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Understanding the Gender and Power Influences Regarding Access to MNH and SRHR Services: A Qualitative Study at Selected Rural Areas of Rangpur, Bangladesh

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Abstract **Background:** Despite policy commitments and programmatic interventions, persistent gendered social norms, discriminatory practices, and structural barriers continue to undermine women's and girls' access to maternal, newborn, and reproductive health services, it's necessary to understand how gender and power relations shape health-seeking behaviors are critical for advancing progress. **Objectives:** This study aimed to explore the influence of gender norms, household and community power dynamics, and institutional practices on access to maternal, newborn, and reproductive health services. **Methods:** A qualitative design was employed using the Gender and Power (GAP) Analysis framework including focus group discussions, in-depth interviews and key informant interviews with pregnant and lactating women, adolescents, men, mothers-in-law, community leaders, and health service providers. Thematic analysis was applied to identify recurring patterns within six GAP domains. **Results:** The findings highlight that myths, taboos, and misconceptions around antenatal care, institutional delivery, contraception, and diagnostic services (e.g., ultrasound) are pervasive. Decision-making regarding maternal, newborn and reproductive health is dominated by husbands and senior family members, while women's autonomy remains constrained by gender norms. Early marriage is widely practiced and socially legitimized. Home deliveries persist, and men show limited engagement in pregnancy or menstrual health issues, though they act as critical gatekeepers in facilitating access to care. Women and minority groups face discrimination and reduced access to quality services, while mistrust of healthcare providers and weak institutional mechanisms further discourage service utilization. **Conclusion:** The study underscores the need for gender-transformative approaches to address entrenched power imbalances and harmful norms limiting women's access to maternal, newborn, and reproductive health services. Policy and programmatic priorities should be focused on addressing these multidimensional barriers, which are essential to advancing equity and achieving national and global maternal and newborn health targets.

Keywords: *Gender, Social Norms, Taboos, Beliefs, Perceptions, Mobility, Dignity*

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1. Introduction

Bangladesh government has set the target of lowering the maternal mortality rate to 70 per 100,000 live births and neonatal mortality to 12 per 1000 live births by 2030, following the commitments of the Sustainable Development Goals (SDGs) [1]. High delivery rate by unskilled birth attendants, maternal and neonatal malnutrition, poor maternal and child health service facilities, low accessibility, and service quality are specified as challenges in the 8th Five-Year Plan. Bangladesh also has the highest rate of child marriage in South Asia [2], which further endangers the health of both mothers and children. It also has an impact on women's social status, deprivation of sexual reproductive self-determination, an increase in adolescent pregnancy, and an increase in maternal mortality, among others. Despite the existence of national laws and policies such as the Child Marriage Restraint Act (2017) and government commitments to gender equality, enforcement remains limited, and institutional mechanisms often fail to protect women and girls from harmful practices [3].

Women rarely have decision-making power in terms of marriage, family planning, and even healthcare choices, as decision-making authority rests with the elders and male members of the household. Women are also disproportionately burdened with unpaid care and domestic work, restricting the time and resources they can devote to their own health. At the community level, taboos, myths, and stigma around menstruation, pregnancy, and contraception discourage women from accessing institutional services. Simultaneously, gaps in the health system, like resource constraints and inadequate service, exacerbate these barriers. Hence, it is important to use gender and power lens to understand how social, relational, and institutional factors shape girls' and women's health-seeking behavior. This study applies a grounded theory approach within a Gender and Power (GAP) Analysis framework, examining how social norms, power relations, resource distribution, institutional dynamics, etc., interact to shape women's and girls' access to maternal, newborn, and reproductive health services in Bangladesh.

2. Materials and Methods

2.1. Theoretical Framework

The basis of this research was the GAP framework, an intersectional approach that examines how power relations and gender interact to shape opportunities, decision-making, and access to resources. Six interrelated areas of the framework can explain how inequalities are manifested. These are (i) Social norms, beliefs, practices, (ii) Patterns of decision-making, (iii) Rules, responsibilities, and time use, (iv) Access and control over resources, (v) Safety, dignity, and wellbeing, and (vi) Laws, policies, regulations, and institutional practices [4]. These domains provide a structured framework for observing how inequalities are reproduced and, crucially, how they can be overcome. The GAP approach is part of a wider corpus of feminist theory focused on gender and power.

Connell's (1987) theory of gender relations highlights how institutions, norms, and practices sustain unequal power structures [5]. Kandiyoti's (1988) concept of the "patriarchal bargain" emphasizes how women and girls navigate systems of constraint [6]. Cornwall and Rivas (2015) showed that transformative change requires individual agency as well as structural shifts in norms, laws, and institutions [7]. These literatures align with GAP's recognition of gendered inequalities and their systemic and multidimensional nature.

2.1.1. Social Norms, Beliefs, and Practices

Social norms, taboos, and beliefs shape women's and girls' access to reproductive and maternal health services in Bangladesh. Cultural myths about menstruation, contraception, and preferences for sons over daughters reinforce discriminatory practices. These norms influence individual behavior and also legitimize restrictions imposed by families and communities.

2.1.2. Patterns of Decision Making/ Power Relations

Power operates on multiple levels: household, community, and institutional. Women and girls' decision-making authority regarding marriage, family planning, and healthcare is often restricted by patriarchal hierarchies in which men or the elder family members are given the role of primary decision-makers. At the community level, religious and traditional leaders frequently reinforce conservative practices, demonstrating how patriarchal power extends beyond the household to broader social and institutional domains.

2.1.3. Roles, Responsibilities, and Time Use

In Bangladesh, gendered divisions of labor assign women the bulk of caregiving and domestic responsibilities while men are positioned as breadwinners and decision-makers. This unequal distribution of roles and time restricts women's ability to pursue education, income-generating activities, or timely health care. The caregiving responsibilities carried by women and girls exacerbate their physical, emotional, and economic vulnerabilities.

