



THESIS TITLE

Utilization, Acceptability, and Satisfaction regarding Reproductive Health Services at Rehabilitated Community Clinics in Climate Disaster Prone Chars in Bogura: A Mixed-Method Research Among Women of Reproductive Age

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A thesis submitted to the BRAC James P Grant School of Public Health in partial fulfilment of the requirements for the degree of
Master of Public Health

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Declaration

I, Pau Sian Muang, hereby declare that this thesis entitled "Utilization, Acceptability, and Satisfaction regarding Reproductive Health Services at Rehabilitated Community Clinics in climate disaster prone area in Bogura: A Mixed-Method Research Among Women of Reproductive Age " is an original work submitted in partial fulfilment of the requirements for the degree of Master of Public Health (MPH) at the James P. Grant School of Public Health (JPGSPH), BRAC University, Dhaka, Bangladesh.

I further declare that this work has not been submitted previously, in whole or in part, for any other degree or examination at this or any other university or institution.

All sources used in this thesis have been duly acknowledged and cited. Any assistance received has been mentioned in the acknowledgements section.

I have also added a separate declaration on GenAI use at the end of this work.

Pau Sian Muang

Date: June 2, 2026

Approval

The thesis/project titled “Utilization, Acceptability, and Satisfaction regarding Reproductive Health Services at Rehabilitated Community Clinics in climate disaster prone area in Bogura: A Mixed-Method Research Among Women of Reproductive Age” submitted by

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Of 2026 has been accepted as satisfactory in partial fulfilment of the requirements for the degree of Master of Public Health.



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Ethics Statement

This study adhered to the ethical principles stated in the International Ethical Guidelines for Health-Related Research Involving Humans (CIOMS, 2016) and the Ethical Considerations in Planning and Reviewing Research Studies on Sexual and Reproductive Health in Adolescents (WHO, 2018).

Prior to the fieldwork, the ethical approval was received from the James P. Grant School of Public Health (JPGSPH), BRAC University, the Institutional Review Board (IRB) (IRB Reference No: MPH-2025-024, dated 22 February 2026). The study strictly followed the IRB-approved protocol without any deviation.

All participation in the primary data collection components was voluntary. Before collecting any data, written informed consent was taken from the individual. A trained field research assistant read an information sheet in Bangla before data collection and interviews. Additional consent was obtained for recording, before the interviews. For the secondary data, no individual consent was obtained as records were accessed in aggregated and anonymized form with no individual identifiers. The permission was obtained from the relevant health authority before the extraction.

To ensure independent informed consent without requiring parental or guardian assent, women aged 15-17 years were excluded. This is consistent with the WHO (2018) guidance on adolescent sexual and reproductive health research and with the *Child Marriage Restraint Act, 2017* of Bangladesh, which sets 18 years as the minimum legal age and below this age is defined as a legal minor.

Throughout the study, data security and confidentiality were secured. Interviews were conducted in private settings. Field research assistants were trained to recognize signs of distress and to pause or terminate sessions where any participant showed discomfort, with referral pathways.

No conflict of interest is declared. Under the academic supervision of JPGSPH, BRAC University the study was conducted and benefited from the operational facilitation of the Bangladesh Red Crescent Society (BDRCS) and the Swiss Red Cross (SRC) as the implementing partners of the JAMUNA Project, neither of which involve in the analytical interpretation of findings.

Abstract

Background: Bangladesh reduced its maternal mortality ratio to 115 per 100,000 live births in 2023 but remains above SDG target. Women in char areas consistently face compound barriers to reproductive health (RH) services. Community Clinics (CCs) are the primary community-level RH service delivery, yet evidence on how rehabilitated CCs in climate-vulnerable settings particularly from women's perspective remains limited.

Objectives: This study evaluated how women of reproductive age experience RH services delivered through rehabilitated CCs under the JAMUNA Project in the char areas of Bogura District, Bangladesh. Specific objectives were to assess utilization trends, measure client satisfaction, explore acceptability of RH services and identify barriers and facilitators to service use.

Methods: A convergent parallel mixed-methods design was used at two rehabilitated CCs. The quantitative part included a cross-sectional client survey (N = 101 women aged 18--49 years; simple random sampling) using 18-item Patient Satisfaction Questionnaire (PSQ-18) and a secondary trend analysis of routine RH services across 26-months period (12 months pre- and 14 months post-rehabilitation). The qualitative part included ten in-depth interviews (IDIs) guided by the Theoretical Framework of Acceptability and non-participant facility observation. Quantitative data were analyzed using Stata/BE 19.5; qualitative data through Framework Analysis. Both strands were combined at interpretation.

Results: The PSQ-18 overall mean satisfaction score was 3.94 (SD = 0.26, scale 1-5) with 60.4% of participants classified as satisfied (95% CI: 50.2% - 70.0%). Interpersonal Manner had the highest score (mean = 4.29) while Accessibility and Convenience had the lowest (mean = 3.71). Clinic site was the only variable significantly associated with satisfaction ($\chi^2 = 8.110$, $p = 0.004$, Cramér's $V = 0.283$) while women at partially rehabilitated Tengra Kura CC reported higher satisfaction (73.6%) than those at fully rehabilitated Pakuria CC (45.8%). Age, education, and type of RH service received were not significantly associated. Utilization trends were mixed. FP volumes increased at both sites (Pakuria CC: +6.2%; Tengra Kura CC: +6.8%) while ANC volumes diverged as +11.3% at Tengra Kura CC and -12.8% at Pakuria CC. PNC showed the weakest uptake, 22.9% declined at Pakuria CC with a marginal +7.1% at Tengra Kura CC. Qualitative findings pointed provider

courtesy and geographic proximity as the primary acceptability facilitators. Seasonal flooding compounded persistent infrastructure deficits, irregular provider attendance, opportunity costs and limited awareness of the full RH service package.

Conclusions: Physical rehabilitation of community clinics in flood-prone char areas is meaningful as client satisfaction reached 60.4% and FP utilization grew consistently. However, PNC declined at the fully rehabilitated site and ANC trends diverged indicating structural completion alone does not reliably translate into increased utilization. The provider-client relationship, gender-responsive staffing, climate-resilient service continuity and basic diagnostic capacity were the factors most consistently associated with whether rehabilitated CCs services are acceptable and accessible. Climate-resilient CC policy should incorporate minimum quality standards with construction metrics and seasonal contingency frameworks.

Keywords: community clinic, reproductive health services, client satisfaction, service acceptability, climate vulnerability, char areas, implementation research

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List of Acronyms

Acronym	Full Form
ANC	Antenatal Care
BDHS	Bangladesh Demographic and Health Survey
BDRCS	Bangladesh Red Crescent Society
BP	Blood Pressure
CC	Community Clinic
CHCP	Community Healthcare Provider
CI	Confidence Interval
CIOMS	Council for International Organizations of Medical Sciences
COVID-19	Coronavirus Disease 2019
CSG	Community Support Group
DHS	Demographic and Health Survey
DRR	Disaster Risk Reduction
FP	Family Planning
FWA	Family Welfare Assistant
GenAI	Generative Artificial Intelligence
HA	Health Assistant
ICF	ICF International (Demographic and Health Survey implementing partner)
IDI	In-Depth Interview
IR	Implementation Research
IRB	Institutional Review Board
JAMUNA	Joint Actions for Mitigating Climate Uncertainties and Natural Adversities
JPGSPH	James P. Grant School of Public Health
LMIC	Low- and Middle-Income Country
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health

MoHFW	Ministry of Health and Family Welfare
NGO	Non-Governmental Organization
NIPORT	National Institute of Population Research and Training
PI	Principal Investigator
PNC	Postnatal Care
PSQ-18	Patient Satisfaction Questionnaire (18-item Short Form)
RH	Reproductive Health
SD	Standard Deviation
SDG	Sustainable Development Goal
SE	Standard Error
SRC	Swiss Red Cross
TFA	Theoretical Framework of Acceptability
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Chapter 1: Introduction

1.1 Background and Rationale

Even though the maternal mortality ratio (MMR) is one of the most preventable tragedies, MMR is still a major public health issue around the world. An estimated 260,000 women died in 2023 from pregnancy-and childbirth-related causes, while 92% of those happened in low-and middle-income countries (LMICs) where reproductive health (RH) services are inequitably distributed, health systems are unsustainable and climate-related disasters frequently disrupt the healthcare delivery (World Health Organization, 2025).

Bangladesh has achieved significant improvement regarding maternal and reproductive health over the last 2 decades; Yet, there are gaps in implementation remaining in remote, climate-vulnerable regions. The country substantially reduced the MMR to 115 per 100,000 live births in 2023 (The World Bank, 2023). However, it remains far behind in achieving the Sustainable Development Goal (SDG) target of 70 MMR per 100,000 live births. The country is believed to be unlikely to achieve that threshold by 2030 if it continues the current trajectories (Nishimura et al., 2024). Although reproductive service coverage has increased, the stagnation of MMR decline between 2010 and 2016 indicates that the availability of services does not translate into reductions in mortality, while quality, acceptability and continuity of care are decisive (Ahsan et al., 2024). In Bangladesh, only 41% of pregnant women had the recommended four or more antenatal care (ANC) visits, and 65% had institutional deliveries (National Institute of Population Research and Training (NIPORT)& ICF, 2023), which highlights poor utilization of essential maternal health services on a national scale.

In Bangladesh, access to maternal, neonatal and child health (MNCH) is directly correlated with women's education, proximity to healthcare facilities, socioeconomic status and autonomy (Anik et al., 2021; Begum & Syed Abdul Hamid, 2023). Furthermore, other factors, such as privacy, provider behavior, previous experiences, satisfaction with healthcare services and concerns about service quality play critical roles in health-seeking behavior among women (Moon et al., 2025; Mahejabin et al., 2016). Therefore, expanding access to services is necessary, but not enough, as the experience of care also determines the utilization of the services.

In 1998, the government of Bangladesh started the community clinic (CC) initiative with over 13,000 CCs nationwide where each CC is intended to serve around 6,000 people at the village level (Riaz et al., 2020). CCs were intended to provide integrated primary care, including antenatal care (ANC), family planning (FP), counselling, postnatal care (PNC) and referral of complicated obstetric cases. Still, challenges such as shortages of healthcare providers, inadequate infrastructure, inconsistent supply of medicines and weak community participation limit the effectiveness and reach of CCs to the community, especially in remote and disaster-prone areas (Zhang & Sajal, 2025). During the COVID-19 pandemic, the accessibility rates of CCs halved especially among women in rural areas, which is disproportionately redirected to informal providers, especially during seasonal flooding (Rahman et al., 2024).

The challenge is more in char areas, which are low-lying, sediment-formed riverine islands along Bangladesh's major river systems. char areas are identified as one of the major climate-stress regions according to the National Adaptation Plan of Bangladesh (2023-2050). Although the char region covers 1.7 % of the country, home to 5% of the country's population, char communities are more climate-vulnerable and are among the poorest, facing frequent flooding that disrupts transportation, isolates communities and decreases continuity of health services (Bari & Hasan, 2025; Bhuiyan et al., 2017; Islam & Hossain, 2013). Comparative analyses stated that women who live in high-disaster-prone areas are more likely to have lower rates of ANC attendance and facility-based delivery than those in low-disaster-prone areas, even after adjusting for socioeconomic confounders (Begum & Syed Abdul Hamid, 2023). Pregnant women in high disaster-prone areas were unable to reach facilities during extreme weather events, which forced them to deliver at home without proper support, increasing the risks of hemorrhage, obstructed labor and neonatal asphyxia (Amin et al., 2025).

The Government of Bangladesh acts to enhance health system resilience in disaster-prone areas with the help of development partners. One such initiative is the Joint Actions for Mitigating Climate Uncertainties and Natural Adversities (JAMUNA) Project, implemented by the Bangladesh Red Crescent Society (BDRCS) with the support of the Swiss Red Cross across 4 districts (Kurigram, Gaibandha, Bogura and Sirajganj). The Government of Bangladesh provides policy support, institutional coordination, public health integration, early warning data, coordination with local government institutions and regulatory oversight for the project. Within this partnership, BDRCS is

the lead national implementing actor. Its mandate in JAMUNA covers physical rehabilitation of Community Clinics in flood-vulnerable char areas, community mobilization and awareness, advocacy for training of CC staff and community health volunteers, and coordination with district health authorities to embed rehabilitated CCs in the national primary care network. SRC provides technical input, financial support and quality assurance for the rehabilitation. The rehabilitated CCs deliver the standard CC package of basic curative care, maternal and child health services and reproductive health services (ANC, postnatal care, counselling, family planning; oral contraceptive pills, condoms and referral for obstetric complications) through the existing CC structure.

Rationale

Despite these investments, there remains limited evidence on how rehabilitated CCs perform in practice in char areas. Most evaluations regarding CC-based interventions have focused on service availability or infrastructure completion, but have paid limited attention to implementation outcomes such as utilization, acceptability and satisfaction from the perspective of women. Knowing how women actually use the rehabilitated CCs, whether they regard the services as acceptable, and what determines their satisfaction is critical because these are the outcomes that ultimately translate physical investment into measurable reductions in maternal morbidity and mortality. Without that user-perspective evidence, the JAMUNA Project risks being judged on construction milestones rather than on the health outcomes.

As Implementation research (IR) helps assess how interventions perform in practice by focusing on outcomes such as acceptability, satisfaction, and barriers and facilitators influencing service delivery (Proctor et al., 2011), IR is needed in this context to explore whether rehabilitated CCs are effectively utilized, acceptable, and satisfactory to women under real-world conditions in flood-prone char areas, and whether improvements need to be made.

Mixed-methods designs are widely used as quantitative findings can provide information on the breadth of any problem while qualitative insights allow for exploring the underlying reasons and generating evidence and evaluating health service interventions that inform both program effectiveness and implementation improvement (Creswell, 2014; Peters et al., 2013).

The generated evidence is directly relevant to the JAMUNA implementation improvements and will ensure service delivery, responsiveness and client-centered reproductive healthcare. Moreover, the findings will provide reliable insights for implementers, health system planners and development partners seeking to design and scale climate-resilient primary healthcare interventions that improve RH equity for marginalized populations living in disaster-prone settings.

1.2 Problem Statement

Women of reproductive age in disaster-prone char areas face compounding barriers when they try to access essential and continuous RH services, especially during frequent climate extreme events. Seasonal flooding prevents the char communities from accessing healthcare services by isolating them from mainland health facilities and disrupting transportation, and safe delivery services are most urgently needed. (Begum & Syed Abdul Hamid, 2023; Amin et al., 2025). These climate-driven disruptions compound established incomplete infrastructure, limited knowledge, restricted decision-making autonomy and poverty that already suppress the service utilization especially among marginalized populations (Anik et al., 2021; Baten et al., 2020). Lower rates of ANC completion and institutional delivery was observed among women in higher-disaster-prone areas compared to the national average, which leads to an increase in the risks of neonatal and maternal complications (Baten et al., 2020; Prantik et al., 2026).

Most evaluations of CC interventions focus mainly on structural completion or general service availability; while largely ignoring the user's experience, this leads to limited knowledge regarding how these upgraded facilities actually perform in reality. To assess the true effectiveness of the rehabilitation efforts, it is necessary to explore the specific barriers and facilitators influencing service delivery and perception regarding RH services. Therefore, to address this evidence gap and determine if those climate-resilient CCs are genuinely utilized in practice, deemed acceptable and satisfactory to the vulnerable women they are intended to serve, IR research lens is sorely needed.

1.3 Research Questions

How do women of reproductive age experience and evaluate reproductive health services delivered through rehabilitated Community Clinics under the JAMUNA Project, in terms of service utilization, acceptability, satisfaction, and barriers to service use?

1.4 Study Objectives

1.4.1 Overall Objective

- To explore how women of reproductive age experience and evaluate reproductive health services delivered through rehabilitated Community Clinics under the JAMUNA Project, with a specific focus on service utilization, acceptability, client satisfaction, and barriers and facilitators influencing service use

1.4.2 Specific Objectives

1. To examine the level, patterns, and changes in utilization of reproductive health services provided through rehabilitated Community Clinics, during pre- and post-rehabilitation periods.
2. To measure the level of client satisfaction with reproductive health services received at rehabilitated Community Clinics among women of reproductive age.
3. To explore the perceived acceptability of the RH services, delivered through rehabilitated Community Clinics among women of reproductive age.
4. To identify key barriers and facilitators faced by women of reproductive age group when seeking reproductive health services at rehabilitated Community Clinics.

1.5 Structure of the Thesis

The thesis has six chapters. Chapter 1 mentions the introduction and rationale, sets out the background and describes the study objectives. Chapter 2 reviews the existing literature on the topic. The methodology section is described in chapter 3 while the findings were reported in chapter 4. Chapter 5 discusses those findings against the existing evidence base. The thesis is ended with conclusion and recommendation in chapter 6.

Chapter 2: Literature Review

2.1 Global Evidence

2.1.1 Climate Change as a Structural Determinant of Reproductive Health

Climate-related exposures such as particulate matter, flooding and extreme temperature increase the risks of miscarriage, preterm birth, low birth weight and congenital anomalies which add to the disease burden in LMICs and disasters-prone communities (Papadiochou et al., 2024). Extreme weather events have an enormous influence on the pregnancy's condition as each of these conditions is associated with specific climatic exposures: heat with low birth weight and preterm birth, particulate matter with congenital anomalies, and acute flooding with miscarriage and obstetric emergencies (Papadiochou et al., 2024). Flooding in particular acts through multiple mechanisms (contamination of water sources, proliferation of vector-borne diseases, displacement of populations, and increased psychological stress from repeated loss) that collectively affect the course of pregnancy (Acosta-España et al., 2024; He et al., 2024).

Flooding has severe and multiple effects, such as contamination of water sources, proliferation of vector-borne diseases, displacement of populations, and increased psychological stress from repeated loss, which collectively have an impact on the condition of pregnancy (Acosta-España et al., 2024; He et al., 2024). Evidence from Southeast Asia and sub-Saharan Africa shows that during acute climate crises, access to ANC, skilled birth attendance and family planning services decline sharply, especially in the most geographically isolated populations (Arunda et al., 2024; Das et al., 2025).

Women in marginalized communities especially in LMICs are more at risk of poor health outcomes from climate disasters due to systemic gender inequalities. Gender norms place the burden of caring for children and elderly which during climate disasters increases their exposure to risk and delays in their evacuation and safety; Physical and cultural restrictions on women's movement restrict them to access emergency care; Women's poor access to decision making delays timely care during climate disasters. (Anjum & Aziz, 2025). Moreover, climate shocks destroy roads, shut down health facilities, displace communities and healthcare providers which reduce access to healthcare services, especially RH services. Flooding, among all kinds of climate disasters, is the most frequently

documented cause of disruption of health services globally, with its effects ranging from temporary closure to permanent infrastructure (Gkouliaveras et al., 2025). Even though the international frameworks like SDG 3 (health) and SDG 13 (climate action) formally acknowledge this intersection, there is limited climate resilience in health service delivery in LMICs (Gkouliaveras et al., 2025; Syal et al., 2026). The utilization of RH services is suppressed not only by physical access barriers but also by the financial and psychosocial stress of climate-induced displacement (Gkouliaveras et al., 2025; Anjum & Aziz, 2025).

2.1.2 Evidence from Community-Level Maternal Health Delivery in South Asia

Across South Asia, evidence shows that community-based primary care delivery is the dominant strategy for extending maternal health services to rural and remote populations. The community clinic and community healthcare workers models in India, Nepal and Pakistan offer useful comparisons for Bangladesh's CC model, particularly in settings where female mobility is constrained and where the first point of formal care is a village-level facility staffed by a small team.

India's Accredited Social Health Activist (ASHA) program has achieved significant improvements in institutional delivery rates in marginalized populations even though evidence on ANC quality, continuity of care, and provider absenteeism is a consistent challenge (Chawla et al., 2025). Nepal's Female Community Health Volunteer network has improved maternal and neonatal healthcare in remote mountain and Terai communities and the community trust in local volunteers and the quality of referral linkages had a substantial influence on the effectiveness of the programme (Panday et al., 2017). Pakistan's Lady Health Worker programme demonstrated that the RH services utilization among women with limited household autonomy is influenced not only by social embeddedness and cultural acceptability of services but also by physical proximity (Mumtaz et al., 2013).

These South Asian models converge on a finding directly relevant to the Bangladesh CC context: community health infrastructure succeeds when it is socially embedded, technically supported, perceived as trustworthy and met the cultural expectations of the women it serves (Mumtaz et al., 2013; Panday et al., 2017; Chawla et al., 2025).

Without corresponding attention to provider behavior, community acceptance and user experience, structural investment in facilities or personnel will produce sub-optimal utilization of RH services

(Sidamo et al., 2024). Settings such as char areas where female mobilities are restricted and household decision-making is constrained, a woman's decision to attend the CC is influenced by whether it is safe, respectful, confidential and crucially by geographical accessibility (Hinata et al., 2024; Yaya et al., 2017). Geographical accessibility in char settings is conditioned on three factors that operate together: travel distance from the woman's home, the seasonality of the connecting pathway (raised earthen embankments, dirt tracks, river crossings) and the woman's mobility autonomy on the day of intended attendance. Each factor on its own can suppress utilization while combined factors can produce the systematic underuse documented in char populations (Begum & Syed Abdul Hamid, 2023; Amin et al., 2025).

2.1.3 Community Clinics in Bangladesh: Performance, Participation, and Gaps

Bangladesh's CC model, the government provided infrastructure and personnel combined with community contributed land and governance through Community Support Group (CSG), is widely cited as an innovative public-private partnership in community-level primary care delivery (Riaz et al., 2020). Strengthening CSGs within CC catchment areas increased ANC attendance and improved skilled birth attendance with the most effects to the poorest wealth quintiles, according to a study (Tobe et al., 2019). However, structural and functional deficiencies such as provider absenteeism, drug stockouts, dysfunctional equipment and inadequate supervision have been found to undermine service delivery (Mahmud et al., 2024; Zhang & Sajal, 2025). Moreover, even though community participation is the one of the principles in the CC model, still there is weakness in practice. A study found that while most CCs had basic infrastructure, participation from community and functioning CSGs activity were still limited and women in the catchment area had limited awareness of the groups' roles or composition (Banik et al., 2023). The evidence so far implies that infrastructure improvement is inadequate without community governance.

The CC accessibility rates fell to half in rural Bangladesh during the COVID-19 pandemic with women being redirected to informal providers, a pattern that mirrors expected dynamics during seasonal flooding events (Rahman et al., 2024). Quality and capacity gaps in delivery care facilities have a huge impact on MMR reduction and adding infrastructure without improving the quality-of-care processes will stunt the reduction of MMR (Ahsan et al., 2024).

2.1.4 Determinants of Maternal Health Service Utilization in Disaster-Prone Areas of Bangladesh

According to a 2023 comparative analysis, women in high disaster-prone areas had less ANC completion and facility delivery rates compared to those who lived in low-disaster-prone areas. The findings further revealed that disaster exposure exerts an independent suppressive effect on maternal health service utilization after controlling for socioeconomic variables (Begum & Syed Abdul Hamid, 2023). A study in a rural riverine area in Bangladesh found that flooding of residential compounds was associated with more than double the prevalence of prenatal depression, while qualitative insights linked this to fear about emergency healthcare access during labor (Hanif et al., 2025). Women who experienced flood-related depression in this study were less likely to plan and complete ANC visits even when access is easily maintained (Hanif et al., 2025). A temporal analysis using four rounds of Bangladesh DHS data (2011–2022) confirms that aggregate national improvements in ANC and delivery indicators mask persistent disparities by wealth quintile, education level and geographic division (Prantik et al., 2026). These disparities are most severe, especially in char communities, where there are less formal education, lower wealth quintiles, and greater geographic remoteness. These findings establish the rationale for studying utilization and experiences at the facility and catchment level in char areas under JAMUNA, where national averages are most likely to obscure local realities and where programmatic interventions most need evidence to guide adaptive management.

