ADDRESSING REPRODUCTIVE COERCION IN HEALTHCARE SETTINGS (ARCHES)

TABLE OF CONTENTS

ACRONYMS

ARCHES	Addressing Reproductive Coercion in Healthcare Settings
BAPSA	Association for Prevention of Septic Abortion, Bangladesh
FDMN	Forcibly Displaced Myanmar National
GBV	Gender-Based Violence
IOM	International Organisation for Migration
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
KIIs	Key Informant Interviews
NGO	Non-governmental Organisation
UCSD	University of California, San Diego
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

One million forcibly displaced Rohingya people – half of them women and girls – live in densely populated refugee camps near Cox's Bazar, Bangladesh, where they face limits to their freedom of movement and access to work and essential services. Women's mobility is further reduced by societal constraints, as is their decision-making power, including their reproductive autonomy. Intimate partner violence is considered a social norm, and among the many Rohingya refugee women not using contraception, the majority cite their husband's disapproval as the primary reason for abstaining from birth control. **Reproductive coercion is a form of gender-based violence** where abusive behaviours are used to control a woman or girl's family planning use or pregnancy decisions. It strips away autonomy and heightens health risks for the women and girls who experience it.

Addressing Reproductive Coercion in Health Settings (ARCHES) is a harm reduction intervention designed to help women use family planning methods without interference. It is thought to be the first intervention of its kind focusing on reproductive coercion. It consists of three core elements, delivered by healthcare workers: a rights-based counselling and screening session on reproductive coercion; counselling and screening for intimate partner violence without pressure to disclose; and the offer of a discreet information booklet.

ARCHES has been used in several countries, and through two Elrha innovation grants Ipas has pioneered its first use in a humanitarian response. Ipas used user-centred design to adapt ARCHES to Cox's Bazar, not just translating materials into Rohingya, but, crucially, contextualising them with input from community members and an advisory group. **Piloting ARCHES saw women receiving the intervention report a 92% increase in self-efficacy to use modern contraceptive methods despite partners' opposition, and a 17% increase in self-efficacy to use intimate partner violence support services**.

The approach is now increasing in scale in Bangladesh: it has **reached more than 25,000 Rohingya women and girls** and United Nations Population Fund (UNFPA) has provided funding to roll ARCHES out across more health centres in Cox's Bazar. While the original ARCHES is a clinic-based intervention, Elrha's second grant has supported further adaptation for the delivery of ARCHES in humanitarian settings where women and girls face heightened barriers to accessing health clinics. Ipas has now developed a community-based ARCHES intervention, to be implemented outside of clinics, through community health-workers.

Drawing on project data and key informant interviews with project staff and other stakeholders, this case study explores the critical need for an intervention such as ARCHES in Bangladesh. It includes reflections on their experience of the adaptation and implementation work, including success factors and some notable challenges. Although there is compelling impact data from the clinic-based intervention, such data was not yet available for the community-based intervention so is not included here. This data will be available in 2025.

The case study shares key learnings from Elrha's support for ARCHES, such as:

- **User-centred design proved highly valuable to the adaption process.** Adapting ARCHES was a challenging process in which key terms could not simply be translated but instead required substantial contextualisation, and taking a design approach to this helped meet user needs.
- **Integrating ARCHES into existing workflows adds to its scalability and sustainability**. The intervention works best when it is not a standalone service, but results and practices during implementation need to be continually monitored to mitigate risks and understand further adaptation needs.

The case study concludes that **ARCHES is a valuable, scalable and unique intervention that responds to the immediate needs of women and girls to have reproductive autonomy and make informed choices with or without their family's support.**

INTRODUCTION

Background

In Bangladesh's Rohingya refugee camps, women and girls face widespread reproductive coercion[1], where male partners or family members often control or deny their reproductive choices.[2] This occurs within a broader context of gender-based violence (GBV), severe restrictions on mobility and the trauma of displacement. The camps, home to nearly one million refugees, offer limited access to essential sexual and reproductive health services due to resource shortages and cultural norms and stigma. As a result, women and girls are left vulnerable to unintended pregnancies and poor reproductive health outcomes, with limited support to address the violence and coercion they experience.[3] The socio-cultural environment, compounded by displacement and lack of autonomy, further marginalises women and girls, making it difficult for them to protect their health and exercise control over their bodies.

This case study focuses on the innovation ARCHES, an evidence-based harm-reduction counselling intervention, funded by Elrha and adapted by Ipas for use in Bangladesh. ARCHES aims to support Rohingya women and adolescent girls facing reproductive coercion and intimate partner violence. Elrha has supported Ipas in adapting ARCHES for clinical settings in Cox's Bazar and is currently funding its adaptation and piloting for community-based use in two of the refugee camps.

As part of Elrha's commitment to accountability and learning, this case study contributes towards the body of evidence about what is being achieved through Elrha's grant-making activities and insights into "what works" when supporting humanitarian innovation. The case study seeks to identify relevant learnings for actors adapting and scaling humanitarian innovations.

Summary of Methodology

The case-study explores five primary research questions:

1. Which humanitarian problem(s) does the innovation address?
2. How does the innovation aim to address the problem, and how does it compare to existing solutions (if any)?
3. How effective has the innovation been in reaching its intended objectives?
4. What impact has the innovation achieved so far and what is the potential for the innovation to achieve further impact in the future and effectively address the problem at scale?
5. What key learning has emerged from the innovation?

The case study captures reflections from 20 interviews with project implementation team members (Ipas and The Center on Gender Equity and Health at the University of California, San Diego), GBV experts, the ARCHES technical advisory group members in Cox's Bazar and trained providers. It also draws on desk-based research undertaken in Cox's Bazar and from other settings where ARCHES adaptations are being implemented. (Annex 2 provides further details on the methodology.)

