

Research Article

Gender lens review of adolescent health care services: a mixed methods study in Bangladesh

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Background

The application of a gender lens enables the identification of gendered power dynamics that are deeply embedded within structures and institutions. This study delved into a comprehensive analysis of gender norms of male and female adolescents in terms of their health needs, the type of health services offered to them, the barriers and facilitators for utilization of health services at the adolescent-friendly health services (AFHS) across different tiers of government health facilities through a gender lens.

Methods

The study was conducted at 23 health facilities across four districts of Bangladesh from February 2022 to June 2022. The study design was cross-sectional with a mixed methods approach. A total of 304 adolescents completed the survey, and 28 adolescents participated in in-depth interviews (IDI). Key-informant interviews (KII) were conducted with 48 key stakeholders, including parents, teachers, health service providers, facility managers, and health managers. Quantitative data were analyzed using descriptive statistics, and qualitative data was analyzed using thematic analysis.

Results

Adolescents have different needs for information about services, types of services provided, and use based on gender. There was a significant association between the marital status of adolescents and the need for different types of health services ($P < 0.05$). Female adolescents receive tetanus-diphtheria (TD) vaccinations and iron folic acid (IFA) tablets, while male adolescents can receive them upon request. TD immunization is common among married female adolescents (14.9%) compared to unmarried female adolescents (11.8%) and unmarried male adolescents (1.1%). Unmarried female adolescents (36.1%) seek help more frequently for menstrual problems, while unmarried male adolescents (24%) are more likely to seek services related to puberty. Parents, teachers, and health service providers have different gendered perceptions of male and female adolescents' health needs and use of health services. These perceptions contribute to understanding male and female adolescents' utilization of services.

Conclusions

This study reveals that gender norms influence adolescents' health needs, types, and utilization of services. This is probably due to differences in gendered perception of the critical stakeholders for adolescents, who sometimes face barriers in the utilization of health services at the facilities.

Gender norms play a significant role in driving differences in health outcomes despite the global emphasis on inclusive health that aims to ensure equal health for all individuals.¹ These cultural schemas, which are often masculine and feminine, have varying levels of importance de-

pending on the specific situation.² The cost of not adhering to these norms can be significant,³ as evidenced by the Violence Against Women Survey 2015 conducted jointly by the United Nations Population Fund (UNFPA) and the Bangladesh Bureau of Statistics (BBS). The survey found

that Gender Based Violence (GBV) against women can lead to their impoverishment and significantly impact the economic development of nations. GBV alone is responsible for a loss of 2.10% of the GDP of Bangladesh⁴

During adolescence, individuals aged 10 to 19 undergo rapid growth and development that encompasses physical, cognitive, social, and emotional changes. According to a mixed methods systematic review gender socialization commences right from birth, and during early adolescence, which falls between the ages of 10 to 14, there is a critical intensification in personal gender attitudes.⁵ This is due to puberty, which causes a reshaping of male and female self-perceptions and social expectations from others, including family members and peers. During puberty, girls may experience a decrease in their freedom of movement, particularly in low and middle-income countries (LMICs), where they are expected to take on more household chores, marry early, and stay away from boys to avoid concerns about their developing bodies and emerging sexuality. Conversely, boys may experience greater freedom to engage in leisure activities while facing increased exposure to environmental risks and expectations to work and support the family financially.^{6,7}

Adolescents need information, including age-appropriate comprehensive education, health services that are acceptable, equitable, appropriate, and effective, and safe and supportive environments for their growth and healthy development. They also need the opportunities to meaningfully participate in the design and delivery of interventions to improve and maintain their health. Expanding such opportunities is the key to addressing adolescents' specific needs and right.⁸ Access to primary health care services is seen as an important component of care, including preventive health for adolescents. Limited accessibility to and less utilization of adolescent-friendly health services (AFHS) creates a universal concern.⁹

