Assessing Women's and Girls' Sexual and Reproductive Health and Rights through a Climate Justice Lens

Ipas Partners for Reproductive Justice
BANGLADESH

নারীপক্ষ

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The Impact of Climate Change on Women's and Girls' Sexual and Reproductive Health, Decision-Making, Behavior, and Outcomes in Char, Haor, and Slum Areas of Bangladesh

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Acronyms and Abbreviations

CDM	Community Dialogue Meetings
CHW	Community Health Worker
DRR	Disaster Risk Reduction
DV	Domestic Violence
EWE	Extreme Weather Event
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
GEF	Global Environment Facility
IDI	In-depth Interview
IDMC	Internal Displacement Monitoring Centre
IPCC	Intergovernmental Panel on Climate Change
IPPF	International Planned Parenthood Federation
IRB	Institutional Review Board
KII	Key Informant Interview
MISP	Minimum Initial Service Package
PAR	Participatory Action Research
RA	Research Assistant
STI	Sexually Transmitted Infection
SRHR	Sexual and Reproductive Health and Right
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WASH	Water, Sanitation, and Hygiene
WB	World Bank
WHO	World Health Organization

Executive Summary

Bangladesh is among the most climate-vulnerable countries in the world, experiencing recurrent floods, riverbank erosion, cyclones, salinity, prolonged waterlogging, drought, temperature rising etc. that disrupt ecosystems, livelihoods, and health. Women and girls are disproportionately affected, as entrenched gender inequalities limit their access to resources, mobility, and decision-making power, intensifying their exposure to climate-induced risks. Despite growing recognition of these challenges, little is understood about how climate change shapes women and girls' reproductive health decision-making and Sexual and Reproductive Health and Rights (SRHR). To begin addressing this gap, Ipas conducted a study in 2020 to 2021 in the coastal areas of Khulna, which explored women's and girls' SRHR experiences with climate change using a participatory, qualitative methodology. Building on that foundation, the present study, conducted by Ipas Bangladesh in collaboration with Naripokkho, expands its focus to three other climate-vulnerable areas, the char of Sirajganj, the haor wetlands of Kishoreganj, and the urban slums of Dhaka to capture a broader and comparative understanding of women's and girls' experiences.

The research, conducted between August 2024 and June 2025, employed a phased, participatory qualitative design. In the first phase, 22 key informant interviews (KIIs) were carried out with local experts such as community health workers, local women and girls' leaders, and climate specialists. The second phase included 27 in-depth interviews (IDIs) with women and girls of reproductive age (15–49 years), stratified into three groups (15–19, 20–24, and 25–49 years), along with 18 community dialogue meetings (CDMs) organized with the same age cohorts. This design ensured that both intergenerational perspectives and collective voices were captured across diverse areas. All data were analyzed thematically using a framework analysis approach, guided by an intersectional and gender-transformative lens to examine the compounded effects of climate vulnerability and gender inequality on reproductive health. The analysis also traced the interlinkages between gender, social norms, structural inequality, and climate stressors, with data management and coding supported by Dedoose software.

Women and girls in Bangladesh are already positioned in vulnerable circumstances due to entrenched gender inequality, economic dependency, and limited autonomy, and these pre-existing disadvantages are sharply intensified by climate change. Women and girls describe climate risks as an immediate and embodied reality, captured in accounts of disrupted seasons, prolonged and unpredictable floods, extreme heat, and even divine punishment. Women's and girls' ability to access reproductive health services is constrained by restrictions on mobility, financial dependence, weak communication and transportation systems, and inadequate institutional responses. These challenges are particularly acute for adolescents, widows, migrants, and women and girls with disability, who face harassment, exclusion from relief, and denial of privacy and reproductive autonomy. Institutional programs and climate education rarely incorporate SRHR considerations or address the needs of unmarried and socially marginalized women and girls, leaving them disproportionately exposed during crises.

Climate stressors compound these vulnerabilities by disrupting nearly every aspect of sexual and reproductive health. Interruptions in contraceptive supply, perinatal care and services, and menstrual health management increase risks of unintended pregnancies, unsafe abortion, maternal morbidity, infections, and psychological distress. Displacement driven by climate induced events and migration breaks the continuity of care, isolates women and girls from trusted providers, and heightens their exposure to gender-based violence and coercion. Economic instability often pushes families toward harmful coping strategies such as child marriage, reproductive coercion, or domestic violence, further eroding women's and girls' autonomy. At both household and institutional levels, decisions concerning healthcare, relocation, and relief

distribution remain dominated by men, landlords, or political figures, reinforcing women and girls' exclusion from critical choices that directly affect their health and survival.

Despite these systemic constraints, women and girls demonstrate resilience and agency through diverse coping and adaptive strategies. Informal peer networks and intergenerational knowledge-sharing provide essential support in times of crisis, while community health workers, midwives, and mothers act as trusted frontline responders despite limited institutional backing. Women and girls employ creative approaches to menstrual management, switch contraceptive methods, adjust fertility intentions to uncertain conditions, and maintain secret savings to prepare for emergencies. Household-level innovations, such as raising storage areas, reinforcing housing structures, or adapting spaces for better ventilation during heatwaves, reflect women and girls' role as everyday innovators in climate adaptation. Yet these efforts often come at a cost, as the burden of care and emotional labor intensifies during disasters, with women and girls sacrificing their own needs for family survival.

Urgent priorities for SRHR in the context of climate change include ensuring consistent access to women and girls- and girls-friendly health services, including contraceptives, perinatal care, and menstrual health support; maintaining mobile and community-based clinics with trained female providers to reach vulnerable populations; integrating reproductive health, climate awareness, and skill-building into education programs; promoting women and girls' leadership and decision-making in SRHR and climate adaptation strategies; and supporting community-led innovations such as low-cost menstrual products and local safety initiatives. Strengthening water, sanitation, and hygiene infrastructure, ensuring equitable access to resources, and providing clear, locally relevant communication are also essential to protect and advance SRHR as climate impacts intensify.

The study identifies clear pathways to strengthen women and girls' resilience and SRHR in the context of climate change. Women and girls advocate for women and and girls' friendly disaster preparedness measures, including shelters with private and secure spaces, menstrual health provisions, contraceptive supplies, and perinatal care, supported by accessible services through locally appropriate mobile clinics and trained female health providers. Education that integrates reproductive health with climate awareness, alongside skill-building and financial support, is critical for enhancing adaptive capacity, while engaging men and boys is essential to shift restrictive gender norms and reduce violence. Community-led innovations, such as low-cost reusable menstrual products and neighborhood safety initiatives, should be recognized, scaled, and supported.

At the national level, embedding SRHR into climate adaptation and disaster response frameworks is vital. This requires dedicated budgets, resilient infrastructure, and trained personnel capable of maintaining services under diverse climate conditions. Long-term, community-rooted programs that link SRHR with climate resilience can reduce dependence on short-term aid and enhance sustainability. Strengthening women and girls' leadership in SRHR and addressing the reproductive health and broader needs of marginalized groups including adolescents, widows, migrants, and women and girls with disability is essential to ensure inclusive, equitable, and effective climate adaptation strategies. Together, these measures constitute urgent priorities for safeguarding women and girls' health, autonomy, and resilience in the face of climate change.

In conclusion, climate change profoundly shapes women and girls' reproductive health decisions, behaviors, and outcomes in Bangladesh's most vulnerable areas. Women and girls face overlapping risks from environmental stress, gender inequality, and institutional neglect, yet they continue to mobilize resilience and creativity to protect their health and dignity. A transformative response, centered on women and girls' voices, inclusive of diverse needs, and supported by

accountable institutions offers the potential to build climate-resilient systems that safeguard autonomy, equality, well-being, and SRHR in the face of escalating climate threats.

Introduction and Methodology

1. Introduction

1.1 Background

Climate change is one of the most pressing global challenges of the 21st century, with profound consequences for ecosystems, economies, and human well-being(1), (2). The Intergovernmental Panel on Climate Change (IPCC) highlights that human activities have caused approximately 1.1°C of warming since the pre-industrial era, leading to rising global temperatures, extreme weather events, and disruptions to natural ecosystems (1). The consequences of climate change extend beyond environmental degradation to affect biodiversity, freshwater availability, food security, and human health (3). These impacts are not experienced equally; rather, they disproportionately affect vulnerable populations, particularly those in low- and middle-income countries, small island states, and climate vulnerable areas (4) (5) (6) (7). Women and girls, particularly those from marginalized communities, bear a disproportionate burden due to gendered social roles, economic inequalities, and restricted access to resources (8). Climate-induced displacement has increased significantly in recent years, with over 30 million people forced to migrate due to extreme weather events in 2022 alone (9). This mass migration further disrupts access to healthcare, including sexual and reproductive health and rights (SRHR) services, exacerbating gender-based vulnerabilities (10).

Recent studies have highlighted a critical but often overlooked impact of climate change: its effect on sexual and reproductive health and rights (SRHR). Climate-induced environmental stressors, such as droughts, floods, and rising temperatures, contribute to poor maternal health outcomes, disruptions in family planning services, and increased risks of gender-based violence (11). Climate disasters often exacerbate existing barriers to reproductive healthcare by displacing communities, damaging healthcare infrastructure, and limiting access to contraception and maternal care. Women and girls in climate-vulnerable areas are often forced to prioritize survival over health, leading to reduced access to antenatal care, increased rates of early marriage, and higher instances of unsafe abortions (12).

Bangladesh is one of the most climate-vulnerable countries globally due to its low-lying geography, high population density, and reliance on climate-sensitive livelihoods (13,14). The Global Climate Risk Index 2021 ranks Bangladesh as the seventh most affected country by climate-related disasters over the past two decades (15). The country faces multiple climate-induced hazards, including rising sea levels leading to coastal erosion and salinity intrusion, intensified cyclones and floods causing displacement and destruction of infrastructure, and erratic rainfall patterns affecting agricultural productivity and food security (16,17).

In 2020–2021, a qualitative study conducted by Ipas Bangladesh in the coastal area of Khulna applied an intersectional climate justice lens to examine how climate change affects SRHR outcomes for women and girls. The study found that climate-induced salinity intrusion, flooding, and displacement directly disrupted reproductive health services, increased maternal health risks, and exacerbated gender-based violence. It further emphasized that intersecting identities such as gender, socio-economic class, and rural residency compound SRHR vulnerabilities and limit adaptive capacities. Local women and girls reported restricted access to contraception, unsafe delivery conditions, and compromised menstrual health, highlighting the urgent need to integrate SRHR into climate adaptation strategies (18,19).

These insights underscored that the challenges observed in coastal areas were unlikely to be unique; rather, they pointed to broader patterns of vulnerability that might manifest differently across Bangladesh's diverse ecological zones. Building on these findings and responding to the

study's recommendations, Ipas Bangladesh, in collaboration with Naripokkho, conducted a research to other climate-vulnerable areas of the country. This included drought-prone and flood-prone areas, as well as settlements of climate-induced migrants such as char (riverine islands), haor (wetland basins), and urban slums (informal vulnerable settlements). These areas were chosen because of their acute exposure to different climate hazards and their distinct socio-economic and environmental contexts, which together shape unique challenges for women and girls' health and wellbeing. Examining SRHR across these diverse areas enables a more comprehensive understanding of how climate change interacts with geographic vulnerability, displacement, and gender inequality to deepen risks and limit resilience.

Despite growing recognition of climate change as a human rights and public health concern, SRHR remains underexplored in climate adaptation research, policy, and programming (12). While evidence suggests that climate impacts can exacerbate maternal and neonatal health risks, disrupt contraceptive access, and increase gender-based vulnerabilities, significant knowledge gaps persist regarding how these effects manifest across different geographic and socio-economic contexts in Bangladesh. This study was therefore designed to explore these gaps, examining the intersection of climate change, women and girls' vulnerabilities, and SRHR to inform equitable, gender-responsive adaptation policies.

1.2 Rationale

Understanding how climate change affects women and girls' reproductive health is crucial for addressing SRHR inequities in climate-vulnerable areas. Existing research highlights that climate-induced migration, extreme weather events, and environmental degradation significantly disrupt access to reproductive healthcare; however, mainstream climate adaptation policies often overlook SRHR considerations (20).

While recent research in coastal area has demonstrated the compounding effects of climate stressors on SRHR, such as reduced access to maternal care, increased gender-based violence, and poor menstrual health there is now a recognized need to investigate how similar vulnerabilities manifest in other geographic contexts (18,19). Considering the coastal findings, this study aims to expand the scope of research to include other climate-affected areas such as char, haor, and urban slums. This expanded inquiry is essential for capturing the diverse experiences of women and girls across Bangladesh's climate-fragile areas and for informing more inclusive and geographically responsive SRHR adaptation policies.

Women and girls' health-seeking behaviors and reproductive decision-making are shaped by a complex interplay of environmental, social, and economic factors. In Bangladesh, climate-induced migration and displacement frequently result in economic precarity, forcing women and girls to navigate reproductive choices under highly uncertain conditions (18,19). Increasing vulnerability and economic instability influence fertility intentions, with some women and girls opting for larger families as a form of social security, while others resort to hazardous or unsafe reproductive health practices due to lack of access to healthcare (13). Additionally, gender-based violence (GBV), exacerbated by climate crises, further restricts women and girls' ability to exercise reproductive autonomy, increasing their risk of unwanted pregnancies and maternal health complications (10).

This study is urgently needed to examine how women and girls in climate-affected areas perceive and respond to reproductive health challenges. By using an intersectionality framework (21), the study will explore how multiple identities like gender, displacement status, socio-economic conditions, and geographical location intersect to shape SRHR outcomes. The gender-transformative lens (22) will help identify and challenge structural barriers that limit reproductive choices and healthcare access. The findings will provide critical insights for policymakers,

healthcare providers, and climate adaptation programs to integrate SRHR into climate resilience strategies.

1.3 Objectives

The main objective of this research is to understand how women and girls' experiences with climate change impact their reproductive health decision-making, behavior, and outcomes in char, haor, and urban slum areas in Bangladesh. The specific objectives are:

- To understand the language and local terminology that women and girls use to describe climate change-related events and environmental changes in their communities.
- To determine how women and girls' experiences with climate change-related events influence their perceptions of personal vulnerability and resilience.
- To examine how women and girls' perceived vulnerability related to climate change affects their fertility intentions and, consequently, their sexual and reproductive health decision-making and behaviors.
- To explore the causal pathways through which climate change impacts women and girls' sexual and reproductive health outcomes, using a gender-transformative lens.

2. Methodology

2.1 Study Design and Approach

This study employed a phased, participatory, and qualitative research design to explore the impact of climate change on women and girls' SRHR, including decision-making, behaviors, access to services, and overall well-being. A qualitative approach was deemed appropriate because of its ability to capture complex, intersectional, and deeply personal experiences, which are essential for understanding how climate change influences SRHR at both individual and community levels (23). The participatory research approach was integrated to amplify women and girls' voices, engage communities actively, and ensure that local knowledge and lived experiences remained central to the research process (24).

The study was conducted in two phases, each employing different qualitative methods to ensure a comprehensive understanding of the lived experiences of women and girls in climate-vulnerable areas. The first phase involved Key Informant Interviews (KIIs) with SRHR experts, community health workers (CHWs), leaders of women and girls' organizations, and climate change specialists. These interviews aimed to explore expert perspectives, refine research tools, and ensure cultural and contextual appropriateness before engaging directly with affected women and girls in second phase. Findings from Phase-I were instrumental in modifying and adapting the data collection instruments used in Phase-II, ensuring that the questions and themes accurately captured the intersection of climate change and SRHR challenges. The study employed cognitive interviewing techniques to validate and refine the IDI guide, ensuring that terminology, phrasing, and question structures were aligned with local dialects, social norms, and cultural sensitivities (Table 1).

The second phase of the study consisted of IDIs and Community Dialogue Meetings (CDMs) with women and girls of reproductive age (15-49 years), which captured both individual narratives and collective experiences regarding the impact of climate change on various aspects of SRHR. IDIs provided a private and confidential space for women and girls to share personal experiences regarding climate-induced stressors, fertility intentions, contraceptive use, menstruation-related challenges, maternal healthcare access, SRHR, gender-based violence (GBV), abortion-related concerns etc. CDMs, on the other hand, served as a participatory method that facilitated open group discussions, allowing women and girls to collectively analyze their SRHR challenges within the context of climate change (Table 1). Participatory approaches such as CDMs have been widely recognized for enhancing community engagement, promoting local agency, and fostering collaborative solutions ((25,26).

Table 1: Study Design

Objectives	Method	Tools	Sample Population	Sample Size
Phase-I Data Collection				
Objective 1 and 4	KIIs	Semi-Structured Guide	• Community health workers (CHWs) • Leaders or senior members of local women and youth groups/organizations • Local experts on climate change and/or climate change-related event response systems	N= 21 (7 Participants × 3 areas); at least 2 of each category

Objectives	Method	Tools	Sample Population	Sample Size
Phase-II Data Collection				
Objective 2, 3, and 4	CDMs using Participatory Action Research (PAR) Methods	PAR Facilitator's Guides	Women and girls ages 15-49, separated by age group: • 15-19 • 20-24 • 25-49	n= 18 (6×3 areas) CDMs n= Approx. 154-180 participants
Objective 2, 3, and 4	IDIs	Semi-Structured Guide	Women and girls ages 15-49, separated by age group: • 15-19 • 20-24 • 25-49	n=27 (9×3 areas) at least 3 from each age group

This study was framed within an intersectional and gender-transformative lens, which acknowledges the complex interplay between gender, social structures, and climate vulnerability in shaping SRHR experiences (27,28). The research process was iterative, allowing for continuous reflection, adaptation, and refinement. To maintain methodological rigor, data triangulation was employed, ensuring that findings from KIIs, IDIs, and CDMs were cross validated. Additionally, daily debriefing sessions were conducted at the end of each data collection day, enabling the research team to reflect on emerging themes, ensure data saturation, and address methodological challenges in real-time.

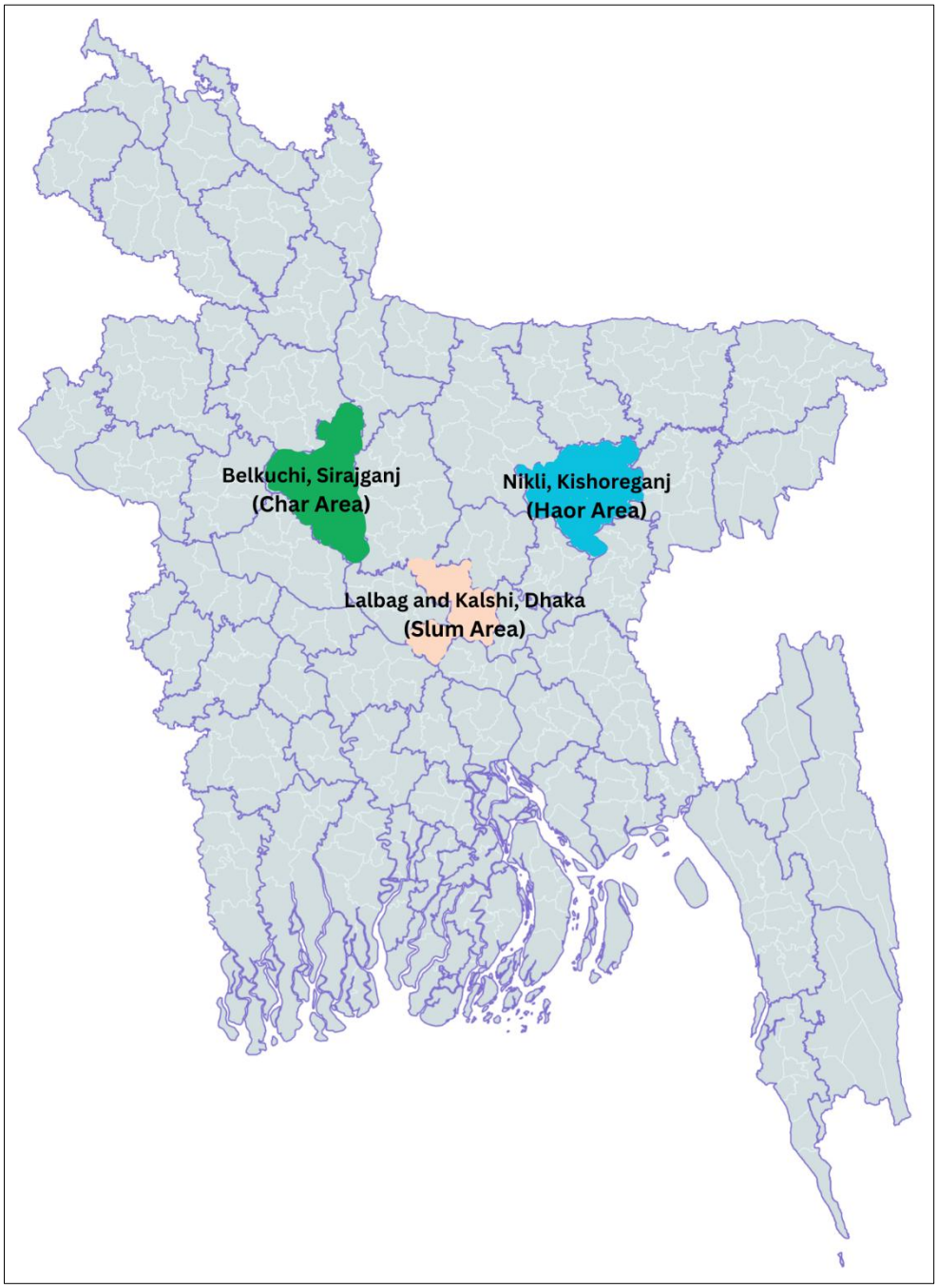
2.2 Study Areas

The study was conducted in three climate-vulnerable areas of Bangladesh, selected for their high exposure to climate-induced environmental hazards. The inclusion of these diverse geographical and socio-economic areas allows for a comparative analysis of climate-related SRHR vulnerabilities across rural and urban contexts.

