

Cross-continental Lessons in Addressing Reproductive Coercion:

Components, Barriers, and Innovative Adaptations
of the ARCHES Clinical Model Across Four Countries

October 2023



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How to Use this Resource

Purpose

This slide doc was created as a stand-alone product to provide background on key concepts relevant to the ***Addressing Reproductive Coercion in Health Settings (ARCHES)*** intervention, to document and understand the interventions' adaptation processes. This document seeks to share key themes across multiple adaptations of the ARCHES intervention, so that practitioners wishing to address reproductive coercion in health care facilities better understand what factors to consider during adaptation, as well as strategies for navigating emerging constraints.

This slide doc is not a presentation. It is also not a comprehensive resource on reproductive coercion, intimate partner violence (IPV), adaptation processes, or the ARCHES intervention model. For more detailed guidance on these topics, please see the references at the end of the document and other external resources:

- ✓ Links to [existing ARCHES work](#) on GEH/UCSD website
- ✓ The Sexual Violence Research Initiative's [ADAPT-IPV Framework](#)
- ✓ Center for Disease Control guidance on [Using Essential Elements to Select, Adapt, and Evaluate Violence Prevention Approaches](#)

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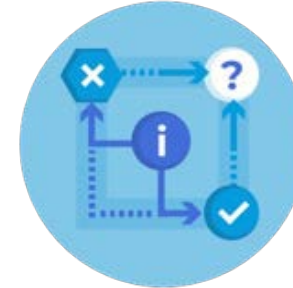
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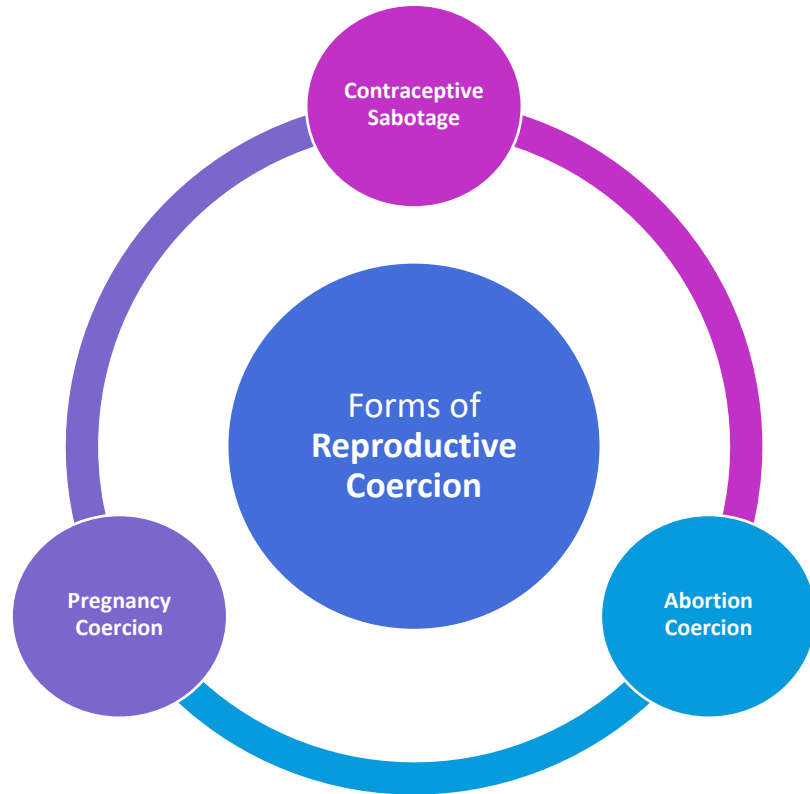