The concept of intersectionality acknowledges that different individuals face various forms of discrimination and oppression based on their unique circumstances. Factors such as gender, education, socioeconomic status, and physical ability can all contribute to marginalization.¹⁰ With respect to health needs, it is crucial to not only address physical illnesses and diseases but also the specific deficiencies and vulnerabilities that arise from an individual's way of life and identity.¹¹ This includes social and environmental factors such as access to housing, food, education, employment, and a safe environment. Adolescents, in particular, face a plethora of multifaceted health needs and challenges due to their age and gender¹²

The Lancet Adolescent Health (AH) series reiterated that 'Failure to invest in the health of the largest generation of adolescents in the world's history jeopardizes earlier investment in maternal and child health, erodes future quality and length of life, and escalates suffering, inequality, and social instability'. The lack of a gender-and-needs-responsive adolescent health framework, inadequate investments in this sector, or the lack of appropriate engagement and participation of adolescents themselves as rights holders will leave critical gaps in a country's overall develop-

ment trajectory. Investing in adolescent health can provide a triple dividend of immediate benefits in adulthood, as well as benefits for the next generation of children.¹³

The adolescent population in Bangladesh stands at 36 million,¹⁴ presenting a significant demographic opportunity.¹⁵ However, the country grapples with one of the highest rates of child marriage in South Asia, with 51% of girls marrying before turning 18.¹⁵ Additionally, a national survey reveals that female adolescents are more prone to experiencing stunted growth and being underweight than their male counterparts.¹⁶ Furthermore, adolescents, irrespective of gender, social class, or gender identity, show low service utilization rates of health services.¹⁷

Bangladesh's government has emphasized that adolescents' health needs differ from the rest of the general population. Hence the 'National Adolescent Health Strategy 2017-2030,¹⁸ the Gender Equity Strategy (GES) 2014,¹⁹ and the Gender Equity Action Plan (2014–2024)²⁰ were developed to address gender-related health issues and to reflect the policy priorities of gender in health. Adolescent Friendly Health Services (AFHS) in Bangladesh are based on eight global World Health Organization (WHO) standards, serving as information and service hubs for adolescent boys and girls. The AFHS protects juvenile clients' privacy and confidentiality so they can openly discuss their problems with service providers and receive counseling and health services.²¹

In Bangladesh, the government provides health services at the community level through community clinics (CC), at the union level through the Union Health and Family Welfare Centre (UH & FWC), at the sub-district level (Upazila) by the Upazila Health Complex (UHC), and across the district level by the District Hospitals and Maternal and Child Welfare Centre (MCWC). Adolescents are provided health services across all these hierarchies of health facilities.^{17,18}

Although adolescent health services and strategies are in place to enhance adolescent health and well-being, according to a national survey (BAHWS 2019-2020), health services utilization was highest (62%) among married female adolescents, slightly lower among unmarried male adolescents (57%), and lowest among unmarried female adolescents (50%).¹⁶ There is variation in the type of services utilized by married female adolescents, unmarried female adolescents, and male adolescents, which probably stems from the surrounding social and gender norms.^{16,22}

The aim of the study was to examine how gender norms affect the care-seeking behavior of adolescents, the provision of health services to this group, and their utilization of these services. Therefore, a gender lens analysis was conducted on 23 government health facilities in four districts of Bangladesh. Using the concept of intersectionality, the study sought to understand the complex power dynamics between genders within various structures and institutions.

METHODS

STUDY DESIGN

A mixed method approach allowed for integrating quantitative and qualitative data by synergizing themes from

the survey and interview. The qualitative interviews probed the specifics surrounding important gender aspects. At the same time, the estimate of the frequency of male and female adolescents visiting health facilities, the association of the health needs of male and female adolescents, their marital status, and the factors hindering and enabling them to access AFHS.