The char of the Jamuna River in Belkuchi Upazila, Sirajganj District, was selected due to its susceptibility to river erosion, seasonal flooding, drought, and extreme heat, which exemplify the challenges of living in highly dynamic riverine landscapes. The haor area in Nikli, Kishoreganj District, a low-lying wetland ecosystem, was included because of its seasonal flooding, waterlogging, and ecological sensitivity, making communities vulnerable to climate-related disruptions. Urban slums in Dhaka City (Mirpur and Lalbagh) were chosen as they represent areas of climate-driven migration, where populations face overcrowding and environmental stress, reflecting urban climate vulnerabilities. (Figure 1).

By selecting these three distinct areas, the study captures a range of climate-exposure contexts, enabling an analysis of how geographical and environmental vulnerabilities intersect with socio-economic factors to influence women and girls' SRHR.

Figure 1: Study Areas



2.3 Study Population and Eligibility

The study population consisted primarily of women and girls of reproductive age, defined as those between 15 and 49 years, residing in the selected areas. Women and girls were eligible to participate in IDIs and CDMs if they were ever-married, had resided in the community for at least twelve months, and had directly experienced climate-related events such as flooding, erosion, or drought. Women and girls who were unable to provide informed consent or who had severe cognitive impairments were excluded to ensure ethical participation. In addition to this primary population, the study also engaged a secondary group of participants for KIIs. These included local experts on SRHR and climate change such as community health workers, leaders of women and girls' and community organizations, and climate or disaster-risk management professionals with contextual expertise (Table 1).

2.4 Sampling Strategy and Sample Size

A purposive sampling strategy was employed to identify and recruit participants who had direct experiences with climate change and its impact on reproductive health. This approach was selected to ensure the inclusion of individuals who could provide in-depth, experience-based insights, aligning with the study's qualitative and participatory objectives (29).

In the first phase, 22 KIIs were conducted with local experts, including CHWs, leaders of women and girls' organizations, and climate change specialists (Table 1). These experts were selected based on their professional expertise and engagement in reproductive health, disaster response, or climate adaptation efforts.

In the second phase, 27 IDIs were conducted with women and girls aged 15-49 years, with nine participants recruited from each study area. Here from each area three participants from three distinct age groups (15-19, 20-24, and 25-49 years) were selected for the interviews. In addition, 18 CDMs were held, with six meetings conducted per area, each comprising 8 to 10 participants (Table 1). To ensure age-specific insights, CDMs were stratified into three distinct age groups (15-19, 20-24, and 25-49 years).

2.5 Field Team Training and Preparation

To ensure systematic, ethical, and high-quality data collection, two structured training sessions were conducted for RAs, combining theoretical instruction with hands-on practice. These sessions equipped RAs with essential qualitative research skills, ensuring methodological rigor and consistency in data collection. The first phase of training, lasting three days, introduced RAs to the study framework, methodology, and timeline. The training covered qualitative interviewing techniques, cognitive interviewing, ethical considerations, informed consent procedures, and verbatim transcription methods. Hands-on exercises involved reviewing and practicing KIIs guided through mock tests and field simulations, ensuring consistency, accuracy, and familiarity with research instruments.

The second phase of training, lasting five days, expanded on the first by incorporating participatory research methods, particularly CDMs. RAs were trained in PAR approach, facilitation techniques, and group dynamics management to enhance community engagement. The training emphasized facilitating inclusive discussions, managing group interactions, and ensuring that participant voices were accurately documented. Mock CDM sessions were conducted which allowed RAs to practice discussion facilitation, participant engagement, and thematic documentation. Additional training sessions focused on refining transcription techniques, data management, and adherence to ethical and quality standards. Supervisors conducted spot-checks and daily debriefings during fieldwork to ensure adherence to research protocols and continuous improvement in data collection accuracy and reliability. The training ensured that RAs were proficient in qualitative research, methodological consistency, and participant engagement, strengthening the overall credibility of the study.

2.6 Recruitment and Informed Consent

Recruitment of women and girls was facilitated through community health networks, local leaders, and referrals from key informants, which helped the research team to build rapport and gain acceptance in each study area. Trained female research assistants (RAs) then conducted direct outreach to identify potential participants for interviews and dialogue meetings. This process ensured diversity of perspectives while remaining sensitive to cultural and social norms surrounding women and girls' participation in research.

Before participation, each woman received a clear explanation of the study's objectives, procedures, anticipated duration, and the voluntary nature of involvement. Issues of confidentiality, potential risks and benefits, and the right to withdraw at any point without consequence were emphasized. Written consent was obtained whenever possible, while thumbprints were used for those unable to sign. For minors under the age of eighteen, assent was obtained alongside guardian consent in line with ethical guidelines (Annexes 6-8). To safeguard privacy, in-depth interviews were conducted in spaces selected for confidentiality, while community dialogue meetings were arranged in neutral and accessible venues where participants could engage openly.

2.7 Data Collection Methods and Tools

The study employed three complementary qualitative methods: KIIs, IDIs, and CDMs. Each method was selected to capture different dimensions of the research focus, ensuring a comprehensive, inclusive, and contextually relevant data collection approach.

KIIs were conducted to gather expert insights on policy gaps, structural barriers, and service accessibility challenges that influence women and girls' SRHR in climate-vulnerable communities (Annex 1). This method was particularly valuable in understanding institutional perspectives, policy dynamics, and service limitations, engaging directly with SRHR specialists, community health workers (CHWs), women and girls' organization leaders, and climate change experts. The semi-structured format of KIIs allowed flexibility in responses while ensuring alignment with research objectives.

IDIs were designed to capture the personal experiences, perceptions, and challenges of women and girls directly affected by climate change (Annex 2). This method allowed for an in-depth exploration of fertility intentions, contraceptive use, maternal healthcare access, and socio-cultural influences. Given the sensitive nature of reproductive health discussions, IDIs were conducted in private and comfortable areas, ensuring participant confidentiality, trust, and ease of communication.

CDMs were used as a participatory research tool to foster collective knowledge-sharing and generate community-driven solutions to climate-related reproductive health challenges. Structured participatory techniques such as free listing (Annex 3), ranking (Annex 4), and reproductive health lifelines (Annex 5) helped analyze key issues. The interactive nature of CDMs ensured that women and girls were active contributors rather than passive respondents, promoting a bottom-up research approach and strengthening community engagement (25,26).

Each of these tools played a crucial role in triangulating data, ensuring that findings from expert opinions (KIIs), individual experiences (IDIs), and collective discussions (CDMs) provided a holistic and nuanced understanding of climate change's impact on SRHR.

2.8 Data Collection Process

Data collection took place between November and December 2024. In Phase I, six RAs with prior qualitative research experience were recruited and assigned in pairs to each study area. This structure ensured that data collection was conducted simultaneously across all three areas, enabling real-time comparative analysis and capturing contextual variations effectively. Within each pair, one RA conducted interviews while the other took detailed notes, observed non-verbal cues, and ensured documentation accuracy. This approach enhanced data quality and reliability.

Phase II expanded the research team by adding three additional RAs, bringing the total to nine. The team was reorganized into three-member groups per area, allowing for more effective

facilitation of CDMs, which required a higher level of interaction and engagement than individual interviews. As in Phase I, data collection continued simultaneously across all locations, ensuring consistency in timing and methodology. To maintain methodological rigor, specific role distributions were assigned across all qualitative methods. For KIIs and IDIs, two RAs participated in each session, one conducted the interview, ensuring a comfortable and open environment, while the second RA served as a dedicated note-taker, capturing key themes, non-verbal cues, and contextual details. Where permitted, audio recordings supplemented the notes to enhance data accuracy and completeness.

For CDMs, each session was conducted by a team of three RAs. One RA acted as the facilitator, leading discussions and ensuring inclusivity and engagement. A second RA supported the facilitator by managing group interactions, asking follow-up questions, and assisting with participatory techniques. The third RA was responsible for detailed documentation, capturing the flow of discussions, participant responses, and emerging themes. Throughout the data collection process, extensive field notes were maintained to document both verbal and non-verbal elements of participant responses.

To ensure data integrity, daily debriefing sessions were conducted at the end of each data collection day, enabling the research team to reflect on emerging themes, ensure data saturation, and address methodological challenges in real-time.

2.9 Data Processing and Coding

Data from KIIs, IDIs, and CDMs were transcribed verbatim in Bangla to preserve the authenticity of responses and then translated into English for analysis. A quality control process was implemented, where bilingual experts reviewed the translations to ensure accuracy and consistency. Randomly selected transcripts were also checked to confirm completeness and fidelity to the original recordings.

The data were coded and managed using Dedoose software, which facilitated systematic organization, retrieval, and interpretation. The coding process combined deductive and inductive approaches, ensuring that existing theoretical frameworks on climate change, gender, and reproductive health were incorporated while also allowing new themes to emerge directly from the data.

To ensure intercoder reliability, two independent researchers coded the same transcripts, and discrepancies were reconciled through consensus discussions. Additionally, data triangulation across KIIs, IDIs, and CDMs was applied to validate findings, ensure methodological rigor, and enhance the credibility of the study.

2.10 Data Analysis and Analytical Framework

All qualitative data were analyzed using thematic analysis, following a framework analysis approach to move beyond data coding toward interpretation (30). Once the data was organized, patterns were systematically mapped to capture recurring themes and variations across areas and participant groups. This process enabled comparison while remaining open to unexpected insights that emerged from the narratives. The framework approach provided both structure and flexibility, ensuring that women and girls' lived experiences were not only described but critically analyzed in relation to broader questions of gender inequality, climate vulnerability, and reproductive health.

2.10.1 Intersectionality Framework

The intersectionality framework provides a lens to analyze how multiple axes of identity-such as gender, socio-economic status, ethnicity, age, and disability intersect to create compounded vulnerabilities, particularly in relation to women and girls' SRHR. In Bangladesh's char, haor, and slum areas, marginalized women and girls often face multiple forms of disadvantage that impact their reproductive health decisions, access to SRHR services, and resilience to climate change. Events like floods, droughts, and rising sea levels can exacerbate these inequalities, disproportionately affecting vulnerable women and girls. By examining how these intersecting identities shape women and girls' experiences with climate-induced reproductive health risks, the intersectionality framework offers insights into how gender, age, ethnicity, socio-economic status, and disability influence access to SRHR services and decision-making. This approach enables a deeper understanding of how climate change affects SRHR outcomes by revealing how these challenges are compounded by other dimensions of social inequality (31,32).

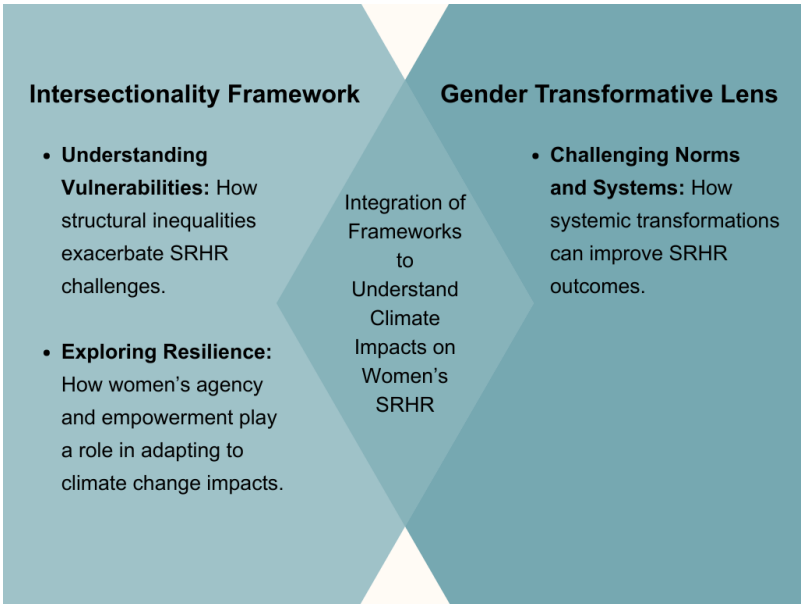
2.10.2 Gender-Transformative Lens

The gender-transformative lens is critical for understanding how climate change impacts women and girls SRHR by addressing and challenging gender norms that limit women and girls' autonomy and decision-making power. This lens emphasizes the importance of empowerment, enabling women and girls to make informed choices about their reproductive health, including family planning, maternal care, and sexual health. In contexts like Bangladesh's char, haor, and slum areas, women and girls often face restrictive gender norms that limit their participation in decision-making about their reproductive health, particularly during climate-related events. Climate change can either reinforce or challenge these norms. A gender-transformative approach focuses on shifting power dynamics, ensuring that women and girls have greater control over their fertility and reproductive health outcomes. It also highlights how empowering women and girls through access to resources and gender-sensitive policies can lead to improved SRHR decisions and outcomes in climate-impacted areas (33,34).

2.10.3 Integration of Frameworks

Combining the intersectionality framework with the gender-transformative lens enables a comprehensive understanding of how climate change affects women and girls SRHR, particularly in terms of decision-making, behavior, and outcomes (Figure 2). The intersectionality framework identifies the compounded vulnerabilities women and girls face due to intersecting identities like gender, age, and socio-economic status, while the gender-transformative lens addresses the power imbalances and gender norms that limit women and girls reproductive health choices.

Figure 2: Analytical Framework

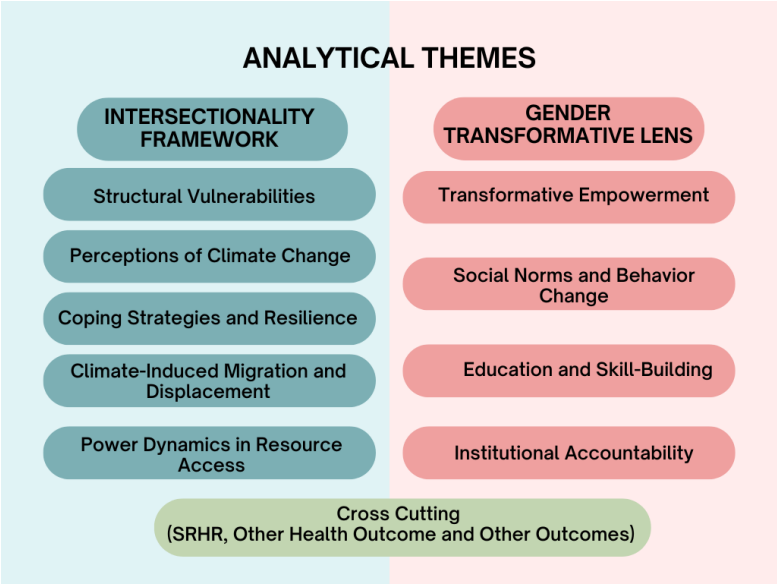


This integration allows the study to examine how these overlapping vulnerabilities, influenced by climate-induced events, impact women and girls' ability to make decisions about their reproductive health. It also facilitates a deeper understanding of how empowering women and girls and challenging harmful gender norms can improve SRHR outcomes, even in the face of climate change (35).

2.10.4 Analytical Themes and Codes

The analysis was guided by several key themes and corresponding codes, which align with the research objectives, particularly focusing on how climate change impacts women and girls' SRHR decision-making, behaviors, and outcomes. Each theme was directly linked to understanding how climate-related vulnerabilities shape women and girls' reproductive health decisions, including family planning, maternal health, and sexual health, which are central to the study's objectives (Figure 3).

Figure 3: Analytical Themes



Structural Vulnerabilities

Structural vulnerabilities refer to the systemic and institutional barriers that limit women and girls' access to SRHR services, particularly in climate-impacted areas. These vulnerabilities are often rooted in social inequalities, affecting marginalized groups disproportionately.

***Gender*-Based Barriers:** Women and girls' restricted mobility, lack of decision-making power, and gender norms limit their access to contraceptives, maternal healthcare, and safe reproductive choices. During climate-induced crises, these barriers intensify, making it harder for women and girls to exercise reproductive autonomy.

***Economic Constraints**:* Climate-induced economic instability such as loss of livelihoods due to climate events often forces women and girls to prioritize survival over reproductive healthcare. In many cases, economic hardship reduces access to contraception, prenatal care, and safe childbirth services.

***Intersectional Marginalization**:* Marginalized groups due to gender, age, caste, or socio-economic identity face systemic discrimination, further restricting access to SRHR services. Climate change exacerbates these inequalities, leading to higher maternal mortality, unplanned pregnancies, and gender-based violence.

Perceptions of Climate Change and SRHR

Women and girls' understanding of climate change and its link to reproductive health risks significantly influence their SRHR behaviors and decisions. This theme examines how women and girls interpret climate-induced disruptions and their effect on reproductive choices.

Local Terminologies for Events: The way women and girls describe climate-related phenomena influences how they perceive risk and prioritize reproductive health.

Vulnerability Perceptions: Women and girls' perceptions of climate-related threats, such as food insecurity, displacement, or increased disease outbreaks, shape their decisions regarding family planning, maternal healthcare, and fertility choices.

Coping Strategies and Resilience

Women and girls develop adaptive strategies to cope with climate change while ensuring their SRHR needs are met. These strategies reflect their agency and resilience in navigating climate-induced reproductive health challenges.

Adaptive Strategies: Strategies such as temporary migration, livelihood diversification, or modifying reproductive plans help women and girls cope with climate-induced disruptions. However, these adaptations often come with increased SRHR vulnerabilities, such as limited access to healthcare, gender-based violence, and unplanned pregnancies.

Community Support Systems: Women and girls' informal networks, community-based organizations, and local health initiatives provide crucial support for SRHR services during climate crises. Such networks help bridge healthcare gaps caused by displacement or resource shortages.

Climate-Induced Migration and Displacement

Migration and displacement due to climate-related disasters often lead to severe disruptions in SRHR services, exposing women and girls to higher reproductive health risks.

Displacement-Related SRHR Challenges: Climate migration increases unplanned pregnancies, unsafe abortions, maternal health complications, and sexual violence due to inadequate access to SRHR facilities.

Family Separation and Vulnerability: Displacement often separates women and girls from their families, increasing their risk of sexual exploitation, gender-based violence, and inadequate maternal healthcare.

Power Dynamics in Resource Access

Access to resources such as food, water, healthcare, and contraceptives is highly gendered, with women and girls facing systemic disadvantages in climate-affected areas.

Gendered Access to Climate Resources: Women and girls have less control over financial and environmental resources, directly impacting their ability to manage reproductive health needs during crises.

Decision-Making Power in Resource Allocation: Men often control household resources, limiting women and girls' ability to prioritize SRHR services. During climate shocks, this power imbalance restricts access to contraception, pregnancy care, and safe delivery options.

Transformative Empowerment

This theme explores how women and girls' empowerment and leadership in climate adaptation influence SRHR outcomes.

Leadership in Climate Adaptation: Women and girls leading adaptation efforts can advocate for SRHR needs, ensuring access to contraception, maternal care, and safe abortion services.

Challenging Gender Norms: Transforming patriarchal structures and harmful gender norms enhances women and girls' SRHR decision-making power.

Policy Innovations: Gender-responsive climate policies integrating SRHR considerations can significantly improve reproductive health outcomes, especially in climate-vulnerable areas.

Social Norms and Behavior Change

Social norms heavily influence reproductive health behaviors, particularly in climate-stressed communities.

Perceptions of Masculinity and Climate Roles: Traditional gender roles shape SRHR decision-making, often reinforcing male dominance in reproductive choices.

Community-Led Gender Norm Shifts: Grassroots efforts that challenge gendered power structures can promote positive SRHR outcomes, increasing contraceptive use and safe maternal health practices.