Section One

UNDERSTANDING REPRODUCTIVE COERCION, IPV, AND ARCHES



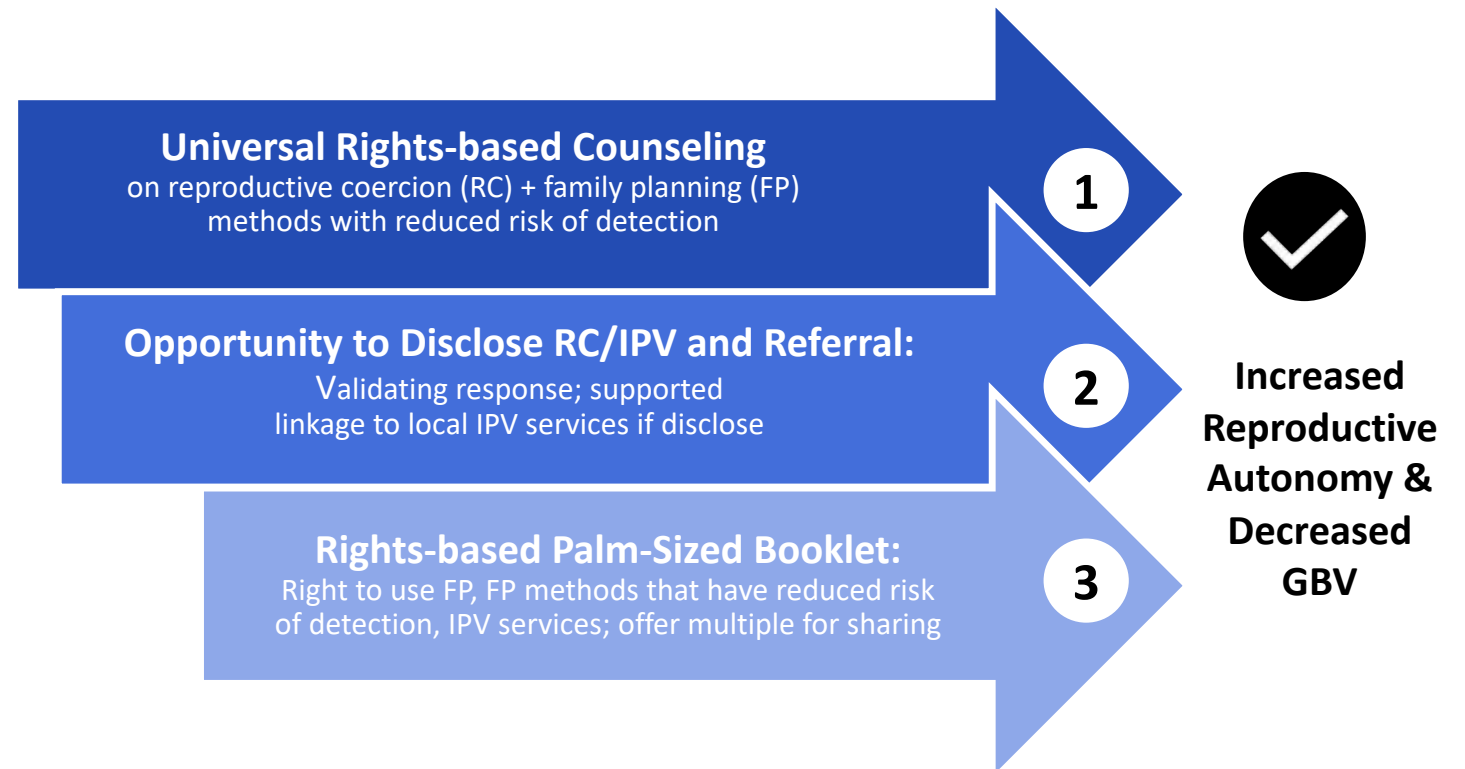
Understanding Reproductive Coercion








- **Reproductive coercion** is a form of IPV that comprises behaviors that interfere with contraceptive access or use, or pregnancy decisions of one partner (Miller et al., 2010; Silverman & Raj, 2014). There are three types of reproductive coercion: 1) contraceptive sabotage (interfering with a partner's use of contraception), 2) pregnancy coercion (pressuring a partner to get pregnant), and 3) abortion coercion (pressuring a partner to have or not have an abortion against their will) (Grace & Anderson, 2018).
- Reproductive coercion is **often associated with other forms of violence**. While a form of gender-based violence (GBV) itself, reproductive coercion often overlaps with other forms of GBV, such as physical or sexual abuse or forms of psychological harm or sexual coercion (World Health Organization, 2012).
- Studies show that **10-27 percent of women experience reproductive coercion and 19-49 percent of women experience IPV across Global South contexts in their lifetimes** (Grace & Fleming, 2016; Silverman et al. 2022; Sardinha et al., 2022). Reproductive coercion often exists alongside other forms of IPV but can also occur in the absence of other forms of violence. For example, 12 percent of women in Uttar Pradesh experienced lifetime reproductive coercion: 54 percent of those women also experienced physical IPV, and eight percent also experienced sexual IPV (Silverman et al., 2019).
- **Reproductive coercion and IPV both increase the risk of unintended pregnancy** (Pallitto et al., 2014; Silverman et al., 2019). Addressing these issues jointly may improve women's sexual and reproductive health.

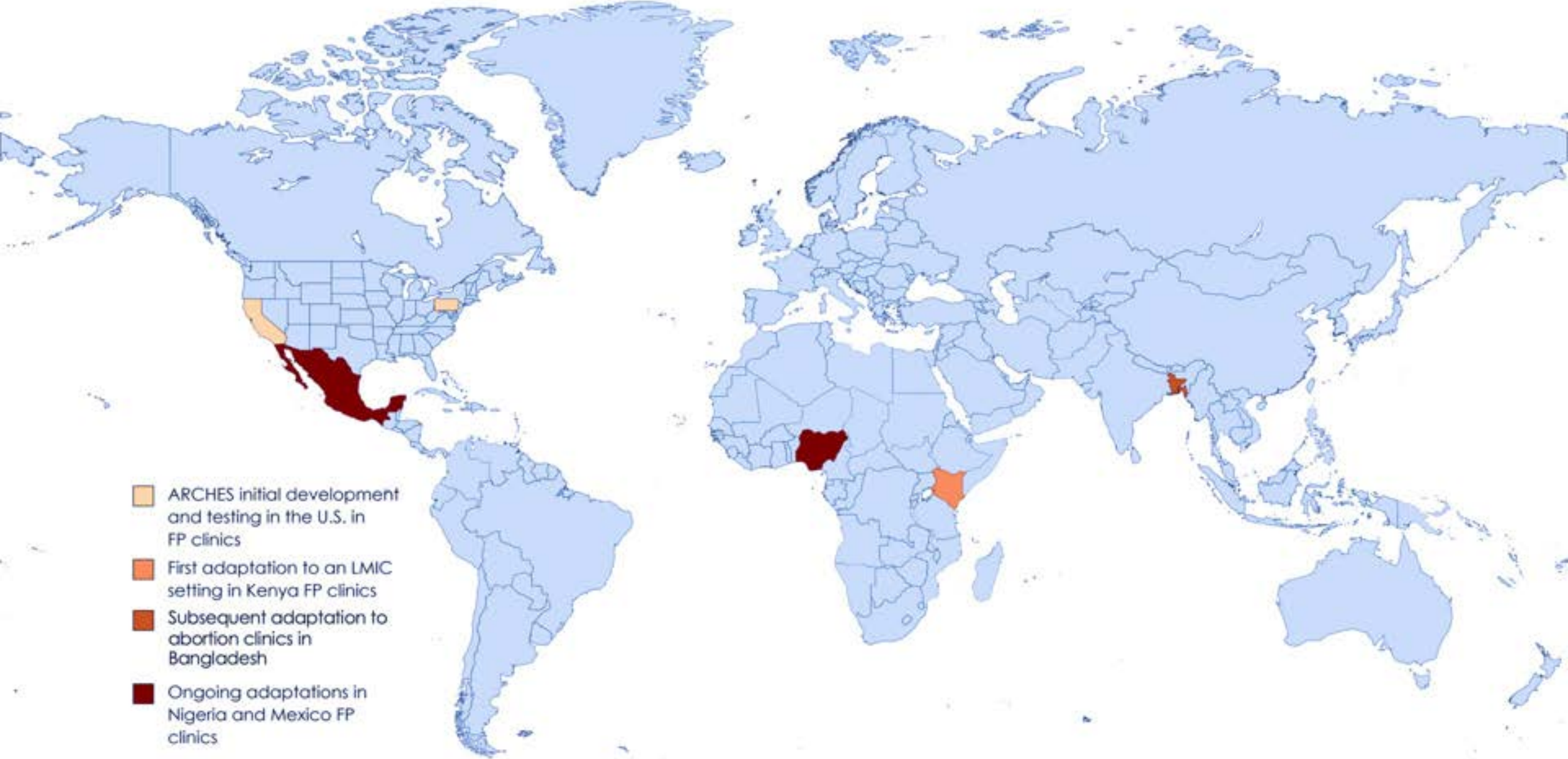
ARCHES is a brief integrated clinical intervention providing education and counseling to address reproductive coercion to clients.