STUDY SITES AND DATA COLLECTION

We collected the data from adolescents visiting the health facilities from February 2022 to June 2022. The data were collected in 23 government health facilities across four districts: Dhaka, Bogura, Khulna, and Bandarban. Out of the 23 government health facilities, the following were selected: two specialized hospitals, two district hospitals, three health facilities under city corporation, three Maternal and Child Welfare Centre (MCWC), one school health clinic at the district level, four Upazila Health Complex (UHC) at the sub-district level, four Union Health and Family Welfare Centre (UH & FWC) at the union level, and four community clinics (CC) at the community level.

PARTICIPANTS RECRUITMENT

For the survey, the health facilities and the number of survey participants from selected facilities were obtained using the probability proportional to size (PPS) sampling technique. Three male and three female-trained data collectors, supervised by one male and one female research assistant, collected the data from the above-mentioned health facilities. The survey of 304 adolescents was collected through face-to-face interviews at the health facility, maintaining privacy and confidentiality. For the adolescents aged 18 years and below, firstly, informed written consent was taken from their parents or legal guardian who accompanied them to the health facility after explaining to them the purpose of the study and data collection procedure. After receiving the informed written consent from these parents/ legal guardians, assent was taken from the adolescents. Informed written consent was obtained from adolescents of the age of 18 years and above.

DATA ANALYSIS

The survey data was entered into SPSS 23. Descriptive analyses were performed to understand respondents' socio-demographic characteristics (age, education, occupation, marital status), health service needs of adolescents, health service utilization of adolescents, and barriers and facilitators to the use of health services. For all variables, frequency, and percentages were evaluated. Bivariate association between nominal variables was assessed using the chi-square test, and $P < 0.05$ was considered significant.

QUALITATIVE SYNTHESIS

The grounded theory was applied for the qualitative component of the study which is a systematic and rigorous approach to data collection and analysis. Purposive sampling

was used for the selection of the participants. The interviews were carried out in Bangla. IDIs were conducted with 21 female adolescents (19 unmarried and 9 married) and 7 unmarried male adolescents at the health facility. KIIs were conducted with 5 male health managers, 8 male facility managers, 2 female facility managers, 10 female health service providers, and 8 male health service providers at their respective workplaces. In addition, KIIs were conducted with 4 fathers, 7 mothers, and 4 male teachers at the health facility while they accompanied adolescents. All the interviews were conducted while ensuring privacy and confidentiality.

During the interview, notes were taken, and interviews were recorded with voice recorders. The qualitative in-depth and key-informant interviews were conducted till no new information was achieved through the interviews and data saturation was achieved. The recordings were then transcribed and each transcript carried a unique identifier. The data was processed for themes or patterns. The qualitative data was analyzed under pre-determined themes and emerging themes. Data analysis was conducted manually. Data validity was checked by triangulation. Two data coders coded the data, and eventually, 12 codes emerged from which 4 themes were developed. These themes were: the health service needs of adolescents, health service utilization of adolescents, barriers, and facilitators to the utilization of health service by adolescents, and initiative to make the health facility gender-responsive.

ETHICS APPROVAL

This study obtained ethical approval from the Institutional Review Board of Bangabandhu Sheikh Mujib Medical University, Shahbag, Dhaka, Bangladesh (Serial No: BSMMU/2022/3055 Registration No: 662).

RESULTS

A total of 304 participants (216 (71%) female adolescents and 88 (29%) male adolescents) consented to participate in the survey, representing a response rate of 99.4%. The mean age of the respondents was 15.4 years ($SD \pm 2.7$ years). The majority of them had completed secondary education (63%). Most adolescents were unmarried (84.5%) and were full-time students (81%). ([Table 1](#)).

The results section has been organized and presented using a thematic analysis approach.

HEALTH SERVICE NEEDS OF ADOLESCENTS

Most adolescents cannot differentiate their health needs and health problems. They regarded the same meaning for health needs and health problems. Both male and female adolescents discussed growing up with dietary challenges, menstrual issues, and other general health concerns as their primary health problems. Female adolescents could mention several health problems of growing adolescent males, but only a few boys could say much about female adolescents' health needs or problems.