Education and Skill-Building

Access to education and skills training enhances women and girls' SRHR resilience in climate-vulnerable areas.

Capacity-Building for Women and girls in Adaptation*:* Women and girls educated in climate adaptation strategies are better equipped to make informed reproductive health decisions.

Gender-Inclusive Climate Education*:* Incorporating SRHR topics into climate education programs enables women and girls to navigate reproductive health challenges more effectively.

Institutional Accountability

Institutions play a crucial role in ensuring gender-sensitive climate policies that protect women and girls' SRHR.

Monitoring and Evaluation of Gender Policies: Strengthening institutional frameworks for gender-sensitive policy monitoring improves SRHR access.

Institutional Support for Women and Girls' Leadership: Governments and NGOs supporting women and girls' leadership in climate adaptation create better SRHR policies and services.

2.11 Ethical Considerations

Ethical safeguards were integral to every stage of the study, in accordance with international guidelines for conducting research with vulnerable populations. Given the sensitive nature of SRHR topics, all interviews and discussions were held in private, safe, and culturally appropriate settings to ensure that participants felt comfortable and empowered to share their experiences.

To protect confidentiality, all identifying information was removed from transcripts, and pseudonyms were assigned where necessary. Data was stored on password-protected devices with access restricted solely to the research team. All regulatory documentation will be securely maintained for three years following study closure, in line with ethical standards.

The study received ethical approval from the Institutional Review Board (IRB) of the Institute of Health Economics, University of Dhaka (IHE/IRB/DU/55/2024/Final), ensuring compliance with both national and international requirements for research involving human participants.

Findings

3. Demographic Profile of the Participants

Key Findings

- KII participants included health and climate experts, as well as community leaders, with average work experience ranging from 10 to 14 years.
- IDI and CDM participants were women and girls aged 15–49, primarily concentrated in the 15–24 age range (67%), with an overall average age of about 31 years.
- The majority (96.6%) of participants were currently married, with a notable portion (19.9%) having no formal education.
- Most participants (77%) were housewives, while others engaged in informal work such as farming, domestic labor, and garment work.
- The majority of the participants identified as Muslim (99.5%).

3.1 Demographic Profile of KII Participants

KII participants were drawn from three distinct groups: community health workers, local climate experts, community leaders or members of women and girls' and youth groups. The gender distribution varied across categories, with a notably higher proportion of females among the groups (Table 2).

Work experience among these participants was considerable, with an average of 10 to 14 years across all categories. Notably, community health workers and local climate experts reported a maximum of up to 36 years and 18 years of experience, respectively, reflecting their long-standing engagement in their respective fields (Table 2).

Table 2: Demographic Information of KII Respondents

Respondent Type	Total	Male	Female	Average Experience (Years)	Experience Range (Years)
Community Health Workers	8	3	5	14	3-36
Local Climate Experts	6	3	3	14	3-18
Community Leaders and Women and girls'/Youth Group Members	8	1	7	10	4-19
Overall	22	7	15	13	-

3.2 Demographic Profile of IDI and CDM Participants

The majority of participants fell within the 15–24 age group, over two-thirds (67%) of the total participants. A notable portion (approximately 19%) were aged 35 and above. The average age of participants was approximately 31 years. Since the inclusion criteria specified ever-married women and girls, respondents were either currently married, widowed, separated, or divorced. A significant majority (over 96%) reported being currently married, with only a small fraction identifying as widowed, separated, or divorced (Table 3).

Educational accomplishment was generally low among respondents. A large proportion had either no formal education or had not completed secondary school. Less than 15% had completed secondary education or pursued higher studies (Table 3).

The participant group was overwhelmingly Muslim (99.5%), with only one respondent identifying as Hindu. The majority of respondents (77%) were housewives, while the remaining participants

were engaged in various forms of informal or low-income labor, including agriculture, day labor, home-based farming, crafting, domestic work, and garment sector employment (Table 3).

Table 3: Demographic Information of IDI and CDM Participants (Women and Girls)

Background	n	%
Age Group		
15-19	69	33.5%
20-24	69	33.5%
25-29	15	7.3%
30-34	14	6.8%
35+	39	18.9%
Average (in years)	30.9	-
Marital Status		
Currently Married	199	96.6%
Widow/Separated/Divorced	7	3.4%
Education		
No education	41	19.9%
Primary Incomplete	22	10.7%
Primary Complete	34	16.5%
Secondary Incomplete	80	38.8%
Secondary Complete and Above	29	14.1%
Religion		
Muslim	205	99.5%
Hindu	1	0.5%
Occupation		
Housewife	159	77.2
Other	47	22.8

4. Contextual Vulnerabilities and Perceptions

Key Findings
• Gendered mobility, financial dependency, and service inaccessibility limit women and girls' ability to access sexual and reproductive health services, particularly during climate-related disruptions. • Women and girls perceive climate change through embodied experience and local metaphors, describing extreme weather, seasonal collapse, and divine punishment as part of their daily struggles. • Reproductive decisions are constrained by male and familial control, while climate stress intensifies fears of pregnancy, menstrual discomfort, and maternal health risks. • Adolescent girls, separated, widows, unmarried, women and girls with disability, and migrants face compounded vulnerabilities, including exclusion from relief, harassment, and denial of privacy and reproductive autonomy. • Institutional climate education and response mechanisms fail to engage women and girls directly, exclude SRHR content, and overlook unmarried or marginalized groups.

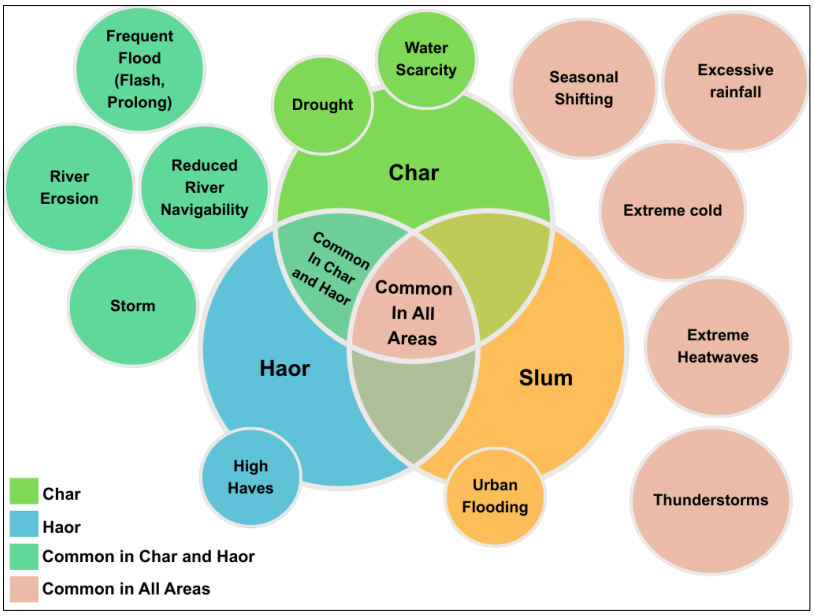
This section sets the foundation for understanding how pre-existing inequalities shape women and girls' experiences of climate change in Bangladesh's climate vulnerable and urban slum areas. It explores the structural and intersectional factors that heighten women and girls' exposure to climate-induced disruptions and constrain their ability to cope and adapt. These vulnerabilities are not experienced uniformly; they are filtered through gender, class, age, disability, marital status, household/family dimension and location, all of which converge to affect women and girls' perception of climate risks and their responses to them. By grounding these experiences in women and girls' voices and everyday realities, the section also surfaces the cultural narratives and community knowledge systems that shape how climate threats are understood and negotiated.

4.1 Climate Context and Environmental Exposure

4.1.1 Type of Climate Events

The study areas are exposed to a variety of climate events (Figure-4) that differ by ecology but share the capacity to disrupt everyday life. In the char areas, seasonal and sudden floods are common, and riverbank erosion can erase entire villages within days. Alongside this, droughts and water scarcity regularly affect crops and force women and girls to walk long distances in search of safe water. In the haor basins, sudden flash floods and prolonged waterlogging dominate. Fields and homes remain submerged for weeks, and strong waves during peak seasons are a constant threat to settlements. In the urban slums, hazards are shaped by poor infrastructure. Heavy rainfall and blocked drains lead to frequent flooding, with stagnant water lingering in lanes and houses. Heatwaves are also a growing concern, especially in tin-roofed, overcrowded homes.

Figure 4: Climate Related Events Reported



Across all areas, respondents described facing common hazards such as storm surges, thunderstorms, and lightning. Many respondents noted the collapse of the traditional six-season cycle into three, summer, monsoon, and winter, a shift that has disrupted farming calendars, food security, and cultural practices.

4.1.2 Frequency, Severity, Livelihood Impacts and Local Perceptions

Respondents consistently stressed that climate events are happening more often and with greater intensity than in the past. In the char regions, families described how floods that once occurred every few years now arrive annually, while river erosion continuously eats away at cultivable land and homestead plots. Siltation and shifting river channels were reported to reduce navigability, which undermined fishing and river-based livelihoods. Respondents explained that repeated losses forced families to abandon farming as their only occupation and shift between fishing, day labor, petty trade, and seasonal migration.

In the haor areas, people emphasized the unpredictability of rainfall and flooding. They explained that farming no longer provides steady income, as crops are regularly destroyed by sudden floods. Women and girls described the uncertainty as “living season to season,” with families unable to plan long term. Many reported that men migrate temporarily to towns in search of work, leaving women and girls to manage households under increasingly fragile conditions.

In urban slums, respondents said that even moderate rainfall now causes immediate flooding due to blocked drainage. Families reported losing stored food, damaged belongings, and disrupted wage labor whenever flooding occurred. Women and girls emphasized that these recurring shocks made it nearly impossible to stabilize income or plan for the future.

Across all areas, respondents agreed that families could no longer rely on one form of livelihood. Instead, households were compelled to constantly adjust, combining farming, fishing, petty trade, and seasonal migration in shifting ways to survive. This instability has left household incomes unpredictable, forced families into borrowing or selling assets, and deepened debt cycles. Women and girls explained that this instability increased their household burdens, as they were left to manage both economic survival and caregiving during the absence of men.

Alongside these material impacts, women and girls also articulated the changes in highly experiential and intergenerational terms, blending livelihood struggles with sensory, moral, and spiritual interpretations of a changing environment.

In all three areas, women and girls do not typically use the term “climate change.” Instead, they describe “the environment has changed,” often referring to more intense floods, prolonged waterlogging, stronger storms, and unbearable heat or cold. In chars and haors, women and girls explained that the traditional six-season cycle has collapsed into “three moods”, hot, cold, and rainy, each harsher and more unpredictable than before. Summers are “unbearable,” winters “biting,” and rains come suddenly or in excess, leaving little time for preparation. One woman from the char explained how these shifts in heat and cold directly affect daily life,

> *“It's a bit more (cold) now than before. It used to be less. Now it's hard to sleep, hard to eat... And the heat during summer has increased too. The sun’s heat feels like it's coming much closer to the ground.”* (IDI_Woman_Char)

Women and girls also rely on local metaphors and spiritual interpretations. Expressions such as “the sky has broken,” “the sun is angry,” or “the river is raging like never before” convey both sensory experiences and moral meanings. Many women and girls view these shifts as signs of divine punishment or warnings tied to social decline and sin. As one woman in the slum mentioned,

> *“What times we’re living in... Things were never like this before. It used to be much better. There's so much sin in the country now, and it’s the consequences. It's Allah’s wrath upon us...”* (IDI_Woman_Slum)

Older respondents often contrasted the past with the present, recalling a time when weather was more predictable, farming was more stable, and disasters less intense. They explained that agricultural and fishing calendars once followed seasonal patterns but now were unreliable. As one woman from haor shared,

> *“Before, everything had a fixed time. What would happen and when, was certain. I saw my father and uncles working by season, planting crops on time. Now, nothing is certain anymore.”* (IDI_Woman_Haor)

Younger women and girls, particularly adolescent girls, expressed a different perspective. Many said they had grown up in a world where instability was normal. For them, repeated floods, displacement, and food insecurity were part of life rather than exceptional events.

> *“Floods have always been there… Nothing has really changed. It's just the same as we've seen before.”* (IDI_Girl_Haor)

This generational gap reflected not only different memories but also shifting moral frameworks: elders emphasized divine will, while younger women and girls struggled with frustration, resignation, and fear about their futures.

4.2 Structural Vulnerabilities

In the climate-vulnerable contexts of Bangladesh’s char, haor, and urban slum areas, women and girls navigate a web of structural disadvantages that shape how they experience and respond to environmental crises. These structural barriers rooted in long-standing gender norms, economic dependence, social hierarchy, inadequate infrastructure, and political neglect- are not new. But climate change deepens their impact, pushing already hazardous lives to the edge. While many of these patterns cut across areas, each context presents its own specific challenges, shaped by geography, access to institutions, and social norms.

4.2.1 Gendered Mobility Constraints and Normative Surveillance

Restrictions on women and girls' mobility emerged as one of the most consistent markers of inequality across char, haor, and slum areas. These restrictions shaped how women and girls were exposed to climate risks, limited their ability to seek SRHR services, and constrained their agency during crises.

In the char areas, women and girls described strong adherence to purdah norms, which discouraged them from leaving home without a male companion. During floods, many reported remaining in submerged houses rather than going to shelters, citing the absence of separate spaces, privacy, and sanitation facilities for women and girls. Even in non-crisis times, accessing clinics or health centers was limited by both distance and stigma. Respondents explained that traveling for SRHR services was often viewed as suspicious, particularly for unmarried girls or newly married women and girls, with community gossip deterring many from seeking needed care. As one woman put it,

> *"In our village, women do not go to the clinic very often. Many people think it's unnecessary, and those who do go are often talked about behind their backs. This creates discomfort and discourages women from seeking care, even when they need it."* (IDI_Woman_Char)

In the haor basins, these barriers were compounded by seasonal isolation. Villages were located far from upazila centers where health services were available. During the dry season, women and girls reported walking for hours or paying high costs for transport, which most families could not afford. In the rainy season, boats provided easier access, but women and girls rarely traveled alone due to social norms requiring male accompaniment. Respondents said these delays were dangerous during late-stage pregnancies or complications, sometimes leading to life-threatening outcomes.

> *"You can't get a vehicle here whenever you want. If no arrangement is made beforehand and if there is no man at home, there is no option but to stay put. Even if a patient's condition gets worse and they die, nothing can be done. Such incidents happen here often."* (IDI_Woman_Haor)

Parents also withdrew girls from school during monsoon periods because of mobility risks, reinforcing domestic confinement and accelerating early marriage. One mother explained,

> *"During the monsoon, my daughter can't go to school. The bamboo bridges get too high to reach, she just can't cross. And it's not always possible to go by boat either; sometimes you can't even find one. Is a child's life more important, or education? Out of fear, we stop sending them to school, they just stay at home. And if they don't follow the lessons in class, who's going to teach them at home? That's how their education ends early. Eventually, we have to get them married off…"* (IDI_Woman_Haor)

In the urban slums, even though services were nearby, people still couldn't access them easily. Women and girls described avoiding narrow lanes where harassment, drug addiction, or gambling were common. Young, single, or working women and girls reported being followed, closely scrutinized, or verbally harassed. Despite being primary income earners or household managers, many women and girls said they faced reputational risks when moving outside, which discouraged them from visiting clinics for SRHR or other health needs. As girls mentioned,

> *"The slum lanes are already narrow and dark. Men sit around in the corners, gossiping, gambling, and taking drugs. During the rainy season, they even do these things sitting on people's doorsteps. In such a situation, just opening the door feels uncomfortable and*

frightening... And going to the hospital or a shop for medicine in this situation is another risk. Someone might see and then make bad comments about it..." (CDM_Girls_Slum)

Across all areas, respondents highlighted that SRHR-related travel carried stigma. Even when transport was available, women and girls felt socially scrutinized for seeking contraceptives, antenatal care, or menstrual products. This created a gendered geography of confinement, where social surveillance merged with physical inaccessibility to restrict women and girls' choices.

4.2.2 Economic Insecurity, Control over Finances, and Gendered Dependency

Economic dependency on men remained a central structural barrier across all study areas. Women and girls contributed to household economies through farming, livestock rearing, tailoring, food processing, vending, or wage work, but rarely had control over earnings.

In char and haor areas, women and girls described earning small incomes from selling milk, eggs, crafts, pickles, or hand-stitched clothes. Yet, they could not decide independently how to spend this money. Even minor personal purchases such as soap, sanitary pads, contraceptive, or medicines required negotiation and approval. Respondents recounted being scolded, denied funds, or told such needs were "unnecessary."

"Here, women working outside is not very acceptable. You could say they are not given permission by the family. There are also religious restrictions. Women are usually seen working from home. They raise ducks, chickens, cows, and goats. By selling those, they earn a little bit of money. But even if they do that, they can't spend as they wish. They need their husband's permission, in-laws' permission… Besides, using methods (family planning) is a different issue, for that they need separate permission first. Whose money it is, how it will be spent, that comes afterward." (KII_Char)

This dependency became severe in SRHR emergencies. Several women and girls reported being denied money or permission for hospital visits during pregnancy, resulting in miscarriage, complications, unsafe home deliveries, or stillbirths. One girl from the slum area stated,

"My mother-in-law and grandmother-in-law did not agree to let me go to the hospital. My condition had gotten really bad, I felt like I wouldn't survive. But still, they wouldn't allow me to be taken to the hospital. In their family, they said babies aren't born in hospitals. They didn't even let me go to my parents' house, fearing that they (my family) might take me to the hospital. I suffered so much, it took such a long time (for delivery).. .but still, they didn't agree." (CDM_Girls_Slum)

Adolescent girls relied on parents for money to buy safe menstrual products; when parents disapproved, they were forced to use unsafe dirty cloth. After marriage, this dependency shifted to husbands, some of whom refused to purchase menstrual products or punished women and girls for spending on them.

"Before marriage, I never used pads. I knew about pads, but I was never given money from home to buy them. After marriage, I use pads now. My husband buys them for me. But when he doesn't buy them, I use clothes like before." (CDM_Girls_Slum)

In the urban slums, many women and girls were primary earners, working in garments, as domestic laborers, or as vendors, often while men were unemployed, abusive, or involved with addiction. Still, their income was usually seized by husbands or pooled for communal use. Respondents explained that men often collected salaries directly from outside garment factories, leaving women and girls with nothing.

> *"Around salary time, the husbands start waiting on the streets in advance. They even sit in front of the garment factory. The moment the salary is received, they take it. Working here is also a form of oppression. If she doesn't want to give the money, the abuse gets worse. They use filthy language. No matter who earns, the money has to go to the husband, it must be given to him."* (KII_Slum)

Some women and girls described hiding small amounts of money, contraceptives, or savings, but many said they delayed seeking health services due to fear of refusal or retaliation.

Across all areas, climate-induced financial shocks, such as crop losses, livestock deaths, or job disruptions (discussed in detail in 4.1.2) deepened this dependency. Women were often the first to reduce meals, postpone care, or use unsafe alternatives when money was scarce. Even NGO-supported livelihood projects did not guarantee autonomy, as male relatives frequently took over women's income and decision-making power.

4.2.3 Service Inaccessibility and Infrastructure Failure

Access to SRHR services, including contraception, antenatal and postnatal care, safe delivery, and menstrual health was reported as severely constrained across study areas, particularly in char and haor areas. These barriers were shaped not only by weak health infrastructure but also by geographic isolation, inadequate transport, and climate volatility.

In char areas, respondents explained that reaching formal health facilities required long and costly travel, often on damaged or submerged roads. During floods, entire villages were cut off, and health workers stopped visiting. One of the key respondents noted,

> *"It has been observed that villages are moving farther away due to river erosion. Therefore, health workers, meaning those involved in family planning, are not going to those places, which is why they are not receiving family planning services. When we talk to family planning workers, they keep saying, 'We don't have enough manpower'…Villages are moving further away, and as a result, family planning workers cannot or do not go there. Especially during flood times... During that time, the roads break due to water flow, and they don't go either. Consequently, in those cases, there is often an increase in unintended childbearing…"* (KII_Char)

Women and girls recounted missing antenatal visits, running out of contraceptive supplies, and being left without delivery support for weeks. Some described giving birth on boats, on roadsides, at shelter or at home in unsafe conditions due to inaccessibility. (See Sections 5.1.2 and 5.1.4 in Chapter 5 for further discussion on interruptions in antenatal/postnatal care and maternal morbidity). One woman mentioned,

> *"Getting access to services inside the char is difficult. For example, if we fall sick, there's no transport available within the char. To get any medical help, we have to go all the way to Mukundagati. That means walking, and on top of that, there's the problem of money, our income is low, and there are many other struggles. Sometimes there's a boat, but often it's hard to find one when needed. During delivery time, we have to rent a rickshaw, which also costs money. If it's nighttime, it becomes even harder. At least during the day, some help might be available. We, the people of the char, generally don't go for (antenatal) check-ups. This is just how we live, relying on Allah. When the labor comes, it just happens like that. I've had all four of my children at home. The problems we face are mainly a lack of doctors, lack of money, and poor roads. During the rainy season, when there's flooding, we can't move around properly, and roads get washed away…"* (IDI_Woman_Char)

In the haor, similar challenges were reported. Women and girls described stormy boat journeys to clinics while in labor, sometimes resulting in injury or stillbirth. Many noted that health centers were under-resourced, with limited staff or equipment, making emergency care nearly impossible.