2.2 Thematic Sub-Sections

2.2.1 Measuring Quality of Care: The Role of the Patient Satisfaction Questionnaire (PSQ-18)

Client satisfaction is considered not only as a secondary outcome but also as a primary outcome which determines the continuity of care and the utilization of healthcare especially in health services research. People with high satisfaction with health services are more compliant with medical advice, higher rates of follow-up care and better overall health outcomes (Donabedian, 2005). To quantify this complex construct, the 18-item short-form Patient Satisfaction Questionnaire (PSQ-18), originally developed by Marshall and Hays (1994), has become a globally validated and widely utilized metric.

PSQ-18 uses a multidimensional approach rather than relying on a single binary measurement. The instruments assess seven distinct subscales: General Satisfaction, Technical Quality, Interpersonal Manner, Communication, Financial Aspects, Time Spent with Doctor, and Accessibility and Convenience, across a total of 18 questions (Marshall & Hays, 1994).

In developing countries, particularly in maternal and reproductive health, the literature indicates that interpersonal domains (how a provider communicates with and treats the patient) and accessibility are often more predictive of a woman's return to a clinic than the objective technical quality of clinical care (Srivastava et al., 2015).

In Bangladesh, previous studies indicate dissatisfaction at primary care levels stemming from long waiting times, shortage of prescribed drugs and poor provider behavior (Aldana et al., 2001; Islam et al., 2015). Applying the PSQ-18 to the rehabilitated Community Clinics under the JAMUNA project will provide a vital quantitative mechanism to test whether upgrading physical, climate-resilient infrastructure has simultaneously translated into improvements across these deeply personal, provider-driven dimensions of care.

2.2.2 Beyond Utilization: Evaluating Acceptability through the Theoretical Framework of Acceptability (TFA)

Even though the PSQ-18 can provide a snapshot of satisfaction, it often falls short in explaining whether an intervention succeeds or fails in particular settings. Acceptability has emerged as a critical, multifaceted outcome which determines the appropriateness of a healthcare intervention among the people (Proctor et al., 2011). The Theoretical Framework of Acceptability (TFA) developed by Sekhon, Cartwright and Francis (2017) claims that acceptability is an emotional and cognitive response to an intervention which can be assessed before, during or after implementation.

The TFA can capture the nuanced, lived experiences of marginalized women, especially in disaster-prone char regions. The domains burden and opportunity cost are profoundly magnified; a flooded road inhibits health services accessing while also increases the time away from household tasks, while the ethicality domain can also explore how a lack of infrastructural privacy can completely deter service utilization (Moon et al., 2025).

2.3 Conceptual/Theoretical Framework

This study is guided by the Theoretical Framework of Acceptability (TFA), which conceptualizes acceptability as a multi-dimensional construct reflecting how people feel and experience a health intervention. TFA defines acceptability in terms of individuals' cognitive and emotional responses to an intervention, making it particularly suitable for examining experiences of reproductive age women for RH services delivered at rehabilitated CCs. The TFA comprises seven constructs that guided the qualitative insights on women's perceptions of reproductive health service delivery.

Affective Attitude: The participant's overall feeling about the RH services, including liking, trust, comfort and emotional response to the provider-client encounter.

Burden: The perceived effort needed to use and utilize the RH services, including waiting time, travel difficulty, heat, crowding and emotional strain at the point of service.

Perceived Effectiveness: The participant's judgement of whether the RH services achieve its intended clinical outcome, based on past experience and observed results.

Ethicality: The extent to which the RH services align with the participant's personal, religious, cultural and familial values, including confidentiality, dignity, and the gender appropriateness of the encounter.

Intervention Coherence: The participant's understanding the purpose, components, and functioning of RH services provided at CCs and awareness of the JAMUNA Project and the rehabilitated CC package falls within this domain.

Opportunity Costs: The trade-offs the participant must make to access the RH services, including lost income, household disruption, childcare arrangements and accompaniment requirements.

Self-Efficacy: The participant's confidence regarding accessing and utilizing RH services successfully, including her ability to attend independently, communicate openly with the provider, and continue care over time.

The study developed a structured understanding of user-level experiences and identified modifiable factors that affect the acceptability and sustained use of reproductive health services at rehabilitated CCs by applying the TFA.

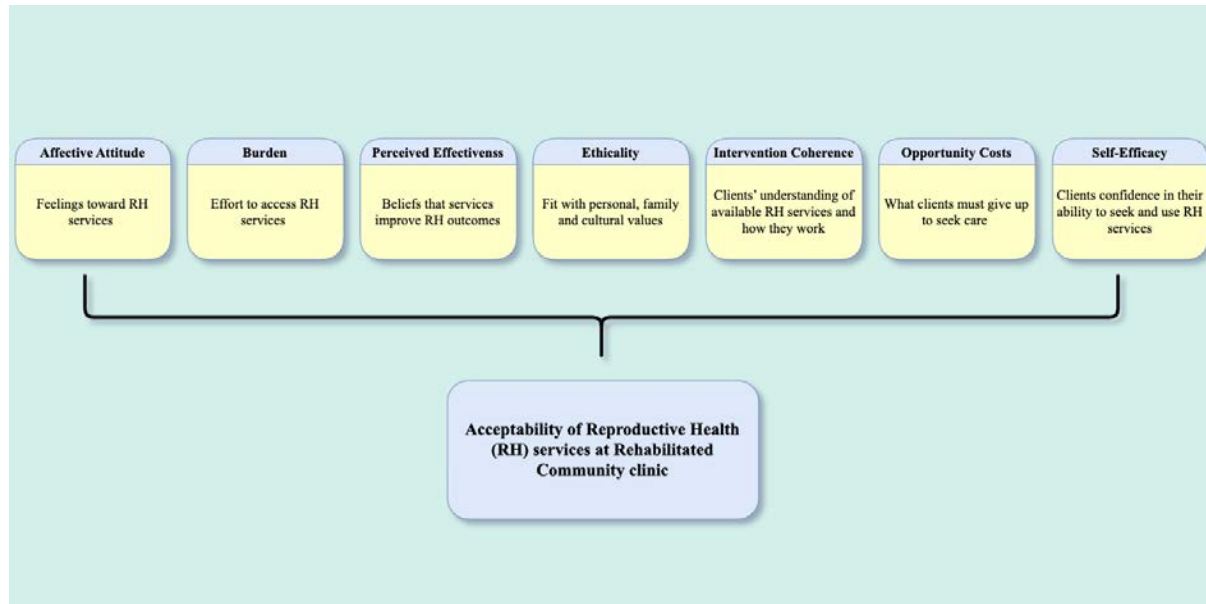


Figure 1: Conceptual Framework

2.4 Operational Definitions

To ensure clarity and consistency in measurement and interpretation throughout the study, the following key variables and concepts are operationally defined:

Client Satisfaction: The level of satisfaction to RH services the participants received were met by the clinic. PSQ-18 questions were used to measure the satisfaction level. It encompasses seven distinct domains: General Satisfaction, Technical Quality, Interpersonal Manner, Communication, Financial Aspects, Time Spent with Doctor, and Accessibility and Convenience. Item responses are averaged to create continuous domain and overall composite scores (ranging from 1 to 5). For binary categorical analysis, an overall mean score of ≥ 4.0 is defined as "Satisfied", while a score of < 4.0 is defined as "Not Satisfied".

Acceptability: Women's perceptions of the appropriateness and quality of the RH services provided. This is operationally defined and explored through the seven domains of the TFA.

Service Utilization: The act of actively seeking and receiving reproductive health care from the targeted facilities. For the secondary quantitative analysis, this is operationally defined as the aggregate monthly count of documented patient visits for ANC, PNC and FP extracted from the clinic monthly reports.

Rehabilitated Community Clinic (CC): The Community clinic which is improved in infrastructures, strengthened in human resources, enhanced in community engagement and improved in community awareness by the JAMUAN Project and provides regular CCs healthcare including RH services. These services include ANC (pregnancy registration, vital sign monitoring such as maternal weight, BP measurement, oedema assessment, iron-folic acid supplementation, and tetanus vaccination), PNC (assessment for danger sign of hemorrhage, pain, fever), FP (pills, condoms, injectable continuation), counselling and referral for pregnancy and child-birth conditions).

Complete Rehabilitation: The construction of new clinics as the previous health centers were damaged or totally destroyed by any climate disasters including floods.

Partial Rehabilitation: As the clinics are already in the community, strengthen and upgrade those clinics to ensure climate-resilient CCs, support WASH components and improve designs to guarantee the continuity of healthcare services.

Women of Reproductive Age: Typically defined globally as females aged 15–49 years. However, for the operational and ethical boundaries of this specific study (to ensure independent informed consent without requiring parental assent), this demographic is strictly operationalized as females aged 18 to 49 years who reside within the designated clinic catchment areas.

Reproductive Health (RH) Services: Essential health services provided reproductive age women through Community Clinics (CCs). This specifically includes ANC, PNC, family planning services, reproductive health counselling, and referrals for pregnancy and childbirth-related conditions.

Barriers and Facilitators: Barriers refer to contextual, systemic, or climate-related factors that deny, hinder or discourage access to RH services. Conversely, facilitators refer to factors that enable, encourage or increase the usage of these RH services.

Chapter 3: Methods

3.1 Study Design

The study was implementation research following a convergent mixed-methods design (Creswell, 2014) to understand how rehabilitated CCs under the JAMUNA Project are functioning in terms of service utilization, acceptability and client satisfaction of RH services in flood-prone char areas. The quantitative component focused on secondary analysis of routine CC service delivery data and a cross-sectional quantitative survey to assess patient satisfaction levels across various domains using validated metrics, while a qualitative approach utilizing In-Depth Interviews (IDIs) captured women's perceptions and contextual implementation barriers and facilitators by using TFA.

Because the design was convergent, both quantitative and qualitative data were collected during the same period, analyzed separately, and integrated to provide an understanding of both service performance and client experiences.

3.2 Study Area and Setting

The study was conducted in the disaster-prone char areas of the Bogura district in Bangladesh. Specifically, the study focused on the CCs in Pakuria and Tengra rehabilitated through the JAMUNA Project. These char areas are characterized by frequent seasonal flooding, severe infrastructural isolation during the monsoon, and high climate vulnerability, making them an ideal setting to evaluate climate-resilient primary healthcare interventions.

3.3 Description of the Intervention: The JAMUNA Project and Community Clinic Rehabilitation

The intervention evaluated in this study is the rehabilitation of selected CCs in flood-vulnerable char areas under the JAMUNA Project.

Implementing actors

The JAMUNA Project is implemented by the BDRCS with technical and financial support from the SRC. The Ministry of Health and Family Welfare (MoHFW) provides policy oversight, public-

system integration and regulatory coordination. Human resources, already mandated by MoHFW, deliver routine RH services at the rehabilitated CCs.

Intervention components

The rehabilitation package has the following components:

- Physical infrastructure rehabilitation: reconstructing the new clinics for the totally washed CC or improving infrastructure like painting, adding water tanks and providing signage etc.
- Human resource strengthening: advocacy for training for healthcare providers, jointly supportive supervision and monitoring of CC, and CC management training.
- Community mobilization: Community group reformation, fund raising for CC and patient referral support.
- Community awareness: Community health and hygiene awareness session, volunteers' capacity building.

Rehabilitation type and site categorization

Pakuria CC (fully rehabilitated): Complete structural rebuild on a new footprint. Components included full reconstruction of the building, a raised plinth, a DRR tubewell, separate provider rooms, repainted walls, fresh signage and new toilet infrastructure. Rehabilitation works began in early 2025 and the rebuilt facility became operational in January, 2026. Before and during the rebuild, CC service hours were reduced as the services were provided at a temporary place specifically a nearby community member's home.

Tengra Kura CC (partially rehabilitated): Layered rehabilitation on the existing building footprint. Components included a BDRCS-installed rooftop water tank, recent repainting, signage updates and minor interior repair. The existing structure, room layout, provider posting and operating hours were retained throughout the rehabilitation. The rehabilitation works were conducted on a rolling basis without sustained service interruption.

3.4 Study Period

The overall study, encompassing protocol development, ethical clearance, data collection and analysis, was begun in January, 2026 and ended in May, 2026. Primary data collection in the Bogura district took place during March, 2026.

3.5 Study Population

3.5.1 Study Population

1. Women of reproductive age (18–49 years) residing in the catchment areas of selected CCs

Since the study is focusing on RH, women of 18 years and above were included to ensure independent informed consent and to minimize ethical risks.

Women aged 15-17 years were excluded since parental or guardian consent in addition to assent will be needed. This exclusion is consistent with international ethical guidelines (CIOMS & WHO, 2016; WHO, 2018) and with the *Child Marriage Restraint Act, 2017* of Bangladesh, which sets the legal age of marriage for women is 18 years and below this age is defined as legal minors.

3.5.2 Inclusion and Exclusion Criteria

Inclusion Criteria

- Women aged 18–49 years living in JAMUNA Project areas for at least last six months before data collection
- Individuals willing to provide informed consent
- Women aged 18–49 who have sought RH services at CCs

Exclusion Criteria

- Women who are severely ill or unable to participate during the data collection period
- Temporary visitors to the study catchment area

- Women visiting the CCs for non-RH services

3.6 Sample Size Calculation

3.6.1 Quantitative Sample Size

The quantitative sample size was calculated using the single population proportion formula. The primary outcome of interest is the proportion of women satisfied with RH services at the rehabilitated CCs and the satisfaction survey is among service users only. Based on the JAMUNA baseline finding that 48.0% of CC visitors were very or rather satisfied, the expected prevalence was set at $p = 0.48$.

The formula applied was: $n = (Z^2 \times p(1-p)) / d^2$

Where:

- $Z = 1.96$ for a 95% confidence level
- $p = 0.48$ (48.0 %)
- $d = 0.10$ margin of error ($\pm 10\%$)

Substituting these values yields:

$$n \approx 96$$

Therefore, the minimum required sample size for the quantitative survey is: $n = 96$ women of reproductive age (18–49 years).

To further account for potential non-response (5%), the final adjusted sample size is:

$$n_{\text{final}} = n_1 / 1 - 0.05 = 96 / 0.95 \approx 101$$

Therefore, the final quantitative sample size was approximately 101 (about 50 per clinic) reproductive age women (18–49 years) living in the study catchment areas served by rehabilitated CCs under the JAMUNA Project.

3.6.2 Qualitative Sample Size

As a systematic review on sample size for saturation of qualitative research mentioned that relatively small sample sizes (9-17 interviews) can reach data saturation, 10 In-depth Interviews were conducted (Hennink & Kaiser, 2022) based on the data saturation. Data saturation was assessed operationally during analysis. Interviews were conducted until no new themes, codes, or conceptual insights emerge across at least two consecutive interviews. Coding comparison meetings were held after every 2–3 interviews to evaluate whether additional data collection is required.

3.7 Sampling Technique

To comprehensively evaluate the utilization, acceptability, and satisfaction of RH services, distinct sampling techniques were used for the quantitative and qualitative components of the study.

Quantitative Component:

For the quantitative component, two sources of data were used: routine CC service records as the secondary data and a structured client satisfaction survey providing the primary data.

Routine CC Record Review (Secondary Data)

To address utilization level and patterns, secondary data was extracted from rehabilitated CCs monthly reports. Both Pakuria and Tengra Kura CCs monthly services reports were collected. The services collected are ANC visits, PNC visits and family planning visits which were extracted for 12 months before and 14 months after the JAMUNA project started (26 clinic-months per clinic) to assess utilization trends.

Client Satisfaction Assessment (Primary Data)

A simple random sampling technique was used for the quantitative cross-sectional survey. A sampling frame was constructed based on the list of all eligible women of reproductive age (18-49 years) who had utilized RH services at the selected rehabilitated CCs in the last 6 months. This list was extracted from the clients' registration books. The participants from that list were selected by using a computer-generated random number sequence till the required sample size (101) was reached. Among them (101), 48 were from Pakuria CC and 53 were from Tengra Kura CC. This

method was used to ensure every eligible woman had an equal chance to be participated and to minimize selection bias. It also ensured that the quantitative findings on patient satisfaction (PSQ-18) were representative of the broader clinic user population.

Qualitative Component:

A quota sampling approach was used for the qualitative In-Depth Interviews (IDIs) stratified by the types of RH services received (e.g., ANC, PNC, and FP) in the last 6 months. This non-probability sampling method allowed to reflect the diverse realities and specific acceptability associated with each distinct service type. To fill these specific quotas, data collectors selected the participants purposefully through community healthcare provider referrals. Until data saturation was reached, the recruitment was continued within each service type which meant no new themes regarding TFA emerged. This approach allowed the collection of relevant, in-depth and comparative insights across the different types of RH services offered during climate-shocks periods.

3.8 Variables

3.8.1 Dependent Variable(s)

Quantitative (Primary Data):

For the cross-sectional survey, the primary dependent variable was Client Satisfaction. This was measured both as continuous domain-specific satisfaction scores (Financial Aspects, Technical Quality, Communication, Interpersonal Manner, Time Spent with Provider, General Satisfaction and Accessibility and Convenience) which are derived from the 18 questions of PSQ-18 and as a binary categorical variable ("Satisfied" vs. "Not Satisfied"), derived from the overall composite score of the 18-item Patient Satisfaction Questionnaire (PSQ-18).

Quantitative (Secondary Data):

The dependent variables for the retrospective analysis of routine CC records were the monthly service utilization counts. Specifically, this used the aggregate monthly volume and measured the volume of ANC, PNC and FP services received by the patients.

Qualitative:

For the qualitative, the main outcome of interest was the acceptability of the RH services among women of reproductive age which was explored through the cognitive, experiential and emotional responses of the patients. This outcome mapped directly to the 7 domains of the theoretical framework of acceptability.

3.8.2 Independent Variables

The independent variables were defined separately for the quantitative and qualitative components to address the mixed-methods objectives comprehensively.

Quantitative Component

Socio-demographic: The participant's age (measured in years and categorized into groups), education level (categorized into 3 groups) and occupation status of the participants.

Service-related factors: The types of RH services received by the participants (ANC, PNC, FP and referral) and the clinic they attended (Pakuria or Tengra Kura).

Qualitative Component (Guiding Areas of Inquiry)

For the qualitative component, it was guided by predefined domains and contextual factors to explore the drivers of healthcare.

Acceptability Domains: Guided by the TFA, the primary factors explored included the participants' Perceived Effectiveness, Ethicality, Intervention Coherence, Opportunity Costs and Self-Efficacy.

3.9 Data Collection

3.9.1 Data Collection Tools

To capture a comprehensive understanding of service utilization, acceptability and client satisfaction, distinct data collection tools were used.

Quantitative Data Collection Tools:

- **Standardized Data Abstraction Tool:** A structured abstraction matrix was utilized to extract aggregated monthly RH services volumes and recorded directly the data from the routine monthly reports of the two selected CCs.
- **Structured Questionnaire (Electronic Form):** A structured, pre-coded questionnaire via the KoBoToolbox was used to collect the primary quantitative data. By using electronic forms, data security was ensured and data entry errors were minimized. Two main modules were included in the questionnaire: a socio-demographic section and satisfaction assessment section. The Patient Satisfaction Questionnaire Short-Form (PSQ-18) was used to measure the satisfaction (Marshall & Hays, 1994). The questionnaires were minimally adapted and translated into local Bangla to specifically reflect the RH services offered at rehabilitated CCs. While strictly maintaining the tool's original multidimensional construct validity, it was adapted to local culture comprehensively.

Qualitative Data Collection Tools:

- **Semi-Structured In-Depth Interview (IDI) Guide:** A semi-structured IDI guideline was used to gather the qualitative insights. The guideline was deductively developed and structured around the core domains of the TFA (Sekhon et al., 2017). To systematically explore the participants' affective attitudes, perceived burdens, opportunity costs, ethicality, and specific climate-induced barriers to utilizing the clinic, the tool was developed by open-ended probing questions.
- **Non-Participant Observation Protocol:** A semi-structured non-participant observation checklist was used to contextualize the insights of qualitative findings.

3.9.2 Pretesting

The structured questionnaire and the standardized data abstraction tool were piloted at the training with 2 women of reproductive age (aged 18-49 years). The pilot ran during the data collector training period and tested item comprehension, the Bangla phrasing of the PSQ-18, KoBoToolbox skip logic, and the categories of all sections. Revisions were made in 2 areas after the pilot: (a) the Bangla

wording of several PSQ-18 items was adjusted to use plain conversational vocabulary that participants understood without prompting and (b) the skip logic in the electronic form was reordered so that service-type-specific items were triggered correctly. The Bangla translation of the PSQ-18 was not subjected to formal forward and back translation and this is acknowledged as a measurement limitation. The semi-structured IDI guide was not separately pretested. It was reviewed with the data collector during the training period.

3.9.3 Data Collection Procedure

Data collection was completed through a highly structured, parallel process to guarantee the integrity and quality of both quantitative and qualitative data streams. Before data collection started, all field data collectors who were native Bangla speakers got comprehensive training. This training covered the study protocol, ethical guidelines for sensitive reproductive health research, obtaining informed consent and the technical use of the data collection instruments.

Quantitative Data Collection:

- **Secondary Data Abstraction:** First, got access to the routine RH service monthly reports at the two selected CCs (Pakuria and Tengra Kura). By using the standardized abstraction tool, monthly service counts for ANC, PNC and FP were extracted for the defined 24-month period from the monthly report.
- **Primary Survey Administration:** The eligible women were contacted by the simple random sampling approach to collect the client satisfaction data. The Bangla-translated PSQ-18 survey was administered face-to-face by trained data collectors only after securing private, comfortable spaces to ensure confidentiality. All the responses were collected by mobile devices using KoBoToolbox directly. The PI conducted daily reviews of the uploaded datasets to ensure quality control and to check for completeness, logical consistency and potential data entry errors, immediately to address any anomalies with the team.

Qualitative Data Collection:

- **In-Depth Interviews (IDIs):** The qualitative IDIs were conducted in quiet, private, safe locations preferred by the individual (such as their homes). Following the semi-structured

TFA guide, interviewers used open-ended probing techniques to encourage detailed narratives. With the participants' explicit written consent, all sessions were audio-recorded.

- **Transcription and Quality Assurance:** Following the interviews, the audio recordings were translated into English directly by the Bangla translator to preserve the authentic voice and local dialect of the char residents. To ensure absolute consistency and semantic accuracy, the Principal Investigator (PI) cross-referenced a random subset of the translated transcripts against the original audio files and field notes. Furthermore, the research team held periodic debriefing sessions to discuss emerging themes, refine probing strategies, and operationally determine when thematic saturation had been reached.
- **Non-Participant Observations:** The PI systematically completed the observation checklists during active clinic hours and documented patient flow, privacy barriers and the physical state of the rehabilitated infrastructure without interrupting patient-provider interactions.

3.10 Data Management and Quality Assurance

For the quantitative data, logic checks and mandatory fields were programmed into the electronic data capture platform to minimize missing data. Extracted data were cleaned and coded using Stata. PSQ-18 items were strictly recoded, reverse-scoring positive statements so that higher scores consistently reflected higher satisfaction prior to scale generation. For qualitative data, audio recordings were translated into English directly by a local translator. Transcripts were cross-checked against audio files and field notes by the team to ensure semantic accuracy and rigor.