ARCHES is implemented by trained providers within routine family planning services who **educate women on reproductive coercion and strategies for contraception use with lower risk of detection from partners or other family members, so that women can use their preferred method despite pressure or coercion from others.** Clients are provided an opportunity to disclose reproductive coercion or other forms of IPV via screening questions and, if disclosing IPV, offered to be connected to IPV services. Disclosure of abuse is not required, however, to receive information about IPV or IPV services. **Clients are offered a palm-size educational pamphlet with content on women's reproductive rights, private contraceptive use strategies, IPV, and local IPV services.** These materials are often taken and shared with family and community members.



ARCHES was first developed and tested in the US, and then adapted across four contexts.

-  Research on the overlap between IPV and unintended pregnancy in Boston, MA revealed that men interfered in their female partners' contraceptive use in a variety of ways. ARCHES was subsequently developed in partnership with US Planned Parenthood and the Massachusetts Department of Public Health and tested in the Planned Parenthood Bay Area.
-  The first iteration of the model brought commonly used concepts in clinical IPV interventions on IPV into contraceptive counseling and added information about reproductive coercion. Initial qualitative findings demonstrated positive impacts on pregnancy coercion, which encouraged further efforts to refine, test, and expand the intervention.
-  After further refinement and rigorous testing in the US, researchers explored opportunities to work with international organizations to adapt ARCHES to better address IPV and reproductive coercion and prevent unintended pregnancy across global contexts.
-  The first global adaptation took place within NGO-run clinics in **Nairobi, Kenya**, in collaboration with Population Council and IPPF. This model was then further adapted for use in NGO-run clinics in **Bangladesh** in collaboration with Ipas. Findings from matched-control and randomized controlled trials of these adaptations show that ARCHES reduces risk of pregnancy in the months following a single visit and improves knowledge of IPV services (Uysal et al, 2023). In Bangladesh, the model was shown to increase modern contraceptive use three months post-intervention. In Kenya, the model was also shown to reduce physical IPV and increase women's agency to leave an abusive relationship compared to women in the control group.
-  To date, ARCHES has been adapted in **four countries across three continents**. In Kenya and Bangladesh, there have been two rounds of adaptation, with the second round focused on bringing the intervention to scale (Kenya) or on a new population (refugees in Bangladesh). In Nigeria, there has been one round of implementation in government-run facilities. In Mexico, the team is in the process of adapting the intervention for NGO-run clinics.