[1]Annex 1 provides a glossary of key terms such as reproductive coercion which are used regularly within this case study.
[2]Toma, L., Chowdhury, M., Laiju, M., Gora, N., Padamada, N. (2018). Rohingya Refugee Response Gender Analysis: Recognizing and responding to gender inequalities. Action Against Hunger, Oxfam, Save the Children.
[3]Baro. S., (2017). In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Situations. Guttmacher Policy Review. Feb. 2017. And Bianca, A. D., Dikaios. S. (2021). Maternal Health in Crisis: A Scoping Review of Barriers and Facilitators to Safe Abortion Care in Humanitarian Crises. Frontiers in Global Women's Health. Vol:2, 2021

THE HUMANITARIAN PROBLEM

Close to one million Rohingya people live in and around Cox's Bazar, Bangladesh, as a result of forced displacement from Myanmar since 2017[4]. Half of the population is female, half of whom are adults.[5] Most refugees are living in the 33 camps in Cox's Bazar, the South-Eastern coastal district, which itself has high levels of infant mortality, GBV and early marriage. Rohingya refugees have no freedom of movement or right to work, and their access to education and healthcare is limited. Cultural norms for both host and refugee communities often restrict women's and adolescent girls' mobility and decision-making ability, including their reproductive autonomy. Child marriage restricts adolescent girls' control over their reproductive choices, making them more vulnerable, and increasing the likelihood of reproductive coercion, intimate partner violence, mental distress and exclusion from social participation and personal growth.[6]

A 2019 study found that around half of Rohingya women surveyed in the refugee camps were not using contraception. The most common reason given for not using contraception was their husband's disapproval.[7] A 2018 study also found that intimate partner violence was considered a social norm by both men and women.[8] Violence against displaced women and girls is a global problem: approximately one in five refugees or displaced women in complex humanitarian settings experienced sexual violence.[9]

While some humanitarian projects distribute contraceptives that can help prevent disease transmission and unwanted pregnancies, distribution alone does not address reproductive coercion, through which women may be denied the use of contraceptives or be stigmatised and threatened with harm if they do not become pregnant.

Reproductive coercion can lead to pregnancies that are unwanted by the mother, involve unsafe abortion, or that are high-risk (for example, adolescent mothers or those with comorbidities) and contribute to the heightened maternal death rate in humanitarian settings. The rate of maternal death and injury in crisis zones is almost double the world average.[10] Ipas found that 70% of women seeking family planning and abortion services at clinical facilities in Cox's Bazar experienced intimate partner violence and 22% experienced reproductive coercion.[11] Addressing reproductive coercion through a harm reduction intervention in humanitarian settings has the potential to be life-saving.

The intersection of humanitarian needs with women's and adolescent girls' contraceptive choices and decision-making processes is a complex and multifaceted issue. Decision-making is shaped by male dominance, familial pressure, socio-cultural connotations, stigma and accessibility. The influence of male dominance often manifests in the form of patriarchal control over women's and adolescent girls' bodies and reproductive choices, while family pressure can stem from traditional expectations and obligations. Socio-cultural connotations and stigma further exacerbate these challenges by perpetuating negative perceptions and judgments about women's use of contraceptives.

Additionally, there are multiple barriers to accessing services including lack of screening protocols, patient privacy concerns, provider workload and the availability and affordability of contraceptive methods. These were

[4]Bangladesh, which is not a signatory to the UN Refugee Convention, terms Rohingya refugees living in camps as Forcibly Displaced Myanmar Nationals. However, for the purpose of this case study, we will follow the UN system that refers to this population as Rohingya refugees, in line with the applicable international framework

[5]Joint Government of Bangladesh - UNHCR Population Factsheet as of September 2024. Available here.

[6] Guglielmi, S., Mitu, K. & Seager, J. 'I Just Keep Quiet': Addressing the Challenges of Married Rohingya Girls and Creating Opportunities for Change. *Eur J Dev Res* **33**, 1232–1251 (2021). https://doi.org/10.1057/s41287-021-00437-6

[7] Khan, M.N., Islam, M.M., Rahman, M.M. and Rahman, M.M., 2021. Access to female contraceptives by Rohingya refugees, Bangladesh. Bulletin of the World Health Organisation, 99 (3),

[8] Toma, L., Chowdhury, M., Laiju, M., Gora, N., Padamada, N. (2018). Rohingya Refugee Response Gender Analysis: Recognizing and responding to gender inequalities. Action Against Hunger, Oxfam, Save the Children.

[9] Vu A, Adam A, Wirtz A, Pham K, Rubenstein L, Glass N, Beyrer C, Singh S. 2014. The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis. PLoS Curr. 2014 Mar. PMCID: PMC4012695

[10] Health Cluster, Sexual Reproductive health and rights in emergencies. WHO. Available here.

[11] Ipas. (2022). Effectiveness of ARCHES in Improving Reproductive Autonomy in Humanitarian Settings. Results from a pre-post study with Forcibly Displaced Myanmar Nationals in Bangladesh. Ipas: Chapel Hill, NC

compounded by “a long history of denial of healthcare” in Myanmar, meaning that Rohingya people were reluctant to seek care in Bangladesh and patients found it difficult to speak openly with health professionals.[12] Consequently, these intersecting factors significantly hinder women’s and adolescent girls’ capacity to make informed and autonomous decisions regarding their reproductive health.

In the camps, there is access to family planning, GBV and sexual reproductive health rights services provided by different actors. Services include GBV case management, sexual and reproductive health advice and support, family planning and abortion services. There are also women and girl safe spaces in the camps, providing a safe, confidential and comfortable place to gather and access services and support. However, ARCHES is a unique counselling intervention focusing on reproductive coercion, which other services do not specifically address.

[12] Chowdhury S.A., et al. (2020). Sexual Violence, Trauma and Neglect: Observations of Health Care Providers Treating Rohingya Survivors in Refugee Camps in Bangladesh. Physicians for Human Rights. Available here.

THE INNOVATION

ARCHES is a harm reduction intervention designed to help women use family planning without interference. It creates a safe and supportive space for women to talk about intimate partner violence and get referrals to support services. ARCHES also aims to improve the quality of family planning counselling by addressing issues like reproductive coercion and intimate partner violence.

