

# Effectiveness of ARCHES in Improving Reproductive Autonomy in Humanitarian Settings

Results from a pre-post study with Forcibly Displaced Myanmar Nationals in Cox's Bazar district, Bangladesh

*Reproductive coercion (RC) describes behaviors designed to interfere with women's and girls' FP use or pregnancy decisions. It often co-occurs with Intimate partner violence (IPV).*

## Summary

The Addressing Reproductive Coercion in Health Settings (ARCHES) intervention is a single counseling session that is designed to address reproductive coercion (RC) and connect clients with available intimate partner violence (IPV) services. Adaptation of ARCHES for use with Forcibly Displaced Myanmar Nationals (FDMN) seeking menstrual regulation (MR), postabortion care (PAC), or family planning (FP) services in Cox's Bazar district, Bangladesh resulted in:

- Increased self-efficacy to use FP in the face of RC
- Increased self-efficacy to use IPV support services
- Attitudes less accepting of RC

The ARCHES intervention was implemented with high fidelity and resulted in improvements in attitudes and self-efficacy, which are important outcomes on the pathway to reproductive autonomy. Scale-up of ARCHES in camp facilities providing MR, PAC and FP services in Cox's Bazar district should be considered.

### What is ARCHES?

ARCHES is a brief, clinic-based intervention delivered by providers to women and girls seeking MR, PAC, and FP services aiming to:

- Increase women's and girls' ability to use FP in the face of RC, facilitating women's voluntary FP uptake and continued use without interference
- Provide a safe and supportive environment for IPV disclosure and subsequent referral to support services
- Educate and support providers to improve quality of care related to FP counseling, including addressing RC and IPV

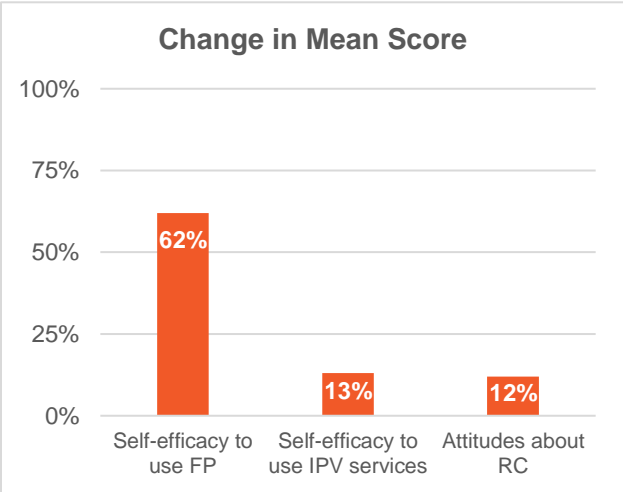
# Background

Women living through humanitarian crises face significant barriers when trying to prevent unwanted pregnancy and meet their basic sexual and reproductive health needs. IPV and RC negatively impact women’s health and well-being and are strongly associated with poor reproductive health including unintended pregnancy. In the uncertain environment of refugee camps, a woman’s ability to manage her reproductive life is crucial to protecting her health and autonomy. ARCHES counselling sensitizes women to the issues of IPV and RC during routine reproductive health services and empowers them with strategies to address IPV and RC and control their pregnancy decisions.

# Methodology

The ARCHES intervention was adapted for use with FDMN women seeking MR, PAC, and FP services in camp facilities using a user-centered design approach that was overseen by the project’s Community Advisory Group, consisting of community women, and Resource Group, which included government and camp officials and partner organizations. We conducted a pre-post evaluation of the adapted ARCHES intervention in four health facilities in the Ukhiya (Camp 3 and Camp 10) and Teknaf (Camp 24 and Camp 21) upazilas of Cox’s Bazar district between July and September 2022.

All female MR, PAC, and FP clients aged 18-49 at study facilities were eligible to participate. Women who consented to participate in the study completed a baseline survey before meeting with the provider and an exit survey after receiving their MR, PAC, or FP service and before leaving the facility. Primary outcomes included self-efficacy to use FP in the face of RC, self-efficacy to use IPV support services, and attitudes about RC. Self-efficacy to use FP in the face of RC was measured using a sum score (range: 0-6) of three questions about confidence using FP in the face of opposition, measured on a three-point Likert scale (not at all confident, somewhat confident, very confident). Self-efficacy to access IPV support services was defined as one question that asked, “If experiencing violence, how confident are you that you could access support services?” measured on the same three-point Likert scale as described above. Attitudes about RC were measured using a sum score (range: 0-33) of 11 questions measured on a four-point Likert scale (strongly disagree, disagree, agree, strongly agree). All scales had Cronbach’s alpha>0.8. Mean scores and percent change from baseline to exit was calculated.



The change in outcomes between baseline and exit was assessed using mixed effects linear regression models adjusting for service type (MR/PAC or FP), age, education, and paid work in the past 12 months, and accounting for clustering at the facility and individual levels.

# Results

## Baseline Sample Characteristics

A total of 592 FDMN women completed the baseline and exit surveys. Ninety percent

were FP clients and 10% were MR/PAC clients. Sixty percent were age 25 or older, and 40% were age 18-24. All were Muslim, and 99% were currently married. Approximately half of women had no education (51%), 43% had some primary education, and 5% had completed primary or higher education. Only 8% of women had participated in paid work in the past 12 months. Participants had been in Bangladesh for an average of 9 years (range: 0-40 years). Seventy percent reported having experienced IPV, and 22% had experienced RC.

## ARCHES Implementation

Fidelity of implementation was high; approximately 85% of participants were exposed to all intervention components. Disclosure of RC and IPV to the provider was high among those who reported RC and IPV at baseline (96% and 87%, respectively). Among those who disclosed IPV to their provider, 27% were offered a referral for IPV support services, and among those offered a referral, 78% accepted.


## Effectiveness of ARCHES

Contraceptive self-efficacy in the face of RC increased from a mean score of 2.6 at baseline to 4.2 at exit, a 62% increase (adjusted Beta=1.62; 95% CI: 1.42 – 1.82). Self-efficacy to use IPV support services increased from a mean score of 1.6 at baseline to 1.8 at exit, a 13% increase (adjusted Beta=0.15; 95% CI: 0.10 – 0.19). Attitudes about RC also improved between baseline and exit from a mean score of 10.8 at baseline to 11.9 at exit, a 12% increase (adjusted Beta = 1.12; 95% CI: 0.80 – 1.46).

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**ARCHES was implemented with high fidelity and resulted in improvements in attitudes and self-efficacy, especially self-efficacy to use contraception in the face of partner opposition.**

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