2.1.4. Access to and Control over Resources

Resources like money and property are unequally distributed. Even when women contribute economically, control over assets and spending often rests with men. Limited access to transportation, financial independence, and information further constricts women's ability to seek institutional health services, reinforcing dependence on male relatives.

2.1.5. Safety, Dignity, and Well-being

Safety and dignity are central to health rights. Despite legal frameworks, gender-based violence persists in Bangladesh, ranging from domestic violence to coercion in marriage. Shifts in forms of violence, from physical to psychological, sexual, and economic, demonstrate the resilience of patriarchal control. Fear of stigma, harassment, or violence often prevents women and girls from accessing health care, undermining both their physical and mental well-being.

2.1.6. Laws, Policies, Regulations, and Institutional Practices

Bangladesh has enacted progressive laws and policies like the Child Marriage Restraint Act (2017) that signal a commitment to equality. However, there are implementation gaps that remain. Local institutions, such as Union Parishads or health committees, often treat gender-based violence and early marriage as private issues. Weak enforcement, bureaucratic hurdles, and limited awareness among communities reduce the effectiveness of these policies.

By analyzing these six domains, the study was explored to link the individual experiences of women and girls with the structural power relations that shape them. These six domains work across three levels of analysis: micro level, meso level, and macro level. At the micro level, the beliefs, norms, practices, and household decision-making patterns shape the lived experiences of women and girls within partner and household relationships. At the meso level, community roles, responsibilities, time use, and access to resources determine how gender power relations are reproduced or challenged in practice. At the macro level, structures of safety, dignity, and well-being, along

with laws, policies, and institutional practices, establish the environment that is either enabling or constraining. Analyzing these six domains within these three levels allows the study to trace the interplay between them and how they together shape women's and girls' rights in Bangladesh.

2.2. Literature Review

Bangladesh has made the commitment to reduce maternal and neonatal mortality in line with the SDGs, yet structural, social, and institutional barriers continue to limit progress. High rates of child marriage, unskilled birth attendance, maternal and neonatal malnutrition, and inadequate healthcare infrastructure persist, creating serious risks for women and children [8]. Child marriage, in particular, not only jeopardizes health outcomes but also restricts girls' social status, autonomy, and reproductive self-determination [9,10].

Patriarchal norms shape women's and girls' access to healthcare at multiple levels. Household decision-making authority typically rests with male or elder family members, limiting women's agency over marriage, family planning, and maternal health [11,12]. At the community level, religious and traditional leaders reinforce conservative practices, while cultural taboos and myths around menstruation, pregnancy, etc. further constrain women's choices [13,14,12].

Gendered divisions of labor exacerbate these constraints. Women bear the bulk of caregiving and domestic responsibilities, reducing the time available for income opportunities, education, or seeking timely healthcare [11,15,16]. Economic dependence, restricted control over household resources, and limited access to information or transportation further impede institutional service use [15,11]. Safety and dignity concerns, including gender-based violence (GBV), coercion, and fear of stigma, also discourage women from accessing health services, highlighting the importance of addressing social and emotional barriers alongside structural ones [17].

Legal and policy frameworks, such as the Child Marriage Restraint Act (2017) and the National Strategy for Adolescent Health (2017), reflect formal commitments to gender equality. However, implementation gaps, bureaucratic hurdles, and weak enforcement at local levels limit their impact [18,10]. Union Parishads and health committees often treat child marriage and gender-based violence as private matters, reducing accountability and reproducing structural inequalities.

The literature demonstrates that women's and girls' health outcomes are shaped by intersecting domains of social norms, power relations, resource access, safety, and institutional capacity. Micro-level factors such as household decision-making and caregiving intersect with meso-level community expectations and macro-level institutional structures, creating multidimensional barriers. Applying a Gender and Power (GAP) lens in combination with grounded theory allows for a nuanced understanding of these dynamics, linking individual experiences to structural determinants and highlighting pathways for transformative change [5,7].

2.3. Objectives

The study aims was to recognize, evaluate, and examine the social and gender equality factors and obstacles concerning 1) access to healthcare facilities and services, 2) utilization of healthcare services, and 3) empowering project participants by addressing issues such as child marriage, the burden of unpaid care work, gender-based violence (GBV), nutrition, and contraception linked to the defined project outcomes, while also investigating the facilitators of gender equality for women and girls within households and communities. The main objectives were as follows:

1. Identify the cultural norms, myths, and beliefs that pose challenges for women and girls regarding their maternal and neonatal health (MNH) rights in relation to institutional health services.
2. Examine the power dynamics involved in decision-making at the household, community, and health service provider levels.
3. Analyze the distribution of resources at the household and community levels, including access to and control over resources, as well as the roles, responsibilities, and time allocation of family members.
4. Identify the factors that enable the promotion of gender equality at various levels.
5. Evaluate the knowledge, attitudes, and practices of women, girls, men, and boys concerning sexual and reproductive health and rights.

2.4. Methods

The study employed a qualitative research approach. Data has been collected from both primary and secondary sources. A purposive sampling strategy was used, and responses were selected randomly to enhance the diversity of perspectives including who can provide information regarding gender and social equality dimensions, as well as constraints faced in accessing health facilities/services. To ensure consistency and depth in data collection, structural checklists and guidelines were also utilized during interviews and discussions. The data was collected from March to April 2024.

