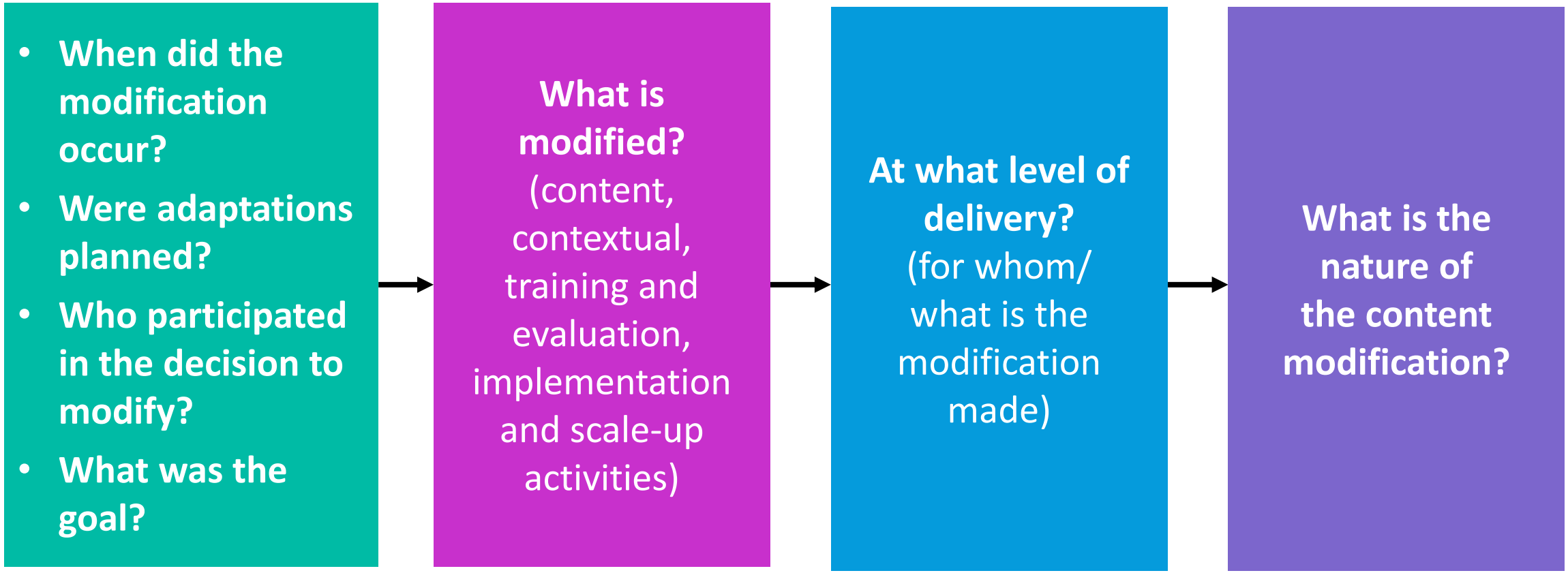


AT THE CENTRE

FRAME Methodology

FRAME Guided Our Study

FRAME is an implementation science framework to document and categorize the types of adaptations made and provides a template for considering how adaptations may affect intervention **fidelity** and **effectiveness**.



Research Questions

1. What core principles and elements, implementation factors, and population or contextual factors, influenced adaptation of the ARCHES model across contexts?

2. How did program staff adapt core principles and messages, implementation processes, and existing tools/guidance to promote high-quality implementation and integration in each context?

Methodology

- **Self-administered reflection matrix** completed by program implementers using a matrix format capturing changes during implementation and lessons learned.

- **In-person workshop** with representatives across 5 organizations, held in November 2022. Structured interview questions followed by open discussion among attendees.

- **Virtual key informant interviews** with 8 representatives across 5 organizations from Bangladesh, Kenya, Nigeria, and Mexico in February 2023. Drew upon FRAME to develop the key informant interview guide and to categorize adaptations and processes shared across the three forms of data collection.