ARCHES consists of three core elements, delivered as a universal education intervention with an overall aim of increasing reproductive agency and decreasing GBV:

- One rights-based counselling and screening session on reproductive coercion, integrated into other sexual and reproductive health consultations for women and girls. This session includes strategies for using family planning methods discreetly, as a way of reducing male partner or family member interference.
- Counselling and screening for intimate partner violence without pressure to disclose. This includes supportive, respectful, validating responses, and offers of referral to support services for those who choose to disclose.
- Offer of an easily concealable mini-booklet (for personal use or sharing with friends, groups or partners) containing information on family planning methods, reproductive coercion, intimate partner violence and information on local GBV-related services

Crucially, it provides women and girls experiencing reproductive coercion with harm reduction strategies that they may choose. Without this intervention, reproductive coercion may go unrecognised and unaddressed, meaning that family planning interventions are undermined, and women and girls trying to use family planning are unaware of strategies and resources that might protect them.

"It really centres women and girls as the experts on their own personal situation. So we train providers not to be prescriptive. Providers are trained to really try to understand exactly what the woman is experiencing and then work with her to find the method that will work best."

– Project Team Member

The Innovation Journey

The Humanitarian Innovation Guide sets out an innovation process in six stages (Recognition, Search, Invention, Adaptation, Pilot, Scale), and recognises that few, if any innovation journeys are linear. These stages bear consideration when identifying ARCHES as an innovation.

ARCHES is thought to be the first clinical intervention to include a formal assessment of reproductive coercion for women seeking reproductive health services, and to facilitate patient and provider discussions of reproductive coercion and related abusive experiences.[13] In terms of the innovation process, in the Recognition and Search phases, the initial innovators recognised the problem of reproductive coercion and found that there were no existing tools they could adapt. ARCHES was co-developed collaboratively by researchers, advocates and community-based practitioners, with significant input from family planning clients in the United States. It was shown to be effective in a cluster randomised control trial in Pennsylvania.[14]

The innovation has since been adapted for use in a wide range of countries (Kenya, Mexico, Bangladesh, Nigeria) and has further adaptions taking shape in Indonesia, Bolivia and India. A variety of ARCHES implementers have used adaptation processes and pilots, generating evidence to ensure proper contextualisation and successful outcomes. ARCHES was first adapted to the Bangladeshi context in 2017 and has since been further adapted twice

[13] Tancredi, D.J., Silverman, J.G., Decker, M.R. et al. Cluster randomized controlled trial protocol: addressing reproductive coercion in health settings (ARCHES). BMC Women's Health 15, 57 (2015). https://doi.org/10.1186/s12905-015-0216-z
[14] Ibid.

with Elrha funding: initially adapting it for humanitarian use in clinics serving Rohingya refugees, and subsequently, in the current project, developing a community-based intervention that addresses reproductive coercion.

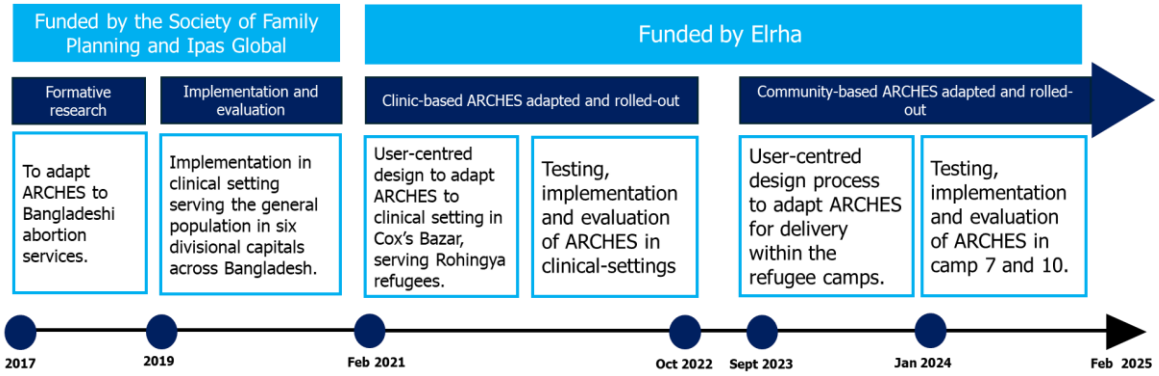

Fig 1. Timeline of ARCHES' development in Bangladesh

The first Elrha grant (2021–2022), researched the problem of reproductive coercion and wider intimate partner violence among Rohingya refugees and adapted and tested ARCHES in clinical settings based nearby the refugee camps in Cox's Bazar (Adaptation and Pilot phases of the innovation process). This initial intervention resulted in a 92% increase in self-efficacy to use modern contraceptive methods in the face of partners' opposition and a 17% increase in self-efficacy to use intimate partner violence support services.[15] Results from the first project have been published in a peer-reviewed journal.[16] Elrha has encouraged and supported further dissemination activities, both locally, through the GBV humanitarian coordination group, and globally, including presenting in an Elrha-led online webinar series and at the biennial Sexual Violence Research Initiative Forum.

At its inception, ARCHES was developed for use in healthcare settings. It has proven effective in diverse locations, including Bangladesh. Nevertheless, being a clinic-based intervention denies the benefits of ARCHES to anyone who is not already attending a clinic. The project's technical advisory group noted that ARCHES in clinical settings may not be accessible to women and girls at high risk of violence or experiencing intimate partner violence in the camps. Barriers to accessing clinics are not unique to humanitarian settings but are frequently exacerbated by humanitarian crises. Health sector guidance notes that a lack of awareness of health services and unsafe access to facilities are among many factors that can prevent survivors from receiving the life-saving services they need.[17] Therefore the second Elrha grant (2023–2025) focusses on adapting ARCHES to community-settings, piloting the approach in two refugee camps alongside a study to understand its efficacy.