Table 1. Sample size

Respondent Groups	Total
FGD	
Pregnant women and Lactating women	9
Husbands of pregnant and lactating women	3
Mothers-in-law of pregnant and lactating women	4
Adolescent girls and boys	8
Frontline health service providers	4
Adolescent boys and girls representing diverse groups	1
Women with disability and diversity group	1
IDI	
Pregnant women and Lactating women	9
Adolescent girls and boys	7
Local Influential	2
KII	
Health Managers and Community Leaders/Influentials	12
Total	60

The sample was taken from community leaders, health service providers, Government and non-governmental organizations (GO/NGO) representatives with expertise in gender and social equality issues in Rangpur and Lalmonirhat districts of Bangladesh. Participants for In-Depth Interviews (IDI), Key-Informant Interviews (KII), and Focus Group Discussions (FGD) were selected based on representation and relevance. Additionally, participants of different genders, age, socioeconomic status, ethnicity, and disability were represented to capture a wide range of experiences and perspectives to provide insights into gender norms, power dynamics, social barriers, and enabling factors affecting access to the health outcomes.

2.5. Data Management and Analysis

Qualitative data management and analysis were conducted in two stages: transcription and content analysis. After each FGD or KII, the facilitator/interviewer noted any specific impressions and observations made during discussions or interviews. The discussion tapes were documented and translated. Thematic analysis was used to interpret the meaning from the context of texts, data, and as such, adheres to the naturalistic paradigm. Coding categories were directly derived from the text data. The study team chose thematic analysis as it allows us to identify recurring patterns and themes in terms of GAP analysis domains without imposing a pre-existing theoretical model. Additionally, NVivo was used for visualizations.

2.6. Ethical Considerations and Accountability

Any participation from children followed the 9 Basic Requirements of Save the Children International (SCI) for meaningful and ethical child participation [19]. Children from different ethnic, social, and religious backgrounds obtained the opportunity to participate and share their insights. Children with disabilities were included as well.

Additionally, the study was guided by ethical considerations such as safeguarding, openness, sensitivity, confidentiality and data protection. The highest standards of behavior were adopted to ensure the safeguarding of children. Sensitivity to child rights, gender, inclusion, and cultural contexts were maintained.

In addition to the routine ethical consideration procedures, pseudonyms were assigned to protect anonymity, in accordance with the GAP factors related to interpretive bias and contextual representation addressed throughout the analysis.

All available information was given to the highest possible degree to all parties involved. Measures were taken to ensure the protection of the identity of participants and any other information that may put them or others at risk. The research protocol was reviewed and approved by the “Ethics Research Committee, Bangladesh Bioethics Society”.

3. Results

The findings of this study were organized and discussed within the six domains of the Gender and Power (GAP) framework, which served as the central analytical lens. These domains include: (i) Social norms, beliefs, practices, (ii) Patterns of decision-making, (iii) Rules, responsibilities, and time use, (iv) Access and control over resources, (v) Safety, dignity, and wellbeing, and (vi) Laws, policies, regulations, and institutional practices.

3.1. Social Norms, Beliefs, and Practices

Social norms, beliefs, and practices refer to the aspects that shape gender roles, identities, behavior, and practices, and establish the different perceptions people develop about the responsibilities of others based on their gender. In the surveyed areas, just like broader society in Bangladesh, the perspective of gender norms, values, and opportunities is quite stringent.

3.1.1. Early Marriage and Contraception Use

During FGDs, the opinions of the respondents showed that they were aware of the legal age of marriage being 18 years for girls and 21 years for boys. FGD sessions with pregnant women and adolescents found that most of the respondents advocated for following the law, while sessions with males and in-laws found respondents justifying early marriage. Other myths and taboos included the belief that early marriage is beneficial for both mother and newborn, that taking contraception after marriage affects fertility, and thus having children before 18 is beneficial. They also insisted that religious guidelines say a girl should be married before her 1st menstruation. There were biological misconceptions as well, such as believing that after 20, women’s sexual desires are reduced, impacting fertility. Apart from these, there were also societal concerns, such as girls marrying by their own choice, which they believe must be stopped by marrying them early, by the parents’ choice. They also believe that finding a good groom is harder after eighteen. There were also concerns about girls harming the honor of the family by having intercourse before marriage.

In contrast, in multiple FGDs, most men said that they do not have any issues with using contraceptives. Some believed that it was easier for their wives to use it, but they also echoed similar concerns about the side effects of long-term use of the pill. They also seemed hesitant about using condoms and saw them as affecting the sexual power of men and causing infertility.

3.1.2. Pregnancy and Contraception

In terms of contraceptive use and pregnancy, in-laws and senior citizens of different families stated that many couples were struggling to conceive as a result of using contraceptives. Most married women and men, on the other hand, believe that women could easily adopt contraceptives for family planning, and have fewer side effects, whereas men do not have as many alternatives to adopting contraception. A large number of women believe that having children early in marriage reduces marital problems later and also perceive having children as a source of power and standing within the family. During FGD sessions, senior male and female members responded that they did not see a problem with girls having children before 18 years but termed it as being

beneficial because taking contraceptives after 20 years will create pregnancy complications. The adolescent girls were aware that early pregnancy causes many complications, such as physical and mental stress, and increased risks associated with unsafe pregnancies. During the sessions, most women said that there is a strong preference for sons over daughters because, in Bangladesh, men carry the family name, inherit property, and are tasked with caring for parents. This leads to more pressure on women to continue having children to have a boy, even if she already has daughters. This has adverse effects on both the mother and the existing daughters.

3.1.3. Perceptions of Sex, Pregnancy, and Menstruation

During FGDs with adolescent girls and boys, they are hesitant to discuss sex, sexual rights, menstruation, symptoms of adolescence, etc., as they have been taught by their parents and elders that children are not to participate in talks regarding these subjects. Males, on the other hand, when it comes to sexual health, believe that doctors talking to them about it implies that they are sexually weak. Doctors revealed that even when men acknowledge that they have problems, they do not want to seek or accept treatment. Doctors said that this could be because of men's perception of power being dependent on their sexual health.