3.11 Data Analysis

The study used a mixed-methods analysis approach, integrating quantitative and qualitative data streams to provide a comprehensive evaluation of reproductive health (RH) service utilization, acceptability, and satisfaction. Stata/BE (version 19.5) was used to process and analyze the primary quantitative data while Microsoft Excel was used for the secondary data analysis of routine clinic records.

3.11.1 Quantitative Analysis

The quantitative component involved the analysis of both primary survey data and secondary routine service records. For secondary data analysis, monthly service volumes for ANC, PNC, and family planning (FP) were summarized using descriptive statistics, including means and total counts. Trend analysis was performed across the 12-month pre-rehabilitation and 14-month post-rehabilitation to assess the utilization patterns over the last 24 months period.

For primary survey data, participant sociodemographic characteristics and service-related factors were summarized using frequencies and percentages. Satisfaction was measured using the PSQ-18. The overall continuous PSQ-18 score is the primary analytic outcome for the satisfaction analysis. A binary categorization (satisfied versus not satisfied) at the sample-median cutoff is reported as an exploratory secondary outcome because no validated dichotomization threshold has been published for the PSQ-18 (Marshall and Hays, 1994). Subgroup analyses using the binary outcome are interpreted descriptively and corroborated against parallel comparisons on the continuous score. Negatively worded items were reverse-coded so that higher scores consistently indicated higher satisfaction. Means, standard deviations, and medians were calculated for the overall scale and the seven specific domains. For all question items of PSQ-18, responses were collapsed into three categories (Agreement, Uncertain, Disagreement) alongside mean scored values. For positively worded items, agreement reflects satisfaction; for negatively worded items, disagreement reflects satisfaction. The internal consistency of the PSQ-18 was evaluated using Cronbach's alpha (α), with a threshold of ≥ 0.70 considered acceptable for the overall scale. Chi-square tests (or Fisher's Exact Test where appropriate) were used for the binary satisfaction outcome.

3.11.2 Qualitative Analysis

The qualitative data, derived from In-Depth Interviews (IDIs), were analyzed using Framework Analysis (Gale et al., 2013), which is particularly suited for research guided by predefined theoretical constructs. Following the five-stage approach outlined in Gale et al. (2013), the analysis proceeded as follows.

1. Familiarization: All ten IDI audio recordings were transcript directly into English by the local translator to capture the char contexts. Each transcript was read at least twice before coding to get familiar with the contexts and data.
2. Identifying a thematic framework: Based on the seven domains of the Theoretical Framework of Acceptability (TFA), an initial coding framework was developed deductively while inductive coding was applied to capture contextual barriers and facilitators.
3. Indexing: Each transcript was systematically coded by using the combined deductive-inductive framework. Indexing was conducted line-by-line to capture the respective codes.
4. Charting: Indexed material was rearranged into a framework matrix, with rows representing each IDI participant and columns representing each TFA domain and each inductive theme. This allowed cross-case comparison within a single theme and within-case comparison across themes.
5. Mapping and interpretation: The charted material was interrogated for patterns (consistencies across participants) and divergences (between Pakuria and Tengra Kura participants, between ANC, PNC and FP users). The interpretive output forms the basis of qualitative insights, TFA-based discussion of acceptability and discussion of barriers and facilitators on the access and utilization of RH services.

Triangulation and Rigor: The study employed methodological triangulation to ensure the consistency. The insights from the qualitative IDIs were integrated with quantitative results and descriptive insights from the facility observation checklists. This process explored the convergent and divergent findings to generate implementation-relevant explanations for CC performance in char settings.

3.12 Ethical Considerations

Ethical approval was obtained from the IRB of the James P. Grant School of Public Health (JPGSPH), BRAC University (Reference No: MPH-2025-024, Date: 22 February 2026). Fieldwork started only after IRB approval was obtained. For the survey and in-depth interview components, a participant information sheet in Bangla was read to all potential participants and covered the study

purpose, voluntary nature of participation, and the right to withdraw without consequence. Written informed consent was obtained prior to data collection and audio recording. For the secondary CC register data, individual consent was waived as records were accessed in aggregated and anonymized form with no individual identifiers. The permission was obtained from the relevant health authority and JAMUNA Project management before the extraction.

All participants were assigned unique study ID codes, with personal identifiers stored separately from analytical datasets. Audio recordings were deleted after transcription and verification, and all transcripts were anonymized before the analysis. Data was stored on encrypted and password-protected system while access was limited only to the research team members. No financial incentives were given. Participants were informed they could withdraw within 24 hours of their interview. Interviews were conducted in private settings, and data collectors were trained to pause or terminate sessions if a participant showed signs of distress, with referral contacts provided as needed.

Chapter 4: Results

4.1 Participants' profile

Table 4.1 presents the participants' profile of 101 women of reproductive age (18–49 years).

Table 4.1. Sociodemographic and Service-Related Characteristics of Participants (N = 101)

Characteristics	Frequency (n)	Percentage (%)
Age (years)		
18–25	43	42.57
26–35	39	38.61
36–49	19	18.81
Mean (SD)	28.6 (7.9) years	—
Level of Education		
No formal education	40	39.60
Primary	34	33.66

Secondary	20	19.80
Higher secondary / Diploma	6	5.94
Graduate or above	1	0.99
Occupation		
Homemaker	89	88.12
Self-employed / Business (Shopkeeping, Tailoring etc.)	10	9.90
Service / Private sector (Teacher, Health Worker, Community/NGO worker)	1	0.99
Student / Other	1	0.99
Type of RH Service Received during Last Visit		
Antenatal Care (ANC)	12	11.88
Family Planning	55	54.46
Postnatal Care (PNC)	31	30.69
Counselling	2	1.98
Referral / Other	1	0.99

Note: Percentages may not sum to exactly 100% due to rounding.

The majority of participants were in the youngest age group (18–25 years, 42.57%), with a mean age of 28.6 years (SD=7.9). About four in ten women (39.60%) did not have formal education while approximately one-third (33.66%) had received primary education. The majority of participants were homemakers (88.12%). The commonly received RH service was FP service (54.46%) followed by PNC (30.69%) and ANC (11.88%). FP was the predominant service at Pakuria CC (29 of 55, 52.73%) while PNC accounted for a larger share at Tengra Kura CC (20 of 31, 64.52%). ANC users were more common at Tengra Kura CC (7 of 12, 58.33%) compared to Pakuria CC (5 of 12, 41.67%) (not shown).

4.2 Internal Consistency of the PSQ-18 Instrument

Cronbach's alpha (α) was used to evaluate the internal consistency of the instrument (Cronbach, 1951). By following established psychometric guidelines, the threshold for acceptable reliability is an alpha coefficient of ≥ 0.70 (George & Mallery, 2003). Subscale alpha values are affected by the small number of items per subscale (2–4 items). The overall scale $\alpha = 0.745$ meets the acceptable threshold and is used as the primary analytic outcome.

Table 4.2 presents alpha values for the overall 18-item scale and each of the seven subscales.

Table 4.2. Internal Consistency of the PSQ-18 Scale and Subscales (N = 101)

SN	Subscale	No. of Items	Cronbach's α	Interpretation
1	Overall PSQ-18 Scale	18	0.745	Acceptable (≥ 0.70)
2	General Satisfaction	2	0.632	Questionable
3	Technical Quality	4	0.358	Poor
4	Interpersonal Manner	2	0.471	Poor
5	Communication	2	0.191	Poor
6	Financial Aspects	2	0.153	Poor
7	Time Spent with Provider	2	0.260	Poor
8	Accessibility and Convenience	4	0.497	Poor

Note: Interpretation based on standard thresholds: ≥ 0.90 Excellent, ≥ 0.80 Good, ≥ 0.70 Acceptable, ≥ 0.60 Questionable, < 0.60 Poor (George & Mallery, 2003).

The overall 18-item PSQ-18 scale demonstrated acceptable internal consistency ($\alpha = 0.745$). Subscale-level reliability was generally poor, ranging from $\alpha = 0.153$ (Financial Aspects) to $\alpha = 0.632$ (General Satisfaction). The particularly low alpha coefficients for Communication ($\alpha = 0.191$), Financial Aspects ($\alpha = 0.153$), and Time Spent with Provider ($\alpha = 0.260$) are consistent with a known psychometric limitation of short subscales: with only two items per subscale, Cronbach's alpha is mathematically constrained and highly sensitive to inter-item covariance, producing systematically attenuated estimates that do not reliably reflect true reliability. At the two-item level, alpha is effectively equivalent to the Spearman-Brown corrected split-half reliability, and a single poorly

correlated item pair is sufficient to depress the coefficient substantially. This does not invalidate the items themselves; it reflects that two-item subscales are structurally unsuitable for standalone reliability assessment using alpha. The PSQ-18 instrument was designed for use as a full 18-item scale, and the internal consistency of the overall scale which meets the acceptable threshold ($\alpha = 0.745$) is the more appropriate and defensible reliability estimate. Based on this assessment, the overall satisfaction score is used as the primary analytic outcome for all remaining analyses, while subscale scores are reported descriptively.

4.3 Descriptive Analysis of Client Satisfaction

4.3.1 Overall and Domain-Level Satisfaction Scores

Table 4.3. Mean Client Satisfaction Scores by PSQ-18 Domain (N = 101)

PSQ-18 Domain	No. of Items	Mean Score	SD	Minimum	Maximum
Interpersonal Manner	2	4.29	0.49	2.00	5.00
Time Spent with Provider	2	4.01	0.28	3.00	5.00
Communication	2	4.00	0.46	2.50	5.00
General Satisfaction	2	3.94	0.54	2.00	5.00
Technical Quality	4	3.94	0.34	2.25	4.50
Financial Aspects	2	3.91	0.50	2.50	5.00
Accessibility and Convenience	4	3.71	0.40	2.00	4.75
OVERALL SATISFACTION SCORE	18	3.94	0.26	2.94	4.72

Note: Scores range from 1 (lowest satisfaction) to 5 (highest satisfaction). All items were scored so that higher values indicate greater satisfaction. The overall score is the mean of all 18 scored items.

A Shapiro-Wilk test indicated that the overall PSQ-18 score distribution deviated significantly from normality ($W = 0.938$, $p < 0.001$), reflecting a left-skewed distribution consistent with the high mean score and limited lower-range responses.

The mean of the overall satisfaction score was 3.94 (SD = 0.26) with a median of 4.00 which indicated a generally high satisfaction level among the participants. The interpersonal manner subscale had the highest mean score (4.29, SD = 0.49), while the accessibility and convenience subscale had the lowest mean score (3.71, SD = 0.40). Since the standard deviation of the overall score is narrow (SD = 0.26), it indicates relatively homogeneous responses.

4.3.2 Proportion of Satisfied Participants

The PSQ-18 instrument has no standardized or validated cutoff score in its original guidelines (Marshall & Hays, 1994); it was designed to generate a continuous satisfaction score, and no published threshold equivalent to 4.00 exists in the psychometric literature. Dichotomization into satisfied and not satisfied categories was chosen to allow the proportion of satisfied participants to be compared across categorical subgroups. Using the sample median as a natural threshold (median overall score = 4.00), 61 of 101 participants (60.4%) were classified as satisfied (scoring at or above the median). The exact binomial 95% confidence interval for this proportion was 50.2% to 70.0% (Std. Err. = 0.049). Table 4.3 presents the overall prevalence of satisfaction.

Table 4.4. Overall Satisfaction Prevalence Based on Median Split (N = 101)

Satisfaction Category	n	Percentage	Proportion	95% CI (Exact Binomial)
Satisfied (score $\geq$ 4.00)	61	60.4%	0.6040	50.2% – 70.0%
Not satisfied (score < 4.00)	40	39.6%	0.3960	30.0% – 49.8%
Total	101	100.0%	—	—

Note: Satisfaction defined as overall PSQ-18 score $\geq$ sample median (4.00). 95% CI computed by exact binomial method (Stata: ci proportions satisfied). Std. Err. = 0.049.

The satisfaction among the participants who had attended Tengra Kura CC had higher proportion (73.6%) than Pakuria CC (45.8%); this difference is examined further in Section 4.4.

4.3.3 Item-Level Satisfaction Responses

Table 4.5 presents the distribution of responses for all 18 PSQ-18 items, collapsed into three categories (Agreement, Uncertain, Disagreement) alongside mean scored values. For positively worded items, Agreement reflects satisfaction; for negatively worded items, Disagreement reflects satisfaction.

Table 4.5. Item-Level Distribution of PSQ-18 Responses (N = 101)

Item	PSQ-18 Item	Agreement n (%)	Uncertain n (%)	Disagreement n (%)	Mean	SD
		n (%)	n (%)	n (%)		
1	The healthcare providers are good about explaining the reasons for medical tests.	89 (88.1)	9 (8.9)	3 (3.0)	4.01	0.66
2	I think the healthcare providers' office has everything needed to provide complete RH services.	75 (74.3)	16 (15.8)	10 (9.9)	3.66	0.68
3	The reproductive healthcare I have been receiving is just about perfect.	91 (90.1)	6 (5.9)	4 (4.0)	3.97	0.57
4	Sometimes the healthcare providers make me wonder if their diagnosis is correct. (–)	4 (4.0)	2 (2.0)	95 (94.1)	4.02	0.60
5	I feel confident that I can get the RH services I need without being set back financially.	86 (85.2)	3 (3.0)	12 (11.9)	3.85	0.82
6	When I go for RH services, they are careful to check	95 (94.1)	3 (3.0)	3 (3.0)	3.99	0.48

Item	PSQ-18 Item	Agreement n (%)	Uncertain n (%)	Disagreement n (%)	Mean	SD
		n (%)	n (%)	n (%)		
	everything when treating and examining me.					
7	I have to pay for more of my reproductive health care than I can afford. (–)	6 (5.9)	1 (1.0)	94 (93.1)	3.97	0.64
8	I have easy access to the medical specialists I need.	69 (68.3)	24 (23.8)	8 (7.9)	3.63	0.72
9	Where I get RH services, people have to wait too long for emergency treatment. (–)	14 (13.9)	12 (11.9)	75 (74.3)	3.61	0.73
10	The healthcare providers act too businesslike and impersonal toward me. (–)	2 (2.0)	0 (0.0)	99 (98.0)	4.22	0.54
11	The healthcare providers treat me in a very friendly and courteous manner.	98 (97.0)	1 (1.0)	2 (2.0)	4.36	0.66
12	The healthcare providers sometimes hurry too much when they treat me. (–)	1 (1.0)	5 (5.0)	95 (94.1)	3.98	0.37
13	The healthcare providers sometimes ignore what I tell them. (–)	5 (5.0)	2 (2.0)	94 (93.1)	3.99	0.57
14	I have some doubts about the ability of healthcare providers who treat me. (–)	3 (3.0)	0 (0.0)	98 (97.0)	4.09	0.57

Item	PSQ-18 Item	Agreement n (%)	Uncertain n (%)	Disagreement n (%)	Mean	SD
		n (%)	n (%)	n (%)		
15	The healthcare providers usually spend plenty of time with me.	98 (97.0)	2 (2.0)	1 (1.0)	4.04	0.37
16	I find it hard to get an appointment for RH services right away. (-)	5 (5.0)	23 (22.8)	73 (72.3)	3.69	0.60
17	I am dissatisfied with some things about the RH services I receive. (-)	8 (7.9)	5 (5.0)	88 (87.1)	3.91	0.69
18	I am able to get RH services whenever I need it.	89 (88.1)	10 (9.9)	2 (2.0)	3.89	0.44

Item 11 ('The healthcare providers treat me in a very friendly and courteous manner') recorded the highest level of agreement (97.0%) and the highest scored mean (4.36, SD=0.66), which indicated near-universal satisfaction with provider interpersonal behaviour. 94.1% agree that providers are careful to check everything during treatment and examination (Item 6) and 90.1% feel the reproductive healthcare they are receiving is "just about perfect" (Item 3) which reflects the quality of care they received and the confidence they had during consulting. Items 8 ('easy access to specialists', 7.9% dissatisfied) and 9 ('waiting too long for emergency treatment', 74.3% disagreement expressed) highlighted that accessibility has the highest proportion of dissatisfied responses.

4.4 Factors Associated with Overall Client Satisfaction

Chi-square tests of independence were conducted to examine associations between the binary satisfaction outcome (PSQ-18 score $\geq$ sample median 4.00; see Section 4.4.2) and each categorical predictor: age group, education level, type of RH service received, and community clinic site.

Table 4.6 Chi-Square Analysis: Binary Satisfaction (Satisfied vs Not Satisfied) by Participant Characteristics (N = 101)

Variable	n(%)	Satisfied n(%)	Not Satisfied n(%)	χ^2	p-value	Effect Size
Age Group				0.662	0.718	0.080
18–25 years	43 (42.6%)	24 (55.8%)	19 (44.2%)			
26–35 years	39 (38.6%)	25 (64.1%)	14 (35.9%)			
36–49 years	19 (18.8%)	12 (63.2%)	7 (36.8%)			
Education Level				2.656	0.265	0.162
No formal education	40(39.6%)	28 (70.0%)	12 (30.0%)			
Primary	34(33.7%)	19 (55.9%)	15 (44.1%)			
Secondary and above	27(26.7%)	14 (51.9%)	13 (48.1%)			
Type of RH Service Received				2.435	0.484*	0.155
ANC	12 (11.9%)	9 (75.0%)	3 (25.0%)			
Family Planning	55 (54.5%)	34 (61.8%)	21 (38.2%)			
PNC	31 (30.6%)	17 (54.9%)	14 (45.1%)			
Others (referral, counselling)	3 (3.0%)	1 (33.3%)	2 (66.7%)			
Community Clinic				8.110	0.004	0.283
Complete Rehabilitated CC (Pakuria CC)	48(47.5)	22 (45.8%)	26 (54.2%)			
Partial Rehabilitated CC (Tengra Kura CC)	53(52.5)	39(73.6%)	14 (26.4%)			

*Note: Satisfied defined as overall PSQ-18 score $\geq$ sample median (4.00); n = 61 satisfied (60.4%), n = 40 not satisfied (39.6%). *p-value calculated using Fisher's Exact Test due to small expected cell counts < 5*

Community clinic site was the only predictor with a statistically significant unadjusted association with binary satisfaction ($\chi^2 = 8.110$, $p = 0.004$). Participants who attending partial rehabilitated CC reported higher satisfaction (73.6%) compared to those attending complete rehabilitated CC (45.8%). The association a small to moderate effect size (Cramér's $V = 0.283$). No statistically

significant association were found between satisfaction and age group, education level or type of the RH services received.

4.5 Secondary Data: Routine RH Service Utilization Trends

4.5.1 Overview of the Record Review

Routine RH service register data were extracted from both rehabilitated CCs across a 26-month observation window: 12 months pre-rehabilitation and 14 months post-rehabilitation. Three service streams were tracked: ANC, PNC and FP services. All 26 clinic-month observations were complete for both clinics, with no missing monthly records. Simple pre-post trend analysis was performed with the rehabilitation completion point (the Month 12–13 boundary) serving as the rehabilitation completion point separating pre- and post-periods. Pre- and post-rehabilitation linear trend lines were fitted separately for each clinic and each service type. All trend descriptions in sections 4.6.2 to 4.6.4 are descriptive in nature. Statistical significance was not formally tested. The percentage changes and trend directions reported should therefore be interpreted as indicative patterns rather than as statistically confirmed effects.

4.5.2 Antenatal Care (ANC) — Monthly Visit Trend

At Pakuria CC, which is fully rehabilitated, pre-rehabilitation ANC volumes were moderate, ranging from 6 to 12 visits per month, with a marginally positive upward trend over the 12-month baseline. Following the rehabilitation process, monthly ANC counts remained within a broadly comparable absolute range, but the trend indicated a flat through the 14-month baseline. The pre-rehabilitation mean of 9.67 visits per month declined to 8.43 in the post-period, representing a 12.8% decrease in average monthly volume, thus reflecting the reduced service hours during and immediately after the rehabilitation.

At Tengra Kura CC, a partially rehabilitated CC, a markedly different pattern was seen. Pre-rehabilitation ANC volumes ranged from 9 to 18 visits per month, peaking at 18 visits in August 2024, then flattening slightly toward the end of the pre-rehabilitation period. Following rehabilitation, a clear upward trend is apparent. Monthly ANC visits increased substantially, from 9 to 27, with a peak of 27 in October 2025. The post-rehabilitation mean of 15.21 visits per month

represents an 11.3% increase over the pre-period mean of 13.67, and the trend shows a sustained upward curve.

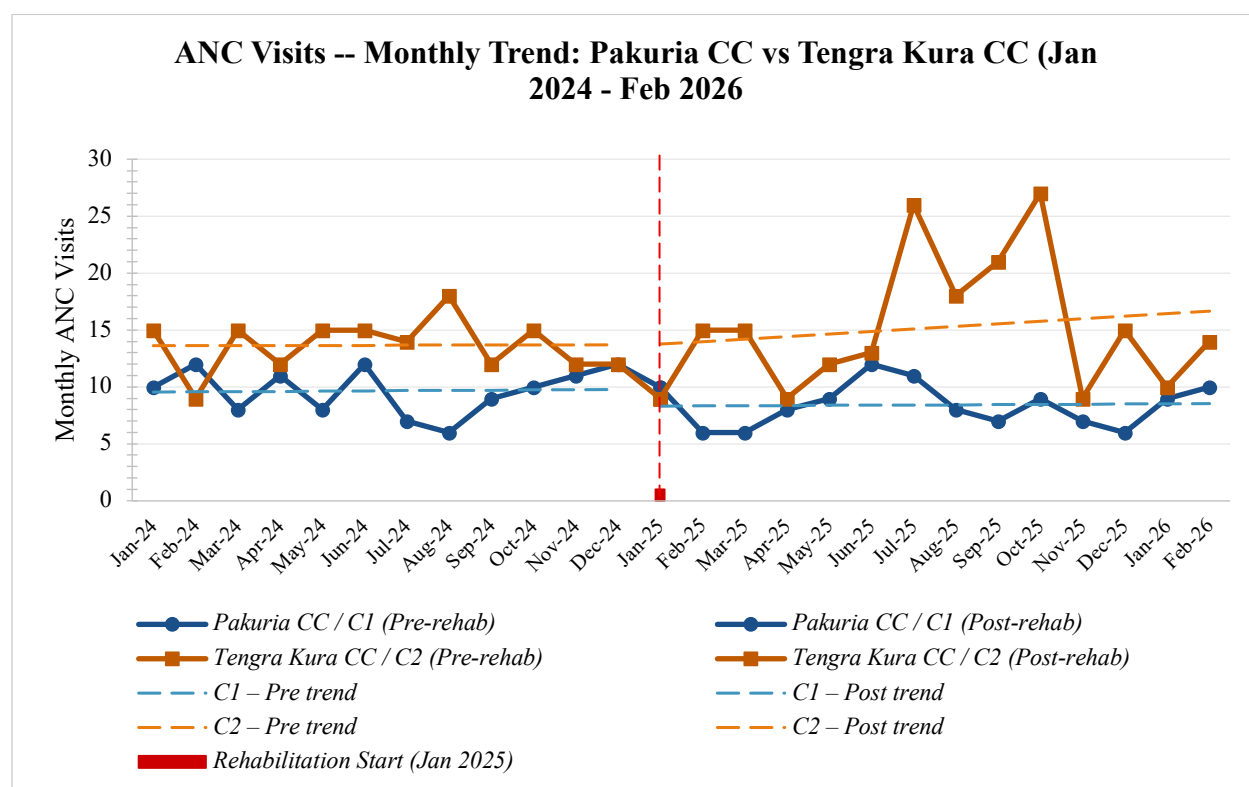


Figure 4.1a. Monthly ANC visit counts January 2024 - February 2026

4.5.3 Postnatal Care (PNC) — Monthly Visit Trend

At Pakuria CC, fully rehabilitated, the monthly PNC visits were relatively stable at 8-10 visits through most of 2024 with a single dip to 5 visits in July 2024. Following the initiation of rehabilitation, PNC visits declined sharply. January 2025 maintained the pre-rehabilitation level at 10 but later fell to 5 and 4 visits in February and March 2025, respectively, which were the two lowest monthly visits in the full 26-month record. Even though the monthly visits count increased to 10 in July 2025, the counts remained flat till January and then increased in February 2026 (8 visits). Overall, PNC monthly volumes at Pakuria CC declined by 22.9% over the full observation period, from a pre-rehabilitation mean of 8.33 to a post-rehabilitation mean of 6.43 visits, which reflects the reduced service hours during rehabilitation period.