The Community-Based Adaptation

ARCHES was adapted for use outside the clinical setting in Rohingya refugee camps for the first time. This community-based intervention aims to extend support to a greater number of women and girls experiencing intimate partner violence and reproductive coercion, particularly those who are most at risk. Successful project implementation is expected to yield comparable results to the clinic-based intervention, while, crucially, reaching highly vulnerable women and girls who face barriers to accessing a clinic. Moreover, this adaptation aims to retain fidelity to the successful ARCHES model, while engaging staff who work outside of clinical roles, introducing a role for community health workers to provide light-touch ARCHES information in specific circumstances.

Through a user-centred design approach, drawing on the experiences of women and girls in the camps, as well as the collective expertise of organisations working in the camps, Ipas adapted the ARCHES model for both

[15]Ipas. (2022). Effectiveness of ARCHES in Improving Reproductive Autonomy in Humanitarian Settings. Results from a pre-post study with Forcibly Displaced Myanmar Nationals in Bangladesh. Ipas: Chapel Hill, NC
[16]Pearson E., et al. (2024). Effectiveness of the Addressing Reproductive Coercion in Health Settings (ARCHES) intervention among abortion clients in Bangladesh: a cluster-randomized controlled trial. eClinicalMedicine, Volume 73, 102699.
[17] Global Protection Cluster. (2015). Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action. WHO. Available here.

midwives and community health workers to use in ways that were appropriate to their level of knowledge and technical ability. The new community-based ARCHES intervention is being implemented through three models:

- Midwives provide one-to-one ARCHES counselling at the women and girls safe spaces and health facilities.
- Midwives provide light-touch ARCHES information in group settings at the women and girls' safe space.
- Female community health workers provide light-touch ARCHES information when women and adolescent girls are found alone at home during house-to-house visits and refer them to women and girl's safe spaces.

Comparison to Existing Solutions

As mentioned, ARCHES is thought to be the first intervention of its kind focusing on reproductive coercion. From our research, we found no intervention with similar aims in the humanitarian response in Bangladesh, or across any other response. Our search identified several substantial and well-resourced methodologies addressing the protection and empowerment of women and girls:

- The Start, Awareness, Support, Action! Together approach is a community mobilisation approach introduced and implemented by UNFPA. Refugee activists and leaders are trained to facilitate community discussions, enhancing capacity for preventing violence against women.
- The Girl Shine approach is an evidence-based curriculum for young Rohingya girls, designed to equip them with the skills, knowledge, social networks and self-confidence to protect themselves from GBV. Additionally, both female and male caregivers are involved in discussions about gender safety.

Notably, no mention of reproductive coercion was found in the various handbooks of these two methodologies. Since ARCHES is unique in addressing reproductive coercion, there is no obvious benchmark against which to measure its comparative effectiveness.

Cost

Innovations are dynamic processes which focus on the creation and implementation of new or improved products and services, processes, positions and paradigms.[18] In this framing, ARCHES might best be seen as a process innovation. Since it is not a standalone process it is hard to isolate a clear unit cost.

Elrha's funding of two adaptation projects represents only a fraction of the cost of the innovation. Over a decade of work by academics and practitioners has contributed to the ARCHES intervention and its evidence-base. Elrha inputs to the innovation process (at the Adaptation and Pilot stages) cannot meaningfully provide the whole picture of what it costs to develop and scale ARCHES. They do, however, provide a benchmark for how an adaptation process can be implemented through a relatively small project, creating materials and a way of working that is already being used to scale up the innovation locally. (Described further in the Impact section).

There is a sense of a return on investment for Elrha. Within a few years of providing £168,000 for the user-centred design of a clinic-based intervention for Rohingya people, 25,000 Rohingya women and girls have received counselling sessions.

[18] OECD. (2005). Oslo Manual- Guidelines for collective innovation data. Available here.

Elrha Contribution to ARCHES

Elrha has supported the development of ARCHES through two separate grants, totalling **£268,096**.

Grant 1: Using user-centred design to adapt the ARCHES model for humanitarian settings: An innovative approach to addressing intimate partner violence and reproductive coercion

Budget: £168,096

Duration: February 2021–October 2022 (20 months)

Grantees: Ipas Bangladesh. **Partners:** Center on Gender Equity and Health at the University of California, San Diego, International Organization for Migration, International Rescue Committee, Multi-Sectoral Programme on Violence Against Women.

The grant funded the adaptation of ARCHES to the humanitarian context for three clinics inside the camps and one clinic adjacent to the camp. This project was selected for funding under Elrha's innovation challenge calling for 'Innovative Responses to Intimate Partner Violence in Humanitarian Settings'.

Grant 2: Follow-on funding to develop a community-based ARCHES intervention

Budget: £100,000

Duration: September 2023–February 2025 (18 months)

Grantee: Ipas Bangladesh **Partners:** Refugee Relief and Repatriation Commission, Center on Gender Equity and Health at the University of California, San Diego.

This follow-on funding was awarded to further adapt the ARCHES model through a user-centred design approach to the challenging humanitarian context of Rohingya refugee camps in Bangladesh by developing the community-based model. Results from this ongoing project are not yet available.

There are useful considerations around cost and value that can be made.

Time, workload and support staff: One of ARCHES' successes in Bangladesh has been its integration into existing workflows. The aim is for existing healthcare workers (and now, to a limited extent, also community health workers) to integrate the counselling into consultations that they are already providing. One of the main running costs in ARCHES is the time requirement for healthcare providers – as the ARCHES counselling is an additional component in healthcare consultations, it will likely mean that consultations take longer, so fewer people per day can be seen by a clinician. The counselling takes a matter of minutes in a clinical setting. However, in adapting it to the community-based setting, service providers reported it is taking longer: between 20–45 minutes to comprehensively go through all the ARCHES material. A further factor affecting time-efficiency in the workflow has been the need for new clients to complete the baseline survey ahead of the counselling session. Baseline data-gathering is a short-term challenge during the brief data collection period and is critical to building the overall evidence-base that could support the development and scaling of ARCHES.

Start-up and running costs: Material running costs include counselling materials (flipcharts, printouts) and the discrete palm-sized booklet handed out to clients. Training and mentoring costs are highest when the innovation is being newly introduced, but success in the long term will also require refresher training and support.