3.1.4. Perception of Antenatal Care and Pregnancy

In the sessions, it was revealed that husbands believe that Antenatal Care (ANC) visits at the local union health centers and Upazilla Hospitals increase the chance of having a C-section. They cited that they have seen deliveries happening through C-section after women had ultrasound tests. They insisted that the Ultrasound (USG) test forces women to have a C-section. Some of the women believed that the gel used during USG leads to painless labor, leading doctors to prescribe a C-section delivery instead of a home birth. Some elder members said that they are not keen to send pregnant women to have a USG because there is no need for it, and that doing a USG hurts the baby's health, which might even lead to their death. They also complained that pregnant women are advised by the health centers to have more food during pregnancy, which, according to them, leads to the babies becoming bigger, leading to C-sections. Husbands also viewed the process as being natural, and thus their wives had the capacity to accept the burden. FGD sessions also revealed that participants saw Iron and Folic Acid supplements with suspicion, saying that they can close the cervix, which can complicate the delivery. They also said that calcium and iron supplements can make the fetus too big.

The FGDs showed that in-laws and senior members of the families firmly believe that women should work hard during pregnancy to ensure a normal delivery, as before women had many children, and performed all household chores without complications. However, many mothers-in-law did agree that in the early days, maternal mortality and infant mortality were high due to a lack of knowledge about ANC.

3.1.5. Perception of Health Service Providers and Doctors

The general perception of Family Welfare Visitor (FWV) and Family Welfare Assistance (FWAs) is that they are not adequately educated or skilled and do not have the experience to provide health services for ANC, delivery, or Postnatal Care (PNC). Many families at the Upazilla level refused to send the women in their families to the health centers because there are not enough female doctors. During FGDs, participants mentioned that they do not see government-provided medicine as being effective, which they believe leads to fewer natural births.

During KII, doctors and midwives mentioned that patients refuse to believe they have any issues in their pregnancies and sexual health. Even if they acknowledge it, they do not want to accept the treatment. Women refuse to talk to male doctors but do not take the midwives' advice seriously. The doctors reported that community members believe that their medical advice is given to increase the number of C-section deliveries at clinics and bring more patients to their clinics.

3.1.6. Norms, Beliefs, and Their Effects on Accessing MNH

Most of these findings paint a picture of a gender-biased socialization process and traditional gender stereotype practices that adolescents, men, and women are influenced by. These systems can be very challenging for women and girls, which leads to them not being able to advocate for themselves. Prevailing beliefs, such as "women should not argue with husbands or in-laws" regarding their decisions, including accessing healthcare for pregnancy and menstruation, have created a glass ceiling for women and girls that is preventing them from accessing the healthcare needed. This is why women and girls are hesitant to visit government health service centers to get MNH services.

3.2. Patterns of decision making/ Power Relations

This domain refers to people's behaviors and actions in life, what they do, and how this varies by gender roles and responsibilities. In different FGDs and KIIs with local government representatives, it was mentioned repeatedly that in Rangpur and Lalmonirhat, women have less access to decision-making and are considered to have less power to make decisions than their male counterparts. Social norms, education, and economic realities are the main factors that influence decision-making patterns within families and in the community. This remains a major hurdle in ensuring pregnant and lactating women get the healthcare that they need.

3.2.1. Decisions about Women's and Adolescents' Health

In the FGDs conducted with males, females, pregnant women, lactating mothers, adolescents, and youth, they said that while there are discussions with all family

members, the ultimate decision is made by the men, and whatever decision is made is supported by the women. Women revealed that even when women gave in-depth analysis regarding a situation, the ultimate decision was made by the men in the family, as they were seen as having better capabilities and knowledge. Some women mentioned that these patterns might be different based on economic and social factors. In terms of pregnancy-related healthcare, women revealed that while they feel comfortable discussing pregnancy-related issues with their husbands for the right support, some husbands do not take the opinion seriously, at times viewing aspects of healthcare like ANC as a waste of resources and time. At times, when husbands do understand the complexities, they are unable to execute their decisions due to influence from the in-laws.

Married adolescent girls, on the other hand, revealed in FGDs that women's freedom to make decisions is not accepted by their families, and if they try to stand for themselves, they are verbally and physically abused. They are also afraid to discuss sexual health and birth control for fear of causing offense or having their opinions disregarded. Some revealed that while they cannot discuss things with their families, their husbands allow them to share their beliefs and find solutions.

3.2.2. Husbands and Family Members and Their Decision-making Powers

Husbands revealed that they believe women do not face any obstacles anymore in decision-making, as they are aware of the government service providers and NGOs regarding health-related issues. However, one section revealed that due to social, cultural, and economic challenges, they prefer to consult with Traditional Birth Assistants (TBA) and have home births. Some husbands expressed that they do not see ANC as being necessary, citing past experiences of delivering healthy babies. The prevailing notion is that healthcare centers or hospital services should only deal with emergencies, but if there are no complications, there is no need for professional assistance.

When it comes to marriage, the decision is ultimately made by the families, especially the male members. The boys have little access to influence the decisions, whilst girls do not get to express their opinions, forcing them to accept the decision made by the family. In FGD sessions, most women and in-laws revealed that the decision-making role belongs to the male and women must follow it. Most respondents said that they never challenged their husbands even if the decisions went against their wills. In-laws expressed that the younger women are courageous enough to challenge any decision if it goes against their will, and they are allowing their daughters-in-law to go for clinic visits. The in-laws did mention that the neighbors tried to influence them by discouraging such visits. They draw examples from their experience that normal delivery is possible without a regular check-up.