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ARCHES Across the Globe

Overview of Adaptations in Four Countries

	BANGLADESH	KENYA	MEXICO	NIGERIA
SETTING AND POPULATION	<p>Urban: Women seeking abortion or post-abortion care (PAC) in six urban areas of Bangladesh (Dhaka, Rajshahi, Faridpur, Chittagong, Rangpur and Sylhet)</p> <p>Humanitarian: Rohingya refugee women attending FP, MR, or PAC services in Cox's Bazar (Teknaf and Ukhiya upazilas)</p>	<p>Urban: Women seeking family planning services in six NGO-run clinics in metropolitan Nairobi</p> <p>Urban, peri-urban and rural: Women seeking family planning services in 24 government clinics across Uasin Gishu county</p>	<p>Urban: Women seeking family planning services in two NGO-run clinics in Ciudad de Mexico (Mexico City)</p>	<p>Women seeking family planning services in 20 facilities across 11 local government areas each in Ebonyi and Sokoto State</p>
PARTNERS	<p>Urban: Ipas; University of California San Diego (UCSD); Reproductive Health Training Services and Education Program (RHSTEP); Bangladesh Association for the Prevention of Septic Abortion (BAPSA)</p> <p>Humanitarian: Ipas; UCSD; International Organization of Migration; Multisectoral Program on Violence Against Women under the Ministry of Women and Children Affairs</p>	<p>Urban: Kenya Ministry of Health; UCSD; Population Council; International Planned Parenthood Federation; FHOK*</p> <p>Urban, peri-urban and rural: Kenya Ministry of Health; UCSD; Population Council</p>	<p>Mexfam; UCSD; International Planned Parenthood Federation</p>	<p>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*</p>
FACILITY TYPES	<p>Urban Bangladesh: Private NGO-run clinics</p> <p>Humanitarian: Government and private (NGO-led) facilities</p>	<p>Nairobi: Private (NGO-run) primary care facilities providing family planning</p> <p>Uasin Gishu: Public primary care facilities providing family planning</p>	<p>Private NGO-run facilities (one larger clinic with higher client volume, one smaller clinic)</p>	<p>Primary and secondary-level public and private facilities</p>
RC PREVALENCE	<p>Urban contexts: 12%</p> <p>Humanitarian: 22%</p>	<p>Urban context: 37%</p>	<p>Mexico City: 16%</p>	<p>5-6%</p>
IPV PREVALENCE	<p>National: 73%</p> <p>Humanitarian: 70%</p>	<p>National: 47%</p>	<p>National: 44%</p>	<p>National: 36%</p>

FHOK = Family Homes of Kenya, NANA = NANA Girls and Women Empowerment Initiative; HHGSF = Helping Hands and Grassroots Support Foundation; RUWOYD: Rural Women and Youth Development; EHNRD = Essential Health Network for Rural Dwellers; DOVENET = Daughters of Virtues and Empowerment Initiative; ECEWS = Excellence Community Education Welfare Scheme; UCSD = University of California San Diego

Types of IPV include emotional, sexual, and physical, current or lifetime experiences.



Section Two

DOCUMENTING ADAPTATION: RESEARCH QUESTIONS AND METHODOLOGY






Adaptation Questions and Methodology

Research Questions

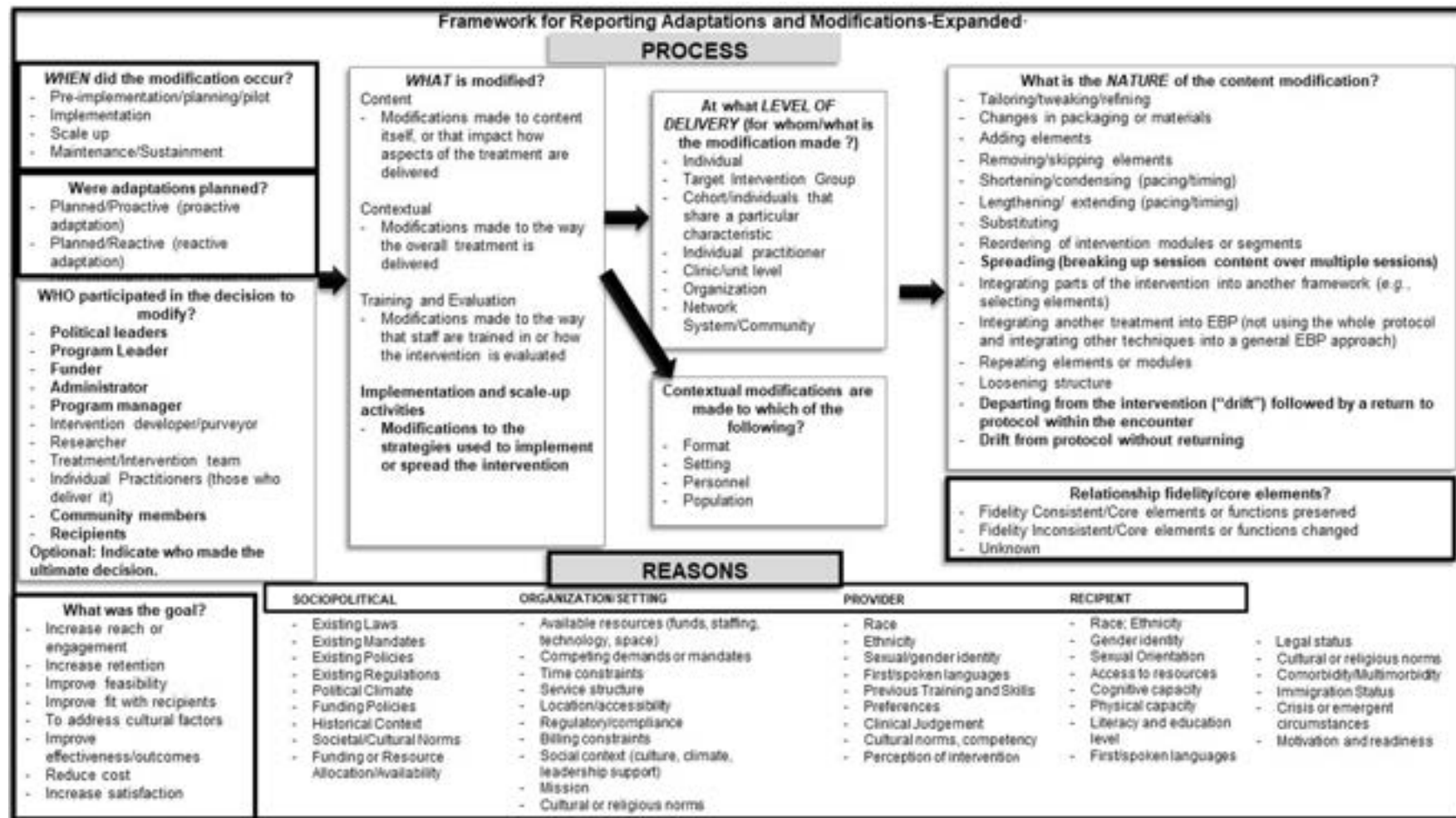
- 1** What core principles and elements, implementation factors, and population or contextual factors, influenced adaptation of the ARCHES model across contexts?
- 2** How did program staff adapt core principles and messages, implementation processes, and existing tools/guidance to promote high-quality implementation and integration in each context?