At Tengra Kura CC, partially rehabilitated, the PNC volumes were low in absolute terms through the whole observation period, ranging from 3-4 visits per month. The pre-rehabilitation mean was 3.33 visits while the post-rehabilitation mean was 3.57 visits which represent a marginal increase of 7.1%.

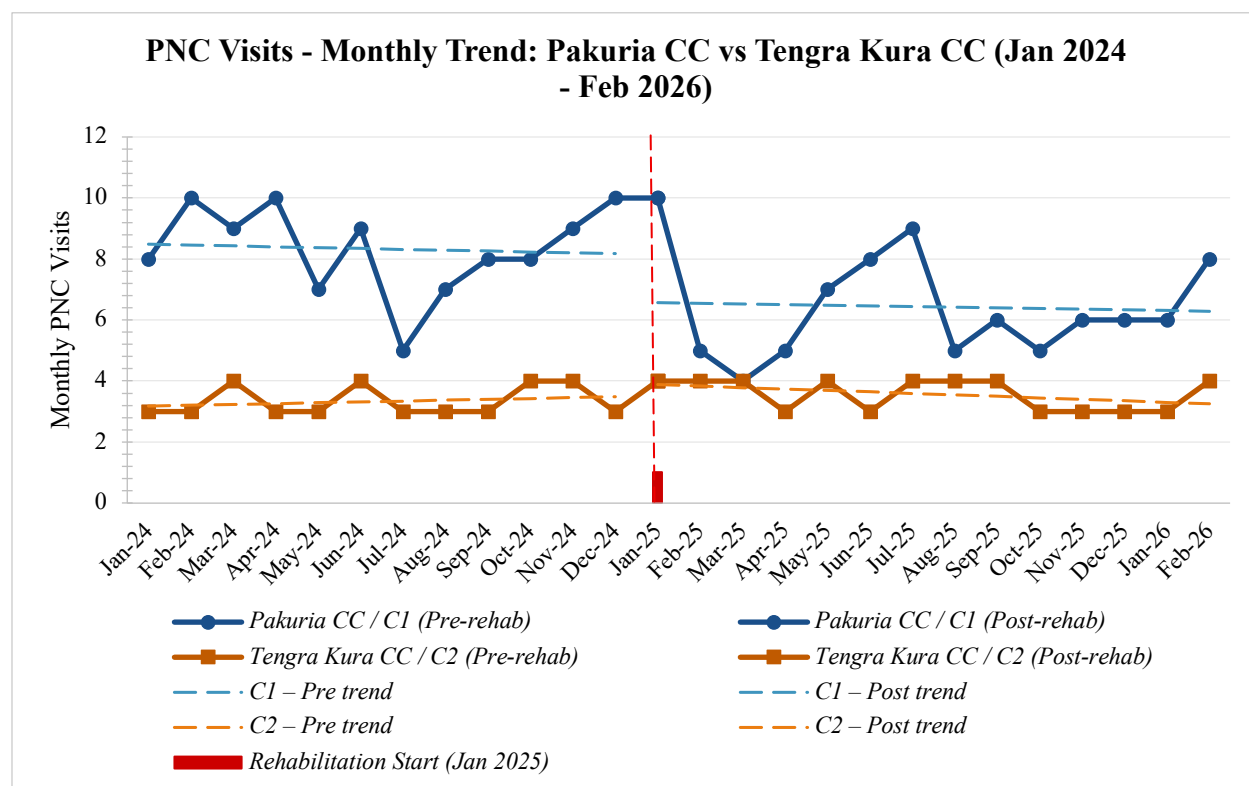


Figure 4.1b. Monthly PNC visit counts January 2024 - February 2026

4.5.4 Family Planning (FP) — Monthly Trend

Pakuria CC was the higher-volume FP provider of the two clinics across the observation period, with a mean of 33.75 visits in the pre-rehabilitation period. The trend in pre-rehabilitation showed considerable within-year variation, peaking in May 2024 (45 visits) and falling to its lowest level in August 2024 (20 visits). Following the rehabilitation process, the FP visits showed an early dip in January, then an increase to 20 visits in February. Later, volumes recovered progressively starting in May 2025, reaching 40 visits in July 2025. Although the volumes gradually decreased later, the FP visits recorded their highest number in February 2026 (90 visits). Overall, FP visits in Pakuria CC increased by 6.2% over the observation period, from a pre-rehabilitation mean of 33.75 visits per month to 35.86 visits per month post-rehabilitation.

At Tengra Kura CC, which is partially rehabilitated, the FP visits count was considerably lower than Pakuria CC, with a pre-rehabilitation monthly mean of 11.83, ranging from 8 to 15 visits per month. Unlike Pakuria CC, no early post-rehabilitation dip was seen in Tengra Kura CC. FP volumes remained broadly stable throughout the post-rehabilitation period, ranging from 1 to 16 visits per month. Overall, with a net positive change of 6.8%, the pre-rehabilitation mean of 11.83 was increased to 12.64 in the post-rehabilitation period.

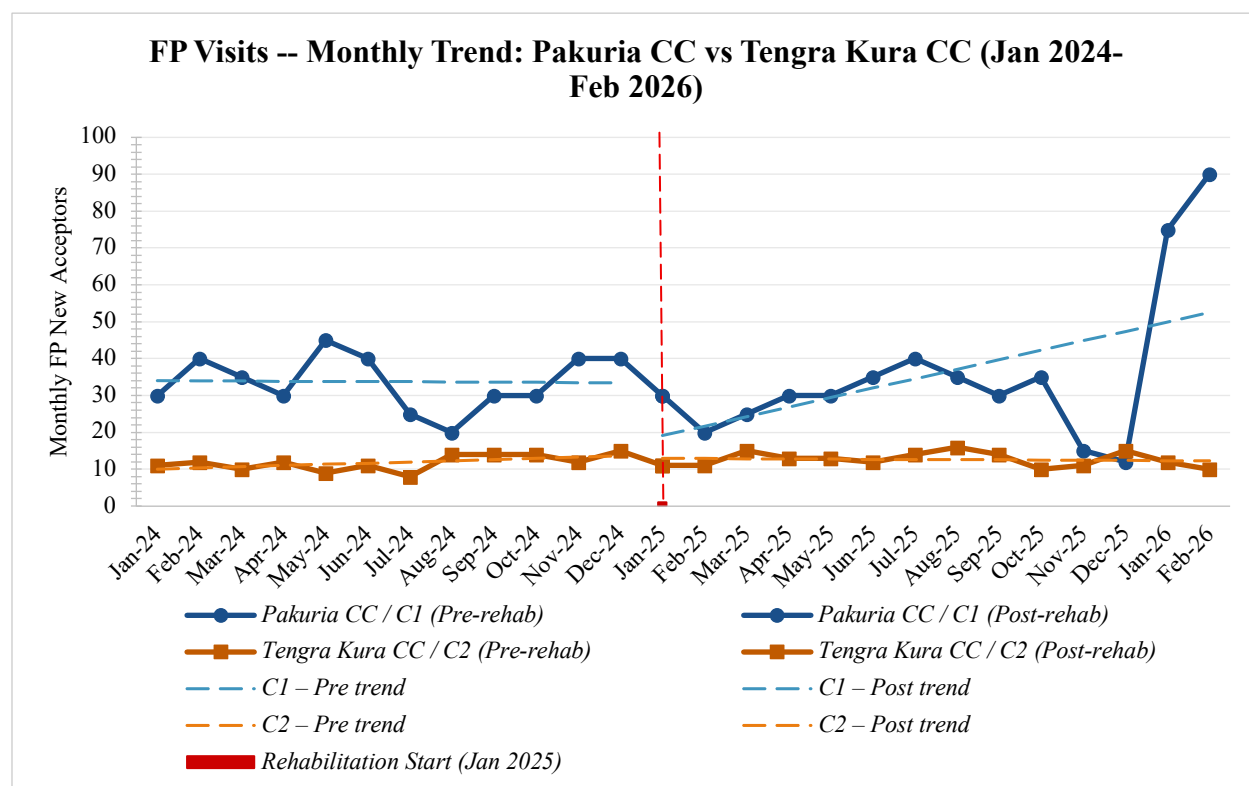


Figure 4.1c. Monthly FP visit counts January 2024 - February 2026

4.6 Qualitative Insights

4.6.1: Participants profile

Among the 10 IDI participants, seven reported ANC as their primary service, five received FP services (including two who used both ANC and FP), and one attended for PNC. Seven participants had no formal education or had completed primary school while three had secondary or higher education. All participants resided in char areas subject to periodic flooding. Table 4.6 summarizes participant characteristics.

Table 4.7. Socio-Demographic Profile of Study Participants

IDI	Age	Education	Occupation	CC	Services Used	CC Status
IDI_01	25	Class 9	Sewing / housework	Pakuria CC	ANC & FP	Fully Rehabilitated
IDI_02	18	Class 9	Sewing / housework	Pakuria CC	ANC	Fully Rehabilitated
IDI_03	24	Class 7	Housework, shop, sewing	Pakuria CC	PNC	Fully Rehabilitated
IDI_04	24	Class 5	Homemaker	Pakuria CC	FP & ANC	Fully Rehabilitated
IDI_05	28	Class 7	Housework	Pakuria CC	FP	Fully Rehabilitated
IDI_06	35	None	Housework / livestock	Tengra Kura CC	ANC	Partially Rehabilitated
IDI_07	40	None	Farming	Tengra Kura CC	ANC	Partially Rehabilitated
IDI_08	19	Pursuing Honors	Student / housewife	Tengra Kura CC	ANC & FP	Partially Rehabilitated
IDI_09	25	Class 5	Housewife	Tengra Kura CC	ANC	Partially Rehabilitated
IDI_10	25	Class 6	Housewife	Tengra Kura CC	FP	Partially Rehabilitated

Note. ANC = Antenatal Care; FP = Family Planning; CC = Community Clinic.

4.6.2 Facility Observation

Observation findings were based on a single site visit and may not fully reflect routine clinic operations across different periods. Direct observation on the facilities confirmed that Pakuria CC, which is a fully rehabilitated site, presented some better physical conditions like a permanent raised-plinth structure, gendered toilets and a DRR tubewell. Tengra Kura, which received a partial rehabilitation process, had fresh paint, a BDRCS water tank and posted service information but lacked functioning toilets, a fan and privacy arrangements for consultation.

Table 4.8. Summary Comparison of Observed Conditions: Pakuria CC vs Tengra Kura CC

Observation Indicator	Pakuria CC (Rehabilitation: Complete)	Tengra Kura CC (Rehabilitation: Partial)
Physical accessibility	Well-connected road; elevated plinth (raised); ramp available; clear signboard; rooms labelled	Road connectivity good but clinic sits lower than main road-slopes down from road; good stairs; clear signboard
General cleanliness	Clean and dry; flies present	Clean and dry; flies present; no trash bin observed
Waiting area	Spacious and clean; adequate seating	Spacious and clean; adequate seating; but clients observed waiting outside and consulting through window
Lighting & ventilation	Well ventilated; adequate natural lighting; no electricity and no fan/light	Well ventilated; poor artificial lighting; has electricity but no fan
Triage / breastfeeding	No triage area; no breastfeeding corner	No triage area; no breastfeeding corner
WASH facilities	Separate gendered toilets; no handwashing station outside toilet; one DRR tubewell on premises	No separate gendered toilets; toilet appears non-functioning; no external handwashing station; rooftop water tank (BDRCS-installed)
Privacy — waiting area	No privacy measures; no gendered separation	No privacy measures; no separate area for women
Privacy — consultation	No privacy measures observed	No privacy measures; no screen; consultation voice easily audible outside
RH services on day of visit	All available (ANC, FP, counselling)	Family planning only
Visible rehabilitation signs	Fully new permanent structure; plinth raised; separate provider rooms; separate toilet; DRR tubewell	Walls recently painted; BDRCS rooftop water tank installed; signboards visible; clinic opening hours posted on wall
Other	Boundary wall/fence not yet developed	Boundary wall/fence not yet developed

4.6.3 Qualitative exploration of acceptability

Theme 1: Affective Attitude

Sub-theme 1.1: Positive Emotions Rooted in Provider Behavior

Most respondents consistently said the healthcare providers' behaviors were well-behaved and fostered a sense of comfort, which empowered them to come back for future treatment. The healthcare providers treated them kindly and behaved well with them, which made them trust the services they are getting. Participants at both Pakuria CC and Tengra Kura CC rated provider attitude positively.

“In fact, when there are not many people around, the healthcare provider immediately tells us that we have this illness or this problem and then gives medicine. There is no need to delay. The healthcare provider doesn't do anything that's rude, condescending, or anything like that with us.” (IDI_05, Pakuria CC)

“The one who provides service, comes, treats well. The doctor is always nearby. When someone goes, she finds what she needs. When he comes, he listens openly to what is happening or not. He explains everything well. We find everything.” (IDI_03, Pakuria CC)

Sub-theme 1.2: Physical Discomfort as a Source of Emotional Strain

The clinic environment had a huge impact on the respondents' feelings, for example, they felt that overcrowding made them uncomfortable, as the healthcare providers annoyed them and made them feel stressed. Moreover, they found it difficult to discuss their problems with healthcare providers in the crowd. The burden is exacerbated by inadequate space and seating, forcing patients to stand in crowded, uncomfortable rooms. This creates a stressful environment, particularly when only a single healthcare provider is available to handle a long line of patients.

At Tengra Kura CC, the absence of a fan created physical discomfort, and the absence of a consultation screen meant conversations could be heard by those waiting outside. Women at this clinic expressed hesitation in disclosing sensitive information under these conditions. Pakuria CC had adequate seating and a spacious waiting area, consistent with generally more positive affective

responses from Pakuria participants. Women also noted that provider behavior changed under workload pressure.

“Sometimes when there are too many people, they may get a little annoyed. And if there are not, if they are satisfied (the healthcare provider feel calm), they don’t say anything. Or they don’t yawn. When there are people, it becomes a little troublesome.” (IDI_09, Tengra Kura CC)

Theme 2: Burden

Sub-theme 2.1: Temporal Burden

This theme encompasses the physical and time-related strain caused by limited capacity and high patient volume at the clinics. Participants consistently reported significant longer waiting times, often ranging from 15 minutes to over half an hour.

“When I visited CC, I needed to wait and felt bored as being alone with a child... I mean, it was hot then. After reaching, it was hot then. It’s been very difficult to stay in the heat... When there are a lot of people, you may have to stay outside, sit down and wait.” (IDI_04, Pakuria CC)

“I need to wait 10–15 minutes before seeing a doctor... Because the place is small, there are so many people, so they had to be delayed. There is some space on the balcony. I stayed there.” (IDI_07, Tengra Kura CC)

Theme 3: Ethicality

Sub-theme 3.1: Aligned with religious beliefs

Notably, the RH services especially family planning services and ANC were generally perceived to be aligned with the participants’ personal, cultural and familial values. Most expressed that using contraceptive pills was not tied to religious restrictions and is compatible with their beliefs. The presence of a female healthcare provider helped to maintain the confidentiality and trustworthiness and they felt the services honor their family honor and respect and dignity.

“No, using family planning services is not tied with my family or religious or social restrictions.” (IDI_01, Pakuria CC)

“Yes, we are treating this in the same way as, with the advice a pregnant woman can be healthy with the baby in the womb. And the confidentiality is maintained.” (IDI_07, Tengra Kura CC)

Sub-theme 3.2: Gender of Provider

Across all interviews, nearly all respondents expressed the cultural norms that create a significant problem for women to disclose sensitive reproductive health matters with male healthcare providers. Almost all discussed showed a strong preference for female healthcare providers that without them they hesitate to go, can't say everything or can't tell secrets. This was not presented as a personal preference but as a culturally embedded norm that participants described as constraints for communication openly. In several cases, the absence of a female provider led women to delegate their communication to a sister-in-law, who would speak on their behalf during consultations with the male doctor.

Both clinics documented no privacy measures during consultations, with the consulting voice easily audible outside at Tengra Kura CC. No separate waiting area for women was observed.

“You can't tell secrets. It would be better if there was a room. If it's a man, you can't say everything at once... It would be better if there was a female healthcare provider.” (IDI_01, Pakuria CC)

“A woman has a problem with a tumour, it can't be told to a man.” (IDI_07, Tengra Kura CC)

“I couldn't say, so the sister-in-law told (to the healthcare provider) on behalf of me.” (IDI_02, Pakuria CC)

Theme 4: Intervention Coherence

Sub-theme 4.1: Limited awareness about services

Most participants were found to have knowledge regarding only the services they personally accessed. There was limited awareness of the broader service package, including PNC and the full scope of ANC protocols. For example, the ANC users mentioned that the CC only provided weight monitoring, iron and calcium supplementation, blood pressure checks, maternal vaccination and nutritional counselling. The participants who received family planning were aware of contraceptive pill provision.

The low awareness seemed to be connected to the absence of displayed information about the range of services. Although both clinics have signboards that clearly indicated the provider rooms and clinic opening hours, none had any health information materials like fact sheets, booklets were noted at either clinic.

“They provide checkups for pregnant women, including cold and fever treatments, and iron pills. Checkups at four months, six months, eight months, nine months.” (IDI_03, Pakuria CC)

Sub-theme 4.2: Limited Awareness of the JAMUNA

Participants across both clinic sites demonstrated markedly limited institutional knowledge about the JAMUNA Project or BDRCS even though they mentioned the visible improvements at the clinics. Several participants acknowledged noticing the physical changes but described them without connecting them to any external project or donor identity.

At Tengra Kura CC, the visible evidence of rehabilitation like a BDRCS-installed rooftop water tank and recently repainted walls were directly observable. At Pakuria CC, the rehabilitation was more comprehensive like full structural reconstruction, a raised plinth, a DRR tubewell and separate provider rooms.

“No. I don’t know that who was involved in the renovation of this clinic... They (healthcare providers) never said who was doing this....I have no idea about the work that the Bangladesh Red Crescent Society is doing here.” (IDI_10, Tengra Kura CC)

“The Red Crescent is providing a lot of things. I mean, toilets, tube wells, hospitals, roads, soil cutting, school grounds, many things are improving. It seems to have improved a lot in a short period of time.” (IDI_03, Pakuria CC)

Sub-theme 4.3: Active Community Outreach and Informal Social Networks

Community-based outreach activities including health worker home visits, yard meetings and public announcements via microphone (miking) played an important role in informing women about available services and encouraging initial attendance. Most of the participants mentioned they heard about the CC from those channels and it encouraged them to visit the CC especially for RH services. In the absence of formal outreach, informal social networks, particularly sister-in-law relationships, served as the primary information channel.

The clinic name, room functions, opening hours, and service information were all posted on the clinic walls at Tengra Kura CC. At Pakuria CC, clearly labelled rooms and a well-organized new facility provided a physical environment conducive to the structured communication that health workers could reference during community outreach.

“The hospital, I mean, there are people who told me that there are facilities for pregnant women to come here. That’s why I went there after hearing that.” (IDI_09, Tengra Kura CC)

“Yes, I came to know what services the clinic have. I mean, whether they are pregnant or have young children, health workers come home and say that the clinic is good, the medicine in the clinic is good.” (IDI_08, Tengra Kura CC)

“They go from house to house and say that you can go here, that’s why we go. You will get services from here, you go. They give you free treatment, that’s why we go.” (IDI_10, Tengra Kura CC)

Theme 5: Opportunity Costs

Sub-theme 5.1: Work, Income, and Domestic Sacrifice

Accessing RH services frequently requires participants to sacrifice or postpone their income-generating activities, leading to perceived financial loss. For respondents engaged in tailoring, such

as “sewing machine” work, the clinic visit necessitates stopping their machine, directly halting their daily earnings.

The mandatory interruption of daily household responsibilities, which are vital to family welfare, is also a consistent opportunity cost. The participants often mentioned having to leave the housework to attend the clinic. This also includes the care of livestock and other domestic obligations like children, cows and chickens. As most are primarily homemakers, the act of leaving those duties is a conscious decision to prioritize health over immediate things. For those who work and manage a household, this forces the clinic visit as a disruptive, necessary sacrifice. This trade-off is often rationalized by the belief that treatment is good but the potential for lost earnings remains a significant barrier that causes others to hesitate.

“I have to leave any important work or responsibilities to come to this clinic and it does cause loss in work.” (IDI_07, Tengra Kura CC)

“There are children, cows and chickens, these need to be done and have to leave those works when visiting the clinic.” (IDI_06, Tengra Kura CC)

“During visiting the clinic, any of my household chores have to be left out and cause trouble. Even if there is trouble, if there is illness, you have to go.” (IDI_10, Tengra Kura CC)

Sub-theme 5.2: Practical Negotiations Before Every Visit

Managing the care of young children during clinic attendance added a layer of practical negotiation that constituted a distinct opportunity cost. As needed to leave the children with their family members, it made them sacrificed and concerned their child’s wellbeing. They lost their chance to take care of their children.

Strategies included taking children along to the clinic, leaving them with a mother-in-law or daughter, or coordinating attendance with other pregnant women to share supervision. Each strategy required time, social capital or physical effort that represented an additional cost of service access.

“To take care, I have a daughter, I leave the baby with her. Sometimes I bring her too with me when I went to the clinic for RH services.” (IDI_06, Tengra Kura CC)

“I have a mother-in-law. I hand over the responsibility of care to my mother-in-law.”
(IDI_02, Pakuria CC)

Neither clinic had a triage area or a breastfeeding corner. The absence of designated child-friendly spaces at both CCs means that women who bring children have no dedicated area for infant care during their visit, increasing the practical burden of taking young children along.

Theme 6: Perceived Effectiveness

Sub-theme 6.1: Demonstrated Usefulness

Participants consistently reported a high level of efficacy for the RH services, confirming that the treatments ranging from basic illness medication to family planning supplies and prenatal supplements achieve their intended outcomes. Women consistently reported that medicines prescribed at the CC such as oral contraceptive pills, iron tablets, calcium supplements, and treatment for common illness worked as expected, that their visit objectives were met, and that the quality of provider communication contributed to positive outcomes.

At Pakuria CC, all RH services (ANC, FP, counselling) were available on the day of observation, providing structural corroboration for participants’ reports of service receipt. At Tengra Kura CC, only family planning was available on the day of observation while this reflects a single observation day and may not represent routine availability, it is consistent with participants’ accounts of inconsistent service provision at that clinic.

“I think reproductive health services have met my needs and it was very good for me as they are providing the right treatment.” (IDI_02, Pakuria CC)

“As I go for family planning, they gave me the pills for contraception and my purpose to going clinic is being fulfilled.” (IDI_09, Tengra Kura CC)

Sub-theme 6.2: Institutional Maturation

When compared to past experiences, the participants overwhelmingly perceived a significant improvement in the CCs services. Improvements were described in terms of physical permanence, from a temporary structure to a fully constructed facility and increased availability of services and

medicines. Participants note that the healthcare providers were now explaining everything and giving the medicines they didn't give before, which leads to a perceived change in treatment.