In terms of sexual health and birth control, women, adolescents, and male groups revealed that such discussions are seen as inappropriate with families. Men viewed birth control as a hassle and did not want to use it. It is the women who adopt birth control methods, mostly in the form of pills.

3.2.3. Adolescents about Women's Decision-Making Process

Most of the adolescents believed that women did not have sufficient knowledge or education regarding their health issues. This creates reliance on husbands, in-laws, and even nurses and midwives. Since women also do not have financial independence, it makes them hesitant to make decisions. They also rely on permission from their husbands to spend money. Adolescents also commented that minorities and occupational castes are always looked at in a derogatory way by others.

3.2.4. Minority, Persons with Disabilities (PWD) and Decision Making

From FGDs, it was found that adolescents and women from minorities suffer more. Respondents who were part of ethnic or religious minorities expressed that they do not go out much and mingle with others due to their identity. This makes minority women have even less influence on decision-making, either at the family or societal level. Tribal and disabled adolescents face additional challenges with limited access to education, healthcare, and open discussions about sexual health. They experience discrimination against healthcare facilities and often lack financial independence.

3.2.5. Decision-making Capabilities and Their Influence on Health Check-ups

Before marriage, women have to follow their parents' decisions, but after their marriage, the power shifts to the husband and in-laws. Pregnant women in the FGDs revealed that they usually are able to access healthcare from different NGOs at doorsteps, satellite clinics, or Union Family Welfare Centers. The major challenges lie in delivery because many families prefer home births. Some families, as already mentioned, use the logic that, in the past, women did not have as many checkups and thus do not need them now for a smooth delivery. The prevailing notion is that health care center visits are for emergencies.

3.2.6. Common Dynamics in Decision Making

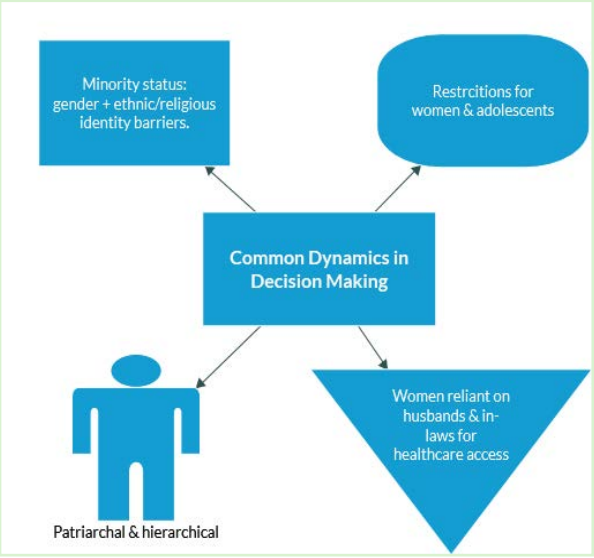

Figure 1. Common dynamics in decision making

From these various opinions, it is apparent that decision-making powers are still patriarchal and hierarchical, and the authority still rests with men. In-laws also strongly influence the decisions regarding women's healthcare during pregnancy. Women, despite some progress, are still dependent on their husbands and in-laws regarding access to healthcare. Women are hesitant to challenge decisions made by their husbands and in-laws, even if they are against them. Adolescents also face barriers to their healthcare decisions. Minorites seem to face double the number of hurdles due to their minority status, along with their gender.

3.3. Roles, Responsibilities, and Time Use

This domain of the GAP analytical framework refers to the differences in the availability and allocation of time for productive and reproductive labor. It determines how men and women contribute to the welfare of the family, community, and society. Gender roles are shaped by the responsibilities, attitudes, and behaviors considered appropriate for men and women by society. These norms and division of labor can significantly impact women and adolescent girls' attitudes and practices at the domestic and societal levels, which affect their growth and opportunities. Restrictive gender norms often discourage women, adolescent girls, and even children from pursuing interests that can be considered inappropriate for their gender. This leads to potential and opportunities being limited.

3.3.1. Roles within the Family and Beyond

Women engage in different roles within the family and beyond in many households in their husbands' absence. In many families, women take an active role in running the household and making decisions. However, when women act as decision-makers, other relatives, in-laws, and even young children challenge them. Most see women as being knowledgeable and skilled in household activities and childcare and see their roles to be confined to domestic work. On the contrary, men are seen as responsible for bigger decisions such as settling marriage, selling or buying land, and such. This is the most common practice amongst the families where the men are seen as the head of the household and primary decision-makers. The men support this view and believe that since traditionally women were engaged in caregiving, cooking, cleaning, etc., it is their responsibility to complete such tasks. This perception eventually leads to women playing a subordinate role within the household.

3.3.2. Adolescents, Women, and In-laws on Assigned Roles

During the FGD sessions, most of the in-laws believed that it is the women's responsibility to take care of the children and the old, and complete the household chores, as it is the men's job to earn money. Men are also not skilled with housework, and the women participants agreed with this perception. They agreed with the in-laws and said that men should not be expected to do household chores. While some women raised concerns about not being able to participate in household decision-making, others had no complaint about this. The women believed that the father's duty towards the children is limited to playing with them and taking them out.

Adolescent boys and girls agreed that household chores and childcare duties should not be men's responsibilities because they work long hours outside the home and, as such, do not have time to do such tasks. They also believed that these are women's tasks because they do not work outside or have income responsibilities. The girls shared that they are more comfortable sharing their challenges with their mothers, and as such, it is their mothers who assisted them.