Table 1. Socio-demographic variable of adolescents (N=304)

Variables		n (%)
Sex	Female	216 (71.1)
	Male	88 (28.9)
Mean age	15.4 years (SD ± 2.7)	
Religion	Islam	221 (72.7)
	Hinduism	36 (11.8)
	Christianity	33 (10.9)
	Buddhism	7 (2.3)
	Others	7 (2.3)
Marital status	Married	47 (14.5)
	Unmarried	257 (84.5)
Education status	Educated	293 (96.4)
	No formal education	11 (3.6)
Completed years of education (n=293)	1 to 5 years	68 (23.2)
	6 to 10 years	184 (62.8)
	10 years and above	27 (9.2)
	Madrassah	14 (4.8)
Occupation of the respondent	Full-time Student	246 (80.9)
	Housewife	40 (13.2)
	Employed	18 (5.9)

“Girls want health service and information about menstruation, food which gives energy, physical changes.....boys want health service about nutrition, cough, and cold” (Male adolescent, 17 years).

The gatekeepers of adolescents also could not differentiate between the health needs and health problems of adolescents. According to them, unmarried female adolescents usually come to the facility because of menstrual problems, and married female adolescents come for family planning advice, immunization, or to take antenatal care. Boys go to the health facility if they have some generalized illness or injury. Upon probing, some health service providers said that some adolescent boys come with problems of nocturnal emission.

“Girls usually come with menstrual problems or when they get pregnant or for contraceptive advice if they get married....it is usually seen that boys get information about puberty or their other health problems from their peers and the internet, though the information they get is not always right” (Health service provider).

We found a significant association between the marital status of adolescents and the need for information on pubertal change, nutrition, sexually transmitted infections (STIs), and vaccination ($p < 0.05$) (Table 2).

To meet the health needs of adolescents, a wide range of services was offered to both male and female adolescents at different tiers of health facilities. These services include nutrition, menstruation, STI, puberty counseling, general disease treatment, TD (Tetanus, Diphtheria) vaccine administration, and IFA (Iron Folic Acid) tablet distribution specifically for female adolescents. (Table 3) Although some services were tailored to only female adolescents, a few male adolescents came to some facilities to refill their IFA tablets and take vitamin capsules. Upon probing during IDI, they said IFA tablets and vitamin capsules provided

them strength and they felt good upon taking these medicines.

“I usually come to this health facility to take IFA and vitamin tablets for myself; these help me in being active, today also I came for the same” (Male adolescent, 17 years)

HEALTH SERVICE UTILIZATION OF ADOLESCENTS

There were differences in health service utilization between male and female adolescents. General health services were used by around 88% of unmarried male adolescents, 60% of married female adolescents, and 58% of unmarried female adolescents. While more married female adolescents (14.9%) sought immunization than unmarried girls (11.8%) or unmarried boys (1.1%). Unmarried female adolescents (36.1%) used health services more frequently to get help with their menstrual problems. More unmarried boys (24%) than unmarried girls (18%) visited for puberty-related services. (Table 4)

Some issues regarding the utilization of health services by male adolescents, as mentioned by the health service providers and facility managers, were that male adolescents were reluctant to discuss their problems with friends and family because they rejected the idea that they needed treatment or counseling. Male adolescents were also less concerned about their health than female adolescents, resulting in fewer facility visits.

Parents and teachers perceived a health facility as where only pregnant women come for check-ups or delivery and children accompanied by their parents come for general illness. Some health service providers said there was a high volume of patients at their facility; hence, they treat an adolescent just like any other patient. Most of the gatekeepers of the adolescents said that the name of the facility, such as ‘*Maa o Shishu Kallayan Kendra*’ (Maternal and Child Welfare Centre (MCWC)) and *Matri Shadan Hashpatal*

Table 2. Association between marital status of adolescents and their health needs (N=304)