Pakuria CC, a new permanent construction with a raised plinth, separate provider rooms, and a DRR tubewell, aligns with the participants' descriptions of visible physical transformation. At Tengra Kura CC, recently painted walls, a BDRCS-installed rooftop water tank and clearly displayed information represented visible but more limited rehabilitation signs.

“Earlier this CC was not here. People could not get services. Earlier the CC was temporary. Now it has become permanent. Now everything is slowly being developed. Everything is being provided. Earlier medicines were not always available, now more or less everything is available. That is why it is improving a little. The more it improves, the better.” (IDI_05, Pakuria CC)

“Now they give all the medicines that they didn't give before. They do everything, they explain everything. I mean, that's why we go. And that's all there is to it.” (IDI_02, Pakuria CC)

Theme 7: Self-Efficacy

Sub-theme 7.1: Growing Faith and Trust in CC

Regarding access to RH services at CCs, the vast majority of participants were confident in themselves and able to visit on their own. This confidence was reported to enhance their intention to come back whenever there is a problem and can improve the follow-up for RH services. Most also mentioned they will recommend the clinic to others and will reinforce a belief that the services are both personally necessary and medically beneficial.

Faith and trust in the CC's institutional integrity and staff competence influenced participants' self-efficacy. This is coming from the belief that the system is better now than before, and the community has confidence in the providers. When the staff explain everything, the participants have huge confidence in the services they got.

“So, I get the service (contraceptive pills) when I go there. And I will go again myself to receive the service (family planning) and will tell others to go for the service and I will take others with me” (IDI_10, Tengra Kura CC)

“Now they (CHCP,FWA,HA etc.) give all the medicines that they didn’t give before. They do everything, they explain everything. I mean, that’s why we go. And that’s all there is to it..... Everything is available now more than before. The more advanced, the better.” (IDI_02, Pakuria CC)

4.6.4 Barriers and Facilitators to Service Utilization

Theme 8: Barriers to Service Utilization

Sub-theme 8.1: Physical Barriers

Seasonal flooding was the most common barrier, and it had a huge impact on the service utilization as it prevented the participants and CC staff from physically reaching the CC and making it difficult to receive maternal services which were supposed to be managed by the CC. The proximity of the CC was a meaningful mitigating factor outside the monsoon, but during the flooding season the pathway to the CC was submerged or impassable irrespective of how close the participant lived. All participants said that even a short journey became physically demanding during flood season, while a minority of the participants still described significant walking distances even in dry conditions.

Pakuria CC had an elevated raised plinth while Tengra Kura CC was positioned lower than the main road and sloping downward, making it structurally more vulnerable to flooding.

"When I go to the clinic by walking, which is very far. It takes 20 minutes to walk from home. When there's a flood, it is difficult to go to the clinic." (IDI_10, Tengra Kura CC)

"If there is water around, the doctor will not be able to come here. We will not be able to go either. Maybe, even if we need medicine, there is no other way." (IDI_04, Pakuria CC)

Sub-theme 8.2: Structural Service-Level Barriers

Three structural service-level conditions operated as barriers at both clinics.

Persistent Gaps: Diagnostic and Supply

Significant barriers still remain despite the positive feedback on effectiveness like inconsistent availability of essential supplies and lack of some basic diagnostic such as blood testing, ultrasound or X-ray equipment. Participants highlighted that service reliability is conditional upon stock which creates an immediate contradiction between what services are offered and what is actually available. This creates unmet patient needs and forces healthcare providers to guess a diagnosis and give medicine based on guess which leads to concerns on appropriateness of treatment.

No diagnostic equipment was visible at either site. These absences corroborate participant accounts of structural diagnostic limitations.

“There (CCs) have no tests here. Here, they (healthcare providers) guess, meaning what disease you say, they give medicine here based on guesses.” (IDI_10, Tengra Kura CC)

“Sometimes service is available, sometimes not. Then we may have to return without taking the service. There was medicine available, but too many people came, they had to give it. There’s no medicine now, come next month.” (IDI_06, Tengra Kura CC)

Infrastructure and Amenity Deficits

Most participants mentioned the internal deficits regarding basic facilities, equipment, and sanitation. Also responded that the essential utilities like electricity and water supply are frequently absent, leaving facilities without functional lights or fans. Sanitation is a major concern, with reports of dirty toilets and a general lack of cleanliness, while security issues arise from the absence of boundary walls and gated systems to protect the facility. Some point out that fundamental furniture like chairs, tables or benches for patient seating are absent.

Both clinics lacked a boundary wall/fence. Pakuria CC had no electricity. Tengra Kura CC had electricity but no fan, poor artificial lighting, and a toilet that appeared non-functioning with no external handwashing station.

“When you go to (the clinic), you have to stand.....And the clinic is not that good. It's dirty, there's garbage, there are no lights, no lamps.....,no fans. The fan is hanging there like a sample. But the fan does not turn, there is no electricity.” (IDI_06, Tengra Kura CC)

“Now, there are no chairs or tables to sit in the clinic. There is no place for women to go and see a female doctor and sit.” (IDI_03)

Inadequate Infrastructure for privacy

Across all interviews, the respondents demonstrated that the physical infrastructure inadequacy leads to compromising of the participants' privacy and confidentiality. The absence of a dedicated consultation room for women meant that sensitive conversations occurred within earshot of other patients, exposing private discussions to other patients. One participant noted the use of a screen system during physical examination as partial mitigation, though this was not consistently reported. Consequently, they didn't get the chance to speak freely.

At Tengra Kura CC, no privacy measures were in place, and the private discussions could be easily heard from outside, structurally confirming the absence of a private consultation environment. At Pakuria CC, although separate rooms existed for providers, no dedicated privacy screening or separate consultation room for women was observed.

“Confidentiality is sometimes compromised because the room is small and patients crowd around, making it difficult to share private information.” (IDI_08, Tengra Kura CC)

“Only when the female doctor comes [can women speak freely]....Now, female doctors don't come. I can't even say anything like that. If a female doctor came, I would have gone to them and told them separately and they would have treated me that way. Now that that's not there, there's no privacy.” (IDI_05, Pakuria CC)

Theme 9: Facilitators to Service Utilization

Sub-theme 9.1: Geographic Proximity and Free Service Delivery

The geographical proximity of the two CCs to participants' households was a facilitator at both sites. Tengra Kura CC, partially rehabilitated, is on the same location which is already familiar to the

community. Pakuria CC, fully rehabilitated, built on a new location which located within the walking distance of the originating community and the new site had an impact on the service utilization as it seems to have lowered the practical cost and reduced the travel time compared with the pre-rehabilitation period. Free services (no fee charged at the clinic) was shared consistently in several IDIs and participants directly contrasted the CC with the upazila health complex on both fee and travel time.

These two structural facilitators operated together as a short walk to a free service generating low-friction first attendance for women whose decision to attend the CCs.

"They give you free treatment, that's why we go." (IDI_10, Tengra Kura CC)

"So, I get the service (contraceptive pills) when I go there. And I will go again myself to receive the service (family planning) and will tell others to go for the service and I will take others with me." (IDI_10, Tengra Kura CC)

Sub-theme 9.2: Family network for healthcare and childcare

The majority of the participants mentioned the help of sister-in-law relationships in consultations with healthcare providers, which made it easier to communicate, especially when the available provider was male. These informal social networks also worked as both a referral pathway and a coordination mechanism for sustained attendance, as some also described they had the help of their mother-in-law, who took care of their responsibilities while they attended the CCs.

"I have a mother-in-law. I hand over the responsibility of care to my mother-in-law..I couldn't say, so the sister-in-law told (to the healthcare provider) on behalf of me." (IDI_02, Pakuria CC)

Besides mothers-in-law, several participants mentioned that they attended the CCs with neighbors or other pregnant women, which helped them to share the childcare during the visit and made travel to the CC easier as they went as a group. This coordination reduced the practical opportunity cost of attendance for each woman and increased the likelihood of attendance from women while looking after their children, while they are at it.

"To take care, I have a daughter, I leave the baby with her. Sometimes I bring her too with me when I went to the clinic for RH services." (IDI_06, Tengra Kura CC)

Chapter 5: Discussion

5.1 Summary of Key Findings

This study evaluated how reproductive health services are delivered among women of reproductive age through rehabilitated CCs under the JAMUNA project in the char areas of Bogura District, Bangladesh.

Client satisfaction was moderate while the only statistically significant predictor for satisfaction was clinic site and the partially rehabilitated Tengra Kura CC outperformed in terms of satisfaction score compared to the fully rehabilitated Pakuria CC. Service utilization was service-specific as the FP grew at both CC while PNC declined at Pakuria CC. The utilization of ANC is diverged between sites. Provider attitude played a key role in the positive perception of the acceptability while intervention coherence around the full RH package and the visibility of the implementing actor were weak. Flood, which was already a barrier, multiplied every other barrier. Provider attitude, the location of the clinic, free services delivery and community outreach were the consistent facilitators at both CCs.

5.2.1 Client Satisfaction: High Interpersonal Scores and a Persistent Accessibility Gap

The overall mean satisfaction score (3.94 out of 5-point scale) and the satisfied percentage (60.4%) found in this study can be broadly compared to the levels of satisfaction reported in other studies of community-level primary care in rural Bangladesh and similar low-resource settings. The JAMUNA project baseline report (2024) reported that 48.0% of CC visitors were very or rather satisfied with the CC services they received, while the 60.4% satisfaction proportion observed in this sample represents a detectable improvement, though the different measurement instruments and study populations limit direct comparison.

The dominance of the interpersonal domain in this study is consistent with other Bangladesh studies which used the comparable instruments. Studies in Rohingya refugee camp primary care settings using the PSQ-18 (Islam et al., 2026), in rural health centers using a short-form instrument

(Mahejabin et al., 2016) and earlier studies on community clinics (Adhikary et al., 2018; Karim et al., 2016) all showed the same pattern that patients had more satisfaction on provider courtesy and behavior than accessibility, technical quality or convenience. In a flood-disaster prone area where physical access to the CC is intermittent, the fact that the community still rates the relational quality of care over the structural conditions shows that providers' behavior had a huge impact on the utilization. As most of the RH services need disclosure about menstrual, pregnancy and contraceptive information which the participants are unlikely to share with a provider they do not trust (Pampati et al., 2019), future RH service investment should also focus on the provider attitude as first input, not as a soft complement to infrastructure (Carvajal et al., 2017).

The accessibility and convenience subdomain had the lowest score among PSQ-18 subdomains, and the interpretation of this finding is more important than the score itself. The accessibility related questions in this study try to capture the practical conditions surrounding the consultation such as travel, waiting time, operating hours, the physical condition of the CC and the predictability of provider availability which have huge impacts on the access to healthcare (Levesque et al., 2013). These are the conditions that a single-clinic rehabilitation alone cannot fix (Uddin et al., 2021) as transport infrastructure, climate-adapting services, staffing rosters and recurrent budget for utilities are not within the scope of the JAMUNA project.

The low accessibility score in a sample that simultaneously rates interpersonal manner tells us that the primary constraint on RH service experience in this catchment is structural and external to the clinic rebuild while the strongest lever inside the rehabilitation package is the relational quality of the providers.

5.2.2 The Paradox of Full Rehabilitation

A paradoxical finding of the current research is that structural completeness did not translate into a higher client satisfaction score. This was reflected in the finding that Tengra Kura CC, which received only partial rehabilitation, had higher overall satisfaction than Pakuria CC, which was fully rebuilt and has a new complete structure. Several explanations are plausible and not mutually exclusive. First, the socio-relational dimension of community-based care may intervene in the satisfaction effect. Tengra Kura CC was a continuity site and has been on the same physical location, the same building and the same community relationships pre-existed rehabilitation. The intervention

at Tengra Kura added a water tank, fresh paint, and improved signage onto a familiar, trusted institutional context. Women attending had established provider relationships; the physical improvement was experienced as an enhancement of something already known. At Pakuria CC, the complete structural replacement involved building a new facility and a new location, which may lead to unfamiliarity with the CC.

Second, the observation data are cross-sectional and may not reflect a usual scenario. The observation checklist documented that on the day of the structured field visit, both clinics offered full ANC, PNC, counselling and FP services. The PSQ-18 was administered to women who had recently used services, not on the day of observation.

Third, Donabedian's (2005) quality framework reminds us that patient satisfaction is determined by expectations, values and relational familiarity as much as by technical or structural quality. Regional evidence, such as that from Pakistan's Lady Health Worker programme (Mumtaz et al., 2013) and Nepal's Female Community Health Volunteer network (Panday et al., 2017) already show that how well the health systems are embedded into the community is a stronger driver to accept the healthcare services than physical facility standards. This effect appears to be operating at Tengra Kura CC, which is partially rehabilitated and has all services available year-round. By contrast, Pakuria CC was newly constructed and had to provide services from a temporary place, which reduced service hours (1.5-2 hours per day and 2-3 days per week) and inadequate space for private consultation, which seems to have an impact on the services utilization.

5.2.3 Utilization Trends: Family Planning Sustained, ANC Divergent, PNC the Persistent Gap

Over the 26-month period and in the satisfaction survey, family planning services were the most utilized among RH services at both clinics. This is consistent with the broader national evidence. The BDHS 2022 key indicators report shows that modern contraceptive prevalence in Bangladesh has remained high (53.2%) and that community-level accessibility is high, driven by community empowerment (Hossain et al., 2026; Pal & Akanda, 2026). The FP increases at both clinics post-rehabilitation (6.2% at Pakuria CC and 6.8% at Tengra Kura CC) align with the expectation that improving facility accessibility and comfort would lower barriers to receiving the RH services, which are by nature periodic and planned rather than emergency-driven.

The divergent ANC trend between the two clinics is harder to explain on the basis of rehabilitation alone. Tengra Kura CC's 11.3% ANC increase (pre-rehabilitation mean of 13.67 visits to post-rehabilitation mean of 15.21 visits per month) and Pakuria CC's 12.8% decrease (pre-rehabilitation mean of 9.67 visits to post-rehabilitation mean of 8.43 visits per month) sit alongside the observation that Tengra Kura CC, despite being partially rehabilitated, had better service availability as the clinic building and location are the same throughout the rehabilitation process. At Pakuria CC, the complete reconstruction involved a period of structural transition, and the clinic service hours were reduced 1.5-2 hours per day, 2-3 days per week, with services provided from a temporary location. It is also possible that the unspecified completion time, which was not directly measured in this study, contributed more to the difference in trends than the physical rehabilitation itself. This interpretation is supported by the qualitative finding from IDI_05 at Pakuria CC, which noted that the clinic's temporal transformation from a temporary to a permanent structure represented institutional maturation rather than a specific point-in-time change in service quality.

Evidence from Bangladesh DHS analyses consistently shows that PNC completion rates are the most dramatically lower among women in geographically isolated areas and those in the lowest socioeconomic quintiles (NIPORT & ICF, 2024). Early PNC is limited by women's physical recovery, cultural expectations and family decision-making dynamics (Hasan & Mujahid, 2023; Enos et al., 2024). In this study, Pakuria CC showed a 22.9% decline in PNC volume after rehabilitation pre-rehabilitation mean of 8.33 visits to post-rehabilitation mean of 6.43 visits per month), while Tengra Kura CC's PNC volumes remained low in absolute terms with a marginal 7.1% increase (from 3.33 to 3.57 visits per month). The flat-but-low Tengra Kura trend and the marked decline in Pakuria together indicate facility-level variation within a broader national pattern of PNC underuse.

5.2.4 Acceptability: What the TFA Framework Revealed Beyond the Satisfaction Scores

The TFA analysis produced seven themes that collectively characterize a pattern of conditional acceptability. Women perceived the rehabilitated CCs to be broadly acceptable when environmental conditions were favorable, when it was not the flood season, when the provider was present, when the stock was available, and when they could arrange childcare and obtain family permission. These conditions were met often enough that 60.4% of the sample were classified as satisfied in the

quantitative component. They were not met reliably enough to generate high and consistent service utilization, particularly for ANC and PNC.

Courteous behavior of providers was the most frequently cited positive experience across all ten IDIs and corresponded to the perception of the acceptability of the RH services provided at CCs. The convergence between the qualitative and quantitative streams strengthens the interpretation that, at the perception level, the provider-client encounter carries more interpretive weight than the visible infrastructure improvements. This is consistent with Sekhon et al. (2017) and Adhikary et al. (2018), who report that interpersonal dimensions of primary care are the strongest correlates of acceptability when both technical and relational dimensions are measured in parallel.

The burden theme, encompassing waiting time, travel difficulty, flood and heat, represents the most multidimensional constraint in the dataset. The absence of fans at both clinics was mentioned repeatedly in IDIs and directly confirmed through observation. This is a minor structural gap that could be remedied with functional electrical connections and basic equipment, but it was generating measurable emotional strain during visits, particularly during the hot season. In the context of the TFA, burden is conceptualized not only as physical effort, but as cumulative cognitive and emotional load and the heat-related discomfort described by participants functions precisely in this way: it reduces the perceived net benefit of attending (Sekhon et al., 2017).

Family planning and ANC services were consistently described by participants across both sites as culturally and religiously acceptable, with no participant expressing conflict between these services and their personal beliefs. FP services given at the CCs are short, do not require machines and require minimal physical examination, and they can be delivered through provider-client interaction that is verbal and discrete. In contrast, ANC and PNC require physical assessment, blood pressure measurement and urine testing, and these depend on equipment and space that were not consistently available. The simplicity of the FP service offers more cultural acceptability. This differs from some earlier literature on South Asia, where family planning acceptability was more contested at the community level (Mumtaz et al., 2013). It reflects generational and educational shifts in Bangladesh, where over half a century of family planning program has normalized modern contraceptives across educational and socioeconomic strata (Bhatia et al., 2024; Karim et al., 2025). The IDI findings do support the PSQ-18 item 3 response, where 90.1% of participants described their current RH care as

"just about perfect", which is a ceiling-level response that is consistent with a population that broadly endorses the legitimacy of these services.

Most participants were unable to describe the full-service BDRCS involvement or the JAMUNA Project mandate. This is a recognized implementation challenge in donor-supported community health program globally. Even though the community awareness of the implementing organization is not mandatory for service uptake, it does affect the sustainability of the program as the communities are less likely to maintain the facilities after the project is completed (Peters et al., 2013). This knowledge gap poses a risk to maintaining the rehabilitated CC, as the JAMUNA project is time-bound.

Regarding the opportunity costs to access RH services, two categories emerged. One was direct income loss, and the other was childcare. Participants who work as tailors or manage poultry or livestock reported stopping work to access RH services, resulting in income loss. This became an economic loss in addition to the loss of household work. As women needed to hand over childcare to relatives, take children along to the CC, or coordinate attendance with neighbors, they sacrificed for their children's well-being when visiting the clinics. From the facilities observation, no specific breastfeeding corners or child-friendly areas are seen, which supports the participants' insights. In rural Bangladesh, Powell-Jackson and Hoque (2011) noted that maternal illness affects household income, leading to borrowing or asset depletion when productive labor is foregone during care-seeking. The time and indirect costs of accessing care exceed the direct costs, especially for women in rural Bangladesh (Rahman et al., 2013). This also helped explain why FP is the most consistently used service, as it requires only a short visit to both clinics. The cost of attending is not constant across service types; it varies with duration and frequency.

Participants overwhelmingly reported that the services they received worked as intended. Contraceptive pills suppressed unintended pregnancy, and iron and calcium supplements were associated with felt improvement during pregnancy. These accounts of demonstrated usefulness were paired with a perception of institutional maturation: women described the rehabilitated clinics as a qualitative step forward from temporary structures and intermittent stocking. This is a meaningful finding for the JAMUNA Project because it indicates that when services are actually

received, they are perceived as clinically valuable, and that this perceived value is, in part, anchored in visible infrastructure improvements.

Self-efficacy was generally high for women who had already attended and had positive experiences, but conditionally reduced for women who feared flood, required a companion, or could not communicate openly with a male provider. The latter point is significant. In both clinics, IDI participants described withholding symptoms or being unable to fully articulate their concerns to male healthcare providers. Communication inhibition in the presence of male providers is well-documented in Bangladeshi maternal health literature, and Anik et al. (2021) stated that gendered communication barriers acted as an independent reason for incomplete ANC uptake and women with less autonomy were less likely to disclose symptoms to male providers. And it represents a clinical risk in addition to a satisfaction concern, as incomplete symptom disclosure increases the likelihood of missed diagnoses.

5.2.5 Barriers and Facilitators: Structural Deficits and the Power of Proximity

The barriers and facilitators identified in this study operated simultaneously at physical, social, institutional and climatic levels, and their interactions were more significant than any single factor considered in isolation. In char areas where the community clinic is the only accessible health facility, floods do not reduce access to care, but they eliminate it.

Most participants mentioned the disruptions of the healthcare services uptake during the monsoon. This is consistent with previous findings in char areas of Bangladesh, as Amin et al (2025) documented that pregnant women were unable to access healthcare during extreme weather events, leading to home delivery without skilled birth attendance and maternal and neonatal complications. Baten et al. (2020) demonstrated using nationally representative data that flood exposure was independently associated with significantly lower odds of ANC attendance by a skilled provider (OR = 0.81 and institutional delivery (OR = 0.88), after adjustment for confounders, confirming that the utilization suppression effect of flood operates at the population level and is not simply an artefact of geographic remoteness. Hanif et al. (2025) documented that flooding of residential compounds in riverine Bangladesh is independently associated with prenatal depression and creates fear of accessing emergency healthcare. The qualitative data from this study reinforce that finding experientially.

Moreover, in some cases, the gender of the healthcare provider affected the utilization of the service. As some healthcare providers are male, the women reportedly felt uncomfortable discussing a gynecological complaint, which led to incomplete symptom disclosure. This can result in undetected gestational hypertension, anemia mismanagement or missed obstetric risk assessment (Kazi et al., 2021; Singal et al., 2026).

Participants described diagnostic services as effectively absent. Observation confirmed this: no blood testing equipment, no ultrasound, no urine dipsticks and no calibrated point-of-care devices were visible at either site. The WHO Standards for Improving Quality of Maternal and Newborn Care in Health Facilities (WHO, 2016) specify hemoglobin testing, urine analysis for proteinuria and reliable blood pressure measurement as minimum components of primary-level antenatal care, and the WHO/UNICEF guidance on Essential Services for Quality Care (2025) sets functional electricity, water and basic diagnostic infrastructure as non-negotiable prerequisites for facility-level quality. Verbunt et al., 2025 reported that anemia testing among pregnant women in Bangladesh remains heavily concentrated in private facilities rather than at the community level, leaving public primary care users systematically under-screened. Participants also reported intermittent stockouts of medicines, which interrupted treatment continuity and reduced perceived service reliability.

The geographic proximity and free service delivery for RH services served as facilitators to access the RH services at both clinics. The sister-in-law relationships and cross-household coordination, which were already present in the community, served as the facilitating factors to sustain the CCs' attendance, while the community engagement awareness sessions provided by the BDRCS also had impacts on the clinic attendance. The community empowerment served as the main information pathway for first attendance and encouraged the women to access the RH services (Pal & Akanda, 2026). The CC served as the first point of care for ANC, PNC and FP while several IDI participants explicitly contrasted the CC with the upazila health complex in terms of cost and travel time.

The barriers and facilitators observed in this study are similar to those reported by Begum and Syed Abdul Hamid (2023), who noted that expanding service availability alone is not enough in char-area populations, where structural, social, and climatic constraints determine the reach and use of the facility.