In the urban slums, clinics were physically closer but often overcrowded, underfunded, or inaccessible to undocumented migrants. During floods and waterlogging, health workers stopped home visits altogether. Respondents described struggling through flooded alleys to reach clinics, with pregnant women and girls facing particular risks. Even when facilities were available, harassment and lack of privacy discouraged women and girls from seeking care. One slum resident shared,

> *"During the monsoon, I was pregnant. There was water in the toilet, so I had to hold my urine for 4 to 5 hours. I even slipped and fell once. A (pregnant) woman in our neighborhood, her husband tried to take her to the medical center through the floodwater. On the way, she slipped and fell, and she had a miscarriage…"* (IDI_Woman_Slum)

Across all three areas, women and girls' ability to access timely and dignified SRHR services is not determined simply by supply-side gaps. It is shaped by a merging of physical remoteness, climate volatility, institutional fragility, and patriarchal norms- all of which create an environment where reproductive rights are structurally undermined.

4.2.4 Reproductive Control and Domestic Power Dynamics

Across all areas, reproductive decision-making remained heavily controlled by husbands, in-laws, and elder relatives, leaving women and girls with little autonomy over contraception, pregnancy, or childbirth.

In char and haor areas, respondents explained that in-laws, particularly mothers-in-law, dictated decisions about when to have children, whether contraception was acceptable, whether and when to continue or discontinue the pregnancy, and where childbirth should occur. Hospital deliveries were often dismissed as unnecessary or wasteful. Women and girls recounted needing explicit permission to use contraceptives, and in some cases, even discussing the topic was forbidden. Some described hiding pills or injections from their husbands or in-laws, while others said they were denied contraception altogether.

> *"Without your husband's order you can do nothing. Here there is no freedom of women. Because, if women had the freedom, women would say they will not take more than two children… But they cannot… It (decision of family planning) depends on men. Because, if someone wants to take any method (FP method) that requires consent of the husband. Method cannot be taken without permission of the husband. The consent of the husband is a must."* (KII_Haor)

In the urban slums, awareness of contraceptive methods was comparatively higher due to NGO outreach, but decision-making power still rested with men. Women and girls reported that even when they initiated use, husbands controlled the choice of method. Others described coercion into unprotected sex or violence when negotiating family planning. Women and girls also highlighted emotional strain, balancing reproductive intentions with financial hardship, spousal neglect, and family pressure.

> *"My house is small, it becomes hard even to sleep. I had the hope of not having more than two kids… I had hope, but the younger daughter was still born. I tried a lot to prevent it, but I couldn't. And because of these disasters water rises a lot. And with the income my husband earns, I can't afford to rent a flat or a house in a better area. To speak truthfully,*

my husband has a bit of an addiction. He takes drag. If he earns 500 taka, 300 goes to me, and 200 goes to him. It's a struggle. And with all the water issues, it's difficult to manage the kids. It is not suitable to live here with three kids. This is one thing, and the other aspect is financial. I already have three kids, and I have no intention of having more. But I do not know if I can prevent it or not." (IDI_Woman_Slum)

Across all areas, respondents explained that when pregnancies failed, children were born female, or unintended pregnancies occurred, women and girls alone were blamed, despite having little control over decisions. This reinforced a system in which women and girls' reproductive autonomy was not only denied but actively managed by others to enforce obedience and control.

4.2.5 Political and Institutional Marginalization

Women and girls consistently reported being excluded from relief distribution, disaster response, and community decision-making processes. In char and haor areas, respondents described how relief distribution was controlled by politically connected men, landlords, or elites. Relief was typically distributed under men's names, leaving widows, separated women and girls, and female-headed households without access. Several women and girls recounted being denied relief during floods because their husband's name was not registered, even when they were the sole caretakers of children.

"Without a man, no benefits can be received. Everyone recognizes only the men of the household. Women are not really known like that. Even if they stand in line, it doesn't help. Their names aren't on the list, so they are turned away." (CDM_Women_Haor)

In the urban slums, respondents explained that relief distribution was filtered through party networks or ward-level lists, also dominated by men. Migrants, renters, and undocumented families were often excluded.

"Here, no one knows us, how will we get help? They give help to familiar faces. Their people get everything..." (IDI_Woman_Slum)

Women and girls described being harassed or deprioritized during distributions, with those connected to political actors receiving preference. Even when women and girls were included in community disaster committees or NGO groups, they reported feeling tokenized. Their input was often ignored, and participation was treated as symbolic rather than meaningful. Across areas, women and girls expressed frustration at being burdened with managing household survival while systematically excluded from formal systems that controlled access to aid and resources.

4.2.6 Invisible Labor and Emotional Burden

Women and girls across char, haor, and slum areas described carrying the primary responsibility for ensuring household survival during both normal times and crises, yet their contributions remained unrecognized and unsupported.

In char and haor areas, women and girls recounted elevating household goods, storing food, managing livestock, collecting water, and caring for children during floods, all while continuing with cooking and cleaning. Respondents explained that these responsibilities often forced them to delay or sacrifice their own SRHR needs, such as antenatal visits, contraceptive refills, or menstrual care. A woman from char shared,

"From children to livestock, women and girls have to take care of everything. In that situation, there is neither time nor the opportunity to think about own selves or do anything for own selves." (IDI_Woman_Char)

In urban slums, women and girls described additional challenges during floods, such as protecting children from open drains, reconstructing makeshift toilets, or cooking in confined, waterlogged spaces.

> *"Whether the water rises or whatever happens, all the work still has to be done by us. Lifting things up, cooking while standing in the water, everything… and then, if a minor fault found, there's the mother-in-law's scolding and even the husband's beating too..."* (IDI_Woman_Slum)

Managing menstruation, pregnancy or newborn care in such environments was reported as particularly difficult.

> *"During disasters, contraception does not get much importance due to the pressure of survival. Many (women and girls) face the risk of unintended pregnancies. In cases where unintended pregnancies occur, women are forced to make difficult decisions. If a child comes unexpectedly in the womb, many people terminate it, and even if someone delivers the child, both the mother and the child suffer from malnutrition. At that time, those who do not want to keep the baby, meaning those who want an abortion, use traditional herbal medicines, buying medicines from market shops, and consuming them as they cannot access the health facilities at that time".* (CDM_Women_Haor)

Women and girls also highlighted the emotional burden of crises. They described absorbing spousal frustration, calming frightened children, and suppressing their own distress to maintain household stability. Respondents linked this constant stress to miscarriages, menstrual irregularities, infections, and chronic fatigue. One woman said,

> *It's hard to stay healthy under so much pressure. If you become pregnant in such a situation, the risk is even higher. Thoughts like what will happen, where to go, what to do, who to get help from, these worries often lead to miscarriage or premature delivery. With so much stress, it's impossible to stay well."* (IDI_Woman_Slum)

Across all areas, women and girls emphasized that their invisible labor, both physical and emotional, was central to community survival but was neither recognized nor compensated. This invisibility reinforced cycles of reproductive vulnerability and left women and girls without rest, autonomy, or support in recovery.

4.3 Gendered Perceptions of Climate Change

Women and girls across the char, haor, and slum areas of Bangladesh perceive climate change not in abstract scientific terms but through its intimate disruptions to their health, bodies, and daily routines. Their perceptions are deeply gendered, grounded in daily caregiving, bodily discomfort, interrupted reproductive rhythms, and the emotional toll of adapting to unpredictability. Despite being largely excluded from formal climate discussions, women and girls offer detailed and significant accounts of how environmental changes disrupt not only landscapes but also intimate dimensions of life- food, health, dignity, and family futures.

4.3.1 Gendered Exposure and Embodied Risk Perception

Women and girls' perceptions of risk are closely tied to their gendered responsibilities. In char and haor areas, floods interrupt the most intimate routines. Women and girls cook with their feet in floodwater, struggle to dry soaked firewood, and manage menstruation without privacy or dry cloths often leading to infections and shame. Some avoid changing clothes to minimize exposure, despite health risks. Pregnant women and girls spoke of heightened anxiety during monsoon

months, fearing miscarriages, delivery complications, or being forced to give birth without skilled attendants.

One group of adolescent girls in the haor reflected on the multiple burdens women and girls face during disasters,

> *"There are too many issues women have to face during disaster. During floods, they face housing problems. They struggle to manage livestock and poultry. If someone falls sick, they cannot take them to the hospital. Using contaminated floodwater leads to various infections and diseases. If a woman is pregnant or has a miscarriage during a flood, she often cannot be taken to the hospital, resulting in maternal and infant deaths. Cooking becomes challenging in floodwater, and toilets and tube wells get submerged, causing severe sanitation issues. Houses go underwater, and parents must stay extra cautious with children, as some drown in the floodwaters… During disasters, food shortages worsen, affecting women the most. They have to skip food to ensure others' meals. Additionally, during disasters, pregnant women face health risks when trying to assist elderly family members…"* (CDM_Girls_Haor)

In slums, women and girls experience climate change through heat stress, infections, and reproductive strain in overcrowded waterlogged housing. Shared toilets often become unusable during floods, leading women and girls to reduce food and water intake to avoid urination, which in turn causes dehydration and illness. Reproductive discomfort, including irregular periods, pelvic pain, and untreated infections, was widely reported. A woman shared,

> *"During the rainy season, I don't even drink water out of fear. If I drink, I will need to urinate. But everything is underwater then, where will I go? Men can go anywhere, but women cannot. Later, from not drinking water and holding urine, burning starts in the private parts and problems occur."* (IDI_Woman_Slum)

These embodied experiences shape a perception of climate change not as an external threat but as a daily, lived assault on women and girls' health and dignity.

4.3.2 Disrupted Reproductive Intentions and Family Planning Fears

Climate stress directly influences how women and girls think about childbearing and contraception. In char and haor areas, many women and girls said they try to avoid pregnancies during dry season or harvest times when their labor is most needed. Yet their agency is limited: husbands, in-laws, or religious beliefs often dictate decisions. Some women and girls delay or reduce family size due to economic insecurity, yet frequent contraceptive shortages and partner refusal undermine these efforts, leading to unintended pregnancies.

> *"Many times, the birth control pills run out, and can't manage to get more. Then we (women and girls) fall into trouble. Men don't understand these things. Even if we tell them, they don't listen, and they don't go to bring it either. As a result, many times women end up getting pregnant unintendingly."* (IDI_Woman_Char)

In slums, overcrowding and stress increase sexual vulnerability. Women and girls reported unplanned pregnancies and unsafe abortions as common coping responses. Many expressed deep moral conflict about bringing children into a world of constant disaster, displacement, and scarcity. A woman living in the slum described her anxiety about raising children under such unstable conditions:

> *"I don't want my child's future to be like mine. I'm afraid that they too might have to live in a slum and suffer like I do. There is no good environment to live in here, no money, no*

security. If more children are born into this, then how will they be raised? If they grow up like this, won't their life turn out just like mine?" (IDI_Woman_Slum)

4.3.3 Perceiving Gaps: Institutional Silence and Lack of Climate Education

Women and girls' perceptions of climate change are shaped not only by what they observe but also by the silence of institutions. Across all areas, women and girls emphasized that they rarely receive timely or accessible information from formal sources. In chars and haors, early warnings were either delayed or inaccessible, often reaching only male household heads. Women and girls explained that they were left unprepared, relying on rumors or the experience of elders rather than official guidance. In slums, NGO meetings were occasionally held, but women and girls said they were irregular, and often not tailored to their realities or context.

> *"Many people come and say many things, but we don't always understand. When it's explained simply, then we can understand and remember it."* (CDM_Women_Slum)

Respondents consistently highlighted the need for inclusive climate education, especially information that addressed SRHR. Many explained that men needed to be included in awareness activities, since husbands often dismissed women and girls' health needs during crises. Women and girls also emphasized that information should be practical, delivered in local language, and communicated by trusted female health workers or community leaders. The absence of institutional engagement left women and girls feeling invisible in formal planning processes, reinforcing the sense that adaptation was their responsibility alone.

4.4 Intersectional Marginalization

Climate change amplifies existing inequalities by disproportionately affecting women and girls who are already marginalized because of age, marital status, disability, or displacement. Their exclusion from education, resources, services, and decision-making is not accidental but embedded in structural hierarchies that climate crises expose and intensify. The experiences of adolescent girls, women and girls without male protectors, women and girls with disacbility, and migrant women and girls show how intersectional disadvantage shapes both vulnerability and survival.

4.4.1 Adolescent Girls: Early Marriage, Education Disruption, and Silencing

Adolescent girls across char, haor, and slum communities described being among the most vulnerable during climate crises. In char and haor areas, repeated flooding and erosion disrupted schooling. Parents frequently withdrew daughters from classes during monsoons, citing unsafe travel across bamboo bridges or by boat. Many girls never returned to school after such interruptions, as families saw little value in continued education for daughters once learning gaps had widened. Early marriage was often presented as a way to reduce household expenses and to shield girls from the perceived risks of harassment or loss of honor.

As one key informant in the haor explained,

> *"Parents see that it is not worthwhile to wait, so they marry their daughters off as soon as possible to free themselves from responsibility. When a young girl is married off, she usually becomes pregnant within a year. She has a child, but she herself is malnourished, and so her baby also becomes malnourished. If you consider their domestic responsibilities, most household tasks are done by women. If anything needs to be managed, whether it's cooking, fetching water, gathering firewood, they handle most of it. During these continuous tasks, women are more affected and face health problems. But*

they cannot properly address their health issues because the decision-makers in their homes do not take their ailments seriously, considering them simple or minor." (KII_Haor)

Girls themselves reported feeling silenced in household decisions about education and reproductive health. They explained that their opinions carried little weight, particularly when discussing whether they should continue school or delay marriage. Even when they wanted to pursue studies, families often overruled them in favor of what was considered "safe" or "honorable."

In urban slums, insecurity and overcrowding created similar pressures. Parents discouraged girls from moving freely outside, fearing harassment in narrow lanes or at water collection points. When schools closed during floods or waterlogging, girls were often confined at home, where they were expected to take on more domestic responsibilities, including childcare and housework. This not only reinforced gendered divisions of labor but also curtailed their independence, aspirations, and future opportunities.

"Because of floods and waterlogging, it often becomes impossible to go to school. And if someone in the area harasses girls on the way, families also stop sending the girls to school. Once girls stop to go to school for any reason, they usually never get to start again. Even if they want to study, the situation doesn't allow it. Instead, they end up staying home doing household work, or they are married off." (IDI_Girl_Slum)

For many adolescent girls, climate disruptions thus not only restricted education but also reinforced early marriage and silencing, limiting their autonomy at a critical stage of life.

4.4.2 Pregnant Women and Girls: Heightened Risk in Crisis

Pregnant women and girls form another marginalized group whose vulnerabilities become acute during climate crises. In chars and haors, late-term pregnant women and girls face difficulties in evacuation; families reported carrying them on makeshift rafts or have to stay in submerged homes due to lack of transport. Shelters rarely provide private delivery spaces, skilled birth attendants, or clean delivery kits, forcing women and girls to give birth in unsafe, unhygienic conditions.

"In the shelters, there are no separate arrangements for men and women. So how would there be anything for pregnant women? Unless it is absolutely necessary, no one wants to leave their home." (IDI_Woman_Haor)

In slums, pregnant women and girls struggled to navigate waterlogged alleys to reach clinics, while ambulances or rickshaws could not enter flooded roads. Several women and girls shared experiences of miscarriages or complications caused by delays in reaching medical facilities. Others described holding urine for hours when toilets were submerged, leading to severe discomfort and health risks.

"When I was pregnant, I would try to go to the toilet less during the rainy season. I used to hold it in all day because the toilets were flooded. If I slipped or fell in that situation, it could have been very dangerous." (IDI_Woman_Slum)

Pregnancy is also intersected with social neglect. Husbands and in-laws sometimes refused to approve emergency hospital visits, dismissing complications as minor or unnecessary. Women and girls explained that they were often blamed for pregnancy-related difficulties, rather than supported.

4.4.3 Widows, Separated, Single and Unmarried Women and Girls: Social Exclusion and Institutional Neglect

Widows, unmarried girls, single women and girls, and separated women and girls consistently reported layered exclusion because they lacked recognized male "protectors." In char and haor communities, aid distribution and disaster relief were typically registered under men's names. Widows described being turned away from relief distribution points because their names did not appear on official lists, even when they were solely responsible for children.

Yet beyond exclusion from resources, women and girls in these groups described the social stigma and insecurity that compounded their vulnerability. In rural areas, widows and separated women and girls were often viewed with suspicion or as burdens. They are also vulnerable to being harassed due to lack of protector. As one the respondent mentioned,

> *"It is (harassment) not limited to disasters. These issues occur all the time. If there's no man in the house, some men try to take advantage of the situation. That's why we always sleep close to our doors securely locked, and the girls often have to hide themselves as a precaution."* (IDI_Haor_Woman)

In urban slums, these dynamics were further intensified by overcrowding, harassment, and political gatekeeping. Relief was distributed through ward-level party networks dominated by men, and without a husband's or father's name, women and girls were often excluded.

Single and unmarried women and girls in particular reported being frequent targets of gossip and harassment. Neighbors questioned their independence, their movement outside the home, and even their use of health services.

In both rural and urban contexts, insecurity was constant. Women and girls without male guardianship faced stalking, threats, and sexual advances, especially during displacement when they lived in temporary shelters or crowded slums. Fear of assault often led women and girls to self-isolate, limit their mobility, or remain silent about their needs.

This intersection of institutional neglect, social stigma, and heightened insecurity left widows, separated women and girls, and single women and girls feeling invisible within both formal aid systems and their communities. Despite often carrying the heaviest caregiving responsibilities, they remained among the least supported and most exposed during climate crises.

4.4.4 Women and Girls with Disability: Compounded Risk and Lack of Accessibility

Women and girls with disability faced multiple, overlapping vulnerabilities across all areas. In char and haor areas, families described the extreme difficulty of evacuating women and girls with disabilities during floods or erosion. Shelters lacked ramps, privacy, or adapted facilities, meaning that women and girls with disability were often left behind in unsafe homes. Some respondents explained that women and girls with disability could not even reach boats or raised platforms, making them dependent on others for basic survival.

In the urban slums, mobility was equally challenging. Narrow, waterlogged alleys made it nearly impossible for women and girls with disability to move independently during floods. Respondents reported that these women and girls were rarely prioritized by outreach workers and that health centers were physically inaccessible. As a result, they were effectively excluded from reproductive and maternal healthcare, unable to attend antenatal appointments, access contraceptives, or seek treatment for infections.

The neglect was compounded by stigma. Communities often assumed that women and girls with disability were non-reproductive, and therefore their SRHR needs were dismissed or ignored. This denial of reproductive agency further isolated them, leaving their health concerns unacknowledged even in spaces meant to provide care. One respondent said,

> *"No one thinks about general people. How will their (women and girls with disability) matters even come up!"* (CDM_Women_Slum)

4.4.5 Migrant and Recently Displaced Women and Girls: Invisible and Unprotected

Women and girls displaced by river erosion, flooding, or eviction faced heightened risks due to their lack of documentation, networks, and recognition. In char and haor areas, displaced families often resettled in new areas where they had no established ties. Women and girls reported being excluded from relief because their names did not appear in local registries, while neighbors treated them as outsiders who were undeserving of support. One women and girls shared,

> *"In an unfamiliar place, no one knows each other. Without knowing anyone, it is hard to get help."* (IDI_Woman_Haor)

In the urban slums, new migrants without proof of residence were similarly excluded from both government and NGO services. Women and girls explained that they were forced to rely on landlords or brokers for survival, which sometimes left them vulnerable to harassment, exploitation, or sexual coercion. Being both uprooted and undocumented made them particularly invisible to formal systems and heightened their sense of insecurity. One woman said,

> *"Those who are new to the slum don't get any help or support. The landlords and old residents know each other, and they get everything. The newcomers are like refugees."* (IDI_Woman_Slum)

This invisibility was not only institutional but also social. Established communities often distrusted new arrivals, viewing them as competitors for scarce resources. For migrant women and girls, this meant exclusion not only from relief but also from informal solidarity networks that might otherwise have offered protection.