Methodology

Qualitative analysis drawing from the Framework for Reporting Adaptations and Modifications-Expanded (FRAME) (Wiltsey Stirman, Baumann, & Miller, 2019) to capture processes and rationale for adaptation, including the level(s) and actor(s) involved. Adaptation data was captured using three qualitative methods:

-  **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 five organizations, held in November 2022. Structured interview questions followed by open discussion amongst attendees.
-  **Virtual key informant interviews** with eight representatives across five organizations from Bangladesh, Kenya, Nigeria, and Mexico in February 2023.

Methodology Snapshot



FRAME is a useful tool for categorizing the types of adaptations made and provides a template for considering how adaptations may affect intervention **fidelity** and **effectiveness**. We drew upon FRAME to develop the key informant interview guide and to categorize adaptations and processes shared across the three forms of data collection.

Analysis Process



Findings from the panel discussion were documented in a question-and-answer format and validated with panelists as part of the meeting report. Information from self-administered reflections and key informant interviews was entered into two Excel matrixes.



Findings were compared with information from publicly available data sources (or self-reflections, when provided) on prevalence of reproductive coercion and IPV and contextual factors (type of facility and reach of intervention, broadly defined).



Information shared was analyzed separately to identify key themes related to core elements, adaptations to accommodate facility-level challenges, and adaptations to address contextual challenges.



Key themes across methods of data collection were then synthesized to identify core elements, common adaptations and related reasons, factors which supported and hindered successful adaptation, and broad differences between adaptations in public and private facilities.



Section Three

**FINDINGS: CORE PRINCIPLES
AND ELEMENTS**



Core ARCHES Principles

Values clarification activities with decision-makers at the onset of partnerships and provider training are important to ensure that adaptations adhere to ARCHES five core principles.



Women's right to client-centered care, which supports their agency to make decisions about their bodies and health



Women's right to use family planning methods regardless of opposition from partners or other family members, including 'private' or 'covert' use of methods



Women's right to live free from violence and coercion



Women's right to education on reproductive coercion and IPV, regardless of whether or not they have had these experiences or choose to tell a provider about these experiences



Women's right to auditory and visual privacy during service provision, and providers' responsibility to ensure that women are given care under these meeting conditions.

Actioning Core Principles: Commitment to Auditory and Visual Privacy

In multiple contexts, client spaces within participating health clinics did not allow for auditory and visual privacy at the onset of adaptations. For example, it was common practice in public facilities for two providers to share one clinic room and conduct visits with multiple clients simultaneously. **Organizational staff across contexts modified clinic spaces or changed their use of existing spaces to ensure adherence to the core intervention principles.**

Strategies to improve auditory and visual privacy included:



Locating additional rooms within facilities which afford more privacy to clients and providers. ARCHES implementers provided support to furnish rooms, when needed, to ensure comfortable use by all.






Changing the physical environment by adding curtains or other physical dividers to improve visual privacy, and fans/noise-generating machines to improve auditory privacy. In the absence of existing protocols, create new protocols that protect client confidentiality.

Core ARCHES Elements

In addition to the core principles, analysis and previous study findings revealed core elements of client-facing content (information shared during the brief integrated clinical intervention), and core elements of training and facility factors.

Client-Facing Content

-  Education on reproductive coercion within family planning counseling, including strategies used by women locally to use family planning privately
-  Rights-based messaging
-  Easy-to-conceal educational materials

Training & Facility Elements

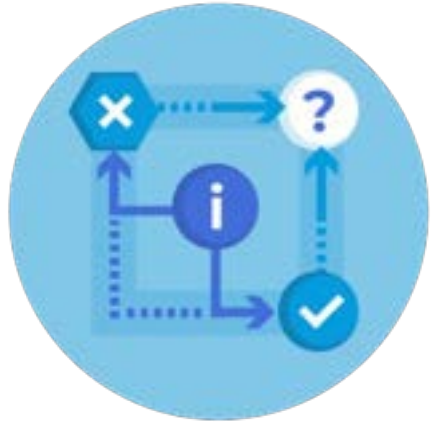
-  Values clarification activities
-  Providing auditory and visual privacy
-  High-quality provider training and follow-up
-  Reproductive coercion content
-  Integration of ARCHES content into facility counseling processes
-  Human resources