Adolescents' marital status	Variable		P value
	Needs for information on puberty		
	Yes (n (%))	No (n (%))	
Married female	19 (40.4)	28 (59.6)	0.001
Unmarried female	118 (69.8)	51 (30.2)	
Unmarried male	49 (55.7)	39 (44.3)	
	Needs for information on nutrition		0.004
Married female	38 (80.9)	9 (19.1)	
Unmarried female	126 (74.6)	43 (25.4)	
Unmarried male	55 (62.5)	33 (37.5)	
	Needs for information on sexually transmitted infection		0.001
Married female	30 (63.8)	17 (36.2)	
Unmarried female	103 (60.9)	66 (39.1)	
Unmarried male	34 (38.6)	54 (61.4)	
	Needs for information on vaccination		0.004
Married female	18 (38.3)	29 (61.7)	
Unmarried female	45 (26.6)	124 (73.4)	
Unmarried male	12 (13.6)	76 (86.4)	

(Mother and child hospital), created an impression that these health facilities served only pregnant women and children.

"This hospital (MCWC) near our school is for women and children. Boys do not go there..... maybe boys go to the pharmacy when they have minor problems" (Teacher).

According to most parents and teachers, boys do not require as much medical attention during puberty because puberty issues in male adolescents are less evident than in female adolescents. For female adolescents, puberty involves menstruation and fertility, which is a significant concern for their parents.

"As a girl's mother, I can say that addressing menstruation issues is very important...in the future, my daughter will get married and have children. If she has problems with menses, it may create problems" (Mother of an adolescent girl).

"Boys do not get periods like us, that is why they do not come to the hospital; they also fall sick less than us" (Female adolescent, 15 years).

BARRIERS AND FACILITATORS TO THE UTILIZATION OF HEALTH SERVICE BY ADOLESCENTS

We also observed the facilitators of and barriers to AFHS access. More than 90% of male and female adolescents reported that having access to all services in one place, having parental consent, and the friendly behavior of the health service providers made it easier for them to use AFHS. More than 80% of male and female adolescents cited the fear or embarrassment of seeking AFHS, lack of AFHS knowledge, and the lack of gender-matched health service providers at health facilities as some of the bottlenecks. Additionally, 50% of male adolescents and 28.2% of female adolescents reported that their voices were audible and their faces were visible from the consultation room.

According to most parents and teachers, boys needed permission to visit a health facility until a certain age, typically early adolescence (10 to 14 years). In contrast, girls required permission, regardless of age or marital status. Most healthcare professionals and facility managers believed adolescents did not require parental consent to use their facilities. However, most facility managers emphasized that parental permission or approval is necessary if a medicolegal case is brought to their facility.

"Girls need permission for everything in whatever they do.... they are always at risk...it is better to take permission.... a boy needs permission up to 10 or 12 years" (Father of an adolescent boy).

In the health facilities, several observations were noted. There were waiting spaces for male and female adolescents at the AFHS. However, there were no sex-segregated waiting spaces for these adolescents at the AFHS. Adolescent boys typically waited in the facility's lobby, while female adolescents sat in the waiting area accompanied by their parents or guardians. There were more female than male health service providers in the health facility. The survey results also showed that adolescents and their parents preferred gender-congruent service providers.

"If the separate sitting place was made for boys and girls, it would have been better...now I have to wait in this heat outside...I don't want to sit with everyone inside" (Male Adolescent, 16 years)

INITIATIVE TO MAKE THE HEALTH FACILITY GENDER RESPONSIVE

We received positive responses from health-service providers, facility managers, and health managers about making the health facility gender-responsive. Most health-service providers stated that they do not differentiate between male and female adolescent patients. During the

Table 3. Services offered to adolescents across different tiers of health facilities