5. Climate Impacts on SRHR and Everyday Lives

Key Findings
• Climate crises disrupt every aspect of SRHR, including access to contraception, antenatal/postnatal care, menstrual health, and safe childbirth, leading to increased maternal morbidity, infections, and unintended pregnancies. • Displacement due to floods, erosion, or migration breaks SRHR service continuity, isolates women and girls from trusted health providers, and increases exposure to violence, coercion, and mental health stressors especially for adolescent girls, widows, and migrants. • Child marriage and reproductive coercion rise during disasters, driven by economic desperation, social control, and a desire to "protect" girls, while consent and reproductive choice are routinely undermined. • SRHR continues to be deprioritized in disaster relief and adaptation plans, where reproductive health is treated as secondary to infrastructure repair or livelihood recovery, leaving women and girls' bodily needs largely invisible.

This chapter explores the multifaceted impacts of climate change on women and girls' sexual and reproductive health and rights (SRHR) in climate vulnerable and urban poor areas. Drawing on evidence from char, haor, and slum communities, the chapter highlights how climate disruptions intensify existing vulnerabilities and create new layers of risk. The analysis is organized across three major areas: direct impacts on SRHR outcomes, consequences of climate-induced migration and displacement, and the power dynamics shaping women and girls' access to land, shelter, health, water, and other critical resources. Together, these findings underscore the urgent need for climate adaptation strategies that center women and girls' autonomy, safety, and reproductive justice.

5.1 Climate Change Induced SRHR Challenges

Climate hazards directly shape women and girls' SRHR, limiting access to essential services, altering fertility intentions, and heightening risks of violence and reproductive coercion. In char, haor, and slum areas, disruptions caused by floods, erosion, droughts, waterlogging, and displacement cut across multiple aspects of SRHR. These outcomes are not isolated; they overlap with the structural vulnerabilities described in Chapter 4, but here they appear in their concrete impacts on women and girls' reproductive health, wellbeing, and autonomy.

5.1.1 Menstrual Health Management Under Climate Stress

Menstrual health was one of the most invisible yet pressing concerns. In chars and haors, disasters destroyed toilets and bathing areas, forcing women and girls to change in unsafe, unsanitary conditions. Shelters rarely included separate facilities, and women and girls described waiting until night to change clothes or using corners of crowded rooms without privacy.

> *"During menstruation, due to the flooded areas being damp, repeated use of wet cloths causes heat rashes in private parts. It itches, and small bumps appear. It feels unrestful. We cannot maintain the necessary hygiene after menstruation. There is already no space inside the house. Then, when we want to go to the toilet, the toilet is submerged. For this reason, due to the lack of privacy, we fail to maintain hygiene."* (CDM_Women_Char)

The lack of safe materials was widespread. Women and girls reported reusing damp cloths, sometimes soaked in floodwater, which caused infections, rashes, and itching. During prolonged

floods, drying cloths hygienically was nearly impossible, cultural stigma prevented drying them outdoors, and indoor drying in dark, damp rooms left them perpetually wet. A girl from the char shared,

> *"Menstrual cloths have to be dried in hiding. If someone sees them, it is considered unacceptable. On rainy days, the cloths don't dry, and then we are forced to use them while still wet. This causes itching."* (IDI_Girl_Char)

Adolescent girls faced acute consequences. Without access to clean menstrual products and private toilets, many missed school during menstruation or withdrew altogether when repeated absences became normalized. In slums, girls reported reducing food and water intake to avoid urination during periods, which worsened dehydration and infections. Some relied on makeshift barriers for privacy when toilets flooded.

Despite being central to women and girls' dignity and health, menstrual needs were consistently absent from relief planning. Women and girls emphasized that while food and shelter were distributed, no one thought of pads or clean cloths, and private spaces. Menstruation was treated as invisible, reinforcing gender hierarchies about whose needs count in a crisis.

5.1.2 Barriers to Contraception and Family Planning Services

Access to contraception was a consistent struggle across all areas, worsened during disasters but rooted in structural inequities. In char and haor areas, women and girls emphasized how geographic isolation combined with poor transport meant that obtaining contraceptives was difficult even in normal times. Most relied on village drug stores for pills, but these were often unreliable, expensive, or run by men, which discouraged young women and girls from approaching them. During floods or river erosion, these fragile supply chains collapsed altogether, health facilities closed, health workers could not reach remote settlements, and drug stores ran out of stock.

> *"Pills can get from shops, but these are always crowded by men. For women, going there to buy pills or pads feels shameful, so they don't want to go. Men (husbands) don't care about these things, and even after being told many times, they don't buy them. And often the shops themselves get flooded. Then there is no way at all."* (IDI_Woman_Haor)

Women and girls described running out of pills for weeks or borrowing from neighbors until health workers resumed visits. For some, this led to unintended pregnancies at the very moment households were struggling with food shortages and displacement. Even when services were technically available, costs of travel and treatment, combined with male control of finances, created barriers. Husbands or in-laws often denied money for contraceptives, framing them as "non-essential" expenses. Without financial independence or permission, women and girls were forced to forgo family planning.

In slum communities, contraceptives were more visible through pharmacies, NGOs, and nearby clinics, yet floods and prolonged waterlogging blocked lanes and forced facilities to close. Many women and girls lost touch with familiar health providers during displacement and were reluctant to approach unfamiliar health workers or male shopkeepers. Renters and undocumented migrants were often excluded from NGO or government-supported family planning programs, further limiting access.

> *"In a new place, everything feels unfamiliar. It takes time to adjust. At first, you can't trust anyone. Back in the village, I could easily share everything with the sisters (community health workers) there, and I trusted their advice. But after coming here, in the beginning I*

couldn't trust anyone like that. They also didn't accept us very easily. I didn't even know where to go or what to do." (IDI_Woman_Slum)

Across all areas, contraception was precarious: controlled by distance, disaster, stigma, and patriarchal decision-making. Climate shocks acted as a multiplier, turning existing fragilities into crises of reproductive autonomy (see Section 4.1.4 in Chapter 4 for reproductive control within households).

5.1.3 Forced Pregnancy and Unsafe Abortion During Crises

Climate shocks not only undermine access to contraception but also heighten women and girls' vulnerability to forced pregnancy and unsafe abortion. During floods, erosion, and displacement, many women and girls described being coerced into conceiving, either due to spousal pressure or family expectations to "rebuild" lineage after losses, or simply due to the unavailability of contraceptives. Forced marital sex was widely reported, leaving women and girls with little ability to refuse or to negotiate contraceptive use. A woman said,

"During disasters, everyone stays stuck at home. Men have no work and can't go out. At that time, husbands put more pressure on their wives. Women want to keep some distance and explain that without contraception it could cause problems. But men don't listen. Even if women try to make them understand, they refuse. As a result, many women end up with unwanted pregnancies." (IDI_Woman_Haor)

Unintended pregnancies during crises often pushed women and girls toward unsafe abortion. Formal services were inaccessible as clinics closed, outreach stopped, or supplies ran out. In response, women and girls resorted to unregulated pills from local shops, traditional herbal remedies, or clandestine procedures performed by untrained providers. These methods carried high risks of excessive bleeding, infection, and sometimes death. One health worker explained how women and girls suffered silently because "abortion is never spoken of openly, even when complications are serious."

"Many women end up getting pregnant unintentionally at that time. But they are not in a position to keep the baby. What can they do then? There is no one nearby to give proper advice or care. So many try using herbs and leaves on their own. This often causes heavy bleeding. And there is usually no way to get them to a hospital then." (KII_Haor)

Stigma further deepened these risks. Women and girls faced intense scrutiny from families and neighbors, making safe services inaccessible. Young women and girls in particular described concealing pregnancies or complications to avoid gossip, only seeking care when it was too late. This silence often turned manageable health concerns into life-threatening crises.

5.1.4 Interruptions in Antenatal, Delivery and Postnatal Care

Pregnancy and childbirth were described as particularly challenging during climate events. In chars, women and girls often missed antenatal check-up even in dry months due to the costs, distance, and need for male accompaniment. During floods, access collapsed entirely. Roads were submerged, boats unavailable, and health workers cut off for weeks. Several women and girls reported giving birth on boats, in flooded homes, or on raised embankments, assisted only by relatives or traditional birth attendants.

In haor areas, prolonged monsoon flooding confined women and girls to their homes, making travel nearly impossible. One woman recounted being transported by boat during a storm while in labor; she was injured on the way, and by the time she reached the clinic, the baby had died. Such

stories illustrate how delayed or absent care transformed routine pregnancies into life-threatening events. The woman described her experience,

> *"When I was pregnant with my first child, labor pains suddenly started during a storm. It was the rainy season. They were taking me to the hospital by boat in the middle of the storm. Because of the strong waves, I got badly hurt in my stomach. After reaching the hospital, they managed to save me, but the baby died inside my womb."* (CDM_Women_Haor)

Cultural beliefs compounded these risks. Many families viewed hospital deliveries as unnecessary or shameful, insisting births should occur at home "as they always had." In-laws or husbands sometimes refused permission for hospital care, even during complications, resulting in obstructed labor, hemorrhage, or infection. Postnatal care was equally neglected. Women and girls described returning to domestic work immediately after delivery, with infections or bleeding left untreated because "the water had to recede first." Woman from hoar shared,

> *"During disasters, boats are not available for travel or to access any kind of service. Along with that due to workload pressures, pregnant women and those who have had miscarriages do not get adequate rest. Transportation to hospitals becomes unavailable, and even if they somehow reach a hospital, doctors are often absent. During floods, makeshift bamboo bridges (sako) are set up in different areas, but pregnant women struggle to cross them and risk slipping and falling. The rough travel conditions during disasters further increase the risk of physical strain. Due to delayed hospital access during floods, pregnant women sometimes die from excessive bleeding during childbirth."* (CDM_Women_Haor)

Urban slum women and girls were closer to facilities, but proximity did not equal access. Flooded, narrow alleys prevented pregnant women and girls from reaching clinics. Ambulances could not enter waterlogged lanes, leaving women and girls to labor in overcrowded homes without sanitation or skilled care. Shared housing heightened risks of postpartum infections. Heatwaves introduced additional stress, several women and girls reported preterm contractions and dizziness in tin-roofed houses without ventilation, worsened by frequent power cuts.

> *"Being pregnant here feels like a punishment. During the heat, it becomes unbearable to survive. I feel so unwell, but the family doesn't understand. They just say, 'Everyone feels hot.' But it is not the same for everyone."* (IDI_Woman_Slum)

In both rural and urban areas, women and girls emphasized that pregnancy under climate stress felt like "taking a gamble," where survival depended less on medical need and more on chance access to transport and facilities. *(See Sections 4.1.3 in Chapter 4 for background on service inaccessibility.)*

5.1.5 Maternal Morbidity and Reproductive Tract Infections

Climate events contributed directly to a range of maternal health problems. Women and girls in char and haor communities reported higher risks of miscarriage, prolonged labor, bleeding, and infection during floods, often linked to delayed care and poor nutrition. Malnutrition during crises left many mothers weak, increasing risks of anemia and poor recovery after childbirth. Many reported being forced to give birth without skilled attendants, relying only on relatives or elderly women and girls in the household.

Reproductive tract infections were also widely reported. Women and girls attributed these to stagnant water, unhygienic toilets, and the use of unsafe materials for menstruation. Many said

they endured pain, discharge, or swelling without treatment, since accessing clinics during disasters was impossible. Over time, untreated infections became chronic, with long-term effects on reproductive health and wellbeing.

> *"Women usually don't share their problems with anyone. Because of not eating properly, drinking less water, holding in urine, and using unclean cloths during menstruation, they develop many health problems. They keep these issues hidden. Even if they speak up, the family doesn't take it seriously. Since the hospital is far and they cannot go alone, they don't seek treatment. Gradually, the problems become severe."* (KII_Char)

The burden was compounded by silence. Women and girls explained that they rarely spoke about these issues, fearing shame or dismissal. Health workers also tended to overlook RTIs, focusing instead on more visible conditions like diarrhea or fever.

5.1.6 Early/Child Marriage and Reproductive Coercion During Crises

Economic distress and insecurity frequently accelerated early and child marriage. In haor areas, families who lost crops to flash floods described marrying off daughters quickly to reduce financial strain or to secure dowries. In char areas, displacement due to erosion pushed families to treat marriage as a way to "protect" daughters, fearing that otherwise they might face harassment or lose marriage prospects. One key informant stated,

> *"People think child marriage is the easiest solution. They believe it will reduce expenses and also secure the girl's future and safety. So, whenever a crisis or problem arises, marrying off the adolescent girl becomes the first solution they choose."* (KII_Char)

In slums, loss of income and repeated evictions similarly drove families to marry off girls early. Parents explained that marriage transferred responsibility to a husband and offered a form of security, even if it meant curtailing education. Girls themselves described feeling silenced in these decisions, forced into marriages that left them vulnerable to early pregnancies. One respondent shared her experience,

> *" After the erosion, now we have nothing left except the living room. We are three sisters. Right after that flood, I got married… I wasn't happy about it (getting married). I wanted to continue studying, at least to complete my SSC. He (my husband) is my cousin on my mother's side. His family was in a better position financially. My parents wanted the marriage. I have two younger sisters. I had no say in it… Right after the marriage, I had to get pregnant. Both my sons were born one after the other. I had hoped to wait at least three years after marriage before having children, but he didn't agree… Now, I don't want to have any more children, but he really wants a daughter. He won't let me use any family planning method unless I have another child. If I have one more baby, only then he'll take me to the doctor (for family planning). I don't have any control over this..."* (CDM_Women_Haor)

Marriage under crisis conditions also exposed girls to reproductive coercion. In-laws and husbands often pressured them to conceive immediately, even when health risks were high. Access to contraceptives was restricted, and several girls reported unintended pregnancies soon after marriage. These outcomes reinforced a cycle of early motherhood, compromised health, and curtailed autonomy. *(See Section 4.4.1 in Chapter 4 for adolescent girls' vulnerability to early marriage.)*

5.1.7 Gender-Based Violence and Heightened SRHR Risk

Gender-based violence (GBV) was reported to intensify in every area during crises. In char and haor areas, women and girls avoided going to shelters because they lacked separate facilities, toilets, and privacy. Those who went described harassment and fear of assault in crowded spaces. Collecting water or firewood during floods also exposed them to harassment in public. One of the girls shared,

> *"Drinking water has to be collected from far away, and that feels scary. Even going to the river to bathe is frightening due to the risk of harassment. We never go anywhere alone; we try to go in groups."* (IDI_Girl_Char)

In slums, women and girls said that narrow, waterlogged lanes became hotspots for harassment, particularly from drug users or men gambling. Young women and girls described being followed, verbally abused, or touched inappropriately, especially when moving alone.

Domestic violence also escalated during crises. Men's frustration over lost crops, homes, or income often erupted into domestic violence. Women and girls reported being beaten during or after disasters, sometimes accused of bringing "bad luck." Forced marital sex was common when men stayed home due to unemployment, with women and girls denied contraceptives or choice.

> *"There is physical abuse. Husbands do beat us. Whenever he gets angry, he hits me. If there's no work, he says things like, 'You're useless...' The beating happens... and during times of disaster, it gets worse. With no work and all the stress, things become harder, and that's when he beats me."* (IDI_Woman_Char)

These experiences highlighted how climate stress not only creates direct health risks but also intensifies existing gender inequalities, leaving women and girls more vulnerable to violence and reproductive harm. *(See Sections 4.1.1 and 4.1.4 in Chapter 4 for mobility constraints and domestic power dynamics.)*

5.2 Climate-Induced Migration and Displacement

Climate-induced migration and displacement are major pathways through which environmental change disrupts women and girls' sexual and reproductive health and rights (SRHR), family structures, and emotional wellbeing. In char, haor, and slum areas, women and girls' experiences of being uprooted due to river erosion, flooding, or livelihood collapse are often marked by loss of continuity in care, breakdowns in family and social support, increased vulnerability to violence and exploitation, and deterioration of both physical and mental health. Displacement deepens existing inequalities and exposes already marginalized women and girls to new, unregulated risks.

5.2.1 Loss of Continuity in SRHR Care and Support Systems

One of the most consistent findings across all areas was that displacement broke women and girls' connections with health services and support networks. In chars, repeated cycles of erosion forced families to resettle on roadsides, embankments, or newly formed sandbars where no clinics existed. Women and girls explained that even when basic services had been available in their former village, relocation severed ties with trusted community health workers and disrupted contraceptive use or antenatal routines.

In haor areas, seasonal migration was common during the dry season, when men and sometimes entire families moved for six months to work elsewhere. Women and girls left behind on isolated homesteads reported being neglected by outreach workers, while those who migrated lost access

to their regular providers. Adolescents and newly married women and girls were particularly affected, cut off from information, supplies, and peer networks that had previously supported them.

> *"In a new place, there is no one familiar. No one is known, even the providers are new. It all feels very confusing and unsettling."* (CDD_Women_Haor).

In slums, most displaced families arrived without identification or health records. Women and girls who were renters or squatters were often excluded from NGO and government service lists. Many said they felt "invisible" to health systems, with no one visiting their homes or recording their pregnancies. Even when clinics were nearby, women and girls hesitated to go, fearing rejection for lack of documents or unfriendly behavior from unfamiliar providers.

Whether temporary or permanent, displacement consistently led to interrupted contraceptive use, missed antenatal care, and unsafe deliveries leaving women and girls to navigate reproductive health without trusted providers or systems of support.

5.2.2 Exposure to Violence, and Exploitation

Displacement environments were repeatedly described as unsafe, especially for single women and girls, widows, or adolescent girls. In chars and haors, displaced families often camped for months on embankments or roadsides with minimal shelter. Women and girls said these areas offered no privacy, no lighting, and no security. Bathing, changing clothes, or sleeping became moments of constant fear. Reports of stalking, harassment, and verbal abuse were common, while rumors and gossip intensified women and girls' sense of vulnerability.

> *"During disasters, if we have to stay on the roads or in crowded places, it becomes a problem for women. Anyone can harass us at any time. We always have to stay alert then."* (IDI_Woman_Haor)

Families often used early marriage as a form of protection, marrying off daughters quickly to avoid harassment or reduce household burdens. Girls described these marriages as unwanted and imposed, marking a loss of agency in both education and reproductive health (see Section 5.1.5 for early marriage outcomes).

In urban slums, displacement compounded risks further. Women and girls relocated after floods or eviction were placed in overcrowded settlements where landlords, neighbors, or brokers wielded power. Several respondents described being propositioned for sex in exchange for food or shelter. Single women and girls and widows were especially targeted, some coerced into exploitative relationships or informal transactional arrangements. One woman shared,

> *If there's no man in the house, some men try to take advantage of the situation. That's why we always sleep close to our doors securely locked, and the girls often have to hide themselves as a precaution."* (IDI_Woman_Slum)

The fear of violence also limited women and girls' mobility. Some skipped health visits during pregnancy or menstruation, afraid of being seen or harassed. Many reported sleeplessness, anxiety, and emotional withdrawal, but psychosocial support services were largely absent. (see Section 4.4 for details on violence and exploitation risks faced by vulnerable women and girls).

5.2.3 Disruption of Family Structures and Emotional Wellbeing

Displacement often fractured families, leaving women and girls with heavier responsibilities and emotional burdens. In chars and haors, men frequently migrated for work after disasters, leaving women and girls behind to manage damaged homes, children, and livestock alone. Pregnant or

postpartum women and girls described carrying these burdens without support from kin or neighbors, which deepened their stress and sense of abandonment.

Even when whole families migrated, structures were disrupted, children left with grandparents, husbands commuting long distances, or relatives scattered across unsafe shelters. This weakened informal safety nets and placed women and girls in charge of caregiving under precarious conditions. Several women and girls recounted being permanently abandoned after men migrated. Husbands remarried elsewhere, leaving wives with children, debt, and stigma. For these women and girls, displacement was not temporary, it marked the beginning of chronic isolation and financial instability.

A key respondent shared,

> *"Many people migrate to the city or other areas. Some go for a short time, while others leave for an uncertain period. The burden of this migration falls mostly on women. If the woman doesn't migrate, then all the household responsibilities fall on her, children's education, food, a daughter's safety if there is one, and caring for in-laws. Until the husband can send money, she manages everything alone. And if the husband marries again and starts a new family elsewhere, then it becomes even worse. Such incidents are not rare."* (IDI_LE_Haor)

In slums, migrant women and girls from rural areas reported loneliness and loss of belonging. Unlike rural communities with courtyard gatherings and mutual aid, slum neighborhoods were fragmented and competitive. Women and girls said they feared asking neighbors for help, worried about gossip or rejection. Living in cramped shelters with little privacy, many reported insomnia, fear, and depression.

> *"In the village, we have our own people. We can sit and talk, share our struggles. But here, we have to live in fear, never knowing who will say what. No one here feels like our own. We have to keep our pain to ourselves. There is no one to help here."* (IDI_Woman_Slum)

Some deliberately postponed pregnancies to avoid additional strain, while others conceived under pressure despite emotional distress. Women and girls who became pregnant in displacement often described feelings of guilt, uncertainty, and grief, reflecting the psychosocial weight of managing reproductive health without supportive family structures.

5.2.4 Lack of Institutional Response and Protection Mechanisms

Institutional neglect was a recurring theme. In chars and haors, relief programs focused on food and shelter, rarely considering women and girls' reproductive needs. Temporary shelters lacked separate toilets, menstrual supplies, or maternal care facilities. Women and girls explained that they were not consulted in disaster planning or resettlement, leaving their SRHR concerns absent from policy responses.

> *"Women opinions are never taken in planning. The needs of women, children and men are not the same. We don't even know when, where, or how plans are made. That's why our problems are never solved." (CDM_Women_Haor)*

In slums, displaced renters or undocumented migrants were excluded from health rosters and relief lists. Aid was distributed through male-led community networks or political brokers, systematically disadvantaging women and girls without male affiliation. Several women and girls reported being turned away from clinics for lack of ID cards. Others received SRHR services only when NGO workers happened to visit their neighborhood.

This lack of institutional accountability forced women and girls to rely on fragile informal networks, such as neighbors or local landlords, who sometimes exploited their vulnerability. As a result, displacement often became a prolonged state of insecurity of housing, health, and bodily autonomy rather than a step toward recovery (see Section 4.1.5 in Chapter 4 for women and girls' political and institutional marginalization).

6. Coping, Agency, and Adaptive Strategies

Key Findings
• Women and girls rely on informal peer networks and intergenerational knowledge-sharing for managing health, reproductive decisions, and access to resources during crises. • Creative and proactive menstrual and SRHR management strategies emerge across all areas, particularly during flood seasons or mobility restrictions. • Community health workers, mothers, and midwives act as trusted frontline responders despite personal risks and institutional neglect. • Women and girls innovate at the household level to reduce exposure and risk reinforcing boundaries, raising storage, or creating ventilation during heatwaves. • Adaptive fertility planning and secret savings practices highlight the ways women and girls prepare for reproductive and financial challenges in uncertain contexts.

This chapter explores how women and girls across climate-affected areas including char, haor, and urban slum areas respond to climate adversity not only as victims but as agents navigating crisis with resourceful strategies grounded in lived experience. While their agency often operates within severe structural constraints, women and girls nonetheless play central roles in protecting health, sustaining family well-being, managing fertility, and preserving dignity during disaster and displacement. These adaptive efforts extend the material, emotional, and social realms, ranging from informal reproductive health responses to localized innovations for safety and survival. Importantly, such labor remains under-recognized, under-supported, and unequally distributed. This chapter presents grounded evidence of how women and girls' coping and resilience practices are intertwined with their SRHR experiences and the persistent gendered inequalities they confront.

6.1 Peer Networks: Informal Safety Nets for SRHR and Survival

In the absence of reliable formal healthcare and institutional support, women and girls across char, haor, and slum areas rely on robust peer networks to manage their reproductive health and overall well-being during crises. These networks comprising female neighbors, relatives, and other community women and girls serve as critical lifelines during periods of isolation, flooding, or displacement. Women and girls seek each other out for practical advice on menstruation, pregnancy, contraception, childbirth, and postpartum care when clinics are closed or unreachable. Older women and girls in char and haor areas guide younger ones through birthing experiences, traditional remedies, and strategies to maintain hygiene during disaster, while in slums, peer networks help newcomers access urban services, identify sympathetic health workers, and coordinate childcare to facilitate clinic visits.

> *"It's not always possible to go to the hospital. During storms and floods, it's impossible, and even at other times it's too far to travel. In those situations, the elderly give advice on what to do or not to do. Neighbors also suggest what might help."* (IDI_Woman_Char)

Family planning and fertility regulation are also deeply embedded in these networks. When women and girls could not go for collecting pills or destroyed the pill they have, neighbors share leftover pills or advise each other on improvised contraception methods. Though constrained by patriarchal norms, these networks allow women and girls to exercise limited but critical forms of agency, building an "invisible safety net" that fills institutional gaps and supports women and girls

through overlapping layers of environmental and social risk. They provided financial support during emergencies like delivery etc.

> *"Many times, the pills run out, and during floods there's no way to get them. Then, if a neighbor learns about it and has an extra packet, she might give me one and say to manage with that for now. Often, we also help each other with advice, like which method (contraceptive method) is better or where it can be obtained. Sometimes we even help with money, because families don't always give money for this. Later, we manage and pay it back."*(IDI_Woman_Haor)

6.2 SRHR Adaptation Under Constraint

Menstrual health management during climate events reveals some of the most sensitive and creative adaptations women and girls employ. In char and haor areas, women and girls routinely prepare in advance of monsoon and flood seasons by purchasing sanitary pads or saving clean clothes in waterproof bags or high places. When pads or clean clothes are not available, they use torn old clothes, cotton, or even toilet paper. In emergencies, they often rely on their creativity and support from neighbors, borrowing supplies or sharing tips.

> *"Whether it's cloth, pads, cotton, or tissue paper, we try to keep them ready in advance so that if menstruation starts suddenly, we don't fall into trouble."* (CDM_Girls_Haor)

For ensuring privacy, in haor and char, women and girls often dry cloths indoors on ropes or clay pots to avoid being seen. Bathing and changing can mean traveling long distances, sometimes by raft, because latrines are damaged and private spaces disappear. In slums, waterlogging blocks toilets, so women and girls use plastic sheets or other makeshift barriers to create privacy in crowded homes. Despite these challenges, women and girls still try to maintain hygiene and reproductive care. They boil water for postpartum baths, use antiseptics for infections, and manage reproductive discomfort without professional help. One of the woman from slum shared,

> *"In such a small, closed, and waterlogged space, it is very difficult to give birth. But often there is no other option. At those times, we take help from some elderly experienced woman. As much as possible, we arrange clean cloths, hot water, and antiseptic like Savlon."* (IDI_Woman_Slum)

Married women and girls often collect birth control pills in advance of disaster seasons and store them in dry containers or hanging shelves to prevent wash-away. Some women and girls opt for contraceptive injections before expected flooding to avoid both menstruation and pregnancy for three months. These practices, while informal, reflect strategic planning aimed at preserving bodily autonomy and reproductive control amid conditions of extreme uncertainty.

> *"I usually take the pill. But before the floodwater rises, I get the injection, then I'm worry-free for three months. Besides, when I take the injection, I don't even get my period, so in a way, it brings peace both ways. Otherwise, if my period starts during the flooding, it feels unbearable, like I might just die from it…"* (CDM_Girls_Slum)

6.3 Care and Emotional Labor in Times of Crisis

Women and girls serve as the emotional and logistical anchors of their families during climate crises, a role that intensifies in the absence of male family members who migrate for work or disengage from caregiving responsibilities. In char, haor, and slum communities, women and girls prepare for floods and disasters by gathering dry food, securing important documents in plastic, and assembling essentials like birth control, medicine, and menstrual supplies. During disasters,

they cook in hazardous conditions, care for the sick and elderly, calm frightened children, and host displaced relatives despite scarce resources.

> *"Women work is to keep everything organized, cook, take care of the children, and look after the elders. If you listed all the work, the list would never end. From deciding what to wear to arranging food, every detail has to be managed. Women have to think about everyone, whether in normal times or during disasters. Even if they themselves go without food, they must make sure everyone else is taken care of." (IDI_Woman_Slum)*

Women and girls often ration food, eating less than other family members to stretch supplies. Emotional caregiving offering comfort during miscarriage, childbirth, or health emergencies becomes an unacknowledged form of frontline support. Women and girls tend to those suffering from injury, postpartum weakness, or mental health distress, even while coping with their own anxiety and exhaustion.

6.4 Frontline Responders: Mothers, Midwives, and Health Workers

Mothers, older female relatives and neighbors, community midwives, and health workers are often the only dependable sources of SRHR support during climate induced emergencies. In char and haor areas, when roads are submerged and clinics close, traditional birth attendants and elder women and girls assist with deliveries, or monitor pregnancies. Some risk their own safety, crossing floodwaters on boats to reach women and girls in labor or bring basic supplies. In the absence of institutional actors, these women and girls become first responders often without formal recognition or adequate resources. A woman shared,

> "*In times of crisis, the neighbors are the first to come forward. In the village, there are many elderly women who have experience with childbirth. There are also mothers and aunts. During emergencies, they are the ones who help deliver the baby. Otherwise, if we wait for the hospital, neither the mother nor the baby may survive."* (IDI_Woman_Haor)

Another woman for char said,

> *"In our village, for example, we have some women (local birth attendants). And in case of complications, we keep the doctor's phone number with us, we call if needed. Sometimes we arrange for a horse to be on standby… since there's no vehicle. During floods, if there's a boat, we try to rent one in advance too…"* (IDI_Woman_Char)

Community health workers, particularly women and girls, play vital roles in disseminating health information, conducting delivery and postnatal checks even under challenging conditions. Their work becomes even more critical in slums, where mobile health units are rare and formal outreach is inconsistent. These women and girls despite being poorly compensated navigate narrow alleys and flooded streets to reach marginalized women and girls, build trust among newly displaced families, and mediate between health institutions and informal settlements.

6.5 Fertility Shifts and Strategic Reproductive Planning

Women and girls across all areas described adjusting fertility preferences and behaviors based on climate patterns, economic strain, and mobility challenges. In char and haor areas, women and girls seek to avoid pregnancy during dry seasons due to the long distances they would need to walk to access health services. Conversely, they sometimes prefer childbirth during flood season,

when water transport is more readily available though costly and unreliable. Others avoid pregnancy during harvest time, when they must work alongside men to maximize income.

> *"Women and girls in the haor areas are also involved in farming. During harvest season, they have to work full-time there. That's why they avoid getting pregnant during that time. They try to conceive during the monsoon season instead, when boats are available for transport. It's relatively more convenient then, and there's also less work pressure."* (KII_Haor)

Women and girls increasingly express a desire to have fewer children due to poverty, rising delivery costs especially with the fear of hospital cost and the burdens of parenting in uncertain environments. However, this shift is not always supported by their families or communities. Some women and girls face pressure to bear more children, especially sons who are viewed as long-term providers.

> *"Having a child means a lot of expenses, the hospital costs, the cost of raising the baby. In a poor household, this is very difficult. Even as it is, the family barely survives, most of the year there is no work. Another mouth to feed only makes things worse. But my thoughts don't matter. Whatever the man of the house decide, that is what will happen."* (IDI_Woman_Char)

In urban slums, similar concerns around flood-related risks, housing insecurity, and limited healthcare drive women and girls to delay or avoid pregnancy altogether. Yet in all cases, decisions around fertility are mediated by economic logic, gender expectations, and climate stress highlighting the complex trade-offs women and girls must navigate.

6.6 Saving for Emergencies: Hidden Economies of Women and Girls' Resilience

Women and girls across char, haor, and slum areas engage in deliberate, long-term financial planning to prepare for times of crisis. They hide small amounts of money from husbands who may misuse it on drugs, gambling, or personal expenses and use these funds during emergencies such as childbirth, medical needs, or temporary displacement. In some cases, women and girls form informal savings groups, pooling resources with trusted neighbors to build emergency funds. These secret or semi-formal savings practices are often the only financial cushion women and girls have, especially when men's earnings are unstable or absent.

Some women and girls save specifically for delivery-related costs, knowing that access to hospitals or skilled care may depend on their ability to pay for transportation, medicine, or emergency procedures. As one of the women and girls shared,

> *"From the time I become pregnant, I secretly save some money for emergencies. In a crisis, where else will money suddenly come from? My husband doesn't know about it. If he found out, he would take it away with some excuse, saying he'll return it later, but in reality, he would waste it. Then, when it's truly needed, I would be left helpless without money."* (IDI_Woman_Slum)

These practices reflect not only financial prudence but a proactive form of reproductive and maternal agency in contexts where public safety nets are either unreliable or inaccessible. Women and girls' saving habits are often carried out quietly, yet they provide a vital foundation for household survival and SRHR resilience.

6.7 Grassroots Innovation for Safety and Survival

Across all three areas, women and girls engage in grassroots innovations to adapt their environments and mitigate climate risks. In haor, women and girls reinforce the boundaries of their homes using bamboo to buffer against tidal waves. In char, households use water-hyacinth plants to stabilize home foundations and prevent erosion. In slums, women and girls construct makeshift barriers from furniture, bricks, or plastic to keep floodwater from entering homes, and design rooftop windows to improve air circulation during heatwaves.

Women and girls across areas craft hanging shelves from bamboo and rope to keep dry food, menstrual kits, contraceptive and important documents above flood levels. In many homes, women and girls elevate cooking stoves or create improvised rainwater collection systems. These techniques are not formally taught but passed through observation and collective experimentation. Although such innovations remain largely unrecognized in formal resilience planning, they are essential, grounded responses to recurring disasters demonstrating women and girls' critical role as engineers of adaptation in spaces where formal support is absent.

6.8 Migration as a Strategy for Survival

Migration whether seasonal, circular, or permanent is increasingly used by families in char and haor areas to secure livelihoods in the face of climate-related displacement. During lean agricultural periods, entire households temporarily migrate to nearby towns or other rural areas for brick field or farm labor.

> *"Seasonal migration happens. When the water rises significantly, people relocate to another place for a while. After some time, they come back. Here, it happens less frequently. There are places where, when the water rises, people move to other areas, and when the water recedes, they return. Sometimes, we see instances of instant migration, where people take small shelters inside the haor areas. They bring their cows, goats, poultry, and other animals to live there. For those few months, they stay there for their survival."* (KII_Haor)

In some cases, families settle in urban slums with the hope of returning once financially stable, though many find this impossible. Men often migrate first, leaving women and girls behind to manage households, which shifts caregiving and economic responsibilities onto them. In many cases, men remarry or permanently abandon their wives and children, creating long-term social and economic vulnerabilities for women and girls.

In slum areas, rural-to-urban migrants live in overcrowded housing, often without tenure or documentation. Women and girls who migrate face unfamiliar health systems, discrimination, and disrupted access to SRHR services. Some rely on peer networks to navigate new environments, while others struggle in isolation. Migration may offer survival, but it also imposes new risks, particularly when formal housing, employment, and healthcare systems remain exclusionary.

Discussion and Recommendations

7. Discussion

The findings from the study show that climate hazards such as floods, cyclones, erosion, waterlogging, and heatwaves combine with existing gender inequalities to harm women and girls' and girls' SRHR. These impacts are not just the result of the environment but are shaped by poverty, restrictive gender roles, and weak institutional support. This reflects global evidence that climate risks are shaped by both physical hazards and social conditions (1). In Bangladesh, women and girls' vulnerability has long been linked to limited mobility, lack of control over resources, and heavy domestic responsibilities (36). Our findings build on this by showing clearly how reproductive health and decision-making are especially affected.

A key finding is that climate events directly disrupt SRHR services and choices. As seen in Chapter 5, problems such as blocked transport, broken supply chains, closed or damaged health facilities, and social barriers led to women and girls missing contraception, delaying antenatal and postnatal care, facing menstrual health challenges, and sometimes giving birth without skilled support. These results echo global studies showing that reproductive health services are often the first to break down in crises, even though international guidelines like the Minimum Initial Service Package (MISP) exist (37,38). They also support findings from previous Ipas study (Ipas, Dijkerman), which showed how climate crises in Khulna reduced women and girls' reproductive autonomy and worsened existing inequalities. The embodied consequences of these disruptions, such as increased reproductive tract infections due to WASH breakdowns or the loss of privacy in shelters remain under-addressed in disaster risk reduction (DRR) and adaptation planning.

Unsafe abortion emerged as a serious but often hidden issue. When safe and affordable services were unavailable, women and girls turned to unsafe methods, especially during climate induced events when facilities were inaccessible or overcrowded. This finding matches international evidence showing that crises increase the risk of unsafe abortion, contributing significantly to maternal deaths and illness (39,40). In Bangladesh, where abortion is legally restricted, many rely on menstrual regulation services. Climate shocks make these services even harder to access, leaving women and girls with fewer safe options.

The findings also show how climate stress deepens patriarchal control. Families facing economic shocks or displacement often turned to early marriage, reproductive coercion, or stricter control over women and girls' mobility. These patterns reflect other studies showing that disasters often lead to higher rates of GBV and coercion, partly due to overcrowded shelters, weakened services, and greater household stress (8,41). As Dijkerman et al. (2025) argue, climate change is not only an environmental or health issue, but also a justice issue that limits women and girls' autonomy.

Migration and displacement also played a major role in disrupting SRHR. Families lost documents, access to regular providers, and stable health care. These findings reflect long-standing gaps in humanitarian contexts, where even though standards exist (37,38), women and girls often struggle to get contraception, safe childbirth, and GBV services. For some groups, such as unmarried adolescents, widows, migrants, and women and girls with disabilities, exclusion from relief and health services was especially severe. This mirrors global evidence that displaced women and girls face much higher risks of unsafe deliveries and lack of reproductive care (42).

Women and girls also showed remarkable resourcefulness. Many prepared by saving contraceptives and menstrual products in waterproof containers, pooling money for emergencies, or sharing advice through peer networks. These strategies show women and girls' agency, but they also highlight gaps in formal systems. As others have noted, we should not romanticize resilience when it relies on women and girls' unpaid and often invisible work. For example,

menstrual management remained a major challenge, forcing women and girls to improvise with unsafe or undignified materials. This shows why menstrual health must be treated as a core humanitarian need, not a side issue (43).

Overall, these findings make clear that climate change has deep and wide-ranging effects on women and girls' SRHR leading to unwanted pregnancy, unsafe abortion, disrupted maternal care, higher risks of GBV, and reduced autonomy. SRHR should be recognized as a central part of climate adaptation and disaster planning. At the same time, the findings remind us that women and girls' coping strategies are not enough on their own and that systems must take responsibility. Future research should combine lived experience with quantitative studies, especially focusing on unsafe abortion, pregnancy outcomes linked to climate stress, and models for delivering climate-resilient SRHR services.

8. Pathways for Transformation and Institutional Accountability

This final chapter presents a comprehensive framework for addressing the urgent and interconnected challenges of climate change and SRHR for women and girls in Bangladesh's most climate-affected geographies. Drawing from field evidence across char, haor, and urban slum communities, the chapter proposes transformative pathways, amplifies the priorities identified by community women and girls, and outlines strategic recommendations from the study team. It concludes with a reflection on the broader implications for health systems, social norms, and institutional accountability.

8.1 Pathways for Advancing SRHR in Climate-Affected Areas

Findings from this study demonstrate that while SRHR is deeply compromised by climate-related stressors, it also presents a vital entry point for transformation. Women and girls' reproductive health needs do not pause during floods, displacement, or economic shocks if anything, they intensify. Yet, SRHR remains largely absent from the planning, infrastructure, and policy responses to climate vulnerability. To bridge this gap, several critical pathways emerge.

The first is the integration of SRHR into climate resilience and disaster risk reduction frameworks. As the evidence shows, the absence of maternal care, contraceptive access, and menstrual hygiene support during and after climate events not only places women and girls' lives at risk but also deepens cycles of poverty, forced marriage, and GBV. SRHR must be recognized as an essential component of humanitarian preparedness and climate adaptation planning on par with food, water, and shelter.

Second, health services must be reconfigured to withstand climate shocks and remain functional during crises. This includes the deployment of mobile clinics during floods, the pre-positioning of SRHR supply kits in vulnerable areas, and the training of female providers to serve in hard-to-reach locations. Without climate-resilient health systems, SRHR access becomes episodic, unreliable, and inequitable.

Third, SRHR cannot be protected in isolation, it is deeply shaped by social norms, family dynamics, and gendered power relations. The findings reveal emerging shifts in how women and girls talk about menstruation, contraception, and reproductive rights. Some men are beginning to support family planning, caregiving, and women and girls' participation in health decisions. These changes, though fragile, signal an opening for long-term transformation. Education and community-based dialogue must be used to shift norms around fertility, autonomy, and bodily integrity especially in contexts where reproductive coercion, early marriage, and shame around menstruation are prevalent.

Fourth, meaningful participation of women and girls in health and disaster governance is essential. Across areas, women and girls acted as first responders, peer educators, and informal health coordinators during climate shocks yet they remain excluded from formal decision-making structures. A rights-based SRHR approach must recognize these roles, compensate them, and embed women and girls' leadership into system design and service delivery.

Finally, sustained investment in locally grounded SRHR programming is necessary. Pilot initiatives such as adolescent life skills clubs, SRHR workshops, or mobile maternal clinics have shown promise, but too often these interventions are discontinued when funding ends. To ensure

continuity, SRHR must be institutionalized within public health systems and disaster response plans, not relegated to short-term NGO projects.

8.2 Recommendations from Community Women and Girls

Women and girls from the study areas were clear and consistent in their articulation of priorities related to SRHR. These community-generated recommendations form the backbone of any responsive, context-sensitive approach.

Foremost among these was the demand for SRHR services to be available and accessible during times of climate crisis. Women and girls recounted instances where pregnant individuals gave birth in unsanitary flood shelters, or where adolescent girls went without menstrual hygiene supplies for days. They called for the inclusion of contraceptives, clean delivery kits, pain relief, and menstrual products in disaster response packages, as well as the presence of trained female providers in relief areas. As one woman from haor stated,

> *"If there were camps nearby with female doctors, it would ease a lot of this suffering."* (CDM_Women_Haor)

Privacy, dignity, and safety were central themes. Women and girls emphasized the need for designated SRHR spaces within shelters areas where women and girls could speak to health workers, change menstrual cloths, or rest without fear of harassment. This also included requests for private toilets, secure sleeping areas, and lighting in wash zones to prevent violence and ensure privacy. As a woman in an urban slum explained,

> *"During disasters, it's we (women and girls) who suffer the most. We also have more responsibilities. That's why we need to be given importance in any kind of planning. What we need or don't need, should be heard directly from us."* (CDM_Women_Slum)

Adolescent girls, in particular, expressed a strong desire for information. Many had never received basic education on menstruation, contraception, or safe pregnancy. They requested school-based programs in local languages, safe discussion spaces, and access to female mentors or peer educators. Mothers supported this, noting that early marriage and unwanted pregnancy often stem from misinformation and stigma. As one girl emphasized,

> *"If we are taught, then we can teach others too. We already solve many problems in our own way. Others learn by watching us, and we learn from them as well. When we work together, things naturally become easier."* (CDM_Women_Haor)

In urban slums, women and girls advocated for more accessible and non-judgmental SRHR clinics. Several reported being denied services due to marital status or lack of documentation. They called for mobile outreach services, clear eligibility criteria, and training for health workers to treat all clients with respect. As one woman explained,

> *"Many people come and say many things, but we don't always understand. When it's explained simply, then we can understand and remember it."* (CDM_Women_Slum)

Another key priority was ensuring that SRHR services do not stop when projects end. Women and girls in all areas had experienced the abrupt withdrawal of mobile clinics, girls' clubs, or awareness sessions once donor funding lapsed. They asked for sustainable, government-supported programs that remain in place during crises and build local ownership through training and compensation. One adolescent girl linked this directly to women and girls' agency,

> *"It is about self-dependence. If a woman becomes self-dependent, she can start making her own decisions. It gives her a certain amount of power."* (CDM_Girls_Haor)

Finally, women and girls highlighted the need to involve men and boys in SRHR awareness. Many reported that husbands' opposition to contraception or misunderstanding about menstruation created conflict and health risks. They proposed targeted education for men particularly younger and newly married men to foster empathy, shared responsibility, and support for reproductive rights. In the words of a woman from the char,

> *"It won't help if only women know and understand. Men need to know too. Families and community members also need to understand. That's the only way change can happen."* (CDM_Women_Char)

8.3 Study Recommendations

Drawing on the evidence and grounded in a rights-based framework, the study proposes the following cross-cutting recommendations for advancing SRHR within the context of climate resilience and gender justice.

- ❑ **Institutionalize SRHR within climate policy** by integrating SRHR indicators, services, and budgets into national adaptation plans, disaster management frameworks, and humanitarian protocols.
- ❑ **Adapt service delivery to climate realities** by expanding mobile health services, training female community health workers, and pre-positioning SRHR supplies in high-risk areas, ensuring inclusion of unmarried women and girls, adolescents, and women and girls with disabilities.
- ❑ **Invest in sustained education and behavior change programs** that challenge harmful gender norms, using culturally appropriate approaches and reinforcing positive shifts through media, community dialogue, and peer networks.
- ❑ **Strengthen women and girls' community leadership** by formalizing and compensating their roles as caregivers, health educators, and mediators, and by granting them training, incentives, and decision-making authority.
- ❑ **Promote intersectoral coordination** by linking SRHR with education, WASH, social protection, and climate governance, and by including SRHR experts, gender advisors, and community women and girls in coordination bodies.
- ❑ **Embed accountability** through accessible complaint channels, gender audits, community feedback systems, and participatory planning processes to ensure responsiveness and equity in SRHR services.
- ❑ **Conduct large-scale quantitative research** to complement qualitative findings, generate robust evidence on climate impacts on SRHR, and guide evidence-based policy and resource allocation.

8.4 Conclusion

This study has revealed the profound and often overlooked impact of climate stress on sexual and reproductive health and rights. It has also illuminated the resilience, clarity, and courage of women and girls who continue to navigate these challenges with determination and ingenuity.

What they demand is not charity or benevolence but justice, recognition, and support. They ask to be seen not only as victims of climate vulnerability but as rights-holders, decision-makers, and leaders. Their vision for SRHR includes privacy, dignity, information, and continuity of care during floods, in slums, on embankments, and in shelters.

To respond adequately, systems must change. Climate adaptation must include menstrual health. Disaster relief must provide contraceptives. Health policies must anticipate and endure environmental disruption. Most of all, governance must move beyond tokenism to create space for women and girls' power not as a gesture, but as a foundation for transformation.

A climate-resilient future cannot be built without SRHR at its core. Nor can it be built without the leadership, insight, and daily labor of women and girls. The evidence is clear. The solutions are known. What is needed now is the political will, institutional courage, and sustained investment to make reproductive justice a central pillar of climate action.

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Annex 1: Key Informant Interview Semi-Structured Interview Guide

1. Let's start out by having you tell me about your professional experience with women and girls' sexual and reproductive health and rights in Bangladesh.
    a. *How does your work involve SRHR? What work do you do on SRHR in Bangladesh [or in a specific community]? How long have you been doing this?*
    b. *Please describe what responsibilities are related to women and girls' SRHR in your current role/job. How do you interact with women and girls in this role? How do you support women and girls' SRHR in this country [or in a specific community]?*
    c. *If you support women and girls in accessing SRHR, please describe what this entails. What does a normal day for you include?*
    d. *If you conduct SRHR-related advocacy, please describe what this entails. What does a normal day for you include?*
    e. *If your work is not directly related to SRHR, how do you think your work on climate change intersects with women and girls' SRHR in this country? Does this connection ever come up in your work, and if so, how?*

2. Please tell me about your professional experience with climate change, such as environmental changes or extreme climactic weather events, in Bangladesh.
    a. *How does your work involve climate change? What work do you do on climate in Bangladesh [or in a specific community]? How long have you been doing this?*
    b. *How do you engage with local communities and women and girls in particular as part of your work on climate change? What does this entail?*
    c. *In your experience, how are women and girls in Bangladesh [or a specific community] most affected by climate change? How are these impacts unique from those experienced by men? How are they the same?*
    d. *If your work doesn't directly relate to climate change, how do you see the connection between climate change and your work? How does it affect the women and girls that you support or work with, or the women and girls in your community in general?*

3. What changes have you witnessed in this country [or a specific community] related to the climate or the environment over the past 5 years or longer?
    a. *What changes have you witnessed or experienced with the weather? If so, how have they affected your country/community?*
    b. *What extreme weather events have you witnessed?*
    c. *Please tell me how these events impacted your country. How have they affected your community, such as the livelihoods of the community?*
    d. *How have these changes or events impacted women and girls in the community?*

4. How does climate change impact the lives and health of women and girls in your country/community?
    a. *How are these impacts related to issues of gender equity and women and girls' empowerment? [Probe on issues of social inclusion, agency and power in decision-making, migration, gender-based violence, and livelihoods.]*
    b. *How has climate change impacted women and girls' participation in society and local communities? For example, their livelihoods, migration, social inclusion, empowerment, etc.*
    c. *How do issues of gender inequality and social inclusion impact women and girls' vulnerability to the negative effects of climate change? Can you tell me a story or real-life example of this?*
    d. *What role does climate change, such as extreme events, have in women and girls' sexual and reproductive health? For example, pregnancy outcomes, access and use of family planning, experiences with gender-based violence, etc.*
    e. *Have you witnessed the impact of climate change on a woman's decision-making related to her health, family, fertility intentions, or future plans? Can you tell me a story or real-life example?*
    f. *In your opinion, how can SRHR programs and services better address the challenges that women and girls face as a result of climate change?*
    g. *How have climate change events or environmental changes affected women and girls' roles within the family, or within your country/community?*
    h. *In your opinion, how does climate change affect women and girls' feelings of personal safety and security in your country/community? How does climate change affect women and girls' vulnerability to violence in this country/community?*

5. I'd like to hear your thoughts on women and girls' role in building the resilience of local communities to climate change and acting in leadership roles.

a. *How do women and girls in this country/community adapt to changes occurring due to climate change?*
b. *In your experience, what role do women and girls currently play in building this country's or local communities' resiliency or adaptive capacity to climate change? What is the role of women and girls during extreme weather events, such as a cyclone/storm surge/flood/heatwave/drought etc., in this community?*
c. *What role do you think women and girls should play in the future? For example, emergency preparedness systems, leadership roles, etc.*
d. *What would it take to make that role a reality? Who must be involved and what resources are required?*
e. *How much power do you feel that women and girls have to adapt to the impacts of climate change? What is this power dependent upon? Please explain.*
f. *In your opinion, what should be the role of men in improving women and girls' resiliency and decreasing their vulnerability to climate change?*
g. *How do you think your country/community can adapt to future changes?*
h. *What strategies can be used to decrease women and girls' vulnerability to climate change, particularly related to their sexual and reproductive health?*

6. In your experience, how do women and girls in your country/community talk about climate change?
    a. *What language, terms, or phrases do they use to describe climate change, extreme weather events, or other environmental changes?*
    b. *How do women and girls talk about the connection between climate change and their plans for their future, such as planning for children (i.e. fertility intentions) and caring for their families?*
    c. *In your opinion, what is the best strategy for engaging women and girls in a discussion about climate change and its impact on their lives? How about talking about its impact on their sexual and reproductive health in particular?*
    d. *Where do women and girls receive information about climate change and related events?*

7. In the next phase of this study, we are going to be speaking to women and girls in local communities about their experiences with climate change-related events and impacts on their sexual and reproductive health. We want to make sure the questions we ask women and girls are relatable and understandable. Now, I would like to review our in-depth interview guide and ask you questions about the clarity and appropriateness of the included questions. Any feedback you provide on this tool will improve the results of our research.
    a. *[Hand a copy of the IDI guide to the key informant. Together, read out loud each of the questions in the tool. Use the following probes to gather feedback about the tool as you go through the tool]*
    b. *What do you think this question is asking?*
    c. *Is there anything confusing about this question?*
    d. *How can this question be improved or made clearer?*
    e. *Are there any terms that you think local women and girls from [x community] may have trouble understanding? How can we say the same thing in a clearer way, with more approachable words or language?*
    f. *[After reviewing the full tool, ask the following.] Are there any important topics that you believe to be missing from this tool that are related to the impact of climate change on women and girls' SRHR? If so, please share.*

8. Thank you for your participation in this interview. Is there anything else that you would like to share with me today?

Annex 2: In-Depth Interview Semi-Structured Interview Guide

1. Let's start out by having you tell me about yourself and your family.
    a. *How do you make your living? What work do you do, paid or unpaid?*
    b. *What is your relationship status? If married, how long have you been married?*
    c. *What sources of income do you or your family rely on?*
    d. *Do you have children? If so, how many? What are their ages?*
    e. *How do you make decisions to plan for your family, such as when and how many children to have? Who is involved in these decisions?*
    f. *What roles and responsibilities do you have in your family?*
    g. *How did your parents of relatives earn their livelihood in the past, and now in the present?*

2. Please tell me about the community/village where you live.
    a. *What kinds of work or industry are most common in this community? What types of jobs do most people have? What are the most common sources of income?*
    b. *What are the biggest changes have you witnessed in this community over your lifetime? For example, changes in livelihoods, environment, culture?*
    c. *What roles and responsibilities do you have in your community?*
    d. *What role do women and girls play in this community, and how is this role different or similar to men?*
    e. *How do women and girls access and use economic and social resources in this community, and how is this different or similar to men?*
    f. *How do women and girls access sexual and reproductive health resources, such as family planning or pregnancy services, in this community?*
    g. *What are barriers to women and girls receiving high quality sexual and reproductive health care in this community?*

3. What changes have you witnessed in your community related to the climate or the environment over the past 5 years or longer?
    a. *What changes have you witnessed or experienced with the weather? If so, how have they affected you and your family?*
    b. *Please tell me how these weather changes have affected you and your family. How have they affected your community?*
    c. *What extreme weather events have you witnessed?*
    d. *Please tell me how these events impacted your and your family. How have they affected your community, such as the livelihoods of the community?*
    e. *How have these changes or events impacted women and girls in the community?*
    f. *How have these changes affected the presence of conflict within groups in the community?*

4. Please tell me about your experience with cyclone/storm/surge/flood/heatwave/ drought etc.
    a. *How and when did you first learn about the cyclone/storm/surge/flood/heatwave /drought etc. happening?*
    b. *How prepared did you feel you and your family were for the cyclone/storm surge/flood/heatwave/drought etc.? For example, did you have adequate information, time, or resources to prepare for the cyclone? Please explain.*
    c. *Please describe your experience before, during, and after the cyclone/storm surge/flood/heatwave/drought etc.: where you were when the cyclone/storm surge/flood/heatwave/drought etc. began, what you did during the cyclone, and what you did immediately following the cyclone/storm/surge/flood/heatwave /drought etc.*
    d. *How was your mobility affected during or after the cyclone/storm surge/flood/heatwave/drought etc., e.g. your ability to evacuate, and what impacted that?*
    e. *How did the cyclone/storm surge/flood/heatwave/drought etc. impact you and your family? For example, your livelihood, your income, your property such as your house, where you live, your health, your children, etc.?*
    f. *What challenges did you face as a woman/girl during the cyclone/storm surge/flood/heatwave/drought etc.? What about after the cyclone/storm surge/flood/heatwave/drought etc.? How did you cope with those challenges?*
    g. *Please tell what effects, if any, the cyclone had on your health.*
    h. *Please tell me if and how the cyclone/storm surge/flood/heatwave/drought etc. impacted your ability to access or use sexual and reproductive health services, such as contraception, pregnancy services, or safe abortion.*

5. What other climate-related or extreme weather events have you experienced?
    a. *How did cyclone/storm surge/flood/heatwave/drought etc. impact you and your family?*
    b. *How and when did you first learn about cyclone/storm/surge/flood/heatwave /drought etc. happening?*
    c. *How prepared did you feel you or your family were for cyclone/storm surge/flood/ heatwave/drought etc.? For example, did you have adequate information, time, or resources to prepare for cyclone/storm surge/flood/heatwave /drought etc.? Please explain.*
    d. *Please describe your experience before, during, and after cyclone/storm surge/flood/heatwave/drought etc.: where you were when cyclone/storm/surge/ flood/heatwave/drought etc. began, what you did during cyclone/storm/surge/ flood/heatwave/drought etc., and what you did immediately following the cyclone/storm surge/flood/heatwave/drought etc.*
    e. *What was your mobility like during cyclone/storm surge/flood/heatwave/drought etc., e.g. your ability to evacuate, and what impacted that?*
    f. *How did cyclone/storm surge/flood/heatwave/drought etc. impact you and your family? For example, your livelihood, your income, your property such as your house, where you live, your health, your children, etc.?*
    g. *What challenges did you face as a woman/girl during cyclone/storm/surge/ flood/heatwave/drought etc.? What about after the cyclone/storm/surge/flood/ heatwave/drought etc.? How did you cope with those challenges?*
    h. *Please tell me what affects, if any, cyclone/storm/surge/flood/heatwave/drought etc. had on your health.*
    i. *Please tell me if and how cyclone/storm surge/flood/heatwave/drought etc. impacted your ability to access or use sexual and reproductive health services, such as contraception, pregnancy services, or safe abortion.*
    j. *If you have not lived through another specific event, can you describe any recent changes in your environment that have affected you and your family?*

6. Thinking back over your entire life, how has climate change or environmental change in general impacted your life or others in your life?
    a. *Have there been changes in how you make your livelihood? If so, how have they affected you and your family?*
    b. *Have you ever had to engage in sex work, or transactional sex, as a result of changes in your livelihood and income? If so, please describe the situation and what happened.*
    c. *How have climate change events or environmental changes impacted you or your family's ability to secure sufficient food or water?*
    d. *How have your experiences with climate change events impacted your feelings of personal security and safety as a woman?*
    e. *How has climate change impacted your mobility outside of your home, i.e. your ability to travel within or outside of your community?*
    f. *Have you ever been forced to migrate, i.e. move to a new community, due to climate change impacts or events? If so, please describe the situation and what happened.*
    g. *How have climate change events impacted your education or ability to go to school?*
    h. *Have you ever personally experienced or heard of other women and girls in your community experiencing violence or sexual assault during a climate change event, or due to changes in the environment? How was this event directly or indirectly impacted by climate changes?*

7. How has climate change impacted your ability to plan for your future and the future of your family?
    a. *How does climate change factor into your decision-making around having children? What factors are most influential in your decisions around having children?*
    b. *How has climate change affected your ability to access health services? What about sexual and reproductive health services? Contraception? Prenatal or postnatal pregnancy services? Abortion/menstrual regulation services? Other sexual health services, such as treatment for STIs or HIV?*
    c. *When thinking about your sexual and reproductive health throughout your lifetime, how much have your experiences with climate change events or environmental change impacted your decisions, behaviors, or health outcomes? Can you tell me a story to explain?*
    d. *How has climate change impacted your decisions to use sexual and reproductive health services, such as contraception, pregnancy services, or safe abortion? Can you tell me a story?*
    e. *How have your experiences with climate change impacted your sexual activity or relationships?*

f. *If you had not experienced or witnessed these climate change-related impacts, how different do you think your choices or behaviors related to sexual and reproductive health would be? Please explain why you feel this way.*

8. How vulnerable, or at risk, do you feel that you are to the impacts of climate change?
    a. *What makes you feel this way?*
    b. *How do these feelings impact your life, specifically, your decisions and your behaviors?*
    c. *How often does the issue of uncertainty or vulnerability related to climate change come up in your life? Frequently? Every day? Every week? Every month? Infrequently?*
    d. *What sorts of things spark conversation about these perceptions of uncertainty or vulnerability to climate change among you and your friends or family? [Probe: personal experiences, friends searing for information, gossip/rumors, news outlets, radio/TV, social media?]*
    e. *How do you talk with your friends and family about climate change and your vulnerability to it? How do you discuss it with your family?*
    f. *Are these conversations generally positive or negative, and how so? How comfortable are you talking about the impact?*

9. Let's talk about your thoughts about the future and how you think climate change will impact on your life and the lives of your friends and family.
    a. *What will be different in the lives of your children, or today's youth, compared with your own? What role does climate change play in these differences?*
    b. *What livelihoods do you think your children, or today's youth, will be able to pursue in the future? How are they different or similar to your livelihood and that of your family today? What role does climate change play in these differences?*
    c. *What concerns or scares you for the future? What role does the changing environment or extreme weather events play into these concerns or fears?*
    d. *Do you think life will be better/easier or harder/worse for future generations? Please tell me why you feel that way.*

10. Now, I'd like to talk about the role that women and girls can play in your community to prepare for and adapt to the impacts of climate change.
    a. *How much power do you feel you have to adapt to the impacts of climate change? What about other women and girls in your community? Please explain.*
    b. *How do you think your community can adapt to future changes?*
    c. *What role do you think women and girls should play in increasing your community's resilience to climate change, such as preparation for extreme weather events? What needs to happen to make that role a reality? Who must be involved? What resources are required?*

11. Thank you for your time and participation in this interview. Is there anything else you would like to share with me today

Annex 3: Free Listing/Ranking Activity: Facilitator's Guide

Purpose: To determine what issues a community groups together, values, or identifies.

Directions (How to Use the Method): The group is asked to list all the different components of some issue using the guiding questions below. The facilitator will record the list on a poster or whiteboard. Once the list has been created, the facilitator will then ask a related ranking question. Respondents can either discuss as a group how to rank the list based on the question, or they could choose to use stones/beans/candy/stickers to vote on the most important item in the list. Once the ranking is completed, the facilitator should ask probing follow-up questions, including, "Why did you rank this way? What is the impact of this on your community? What is the impact on women and girls? What is the impact on women and girls' sexual and reproductive health?".