3.3.3. Role of Women and Its Consequences

In FGD sessions, participants accepted that women are living as subordinates and have to live under men's control about economic, social, sexual, and political perspectives. Many women participants noted that they would like to live with more freedom and without physical or psychological abuse from family, neighbors, peers, society, etc. Women believed that not letting them live their lives with freedom is gender-based violence (GBV). Some acknowledged that pregnant and lactating mothers go through physical and mental abuse. Overall, in marriage, women are considered dependents and property of their husbands. If a woman wants to dress according to her wishes, she faces mental and physical violence from her in-laws and husband. It is not about just clothes. Anytime women go against established social norms, they are subjected to harsh criticism and even abuse. Women agreed that sometimes husbands' resort to violence against wives to satisfy their parents.

3.4. Access to and Control over Resources

This domain refers to the person's ability to use the necessary resources to become a productive part of society. This includes access to resources, income, information, education, and assets, among others. Financial dependence limits decision-making, and a lack of information can create challenges for pregnant and lactating women in accessing good healthcare.

3.4.1. Access to Information and Services

Men agreed that, in most cases, women and girls had adequate knowledge and awareness of their reproductive and sexual health because they have access to information, mobile phones, and television. They believed that women and girls do not face any issues getting services from doctors and healthcare providers. They also believed that women and girls can make their own decisions regarding health and hygiene aspects because they are included in various platforms by the government and different NGOs. They felt that the women's and girls' decisions were even superseding than that of their male counterparts. On the other hand, female participants said during the FGD sessions that most husbands do not want to purchase hygiene products for their wives, and they have to manage on their own by buying them themselves. Adolescent girls do not intend to discuss their menstruation issues with male family members, making it harder for them to access hygiene products.

3.4.2. Non-Minority and Minority Women's Agency in Accessing Healthcare Services

Government healthcare services are considered affordable, but some families face challenges accessing them due to the costs of transportation and distance to healthcare facilities. Women's roles and responsibilities within the household also act as barriers to accessing services. Women also have to get permission from their mothers-in-law before going to the hospital.

Minority women (religious and ethnic) strongly believed that discrimination happens against them. They are often asked to come later and are not given medicine in the proper quantity. Staff are often rude to them, which discourages them from going there, but since many are facing economic hardship, they lack options to explore. These findings can be corroborated by findings from some FGDs. In FGDs, it was revealed that non-minority women saw the minority women as unclean and did not like that the same equipment was being used for all. This leads to the staff asking them to come at a less busy time and often discriminate against them. They believed that lower caste women do not need as much attention. Some participants revealed that there are people who think separate facilities need to be built for the minority and the occupational caste people.

Ethnic minority women who do not speak the same language as the providers also face barriers when accessing healthcare services. The cultural differences can hinder the problems the clients are facing, which can affect medical consultations. Although the service providers claim that they give the same service regardless of caste, ethnicity, or religion, people from the ethnic minorities hardly come to the facilities unless they are out of options.

3.4.3. Adolescents and Access to Income and Healthcare

Many of the adolescent girls mentioned several societal norms that keep them financially dependent. Restrictions are placed on them from pursuing employment or involvement in business due to restrictions on mobility. The in-laws often restrict the food intake of pregnant women in fear that the baby will become too big. They also expect women to give birth at home. Women are not able to overcome these situations because they have no access to income. These limits make women subordinate to their husbands. Due to financial constraints, many girls are not able to access menstrual hygiene products as well. Since their families are not able to afford them, and the girls have no access to income, they are forced to use old clothes as substitutes. Some families do not believe that sanitary napkins are useful and feel that old clothes are enough. Some girls said that if they need to go to the healthcare center, their families are supportive and might even borrow money to get them the service. However, others mentioned that they are not generally sent to the healthcare centers due to their family's financial situation.

3.4.4. View of Frontline Staff about Access to Services

In the FGDs, frontline service providers (FWV, midwives, etc.) expressed that childbirth under trained personnel would reduce maternal and infant mortality, but the task is challenging due to existing norms and restrictions. According to them, there is a shortage of SRHR services for adolescents at the doorstep. The burden of healthcare expenses and families' lack of knowledge prevent women and girls from getting adequate healthcare at health centers. The lack of child care, transport, safety, and societal challenges also stop women from getting the needed care.

3.4.5. Reality of Health Service

Each health center is meant to have separate corners for girls and breastfeeding areas for lactating mothers. The service providers are also meant to offer counselling and support to women coming for ANC and PNC services. In practice, there is not enough space for breastfeeding mothers, and there is no provision for staff to provide counselling and support to mothers coming for ANC and PNC services. This, combined with a lack of medication at times, has created mistrust between the staff and those receiving care.

Staff reported that treatment, medicines, and ambulance services for pregnant women are free at the Upazila health complex. However, patients are often referred elsewhere for services beyond the center's capacity, and many women do not follow medical advice, such as staying admitted after delivery. Although a referral system exists, it lacks clear guidelines. Services provided include counseling on pregnancy, family planning, menstruation, and immunization. Frontline staff promote barrier methods of contraception over hormonal pills due to fewer side effects. Male doctors face challenges discussing sexual health, as women are uncomfortable with them and communities often distrust their advice. Adolescents frequently seek pregnancy-related guidance and contraceptives, but are usually referred to higher facilities, sometimes involving guardians for legal support. Service providers noted that women and persons with disabilities face greater barriers than men, who are more independent and able to visit health centers freely.

3.4.6. Women, Power, and Control over Resources

In terms of gender and power, the patriarchal culture and assigned roles reinforce the prevailing distribution of power within families, as men maintain power and control over resources and subsequently, over women as well. Within their own families, women are forced into a subordinate role, often leading to physical and mental abuse due to their lack of financial resources. Due to norms and traditions, this situation is even accepted by women.