5.3 Strengths of the Study

The primary strength of this study lies in its mixed-methods convergent parallel design, which enabled both quantitative measurement of satisfaction levels and qualitative explanation of why and how those levels were reached. Neither component alone would have generated the same depth of insight. Without the PSQ-18, the clinic-site satisfaction difference would have remained subjective. Without the IDIs, the paradox of Tengra Kura CC outperforming the fully rehabilitated Pakuria CC on satisfaction scores would have been uninterpretable.

The non-participant observation at both clinics provided a third data stream that functioned as an independent corroboration tool. Acoustic privacy failures, the absence of fans, non-functioning toilets, and CHCP room availability were reported in IDIs and directly verified through structured fieldwork observation. The triangulation allowed for strengthening the validity of findings, as social desirability bias in qualitative data could have produced the most favorable accounts. The use of validated PSQ-18, which was adapted into Bangla while maintaining construct validity and ensuring cultural appropriateness, further supports reliability. The TFA has been applied in reproductive health implementation research across multiple low- and middle-income country settings (Nyumwa et al., 2023; Eze et al., 2023). Quota sampling for IDIs stratified by service type (ANC, PNC, FP) ensured that acceptability dimensions specific to each service category were captured, rather than producing a general account dominated by the most commonly attending service users.

The study's geographic focus is itself a contribution to the evidence base. Char areas are systematically underrepresented in Bangladesh's health research literature. This study generates the user-perspective evidence on how those rehabilitated clinics are functioning and addressing the mandatory needs of the communities in the flood-prone char areas of Bangladesh. By doing pre-and post-rehabilitation secondary data review, the study also adds a temporal dimension which was regularly absent in pure cross-sectional satisfaction studies.

5.4 Limitations of the Study

The study was conducted at two purposely selected clinics in a single district. Pakuria and Tengra Kura CCs were chosen as JAMUNA implementation sites rather than as a representative sample of the 24 rehabilitated facilities across the project's four districts. These two clinics differ in

rehabilitation type, geographic sub-location and staffing patterns in ways that already produced divergent satisfaction and utilization outcomes within the same study radius. The findings cannot be applied to the broader CC network in Bangladesh, to char communities in Kurigram, Gaibandha or Sirajganj with different riverine geographies and flood intensities, or to non-JAMUNA CCs.

The client satisfaction assessment was conducted as a cross-sectional survey at a single time point, capturing women who had accessed services during the post-rehabilitation period. No individual-level satisfaction measurement was taken before rehabilitation using the same instrument or with the same population. The 12.4 percentage-point improvement from the JAMUNA baseline report (48.0% to 60.4% satisfied) is indicative of a positive directional change but cannot be causally attributed to the rehabilitation intervention because the two measurements used different instruments, different study populations, and different survey periods. This design limitation was acknowledged throughout the analytical approach by restricting causal language and framing utilization trend findings as descriptive rather than attributive.

Participants in the IDIs were recruited through referrals from community health workers within the CC catchment area. Because community health workers are trusted and familiar figures, and because the study's explicit focus on CC services was known to participants, respondents may have provided more favorable accounts than an independent assessment would produce, particularly regarding provider attitude and institutional performance. The non-participant observation checklist served as a structural countermeasure by providing an independent facility assessment against which IDI accounts could be cross-verified. Despite these precautions, the possibility of social desirability bias cannot be entirely ruled out in the qualitative data.

The PSQ-18 was administered to women reflecting on service encounters during the previous six months. Retrospective satisfaction ratings are subject to the salience effect, whereby a particularly positive or negative recent encounter may be disproportionately weighted relative to routine visits when participants recall the overall service period. The standardized PSQ-18 instrument and its established validation history offer structural protection against random response error, but recall bias cannot be fully eliminated in retrospective cross-sectional designs.

5.5 Implications for Public Health Policy and Practice

5.5.1 Quality-Centered Community Clinic Policy: Beyond Physical Infrastructure

In the Bangladesh health system, community clinics serve as the first point of care for delivering village-level universal health care coverage. The findings from this study indicate that a substantive change in monitoring CC performance will be required to achieve this goal. This means that to measure the accountability of CC performance in flood-prone areas, construction milestones alone are not enough and will need to include female provider availability, functional WASH infrastructure, privacy provisions and basic amenity standards. These are the service-side conditions that determine how the structural rehabilitation transforms into full improvement of RH services.

5.5.2 Climate-Resilient Service Delivery and the National Adaptation Plan

The National Adaptation Plan of Bangladesh (2023–2050) explicitly designates char areas as priority climate-stress zones requiring adaptation of the health system. The ANC and PNC utilization trends observed in this study provide a glimpse into how the physical facility rehabilitation performs when undertaken without a parallel mechanism for maintaining service access during climate shocks. This implies that construction outputs alone in the climate-resilience policy are not enough, while combined with service-continuity outcomes need to be in the policy for char-area CCs. As the Bangladesh Climate Change Strategy and Action Plan presume that the health system remains functional through climate stress, the findings will add to the wider policy architecture of the national adaptation plan and the country's commitments to SDG 13.

5.5.3 Gender-Responsive Service Design in Reproductive Health Delivery

Across the qualitative insights, the availability of a female provider was found to be crucial for communication. The majority of the participants mentioned the absence of a female provider, which compromises the continuity of care and the privacy of RH services. This implication is structural rather than attitudinal as the main course for limited presenting of the female provider is at the CC level rather than community demand. The MoHFW have already designated female healthcare provider roles, which means the absence of a female provider is rather a roster-management gap than a gap in policy. The privacy failures mentioned at both CC carry an implication as privacy

infrastructure is not peripheral, but it is a precondition for the symptom disclosure that clinically effective reproductive health care depends upon. Its absence constitutes a structural barrier to quality of care that no amount of provider training alone can fully overcome.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

The findings highlight that rehabilitation is a crucial phase to ensure equitable quality reproductive health care and that fixing the infrastructure alone is not sufficient but requires a combination of other efforts including good relationships with clients to enhance the experience and adapt to the needs of different reproductive health services. To convert rehabilitated infrastructure into reliable and accessible RH services, the contingency plan for flood months, pre-positions drugs and protects female provider availability will be required.

6.2 Recommendations

6.2.1 Recommendations for Program Implementers

Three findings of this study carry direct implications for the Bangladesh Red Crescent Society, Swiss Red Cross and the wider JAMUNA Project consortium. First, the visibility gap that emerged across the qualitative insights is an addressable sustainability risk. A standard community engagement apart from health promotion activities like structured community orientation sessions should be conducted to clearly mention the rehabilitating organization. Second, the diagnostic capacity gap should be closed within the remaining implementation period through a minimum diagnostic kit at each rehabilitated CC, given that participants explicitly described what they were receiving as treatment by guessing. Third, the implementing organization should coordinate and advocate with the respective health departments to ensure the timely presence of healthcare providers at respective CC for RH services and the availability of healthcare providers should be announced through the community outreach channels.

6.2.2 Recommendations for Future Research

This two-clinic, single-district study has exposed evidence gaps that future research should address. A multi-site evaluation using consistent methods across all four JAMUNA districts would test whether the Pakuria-Tengra Kura paradox is a site-specific artefact or a pattern that holds in other char geographies; the current findings cannot be applied to Kurigram, Gaibandha or Sirajganj without that confirmation. A multiple-baseline interrupted time series design that includes non-rehabilitated control CCs in the same district would provide stronger causal evidence on the effect of rehabilitation on service utilization than the descriptive pre-post comparison reported here.

A longitudinal follow-up of the same participant cohort, measuring satisfaction with the same PSQ-18 instrument before and after rehabilitation would resolve the baseline expectation confound that the cross-sectional design carries. Beyond methodological extensions, two thematic gaps deserve attention. The effect of male versus female provider availability on symptom disclosure and clinical outcome quality at CC level has not been quantitatively tested in the char context of Bangladesh, despite the consistent qualitative signal in this study and in the wider South Asian literature. The long-term sustainability of donor-funded climate-resilient health infrastructure beyond project funding cycles also remains unevaluated; a follow-up assessment of the same JAMUNA-rehabilitated CCs three to five years after project closure would generate the sustainability evidence the field currently lacks.

Declaration of GenAI Use

I, Pau Sian Muang, declare that in preparing this assignment, I used ChatGPT (OpenAI, GPT - 5.5, May 21, 2026) to assist with brainstorming section outlines, organizing manuscript structure, and editing for clarity and language in drafts I wrote myself. AI was not used in data collection, analysis and interpretation processes. All statistical findings, numbers in the text and empirical claims remain my own and are verified against primary Stata output and source papers. ChatGPT did not generate original arguments and I did not use AI to fabricate or alter citations or results. All references have been independently verified against the actual papers. My basic ideas, judgments about study limitations and conclusions are my own.

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Appendices (Optional)

Appendix A: Data Collection Instrument

Exploring Utilization, Acceptability, and Satisfaction of Reproductive Health Services Among Women of Reproductive Age Delivered Through Rehabilitated Community Clinics in Bogura District, Bangladesh

Study: Utilization, Acceptability, and Satisfaction of Reproductive Health (RH) Services Delivered Through Rehabilitated Community Clinics under the JAMUNA Project in Bogura District, Bangladesh

Participants: Women of reproductive age (18–49 years)

Duration: 20–25 minutes

Purpose: To explore acceptability, barriers, and facilitators influencing utilization of RH services

Part 1: Identification and Interview related information

Sl. no.	Question	Codes/Answers
1	Date of the interview	_ _ _ / _ _ _ /20 _ _ _ Day/ Month/ Year
2	Participant ID:	
3	Name of the interviewer:	
4	Interview starting time:	
5	Interview ending time:	
6	Place of interview [setting details]:	

Part 2: Background information of the respondent

Sl. No.	Question	Response Options / Codes
1	Age (in completed years)	___ ___ years

2	Highest level of education completed	0 = No formal education 1 = Primary 2 = Secondary 3 = Higher secondary/Diploma 4 = Graduate or above
3	Main occupation	1 = Homemaker 2 = Daily laborer 3 = Service/Private sector 4 = Self-employed/Business 5 = Student 6 = Other (specify): _____
4	Community Clinic name (where reproductive health service was received)	
5	Type of RH service received during last visit	1 = Antenatal care (ANC) 2 = Family planning 3 = Postnatal care 4 = Counseling 5 = Referral 6 = Other (specify): _____
6	Village / Union	

Part 3: PSQ-18 Survey (Terminology-Adjusted Version)

This questionnaire retains the original PSQ-18 item structure and meaning. Only terminology has been modified by replacing 'medical care' with 'reproductive health (RH) services' and 'doctors' with 'healthcare providers'.

Response options:

1 = Strongly agree, 2 = Agree, 3 = Uncertain, 4 = Disagree, 5 = Strongly Disagree

No.	Questions	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1	The healthcare providers are good about explaining the reasons for medical tests.	1	2	3	4	5
2	I think the healthcare providers' office has everything needed to provide complete reproductive health services.	1	2	3	4	5

3	The reproductive healthcare I have been receiving is just about perfect.	1	2	3	4	5
4	Sometimes the healthcare providers make me wonder if their diagnosis is correct.	1	2	3	4	5
5	I feel confident that I can get the RH services I need without being set back financially.	1	2	3	4	5
6	When I go for RH services, they are careful to check everything when treating and examining me	1	2	3	4	5
7	I have to pay for more of my reproductive health care than I can afford.	1	2	3	4	5
8	I have easy access to the medical specialists I need	1	2	3	4	5
9	Where I get reproductive health services, people have to wait too long for emergency treatment.	1	2	3	4	5
10	The healthcare providers act too businesslike and impersonal toward me.	1	2	3	4	5
11	The healthcare providers treat me in a very friendly and courteous manner.	1	2	3	4	5
12	The healthcare providers sometimes hurry too much when they treat me.	1	2	3	4	5
13	The healthcare providers sometimes ignore what I tell them.	1	2	3	4	5
14	I have some doubts about the ability of healthcare providers who treat me	1	2	3	4	5
15	The healthcare providers usually spend plenty of time with me	1	2	3	4	5

16	I find it hard to get an appointment for RH services right away	1	2	3	4	5
17	I am dissatisfied with some things about the RH services I receive	1	2	3	4	5
18	I am able to get RH services whenever I need it.	1	2	3	4	5

বাংলাদেশের বগুড়া জেলায় সংস্কারকৃত কমিউনিটি ক্লিনিকগুলোর মাধ্যমে প্রজননক্ষম নারীদের প্রদানকৃত প্রজনন স্বাস্থ্য সেবার ব্যবহার, গ্রহণযোগ্যতা এবং সন্তুষ্টি অনুসন্ধান।

গবেষণার বিষয়: বাংলাদেশের বগুড়া জেলায় যমুনা (JAMUNA) প্রকল্পের অধীনে সংস্কারকৃত কমিউনিটি ক্লিনিকগুলোর মাধ্যমে প্রদত্ত প্রজনন স্বাস্থ্য সেবার ব্যবহার, গ্রহণযোগ্যতা ও সন্তুষ্টি।

অংশগ্রহণকারী: প্রজননক্ষম নারী (১৮-৪৯ বছর)।

সময়কাল: ২০-২৫ মিনিট।

উদ্দেশ্য: প্রজনন স্বাস্থ্য সেবা গ্রহণের ক্ষেত্রে গ্রহণযোগ্যতা, প্রতিবন্ধকতা এবং সেবাপ্রাপ্তি সহজকারী বা সহায়ক বিষয়সমূহ অনুসন্ধান করা।

অংশ ১: পরিচিতি ও সাক্ষাৎকার সংক্রান্ত তথ্য

ক্রমিক নং	প্রশ্ন	উত্তর / কোড
১	সাক্ষাৎকারের তারিখ	____/____/২০____ (দিন/মাস/বছর)
২	অংশগ্রহণকারী আইডি	
৩	সাক্ষাৎকার গ্রহণকারীর নাম	
৪	সাক্ষাৎকার শুরু করার সময়	
৫	সাক্ষাৎকার শেষ করার সময়	
৬	সাক্ষাৎকারের স্থান (পরিবেশের বিবরণ)	

অংশ ২: উত্তরদাতার পটভূমি সংক্রান্ত তথ্য

ক্রমিক নং	প্রশ্ন	উত্তর বিকল্প / কোড
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১	বয়স (পূর্ণ বছরে)	___ বছর
২	সর্বোচ্চ শিক্ষাগত যোগ্যতা	০=প্রাতিষ্ঠানিক শিক্ষা নেই ১=প্রাথমিক ২=মাধ্যমিক ৩=উচ্চ মাধ্যমিক/ডিপ্লোমা ৪=স্নাতক বা তদুর্ধ্ব
৩	প্রধান পেশা	১=গৃহিণী ২=দিনমজুর ৩=চাকরি ৪=স্বনিয়োজিত/ব্যবসা ৫=শিক্ষার্থী ৬=অন্যান্য
৪	প্রজনন স্বাস্থ্যসেবা গ্রহণকৃত কমিউনিটি ক্লিনিকের নাম	
৫	সর্বশেষ ভিজিটে প্রাপ্ত সেবার ধরন	১=প্রসব পূর্ব সেবা ২=পরিবার পরিকল্পনা ৩=প্রসবোত্তর সেবা ৪=কাউন্সেলিং ৫=রেফারাল ৬=অন্যান্য
৬	গ্রাম / ইউনিয়ন	

অংশ ৩: পিএসকিউ-১৮ জরিপ (PSQ-18 Survey)

নির্দেশাবলী: নিচের বিবৃতিগুলোতে প্রজনন স্বাস্থ্য সেবা সম্পর্কে মানুষের কিছু মতামত তুলে ধরা হয়েছে। দয়া করে প্রতিটি বিবৃতি মনোযোগ সহকারে পড়ুন এবং পাশে থাকা বিকল্পগুলো থেকে আপনার মতামত অনুযায়ী সঠিক সংখ্যাটি নির্বাচন করুন।

উত্তর প্রদানের বিকল্পসমূহ: ১ = দৃঢ়ভাবে একমত (Strongly agree) ২ = একমত (Agree) ৩ = নিশ্চিত নই (Uncertain) ৪ = একমত নই (Disagree) ৫ = দৃঢ়ভাবে একমত নই (Strongly disagree)

ক্রমিক	প্রশ্ন (Questions)	দৃঢ় ভাবে এক মত	এক মত	নিশ্চি ত নই	এক মত নই	দৃঢ় ভাবে এক মত নই
১	স্বাস্থ্যসেবা প্রদানকারীরা প্রয়োজনীয় শারীরিক পরীক্ষা-নিরীক্ষার (medical tests) কারণগুলো ভালোভাবে বুঝিয়ে বলেন।	১	২	৩	৪	৫

২	আমি মনে করি, পূর্ণাঙ্গ প্রজনন স্বাস্থ্য সেবা দেওয়ার জন্য স্বাস্থ্যসেবা প্রদানকারীদের অফিসে প্রয়োজনীয় সব ব্যবস্থা আছে।	১	২	৩	৪	৫
৩	আমি প্রজনন স্বাস্থ্যসেবা যেটা পাচ্ছি, সেটাতে আমি পুরোপুরি সন্তুষ্ট।	১	২	৩	৪	৫
৪	মাঝে মাঝে স্বাস্থ্যসেবা প্রদানকারীদের দেখে আমার সন্দেহ হয় যে তাদের রোগ নির্ণয় সঠিক কি না।	১	২	৩	৪	৫
৫	আমার বিশ্বাস, টাকার সমস্যায় না পড়েই আমি আমার প্রয়োজনীয় চিকিৎসাসেবা নিতে পারি।	১	২	৩	৪	৫
৬	আমি যখন প্রজনন স্বাস্থ্যসেবা নিতে যাই, তখন চিকিৎসা ও পরীক্ষা করার সময় তারা সবকিছু খুব সতর্কভাবে পরীক্ষা করেন।	১	২	৩	৪	৫
৭	প্রজনন স্বাস্থ্য সেবার জন্য আমাকে আমার সামর্থ্যের চেয়ে বেশি অর্থ খরচ করতে হয়।	১	২	৩	৪	৫
৮	আমার প্রয়োজনীয় চিকিৎসা বিশেষজ্ঞদের কাছে আমার সহজে পৌঁছানোর সুযোগ আছে।	১	২	৩	৪	৫
৯	আমি যে জায়গা থেকে প্রজনন স্বাস্থ্য সেবা নেই, সেখানে জরুরি চিকিৎসার জন্য মানুষকে অনেকক্ষণ অপেক্ষা করতে হয়।	১	২	৩	৪	৫
১০	স্বাস্থ্যসেবা প্রদানকারীরা আমার সাথে একটু বেশি রাড়ও আন্তরিকতাহীন আচরণ করেন।	১	২	৩	৪	৫

১১	স্বাস্থ্যসেবা প্রদানকারীরা আমার সাথে অত্যন্ত বন্ধুত্বপূর্ণ এবং ভদ্র আচরণ করেন।	১	২	৩	৪	৫
১২	চিকিৎসা দেওয়ার সময় স্বাস্থ্যসেবা প্রদানকারীরা মাঝে মাঝে খুব তাড়াতাড়ি করেন।	১	২	৩	৪	৫
১৩	স্বাস্থ্যসেবা প্রদানকারীরা মাঝে মাঝে আমার কথা উপেক্ষা করেন।	১	২	৩	৪	৫
১৪	আমাকে যারা চিকিৎসা দেন, সেই সব স্বাস্থ্যসেবা প্রদানকারীদের যোগ্যতা নিয়ে আমার কিছুটা সন্দেহ আছে।	১	২	৩	৪	৫
১৫	স্বাস্থ্যসেবা প্রদানকারীরা সাধারণত আমাকে যথেষ্ট সময় দেন।	১	২	৩	৪	৫
১৬	প্রজনন স্বাস্থ্য সেবার জন্য দ্রুত অ্যাপয়েন্টমেন্ট (সাক্ষাতের সময়) পাওয়া আমার জন্য কঠিন।	১	২	৩	৪	৫
১৭	আমি যে প্রজনন স্বাস্থ্য সেবা পাই, তার কিছু বিষয় নিয়ে আমি অসন্তুষ্ট।	১	২	৩	৪	৫
১৮	যখনই আমার প্রয়োজন হয়, আমি প্রজনন স্বাস্থ্য সেবা পেতে পারি।	১	২	৩	৪	৫

Exploring Utilization, Acceptability, and Satisfaction of Reproductive Health Services Among Women of Reproductive Age Delivered Through Rehabilitated Community Clinics in Bogura District, Bangladesh

Guideline for In-Depth Interview (IDI)

Participants: Women of reproductive age (18–49 years) who have received RH services at rehabilitated Community Clinics

Interview Duration: 45–60 minutes

Purpose: To explore acceptability, barriers, and facilitators influencing utilization of RH services

Opening Script (Mandatory)

- Introduce yourself and your affiliation
- Explain the purpose of the study and why the participant was selected
- Emphasize voluntary participation, confidentiality, and the right to withdraw
- Obtain informed consent
- Request permission for audio recording, and photo (will not include face)

Part 1: Identification and Interview related information

Sl. no.	Question	Codes/Answers
1	Date of the interview	_ _ _ / _ _ _ /20 _ _ _ Day/ Month/ Year
2	Participant ID:	
3	Name of the interviewer:	
4	Name of note taker:	
5	Interview starting time:	
6	Interview ending time:	
7	Place of interview [setting details]:	

Part 2: Background information of the respondent

Question 1: Can you tell me your age?

Question 2: Can you tell me your education background?

Question 3: Can you tell me what your occupation is?

Question 4: Can you tell me the name of a community clinic you regularly visit?

Question 5: Can you tell me your village name?

Part 3: Interview Process

SECTION 1: SERVICE USE CONTEXT

(Links to utilization patterns)

Core Question 1.1

Can you describe what type of services are provided in the community clinic?

Can you describe what type of services you have received from the community clinic?

Can you describe the reproductive health services you have received from this Community Clinic?

(Intervention Coherence)

Probes (use selectively):

- Type of service received (ANC, FP, counseling, postnatal care, referral)
- Frequency and duration of service use
- first visit or repeated use
- Reasons for choosing this clinic over other options

Core Question 1.2

What was the reason for your most recent visit to this clinic?

Can you describe the reason for your most recent visit to this clinic?

Probes:

- Planned vs. urgent visit
- Whether the visit was related to pregnancy, spacing, or general RH concerns
- Whether the visit met the intended purpose

Core Question 1.3

When was the most recent time that you visited this Community Clinic?

Probe :

- Last week / last month / during pregnancy / during flooding season

Core Question 1.4

After you arrived at the clinic, what was the process you went through to seek care?

Follow-up Probes (use selectively):

- Where did you go first after arriving?

- Did anyone guide you or give instructions? Who?
- How long did you wait before seeing the provider?
- How did you feel about the waiting time?
- How did staff or providers behave toward you while you were waiting?
- Were you informed about what would happen next?

Core Question 1.5

How was your experience while waiting and during the consultation?

Probes:

- Comfort of seating and space
- Cleanliness and ventilation
- Privacy while discussing reproductive health issues
- Any difficulties or positive experiences

Core Question 1.6

How did you learn about the services provided at this clinic?

Probes:

- Community outreach
- word of mouth
- Media
- health workers

SECTION 2: COMMUNITY CLINIC REHABILITATION & JAMUNA INTERVENTION

(Core implementation research section)

Core Question 2.1 – Awareness of Rehabilitation

Have you noticed any changes or improvements at this Community Clinic in recent times?

Probes:

- Physical changes to the building or rooms
- Waiting area, seating, cleanliness
- Water, sanitation, electricity, fans, lighting
- Privacy arrangements
- Any new equipment, posters, or layout changes

Core Question 2.2 – Before and After Comparison

Can you describe how the clinic was before these changes and how it is now?