Value: Successful innovations are those that result in improvements in efficiency, effectiveness, quality or social outcomes and impacts.[19] At this stage, calculating the average unit cost of each ARCHES intervention or the precise amount of harm reduced is unfeasible, particularly across varying economic contexts around the world. However, Ipas have grounds to contend that ARCHES in Cox's Bazar is making an improvement in the quality of

[19] Ramalingam B., Scriven K. and Foley C. (2009). Innovations in International Humanitarian Action, Review of Humanitarian Action, Alnap. Available here.

social outcomes for women experiencing reproductive coercion. In turn, this intervention may also be increasing the effectiveness of parallel programming such as contraceptive distribution (by counselling on strategies for their safe use), and contributing to public health as a preventative approach to maternal health in settings with high rates of maternal morbidity.

EFFECTIVENESS

Since ARCHES is an evidence-based approach, its roll-out in various countries including in Bangladesh has been accompanied by research and scientific analysis of the impact results. Key metrics relating to the impact in clinics serving the Rohingya population were quoted in the previous section. Once the results of the community-based ARCHES approach are available[20], it will be important to ensure that these achieve the positive changes found in the clinic-based intervention, or to closely analyse where and why any quality might be lost by transitioning out of the clinical setting.

However, the feedback received from providers has so far been positive, (n=6). Providers felt that bringing ARCHES counselling into the camp setting will allow more women experiencing reproductive coercion and intimate partner violence to access support. They noted a high level of information sharing among women and girls who received ARCHES counselling, through word of mouth and sharing the ARCHES information card.

"ARCHES one-to-one sessions are great for informing and making women aware of the mental and physical offences they face at home by their husband."

– Provider

Enablers of Success

Key enabling factors identified for successful adaptation of ARCHES include:

- The user-centred design approach which has included female community members guiding the cultural and linguistic adaptation of ARCHES materials, alongside reflections on the realities Rohingya women and girls face, ensuring images are relevant and relatable to life in the camps.
- Engagement with and cultivation of aligned partnerships. This ensured that service providers felt motivated to introduce ARCHES into their work and are aligned to the ARCHES core principles of a woman's right to autonomy on their reproductive health.
- The passion and dedication of trained providers to integrate ARCHES counselling into their regular family planning sessions or community work without monetary incentives, despite concerns about time and workload. "
- Promoting the ARCHES client-centred approach that emphasises the importance of understanding each client's unique situation and enabling them to gain agency and make informed decisions.
- Follow-up mentorship and supervision to support providers in delivering ARCHES accurately and to work through their challenges.

After completing ARCHES training, we can now adequately help women with choosing birth control methods, hooking them up with referrals for menstrual regulation, and supporting them to avoid frequent births that are harmful to their bodies and minds."

– Provider

Challenges

Several challenges were identified that could impact long-term quality assurance and fidelity to the methodology as ARCHES continues to be rolled out and adapted across Cox's Bazar.

Privacy: While adaptation and locally sensitive contextualisation is essential, 'Do No Harm' considerations, which are at the heart of ARCHES must be retained for client safety. The need for privacy is important and is enshrined

[20] At the time of this case study, Ipas was collecting baseline data from women who have never had ARCHES counselling before.

in the ARCHES core principles, as well as in the global GBV guiding principles. In some locations, this has required setting up additional rooms or reconfiguring crowded spaces to enable private consultations. However, maintaining privacy remains a recurring challenge, particularly when chaperoning relatives, who may themselves be coercers, expect to be present during consultations.

Risk of discovery: For women and girls taking contraceptives covertly, the risk of discovery and of exposure to further harm by perpetrators is a concern. This was highlighted by service providers and technical advisory group members, underscoring the importance of the ARCHES commitment to "client-centred care" that supports their agency in making decisions about their bodies and health. Providers counsel clients on the risks and benefits of covert family planning use, enabling them to make informed choices.

Nevertheless, one provider said: ***"I had a client several months ago with a swollen arm on her implant scar. She had been beaten by her husband for getting the implant, and now she wants to have it removed. Her family members were very angry with us for providing her with the service."*** In another instance, a woman wanted an IUD[21] removed because her husband was aware of it and was threatening her with divorce if it were not removed. These risks are not unique to ARCHES but are prevalent across family planning interventions.

Comprehension and time requirement: Ensuring clear comprehension was another issue, with service providers reporting that sometimes it took between 20–45 minutes to build a rapport and provide the ARCHES counselling. Key informants raised this as a concern both for the time-burden on providers, and on the time and level of concentration required of clients if they are to focus and fully comprehend the strategies and risks well enough to make informed choices.

Diversity: There is a need for more guidance on engaging with clients who have diverse needs, such as disability, age, sexual orientation, gender identity, gender expression and sex characteristics. Age is a key consideration, as parental consent may be a legal requirement in some legislative environments if a child is seeking support.

[21] An intrauterine device, or IUD, is a small t-shaped device inserted into the uterus by a clinician and can provide highly effective contraception for 5-10 years.

IMPACT

In the 22-month period up to 31 July 2024, over 43,300 women (including 230 girls) in Bangladesh were counselled through the ARCHES intervention in Cox's Bazar. This includes over 16,000 from the Bengali host population, from two sub-districts, Ukhiya and Teknaf.[22]

While much of Elrha's funding supported the adaptation process, and the data collection and dissemination that upholds the evidence base, ARCHES has since received significant additional funding from UNFPA. Crucially, in Bangladesh, the ARCHES adaptation has thus far avoided the "pilot and crash" pattern in humanitarian innovation and has made the difficult transition from innovation funding to standard humanitarian funding.[23]

Receiving counselling in clinical settings	In 3 women and girl safe spaces	At household level	Total
26,000[24] (since Oct 23)	1,000 (Since Jun 24)	200 (Since Jun 24)	43,000

Table 1. Number and setting of women and girls counselled through ARCHES in Bangladesh

"The clinic-based success was significant. Ipas worked so well with the clinic-based model and seeing the results the biggest donor UNFPA scaled up this model to 40 health facilities where ARCHES counselling is being given and some camps in Bhashan Char are considered. Ipas intends to include the ARCHES model with other sexual reproductive health service providers."