Facility level	Marital status of adolescents		
	Unmarried female adolescents	Married female adolescents	Unmarried male adolescents
Specialized tertiary-level facilities	<ul style="list-style-type: none"> • Counseling • Treatment of general diseases 	<ul style="list-style-type: none"> • Counseling • Treatment of general diseases 	<ul style="list-style-type: none"> • Counseling • Treatment of general diseases
District Hospital	<ul style="list-style-type: none"> • TD vaccination* • Supply of IFA tablets** • Medicine supply 	<ul style="list-style-type: none"> • TD vaccination* • Supply of IFA tablets** • Medicine supply • Pregnancy care & Family Planning 	<ul style="list-style-type: none"> • Medicine supply
Maternal and Child Welfare Center (MCWC)	<ul style="list-style-type: none"> • Counseling • Treatment of generalized diseases • TD vaccination* • Supply of IFA tablets** • Medicine supply 	<ul style="list-style-type: none"> • Counseling • Treatment of generalized diseases • TD vaccination* • Supply of IFA tablets** • Medicine supply • Pregnancy care, Family Planning & MR** 	<ul style="list-style-type: none"> • Counseling • Treatment of generalized diseases • Medicine supply
City Corporation Hospitals	<ul style="list-style-type: none"> • Counseling • Treatment of general diseases 	<ul style="list-style-type: none"> • Counseling • Treatment of generalized diseases 	<ul style="list-style-type: none"> • Counseling • Treatment of generalized diseases
Upazilla (<i>Sub-district</i>) Health Complex	<ul style="list-style-type: none"> • TD vaccination* • Supply of IFA tablets** 	<ul style="list-style-type: none"> • TD vaccination* • Supply of IFA tablets** 	<ul style="list-style-type: none"> • Medicine Supply
Union (<i>below sub-district</i>) Health & Family Welfare Centre	<ul style="list-style-type: none"> • Medicine supply 	<ul style="list-style-type: none"> • Medicine supply • Pregnancy care & Family Planning 	
Community Clinic	<ul style="list-style-type: none"> • Counseling • Treatment of general disease if a health service provider is available • Medicine supply 	<ul style="list-style-type: none"> • Counseling • Treatment of general disease if a health service provider is available • Medicine supply 	<ul style="list-style-type: none"> • Counseling • Treatment of general disease if a health service provider is available • Medicine supply
School Health Clinic	<ul style="list-style-type: none"> • Counseling • Treatment of generalized diseases • Medicine supply • School Health visit 	-	<ul style="list-style-type: none"> • Counseling • Treatment of generalized diseases • Medicine supply • School Health visit

*TD Vaccination: Tetanus-Diphtheria Vaccination

**IFA tablets: Iron Folic Acid Tablets

***MR: Menstrual Regulation

Table 4. Types of health services utilized by adolescents (N=304)

Types of service utilized	Marital status of adolescents		
	Unmarried female adolescents n (%)	Married female adolescents n (%)	Unmarried male adolescents n (%)
General health services	98 (58.0)	28 (59.6)	77 (87.5)
Puberty	30 (17.8)	2 (4.3)	21 (23.9)
Menstrual problems	61 (36.1)	7 (14.9)	0
Nutrition advice	48 (28.4)	13 (27.7)	27 (30.7)
Pregnancy and family planning	1 (0.6)	15 (31.9)	0
Vaccination	20 (11.8)	7 (14.9)	1 (1.1)

(Multiple Responses)

data collection we have found that one of the health facility took an initiative to provide health services to transgender

adolescents. Some facilities even held monthly meetings to monitor the trend of male and female adolescent arrivals

and planned to modify their services accordingly. According to some health managers, creating positions in health facilities that only provide services to adolescents would help create a gender-responsive facility.

“Our monthly meeting discusses how many males and females took services. Depending on that, our program manager and other members send field workers to nearby areas to know adolescents’ whereabouts” (Facility Manager).

“We need a special service provider for AFHS who is gender-responsive. They will work only for adolescents even if they get transferred...I would rather say adolescents’ specific service provider” (Health Manager).

DISCUSSION

Gender norms have a significant impact on health behaviours, such as health-seeking, access to health services, and comprehension of health needs.²³⁻²⁵ Our study, which used an intersectional approach considering adolescent sex, marital status, and education, aimed to comprehend the gender power dynamics present in structural institutions, specifically health facilities. The adolescents were stratified into privileged or disadvantaged categories based on their healthcare-seeking behaviour, health service utilization, and understanding of health needs. This division created disparities that led to unequal health outcomes among specific groups of individuals.