Probes:

- Differences in comfort, safety, or cleanliness
- Ease of using services before vs after
- Changes during floods or rainy seasons

Core Question 2.3 – Attribution to JAMUNA / BDRCS

Do you know who supported or carried out these improvements at the clinic?

Probes:

- Awareness of JAMUNA Project
- Awareness of Bangladesh Red Crescent Society (BDRCS)
- Information shared by health workers

Core Question 2.4 – Perceived Usefulness of Rehabilitation

In your opinion, how useful are these clinic improvements for women seeking reproductive health services?

Probes:

- Comfort during waiting and consultation
- Privacy for sensitive discussions
- Feeling respected or safe
- Willingness to return because of improvements

Core Question 2.5 – Impact on Service Use

Have these improvements influenced how often you or other women use this clinic?

Probes:

- Increased or decreased visits
- Reduced hesitation
- Use during floods or emergencies

Core Question 2.6 – Remaining Gaps

Despite these improvements, are there still problems or limitations at the clinic?

Probes:

- Missing services
- Staff or medicine availability

- Flood-related disruptions
-

SECTION 3: ACCEPTABILITY OF RH SERVICES

Core Question 3.1 (Burden)

How was your experience of accessing and using services at this clinic?

Probes:

- Distance and transportation
- Impact of flooding or seasonal barriers
- Waiting time and clinic hours
- Physical or emotional strain during visits

Core Question 3.2 (Affective Attitude)

What do you feel about the reproductive health services you received the last time at this clinic?

Please share your experiences with us. Give an example of why you feel this way.

Probes:

- Feelings of comfort, trust, fear, embarrassment, respect
- First impressions of the clinic environment
- Emotional response to provider behavior
- Experiences that made the service feel welcoming or discouraging

Core Question 3.3 Perceived Effectiveness

How well do these services address your reproductive health needs?

Probes:

- Improvement in concerns
- Trust in provider skills
- Comparison with past experiences

Core Question 3.5 Ethicality

Do these services align with your personal, cultural, or family beliefs?

Probes:

- Privacy and confidentiality
- Comfort discussing RH topics
- Gender of provider
- Influence of family or community norms

Core Question 3.6 Opportunity Costs

(Trade-offs required to seek care)

Core Question

Did coming to the clinic require you to give up anything important?

Probes:

- Household responsibilities
- Work or income loss
- Childcare arrangements
- Need for permission or accompaniment

Core Question 3.7 Self-Efficacy

(Confidence in using services)

Core Question

How confident do you feel about using this clinic for reproductive health services in the future?

Probes:

- Ability to visit independently
- Confidence in asking questions
- Knowledge of available services
- Past experiences affecting confidence

SECTION 4: BARRIERS AND FACILITATORS

Core Question 4.1

Can you describe the factors that make it easier for women like you to use reproductive health services at this clinic?

Probes:

- Facility improvements
- Provider behavior
- Community support
- Awareness and outreach

Core Question 4.2

Can you describe the factors that make it difficult for women to use these services?

Probes:

- Environmental barriers (flooding, distance)
- Health system issues (staff, supplies)
- Social or family constraints
- Safety or mobility concerns

Core Question 4.3

Have you ever hesitated to visit the community clinic? Why?

Have you ever heard anyone else hesitate to visit the community clinic? Why?

SECTION 5: OVERALL ACCEPTABILITY & RECOMMENDATIONS

Core Question 5.1

Overall, how would you describe your experience with the reproductive health services provided at this Community Clinic?

Probes:

- Reasons for overall judgment
- Comparison with expectations
- Willingness to return or recommend

Core Question 5.2

From your perspective, what changes could be made to improve reproductive health services for women in your community?

Probes:

- Infrastructure
- Service availability
- Provider communication
- Privacy and dignity

Core Question 5.3

Are there services you expected but were not available?

SECTION 6 : CLIMATE HAZARDS & DISASTER CONTEXT

Core Question 6.1 Exposure to Climate Hazards

What kinds of climate-related events or disasters do people in your community usually face?

Probes:

- Flooding, river erosion
- How often these events occur

Core Question 6.2 – Recent Climate Event

When was the most recent time you or your household experienced a climate-related event?

Probes:

- Approximate timing (last month, last year, during pregnancy, monsoon season)
- Type of event (flood, erosion, storm, heat)
- Duration and severity

Core Question 6.3 – Impact on Daily Life and Health

How did this event affect your daily life or health needs?

Probes:

- Displacement or damage to home
- Loss of income or livelihood
- Health problems or stress
- Increased need for healthcare services

Core Question 6.4 – Impact on Clinic Access

How did this climate event affect your ability to visit the Community Clinic?

Probes:

- Difficulty traveling to the clinic
- Clinic closure or reduced services
- Delay or cancellation of visits
- Needing alternative care

Core Question 6.5 – Role of Rehabilitated Clinic During Disasters

During or after such climate events, how helpful was this Community Clinic for you or other women?

Probes:

- Whether the clinic remained open

- Physical safety of the clinic building
- Availability of RH services during floods
- Whether rehabilitation helped the clinic function better

SECTION 6: CLOSING

- Is there anything else you would like to share?
- Thank the participant and close respectfully

বাংলাদেশের বগুড়া জেলায় সংস্কারকৃত কমিউনিটি ক্লিনিকগুলোর মাধ্যমে প্রজননক্ষম নারীদের প্রদানকৃত প্রজনন স্বাস্থ্য সেবার ব্যবহার, গ্রহণযোগ্যতা এবং সন্তুষ্টি অনুসন্ধান।
ইন-ডেপথ ইন্টারভিউ (IDI) নির্দেশিকা

অংশগ্রহণকারী:

প্রজনন বয়সী নারী (১৮–৪৯ বছর), যারা পুনর্বাসিত কমিউনিটি ক্লিনিক থেকে প্রজনন স্বাস্থ্যসেবা গ্রহণ করেছেন

সাক্ষাৎকারের সময়কাল:

প্রায় ৪৫–৬০ মিনিট

উদ্দেশ্য:

এই ইন-ডেপথ সাক্ষাৎকারগুলোর উদ্দেশ্য হলো পুনর্বাসিত কমিউনিটি ক্লিনিকের মাধ্যমে প্রদত্ত প্রজনন স্বাস্থ্যসেবার গ্রহণযোগ্যতা, সেবা গ্রহণে প্রতিবন্ধকতা এবং সহায়ক উপাদানসমূহ অন্বেষণ করা, যা সেবার ব্যবহারে প্রভাব ফেলে।

সাক্ষাৎকার শুরুর বক্তব্য (আবশ্যিক)

নিজের নাম ও পরিচয় দিন

গবেষণার উদ্দেশ্য ও অংশগ্রহণকারী নির্বাচনের কারণ ব্যাখ্যা করুন

স্বৈচ্ছাসেবী অংশগ্রহণ, গোপনীয়তা এবং যেকোনো সময় অংশগ্রহণ প্রত্যাহারের অধিকার জোর দিয়ে বলুন

অবগত সম্মতি গ্রহণ করুন

অডিও রেকর্ড করার অনুমতি নিন

অংশ ১: পরিচিতি ও সাক্ষাৎকার সংক্রান্ত তথ্য

ক্রমিক নং	প্রশ্ন	উত্তর / কোড
১	সাক্ষাৎকারের তারিখ	____/____/২০____ (দিন/মাস/বছর)
২	অংশগ্রহণকারী আইডি	
৩	সাক্ষাৎকার গ্রহণকারীর নাম	
৪	নোট গ্রহণকারীর নাম	
৫	সাক্ষাৎকার শুরু করার সময়	

৬	সাক্ষাৎকার শেষ করার সময়	
৭	সাক্ষাৎকারের স্থান (পরিবেশের বিবরণ)	

অংশ ২: উত্তরদাতার পটভূমি সংক্রান্ত তথ্য

প্রশ্ন ১: দয়া করে আপনার বয়সটা বলবেন কি?

প্রশ্ন ২: আপনি কতদূর পড়াশোনা করেছেন?

প্রশ্ন ৩: আপনার পেশা কী, তা বলবেন কি?

প্রশ্ন ৪: আপনি নিয়মিত যে কমিউনিটি ক্লিনিকে যান, তার নামটা বলবেন কি?

প্রশ্ন ৫: আপনার গ্রামের নামটা বলবেন কি?

পর্ব ৩: সাক্ষাৎকার প্রক্রিয়া

সেকশন ১: সেবা ব্যবহারের প্রেক্ষাপট

মূল প্রশ্ন ১.১

এই কমিউনিটি ক্লিনিকে কী কী ধরনের সেবা দেওয়া হয় তা কি বলতে পারেন?

আপনি এই কমিউনিটি ক্লিনিক থেকে কী কী সেবা নিয়েছেন?

আপনি এই ক্লিনিক থেকে প্রজনন স্বাস্থ্য বিষয়ক কী কী সেবা নিয়েছেন তা কি বর্ণনা করতে পারেন?

সহায়ক প্রশ্ন

সেবার ধরন (গর্ভকালীন সেবা/ANC, পরিবার পরিকল্পনা/FP, পরামর্শ, প্রসব-পরবর্তী সেবা, রেফারেল)

কতবার এবং কতদিন ধরে সেবা নিচ্ছেন

প্রথমবার এসেছেন নাকি নিয়মিত আসেন

অন্য কোথাও না গিয়ে এই ক্লিনিকটি বেছে নেওয়ার কারণ

*মূল প্রশ্ন ১.২

আপনার শেষবার এই ক্লিনিকে আসার কারণ কী ছিল?

শেষবার আসার কারণটি কি একটু বিস্তারিত বলবেন?

সহায়ক প্রশ্ন

এটি কি পূর্বপরিকল্পিত ছিল নাকি জরুরি প্রয়োজনে আসা?

ভিজিটটি কি গর্ভাবস্থা, জন্মবিরতিকরণ, নাকি সাধারণ প্রজনন স্বাস্থ্য সমস্যার সাথে সম্পর্কিত ছিল?

আসার উদ্দেশ্য পূরণ হয়েছে কি না?

মূল প্রশ্ন ১.৩

আপনি শেষ কবে এই কমিউনিটি ক্লিনিকে এসেছিলেন?

সহায়ক প্রশ্ন (Probes):

গত সপ্তাহে / গত মাসে / গর্ভাবস্থায় / বন্ধ্যার সময় ।

*মূল প্রশ্ন ১.৪

ক্লিনিকে পৌঁছানোর পর সেবা পাওয়ার জন্য আপনাকে কী কী করতে হয়েছে বা কোন প্রক্রিয়ার মধ্য দিয়ে যেতে হয়েছে?

সহায়ক প্রশ্ন

পৌঁছানোর পর প্রথমে কোথায় গিয়েছিলেন?

কেউ কি আপনাকে পথ দেখিয়েছিল বা নির্দেশনা দিয়েছিল? কে দিয়েছিলেন?

ডাক্তার বা সেবাদাতাকে দেখানোর আগে কতক্ষণ অপেক্ষা করতে হয়েছিল?

এই অপেক্ষার সময়টি আপনার কেমন লেগেছে?

অপেক্ষা করার সময় স্টাফ বা সেবাদাতারা আপনার সাথে কেমন আচরণ করেছিলেন?

এরপর কী করতে হবে, সে সম্পর্কে কি আপনাকে জানানো হয়েছিল?

মূল প্রশ্ন ১.৫

অপেক্ষা করা এবং পরামর্শ নেওয়ার সময় আপনার অভিজ্ঞতা কেমন ছিল?

সহায়ক প্রশ্ন

বসার জায়গা এবং স্থানের আরামদায়কতা ।

পরিষ্কার-পরিচ্ছন্নতা এবং আলো-বাতাসের ব্যবস্থা ।

প্রজনন স্বাস্থ্য নিয়ে কথা বলার সময় গোপনীয়তা বা প্রাইভেসি রক্ষা ।

কোনো অসুবিধা বা ভালো লাগার অভিজ্ঞতা ।

মূল প্রশ্ন ১.৬

এই ক্লিনিকে কী কী সেবা পাওয়া যায়, সে সম্পর্কে আপনি কীভাবে জেনেছেন?

সহায়ক প্রশ্ন

কমিউনিটি প্রচার বা উঠান বৈঠক ।

লোকমুখে শোনা (প্রতিবেশী/আত্মীয়) ।

গণমাধ্যম (রেডিও/পোস্টার) ।

স্বাস্থ্যকর্মী

সেকশন ২: কমিউনিটি ক্লিনিক পুনর্বাসন ও যমুনা (JAMUNA) প্রকল্পের কার্যক্রম

মূল প্রশ্ন ২.১ – পুনর্বাসন সম্পর্কে সচেতনতা

আপনি কি ইদানীং এই কমিউনিটি ক্লিনিকে কোনো পরিবর্তন বা উন্নতি লক্ষ্য করেছেন?

সহায়ক প্রশ্ন

ভবন বা রুমের বাহ্যিক পরিবর্তন।
অপেক্ষার স্থান, বসার ব্যবস্থা, পরিষ্কার-পরিচ্ছন্নতা।
পানি, স্যানিটেশন (টয়লেট), বিদ্যুৎ, ফ্যান, লাইটিং।
গোপনীয়তা বা প্রাইভেসির ব্যবস্থা।
নতুন কোনো সরঞ্জাম, পোস্টার বা সাজসজ্জার পরিবর্তন।

মূল প্রশ্ন ২.২ – আগে ও পরের তুলনা

এই পরিবর্তনগুলোর আগে ক্লিনিকটি কেমন ছিল এবং এখন কেমন—তা কি বর্ণনা করতে পারেন?

সহায়ক প্রশ্ন

আরাম, নিরাপত্তা বা পরিচ্ছন্নতার পার্থক্য।
আগের তুলনায় এখন সেবা নেওয়া কতটা সহজ।
বন্যা বা বর্ষাকালে কোনো পরিবর্তন হয়েছে কি না।

মূল প্রশ্ন ২.৩ – যমুনা/বিডিআরসিএস (BDRCS)-এর অবদান

আপনি কি জানেন ক্লিনিকের এই উন্নতিগুলো কারা করেছে বা সহযোগিতা করেছে?

সহায়ক প্রশ্ন

যমুনা (JAMUNA) প্রজেক্ট সম্পর্কে জানেন কি না।
বাংলাদেশ রেড ক্রিসেন্ট সোসাইটি (BDRCS) সম্পর্কে জানেন কি না।
স্বাস্থ্যকর্মীদের মাধ্যমে কোনো তথ্য পেয়েছেন কি না।

মূল প্রশ্ন ২.৪ – পুনর্বাসনের উপযোগিতা

আপনার মতে, প্রজনন স্বাস্থ্য সেবা নিতে আসা নারীদের জন্য এই উন্নতিগুলো কতটা উপকারী বা কাজে লাগছে?

সহায়ক প্রশ্ন

অপেক্ষা এবং পরামর্শের সময় স্বাচ্ছন্দ্য বা আরাম।
স্পর্শকাতর বিষয়ে কথা বলার জন্য গোপনীয়তা।
সম্মান বা নিরাপত্তা বোধ করা।

উন্নয়নের কারণে পুনরায় আসার আগ্রহ।

মূল প্রশ্ন ২.৫ – সেবা ব্যবহারের ওপর প্রভাব

এই উন্নতিগুলো কি আপনার বা অন্য নারীদের ক্লিনিকে আসার আগ্রহ বাড়িয়ে দিয়েছে?

সহায়ক প্রশ্ন

আসা-যাওয়া বেড়েছে না কমেছে।

দ্বিধা বা জড়তা কমেছে কি না।

বন্যা বা জরুরি অবস্থায় ব্যবহার।

মূল প্রশ্ন ২.৬ – বিদ্যমান ঘাটতি

এত উন্নতির পরেও, ক্লিনিকে কি এখনো কোনো সমস্যা বা সীমাবদ্ধতা রয়ে গেছে?

সহায়ক প্রশ্ন

কোনো সেবা পাওয়া যাচ্ছে না এমন।

স্টাফ বা ঔষধের প্রাপ্যতা।

বন্যা সংক্রান্ত সমস্যা।

সেকশন ৩: প্রজনন স্বাস্থ্য সেবার গ্রহণযোগ্যতা

মূল প্রশ্ন ৩.১ (অভিগম্যতা/ভোগান্তি)

এই ক্লিনিকে আসা এবং সেবা ব্যবহার করার অভিজ্ঞতা আপনার কেমন ছিল?

সহায়ক প্রশ্ন

দূরত্ব এবং যাতায়াত ব্যবস্থা

বন্যা বা ঋতুগত বাধার প্রভাব

অপেক্ষার সময় এবং ক্লিনিক খোলার সময়সূচি

আসার সময় শারীরিক বা মানসিক চাপ

মূল প্রশ্ন ৩.২ (আবেগীয় মনোভাব)

গতবার এই ক্লিনিক থেকে প্রজনন স্বাস্থ্য সেবা নিয়ে আপনার অনুভূতি কেমন ছিল?

আপনার অভিজ্ঞতা আমাদের সাথে শেয়ার করুন। কেন এমন মনে হয়েছে তার একটি উদাহরণ দিন।

সহায়ক প্রশ্ন

আরাম, বিশ্বাস, ভয়, লজ্জা বা সম্মানের অনুভূতি ।
ক্লিনিকের পরিবেশ দেখে প্রথম ধারণা ।
সেবাদাতার আচরণের প্রতি প্রতিক্রিয়া ।
এমন কোনো অভিজ্ঞতা যা আপনাকে আপন করে নিয়েছে বা নিরুৎসাহিত করেছে ।

মূল প্রশ্ন ৩.৩ (কার্যকারিতা)

আপনার মতে, এই সেবাগুলো আপনার প্রজনন স্বাস্থ্যের প্রয়োজন কতটুকু মেটাতে পেরেছে?

সহায়ক প্রশ্ন

সমস্যার বা উদ্বেগের উন্নতি
সেবাদাতার দক্ষতার ওপর আস্থা
অতীতের অভিজ্ঞতার সাথে তুলনা

মূল প্রশ্ন ৩.৫ (নৈতিকতা ও মূল্যবোধ)
এই সেবাগুলো কি আপনার ব্যক্তিগত, সাংস্কৃতিক বা পারিবারিক বিশ্বাস/মূল্যবোধের সাথে
সামঞ্জস্যপূর্ণ?

সহায়ক প্রশ্ন

গোপনীয়তা এবং বিশ্বস্ততা রক্ষা
প্রজনন স্বাস্থ্য বিষয়ে কথা বলতে স্বাচ্ছন্দ্যবোধ ।
সেবাদাতার লিঙ্গ (নারী/পুরুষ) ।
পরিবার বা সমাজের রীতিনীতির প্রভাব ।

মূল প্রশ্ন ৩.৬ (সুযোগ ব্যয়)

এই ক্লিনিকে আসার জন্য আপনাকে কি জরুরি কোনো কাজ বা দায়িত্ব বাদ দিতে হয়েছে?

সহায়ক প্রশ্ন

ঘরের কাজকর্ম
কাজ বা আয়ের ক্ষতি
বাচ্চা দেখাশোনার ব্যবস্থা
অনুমতি নেওয়া বা কাউকে সাথে আনার প্রয়োজন

মূল প্রশ্ন ৩.৭ (আত্মবিশ্বাস/সক্ষমতা)

ভবিষ্যতে প্রজনন স্বাস্থ্য সেবার জন্য এই ক্লিনিকটি ব্যবহার করার ব্যাপারে আপনি কতটা
আত্মবিশ্বাসী?

সহায়ক প্রশ্ন

একা আসার সক্ষমতা ।

প্রশ্ন করার সাহস বা আত্মবিশ্বাস ।

কী কী সেবা পাওয়া যায় সে সম্পর্কে জ্ঞান ।

অতীতের অভিজ্ঞতা যা আত্মবিশ্বাস বাড়িয়েছে বা কমিয়েছে ।

সেকশন ৪: বাধা এবং সহায়ক সমূহ

মূল প্রশ্ন ৪.১

আপনার মতো নারীদের জন্য এই ক্লিনিক থেকে প্রজনন স্বাস্থ্য সেবা নেওয়াটা সহজ করে দেয়—
এমন বিষয়গুলো কী কী?

সহায়ক প্রশ্ন

ক্লিনিকের অবকাঠামোগত উন্নতি

সেবাদাতার আচরণ ।

কমিউনিটি বা সমাজের সহযোগিতা

সচেতনতা এবং প্রচার

মূল প্রশ্ন ৪.২

নারীদের জন্য এই সেবাগুলো ব্যবহার করা কঠিন করে তোলে—এমন বিষয়গুলো কী কী?

সহায়ক প্রশ্ন

পরিবেশগত বাধা (বন্যা, দূরত্ব)

স্বাস্থ্যসেবা ব্যবস্থার সমস্যা (স্টাফ, সরঞ্জাম)

সামাজিক বা পারিবারিক বাধা

নিরাপত্তা বা চলাচলের সমস্যা

মূল প্রশ্ন ৪.৩

আপনি কি কখনো এই কমিউনিটি ক্লিনিকে আসতে দ্বিধা করেছেন? কেন?

আপনি কি অন্য কাউকে এই ক্লিনিকে আসতে দ্বিধা করতে শুনেছেন? কেন?

সেকশন ৫: সামগ্রিক গ্রহণযোগ্যতা ও সুপারিশ

মূল প্রশ্ন ৫.১

সব মিলিয়ে, এই কমিউনিটি ক্লিনিকের প্রজনন স্বাস্থ্য সেবা সম্পর্কে আপনার অভিজ্ঞতা কেমন ছিল?

সহায়ক প্রশ্ন

এমন মতামতের কারণ

প্রত্যাশার সাথে তুলনা

আবার আসার বা অন্যদের সুপারিশ করার ইচ্ছা

মূল প্রশ্ন ৫.২

আপনার মতে, এলাকার নারীদের প্রজনন স্বাস্থ্য সেবার মান বাড়াতে এখানে কী কী পরিবর্তন করা দরকার?

সহায়ক প্রশ্ন

অবকাঠামো।

সেবার প্রাপ্যতা।

সেবাদাতার যোগাযোগ বা কথাবার্তা।

গোপনীয়তা এবং সম্মান

মূল প্রশ্ন ৫.৩

এমন কোনো সেবা কি ছিল যা আপনি পাওয়ার আশা করেছিলেন কিন্তু পাননি?

সেকশন ৬: জলবায়ু ঝুঁকি এবং দুর্যোগ প্রেক্ষাপট

মূল প্রশ্ন ৬.১ – জলবায়ু ঝুঁকির সম্মুখীন হওয়া

আপনার এলাকার মানুষ সাধারণত কী ধরনের প্রাকৃতিক দুর্যোগ বা জলবায়ুজনিত ঘটনার সম্মুখীন হয়?

সহায়ক প্রশ্ন

বন্যা, নদী ভাঙন।

এই ঘটনাগুলো কত ঘন ঘন ঘটে

মূল প্রশ্ন ৬.২ – সাম্প্রতিক দুর্যোগের অভিজ্ঞতা

শেষ কবে আপনি বা আপনার পরিবার কোনো প্রাকৃতিক দুর্যোগের শিকার হয়েছিলেন?

সহায়ক প্রশ্ন

আনুমানিক সময় (গত মাসে, গত বছর, গর্ভাবস্থায়, বর্ষাকালে) ।
দুর্যোগের ধরন (বন্যা, ভাঙন, ঝড়, তাপপ্রবাহ) ।
স্থায়িত্ব এবং তীব্রতা

মূল প্রশ্ন ৬.৩ – দৈনন্দিন জীবন ও স্বাস্থ্যের ওপর প্রভাব
এই দুর্যোগ আপনার দৈনন্দিন জীবন বা স্বাস্থ্যের ওপর কীভাবে প্রভাব ফেলেছিল?