– Project Team Member

With backing from UNFPA, support from the technical and community advisory groups, and continued funding from Elrha, ARCHES has expanded to 40 Ipas clinics in Cox's Bazar. To date 90 people have received ARCHES training (49 clinic-based clinicians/providers, 32 community health workers, three midwives and six master trainers).

Counselling sessions are not an end in and of themselves; however, there is impact data from the ARCHES intervention in clinical settings. A 2021 research study showed that among Bangladeshis, ARCHES was associated with higher likelihood of uninterrupted use of modern contraception at both the three-month and 12-month follow-ups. ARCHES was also associated with a decrease in incident pregnancy at the 12-month follow up, increases in knowledge about available intimate partner violence support services and decreases in recent intimate partner violence experiences.[25]

Among service providers, there is a strong belief that introducing ARCHES contributes to capacity building, enhancing their overall quality of healthcare service delivery. This impact is likely to extend in the community model to the capacity building of midwives and community health workers.

"I plan to continue supporting women by sharing the core principles of ARCHES to enhance their ability to make decisions regarding family planning methods and preventive actions against any sort of violence."

[22]The Bangladeshi population of Ukhiya and Teknaf is approximately 540,000. (https://rohingyaresponse.org/wp-content/uploads/2024/03/JRP-2024.pdf)
[23]Bruder, M., Baar, T. Innovation in humanitarian assistance—a systematic literature review. Int J Humanitarian Action 9, 2 (2024). https://doi.org/10.1186/s41018-023-00144-3
[24]Currently Elrha supports three clinics that are providing ARCHES intervention. About 3100 clients received ARCHES counselling during Oct '23-Jun 24 from these three clinics.

[25] Pearson, E., Paul, D., Menzel, J., Shakhider, M.A.H., Konika, R.A., Uysal, J., Silverman, J.G., 2024. Effectiveness of the Addressing Reproductive Coercion in Health Settings (ARCHES) intervention among abortion clients in Bangladesh: a cluster-randomised controlled trial. eClinicalMedicine 73. https://doi.org/10.1016/j.eclinm.2024.102699

– Provider

Key risks, common to most humanitarian programming, include the short term and unreliable nature of limited humanitarian funding. This is coupled with the challenges of working in a humanitarian context with urgent and vast competing needs, high staff turnover, vulnerability to shifts in government policy, competition and insufficient coordination between agencies, and mistrust from the affected populations. This is particularly true for the Rohingya people in Cox's Bazar, where living conditions are overcrowded, poorly lit and lacking adequate sanitation, and where the services being delivered frequently change depending on the funding and staffing of implementing agencies.

A challenge, more specific to ARCHES, is their commitment to women and girls' autonomy over sexual and reproductive health decisions. The majority of the Rohingya population follows conservative, patriarchal cultural practices, where women's and adolescent girls' choices are often restricted, and intimate partner violence is widely accepted as a social norm. Women having reproductive autonomy is new for both men and women. Discussions about sexual reproductive health rights and GBV are often prohibited or considered 'taboo' within Rohingya communities making it difficult to address these issues openly and to provide necessary services.[26] This is coupled with Bangladeshi government strategy which emphasises community engagement, facility-based services and cultural sensitivity, encouraging family planning as a couple's decision which may be perceived as contrary to ARCHES' principles of supporting individual autonomy.

If these challenges are addressed, positive evidence continues to grow, and humanitarian healthcare programme funding (as opposed to innovation funding) continues to support ARCHES in Cox's Bazar, then there is significant scope for further impact.

[26] Ahmed, R., Aktar, B., Farnaz, N. et al. Challenges and strategies in conducting sexual and reproductive health research among Rohingya refugees in Cox's Bazar, Bangladesh. Confl Health 14, 83 (2020). https://doi.org/10.1186/s13031-020-00329-2

CONSIDERATIONS FOR SCALE

In Elrha's handbook of tactics for scale through adoption, the first tactic is for innovators to understand their long-term role.[27] A sustainable business model is critical for the sustained impact of an innovation at scale: "the innovation must effectively deliver value through a business operation that allows for deployment, ownership, support of existing users, and continued evolution of the innovation."[28]

The early signs for ARCHES are promising globally, not just in Bangladesh, with strong enabling factors for scale. Adoption by organisations whose values align has been critical. To date, ARCHES has been adapted in four countries (Kenya, Mexico, Bangladesh and Nigeria), with ongoing adaptations in Indonesia, India and Bolivia, supported through technical assistance from academics at Tulane University and The Center on Gender Equity and Health at UCSD. It is implemented by national and international NGOs such as Ipas, Jhpiego and International Planned Parenthood Federation (IPPF). In Nigeria, Kenya, Bolivia, and Indonesia, it is being adapted for government-run facilities. In Nigeria and Kenya, government bodies are interested in or have adopted ARCHES within their practices. By gaining government buy-in and scaling ARCHES through public services, the intervention can have a larger reach than through NGO or private family planning and sexual reproductive health services. This could be an excellent development for sustaining impact at scale.

The community-based model has significant scope for scaling within the camps, extending to other women and girl safe spaces if appropriate. Adopters and potential adopters have expressed strong support and interest in the clinical and community-based models. A similar community-based model is being tested in India by the Family Planning Association of India, an IPPF affiliate. In Kenya, researchers from UCSD and Tulane University are testing a different community-based model, incorporating elements of ARCHES along with content on other forms of violence into a curriculum for delivery within women's economic empowerment groups (Village Savings and Loans Associations/chamas).

The sense of shared ownership, diverse funding sources and the culture of building the evidence base through academic publications should facilitate adoption. Meanwhile the long-standing support of several academics, and the ongoing efforts to codify the lessons learned from ARCHES adoption and adaptation processes, highlight the potential for a sustainable model of technical guidance that upholds the quality of the intervention.