ADAPTATION

Study Findings

Core ARCHES Elements
Training and Facility Factors

Values clarification activities

Reproductive coercion content

Integration of ARCHES into facility counseling processes

Whole site provider training and follow-up

Adequate human resources

Auditory and visual privacy

Innovative strategies to improve quality of adaptation and build support for scale

- Engaging local groups of research experts or professional medical or health societies improved identification of solutions to challenges.
- Utilizing advisory groups made up of a range of actors improved support for the intervention
- Creating a **Community Advisory Group** comprising women and girls from the population ensured adaptations align with local needs and values.

Common Decision-makers at Each Stage of Adaptation

Researchers, policy makers, leadership, donors	IRBs, research & implementation partners, NGO reps, ministry reps	Implementation partners, health providers, health facility clients	Government ministry officials, research partners, implementation partners
Select contexts, facilities, health units within facilities, and roles within partnerships	Conduct formative research and host an adaptation workshop	Validate adapted materials with providers and clients	Regular meetings to review monitoring data & adjust implementation

FOR FUTURE ADAPTATIONS

Recommendations

Key Takeaways

Engage ministry representatives and other decision-makers early and often.

Apply human-centered design processes to promote efficiency and cultural acceptability of adaptation**.**

Collect data regularly and use program monitoring data to allow for rapid analysis.

Develop strong coordination and communication processes from the start, with regularly scheduled meetings.

Consider client load in all adaptations. Without proper consideration of provider workload, ARCHES may add unacceptable and infeasible time to client visits, and increasing staffing is not feasible or scalable in most settings.

LEARNING FROM ADAPTATION: FPAI

ARCHES Model in India

In public (*Government of India*) and private (*Family Planning Association of India*) family planning service delivery settings

Public Facilities

1 District Hospital
1 Community Health Centre
2 Primary Health Facilities
21 Sub-Centres

+

Private Facilities

1 FPAI Clinic
1 Satellite Clinic

Community Health Workers (ANM, ASHA, AWW) are an **integral part of the ARCHES implementation.**

Adapting Lesson from ARCHES

- **Fidelity** – ARCHES core components retained but contextualized *(e.g., language edited to be culturally acceptable, visuals used for low literacy, simplified training materials, etc.)*
- **Fit** – needs assessment to better understand the context *(e.g., learned about common provider misconceptions to address during training and challenges with privacy to strategize solutions with providers)*
- **Local partner's experience** – co-creation in designing the intervention, ARCHES community component

Adaptation works best **when partners trust and value each others' contributions.**


FPAI
IPPF
Addressing Reproductive Coercion in Health Settings (ARCHES)
Co-Creation Workshop
Gwalior - India
July 30- August 1, 2024

Thank you to our ARCHES Partners!

BANGLADESH	KENYA	MEXICO	NIGERIA	INDIA
Urban: Ipas; UCSD; Reproductive Health Training Services and Education Program (RHSTEP); Bangladesh Association for the Prevention of Septic Abortion (BAPSA) *Humanitarian*: Ipas; UCSD; IOM; Multisectoral Program on Violence Against Women under the Ministry of Women and Children Affairs	*Urban*: Kenya Ministry of Health; UCSD; Population Council; International Planned Parenthood Federation; FHOK* *Urban, peri-urban and rural*: Kenya Ministry of Health; UCSD; Population Council	Mexfam; UCSD; International Planned Parenthood Federation	MOMENTUM Country and Global Leadership (MCGL) GBV program: JHPIEGO; UCSD; Federal Ministry of Health; Federal Ministry of Women's Affairs; State Ministry of Health; State Ministry of Women's Affairs; State Primary Health Care Development Agencies; NANA Women and Girls initiative; HHGSF*; RUWOYD*; EHNRD*; ECEWS*; DOVENET*	Family Planning Association of India (FPAI), International Planned Parenthood Federation, UCSD, Sambodhi and Ministry of Health & Family Welfare-Government of India

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