সহায়ক প্রশ্ন

বাসস্থান পরিবর্তন বা ঘরবাড়ির ক্ষতি
আয় বা জীবিকার ক্ষতি
শারীরিক সমস্যা বা মানসিক চা
স্বাস্থ্যসেবার প্রয়োজনীয়তা বেড়ে যাওয়া

মূল প্রশ্ন ৬.৪ – ক্লিনিকে যাতায়াতের ওপর প্রভাব

এই দুর্যোগ আপনার কমিউনিটি ক্লিনিকে আসার ক্ষেত্রে কীভাবে প্রভাব ফেলেছিল?

সহায়ক প্রশ্ন

ক্লিনিকে আসার পথে যাতায়াতের সমস্যা
ক্লিনিক বন্ধ থাকা বা সেবা কমে যাওয়া
আসতে দেরি হওয়া বা না আসা
বিকল্প চিকিৎসার প্রয়োজন হওয়া

মূল প্রশ্ন ৬.৫ – দুর্যোগকালীন সময়ে পুনর্বাসিত ক্লিনিকের ভূমিকা
দুর্যোগের সময় বা পরে, এই কমিউনিটি ক্লিনিকটি আপনার বা অন্য নারীদের জন্য কতটা সহায়ক ছিল?

সহায়ক প্রশ্ন

ক্লিনিকটি খোলা ছিল কি না
ক্লিনিক ভবনের নিরাপত্তা
বন্যার সময় প্রজনন স্বাস্থ্য সেবা পাওয়া গেছে কি না
মেরামত বা সংস্কারের ফলে ক্লিনিকটি আরও ভালোভাবে কাজ করেছে কি না

সমাপ্তি

আপনি কি আরও কিছু বলতে বা জানাতে চান?
অংশগ্রহণকারীকে ধন্যবাদ জানিয়ে সম্মান প্রদর্শনপূর্বক শেষ করুন ।

Semi - Structured Non-Participant Observation Checklist

Reproductive Health Services at Rehabilitated Community Clinics (JAMUNA Project)

This semi-structured non-participant observation guide is designed to systematically document the physical environment, service delivery processes, privacy arrangements, and provider–client interactions at rehabilitated Community Clinics. Instead of marking responses as “Yes” or “No,” observers will provide detailed narrative descriptions under each predefined indicator based on direct observation during routine clinic operations.

The guide ensures consistency across clinics while allowing flexibility to capture contextual details, unanticipated issues, and observable signs of rehabilitation. The observation is intended for descriptive and contextual documentation only; no numerical scoring or composite indices will be calculated.

Clinic ID: _____. Date: _____ Observer: _____

Indicator	Observation Notes (Describe what you see)
Physical accessibility of the clinic (location, signage, ease of entry)	
General cleanliness of the clinic environment	
Condition of waiting area (space, cleanliness, seating)	
Availability and adequacy of seating for clients	
Lighting and ventilation in waiting and consultation areas	
Triage Area (for pregnant women, breast feeding corner)	
Water, sanitation, and hygiene facilities (toilet, handwashing)	
Use of waiting space (crowding, comfort, privacy)	
Privacy arrangements during RH consultations (room, screens, noise)	
Availability of RH services on the day of visit (ANC, FP, counseling)	

Visible signs of rehabilitation or recent improvements	
Other observations (any issues or strengths not anticipated above)	

আধা-কাঠামোগত নন-পার্টিসিপেন্ট (অংশগ্রহণকারী বিহীন) পর্যবেক্ষণ চেকলিস্টসংস্কারকৃত কমিউনিটি ক্লিনিকগুলোতে প্রজনন স্বাস্থ্যসেবা (যমুনা প্রকল্প)

এই আধা-কাঠামোগত নন-পার্টিসিপেন্ট (অংশগ্রহণকারী বিহীন) পর্যবেক্ষণ গাইডটি সংস্কারকৃত কমিউনিটি ক্লিনিকগুলোর ভৌত পরিবেশ, সেবা প্রদানের প্রক্রিয়া, গোপনীয়তা রক্ষার ব্যবস্থা এবং সেবাদানকারী-সেবাগ্রহীতার মিথস্ক্রিয়া নিয়মতান্ত্রিকভাবে নথিভুক্ত করার জন্য তৈরি করা হয়েছে। প্রতিক্রিয়াগুলো "হ্যাঁ" বা "না" হিসেবে চিহ্নিত করার পরিবর্তে, পর্যবেক্ষকরা ক্লিনিকের স্বাভাবিক কার্যক্রম চলাকালীন সরাসরি পর্যবেক্ষণের ভিত্তিতে প্রতিটি পূর্বনির্ধারিত সূচকের অধীনে বিস্তারিত বর্ণনামূলক বিবরণ প্রদান করবেন।

এই গাইডটি বিভিন্ন ক্লিনিকের তথ্যের মধ্যে ধারাবাহিকতা নিশ্চিত করে এবং সেইসাথে প্রেক্ষাপট-ভিত্তিক বিস্তারিত তথ্য, অপ্রত্যাশিত সমস্যা এবং সংস্কারের দৃশ্যমান চিহ্নগুলো ধারণ করার নমনীয়তা প্রদান করে। পর্যবেক্ষণটি শুধুমাত্র বর্ণনামূলক এবং প্রেক্ষাপট-ভিত্তিক নথিকরণের উদ্দেশ্যে তৈরি; এক্ষেত্রে কোনো সংখ্যাগত স্কোরিং বা যৌগিক সূচক গণনা করা হবে না।

ক্লিনিক আইডি: _____ তারিখ: _____ পর্যবেক্ষকের নাম: _____

নির্দেশক	পর্যবেক্ষণ নোট (আপনি যা দেখছেন তা বর্ণনা করুন)
ক্লিনিকের শারীরিক প্রবেশযোগ্যতা (অবস্থান, সাইনেজ, প্রবেশের সহজতা)	
ক্লিনিক পরিবেশের সাধারণ পরিচ্ছন্নতা	
ওয়েটিং এরিয়ার অবস্থা (স্থান, পরিচ্ছন্নতা, বসার ব্যবস্থা)	
ক্লায়েন্টদের জন্য বসার জায়গার প্রাপ্যতা এবং পর্যাপ্ততা	
ওয়েটিং এবং কনসালটেশন এরিয়ার আলো এবং বায়ু চলাচল	
ট্রায়াজ এরিয়া (গর্ভবতী মহিলাদের জন্য, স্তন্যদান কর্তার)	

পানি, স্যানিটেশন এবং স্বাস্থ্যবিধি সুবিধা (টয়লেট, হাত ধোয়া)	
ওয়েটিং স্পেসের ব্যবহার (জেনাকীর্ণতা, আরাম, গোপনীয়তা)	
প্রজনন স্বাস্থ্য (RH) পরামর্শের সময় গোপনীয়তা ব্যবস্থা (কক্ষ, পর্দা, শব্দ)	
পরিদর্শনের দিনে প্রজনন স্বাস্থ্য (RH) সেবার প্রাপ্যতা (ANC, FP, পরামর্শ)	
সংস্কার বা সাম্প্রতিক উন্নতির দৃশ্যমান লক্ষণ	
অন্যান্য পর্যবেক্ষণ (উপরে উল্লেখ করা হয়নি এমন কোনো সমস্যা বা ইতিবাচক দিক)	

Appendix B: Informed Consent Form

Exploring Utilization, Acceptability, and Satisfaction of Reproductive Health Services Among Women of Reproductive Age Delivered Through Rehabilitated Community Clinics in Bogura District, Bangladesh: A Mixed-Methods Implementation Research Study Under the JAMUNA Project

Information Sheet

Introduction: My name is [_____], and I am coming with James P Grant, School of Public Health, Brac University. We are conducting a research study under the JAMUNA Project in collaboration with the Swiss Red Cross and the Bangladesh Red Crescent Society to understand women's experiences with reproductive health services provided through rehabilitated Community Clinics in Bogura District, Bangladesh.

Research Team

This study is conducted by Pau Sian Muang (Principal Investigator), Dr. Mrityika Barua and affiliated researchers from the James P Grant School of Public Health (JPGSPH), BRAC University.

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Aim: The purpose of this study is to explore how women use and experience reproductive health services at rehabilitated Community Clinics, including service utilization, acceptability, satisfaction, and challenges to service use. The findings will help improve service delivery and inform future programs in climate-vulnerable settings

Justification of participation: You are being invited to participate because you have received reproductive health services from this Community Clinic. Your experiences and opinions are important for understanding how these services are delivered in real-world settings.

Procedure: If you agree to participate, you may be asked to take part in:

- A survey lasting approximately 20–25 minutes, or
- An in-depth interview lasting approximately 45–60 minutes (for selected participants)

Questions will focus on your experiences with reproductive health services. With your permission, interviews may be audio-recorded. No photographs will be taken unless separately requested and approved. If you allow, we will take photographs as part of our interview session but no face will be shown.

Benefits of participation: There is no direct personal benefit from participating in this study. However, the information you provide will help improve reproductive health services for women living in similar communities.

Compensation: Your participation in this study is entirely voluntary. You do not need to pay us for taking part in this study. Similarly, no compensation will be given to you for participating in the interview.

Risk: This study involves minimal risk. Some questions may be sensitive and may cause mild discomfort. You may skip any question or stop the interview at any time without any consequences.

Confidentiality and anonymity: All information you provide will be kept confidential. Your name will not appear in any report or publication. Data will be stored securely and accessed only by the research team. Findings may be published or shared for academic and programmatic purposes, but no individual participant will be identifiable. No identifiable or raw data will be shared with any foreign researchers. If findings are published in peer-reviewed international journals, only aggregated and anonymized results will be disseminated.

Nature of participation: Your participation is completely voluntary. You may choose not to participate or withdraw at any time without affecting your access to healthcare services or any benefits you are entitled to. You will get 24 hours to withdraw your interview after it is recorded.

Declaration of Artificial Intelligence (AI) Usage

To explore literatures and deep understanding of the design, artificial intelligence (AI) was utilized. AI was also used for tools translation. But AI will not be used for data collection, analysis and writing phases of this research.

Contact information: If you have any questions about this study, please contact:

Pau Sian Muang

James P Grant School of Public Health (JPGSPH), BRAC University

Phone: + 8801794676939, Email: pau.sian.muang@g.bracu.ac.bd

For ethical concerns, you may contact:

Institutional Review Board (IRB), James P Grant School of Public Health (JPGSPH), BRAC University

Phone: + 8801993379512. Email: irb-jpgsph@bracu.ac.bd

Consent Form

I have read (or have had read to me) the information above. I understand the purpose of the study and my role as a participant. I understand that my participation is voluntary and that I may withdraw at any time without any negative consequences.

By signing or providing my thumbprint below, I indicate that I agree to participate in this study.

Thank you for your cordial cooperation.

Do you give permission for the interview to be audio recorded?	Yes	No
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Please note that at any point during the interview, you can ask the interviewer to turn off the recording device.

Do you give permission to share your findings?	Yes	No
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Do you give permission to take photos?	Yes	No
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Do you give permission to share the photos?	Yes	No
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Do you give permission to be contacted again if clarification is needed?	Yes	No
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Do you have any questions?	Yes	No
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State the question

Interviewer name:

Respondent's name:

Interviewer signature:

Respondent's signature/thumbprint:

Date:

Date:

বাংলাদেশের বগুড়া জেলায় সংস্কারকৃত কমিউনিটি ক্লিনিকের মাধ্যমে প্রজনন বয়সী
নারীদের প্রজনন স্বাস্থ্য সেবার ব্যবহার, গ্রহণযোগ্যতা এবং সন্তুষ্টি নিরূপণ: যমুনা
(JAMUNA) প্রকল্পের অধীনে একটি মিশ্র-পদ্ধতির বাস্তবায়ন গবেষণা

তথ্য বিবরণী (Information Sheet)

ভূমিকা: আমার নাম [_____], এবং আমি ব্র্যাক ইউনিভার্সিটির জেমস পি গ্রান্ট স্কুল অফ পাবলিক হেলথ থেকে এসেছি। আমরা যমুনা (JAMUNA) প্রকল্পের আওতায় সুইজারল্যান্ড রেড ক্রস এবং বাংলাদেশ রেড ক্রিসেন্ট সোসাইটির সহযোগিতায় একটি গবেষণা পরিচালনা করছি। এই গবেষণার উদ্দেশ্য হলো, বাংলাদেশের বগুড়া ও সিরাজগঞ্জ জেলায় সংস্কারকৃত কমিউনিটি ক্লিনিকগুলোর মাধ্যমে প্রদত্ত প্রজনন স্বাস্থ্য সেবা সম্পর্কে নারীদের অভিজ্ঞতা বোঝা।

গবেষণা দল

এই গবেষণাটি পরিচালনা করছেন পাউ সিয়ান মুয়াং (প্রধান গবেষক), ড. মৃতিকা বড়ুয়া এবং ব্র্যাক ইউনিভার্সিটির জেমস পি গ্রান্ট স্কুল অফ পাবলিক হেলথ (জেপিজিএসপিএইচ)-এর সংশ্লিষ্ট গবেষকরা।

তহবিল প্রদানকারী উৎস

এই গবেষণাটি ব্র্যাক ইউনিভার্সিটির জেমস পি গ্রান্ট স্কুল অফ পাবলিক হেলথ (জেপিজিএসপিএইচ) কর্তৃক অর্থায়নকৃত। গবেষকদের কোনো অতিরিক্ত ব্যক্তিগত আর্থিক প্রণোদনা প্রদান করা হয়নি।

ক্রমিক নং: [প্রটোকল নম্বর]

গবেষণার উদ্দেশ্য: এই গবেষণার উদ্দেশ্য হলো সংস্কারকৃত কমিউনিটি ক্লিনিকগুলোতে নারীরা কীভাবে প্রজনন স্বাস্থ্য সেবা গ্রহণ করেন এবং তাদের অভিজ্ঞতা কেমন, তা অনুসন্ধান করা। এর মধ্যে সেবার ব্যবহার, গ্রহণযোগ্যতা, সন্তুষ্টি এবং সেবা গ্রহণের ক্ষেত্রে বিদ্যমান চ্যালেঞ্জগুলো অন্তর্ভুক্ত। এই গবেষণার ফলাফল সেবার মানোন্নয়ন এবং জলবায়ু-বুঁকিপ্রবণ এলাকায় ভবিষ্যৎ কর্মসূচি প্রণয়নে সহায়তা করবে।

অংশগ্রহণের যৌক্তিকতা: আপনাকে এই গবেষণায় অংশগ্রহণের জন্য আমন্ত্রণ জানানো হয়েছে কারণ আপনি এই কমিউনিটি ক্লিনিক থেকে প্রজনন স্বাস্থ্য সেবা গ্রহণ করেছেন। বাস্তব প্রেক্ষাপটে এই সেবাগুলো কীভাবে প্রদান করা হচ্ছে তা বোঝার জন্য আপনার অভিজ্ঞতা এবং মতামত অত্যন্ত গুরুত্বপূর্ণ।

পদ্ধতি: আপনি যদি অংশগ্রহণ করতে সম্মত হন, তবে আপনাকে নিচের যে কোনো একটি প্রক্রিয়ায় অংশ নিতে হতে পারে:

- একটি জরিপ (যা প্রায় ২০-২৫ মিনিট সময় নেবে), অথবা
- একটি বিশদ সাক্ষাৎকার বা In-depth interview (যা প্রায় ৪৫-৬০ মিনিট সময় নেবে, শুধুমাত্র নির্বাচিত অংশগ্রহণকারীদের জন্য)।

প্রশ্নগুলো মূলত প্রজনন স্বাস্থ্য সেবা নিয়ে আপনার অভিজ্ঞতার ওপর ভিত্তি করে করা হবে। আপনার অনুমতি সাপেক্ষে, সাক্ষাৎকারের অডিও রেকর্ড করা হতে পারে। আলাদাভাবে অনুরোধ ও অনুমোদন ছাড়া কোনো ছবি তোলা হবে না। আপনার অনুমতি থাকলে আমরা সাক্ষাৎকারের অংশ হিসেবে কিছু ছবি তুলব, তবে ছবিতে আপনার মুখমণ্ডল বা চেহারা দেখা যাবে না।

অংশগ্রহণের সুবিধা: এই গবেষণায় অংশগ্রহণের ফলে সরাসরি কোনো ব্যক্তিগত সুবিধা বা লাভ নেই। তবে, আপনার প্রদানকৃত তথ্য আপনার মতো কমিউনিটিতে বসবাসকারী নারীদের জন্য প্রজনন স্বাস্থ্য সেবার মানোন্নয়নে সহায়তা করবে।

সম্মানী: এই গবেষণায় আপনার অংশগ্রহণ সম্পূর্ণ স্বৈচ্ছামূলক। এতে অংশ নেওয়ার জন্য আপনাকে কোনো অর্থ খরচ করতে হবে না। একইভাবে, এই সাক্ষাৎকারে অংশগ্রহণের বিনিময়ে আপনাকে কোনো আর্থিক সুবিধা বা সম্মানীও প্রদান করা হবে না।

ঝুঁকি: এই গবেষণায় ঝুঁকির সম্ভাবনা খুবই কম। কিছু প্রশ্ন সংবেদনশীল হতে পারে এবং সামান্য অস্বস্তির কারণ হতে পারে। আপনি চাইলে যে কোনো প্রশ্নের উত্তর না দিয়ে এড়িয়ে যেতে পারেন অথবা যে কোনো সময় সাক্ষাৎকার বন্ধ করে দিতে পারেন। এর জন্য কোনো নেতিবাচক প্রভাব পড়বে না।

গোপনীয়তা এবং নাম প্রকাশ না করা: আপনার দেওয়া সমস্ত তথ্য গোপন রাখা হবে। কোনো প্রতিবেদন বা প্রকাশনায় আপনার নাম উল্লেখ করা হবে না। তথ্যগুলো নিরাপদে সংরক্ষণ করা হবে এবং শুধুমাত্র গবেষক দল তা ব্যবহার করতে পারবে। গবেষণার ফলাফল শিক্ষাগত এবং কর্মসূচিসংক্রান্ত প্রয়োজনে প্রকাশ বা শেয়ার করা হতে পারে, কিন্তু সেখানে কোনো অংশগ্রহণকারীকে ব্যক্তিগতভাবে শনাক্ত করা যাবে না। কোনো শনাক্তযোগ্য (identifiable) বা মূল তথ্য (raw data) কোনো বিদেশি গবেষকের সাথে শেয়ার করা হবে না। যদি গবেষণালব্ধ ফলাফল কোনো আন্তর্জাতিক পিয়ার-রিভিউড জার্নালে প্রকাশিত হয়, তবে শুধুমাত্র সম্মিলিত (aggregated) এবং পরিচয় গোপন রাখা (anonymized) ফলাফলই প্রকাশ করা হবে।

অংশগ্রহণের ধরণ: আপনার অংশগ্রহণ সম্পূর্ণ স্বেচ্ছামূলক। আপনি চাইলে অংশগ্রহণ না করার সিদ্ধান্ত নিতে পারেন অথবা যে কোনো সময় নিজেকে প্রত্যাহার করে নিতে পারেন। এতে আপনার স্বাস্থ্যসেবা পাওয়ার অধিকার বা অন্য কোনো সুবিধাপ্রাপ্তিতে কোনো প্রভাব পড়বে না। সাক্ষাৎকারটি রেকর্ড করার পরবর্তী ২৪ ঘণ্টার মধ্যে আপনি চাইলে তা প্রত্যাহার করে নিতে পারবেন।

কৃত্রিম বুদ্ধিমত্তা (AI) ব্যবহারের ঘোষণা

গবেষণাপত্র পর্যালোচনা (literature review) এবং নকশা (design) সম্পর্কে গভীর ধারণা লাভের জন্য কৃত্রিম বুদ্ধিমত্তা (AI) ব্যবহার করা হয়েছে। গবেষণার সরঞ্জামসমূহ বা টুলস অনুবাদের ক্ষেত্রেও AI ব্যবহার করা হয়েছিল। তবে, এই গবেষণার তথ্য সংগ্রহ, বিশ্লেষণ এবং লেখার ধাপে AI ব্যবহার করা হবে না।

যোগাযোগের তথ্য: এই গবেষণা সম্পর্কে আপনার কোনো প্রশ্ন থাকলে, দয়া করে যোগাযোগ করুন: প্যাউ সিয়ান মুয়াং (Pau Sian Muang) জেমস পি গ্রান্ট স্কুল অফ পাবলিক হেলথ (JPGSPH), ব্র্যাক বিশ্ববিদ্যালয় ফোন: +৮৮০১৭৯৪৬৭৬৯৩৯, ইমেইল: pau.sian.muang@g.bracu.ac.bd

গবেষণার নৈতিক বিষয় সংক্রান্ত প্রশ্নের জন্য যোগাযোগ করুন: প্রাতিষ্ঠানিক পর্যালোচনা বোর্ড (IRB) জেমস পি গ্রান্ট স্কুল অফ পাবলিক হেলথ (JPGSPH), ব্র্যাক বিশ্ববিদ্যালয় ফোন: +৮৮০১৯৯৩৩৭৭৫১২, ইমেইল: irb-jpgsph@bracu.ac.bd

সম্মতিপত্র (Consent Form)

আমি উপরের তথ্যগুলো পড়েছি (অথবা আমাকে পড়ে শোনানো হয়েছে)। আমি এই গবেষণার উদ্দেশ্য এবং একজন অংশগ্রহণকারী হিসেবে আমার ভূমিকা বুঝতে পেরেছি। আমি বুঝতে পেরেছি যে আমার অংশগ্রহণ সম্পূর্ণ স্বৈচ্ছামূলক এবং আমি যে কোনো সময় কোনো নেতিবাচক ফলাফল ছাড়াই নিজেকে প্রত্যাহার করে নিতে পারি।

নিচে স্বাক্ষর বা টিপসই প্রদানের মাধ্যমে আমি এই গবেষণায় অংশগ্রহণের সম্মতি জানাচ্ছি।

আপনার আন্তরিক সহযোগিতার জন্য ধন্যবাদ।

আপনি কি সাক্ষাৎকারটি অডিও রেকর্ড করার অনুমতি দিচ্ছেন? (দয়া করে মনে রাখবেন, সাক্ষাৎকার চলাকালীন যেকোনো সময় আপনি রেকর্ডিং বন্ধ করতে বলতে পারেন।)	হ্যাঁ	না
আপনি কি গবেষণার ফলাফল শেয়ার / প্রচার করার অনুমতি দিচ্ছেন?	হ্যাঁ	না
আপনি কি ছবি তোলার অনুমতি দিচ্ছেন?	হ্যাঁ	না
আপনি কি ছবিগুলো শেয়ার বা প্রকাশ করার অনুমতি দিচ্ছেন?	হ্যাঁ	না
কোনো তথ্যের স্পষ্টীকরণের প্রয়োজনে আপনার সাথে পুনরায় যোগাযোগ করার অনুমতি দিচ্ছেন কি?	হ্যাঁ	না
আপনার কি কোনো প্রশ্ন আছে?	হ্যাঁ	না
প্রশ্ন:		

সাক্ষাৎকার গ্রহণকারীর নাম:

উত্তরদাতার নাম:

সাক্ষাৎকার গ্রহণকারীর স্বাক্ষর:

উত্তরদাতার স্বাক্ষর/আঙুলের ছাপ:

তারিখ:

তারিখ: