Exploring Current Practices of Multidisciplinary Teams in Enhancing Sexual Function among People with Spinal Cord Injury at Centre for the Rehabilitation of the Paralysed

By
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This thesis is submitted in total fulfilment of the requirements for the subject RESEARCH 2 & 3 and partial fulfilment of the requirements for the degree of

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Statement of Authorship

Except where it is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for any other degree or seminar. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any other degree in any other tertiary institution. The ethical issue of the study has been strictly considered and protected. In case of dissemination of the findings of this project for future publication, the research supervisor will be highly concerned, and it will be duly acknowledged as an undergraduate thesis.

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Dedication

To the All Spinal Cord Injury Patients.

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List of Abbreviations

Short Form	Abbreviations
AD	Autonomic Dysreflexia
BHPI	Bangladesh Health Professions Institute
B.Sc.	Bachelor of Science
CRP	Centre for the Rehabilitation of the Paralyzed
HCP	Health Care Professional
IRB	Institutional Review Board
MBBS	Bachelor of Medicine and Bachelor of Surgery
MDT	Multidisciplinary Team
MOHO	Model of Human Occupation
MPH	Master of Public Health
OT	Occupational Therapy / Occupational Therapist
PDE5	Phosphodiesterase Type 5
PEOP	Person –Environment- Occupation- Performance
RCT	Randomized Controlled Trial
SCI	Spinal Cord Injury
WHO	World Health Organization
WMA	World Medical Association

Abstract

Background: Sexual function is an essential part of overall health and quality of life. Every year around 800 to 1000 new SCI patients are seen in Bangladesh. After spinal cord injury (SCI), many individuals experience sexual dysfunction, which affects their physical, emotional, and marital well-being. In Bangladesh, sexual health is considered a sensitive and taboo topic, and as a result, sexual rehabilitation for SCI patients often receives little attention. Although multidisciplinary teams (MDTs) play an important role in SCI rehabilitation, there is limited evidence regarding their current practices in addressing sexual function at rehabilitation centers such as the Centre for the Rehabilitation of the Paralysed (CRP).

Aim: The aim of this study was to explore current practices of multidisciplinary teams in enhancing sexual function among people with spinal cord injury at CRP.

Methods: A qualitative research design was used for this study. Purposive sampling was used to choose eleven healthcare experts from various specialties, including physiotherapists, occupational therapists, doctors, nurses, and a psychologist. Face-to-face, in-depth, semi-structured interviews under the direction of a self-developed interview guide were used to gather data. Braun and Clarke's six-step method for thematic analysis was used to analyse the data.

Results: Eight themes were identified. These were: 1) Profession-specific and clinically diverse sexual rehabilitation practices within the multidisciplinary team; 2) Limited interdisciplinary integration and fragmented communication; 3) Systemic and organizational constraints in service delivery; 4) Gender-related communication barriers; 5) Sociocultural influences on sexual rehabilitation engagement; 6) Psychosocial, relational, and marital impacts of sexual dysfunction; 7) Gender

disparities in sexual rehabilitation service utilization; and 8) Recommendations for strengthening sexual rehabilitation services. Discipline-specific interventions are used at CRP to provide sexual rehabilitation, but services are still dispersed because of poor MDT coordination and an excessive dependence on the psychologist. Important obstacles include inadequate organizational integration, a lack of a dedicated unit, inadequate equipment and medication and a lack of professional training. Male patients receive more care than female patients due to erectile dysfunction. Psychosocial and marital issues, such as fear of divorce and fertility issues are also brought on by sexual dysfunction. To improve services, participants suggested a specialized unit, better coordination, organized MDT training and stronger policy support.

Conclusion: Sexual rehabilitation remains underdeveloped in SCI care in Bangladesh. Strengthening MDT collaboration, improving training, and establishing dedicated services, and supporting these efforts through appropriate health system and policy level initiatives are essential to enhance sexual health and overall quality of life for individuals with SCI.

Key words: Spinal cord injury, Sexual function, Multidisciplinary team, Sexual rehabilitation, Qualitative study.

CHAPTER I: INTRODUCTION

1.1 Background

Damage to the spinal cord that causes a loss of function, including movement and sensation, is known as a spinal cord injury (SCI). For people with SCI and their families, sexuality is essential to their life and a vital component of wellbeing (Longoni Di Giusto et al., 2022). SCI can impair multiple components involved in sexual function, including libido, achieving and maintaining an erection, ejaculation, and orgasm etc. (Bryant, Aplin, et al., 2022) (Bello et al., 2022). Moreover now a days many safe and effective fertility treatments are available to couples affected by SCI. But in the healthcare industry, sex-related subjects are frequently avoided, especially when it comes to disabilities, and as a result, healthcare professionals overlook them (HCP) (Bryant, Aplin, et al., 2022) .

People must adapt in their sexual lives after suffering a spinal cord injury. According to earlier research, there are a variety of obstacles to provide sexual health counseling to individuals with SCI: ignorance, insufficient time, pain, and Some of the stated explanations for why this subject is frequently ignored include insufficient training (Rassem et al., 2020). Multidisciplinary teams—including doctors, nurses, psychologists, occupational therapists, and physiotherapists—play a crucial role in addressing the complex needs of SCI patients, including their sexual health. Evidence suggests that an integrated, team-based approach enhances communication, normalizes sexual discussions, and ensures that patients receive comprehensive, person-centered care (Bryant, Aplin, et al., 2022). Training

rehabilitation professionals in sexual health improves their confidence, knowledge, and willingness to engage in these sensitive conversations (Pieters et al., 2018).

In Bangladesh, cultural stigma around sexuality may further hinder open dialogue, underscoring the importance of equipping the entire rehabilitation team with the skills to address sexual function. If multidisciplinary team don't handle this appropriately, it impacts a multidisciplinary teams ability to address specific difficulties. Because everyone has a valuable need for sexuality. It is a significant component of a married person's life that is necessary to raise a SCI patient's quality of life. According to WHO estimates, there are occurrences of 40–80 cases of SCI patients per million worldwide each year (Longoni Di Giusto et al., 2022) (Afferi et al., 2020).With 164 million people living in Bangladesh, There are 1,968 to 10,168 new cases of SCI patients every year (Rahman et al., 2017). Individuals with SCI must adjust to a variety of sexual challenges. They may experience a variety of sexual discomforts, such as physical limitations, worry, and dread, which causes him to feel angry and rejected. They go under depression, anxiety, frustration etc. and these make them lonely.

1.2 Justification of the study

Sexual dysfunction is a common and significant consequence of spinal cord injury (SCI) that greatly affects quality of life, psychological well-being, and social relationships. Despite this, sexual health is often overlooked in rehabilitation, particularly in culturally sensitive contexts like Bangladesh. The Centre for the Rehabilitation of the Paralyzed (CRP) provides comprehensive SCI care using a multidisciplinary team (MDT) approach; however, there is limited evidence on how

MDT practices at CRP which is the largest specialized SCI rehabilitation center in Bangladesh address sexual function among SCI patients.

This study is justified as it aims to explore current MDT practices in enhancing sexual function, identify existing gaps and challenges, and understand how sexual rehabilitation is integrated into SCI care at CRP. Furthermore, sexual dysfunction has been shown to have serious emotional and relational consequences, including fear of divorce, marital conflict, reduced intimacy, and anxiety about fertility. Without proper sexual rehabilitation, these issues can undermine the overall goals of rehabilitation and community reintegration. Understanding current practices and barriers is therefore essential to improving holistic SCI care. The findings will provide context-specific evidence that can support improved MDT collaboration, guide training and policy development, and promote holistic, patient-centered rehabilitation for individuals with SCI in Bangladesh.

1.3 Operational Definition

1.3.1 Spinal Cord Injury

The term spinal cord injury (SCI) refers to damage to the spinal cord resulting from trauma (e.g. from falls and road traffic injuries) or non-traumatic causes like tumors, degenerative and vascular conditions, infections, toxins or birth defects (WHO, 2024).

1.3.2 Sexual Function

Sexual function refers to the ability to engage in sexual activity in a satisfying manner, either alone or with a partner. (Moore, D. P., & Jefferson, J. W. , 2004).

1.3.3 Multidisciplinary Team

The World Health Organization (WHO) defines a multidisciplinary team as an approach in which professionals from various health fields work together to provide comprehensive services that address the physical, psychological, and social needs of patients (WHO, 2010).

1.4 Aim of the study

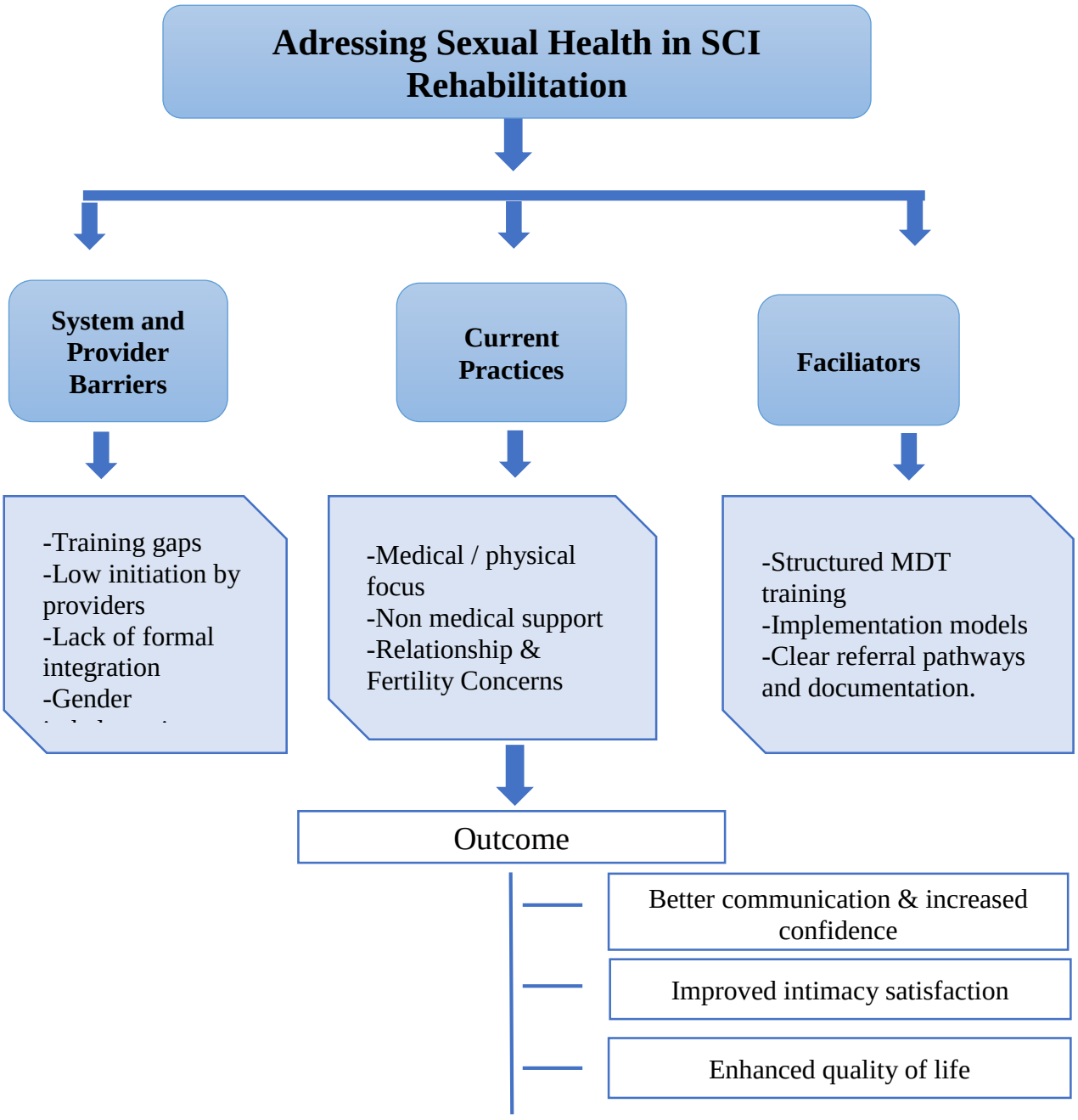
To explore current practices of multidisciplinary teams in enhancing sexual function among people with spinal cord injury at CRP.

CHAPTER II:LITERATURE REVIEW

This chapter will show similar key findings among some articles related to my research that had done previously.

Figure 2.1

Overview of the literature review



2.2 System & Provider barriers

The literature consistently highlights that system-level and provider-level factors play a decisive role in shaping how sexual rehabilitation is delivered for individuals with spinal cord injury. Even when sexual health is recognized as an important rehabilitation outcome, multiple structural and professional barriers limit its consistent implementation across rehabilitation settings.

2.2.1 Training gaps

A recurring challenge across SCI rehabilitation contexts is the pervasive lack of formal training in sexual health among healthcare professionals, which significantly hinders their confidence and willingness to address patients' sexual concerns. Despite recognizing the importance of sexual rehabilitation, many professionals, including nurses, occupational therapists, and psychologists, report feeling ill-equipped due to insufficient education and institutional support (Pascual et al., 2021). This discomfort often results in sexuality being overlooked or deprioritized during rehabilitation (Pieters et al., 2018)..However, structured training programs and multidisciplinary interventions have shown promising outcomes. Studies demonstrate that such programs can significantly improve professionals' knowledge, comfort level, and proactive engagement in sexual health discussions with SCI patients (Pieters et al., 2018). For instance, team-based sexual health education not only fosters open communication among team members but also empowers them to integrate sexuality into their clinical routines (Arnhalt, 2021).

2.2.2 Low initiation by providers

Another important provider-level factor is the low rate at which professionals initiate conversations about sexual health. Although many clinicians acknowledge that sexuality should be addressed during rehabilitation (Bryant, Aplin, et al., 2022).

.Research shows that they often wait for patients to raise the topic themselves found that discomfort, fear of offending patients, uncertainty about professional boundaries, and cultural sensitivity contribute to clinicians' reluctance to initiate sexual health discussions (Bryant, Gustafsson, et al., 2022). This passive approach can disadvantage patients who feel embarrassed or are unaware that sexual rehabilitation support is available, leading to unmet needs and delayed intervention.

2.2.3 Lack of formal integration

At the system level, the absence of formal integration of sexual rehabilitation into routine SCI care significantly affects service delivery. Sexual health is often not included in standardized assessment tools, treatment plans, or MDT documentation highlighted that without clear organizational policies, referral pathways, and documentation systems, sexual rehabilitation remains dependent on individual clinicians rather than being embedded into institutional practice (Rassem et al., 2020). This lack of formal integration reduces accountability, limits continuity of care, and contributes to inconsistent MDT involvement across rehabilitation settings (Lepage et al., 2021).

2.2.4 Gender imbalance in clinical attention

Gender imbalance in sexual rehabilitation is another critical provider- and system-related issue identified in the literature. Research indicates that male sexual dysfunction, particularly erectile dysfunction, receives greater clinical attention, while female sexual health concerns are less frequently addressed emphasized that women with spinal cord injury often experience under-recognition of their sexual needs due to sociocultural norms, clinician discomfort, and limited research focus (Bryant, Gustafsson, et al., 2022). This imbalance not only affects service access but also

reinforces inequities in sexual rehabilitation, with women receiving less information, counseling, and support compared to men(Bryant, Gustafsson, et al., 2022).

2.3 Current Practices

The international literature consistently demonstrates that sexual rehabilitation practices for individuals with spinal cord injury vary considerably across healthcare systems, rehabilitation centers, and professional disciplines. Although sexuality is widely acknowledged as an important aspect of quality of life, it is not uniformly addressed within routine rehabilitation practice. Instead, the type and depth of sexual rehabilitation provided often depend on clinician expertise, service structure, and institutional priorities. This variability has resulted in uneven access to care and a lack of standardized sexual rehabilitation pathways across settings.

2.3.1 Medical & physical focus

One prominent feature of current practice is the strong emphasis on medical and physical aspects of sexual function. Much of the existing sexual rehabilitation focuses on physiological impairments, particularly erectile dysfunction among male patients (Lombardi et al., 2015). Clinical management often prioritizes pharmacological treatment, physiological assessment, and functional performance, while broader aspects of sexuality receive less attention. Several studies indicate that sexual rehabilitation is frequently equated with restoring sexual performance rather than supporting sexual well-being in a holistic sense (Mcmahon, 2015). This biomedical focus can be effective for managing specific dysfunctions but may fail to address emotional, relational, and psychosocial needs, particularly for women and older patients (Iyer et al., 2025). As a result, sexual rehabilitation remains narrowly defined in many clinical settings, reinforcing gender bias and limiting comprehensive care.

2.3.2 Non medical support

Non-medical approaches play a vital role in addressing the complex sexual health needs of individuals with spinal cord injury (SCI), complementing medical and surgical interventions (Arnhalt, 2021). These approaches encompass counselling, intimacy-focused strategies, and the use of assistive devices and positioning tools, which together provide holistic support tailored to the physical, psychological, and social challenges faced by SCI patients. Counselling forms the cornerstone of non-medical care, delivered by psychologists, nurses, occupational therapists, and other MDT members (Bryant, Gustafsson, et al., 2022). It aims to normalize conversations about sexuality, reduce stigma, and empower patients to explore their sexual identity and desires despite physical limitations. Through therapeutic dialogue, patients and their partners receive guidance on communication, emotional adjustment, and the reconceptualization of sexuality beyond conventional definitions. This person-centered counselling fosters self-esteem and helps rebuild intimate relationships, encouraging openness and mutual understanding between partners. Intimacy-focused interventions extend beyond the physical act of sex to include emotional connection, affectionate touch, and non-genital sexual expression (Krull et al., 2022).

2.3.3 Relationship & fertility concern

Another area where current practice varies significantly is the attention given to relationship and fertility-related concerns. Research shows that individuals with spinal cord injury often experience anxiety about intimacy, marital stability, reproductive ability, and future family planning. Despite the importance of these issues, relationship and fertility concerns are not consistently addressed during rehabilitation (Bryant, Gustafsson, et al., 2022) .In many settings, sexual rehabilitation focuses on the individual patient, with limited involvement of partners or spouses. This lack of partner-

inclusive care can contribute to misunderstanding, emotional distance, and relationship strain. Furthermore, fertility-related counseling is often provided only when patients explicitly ask or when medical complications arise, rather than being integrated into routine sexual health discussions(Rahimi-movaghar, 2012) . As a result, patients and partners may leave rehabilitation with unresolved concerns that affect long-term adjustment and quality of life.

2.3.4 Outcome

The literature suggests that when sexual rehabilitation is meaningfully integrated into spinal cord injury care, its impact extends far beyond the management of sexual dysfunction. Effective sexual rehabilitation contributes to improved communication, relational adjustment, emotional well-being, and overall quality of life. These outcomes are interrelated and reflect the holistic nature of sexuality as a physical, psychological, and social experience.

2.3.4.1 Better confidence & increased outcome

One of the most fundamental outcomes of effective sexual rehabilitation is improved communication. When healthcare professionals create opportunities for open, respectful, and non-judgmental discussion of sexual health, patients feel validated and reassured that their concerns are legitimate and worthy of attention. This open communication reduces feelings of embarrassment, shame, and isolation that are commonly associated with sexuality after spinal cord injury. Improved communication also enhances patient confidence (Giurleo et al., 2022). As individuals gain accurate information and guidance, they develop greater confidence in understanding their bodies, expressing their needs, and navigating intimate situations. Confidence is further strengthened when patients experience supportive interactions with healthcare providers who are knowledgeable and comfortable discussing sexual health (Pieters et

al., 2018). This confidence can extend into personal relationships, enabling individuals to communicate more openly with partners and to participate more actively in decision-making related to their sexual and reproductive health (Pieters et al., 2018).

2.3.4.2 Improved intimacy satisfaction

Another important outcome of effective sexual rehabilitation is improved intimacy and sexual satisfaction. Sexual rehabilitation that addresses both physical adaptation and emotional adjustment helps individuals and couples redefine intimacy after spinal cord injury (Arnhalt, 2021). Rather than focusing solely on sexual performance, comprehensive rehabilitation supports exploration of pleasure, closeness, and emotional connection in ways that are meaningful and achievable. By receiving guidance on adaptation strategies, positioning, communication, and emotional support, individuals are better able to engage in satisfying intimate relationships (Bryant, Gustafsson, et al., 2022).

2.3.4.3 Enhanced Quality of life

Enhanced quality of life is a broader outcome associated with comprehensive sexual rehabilitation. Addressing sexual health contributes to psychological well-being, self-esteem, and overall life satisfaction (Arnhalt, 2021). Individuals who receive appropriate sexual rehabilitation are better able to adapt to their injury, maintain meaningful relationships, and participate fully in social and family life (Lepage et al., 2021). By recognizing sexuality as a normal and important aspect of human life, rehabilitation services support holistic recovery rather than focusing solely on physical independence.

2.4 Facilitators

Several studies have highlighted that effective sexual rehabilitation after spinal cord injury depends on supportive systems and structured approaches. Recent evidence

suggests that when appropriate facilitators are in place, sexual rehabilitation becomes more consistent, coordinated, and patient-centered. Key facilitators identified across the literature include structured multidisciplinary training, the use of implementation models, and clear referral and documentation systems.

2.4.1 Structured MDT training

Previous studies have shown that structured MDT training is an essential facilitator for improving sexual rehabilitation practice. One study reported that targeted training programs enhance rehabilitation professionals' knowledge, confidence, and communication skills, enabling them to initiate sexual health discussions more comfortably (Rassem et al., 2020). Other studies suggest that joint training promotes shared responsibility across MDT members and reduces overreliance on individual specialists, contributing to more consistent service delivery (Pieters et al., 2018).

2.4.2 Implementation models

Several studies have demonstrated that implementation models such as the PLISSIT framework provide a clear and ethical structure for addressing sexual health concerns(Rizio et al., 2012). Recent research indicates that stepwise models support clinicians in initiating discussions at appropriate levels, reduce professional discomfort, and improve consistency in sexual rehabilitation practices across different disciplines (Pieters et al., 2018) .

2.4.3 Clear referral pathways and documentation

Previous research has highlighted that clear referral pathways and proper documentation are important facilitators for coordinated sexual rehabilitation services. Some studies have shown that structured referral systems improve continuity of care, while others emphasize that documenting sexual health discussions enhances MDT

communication, accountability, and follow-up, helping to integrate sexual rehabilitation into routine spinal cord injury care (Giurleo et al., 2022).

Key Gaps of the Evidence

• Several international studies have explored sexual health and sexual rehabilitation among individuals with spinal cord injury; however, most research focuses on patient outcomes rather than clinical practice within multidisciplinary teams.

• The majority of existing literature emphasizes medical and psychological aspects of sexual dysfunction, particularly erectile dysfunction, with limited exploration of holistic sexual rehabilitation approaches.

• Multidisciplinary team (MDT) involvement in sexual rehabilitation is mentioned in the literature, but detailed exploration of how MDT members practice, coordinate, and contribute to sexual rehabilitation is limited.

• Most studies highlight healthcare professionals' discomfort and lack of training, yet few studies explore profession-specific roles (physiotherapist, occupational therapist, nurse, doctor, sexologist) in sexual rehabilitation.

• Gender disparities are evident in the literature, with male patients receiving more sexual rehabilitation services; however, female sexual health needs after SCI often remain underexplored.

• Sociocultural and religious influences on sexual rehabilitation are acknowledged, but there is insufficient in-depth qualitative evidence explaining how these factors shape clinical practice.

• Evidence from low- and middle-income countries is limited, and very few studies examine sexual rehabilitation practices within culturally conservative contexts.

• To date, there is little evidence from Bangladesh exploring sexual rehabilitation among SCI patients, particularly from the perspective of multidisciplinary healthcare professionals.

• No known qualitative study has explored the current practices of MDTs in enhancing sexual function among SCI patients at CRP.

Therefore, this study aimed to explore the current practices of multidisciplinary teams in enhancing sexual function among spinal cord injury patients at CRP, Bangladesh.

CHAPTER III: METHODS & MATERIALS

3.1 Study Question, Aim, Objective

3.1.1 Study Question

What are the current practices use by multidisciplinary team members to enhance sexual function among people with spinal cord injury patients at CRP?

3.1.2 Aim

This study aims to explore current practices of multidisciplinary teams in enhancing sexual function among people with spinal cord injury patients at CRP.

3.1.3 Objectives

- To explore the current clinical practices used by the multidisciplinary teams to enhance sexual function and sexual well-being of SCI patients.
- To understand the challenges multidisciplinary teams, face while providing sexual rehabilitations in their treatment plans for SCI patients according to our cultural context.
- To find out the recommendations from MDT perspective for betterment of sexual rehabilitation.

3.2 Study Design

3.2.1 Study Method

The student researcher followed a qualitative research which employs observation and description, combined with a naturalistic interpretive method, to study a subject's environment and gain insight into their experiences, perceptions, intentions, motivations, and behaviors (Creswell & Poth,2018). Qualitative methods were utilized

to explore current practices of multidisciplinary teams in enhancing sexual function among spinal cord injury patients.

3.2.2 Study Approach

This study used a phenomenological approach to explore the current practices of multidisciplinary teams in enhancing sexual function among spinal cord injury patients at CRP. Phenomenological study describe how individuals perceive and interpret their natural experiences of a specific phenomenon (Creswell & Poth, 2018). It enables us to understand the significance of each person's perspective, knowledge, and lived experiences (Neubauer et al., 2019). This study followed an inductive approach, allowing themes and meanings to emerge directly from participant's experience.

3.3 Study Setting and Period

3.3.1 Study Setting

This student researcher has conducted the data collection at CRP, Chapain, Savar,1343 in Bangladesh.

3.3.2 Study Period

The study period was from 15th June, 2025 to 15th December 2025 and the data collection period was from 2nd August, 2025 to 15th September, 2025.

3.4 Study Participant

3.4.1 Study Population

Two occupational therapists, three physiotherapists, three nurses, two doctors and one psychologist.

3.4.2 Sampling Techniques

The student researcher selected a purposive sampling procedure to collect the data. Purposive sampling is a non-probability method that sometimes referred to as judgment, selective, or subjective sampling, is a non-probability sampling approach in

which the researcher uses judgment to select study participants (Creswell & Poth,2018). By targeting participants who actively engage with these issues, this study can explore real-world practices, barriers, and multidisciplinary interactions more effectively.

3.4.3 Inclusion Criteria

- Both male & female Doctors, Nurses, Psychologist, Occupational Therapists, Physiotherapists who are involved in spinal cord injury rehabilitation.
- Minimum of 1 year of experience in providing sexual health care, counselling, or rehabilitation services to spinal cord injury (SCI) patients.

3.4.4 Exclusion Criteria

Less than 1 year of experience in providing sexual health care, counselling, or rehabilitation services to spinal cord injury (SCI) patients.

3.4.5 Participant Overview

Eleven participants responded to this study who were the health professionals from multidisciplinary teams. From them there were three physiotherapists, two occupational therapists, two doctors, three nurses, one Psychologist. All participants have professional experience more than one year. All health professionals have been working in spinal cord injury department. To maintain confidentiality participants name were coded with a pseudo name. An overview of the identified participant is given in Table 3.1

Table 3.1

Participant Overview

Pseudo name	Educational level	Profession	Years of professional experience
Fatema	MBBS	Doctor	6 Years
Kamal	MBBS, MPH	Doctor	13 Years
Johra	Diploma	Nurse	18 Years
Tasnim	H.S.C	Nurse	25 Years
Imran	B.Sc.	Nurse	27 Years
Sakib	Masters	Psychologist	25 Years
Shaila	B.Sc.	Occupational Therapist	1 Years
Saima	Masters	Occupational Therapist	10 Years
Rahim	Masters	Physiotherapist	7 Years
Runa	Masters	Physiotherapist	14 Years
Abir	Masters	Physiotherapist	10 Years

3.5 Ethical Considerations

As a statement of ethical principles for medical research, the World Medical Association (WMA) created the Declaration of Helsinki (World Medical Association Declaration of Helsinki, 2022).

3.5.1 Ethical Clearance

Ethical clearance was obtained from the Institutional Review Board of Bangladesh Health Professions Institute through the Department of Occupational Therapy, along with a brief description of the aim and objectives. The IRB clearance number is CRPBHPI/IRB/07/2025/1105 (see Appendix A).

3.5.2 Informed Consent (Information Sheet, Consent Form)

- **Information sheet:** The student researcher provided each participant with an information sheet that clearly and concisely outlined all pertinent details about the study, including its aim and objectives.
- **Consent form:** Participants voluntarily participated in this study after being informed of its purpose. Written consent forms were used to obtain their formal consent.
- **Withdrawal form:** Before the data analysis began, participants were informed that they could withdraw from the study. They were given a withdrawal form attached to the information sheet to formalize their decision if they chose to withdraw.

3.5.3 Unequal Relationship

The student researcher did not have any unequal relationship with the participants.

3.5.4 Risk and Beneficence

It was explained to the participants that this research posed no physical, social, or psychological risk to them. Participants were informed that they would not receive any benefit from the researcher.

3.5.5 Power Relationship

The student researcher did not have any power relationships with any participants.

3.5.6 Confidentiality

The student researcher was highly concerned about the confidentiality of the participant's information. Their socio-demographic information, such as name and identity, was not disclosed except to the supervisor, as clearly stated in the information sheet. Participants were assured that their identities would remain private for all future purposes, including report writing, publication, conferences, and other written or verbal

discussions.

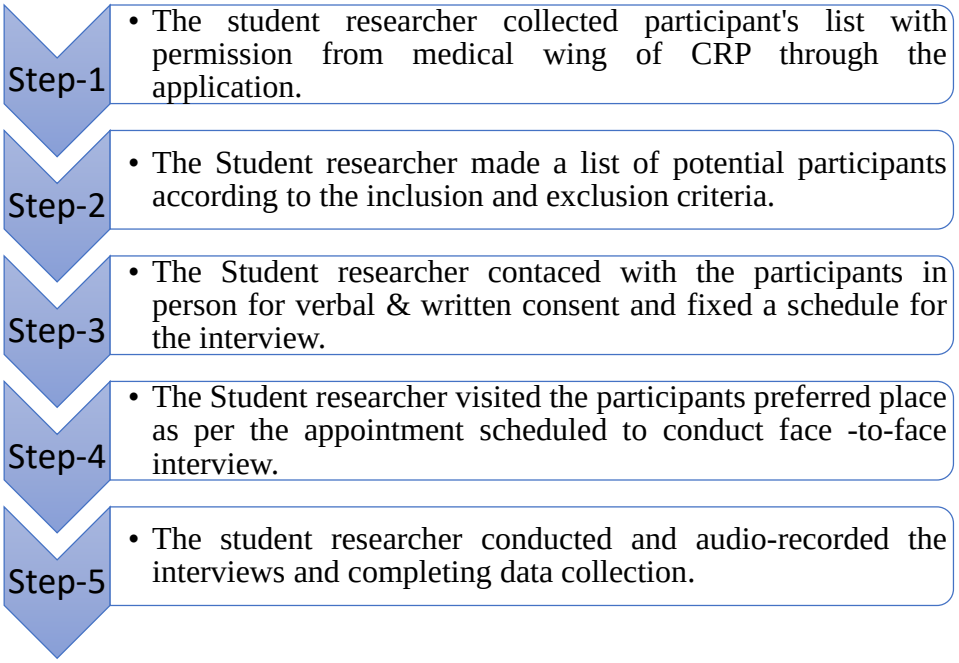
3.6 Data Collection Process

3.6.1 Participant Recruitment Process

The participant recruitment process has shown in Figure 3.6

Figure 3.6

Overview of participant recruitment process



3.6.2 Data Collection Method

The researcher contacted the CRP authority to collect data from individuals with SCI. The researcher obtained verbal consent from all the participants. Data were collected from all patients who met the inclusion and exclusion criteria. Data was collected using a face-to face semi-structured interviews . An interview is one of the most popular ways to collect qualitative research information since it is seen as speaking, and speaking is natural (Griffee, 1997). The student researcher performed in-depth, in-person, semi-structured interviews to gather data for the study. Building rapport, providing thorough answers, and observing behavioral indicators were all made possible by this method.

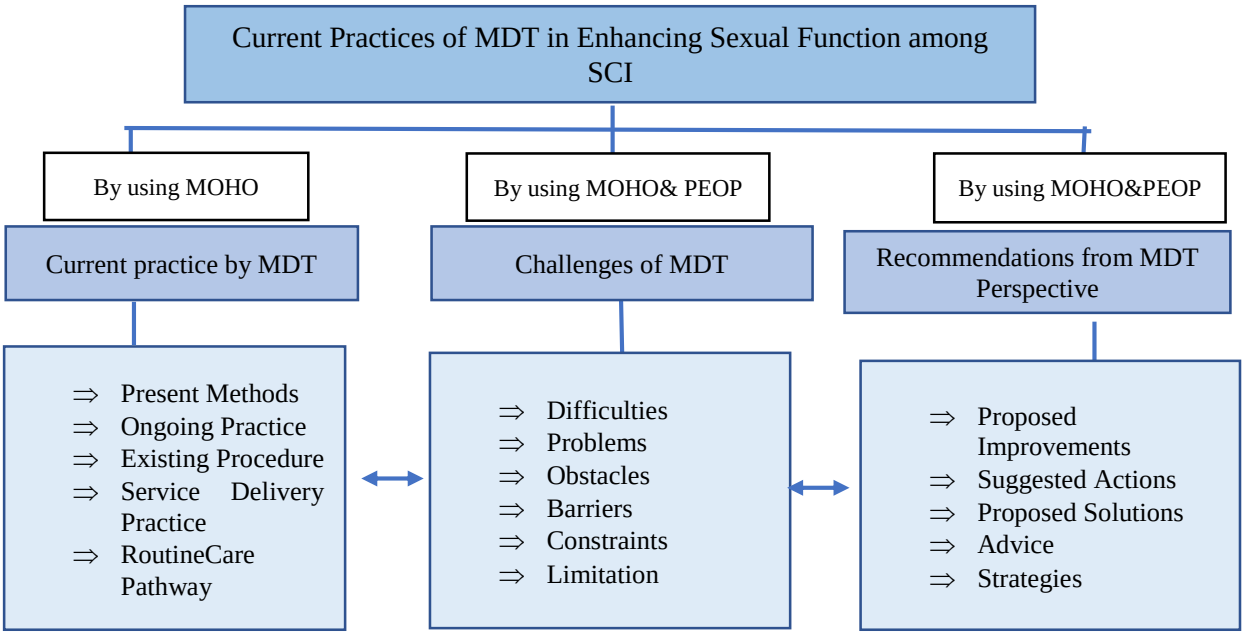
Open-ended questions facilitated in-depth conversations. To reduce distractions, interviews were conducted in peaceful settings. The researcher-built rapport, outlined the study's goal, and emphasized the importance of the results before each session. The 25 to 60-minutes interviews were recorded in flight mode using a mobile phone recorder.

3.6.3 Data Collection Instrument

A self-developed semi-structured interview guide was used by the student researcher to collect data from the participants (See Appendix C). A semi-structured format was chosen as it allows flexibility, encourages in-depth responses, and helps keep the discussion focused on the research aim and objectives. The interview guide was developed based on a review of relevant literature and aligned with the study objectives related to this topic (Pascual et al., 2021).Guidance from academic supervisors was also considered during its development. The interview guide included open-ended questions. A short sociodemographic and professional information section was also included to collect background information of the participants (See Appendix C). The student researcher used model including MOHO, PEOP.

Figure 3.6.3

Overview of conceptual framework



3.6.4 Field Test

The student researcher conducted a field test with 3 participants before starting data collection. A field test before the final data collection was crucial as it allowed the researcher to refine the data collection method and identify any challenges in questioning and develop strategies to build rapport with participants to elicit authentic responses. The semi-structured questionnaire was used, and based on the findings, a new question about the giving treatment according to gender basis was added to the interview guide. The structure of the interview guide was slightly modified to better understand the participants' responses.

3.7 Data Management and Analysis

The primary definition of thematic analysis is an independent qualitative descriptive method, which is described as "a method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2013 .It has also been presented as a qualitative descriptive approach that gives researchers the fundamental knowledge and abilities needed to carry out a wide range of additional qualitative analyses. The student researcher selected thematic analysis based on Braun and Clarke's six steps of thematic analysis. The six steps are:

Step 1: Making yourself familiar: In the first step, the student researcher listens to audio recordings and reviews interview transcripts. This enables the researcher to better understand the participant' meanings, tone, emotions and overall experiences. Important ideas and initial thoughts were noted down at this time.

Step 2: Generating the initial codes: In this step the student researcher identified some important point from the data and highlighting those sentences. Then the student researcher generated some initial code from the marking of important point and named them. The initial codes were checked by the supervisor.

Step 3: Searching for tentative themes: The student researcher wrote down the code from every interview in individual paper by serially and highlighted the similar codes through reading the translation and speaking with the supervisor. Following that student researcher organized the codes into potential theme and wrote them on different sticky notes. Sticky notes hanged on wall so that related concepts could be conveniently grouped together to identify potential theme.

Step 4: Reviewing themes: The student researcher created an initial thematic map and discussed with supervisor. With supervisor help Eight themes with some sub-themes were emerged from the study.

Step 5: Defining and naming themes: The student researcher refined and revised the theme and sub theme and finalized those themes and sub-themes for results. Then generated clear name and definition for the theme and sub-themes so that reader can clearly understand. The respected supervisor checked all the theme and sub-theme.

Step 6: Producing the report: In the final step, the researcher produced a clear and complete report on the findings. Each theme was thoroughly described and demonstrated by direct quotations from participants. This stage involves conveying the story of the data in a way that reflects the caregivers' actual experiences while also connecting back to the research topic and current literature.

3.8 Trustworthiness and Rigor

Trustworthiness was maintained by methodological and interpretive rigour (Fossey et al., 2002)

3.8.1 Methodological rigor

Congruence: Phenomenological approach of qualitative design was selected for the research which was accurately fit to the aim and objectives (see section 3.2: Study Design).

Responsiveness to social context: Face-to-face interview was conducted in a suitable place by manually convenient. By verbal communication with the participant, student researcher become familiar with the context (see section 3.3.1: Study setting)

Appropriateness and adequacy: Purposive sampling are followed to find out the participants for the study. Eleven participants were selected in this study based on some inclusion and exclusion criteria. Data were collected by face-to-face interview (see section 3.4.2 and 3.6.1: Sampling techniques and participant recruitment process).

Transparency: The student researcher collected and analysed data. There was no risk of bias because the supervisor was actively involved in every step of data analysis process, giving the data variety of viewpoints (see section 3.6 and 3.7: Data collection process and data management and analysis).

3.8.2 Interpretive rigor

Authenticity: Presentation of finding and interpretation was maintained by providing verbatim quotation of participant. Following the participants' statements, the student researcher verbally checked the participants' understanding of the explanation by asking follow up questions. (See chapter IV: Result section).

Coherence: Data was fitted to the aim and objectives. The student researcher transcribed data verbatim listening to the audio in Bengali as first language and translated them in English. The respected supervisor rechecked every transcription after listening to the audio recording, then student researcher started to analyse data (see section 3.6: Data management and analysis).

Reciprocity: Student researcher translated the data in verbatim by keeping the original data unchanged. Data analysis was not discussed with any participants. (See section 3.7: Data management and analysis).

Typicality: The term “typicality” describes how well the results can be applied to

different contexts (Fossey et al., 2002). The student researcher addressed this concern by describing the context of the study in details, allowing the reader to clarify and comprehend the results (see Sections 3.4.5 and 3.7 Participant Overview and Data Management and Analysis).

Permeability of the researcher's: By strictly adhering to the rules of ethics, the student researcher's intentions, preconceptions, values, or preferred theories were maintained. The student researcher completed all the strategy of the research after checked and discussed with the supervisor which beneficial for keeping the study unbiased (see section 3.7: Data management and analysis).

CHAPTER IV: RESULTS

This chapter discusses the current practices of multidisciplinary teams in enhancing sexual function among spinal cord injury patient at CRP. Eleven professionals from multidisciplinary teams shared their experiences on the treatment practices for sexual dysfunction among spinal cord injury patients. Eight themes that emerged from the data analysis included: i) Profession-Specific and Clinically Diverse Sexual Rehabilitation Practices, ii) Limited Interdisciplinary Integration and Fragmented Communication, iii) Systemic and Organizational Constraints Undermining Sexual Rehabilitation, iv) Gender-Related Communication Barriers, v) Sociocultural Contexts as Powerful Determinants of Sexual Rehabilitation Engagement, vi) Psychosocial, Relational, and Marital Impacts of Sexual Dysfunction Following SCI, vii) Male Patients Receive More Sexual Rehabilitation Treatment Than Female Patients, viii) Strengthening Sexual Rehabilitation Services. There are multiple sub-themes found for each theme. In this chapter they are listed below in table 4.1: overview of results.

Table 4.1

Overview of Results

Theme	Sub -Theme
Theme 1: Profession-Specific and Clinically Diverse Sexual Rehabilitation Practices	Physical rehabilitation interventions
	Occupational therapy interventions
	Medication management
	Psychosexual counseling & therapeutic techniques
	Nursing contributions
Theme 2: Limited Interdisciplinary Integration and Fragmented Communication	Lack of sexuality-focused MDT meetings
	Overdependence on the psychologist
Theme 3: Systemic and Organizational Constraints Undermining Sexual Rehabilitation	Lack of equipment & medication availability
	Lack of dedicated sexual rehab unit
	Lack of sexual rehab-based professional training
Theme 4: Gender-Related Communication Barriers	Female patient shyness
	Therapist–patient gender mismatch discomfort
Theme 5: Sociocultural Contexts as Powerful Determinants of Sexual Rehabilitation Engagement	Sexuality taboo in Bangladeshi culture
	Misconceptions about harm
Theme 6: Psychosocial, Relational, and Marital Impacts of Sexual Dysfunction Following SCI	Fear of divorce or marital breakdown
	Anxiety about fertility
Theme 7: Male Patients Receive More Sexual Rehabilitation Treatment Than Female Patients	Focus on Male-Specific Erectile dysfunction
	Higher Help-Seeking Behavior Among Male Patients
Theme 8: Strengthening Sexual Rehabilitation Services	Need for Structured training programs
	Need for Dedicated sexual rehab unit
	Regular MDT coordination meetings
	Government & policy involvement

4.1 Theme One: Profession-Specific and Clinically Diverse Sexual Rehabilitation Practices

This theme highlights the varied and profession-specific approaches used by different MDT members to address sexual function among SCI patients. Sexual rehabilitation was not delivered through a unified framework; instead, each professional contributed based on their individual scope of practice.

4.1.1 Sub Theme One: Physical Rehabilitation Interventions

Physiotherapists provide initial counselling and primarily focused on physical aspects of sexual function, particularly sets strengthening programs such as Kegel exercises and core muscle stabilization exercises were frequently used to stabilize pelvic floor muscles. Physiotherapist Abir stated that –" *If there is improvement in the pelvic floor muscles, then improvement will occur in sexual rehabilitation."* These treatments mainly help with erectile dysfunction, premature ejaculation, and pelvic muscle weakness. Participants reported that noticeable improvement was most commonly observed in male patients with erectile dysfunction. Physiotherapist Rahim stated that- *"Through these treatments, the most improvement is seen in erectile dysfunction"*. Moreover physiotherapists teach some positioning techniques to maintain during intimacy as when the patient is male, the female partner has to play the role in the active phase and the male partner should be in the passive phase. Male patients with good trunk control can do the intercourse in side lying position. Physiotherapist Runa stated that-*" If the patient is male, he is no longer in the active phase; in that case, the female partner has to perform most of the activities."* However they also provide safety education regarding autonomic dysreflexia.

4.1.2 sub Theme two: Occupational Therapy Interventions

Occupational therapists primarily focused on giving education to the patients related to

fertility and family roles . Occupational Therapist Shaila stated that –*" At this stage, our intervention is limited only to education besides that We are not yet providing any exercises or other active activities."* OTs emphasized increasing patient awareness that sexual activity remains possible after SCI. Occupational therapist Saima stated that – *"Many patients initially do not know that even after SCI they can participate in intercourse."*

4.1.3 Sub Theme Three: Medication Management

Doctors contributed mainly through assessment, counseling, and pharmacological management. Medications such as PDE5 inhibitors (e.g., sildenafil, tadalafil), SSRI or antidepressants (Citalopram, Fluoxetine), vitamins(vitamin E capsule), and antioxidants (such as Brinox, astaxanthin) were prescribed based on individualized problems. Doctor Kamal stated that – *"For male patients who develop erectile dysfunction, we prescribe oral medications like sildenafil or tadalafil.".*These medicines help to improve erectile dysfunction, premature ejaculation, desirability of intimacy. These medicines are advised to intake half an hour before intercourse. Participants reported that all the medicines are only advisable for male patients. For reproductive stage female patients doctors advice them about contraception. Doctors emphasized safety screening, particularly for autonomic dysreflexia, before prescribing medications. Surgical options were not practiced due to lack of facilities and local precedent. Doctor Fatema stated that – *"I have been working here for almost five and a half years, and I haven't seen any patient who went for surgical intervention."*

4.1.4 Sub Theme Four: Psychosexual counseling & therapeutic techniques

The psychologist played a central role in sexual rehabilitation using structured psychosexual therapy models such as the PLISSIT/PLACID framework. Interventions included couple-based counseling, sexual therapies such as - guided masturbation (solo

sex), sensate focus therapy, stop-start technique, short penetration technique (uses as the most important positioning technique), penial ring and squeeze techniques, adaptive sexual positioning, and emotional intimacy enhancement. Penial ring is not available in our country so therefore psychologist suggests local way to use condom ring instead of penial ring. The sexologist emphasized emotional connection over performance and reported improvements in premature ejaculation for stop-start technique and short penetration, erectile dysfunction, sexual satisfaction, increased movement and reduced spasticity, and even successful pregnancies following intervention. Participant also reported that these sexual therapies also develop sperm quality. Psychologist Sakib stated that – *"I often see that ejaculation is normal, but the sperm quality is not good… Along with improving erectile and ejaculatory dysfunction, it also improves sperm quality*. Psychologist more works with couple abilities so that they can enjoy their sexual life. Psychologist Sakib stated that –*" Patients never believed that they would be able to enjoy their sexual life again after a spinal cord injury."*

4.1.5 Sub Theme Five : Nursing Contributions

Nurses focused on bowel and bladder management, hygiene education of genital organ, catheter care, and initial counseling. Participant reported that bladder and catheter management included using a polys or permanent catheter for 5–7 days in the acute stage, then shifting to self-catheterization every 4 hours with individual hygiene and technique training, along with recommending 2–2.5 liters of water intake daily. Bowel management involved daily tracking, using lubricant and medication if no stool by 3 days, glycerin first, then shift to manual evacuation if no stool for 5–7 days, and establishing a morning commode routine (6–7 am) with 30–40 minutes sitting time. They also advise dietary intake as vegetables and raw salad to smoothen the stools.

Nurse Imran stated that- *“ We give plenty of vegetables with daily meals and also provide a raw salad so that the stool remains soft.”* These interventions were considered essential for enabling smooth and comfortable sexual activity. Nurse Imran stated that- *“If the patient has continuous urine or bowel leakage during intercourse, the intercourse cannot happen smoothly.”* However, most nurses reported that they were unaware about the relation between these interventions and sexual function improvement due to limited knowledge about sexual rehabilitation .Nurse Johra stated that -*“I don’t have training on this, so I cannot say exactly how this improves sexual function.”*

4.2 Theme Two: Limited Interdisciplinary Integration and Fragmented Communication

This theme reflects gaps in coordinated team functioning regarding sexual rehabilitation.

4.2.1 Sub Theme One : Lack of Sexuality-Focused MDT Meetings

Participants consistently reported that no MDT meetings were dedicated exclusively to sexual rehabilitation. Physiotherapist Rahim stated that -*“As far as I know, no MDT meeting is held specifically focusing on sexual rehabilitation.”* Sexual health was either briefly discussed within general ward rounds or managed individually. As a result, shared goal-setting and integrated care planning for sexual health were largely absent.

4.2.2 Sub Theme Two: Overdependence on the Psychologist

Sexual rehabilitation was heavily centralized around the Psychologist, leading to overreliance on one professional. Nurse Johra stated that –*“ Jobbar Bhai handles the whole matter related to sexuality separately.”* Other MDT members perceived sexual health as outside their primary responsibility, limiting holistic team involvement and continuity of care.

4.3 Theme Three: Systemic and Organizational Constraints Undermining Sexual Rehabilitation

This theme captures systemic limitations affecting service delivery.

4.3.1 Sub Theme One : Lack of Equipment and Medication Availability

Participants highlighted the absence of specialized sexual rehabilitation equipment such as pelvic floor devices, shock rip therapy machines, penile rings, and vibrators, electric stimulators etc. as they are very useful to the sexual rehabilitation treatment. Physiotherapist Abir Stated That –*"We don't have modern equipment like EMS or pelvic floor kits… these bring a lot of improvement."* But some how one physiotherapist opposed with the effective outcome of these electric equipment and gave more significance to expertise and regular manual therapy rather than tools. Physiotherapist Runa stated that – *"EMS is not clearly proven yet, and available studies show only mild effects."* Additionally, medications were often unavailable in-house, requiring patients to purchase them externally.

4.3.2 Sub Theme Two: Lack of Dedicated Sexual Rehabilitation Unit

The absence of a dedicated sexual rehabilitation unit or private space was viewed as a barrier by most of the participants. Professionals believed that a specialized unit would improve privacy, service quality, and research opportunities. Physiotherapist Abir stated that -"*It would be very good if there were a separate unit for sexual rehabilitation."*

4.3.3 Sub Theme Three: Lack of Sexual Rehab-Based Professional Training

All MDT members except the psychologist reported receiving no formal training in sexual rehabilitation was viewed as a major barrier. All the interventions are being providing by self-learning from internet. Psychologist reported that doctors are even unaware of the medicines of sexual dysfunctions due to lack of knowledge, often led to

suggested by the Psychologist himself. Psychologist Sakib stated that – *"Many times, I have to guide the doctors about which medications to use, as they are not always sure by themselves."* This knowledge gap reduced professional confidence and limited the scope of interventions delivered. Occupational Therapist Shaila stated that -*"I have not received any formal or informal training on this matter from CRP."*

4.4 Theme Four: Gender-Related Communication Barriers

This theme illustrates how gender influences disclosure and care delivery.

4.4.1 Sub Theme One: Female Patient Shyness

Female patients were consistently described as more reluctant, shy, and less communicative about sexual concerns. Cultural expectations and internalized modesty contributed to underreporting of sexual problems. Occupational Therapist Saima stated that –*"Female patients feel very shy and do not want to speak about this matter most of the time."*

4.4.2 Sub Theme Two: Therapist–Patient Gender Mismatch Discomfort

Gender mismatch between therapists and patients often created discomfort for both parties. Female therapists reported difficulty discussing sexual matters with male patients, and male patients frequently avoided discussing sexuality with female staff. Occupational Therapist Saima stated that-*"When I, as a female therapist, discuss these topics with male patients, they do not feel comfortable…and it is a matter of discomfort for me as well as ."*

4.5 Theme Five : Sociocultural Contexts as Powerful Determinants of Sexual Rehabilitation Engagement

Sexual rehabilitation was deeply influenced by sociocultural norms.

4.5.1 Sub theme One: Sexuality as a Taboo in Bangladeshi Culture

Sexuality was widely viewed as a taboo topic within Bangladeshi culture.

Physiotherapist Rahim stated that - *"Since Bangladesh is a conservative country, we do not openly discuss these matters."* Patients often avoided discussion, feared judgment, or used indirect language, making intervention challenging.

4.5.2 Sub Theme Two: Misconceptions About Harm

Many patients believed that sexual activity could worsen their physical condition or cause harm. Psychologist Sakib stated that - *"Some patients think sexual activity could lead to other problems, so they lose interest."* These misconceptions led to fear-based avoidance and reduced engagement in rehabilitation.

4.6 Theme Six: Psychosocial, Relational, and Marital Impacts of Sexual Dysfunction Following SCI

Sexual dysfunction had profound psychosocial effects.

4.6.1 Sub Theme One :Fear of Divorce or Marital Breakdown

Participants reported that many patients feared abandonment or divorce due to perceived sexual inadequacy. Relationship strain and separation were commonly observed consequences. Physiotherapist Abir stated that -*"Later it is observed that their personal and family relationships do not last and they end up with separating."*

4.6.2 Sub Theme two: Anxiety About Fertility

Concerns regarding fertility and parenthood were prevalent among both male and female patients. Addressing reproductive potential was a critical component of counseling. Occupational Therapist Saima stated that-*"Patients often ask, 'Will I ever be able to become a mother ?"*

4.7 Theme Seven : Male Patients Receive More Sexual Rehabilitation Treatment Than Female Patients

This theme highlights gender-based disparities in service utilization.

4.7.1 Sub Theme one: Focus on Male-Specific Erectile Dysfunction

Clinical interventions largely targeted male erectile dysfunction, reinforcing a male-centric model of sexual rehabilitation. Doctor Fatema stated that-*"Male patients have erectile dysfunction, so we prescribe medication more often for male patients."*

4.7.2 Sub Theme Two: Higher Help-Seeking Behavior Among Male Patients

Male patients were more likely to disclose sexual concerns and seek treatment, whereas female patients remained underserved despite comparable needs. Doctor Kamal stated that-*"In most cases, male patients bring these kinds of complaints to us."*

4.8 Theme Eight: Strengthening Sexual Rehabilitation Services

Participants proposed several strategies for improvement.

4.8.1 Sub Theme One: Need for Structured Training Programs

Mandatory, SCI-specific sexual rehabilitation training for all MDT members was strongly recommended by all the participants. Occupational therapist Saima stated that-*"There should be structured training programs for all MDT members…so that we can know that what is the role of an occupational therapist for managing sexual dysfunction."*

4.8.2 Sub Theme Two: Need for Dedicated Sexual Rehab Unit

A specialized unit with appropriate equipment and privacy was considered essential. Physiotherapist Abir stated that- *" it would be more better if there was a separate unit for sexual rehabilitation."*

4.8.3 Sub Theme Three: Regular MDT Coordination Meetings

Weekly or monthly sexuality-focused MDT meetings were recommended to improve communication and role clarity by all the participants. Nurse johra stated that -*"I want a separate MDT meeting to be held specifically on this matter."*

4.8.4 Sub Theme four: Government and Policy Involvement

Participants emphasized the need for government-level policies, funding, training programs, and community-based awareness initiatives to integrate sexual rehabilitation into national healthcare services. Psychologist Sakib stated that-*"Government policies must include sexual health for SCI patients."*

CHAPTER V: DISCUSSION

This study explored the current practices of multidisciplinary teams (MDTs) in enhancing sexual function among spinal cord injury (SCI) patients at the Centre for the Rehabilitation of the Paralyzed (CRP). Eleven healthcare professionals from different disciplines participated in the study. The findings revealed multiple themes related to profession-specific practices, MDT coordination, organizational barriers, sociocultural influences, gender disparities, and recommendations for improving sexual rehabilitation services.

The findings of this study indicate that sexual rehabilitation for SCI patients is addressed in CRP through discipline-specific practices rather than through an integrated MDT approach. At CRP Physiotherapists mainly focus on physical preparation (e.g., pelvic floor/Kegel exercise and core muscle strengthening), basic counseling, adaptive positioning guidance, and safety education (including autonomic dysreflexia precautions). However, a recent study found that physiotherapy's potential is more broader and specialized, including structured pelvic floor physical therapy programs for urogenital outcomes over 8–12 weeks and greater awareness of cueing and women's health approaches (Iyer et al., 2025). Occupational therapist's input is largely education-based (positioning pictures, fertility/family role counseling), and OTs themselves describe the intervention scope as limited mainly to education rather than active skill-based programs. In a previous literature reported that occupational therapists routinely screening sexuality, providing practical functional support (positioning/energy conservation techniques)(Lepage et al., 2021). Medical

management is present, but primarily in the form of oral medication, especially PDE5 inhibitors (sildenafil/tadalafil) antioxidants (such as Brinox, astaxanthin) for erectile dysfunction or SSRI (sertraline , citalopram)for premature ejaculation, vitamins(vitamin E capsule), and initial counseling; but importantly they also clearly state that surgical interventions are not offered or practiced. In USA a study shows that explicitly asking about sexual problems (before and after SCI), documenting orgasm/erection/lubrication status, and integrating sexuality education and counseling as part of routine rehabilitation (Alexander et al., 2017). In Sydney, Australia a study reported that antidepressants more as targeted sexual-medicine treatment: SSRIs (paroxetine, sertraline, fluoxetine, citalopram) and clomipramine are used to delay ejaculation, either daily or as on-demand dapoxetine, and it even provides timing guidance (e.g., on-demand dosing 1–3 hours before intercourse) (Mcmahon, 2015) . Moreover in Italy a literature also noted that when premature ejaculation exists with erectile dysfunction, patients may respond better with a PDE5 inhibitor alone or combined with an SSRI, rather than SSRI alone (Lombardi et al., 2015) (Siroosbakht, 2019).A major “treatment gap” becomes clearer when comparing biomedical and assistive sexual function interventions. Previous literature , however, describe a broader and more layered ED management package for SCI: ED care is not limited to PDE5 inhibitors, but can extend to intracavernosal injections (ICI), vacuum erection devices (VEDs), urethral therapies, and even penile implants, depending on lesion characteristics, response, and patient goals (Bello et al., 2022). In fact, in Chicago, USA oral PDE5 inhibitors are repeatedly reported as effective in SCI populations (improving IIEF outcomes), and comparative work discusses patient preferences across options such as sildenafil vs ICI/vacuum devices (Rizio et al., 2012). Highlighting that in abroad the service pathway often includes multiple “next-step” options when oral

therapy is insufficient or contraindicated. Psychosexual rehabilitation is comparatively more developed inside CRP because it is highly centralized around the psychologist, using PLISSIT/PLACID and structured techniques (sensate focus, stop-start, guided masturbation, squeeze/positioning approaches), including “local adaptation” where penile ring is substituted because the device is not available locally. Previous literature shows that evidence-informed counseling commonly includes behavioral techniques such as the “stop–start” and “squeeze” methods, which are well described in clinical reviews (though not SCI-specific) and can be adapted within disability contexts when appropriate (Saleh et al., 2021). Nursing contributions support sexual participation indirectly through bladder/bowel routines, hygiene , catheter care and healthy dietery intake and refer patients to doctor and psychologist; however, many nurses themselves report limited training/knowledge about how these actions connect to sexual function improvement. A study shows that nurses usually address sexual disability reactively—they respond to patient “signals” and give basic information, then refer to doctors/nurse practitioners/social workers(Pascual et al., 2021). In that case CRP appears to be more practice -based in nursing contributions.

A major finding of this study was the lack of sexuality-focused MDT meetings at CRP. Sexual health was rarely discussed in MDT rounds and was not included as a formal rehabilitation goal. Similar gaps have been identified in studies from other countries, the Australian study highlights that rehabilitation teams frequently agree sexuality is part of holistic rehabilitation, but MDT practice often remains reactive, with limited confidence, variable role clarity, and dependence on individual clinician comfort (Bryant, Aplin, et al., 2022). Similarly, a large Latin American study reported that while 99% of rehabilitation professionals believed sexuality should be addressed,

only 33.2% were very likely to initiate conversations and 61.5% reported not being prepared to advise patients at a scientific/therapeutic/educational level (Longoni Di Giusto et al., 2022). The absence of coordinated MDT meetings in the present study resulted in inconsistent referral pathways and overdependence on the psychologist. But in Switzerland a study reported that professionals described the content of sexual rehabilitation as including education about post-injury changes in sexual response, practical guidance for safe and comfortable intimacy, fertility and reproduction-related counseling, and psychosocial support, often delivered within multidisciplinary teamwork rather than as a discrete service (Afferi et al., 2020).

Organizational and structural barriers were strongly evident in this study. Participants reported limited access to sexual rehabilitation equipment, medicines , absence of a dedicated sexual rehabilitation unit and lack of training which leads to given treatments are just based on internet-based self-learning . Similar findings from other low- and middle-income countries, medications and assistive sexual devices were often unavailable within the organization, forcing patients to purchase them externally (Macleod & Mccabe, 2020). But in some other international countries have been used equipment such as electrical stimulator or electro ejaculation etc. (Rahimi-movaghar, 2012). In foreign settings like in Netherlands, training-based implementation studies show measurable improvements after structured staff training: staff initiate sexuality discussions more often, sexuality is discussed more in interdisciplinary/multidisciplinary meetings, and staff knowledge/comfort/skills improve significantly (Pieters et al., 2018).

Gender-related challenges were a prominent theme in this study. Female

patients were reported to be more shy, less communicative, and less likely to seek sexual rehabilitation services. Male patients, on the other hand, received more attention due to visible sexual dysfunction such as erectile dysfunction problem and higher help-seeking behavior where as female patients treatment only limited to counselling. This finding is consistent with previous literatures, which shows that sexual rehabilitation after SCI is often male-focused and centered on erectile dysfunction, while female sexual concerns remain underexplored (Bryant, Gustafsson, et al., 2022) . Similar gender disparities have also been reported in some studies highlighting that women's sexual desire, emotional intimacy, and reproductive concerns receive less clinical attention. But a study reported that female sexual pain (dyspareunia/vulvodynia) should be treated as equal as erectile dysfunction through a MDT approach—validation and assessment, education, pelvic floor physiotherapy and CBT—with targeted options like topical 5% lidocaine (6–8 weeks trial) and topical vaginal estrogen when appropriate (Sorensen et al., 2018).

Sociocultural factors significantly influenced sexual rehabilitation practices in this study. Sexuality was considered as a taboo topic, and patients often felt embarrassed or fearful about discussing sexual activity. These findings align with studies conducted in culturally conservative societies, where sexual health discussions are limited by stigma, religious beliefs, and misconceptions about harm (Wilbur et al., 2021). Misconceptions that sexual activity could worsen physical health were also reported in this study, consistent with findings from previous research indicating that fear-based beliefs reduce patient engagement in sexual rehabilitation (Rizio et al., 2012).

The emotional and relational consequences of sexual dysfunction were highlighted in this study. Participants reported fear of divorce, marital conflict,

emotional distress. Moreover participants also addressed anxiety about fertility among SCI patients. Similar psychosocial consequences have been reported in earlier studies, which found that untreated sexual dysfunction negatively affects marital relationships, self-esteem, and overall quality of life (Arnhalt, 2021). The current study adds depth by highlighting how these emotional concerns influence rehabilitation engagement within the Bangladeshi context. Moreover participants also addressed anxiety about fertility among SCI patients. The fertility and ejaculatory dysfunction pathway shows another area where foreign practice is more medically developed. In USA and Iran literatures describe specific infertility management techniques for SCI such as penile vibratory stimulation, electrical stimulation/electro ejaculation, and surgical sperm retrieval/biopsy, with subsequent use in IUI/IVF—often combined alongside ED management (Rahimi-movaghar, 2012).

Unlike many previous studies that focused mainly on patient experiences, this study uniquely explored sexual rehabilitation from the perspective of MDT professionals. The findings provide insight into professional discomfort, role ambiguity, and lack of training, which have also been reported internationally. However very few studies have explored these issues in Bangladesh, making this study a valuable contribution to the literature.

Participants in this study strongly recommended structured training programs, dedicated sexual rehabilitation units, regular MDT coordination meetings, and government-level policy support. Similar recommendations have been proposed in international literature, emphasizing the need for capacity building, interdisciplinary collaboration, and integration of sexual health into rehabilitation policy (Lepage et al.,

2021). Evidence from the Netherlands/Belgium-based evaluation of a multidisciplinary training intervention (the training rehabilitation teams in sexual health care model) suggests that structured team training can improve confidence and competence in addressing sexuality within rehabilitation contexts (Pieters et al., 2018).The present study supports these recommendations and contextualizes them within a low-resource, culturally conservative setting.

Overall, this study expands existing literature by providing in-depth qualitative evidence on MDT practices in sexual rehabilitation for SCI patients in Bangladesh. It highlights the need to move from fragmented, individual-based care toward coordinated, MDT-driven sexual rehabilitation services. The findings have important implications for rehabilitation professionals, organizational planning, and policy development and can guide future research and service improvement in similar contexts.

CHAPTER VI: CONCLUSION

6.1 Strengths and Limitations

6.1.1 Strengths

The strengths of this study are as follows:

• This study included participants from different professional backgrounds, such as physiotherapists, occupational therapists, nurses, doctors, and a psychologist, which provided diverse and rich perspectives on sexual rehabilitation practices for spinal cord injury (SCI) patients.

• Participants had varied levels of clinical experience and worked across different service areas within CRP, which strengthened the depth and credibility of the findings.

• A qualitative research approach was appropriate for achieving the study aim, as it allowed in-depth exploration of sensitive issues related to sexual function and rehabilitation.

• This is one of the first qualitative studies in Bangladesh to explore sexual rehabilitation from a multidisciplinary team (MDT) perspective in the context of SCI.

• The study followed a systematic thematic analysis process, which enhanced the rigor and transparency of data analysis.

• The findings contribute new context-specific evidence to the limited literature on sexual rehabilitation practices in low- and middle-income countries.

6.1.2 Limitations

Despite its strengths, the study has several limitations:

• The study used a qualitative design with a small sample size, which limits the generalizability of the findings.

• As sexual health is a sensitive topic in Bangladesh, some participants may have felt

hesitant or uncomfortable sharing their full experiences, which could have influenced the depth of the data.

• The study was conducted in a single rehabilitation center (CRP), which may not reflect practices in other settings across the country.

• The findings were based on self-reported experiences of healthcare professionals, which may be influenced by personal bias or recall limitations.

• As this was a student-led study, limited time and resources may have affected the scope of data collection and analysis.

6.2 Practice Implications

6.2.1 Recommendations

Recommendations for Professionals

• Healthcare professionals should receive structured training on sexual rehabilitation specific to SCI patients.

• Sexual health should be openly discussed with patients and, where appropriate, with their partners, in a culturally sensitive and confidential manner.

• MDT members should collaborate regularly through sexuality-focused MDT meetings to improve coordinated care.

Recommendations for Policy Makers and Organizations

• Dedicated sexual rehabilitation units with adequate privacy, equipment, and medication should be established in rehabilitation centers.

• Sexual rehabilitation should be included in national rehabilitation and disability health policies.

• Government and non-government organizations should support awareness programs and professional training related to sexual health and disability.

Recommendations for Future Research

• Future studies should include larger samples and multiple rehabilitation centers to improve generalizability.

• Further studies focusing on the role of occupational therapists in assistive device use and tool modification for sexual dysfunction are recommended.

• Further studies focusing on female sexual health after SCI and culturally sensitive intervention models are needed.

6.3 Conclusion

This study concludes that sexual rehabilitation for spinal cord injury patients at CRP is recognized as important but is currently practiced in a fragmented and uncoordinated manner. Multidisciplinary team members address sexual function based on individual professional roles rather than through an integrated MDT approach. Lack of training, limited resources, absence of dedicated sexual rehabilitation units, and strong sociocultural taboos significantly restrict effective service delivery.Gender disparities were evident, with male patients receiving more sexual rehabilitation services than female patients. Sexual dysfunction was found to have serious emotional, relational, and marital consequences, highlighting the need for comprehensive and inclusive sexual rehabilitation services.Overall, this study underscores the necessity of strengthening MDT coordination, improving professional training, and integrating sexual rehabilitation into routine SCI care. Addressing sexual health as a fundamental component of rehabilitation can improve quality of life, emotional well-being, and social participation for individuals living with spinal cord injury in Bangladesh.

CHAPTER VII: REFERENCE

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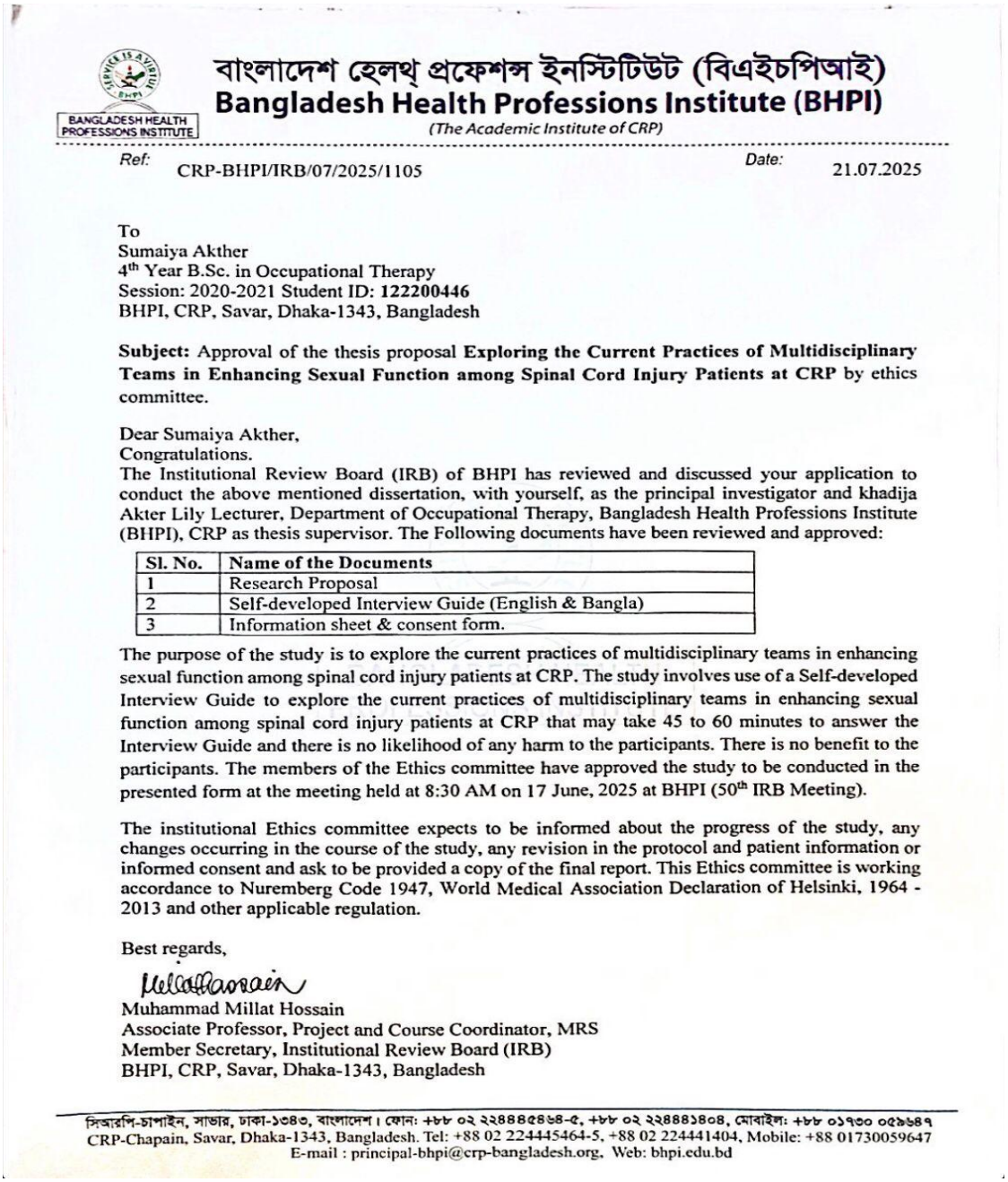
APPENDICES

Appendix A: Approval / Permission Letter

Ethical Approval Letter from IRB



বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

BANGLADESH HEALTH PROFESSIONS INSTITUTE

Ref: CRP-BHPI/IRB/07/2025/1105 Date: 21.07.2025

To
Sumaiya Akther
4th Year B.Sc. in Occupational Therapy
Session: 2020-2021 Student ID: **122200446**
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of the thesis proposal **Exploring the Current Practices of Multidisciplinary Teams in Enhancing Sexual Function among Spinal Cord Injury Patients at CRP** by ethics committee.

Dear Sumaiya Akther,
Congratulations.
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above mentioned dissertation, with yourself, as the principal investigator and khadija Akter Lily Lecturer, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as thesis supervisor. The Following documents have been reviewed and approved:

Sl. No.	Name of the Documents
1	Research Proposal
2	Self-developed Interview Guide (English & Bangla)
3	Information sheet & consent form.

The purpose of the study is to explore the current practices of multidisciplinary teams in enhancing sexual function among spinal cord injury patients at CRP. The study involves use of a Self-developed Interview Guide to explore the current practices of multidisciplinary teams in enhancing sexual function among spinal cord injury patients at CRP that may take 45 to 60 minutes to answer the Interview Guide and there is no likelihood of any harm to the participants. There is no benefit to the participants. The members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 8:30 AM on 17 June, 2025 at BHPI (50th IRB Meeting).

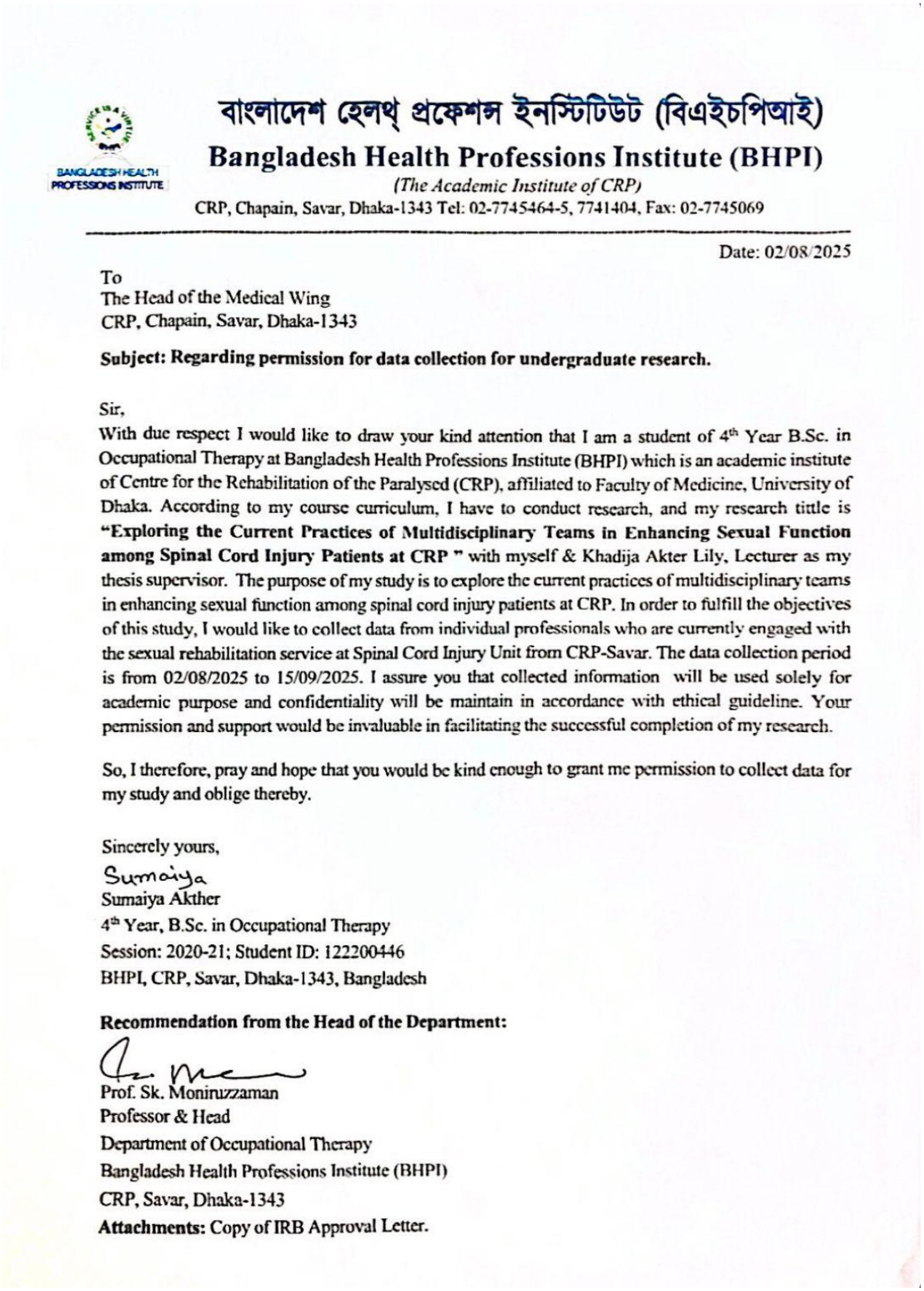
The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance to Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013 and other applicable regulation.

Best regards,

Muhammad Millat Hossain
Associate Professor, Project and Course Coordinator, MRS
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৯৬৪৭
CRP-Chapain, Savar, Dhaka-1343, Bangladesh. Tel: +88 02 224445464-5, +88 02 224441404, Mobile: +88 01730059647
E-mail : principal-bhpi@crp-bangladesh.org, Web: bhpi.edu.bd

Permission letter for data collection:



বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 02/08/2025

To
The Head of the Medical Wing
CRP, Chapain, Savar, Dhaka-1343

Subject: Regarding permission for data collection for undergraduate research.

Sir,

With due respect I would like to draw your kind attention that I am a student of 4th Year B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka. According to my course curriculum, I have to conduct research, and my research tittle is **"Exploring the Current Practices of Multidisciplinary Teams in Enhancing Sexual Function among Spinal Cord Injury Patients at CRP "** with myself & Khadija Akter Lily, Lecturer as my thesis supervisor. The purpose of my study is to explore the current practices of multidisciplinary teams in enhancing sexual function among spinal cord injury patients at CRP. In order to fulfill the objectives of this study, I would like to collect data from individual professionals who are currently engaged with the sexual rehabilitation service at Spinal Cord Injury Unit from CRP-Savar. The data collection period is from 02/08/2025 to 15/09/2025. I assure you that collected information will be used solely for academic purpose and confidentiality will be maintain in accordance with ethical guideline. Your permission and support would be invaluable in facilitating the successful completion of my research.

So, I therefore, pray and hope that you would be kind enough to grant me permission to collect data for my study and oblige thereby.

Sincerely yours,
Sumaiya
Sumaiya Akther
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200446
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

Prof. Sk. Moniruzzaman
Professor & Head
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
CRP, Savar, Dhaka-1343
Attachments: Copy of IRB Approval Letter.

Appendix B: Information Sheet & Consent Form (English & bangla Version)

Information Sheet (English Version)

Title of the study: Exploring the Current Practices of Multidisciplinary Teams in Enhancing Sexual Function among Spinal Cord Injury Patients at CRP.

Name of The Student Researcher: Sumaiya Akther

4th year, B.Sc in Occupational Therapy.

Bangladesh Health Professions Institute(BHPI)

CRP, Savar, Dhaka

Phone: 01406473153

E-MAIL: sumaiya3750@gmail.com.

Supervisor: Khadija Akter Lily

Lecturer,

Dept. of Occupational Therapy

Bangladesh Health Professions Institute ,(BHPI)

Email: lilyot.29@gmail.com

I'm Sumaiya Akhter and I want to invite you to participate in research study. Before deciding to participate, it is crucial that you understand the purpose of the study, what will be asked of you and how you are related to it. Please read the information below and feel free to ask any questions that you may have.This information sheet is for you to keep.

I am conducting a research project to explore the current practices of multidisciplinary teams in enhancing sexual function among SCI patients. This study aims to investigate how multidisciplinary team at CRP improves sexual function in patients with spinal cord injuries. You are invited to participate in a semi-structured qualitative interview at a location of your convenience. During the interview, you will be asked to share your experiences related to: your opinions on the current practices of multidisciplinary teams in enhancing sexual function among patients.

Why Were You Chosen for This Research?

You have been invited to participate because you are a member of multidisciplinary teams of SCI rehabilitation who can provide to the researcher valuable information.

Source of Funding

This study is carried out on self funding.

Consenting to participate in the project and withdrawing from the research

If you agree to participate in this research, you will need to sign the accompanying consent form provide it to the researcher at the time of the interview. Participating in this research involuntary and you are under no obligation to consent to participate. However, if you do consent to participate, you may withdraw from further participation at any stage up until the data are analysed. There will be no negative consequences if you choose to withdraw. You are also able to refuse to answer any questions with no negative consequences.

Possible Benefits and Risks

There may not be direct benefits to you from participating in this research. However, the findings will contribute to improving multidisciplinary teams services for enhancing sexual functions among SCI pateints. However, discussing your experiences may make you discomfort. There is a potential risk of break of confidentiality of patients history

.**Confidentiality**

The study will maintain confidentiality of all participant details, with their name not disclosed in any published documentation. A unique code will be used for de-identification after interviews, ensuring anonymous data analysis. The original interview transcripts, featuring the participant's name, will only be accessible to the researchers, ensuring high privacy and security.

Storage of data

The collected data will be stored in a password-protected computer and cloud system, accessible only to the researchers, and physical copies and recordings will be made anonymous.

Results

This research will combine interviews and data from interviews to create a comprehensive descriptive report. Highlights may be published in scholarly journals or conference proceedings. For a concise summary, contact project investigators using provided contact details. The study's outcomes may also be featured in conference proceedings.

Complaints

If you have any concerns or complaints about the research's conduct, you are welcome to contact the supervisor. All complaints will be handled respectfully.

Supervisor: Khadija Akter Lily

Lecturer,

Dept. of Occupational Therapy

Bangladesh Health Professions Institute ,(BHPI)

Email: lilyot.29@gmail.com

Thank you,

Consent Form (English Version)

Research title: Exploring the Current Practices of Multidisciplinary Teams in Enhancing Sexual Function among Spinal Cord Injury Patients at CRP.

Student invstigator: Sumaiya Akther

I have been asked to participate in the research conducted by the Bangladesh Health Professions Institute, as specified above. I have read and understood the Explanatory Statement, and I hereby consent to participate in this research.

I consent to the following:	**Yes**	No
1)Have you read and understood the information provided about this study?	☐	☐
2)Do you understand that your participation is voluntary and that you can withdraw at any time without consequences?	☐	☐
3)Do you understand that your responses will remain confidential and will only be used for research purposes?	☐	☐
4)Do you agree to participate in this study?	☐	☐

Name of participant: _____

Signature of participant/ thumb print: _____

Mobile:

Date:

Withdrawal of Consent Form (English version)

Research title: Exploring the Current Practices of Multidisciplinary Teams in Enhancing Sexual Function among Spinal Cord Injury Patients at CRP.

Student investigator: Sumaiya Akther

I_____ (the participant), wish to WITHDRAW my consent to the use of data arising from my participation. Data arising from my participation must NOT be used in this research project as described in the Information and Consent Form. I understand that data arising from my participation will be destroyed provided this request is received within four weeks of the completion of my participation in this project. I understand that this notification will be retained together with my consent form as evidence of the withdrawal of my consent to use the data I have provided specifically for this research project.

Name of participant: _____

Signature of participant/ thumb print: _____

Mobile:

Date:

Information Sheet (Bangla Version)

তথ্যপত্র

গবেষণার শিরোনাম: সিআরপি- তে মেরুদণ্ডে আঘাতপ্রাপ্ত (SCI) রোগীদের যৌনক্ষমতা বৃদ্ধিতে মাল্টিডিসিপ্লিনারি দলের কার্যপ্রণালির অনুসন্ধান।

ছাত্র গবেষকের নাম: সুমাইয়া আক্তার

৪র্থ বর্ষ, বি.এসসি ইন অকুপেশনাল থেরাপি

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই) ,সিআরপি, সাভার, ঢাকা

ফোন: ০১৪০৬৪৭৩১৫৩

ইমেইল:sumaiya3750@gmail.com

পর্যবেক্ষক (সুপারভাইজর): খাদিজা আক্তার লিলি

প্রভাষক,

অকুপেশনাল থেরাপি বিভাগ

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই)

ইমেইল: lilyot.29@gmail.com

আমি সুমাইয়া আক্তার এবং আমি আপনাকে একটি গবেষণায় অংশগ্রহণের জন্য আমন্ত্রণ জানাতে চাই। অংশগ্রহণের সিদ্ধান্ত নেওয়ার আগে, এই গবেষণার উদ্দেশ্য, এতে আপনার কাছ থেকে কী প্রত্যাশা করা হচ্ছে, এবং আপনি এই গবেষণার সঙ্গে কীভাবে সম্পর্কিত—তা বোঝা অত্যন্ত গুরুত্বপূর্ণ। অনুগ্রহ করে নিচের তথ্যগুলো পড়ুন এবং আপনার কোনো প্রশ্ন থাকলে নির্দ্বিধায় জিজ্ঞাসা করুন।

এই তথ্যপত্রটি আপনার কাছে রাখার জন্য।

আমি একটি গবেষণা প্রকল্প পরিচালনা করছি যার উদ্দেশ্য হলো সিআরপি- তে মেরুদণ্ডে আঘাতপ্রাপ্ত (SCI) রোগীদের যৌনক্ষমতা বৃদ্ধিতে মাল্টিডিসিপ্লিনারি দলের কার্যপ্রণালির অনুসন্ধান করা । এই গবেষণার মাধ্যমে জানা যাবে, কীভাবে বাংলাদেশে মাল্টিডিসিপ্লিনারি দল মেরুদণ্ডে আঘাতপ্রাপ্ত রোগীদের যৌনক্ষমতা উন্নত করতে সহায়তা করেন।আপনাকে এই গবেষণায় অংশগ্রহণের জন্য আমন্ত্রণ জানানো হচ্ছে, যেখানে একটি অর্ধ -

সংগঠিত, সামনাসামনি সাক্ষাৎকারে অংশ নিতে হবে, যা আপনার সুবিধাজনক সময় ও স্থানে অনুষ্ঠিত হবে। সাক্ষাৎকারের সময়, আপনাকে এমন কিছু অভিজ্ঞতা জানতে হবে যা আপনি মাল্টিডিসিপ্লিনারি দলের কার্যপ্রণালী সম্পর্কে জানেন বা মতামত রাখেন—বিশেষ করে, তারা কীভাবে রোগীদের যৌনক্ষমতা উন্নত করতে ভূমিকা রাখেন সেই বিষয়ে।

আপনাকে এই গবেষণার জন্য কেন নির্বাচিত করা হয়েছে?

আপনাকে অংশগ্রহণের জন্য আমন্ত্রণ জানানো হয়েছে কারণ আপনি এসসিআই (মেরুদণ্ডে আঘাতপ্রাপ্ত) বিভাগের একজন, মাল্টিডিসিপ্লিনারি দলের সদস্য যিনি গবেষকের জন্য মূল্যবান তথ্য প্রদান করতে পারেন।

তহবিলের উৎস

এই গবেষণাটি স্ব-অর্থায়নে পরিচালিত হচ্ছে।

গবেষণায় অংশগ্রহণে সম্মতি প্রদান এবং গবেষণা থেকে প্রত্যাহার করা

আপনি যদি এই গবেষণায় অংশগ্রহণে সম্মতি দেন, তাহলে আপনাকে সংযুক্ত সম্মতি ফর্মে স্বাক্ষর করতে হবে এবং সাক্ষাৎকারের সময় সেটি গবেষকের কাছে জমা দিতে হবে। এই গবেষণায় অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাসেবাভিত্তিক, এবং এতে অংশগ্রহণ করার জন্য আপনার ওপর কোনো বাধ্যবাধকতা নেই। তবে, আপনি যদি অংশগ্রহণে সম্মতি দেন, তাহলে তথ্য বিশ্লেষণের আগ পর্যন্ত আপনি যেকোনো সময় গবেষণায় অংশগ্রহণ থেকে সরে আসতে পারেন। প্রত্যাহার করার ফলে আপনার কোনো নেতিবাচক পরিণতি হবে না। আপনি চাইলে কোনো প্রশ্নের উত্তর না দেওয়ার সিদ্ধান্তও নিতে পারেন, এবং এর ফলেও আপনার জন্য কোনো নেতিবাচক প্রভাব পড়বে না।

সম্ভাব্য উপকারিতা ও ঝুঁকি

এই গবেষণায় অংশগ্রহণের ফলে আপনার সরাসরি কোনো উপকার নাও হতে পারে। তবে, এই গবেষণার ফলাফল মেরুদণ্ডে আঘাতপ্রাপ্ত (SCI) রোগীদের যৌনক্ষমতা বৃদ্ধিতে মাল্টিডিসিপ্লিনারি দলের সেবার মানোন্নয়নে সহায়ক হবে। এছাড়াও, রোগীর ইতিহাসের গোপনীয়তা ভঙ্গের সম্ভাব্য ঝুঁকি রয়েছে।

গোপনীয়তা

গবেষণাটি সমস্ত অংশগ্রহণকারীর তথ্যের গোপনীয়তা রক্ষা করবে, এবং তাদের নাম কোনো প্রকাশিত নথিতে উল্লিখিত হবে না। সাক্ষাৎকারের পর পরিচয়হীনকরণ নিশ্চিত করতে একটি অনন্য কোড ব্যবহার করা হবে, যাতে তথ্য বিশ্লেষণ অজ্ঞাত থাকে। মূল সাক্ষাৎকারের ট্রান্সক্রিপ্ট, যা অংশগ্রহণকারীর নাম অন্তর্ভুক্ত করবে, শুধুমাত্র গবেষকদের জন্য উন্মুক্ত থাকবে, যাতে উচ্চ গোপনীয়তা এবং নিরাপত্তা নিশ্চিত হয়।

তথ্য সংরক্ষণ

সংগ্রহীত তথ্য একটি পাসওয়ার্ড সুরক্ষিত কম্পিউটার এবং ক্লাউড সিস্টেমে সংরক্ষিত হবে, যা শুধুমাত্র গবেষকদের জন্য প্রবেশযোগ্য হবে, সাক্ষাৎকারের ট্রান্সক্রিপ্ট ও অডিও রেকর্ডিং গোপনীয় রাখা হবে।

ফলাফল

এই গবেষণাটি সাক্ষাৎকার এবং সাক্ষাৎকার থেকে সংগৃহীত তথ্য একত্রিত করে একটি বিস্তারিত বর্ণনামূলক রিপোর্ট তৈরি করবে। গুরুত্বপূর্ণ ফলাফলগুলি বৈজ্ঞানিক জার্নাল বা সম্মেলনের প্রক্রিয়াপত্রে প্রকাশিত হতে পারে। সংক্ষিপ্ত সারাংশের জন্য, প্রকল্পের তদন্তকারীদের প্রদত্ত যোগাযোগের বিস্তারিত ব্যবহার করে যোগাযোগ করা যেতে পারে। গবেষণার ফলাফল সম্মেলনের প্রক্রিয়াপত্রে উল্লেখিত হতে পারে।

অভিযোগ

যদি গবেষণার পরিচালনা নিয়ে আপনার কোনো উদ্বেগ বা অভিযোগ থাকে, তবে আপনি সুপারভাইজারের সাথে যোগাযোগ করতে পারেন। সমস্ত অভিযোগ সম্মানের সাথে বিবেচনা করা হবে।

পর্যবেক্ষক (সুপারভাইজর): খাদিজা আক্তার লিলি

প্রভাষক,

অকুপেশনাল থেরাপি বিভাগ

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই)

ইমেইল: lilyot.29@gmail.com

সম্মতি পত্র

গবেষণার শিরোনাম: সিআরপি- তে মেরুদণ্ডে আঘাতপ্রাপ্ত (SCI) রোগীদের যৌনক্ষমতা বৃদ্ধিতে মাল্টিডিসিপ্লিনারি দলের কার্যপ্রণালির অনুসন্ধান।

ছাত্র গবেষকের নাম: সুমাইয়া আক্তার

আমাকে উপরোক্তভাবে উল্লেখিত বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট কর্তৃক পরিচালিত গবেষণায় অংশগ্রহণ করার জন্য অনুরোধ করা হয়েছে। আমি ব্যাখ্যামূলক বিবৃতি পড়েছি এবং বুঝেছি, এবং আমি এই গবেষণায় অংশগ্রহণে সম্মতি প্রদান করছি।

আমি নিম্নোক্ত বিষয়ে সম্মতি প্রকাশ করছি:	**হ্যাঁ**	**না**
১) আপনি কি এই গবেষণা সম্পর্কে প্রদত্ত তথ্য পড়েছেন এবং বুঝেছেন?	☐	☐
২) আপনি কি বুঝতে পেরেছেন যে এই গবেষণায় অংশগ্রহণ সম্পূর্ণ স্বেচ্ছামূলক এবং আপনি যেকোনো সময় কোনো রকম পরিণতি ছাড়াই অংশগ্রহণ প্রত্যাহার করতে পারেন?	☐	☐
৩) আপনি কি বুঝতে পেরেছেন যে আপনার উত্তরগুলো গোপন রাখা হবে এবং শুধুমাত্র গবেষণার উদ্দেশ্যে ব্যবহার করা হবে?	☐	☐
৪) আপনি কি এই গবেষণায় অংশ নিতে রাজি?	☐	☐

অংশগ্রহণকারীর নাম: _____

অংশগ্রহণকারীর স্বাক্ষর/আঙুলের ছাপ: _____

তারিখ: _____

সম্মতি প্রত্যাহার পত্র

গবেষণার শিরোনাম: সিআরপি- তে মেরুদণ্ডে আঘাতপ্রাপ্ত (SCI) রোগীদের যৌনক্ষমতা বৃদ্ধিতে মাল্টিডিসিপ্লিনারি দলের কার্যপ্রণালির অনুসন্ধান।

ছাত্র গবেষকের নাম: সুমাইয়া আক্তার

আমি, _____

(অংশগ্রহণকারী), আমার অংশগ্রহণ থেকে প্রাপ্ত তথ্য ব্যবহারের জন্য প্রদত্ত সম্মতি প্রত্যাহার করতে চাই। আমার অংশগ্রহণ থেকে প্রাপ্ত কোনো তথ্য এই গবেষণা প্রকল্পে, তথ্য ও সম্মতি ফর্মে বর্ণিতভাবে, ব্যবহার করা যাবে না। আমি বুঝতে পারি যে, আমার অংশগ্রহণ থেকে প্রাপ্ত তথ্য আমার অংশগ্রহণ শেষ হওয়ার চার সপ্তাহের মধ্যে এই অনুরোধ গ্রহণ করা হলে ধ্বংস করে ফেলা হবে। আমি আরও বুঝতে পারি যে, এই অবগতিপত্রটি আমার সম্মতি ফর্মের সঙ্গে সংরক্ষণ করা হবে, যা আমি এই গবেষণা প্রকল্পের জন্য প্রদান করা তথ্য ব্যবহারের সম্মতি প্রত্যাহার করেছি তার প্রমাণস্বরূপ।

অংশগ্রহণকারীর নাম: _____

অংশগ্রহণকারীর স্বাক্ষর/আঙুলের ছাপ: _____

তারিখ: _____

Appendix C : Interview Guide (English& Bangla Version)

Interview Guide (English Version)

Socio demographic question:

Name:

Educational level:

Profession:

Workplace setting:

Years of professional experience:

Interview Guide Question :

Section 1: Current Practices

1. Can you describe the common clinical practices or interventions your team uses to address sexual function in SCI patients?
2. In the context of sexual rehabilitation, which specific part of sexual function do you think this treatment mainly helps with or aims to improve?
3. "Between men and women, who do you think is given sexual rehabilitation treatment more often, or who needs it more?" why ?
4. How is sexual health typically addressed during rehabilitation planning for SCI patients in your setting?
5. How does your team coordinate or collaborate when managing sexual health aspects for SCI patients?
6. What formal or informal training have you received to support patients' sexual rehabilitation?

Section 2: Challenges

5. What are some of the challenges you face when addressing sexual function with SCI patients?
6. How do patients and their families typically respond when sexual health is discussed during rehabilitation?
7. Do you feel supported by your organization or healthcare system in providing sexual rehabilitation? Why or why not?
8. Are there any cultural or societal factors that make it harder to talk about or address sexual health in your professional context? Why?

Section 3: Recommendations for Improvement

9. What changes or improvements would help your team better support SCI patients in their sexual recovery?
10. Are there specific tools, programs, or training you wish were available to improve sexual rehabilitation services?
11. From your experience, what advice would you give to new professionals entering the field on handling sexual health with SCI patients?
12. How can the healthcare environment (e.g., policies, leadership, infrastructure) better support sexual rehabilitation for SCI patients?

Interview Guide (Bnagla version)

অংশগ্রহণকারীর ব্যক্তিগত তথ্যনাম:

অভিজ্ঞতার বছর:

পদবি:

কর্মস্থলের পরিবেশ:

শিক্ষাগত যোগ্যতা:

সাক্ষাৎকার প্রশ্নসমূহ:

বর্তমান চর্চা / চলমান কার্যপ্রণালি :

1. মেরুরজ্জুতে আঘাতপ্রাপ্ত (SCI) রোগীদের যৌন স্বাস্থ্য উন্নয়নের জন্য আপনি সাধারণত কী ধরণের চিকিৎসা পদ্ধতি ব্যবহার করেন ?

2. যৌন পুনর্বাসনের ক্ষেত্রে, আপনার মতে এই চিকিৎসাগুলো মূলত যৌন ক্ষমতার কোন নির্দিষ্ট অংশগুলো উন্নত করতে সাহায্য করে?

3. আপনার মতে যৌন পুনর্বাসন চিকিৎসা নারী ও পুরুষের মধ্যে কাকে বেশি দেওয়া হয়, অথবা কার ক্ষেত্রে এর প্রয়োজনীয়তা বেশি বলে আপনি মনে করেন? ? কেন?

4. মেরুরজ্জুতে আঘাতপ্রাপ্ত রোগীদের পুনর্বাসনের সময় যৌন স্বাস্থ্য বিষয়টি কীভাবে আলোচনায় আসে বা পরিকল্পনায় রাখা হয়?

5. মেরুরজ্জুতে আঘাতপ্রাপ্ত রোগীদের যৌন স্বাস্থ্য ব্যবস্থাপনায় আপনার দল কীভাবে একসাথে কাজ করে?

6. মেরুরজ্জুতে আঘাতপ্রাপ্ত রোগীদের যৌন পুনর্বাসনে সহায়তা করতে আপনি কোনো ধরনের আনুষ্ঠানিক বা অনানুষ্ঠানিক প্রশিক্ষণ পেয়েছেন কি?

সমস্যা / বাধা:

7. মেরুরজ্জুতে আঘাতপ্রাপ্ত রোগীদের যৌন স্বাস্থ্য নিয়ে কাজ করতে গিয়ে আপনি কী ধরনের চ্যালেঞ্জ বা সমস্যার মুখোমুখি হন?

8.পুনর্বাসনের সময় যৌন স্বাস্থ্য বিষয়টি আলোচনা করলে রোগী ও তাদের পরিবার সাধারণত কেমন প্রতিক্রিয়া দেখায়?

9.আপনি কি মনে করেন আপনার প্রতিষ্ঠান বা স্বাস্থ্য ব্যবস্থা যৌন পুনর্বাসন বিষয়ে আপনাকে যথাযথ সহায়তা দেয়? কেন বা কেন নয়?

10.আপনার পেশাগত পরিপ্রেক্ষিতে যৌন স্বাস্থ্য নিয়ে কথা বলা বা কাজ করা কতটা কঠিন হয় ? কেন?

পরামর্শ / উন্নয়নের প্রস্তাবনা:

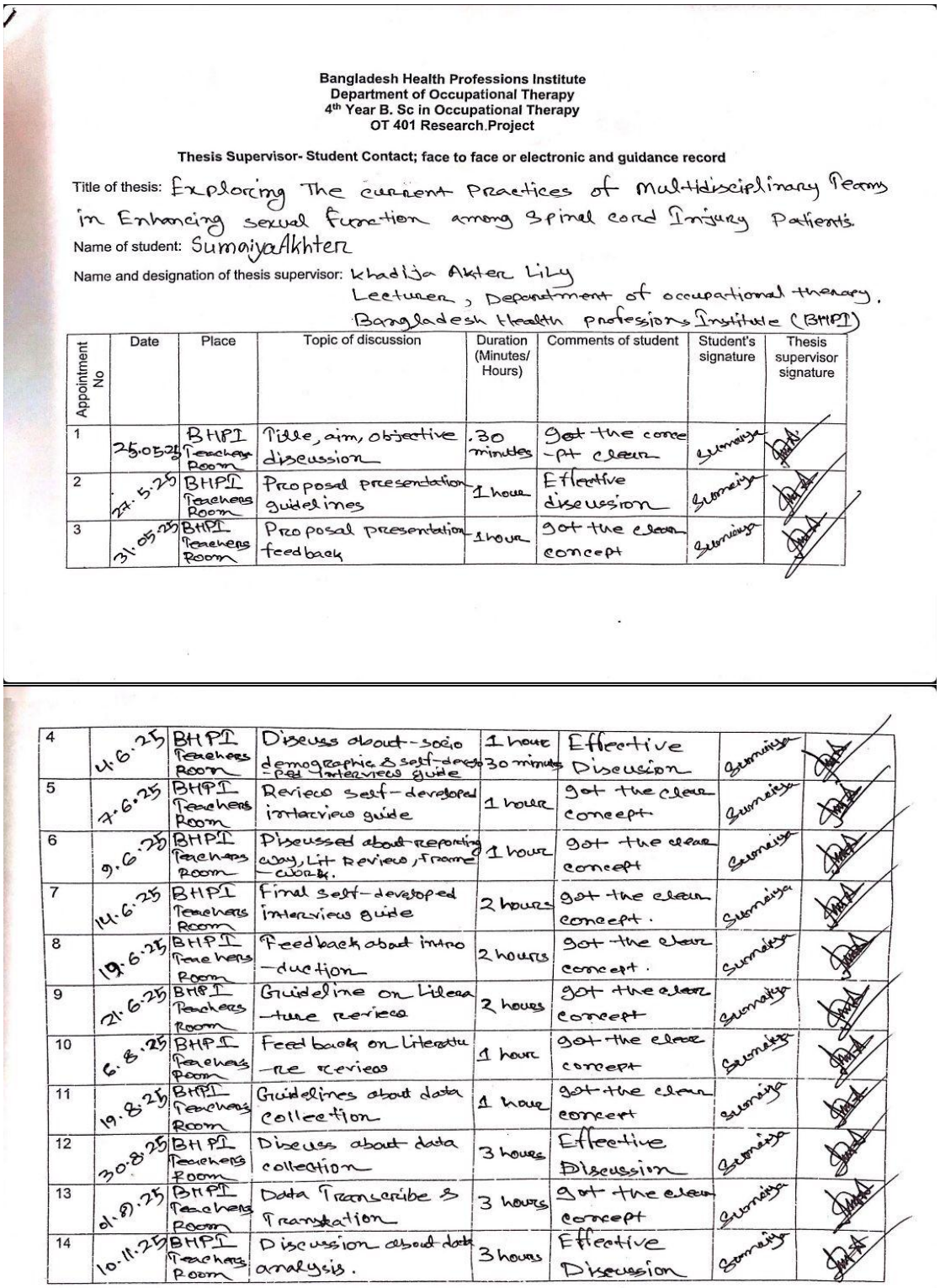
11. মেরুরজ্জুতে আঘাতপ্রাপ্ত রোগীদের যৌন পুনরুদ্ধারে সহায়তা করতে আপনার দলে কী ধরনের পরিবর্তন বা উন্নয়ন প্রয়োজন বলে আপনি মনে করেন?

12.যৌন পুনর্বাসন সেবা উন্নত করার জন্য আপনি কি কোনো নির্দিষ্ট সরঞ্জাম, প্রোগ্রাম বা প্রশিক্ষণ পেতে চান?

13.নতুন যারা এই পেশায় আসছেন, তাদের জন্য মেরুরজ্জুতে আঘাতপ্রাপ্ত (SCI) রোগীদের যৌন স্বাস্থ্য নিয়ে কাজ করার বিষয়ে আপনি কী পরামর্শ দেবেন?

14.স্বাস্থ্যখাতের পরিবেশ (যেমন: নীতিমালা, নেতৃত্ব, অবকাঠামো) কীভাবে মেরুরজ্জুতে আঘাতপ্রাপ্ত (SCI) রোগীদের যৌন পুনর্বাসনে আরও ভালো সহায়তা দিতে পারে বলে আপনি মনে করেন?

Appendix D : Supervision record sheet



Bangladesh Health Professions Institute
Department of Occupational Therapy
4th Year B. Sc in Occupational Therapy
OT 401 Research Project

Thesis Supervisor- Student Contact; face to face or electronic and guidance record

Title of thesis: Exploring The current Practices of Multidisciplinary Teams in Enhancing sexual Function among Spinal cord Injury Patients.

Name of student: Sumaiya Akhter

Name and designation of thesis supervisor: Khadija Akter Lily
Lecturer, Department of occupational therapy,
Bangladesh Health professions Institute (BHPI)

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/ Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	25.05.25	BHPI Teachers Room	Title, aim, objective discussion	30 minutes	Got the concept clear	Sumaiya	
2	27.5.25	BHPI Teachers Room	Proposal presentation guidelines	1 hour	Effective discussion	Sumaiya	
3	31.05.25	BHPI Teachers Room	Proposal presentation feedback	1 hour	Got the clear concept	Sumaiya	
4	4.6.25	BHPI Teachers Room	Discuss about - socio demographic & self-developed interview guide	1 hour 30 minutes	Effective Discussion	Sumaiya	
5	7.6.25	BHPI Teachers Room	Review self-developed interview guide	1 hour	Got the clear concept	Sumaiya	
6	9.6.25	BHPI Teachers Room	Discussed about reporting way, Lit Review, Frame-work.	1 hour	Got the clear concept	Sumaiya	
7	14.6.25	BHPI Teachers Room	Final self-developed interview guide	2 hours	Got the clear concept.	Sumaiya	
8	19.6.25	BHPI Teachers Room	Feedback about introduction	2 hours	Got the clear concept.	Sumaiya	
9	21.6.25	BHPI Teachers Room	Guideline on Literature review	2 hours	Got the clear concept	Sumaiya	
10	6.8.25	BHPI Teachers Room	Feedback on Literature review	1 hour	Got the clear concept	Sumaiya	
11	19.8.25	BHPI Teachers Room	Guidelines about data collection	1 hour	Got the clear concept	Sumaiya	
12	30.8.25	BHPI Teachers Room	Discuss about data collection	3 hours	Effective Discussion	Sumaiya	
13	01.9.25	BHPI Teachers Room	Data Transcribe & Translation	3 hours	Got the clear concept	Sumaiya	
14	10.11.25	BHPI Teachers Room	Discussion about data analysis.	3 hours	Effective Discussion	Sumaiya	

15	11.11.25	Library Room	Discussion about Theme & subtheme	3 hours	Effective Discussion	Seminar	
16	12.11.25	Library Room	Theme - subtheme selection	4 hours	Effective Discussion	Seminar	
17	13.11.25	~~bida~~ Library room	Feedback on Result writting	3 hours	got the con-cept clear	Seminar	
18	15.11.25	Library Room	Guidelines for discussion	3 hours	got the concept clear	Seminar	
19	03.01.26	BHPI Teachers Room	Overall feedback	2 hours	Effective discussion	Seminar	
20	05.01.26	BHPI Teachers Room	Feedback on 1st draft	4 hours	Effective discussion	Seminar	

Note:

1. Appointment number will cover at least a total of 40 hours; applicable only for face to face contact with the supervisors.
2. Students will require submitting this completed record during submission your final thesis.