3.5. Safety, Dignity, and Well-being

This domain of the GAP framework refers to the importance of safeguarding individuals' health, physical safety, and psychological well-being while ensuring that their social respect and fundamental rights are upheld. It underscores the right to live without fear of violence, abuse, or harm, and stresses the need to protect and respect bodily autonomy and integrity. For women and girls in particular, freedom of movement is closely tied to their ability to access education, healthcare, and economic

opportunities. Addressing barriers such as gender-based violence, harassment, and restrictive social norms is therefore essential to creating an environment where all individuals can move safely and with dignity.

3.5.1. Perception of Safety and Security of Women and Girls

The participants of the various FGD sessions said that girls and women are weaker at the family and society levels than men and boys, and as such, cannot protest when they are harassed. Families, especially mothers, also teach girls to stay quiet if anything untoward happens. They say that the incident ultimately affects the lives of the girls. Mothers and families pressure girls to cover themselves while on the streets and limit communication with others to ensure safety. The situation is worse for ethnic and religious minorities who report that their identities, as well as a lack of social support, make the outside world very unsafe for them. They are scared to send their daughters alone because they worry about violence and eve-teasing.

Female participants in the FGDs agree that women face a much greater risk outside due to men. This leads to restrictions on the girls' movements, where they are forced to always be accompanied by a chaperone. Women said that they are unable to leave the house without permission from their husbands or in-laws. They feel more unsafe at night, like when they have to go out to collect water or use the toilet. Girls reported that they felt uncomfortable when they saw men walking around the toilets.

Male participants in the FGDs said that there are high chances of a girl child becoming a victim of sex offenders anywhere and anytime. As a result, girl-children are not allowed to go to school in remote areas and are not allowed to play outside.

3.5.2. Views on Gender Based Violence

Males in FGD sessions said that GBV is not as common anymore, as they are aware of the consequences of GBV, especially the in-laws. Female participants, on the other hand, revealed that while physical violence is not as common, other forms of abuse, such as mental, sexual, incidence of discrimination, not allowing healthcare, etc., are quite common and acceptable. While participants were reluctant to reveal more details in FGDs, more information came out during IDIs.

During IDIs, some of the boys reported seeing women in the communities and households being beaten by their husbands and in-laws. They mentioned that many times marital quarrels devolve into violence against women by their husbands. They mentioned that even now, society puts more value on men's opinions and imposes them on women despite women's protests. Some participants tried to explain that the abuse was a result of poverty. They believed that the government should take more initiatives to reduce GBV, like providing counselling for the addicted and planning meetings and sessions conducted by hospitals.

Married adolescent girls, during FGDs, reported that if women have arguments with their in-laws, the husbands physically assault the wives. They also said that if husbands come back from outside and do not see their wives working in the kitchen, they verbally and physically assault them. Many reported that they do not feel that their opinions are taken seriously in the household, and they have to adhere to any decisions made by their husbands and in-laws.

3.5.3. Infrastructure and Safety and Security

Many pregnant women in rural areas face challenges accessing healthcare due to long distances and poor road conditions. Senior family members often view travel on rough village roads as unsafe and therefore discourage pregnant women from seeking care at health facilities. Women also report feeling unsafe going outside at night for basic needs, such as fetching water or using toilets located away from the home. The absence of household toilets heightens safety risks and leads many women to avoid using external facilities, which in turn contributes to health problems such as urinary tract infections, ovarian infections, and kidney complications. Additionally, women may experience physical violence if they are unable to fulfill their husband's expectations or household responsibilities because of illness. As a result, many women and adolescent girls practice a form of self-censorship in their mobility, particularly when it comes to accessing local healthcare services.

3.6. Laws, Policies, Regulations, and Institutional Practices

This domain of GAP analysis focuses on how people are treated by customary and formal legal codes and judicial systems. The Government of Bangladesh has shown its commitment to gender equality and women's empowerment by adopting gender-responsive policies and budgetary measures. While significant progress has been made in addressing gender-based violence, advancing gender equality, and acknowledging third-gender groups, women and adolescent girls remain unable to fully benefit from these policy-level improvements. Deeply ingrained gender norms, attitudes, and practices continue to restrict their access to resources and opportunities. Physical and sexual abuse affects a large section of women, and the preference for having sons continues to plague Bangladeshi society. Despite laws, child marriage still persists, limiting girls and women from education and economic opportunities.

3.6.1. Gender-Based Violence and Relevant Laws

As per the findings of FGD, the prevalence of domestic violence is debated amongst the different participant demographics. Most husbands believe that they cannot be abusive anymore because of relevant laws and the women's united stance against it. The in-laws agreed with such sentiments, but adolescent girls and boys raised their concerns. While women agreed that they are able to raise concerns against physical violence, they mentioned that forms of violence are changing from physical to mental, economic, and sexual abuse. Female Participants mentioned that the Local Union Parishad fails to take such matters seriously when brought to them, and despite existing laws, female victims do not want to go through the hassle of filing a report due to the uncertainty of receiving help.

3.6.2. Adolescents on Marriage Laws

Married and unmarried adolescent girls who participated in the FGDs were fully aware of the Bangladeshi marriage laws and the minimum marriage age. They mentioned that despite the awareness, when parents pressure them for marriage before 18 years, they are unable to fight it because of a lack of wider support from the community, society, and legal institutions. The participants knew about the adverse effects of early pregnancies but said that most married couples before 18 years have two children by 20 years. Even when they do not want to, they have to get married early because of their parents' decision. Many of the participants said that early marriages are happening without official registration to bypass the birth certificate requirement. Participants said that there is no initiative from the law enforcement side to enforce the existing laws to prevent child marriage in their villages. This has led early marriage to become an accepted practice.

4. Discussion

4.1. Patriarchal Power and Gendered Decision-Making

Men and in-laws dominate decisions on marriage, pregnancy, and healthcare. Women's input is routinely disregarded and attempts at asserting autonomy led to abuse. Even adolescents and minority women remain dependent on male authority due to financial, social, and cultural constraints. This hierarchy leaves women without meaningful decision-making power over their own bodies.