The fact that female adolescents are more likely to marry young and have children early and male adolescents are less likely to seek health services and obtain correct information about puberty makes them equally vulnerable.^{26,27} Our research indicates that stakeholders and adolescents assumed that female adolescents require medical attention during puberty than males. This is due to the fact that puberty-related issues are generally more noticeable in females, as it involves menstruation and fertility. On the other hand, parents, teachers, and healthcare providers tend to believe that boys require less medical attention during puberty because these issues are less apparent. Consistent with our research, a study on gender norms has shown that mothers usually take their daughters to healthcare facilities if they encounter any problems with menstruation. This is mainly because the primary concern is whether their daughter has become pregnant or is experiencing fertility issues.²⁸

Male adolescents often hesitate to discuss their problems with friends and family and reject the idea of seeking treatment or counselling. The majority (50%) of the male adolescents who sought health services said that their privacy and confidentiality were at bay during the consultation. All these factors made the male adolescents visit health facilities less often. Similarly, a study among male high school students revealed that a quarter of them would avoid seeking medical attention for private matters if they thought their information might not be kept confidential.²⁹

Our study found significant associations between the need for information on puberty changes and STIs with the marital status of adolescents ($p < 0.001$). Here, gender norms play a role in shaping parents’ perceptions of their

adolescents’ health needs. Government health facilities in Bangladesh offer a wide range of health services for both male and female adolescents. However, parents and health service providers perceived that unmarried females visit medical facilities for menstrual issues, while married adolescents seek family planning advice, immunization, or antenatal care. In contrast, unmarried male adolescents often seek medical attention for general illness, injury, and sometimes nocturnal emission issues. Similarly, a study conducted on high school students in Taiwan showed an association between the need for information on puberty ($p < 0.001$) and STIs ($p < 0.02$) with the sex of high school students.³⁰ Another study on adolescent boys showed that although boys wanted information and health services regarding sexual and reproductive health (SRH), they were discouraged and criticized when seeking information or services for SRH. Boys did not share their emotions and experiences on sexual feelings, gender-based violence, and drug use. As a social norm, expressing these emotions was considered a poor reflection of personality.³¹

Although this study has yielded valuable findings, it is essential to note that there are some limitations that need to be addressed. One such limitation is the difficulty in establishing a causal relationship between self-rated health status and healthcare service use in a cross-sectional survey. It is plausible that poor perceived health status may predict frequent use of healthcare services, but it is also possible that it may simply reflect an illness that requires intensive medical care. This aspect must be carefully considered when interpreting the study results. Another reason is that research involving high-risk group adolescents may reveal more diverse results regarding adolescent health services.

CONCLUSIONS

Since its inception in Bangladesh, awareness about AFHS among adolescents and their parents, teachers, and health service providers has increased. Surveys nationwide also show that adolescents from all walks of life utilize the health services at AFHS – making AFHS a gender-responsive health care center. This cross-sectional study demonstrated that the perception of the critical stakeholders, such as parents, teachers, and health service providers of adolescents, influences adolescents’ health service needs, utilization, and access to health services. These perceptions are related to gender norms. Hence, exploration and comprehension of gender norms are needed to better understand adolescents’ needs, types, and utilization of services to address the gender-focused obstacles to accessing and utilizing health services and comprehend the gender norms of their critical stakeholders.

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AUTHORSHIP CONTRIBUTION

FH and H wrote the manuscript with input from all co-authors, FH, SSI, and SN developed the research design and methodology, and FH, SN, NA, SAC, H, UH, SRH, NZ, and AGMMR planned and supervised data collection. NA, H, UM, and SSI contributed to data analysis. All authors provided critical feedback and helped to shape the manuscript.

COMPETING INTEREST

The authors completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available upon

request from the corresponding author) and declared no conflicts of interest.

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