Example guiding questions (additional questions to be added over time)**:**

Free Listing	**Ranking**
What experiences with climate change events or extreme weather events has this community faced?	Which of these experiences had the greatest impact on women and girls in this community?
What environmental changes have you seen in your community, potentially due to climate change?	Which of these changes had the greatest impact on women and girls in this community?
How does climate change affect women and girls in this community?	Which of these effects are most related to women and girls' sexual and reproductive health?
How have climate change events or environmental changes affected women and girls' roles within the family, or within this community?	Which of these changes have had the greatest impact on women and girls' sexual and reproductive health?
How does climate change affect women and girls' feelings of personal safety and security in this community?	Which of these effects have the greatest impact on women and girls' lives? Which of these effects are most related to women and girls' sexual and reproductive health?
How does climate change affect women and girls' vulnerability to violence in this community?	Which of these effects are more common?
How do women and girls in this community adapt to changes occurring due to climate change?	Which of these adaptations are most successful in dealing with the impacts of climate change?
What is the role of women and girls during extreme weather events, such as a cyclone/storm surge/flood/heatwave/drought etc., in this community?	Which of these roles are most common for women and girls in this community?
How do experiences with climate change affect how women and girls plan for their futures, their lives?	Which of these has the greatest impact on women and girls? Which of these effects are most related to women and girls' sexual and reproductive health?
How do experiences with climate change affect how women and girls take care of their families and/or children?	Which of these effects are the most common among women and girls in this community?
How does climate change affect women and girls' decision-making around using contraception to prevent unplanned pregnancy?	Which of these effects have the greatest impact on women and girls' lives?
How does climate change affect women and girls' decision-making around when to have children?	Which of these effects is most common among women and girls in this community?
What sexual and reproductive health problems exist in your community?	Which of these problems are most impacted by climate change?
How do women and girls in your community adapt to the impacts of climate change on their lives? On their communities?	Which of these strategies are the most successful in dealing with the impacts of climate change?
What are common sources of information about climate change in your community?	What are the most preferred and least preferred sources of information about climate change in your community?
How do climate change events, like the recent *cyclone/storm surge/flood/heatwave/drought etc.*, affect women and girls' access to contraception or other reproductive health services?	Which of these effects are the greatest barriers to women and girls successfully accessing SRH services?

How does climate change affect young women and girls under 20 years old in this community?	Which of these effects are most related to young women and girls' sexual and reproductive health?
What role should women and girls play in helping your community adapt to and prepare for climate change events or related environmental changes?	Which roles will be the most challenging for women and girls to obtain? Which roles would be the most important for preparing this community?
How do environmental changes or extreme events due to climate change affect women and girls' pregnancy experiences?	Which of these effects are most common? Which have the biggest burden on women and girls' lives?
How do environmental changes or extreme events due to climate change affect women and girls' sexuality, decision-making, or behavior?	Which of these effects are most common? Which have the biggest burden on women and girls' lives?

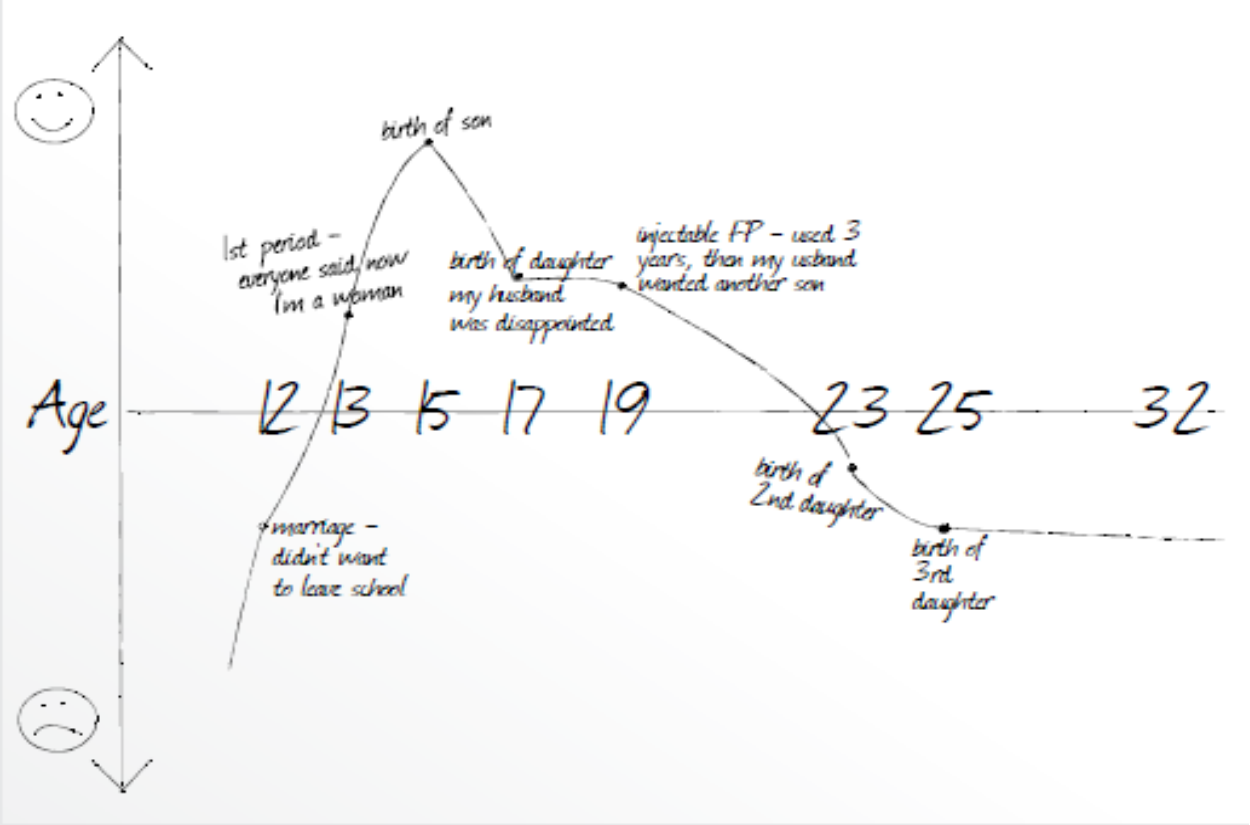
Data Collection Procedure: There should be one primary facilitator and at least one note-taker. The facilitator should try to get a volunteer from the group to write down the participants' responses, instead of the facilitator. This method does not require audio recordings. The note-taker will listen and take detailed notes of the conversations happening during the activity. The note-taker should try to capture interesting quotes verbatim, as possible. Take a photo of the lists/rankings and any accompanying products that are developed and save these as well any notes taken.

Annex 4: Reproductive Health Lifelines: Facilitator's Guide

Purpose: To get a comprehensive understanding of a woman's sexual and reproductive health over time, not just around abortion. This activity is used to guide women and girls through a reflection of the impact of climate change-related events on their sexual and reproductive health.

Directions (How to Use the Method): Each participant will receive a lifeline template. On the template, they will map moments in their lives related to their own sexuality and sexual and reproductive health. Once they have completed the lifeline, the facilitator will guide them in mapping significant moments of climate change-related events in their lives on top of the first lifeline. Afterward, participants will be given time to look at the lifelines and reflect on the connections between the two. As a larger group, women and girls will share their maps with each other, discuss the connections between climate change events and their reproductive lifelines, share their visions for the future of women and girls' sexual and reproductive health in their communities, and discuss what would need to change for that to become a reality.

Lifeline Template Example:



Resource: Ipas, *Young women and girls and Abortion: A Situation Assessment Guide*, 2011, Ipas: Chapel Hill.

Annex 5: Community Action Plan: Facilitator's Guide

Purpose: To develop a participatory Community Action Plan.

Directions (How to Use the Method):

- Explain the exercise to all participants. Take an actual problem and use it as an example for the activity so that the participants can understand how to do this exercise on their own.
- Have participants brainstorm problems related to climate change and women and girls' SRHR in their communities. Write each problem on a card.
- Divide into small groups and spread the cards out amongst the groups. If there are too many cards, prioritize the top five issues for which to make a plan.
- Give each group the Action Plan matrix (below). Ask each group to talk about and fill out one matrix plan for each problem identified in the brainstorming session.
- After all matrices are complete, leave time to discuss the proposed solutions. If there is extra time, have a discussion about who will commit to what role to help move forward the action plan.

Example:

Community Action Plan Matrix

Key Problem	Data to Be Used	Steps You Will Take to Solve the Problem	Resources You Will Use	Short-Term (Three Months) and Long-Term Indicators	Person Responsible	Time Frame

Resource: COMMPAC, *A Guide to Action for Community Mobilization and Empowerment Focused on Post-abortion Complications*, 2010, Engender Health: New York.

Annex 6: Informed Consent for Key Informant Interviews

Introduction:

Hello. My name is _____.

I am an interviewer/a facilitator working with Ipas Bangladesh and Naripokhho. We are conducting a study with women and girls on their experiences with climate change-related events and how these experiences have impacted their sexual and reproductive decision-making, behaviors, and health outcomes. As part of this study, we are interviewing local experts about the topic of climate change and its impact of women and girls' sexual and reproductive health in local communities.

Purpose of the Research:

The purpose of this study is to gain insight into if and how women and girls' experiences with climate change-related events have impacted their sexual and reproductive health, in order to generate evidence to inform sexual and reproductive health and rights programming and advocacy.

Eligibility Criteria:

You must be 18 years or older to participate in this interview.

Procedures of Participation:

If you agree to participate, I will be asking questions about your professional and personal experiences with climate change. I will ask you questions regarding the impact of climate change-related events on women and girls' sexual and reproductive health. I will also ask you to review and comment on an interview guide that we are planning to use with women and girls in local communities during the next phase of this study, to obtain your feedback on the relevance and appropriateness of the questions and language in the tool. Your feedback will be used to update the interview guide.

During the interview, I or another interviewer/notetaker will sit down with you in a comfortable place. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. There will also be a notetaker in the interview who is there to help the facilitator take notes during the interview. No one else but the interviewer and notetaker will be present unless you would like someone else to be there. Even if you agree to begin with the interview, you are allowed to change your mind about participating, at any time.

Duration of the Interview:

The interview will take approximately 45 minutes of your time to complete. It may take a little longer or shorter depending on how much you share.

Potential Benefits and Risks of Participating:

There are no direct benefits to you for participating in this study. Information collected from you and others will be analyzed to generate answers for the research question and will be used as evidence to inform SRHR programming and advocacy efforts. There are no risks or hazards associated with your participation in the individual interview. We will not collect your name or any personal information. We will be audio-recording and taking notes of the interview/discussion. We will do our best to keep the recording/notes safe by not recording your name and by keeping files in a secure cabinet and password protected computer. The only discomfort is the time of participation which you could use for something else. There may be some sensitive questions asked. You do not have to answer any questions that make you uncomfortable and you can stop the interview any time.

Privacy, Anonymity and Confidentiality:

We do hereby affirm that privacy, anonymity and confidentiality of information identifying you will strictly be maintained. The interview will be held in a private room. Study records with identifiable information will be kept confidential by storing them on locked, password-protected computers, and securely in the cloud. All audio recordings will be deleted from the digital recorders at the completion of the study. The audio recordings will remain stored securely in the cloud for seven years following study completion, and any identifiable information will not be included in the transcripts used for analysis.

Right not to Participant and Withdraw:

Your participation in the study is entirely voluntary. You have the sole authority to decide for or against your participation. You may refuse to participate or withdraw or refuse to answer specific questions in an interview at any time without showing any cause. Refusal to participate in the study will not cause you any penalty or loss of benefits to which you are entitled.

Cost and Reimbursements for Participating in the Research:

There will be no cost to you for participating in this study. In compensation for your time and/or travel, you will receive 300 BDT for participating in this research.

Contact for Further Information:

If you have any questions about the study, you may contact:

- General questions about this study or to report a study-related problem or injury, please contact: Principal Investigator: Dipika Paul, Ipas Bangladesh at +880-2-222286583. You can also contact her via email at pauld@ipas.org.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

Consent for Audio Recording

Now I would like to tell you more about the audio recording. We would like to audio record the interviews we conduct so that we do not miss any of the information you share. The recording will be used for research purposes only and will not be shared outside the research team. There is always a chance of loss of confidentiality, but we will do our best to protect your information. The recording will be deleted as soon as it is transcribed. The transcript of the recording will not include any names or personal information, only a unique code. Do you agree to having the interview audio recorded?

□ Yes

□ No

Statement of Informed Consent:

By participating in this study, you confirm that:

- You understand the information provided on this permission form and by the study staff.
- All your questions about the research have been answered to your satisfaction.
- You agree to take part in this study.
- A copy of this form has been made available to you.

Your signature/thumbprint below indicates your permission to take part in this research.

Printed Name of Participant_____

Signature/Thumbprint of Participant: _____ Date: _____

Printed Name of Person Obtaining Consent: _____

Signature of Person Obtaining Consent: _____ Date: _____

Annex 7: Informed Consent for In-Depth Interviews

Introduction:

Hello. My name is _____.

I am an interviewer/a facilitator working with Ipas Bangladesh and Naripokkho. We are conducting a study with women and girls on their experiences with climate change-related events and how these experiences have impacted their sexual and reproductive decision-making, behaviors, and health outcomes.

Purpose of the Research:

The purpose of this study is to gain insight into if and how women and girls' experiences with climate change-related events have impacted their sexual and reproductive health, in order to generate evidence to inform sexual and reproductive health and rights programming and advocacy.

Eligibility Criteria:

You must be 15 years or older to participate in this interview. Minors (under 18 years) that wish to participate will undergo informed assent instead of informed consent and will require permission from an accompanying adult, such as a guardian or parent over the age of 18.

Procedures of Participation:

If you agree to participate, I will be asking questions about your personal experiences. During the interview, I or another interviewer/note taker will sit down with you in a comfortable place. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. There will also be a notetaker in the interview who is there to help the facilitator take notes during the interview. No one else but the interviewer and notetaker will be present unless you would like someone else to be there. Even if you agree to begin the interview, you are allowed to change your mind about participating at any time.

Duration of the Interview:

The interview will take approximately 45 minutes of your time to complete. It may take a little longer or shorter depending on how much you share.

Potential Benefits and Risks of Participating:

There are no direct benefits to you for participating in this study. Information collected from you and others will be analyzed to generate answers for the research question and will be used as evidence to inform SRHR programming and advocacy efforts. There are no risks or hazards associated with your participation in the individual interview. We will not collect your name or any personal information. We will be audio-recording and taking notes of the interview/discussion. We will do our best to keep the recording/notes safe by not recording your name and by keeping files in a secure cabinet and password protected computer. The only discomfort is the time of participation which you could use for something else. There may be some sensitive questions asked. You do not have to answer any questions that make you uncomfortable and you can stop the interview any time.

Privacy, Anonymity and Confidentiality:

We do hereby affirm that privacy, anonymity and confidentiality of information identifying you will strictly be maintained. The interview will be held in a private room. Study records with identifiable information will be kept confidential by storing them on locked, password-protected computers, and securely in the cloud. All audio recordings will be deleted from the digital recorders at the completion of the study. The audio recordings will remain stored securely in the cloud for seven years following study completion, and any identifiable information will not be included in the transcripts used for analysis.

Right not to Participant and Withdraw:

Your participation in the study is entirely voluntary. You have the sole authority to decide for or against your participation. You may refuse to participate or withdraw or refuse to answer specific questions in an interview at any time without showing any cause. Refusal to participate in the study will not cause you any penalty or loss of benefits to which you are entitled.

Cost and Reimbursements for Participating in the Research:

There will be no cost to you for participating in this study. In compensation for your time and/or travel, you will receive 200 BDT for participating in this research.

Contact for Further Information:

If you have any questions about the study, you may contact:

- General questions about this study or to report a study-related problem or injury, please contact: Principal Investigator: Dipika Paul, Ipas Bangladesh at +880-2-222286583-4. You can also contact her via email at pauld@ipas.org.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

Consent for Audio Recording

Now I would like to tell you more about the audio recording. We would like to audio record the interviews we conduct so that we do not miss any of the information you share. The recording will be used for research purposes only and will not be shared outside the research team. There is always a chance of loss of confidentiality, but we will do our best to protect your information. The recording will be deleted as soon as it is transcribed. The transcript of the recording will not include any names or personal information, only a unique code. Do you agree to having the interview audio recorded?

☐ Yes

☐ No

Statement of Informed Consent:

By participating in this study, you confirm that:

- You understand the information provided in this permission form and by the study staff.
- All your questions about the research have been answered to your satisfaction.
- You agree to take part in this study.
- A copy of this form has been made available to you.

Your signature/thumbprint below indicates your permission to take part in this research.

Printed Name of Participant: _____

Signature/Thumbprint of Participant: _____ Date:_____

Printed Name of Person Obtaining Consent: _____

Signature of Person Obtaining Consent: _____ Date: _____

Note: For participant under the age of eighteen, separate assent was obtained from the minor alongside guardian consent, in accordance with this consent form.

Annex 8: Informed Consent for Community Dialogue Meetings

Introduction:

Hello. My name is _____.

I am an interviewer/a facilitator working with Ipas Bangladesh. We are conducting a study with women and girls on their experiences with climate change-related events and how these experiences have impacted their sexual and reproductive decision-making, behaviors, and health outcomes.

Purpose of the Research:

The purpose of this study is to gain insight into if and how women and girls' experiences with climate change-related events have impacted their sexual and reproductive health, in order to generate evidence to inform sexual and reproductive health and rights programming and advocacy. We are facilitating Community Dialogue Meetings with women and girls of reproductive age from your community to explore issues related to climate change and women and girls' sexual and reproductive health.

Eligibility Criteria:

You must be 15 years or older to participate in this Community Dialogue Meeting. Minors that wish to participate will undergo informed assent instead of informed consent and will require permission from an accompanying adult over the age of 18.

Procedures of Participation:

If you agree to participate, you will be involved in a group discussion with about 10-15 other women and girls from your community. Discussion facilitators will ask questions about women and girls' experiences with climate change and its impacts on their sexual and reproductive health in your community. You will be asked about your personal experiences and the experiences of others in your community. The discussion will take place in a community hall or any other comfortable place. Some other women and girls from your community will involve in the discussion and the discussion facilitators will be present in the room. Notes will be taken by the facilitators, but no participants' names will be written down.

Duration of the Interview:

The Community Dialogue Meeting will take approximately 4-5 hours of your time. It may take a little longer or shorter depending on how much you or others share.

Potential Benefits and Risks of Participating:

There are no direct benefits to you for participating in this study. Information collected from you and others will be analyzed to generate answers for the research question and will be used as evidence to inform SRHR programming and advocacy efforts. There are no risks or hazards associated with your participation in the individual interview. We will not collect your name or any personal information. We will be taking notes of the interview/discussion. We will do our best to keep the notes safe by not recording your name and by keeping files in a secure cabinet and password protected computer. The only discomfort is the time of participation which you could use for something else. There may be some sensitive questions asked. You do not have to answer any questions that make you uncomfortable and you can stop participating at any time.

Privacy, Anonymity and Confidentiality:

We do hereby affirm that privacy, anonymity and confidentiality of information identifying you will strictly be maintained. The interview will be held in a private room. Study records with identifiable information will be kept confidential by storing them on locked, password-protected computers, and securely in the cloud.

Right not to Participant and Withdraw:

Your participation in the study is entirely voluntary. You have the sole authority to decide for or against your participation. You may refuse to participate or withdraw or refuse to answer specific questions in an interview at any time without showing any cause. Refusal to participate in the study will not cause you any penalty or loss of benefits to which you are entitled.

Cost and Reimbursements for Participating in the Research:

There will be no cost to you for participating in this study. In compensation for your time and/or travel, you will receive 300 BDT and light snacks and refreshments for participating in this research.

Contact for Further Information:

If you have any questions about the study, you may contact:

- General questions about this study or to report a study-related problem or injury, please contact: Principal Investigator: Dipika Paul, Ipas Bangladesh at +880-2-222286583-4. You can also contact her via email at pauld@ipas.org.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

Statement of Informed Consent:

By participating in this study, you confirm that:

- You understand the information provided in this permission form and by the study staff.
- All your questions about the research have been answered to your satisfaction.
- You agree to take part in this study.
- A copy of this form has been made available to you.

Your signature/thumbprint below indicates your permission to take part in this research.

Printed Name of Participant: _____

Signature/Thumbprint of Participant: _____ Date:_____

Printed Name of Person Obtaining Consent: _____

Signature of Person Obtaining Consent: _____ Date: _____

Note: For participant under the age of eighteen, separate assent was obtained from the minor alongside guardian consent, in accordance with this consent form.

Ipas Partners for Reproductive Justice