ARCHES can be integrated into existing services relatively easily, without the need to create new programmes or make drastic changes to current family planning offerings. It can be integrated into screening questions and incorporated into existing family planning sessions. It does take time to contextualise ARCHES and support service providers to integrate practices. However, the user-centred approach has established strong strategies for successful adaptation into existing workflows. By mainstreaming reproductive coercion counselling into existing family planning work, especially when gaining government buy-in (eg, Kenya), ARCHES can draw on typical healthcare funding rather than on innovation or adaptation funding.

Plans for Scale

Ipas and its partners intend to complete the research study on the community-based ARCHES model and disseminate the findings. Ipas is also adapting ARCHES for roll out in non-humanitarian settings in Bolivia and Indonesia in 2025. Ongoing adaptations and comparative analysis of ARCHES in different settings will be needed. Academics from the UCSD Center on Gender Equity and Health and at Tulane University plan to continue their technical support for partners implementing ARCHES. They have also advocated for ARCHES to be recognised in global guidance and by organisations such as WHO and USAID as a "promising" or "high impact" practice.

[27] Elrha. (2022) How to Scale: Tactics to enable the adoption of humanitarian innovation. Elrha Scaling Series. Available here.
[28] McClure, D; Bourns, L and Obrecht, A. (2018) 'Humanitarian Innovation: Untangling the many paths to scale. Global Alliance for Humanitarian Innovation (GAHI). Available here.

WHAT HAVE WE LEARNT?

Implementation and scaling of ARCHES highlighted six key learnings:

ARCHES is a valuable and unique intervention.
ARCHES counselling is an important and positive addition to family planning sessions, enabling providers to address reproductive coercion and intimate partner violence with their clients. It provides women and adolescent girls with the advice and information they need to make informed reproductive choices. Despite the presence of many GBV agencies and activities in humanitarian settings, ARCHES responds to the immediate needs of women and girls to have reproductive autonomy and make informed choices with or without their family's support. Reproductive coercion and autonomy are important lenses which should continue to be introduced into broader family planning and GBV programming.

Putting ARCHES into a humanitarian setting has sparked innovation.
Adapting the model for use outside of clinical settings expands its the pool of who may benefit from ARCHES. Through the ongoing research in Bangladesh and Kenya, more insights will be gathered on support and follow-up needs for service providers to ensure the core principles of ARCHES are maintained.

Translation and contextualisation are challenging processes.
Despite some cultural similarity and geographical proximity, translating ARCHES materials from Bangla to Rohingya was not simply a word-for-word translation process. Several key components of ARCHES are not commonly talked about or have no literal translation in Rohingya. Significant work was also needed for adaptation of information materials. The user-centred design proved highly valuable to the adaptation process. Paying close attention to how the language and messaging of an innovation is received locally is important, especially in contexts where some implementers receive limited training. For example, community health workers only receive a one-day training, yet they may be among the trainees that find these concepts least familiar.

Managing partnerships and supportive champions is key.
One of the success factors behind the implementation of ARCHES in Bangladesh has been Ipas' effective management of relationships, both with its technical and community advisory groups and through other coordination mechanisms. Building a supportive network is key, especially as ARCHES is integrated into the workflows of existing clinics and teams, rather than being a standalone intervention. A supportive network is particularly valuable where an innovation risks facing local opposition, whether that is because it disrupts older ways of working or, as in the case of ARCHES, addresses taboo subjects and counters patriarchal authority. Providers noted that the interviews for this case study were the first time their opinions on ARCHES were sought. A useful complement to client-focused and clinician user-centred design would be to ensure that there are opportunities to explore, together with trained providers, what is working well and what are the challenges, especially when trialling the community-based model.

There's a lot to learn about the community-based model.
A facilitated learning process, alongside the development of a community-based model, would be valuable to ensure a nuanced understanding of the light-touch ARCHES information-sharing sessions. Clear understanding of work-as-done with rich and open feedback from the community health workers and from visited households could help complement clients' pre and post surveys. Shifting ARCHES away from the clinic may be game-changing, and practices and results should be monitored closely.

Scope for further work on diversity
Areas for further attention in Bangladesh and for ARCHES more broadly, as it aims to roll out at ever larger scale, include exploring and developing further guidance relating to clients with diverse needs, including adolescents, people with disabilities and people with diverse sexual orientation, gender identity, gender expression and sex characteristics.

In Conclusion

ARCHES counselling is an important and positive addition to family planning sessions which allow for providers to explore reproductive coercion and intimate partner violence with their clients, providing advice and information for women and adolescent girls to make their own reproductive choices.

ANNEXES

Annex 1: Glossary

- **Violence against women** is any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[29]
- **Intimate partner violence** refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual or reproductive coercion, psychological abuse and controlling behaviours. It is one of the most common forms of violence against women.[30]
- **Reproductive coercion** is a form of gender-based violence that comprises abusive behaviours aimed at controlling a woman or girl's family planning use or pregnancy decisions, which can put their health, safety and well-being at risk.[31] Examples include threatening harm if the woman does not become pregnant or sabotaging birth control methods. It strips away autonomy and decision-making ability in matters of reproductive and sexual health.[32]
- **Women and Girls Safe Spaces** are formal or informal places where women and girls can feel physically and emotionally safe. It is a space where women and girls can feel comfortable, socialise and enjoy the freedom to express themselves without the fear of judgement or harm. Safe spaces include a wide-range of age-appropriate and structured psychosocial support and services, including case management services for survivors of violence and reproductive health services.[33]

  These spaces may take different names such as women friendly centres or spaces, women and girls friendly centres, women community centres or listening and counselling centres…etc. In the Rohingya refugee camps both **women friendly spaces** and **women and girl safe spaces** exist. ARCHES counselling is delivered in three women friendly spaces, where all ages of women and girls can seek support. For the purposes of this case study we will use the internationally recognised term women and girls' safe spaces.