Core ARCHES Elements: **Client-Facing Content**

CORE ELEMENT	RATIONALE FOR INCLUSION
<p>REPRODUCTIVE COERCION EDUCATION WITHIN FAMILY PLANNING COUNSELING</p>	<p>Defining reproductive coercion, supporting women’s right to choose, and sharing strategies other women use to facilitate private contraceptive use:</p> <ul style="list-style-type: none"> • Addresses misconceptions or incomplete understandings of FP and their right to use it. • Improves women’s self-efficacy to protect themselves from reproductive coercion by providing concrete examples of how women like them have used FP without detection. • Ensures that more women receive needed advice than would be reached if disclosure was a pre-requisite to information sharing. • Combats stigma by affirming that other women have had experiences of RC in the community.
<p>RIGHTS-BASED MESSAGING</p>	<p>Messaging regarding women’s right to live free from violence and the availability of local IPV services allowed providers to:</p> <ul style="list-style-type: none"> • Reduce stigma of experiences of IPV (e.g., victim-blaming) and improves women’s ability to identify abusive behavior in their own relationships. • Combat normalization of violence and validates women’s right to live free from abuse through vocal support of their rights from a commonly recognized authority figure (medical providers).
<p>EASY-TO-CONCEAL EDUCATIONAL MATERIALS</p>	<p>Women using materials such as the mini-booklet to diffuse information was identified as a core component because it:</p> <ul style="list-style-type: none"> • Challenges the acceptability of IPV among family and peers by sharing information about organizations that provide services to combat this abuse. • Improves the self-efficacy of women as they take on the role of sharing important and useful information with their family and peers. • Reaches women who do not receive ARCHES with rights-based and educational material on family planning, RC and IPV and what they can do to improve their health and safety.

Core ARCHES Elements: Training and Facility Factors

CORE ELEMENT	RATIONALE FOR INCLUSION
VALUES CLARIFICATION ACTIVITIES	<p>Values clarification activities conducted during workshops and trainings with decision-makers and providers are essential for:</p> <ul style="list-style-type: none"> • Providing space to unpack and reconcile women-centered client care while making space for open communication about contraception with male partners, challenging deeply entrenched norms toward gender roles in relationships. • Shifting provider attitudes toward clients and support for women-centered care. • Improving buy-in of the intervention across partners and levels of decision-making.
AUDITORY AND VISUAL PRIVACY	<p>Ensuring that spaces used for client visits have auditory and visual privacy is necessary for:</p> <ul style="list-style-type: none"> • Creating a safe space for clients to disclose RC and IPV and gain information on private contraceptive use. • Maximizing the opportunity to improve client understanding of RC and IPV by creating a comfortable environment for asking questions about sensitive topics.
PROVIDER TRAINING AND FOLLOW-UP	<p>Sufficient training time to learn concepts, practice implementation, and obtain constructive feedback are essential for building provider competence and confidence to implement the intervention with fidelity to key values and with client-centered care principles.</p>
REPRODUCTIVE COERCION CONTENT	<p>Including definitions of reproductive health and local experiences of reproductive coercion in meetings and trainings are essential for:</p> <ul style="list-style-type: none"> • Improving competency to implement ARCHES with high fidelity by improving understanding of the concept of RC and providing examples that can be used independently or integrated into existing FP counseling and GBV training materials. • Proactively addressing resistance to implementation among providers and leaders, or assumptions that RC is not an issue which clients and communities experience.
INTEGRATION OF ARCHES INTO FACILITY COUNSELING PROCESSES	<p>Integrating the ARCHES content into regular facility processes and workflow for screening and counseling were central to improving long-term sustainability of the intervention so that it becomes routine practice; otherwise, it will be abandoned once a specific project and related oversight wanes.</p>
HUMAN RESOURCES	<p>Sufficient staffing and oversight (and related funding allocations) are essential because they address high client volume and intensive oversight needs. A greater number of trained health providers reduces the client volume for each provider, which allows all components of integrated counseling to be provided to each client.</p>



Section Four

**FINDINGS: FACTORS
AFFECTING ADAPTATION AND
STRATEGIES TO RESPOND**



Decisions and Decision-makers

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

- Engaging local groups of research experts or professional medical or health societies within the country context built support for scale-up and improved identification of solutions to challenges.
- Utilizing advisory groups made up of a range of actors improved support for the intervention and created spaces for shared brainstorming to creatively address solutions or advocate for needed changes.
- Creating a **Community Advisory Group** comprising women and girls from the population (for example, refugee and internally displaced women and girls in humanitarian settings) from the beginning to center them as experts working alongside NGO staff as part of the design team ensured adaptations align with local needs and values.

Common Decision-makers at Each Stage of Adaptation

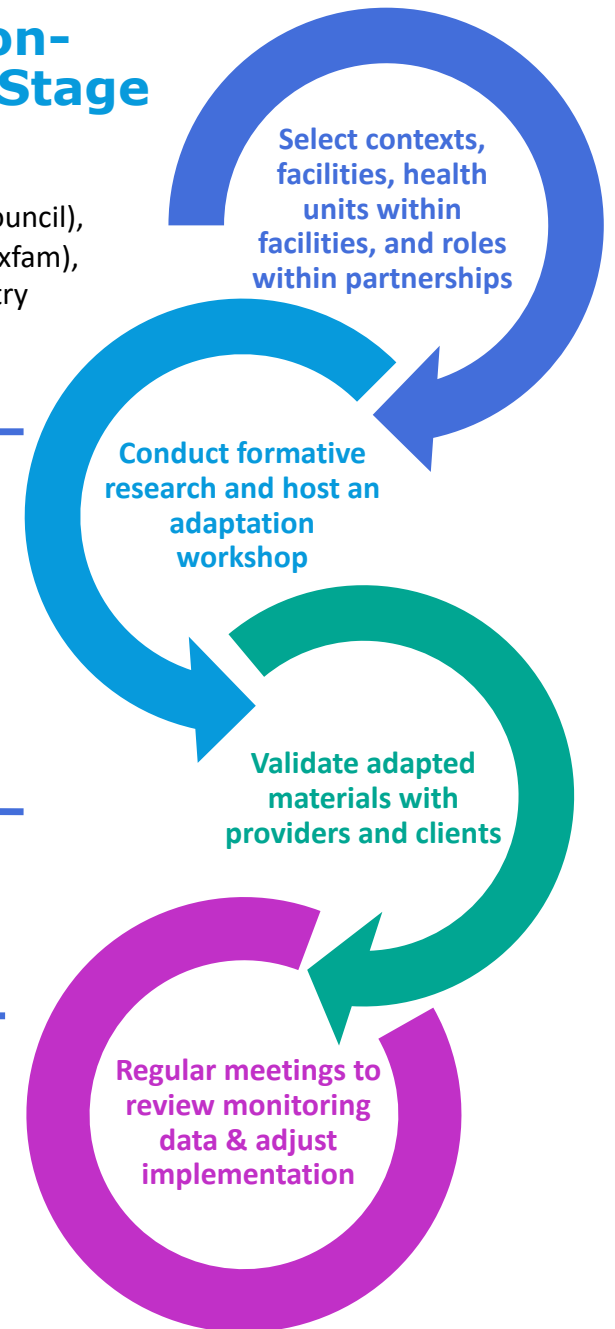
Researchers (UCSD, Population Council), implementers (JHPIEGO, Ipas, Mexfam), policy makers (government ministry offices) leadership, and donor representatives