4.2. Knowledge vs. Practice

While communities are aware of laws such as restrictions on early marriage and medical facts such as risks of early pregnancy, harmful myths and taboos still drive behavior. Misconceptions around contraception, ANC, USG, and other services deter people from seeking healthcare. Religious and cultural beliefs carry more weight than medical knowledge, which sustains these harmful practices.

4.3. Reproductive Burden and Internalized Subordination

Women can carry the physical, social, and cultural burden of reproduction. They are pressured to marry early, have sons, and manage contraception while men distance themselves from responsibility by placing it on women. At the same time, many women and adolescents internalize these gender roles as natural and continue the cycle of rigid gender roles, limited freedom, and subordination. This normalization reinforces systemic inequality and halts change.

4.4. Restricted Mobility, Safety Concerns, and Discrimination

Social norms, harassment fears, and infrastructural barriers restrict women's movement outside the home and put restrictions on accessing healthcare, education, and work opportunities. Minority and disabled women face additional discrimination through biased treatment by health staff, cultural marginalization, or language barriers affecting their quality of care.

4.5. Weak Institutions and Distrust of Services

Although laws and policies exist to protect women against child marriage, GBV, etc., enforcement is weak, and community-level practices often bypass regulations. Health institutions are distrusted, with families mistrusting service providers. Limited female doctors, poorly trained staff, poor facilities, and inconsistent services deepened the mistrust and further discouraged women from accessing care.

5. Limitations of the Study

Due to the social circumstances of Bangladesh, no transgender or non-binary individual could be included in the study. Thus, this study represents the situation of cisgender individuals only as the experiences of trans and non-binary individuals might vary than those of cisgender identity.

Majority of the participants were also from the majority ethnicity and religious backgrounds, with only a few individuals from the minority groups. This limited the amount of data collected on these groups compared to the majority.

6. Conclusion

Overall, the findings indicate that the relationship between gender and power is a fundamental factor influencing human behavior, with gender being a core category shaping human perception. Consequently, gender and power are intricately linked and create social divisions. The study demonstrated that:

Numerous myths, taboos, norms, and values exist at both family and societal levels that limit pregnant women from accessing MNH services.

Pregnant women face barriers to accessing qualified medical service providers for MNH and SRHR services and are often encouraged to consult local healers instead.

Child marriage prevalence is high and is socially accepted based on traditional beliefs and gender-stereotypical practices.

Women are affected by prevailing norms and values that lead them to believe they lack self-reliance and the right to make their own decisions.

Husbands play a vital role in transporting pregnant women to healthcare facilities, especially during the early stages of labor.

The common practice of home delivery for newborns remains critical, and men often show little interest in issues related to pregnancy and menstrual health.

Men are viewed as gatekeepers and decision-makers who facilitate access to maternal and newborn healthcare

(MNH) services at both household and community levels.

Decision-making regarding MNH is predominantly in the hands of men and senior family members, who often prevent women from attending meetings organized with frontline health service providers specifically for pregnant women and adolescents.

Communities are significantly impacted by gender-insensitive practices, with a lack of knowledge, beliefs, and attitudes failing to recognize the importance of professional health service providers.

There are widespread misconceptions surrounding ANC, institutional delivery, PNC, medical tests such as ultrasounds, and the use of contraceptives.

6.1. Recommendations

1. Context-specific communication strategies should be developed to dispel myths, misconceptions, and taboos related to ANC, delivery care, PNC, contraceptives, and SRHR along with engagement with religious leaders, teachers, and respected community figures to improve acceptance.
2. Interventions should be designed that target men as key decision-makers and gatekeepers, encouraging their active participation in antenatal visits, safe delivery planning, and postnatal care, as well as menstrual health awareness.
3. Programs that build women's knowledge, decision-making capacity, and self-efficacy regarding MNH and SRHR should be introduced. This may include peer-support groups, leadership training, and education on rights and entitlements.
4. Existing child marriage prevention laws and integrate livelihood, education, and life skills programs for adolescent girls should be enforced to reduce early marriage and its impact on maternal health outcomes.
5. Expanded outreach and deployment of trained midwives, community health workers, and mobile health clinics should be ensured to reduce dependency on unqualified local healers.
6. Community support groups, including both men and women, that facilitate discussions around MNH decision-making should be established and thus creating safe spaces for women to engage with frontline health providers.
7. Community-based emergency transport mechanisms (e.g., community savings groups for transport, local ambulance networks) should be developed that recognize the vital role of husbands and family members in facilitating timely care during labor.
8. Inclusion of modules on challenging harmful gender norms, promoting shared household responsibilities, and highlighting the value of professional maternal healthcare in program design and implementation should be included
9. Advocacy for policies that prioritize institutional delivery, universal ANC/PNC coverage, and subsidized diagnostic services particularly for rural and low-income populations.
10. Systems to monitor gender-related barriers to MNH service uptake and generate evidence for continuous policy adjustments should be established along with encouraging documentation of both success stories and failures for learning and scaling best practices.

Use of AI Tools Declaration

The authors declare they have not used Artificial Intelligence (AI) tools in the creation of this article.

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Authors' Contributions

Uzzal Kumar Roy: Conceptualization, Methodology, Data Validation, Writing - Original Draft; Golam Mothabbir: Writing - Review & Editing; Md. Atikur Rahman: Software, Data Validation, Formal Analysis, Writing - Original Draft, Supervision; Rafa Raina Islam – Data management, Data Cleaning, Interpretations. The final manuscript was approved by all authors.

Conflict of Interest

The authors declare that there are no conflicts of interest relevant to the content of this paper.

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