[29] World Health Organisation, Violence Against Women Overview. Available here
[30] ibid
[31] Grace K.T., Anderson J.C, 2016. Reproductive Coercion: A Systematic Review. Trauma Violence Abuse. 2018 Oct;19(4):371-390.
[32] Islam, M.M., Khan, M.N. and Rahman, M.M. (2022) 'Intimate Partner Abuse Among Rohingya Women and Its Relationship with Their Abilities to Reject Husbands' Advances to Unwanted Sex', Journal of Interpersonal Violence, 37(13–14).
[33] Megevand, M. and Marchesini, L. (2019) Women and Girls Safe Spaces: A Toolkit for Advancing Women's and Girls' Empowerment in Humanitarian Settings. International Rescue Committee and International Medical Corps. Available at IRC-WGSS-Toolkit-Eng.pdf. And Dey, R., Mirjahan, M.D., Smith, M., Valerio, A. and Zannat, R. (2022) Establishing Women and Girls' Safe Spaces in Rohingya Response: A Guidance Note and Best Practice from Cox´s Bazar, Bangladesh. International Organization for Migration Bangladesh. Available here

Key objectives of a women and girls' safe space?

- Facilitate access for all women and girls to knowledge, skills, and a range of relevant services.
- Support women's and girls' psychosocial wellbeing and creation of social networks.
- Serve as a place where women and girls can organise, access information and resources to reduce risk of violence.
- Serve as a key entry point to specialised services for GBV survivors.
- Provide a place where women and girls are safe and encouraged to use their voice and collectively raise attention on their rights and needs.

- **Universal education** is the clinical strategy used to educate all patients (in this case women and girls) on healthy and unhealthy relationships and supportive referral services. This approach differs from screening in that it advocates for **all** patients to be given information on the health impacts of intimate partner violence and reproductive coercion and available support services regardless of whether they disclose current or past experience of violence.[34]
- **Menstrual regulation** involves taking two lots of medication that ensures you are not pregnant after missing a period. The first pill that is taken blocks the hormone needed for pregnancy to occur. 24-48 hours later, a second pill is taken, which causes the body to expel the contents of the womb. This two-stage dose of medication is a low risk, non-surgical way to ensure you are not pregnant. Many women opt for this kind of procedure because it's safe, non-invasive and very reliable.[35]

Annex 2: Methodology

Case study development entailed the following six steps:

1. **Inception**

We held an inception meeting with Elrha to finalise the research questions, agree on the methodology and develop the data collection tools. We also conducted a document review of both academic and grey literature. We used a structured template to synthesise the information against each research question to enable further analysis and triangulation of different data sources. The document review was used to analyse the existing evidence available, which was later triangulated with the primary data collected.

2. **Exploratory sessions**

We conducted an introductory session with the Ipas and The Center on Gender Equity and Health at the UCSD to understand the innovation better, its status and identify any further research undertaken. We also facilitated an assumptions meeting with both teams to understand the changes they envisioned ARCHES making and the assumptions on how this change would happen. This enabled the team to gather findings on the assumptions during implementation.

3. **Key informant interviews (KIIs)**

We conducted 20 remote interviews, guided by a semi-structured template with open-ended questions that lasted 45-60 minutes. Ipas identified the interviewees. All but four of the interviews were conducted in Bangla

[34] IPVHealthPartners Toolkit. Available here
[35] Marie Stopes Bangladesh, Medical Menstrual regulation. Available at: Medical menstrual regulation - Marie Stopes Bangladesh

and summaries and quotes were translated into English. We conducted 13 interviews as indicated in the table below.

Table 2: Case study participants breakdown

KII Category	Organisation	No. of respondents
Project Team	Ipas Bangladesh	3
	The Center on Gender Equity and Health at the University of California, San Diego	1
Technical Advisory Group	International Rescue Committee	1
	IOM	1
	BAPSA	1
	Mukti	1
Master Trainers	BAPSA	1
	Ipas	1
Providers	BAPSA	1
	IRC	1
	Partners in Health and Development	1
Adopters	UNFPA	1
	BAPSA	1
	Ipas Indonesia	2
Total		20

4. **Analysis**

We used thematic analysis, coding the primary data against the research questions, changing areas and key assumptions to identify the key trends to inform the findings. Secondary data supported triangulation and contextualisation.

5. **Validation meeting**

We presented emerging findings from the data collection to the project team and Elrha for reflection, validation and feedback.

6. **Case study drafting**

We then developed the case study, which underwent two rounds of feedback from Elrha, the project team and other key stakeholders. A long draft of findings was heavily summarised with support from Elrha to produce the final case study report.

Limitations

There were five main limitations as follows:

- The ARCHES community-based project and research study was ongoing and delivery of ARCHES had only been going for a few months in the women and girls safe spaces at the time of data collection which means we had limited data on effectiveness and could not draw conclusions about the impact or potential to scale the community-based model of ARCHES.
- As the project was mid-way through, it also presented challenges in collecting data about costs and cost comparisons between the community-based and clinical model.
- As the research about the efficacy of the ARCHES community-based model is ongoing and it was out of scope of this case study to speak to women and girls receiving ARCHES counselling we could only draw on secondary data from clinical delivery of ARCHES about the changes for women and girls.
- We interviewed a small number of providers, so could only provide feedback rather than conclusions on the delivery of the community-based ARCHES. We only interviewed one community health worker and therefore had very limited insights into their reflections on delivering ARCHES and the quality of their work after a 1-day training.
- Being limited in length and scope, this case study does not create a manual for humanitarian innovation for the adoption or adaptation of the ARCHES intervention. More detailed information on the ARCHES intervention is available in open-access journal articles and on the Elrha website. The ARCHES team also plans to develop a handbook documenting key processes and lessons from its implementation in various contexts.

WRITTEN BY:
Afsana Yasmeen and
Joanna Knight

October 2024

Commissioned by Elrha's
Humanitarian Innovation Fund

ABOUT ELRHA

Elrha is a global organisation that finds solutions to complex humanitarian problems through research and innovation. The innovations funded through our Humanitarian Innovation Fund (HIF) identify, nurture and share more effective and scalable solutions to some of humanity's most difficult challenges. The HIF is funded by the UK Foreign Commonwealth and Development Office (FCDO) and Norway.

elrha.org

@Elrha

/Elrha