Institutional and national and state-level ethical review boards, research & implementation partners

Representatives from all organizations, including government ministries

Implementation partners, health providers, health facility clients

Government ministry officials, research partners implementation partners



Sociopolitical Factors

CHALLENGE: ACCEPTANCE OF WOMEN'S RIGHT TO USE FP WITHOUT DETECTION

In three of the four countries, the core ARCHES principle of women's right to use FP methods without detection was met with hesitancy from program leadership and government actors. In one case, there was explicit refusal to include any form of messaging on private contraceptive use in materials.

SOLUTION: USE FORMATIVE RESEARCH, MONITORING DATA AND HUMAN-CENTERED DESIGN TO FIND WORKAROUNDS

- **To increase clinic leadership acceptance:** Share research findings to confirm that IPV & reproductive coercion were locally relevant issues and provide examples of private use relevant to the context.
- **To ensure client acceptability:** Use a human-centered design process to ensure intervention acceptability, use terminology that is locally acceptable, adapt images to ensure they are culturally appropriate.
- **To increase acceptance from government actors:** Include government actors early in decision-making and design and across leadership transitions. Use evidence from formative research and program monitoring to address intervention gaps. Find acceptable workaround solutions. In one context where the decision-makers would not include information on private use within written materials, the team included this information on the notes pages of training presentations and through post-training mentorship visits. This was not an ideal strategy, as core information may be diluted or forgotten in subsequent trainings but was better than not including the information at all.

Implementation Factors

Expanding reach of the intervention through CHWs

In all contexts where ARCHES has been implemented, partners have identified a need to reach women in the community with need for FP who do not frequent the clinic. In two adaptations, Community Health Workers (CHWs) were engaged to provide linkages between the community and health services.

In Bangladesh, some facilities were located outside the refugee camps where clients lived, making outreach difficult. During design meetings, clinic managers and providers explained the importance of CHWs in improving service utilization and recommended engaging them in ARCHES. CHWs were oriented to the issues of RC and IPV and learned where to refer women to obtain supportive services. CHWs did not provide the integrated counseling sessions themselves.

In Veracruz, Mexfam is planning to adapt ARCHES to engage their community health promoters who can expand the intervention's reach into the community.

Next steps: Research on a community adaptation of ARCHES is currently underway. In Kenya, NICHD has funded a pilot of a community-based ARCHES project to be implemented with women's economic empowerment groups, and Elrha is funding a community adaptation in refugee settings in Bangladesh.



A WORD OF CAUTION

Key informants stressed the need to adapt the intervention for delivery in the community setting including orientation, values clarification and training for CHWs on issues of reproductive coercion and IPV.

Since these are sensitive and often stigmatized topics, engaging CHWs without appropriate preparation could lead to further stigmatization and loss of confidentiality, posing further risks to women experiencing violence.

Organizational and Setting Factors

CHALLENGE: SERVING A VULNERABLE POPULATION ALONGSIDE HIGH STAFF TURNOVER

In **Bangladesh**, working with the Rohingya population presented a challenge compared to a prior adaptation in urban Bangladesh settings in terms of spoken language and low literacy among clients. This issue was compounded by new staff or staff turnover, where staff were both new to ARCHES and did not have language skills required to provide comprehensive counselling with the population.

SOLUTION: IMPROVE ACCESSIBILITY OF CLIENT-FACING MATERIALS

The mini-booklet was redesigned as a simple information card with pictorial descriptions, service provider logos and phone numbers. More simply, pictorial guides remove language and literacy barriers. Pictorial aids were also created for IPV and RC screening materials to facilitate understanding of screening questions.

Availability of psychosocial support or GBV case management staff

In some contexts, facilities had additional staff on-site who provided direct support services to women experiencing GBV. In **Kenya**, the Ministry of Health created a refresher training specifically for psychosocial support staff to build understanding of ARCHES and informed staff that they may see an increase in demand for services. Availability of psychosocial support staff created a direct pathway for referrals eliminating the need for referrals to less accessible external services. Similarly, in **Mexico**, facilities offer GBV support free-of-charge, reducing barriers for women seeking these services.

CHALLENGE: HIGH CLIENT FLOW AND LIMITED TIME WITHIN PUBLIC FACILITIES AFFECTS FEASIBILITY OF IMPLEMENTING ALL ARCHES COMPONENTS

In public facilities, providers often addressed a wider range of needs and a greater volume of clients than providers in private facilities. In one context, ARCHES elements were added to FP counseling on top of other recommended GBV interventions, significantly increasing the length of the client visits (this was not found in other adaptations). Because of this, there was pushback from providers who felt it would increase efficiency to provide IPV and RC counseling only to clients who disclosed abuse.

SOLUTION: INTEGRATE ARCHES MATERIALS INTO EXISTING CLIENT-FACING SCREENING AND IPV REFERRAL PROCEDURES

- **Consider screening questions as pathways to discussion of IPV and RC with clients that may lead to improved care, and not as a required clinical screen for a disease or condition; this prevents providers from feeling pressured to elicit information and clients from feeling coerced to disclose. In Kenya and Bangladesh, screening procedures were modified to encourage providers to ask a single IPV screening question to reduce provider and client burden, allowing for more efficient implementation.**
- **Integrate screening questions and content into family planning algorithms such as GATHER, the Balanced Counseling Strategy (BCS) or Balanced Counseling Strategy Plus (BCS+). In Nigeria, adding this information to the algorithm ensured that clients would receive it; additional messaging can also be added to cue providers to discuss RC and private use strategies. In Kenya, ARCHES content was integrated into the BCS+ algorithm. The team developed a mobile app mirroring the adapted BCS+ as a portable and scalable job aid that has drastically improved fidelity to the counseling algorithm**

Maximizing Partnerships

Reframing Challenges as Opportunities for Strengthening Relationships and Providing Mutual Support

Qualitative findings revealed several instances in which implementing organizations reframed adaptation or implementation challenges into opportunities to strengthen relationships with governmental partners and provide mutual support. When working with partners, one key informant stressed the importance of **“meeting them halfway so that it feels that it is not just about you, it is about them too.”**



Leveraging partnerships to address gaps in contraceptive commodities and supplies. ARCHES faced stock outs in several contexts. In one setting, providers referred clients to other facilities; however, this increased costs for clients. In Nigeria, commodities are managed by each state’s commodity logistics unit. Pre-existing partnerships with the ministry, which included engaging ministry staff as ARCHES co-trainers, were valuable in advocating for consistent supplies.



Support for staff time to meet project milestones while juggling competing priorities. ARCHES adaptation can be time- and resource-intensive, often involving modifications to client-facing materials as well as integration into health facility workflows. Protecting the time of government and partner staff for this work can be difficult. In Kenya, Population Council provided support for intervention-focused meetings and workshops that included a small group of ministry colleagues to enable dedicated time over multiple days to meet project milestones related to adapting and integrating ARCHES content into materials, workflows, and processes.



Capacity-building to address gaps between national strategies and clinic practices. In Kenya, the Ministry of Health adopted the BCS+ algorithm as a best practice FP counseling strategy, but many clinics and providers did not have these materials or training to use the algorithm. The adaptation team worked with the ministry to build capacity on the BCS+ model along with integration of ARCHES content within standard provider training materials.

Innovative Contextual Adaptations

Including a mentorship and supervision model strengthens fidelity, but requires adequate resources

In almost all contexts, a mentorship and supervision component was added to the ARCHES model to improve fidelity. Monitoring data in multiple settings revealed low initial uptake of the intervention among providers, and in alignment with other provider training interventions, a supervision component was included to:

1. Observe integrated counseling sessions to improve adherence to core messages and components.
2. Create structured opportunities for groups of providers to identify common barriers and brainstorm solutions.
3. Clarify ARCHES principles and facilitate peer support for ARCHES implementation.

In **Bangladesh**, supervision visits were complemented by weekly phone calls to increase provider motivation in the face of time burdens. In **Nigeria**, supervision visits included direct observation and demonstrations and supported IPV screening during clinic visits. Conducting visits with ministry representatives increased provider motivation by demonstrating that ARCHES was a government priority. In **Kenya**, the MOH developed brief guidance on mentorship and supervision that could be used for ARCHES as well as other provider training initiatives.

While essential in most provider training initiatives, **mentorship and supervision models are time-consuming, costly, difficult to conduct consistently (especially in conflict-affected context) and may not be scalable.** In Bangladesh, timing and budget constraints limited the number of visits, and in Nigeria, some visits were postponed due to security concerns. Implementation of a mobile app may reduce the need for heavy external support; a mobile app is being used in an ongoing ARCHES trial in Kenya.



Section Five

TAKEAWAYS FOR FUTURE IMPLEMENTERS



Key Takeaways

In addition to the strategies already presented for navigating common implementation problems, key informants shared reflections for future implementers, as well as some suggestions related to *a priori* design and research decisions:

1

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

Early engagement promoted buy-in of the intervention in most implementation contexts, and in some cases offered unexpected advocacy pathways for needed resources.

2

Consider use of human-centered design processes to promote efficiency and cultural acceptability of adaptation. Use of human-centered design can reduce the need for formal research and increase involvement and co-ownership by providers, clients, community, and women.

3

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

Data should be collected regularly and used for decision-making to identify issues and inform potential solutions. Approach monitoring and learning adaptively, using regular monitoring data to understand how the program is rolling out. If needed, use supplemental in-depth studies to support learning and iteration.

4

Develop strong coordination and communication processes from the start, with regularly scheduled meetings. Clear plans and shared understandings reduced confusion and improved decision-making during implementation, and regular meetings offered opportunities for adaptive management to emerging or ongoing challenges.

5

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. Attention to ease of integration, clarity, and brevity and avoiding adding new time-consuming components to clinical practice will support successful adaptation and implementation.

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