

# Gender, Youth, and Social Inclusion Analysis in Bihar, India



EngenderHealth



**Acknowledgements.** EngenderHealth's India team—including Ajay Khera, Priyanka Kochar, Akash Porwal, Mini Kurup, Vijay Bhaskar, Sudarshan Shukla, and Manish Chaubey—implemented this study. Amy Agarwal, EngenderHealth's Principal Writer and Editor, provided substantive editorial and design support for this report. EngenderHealth global support staff—Renu Golwalkar, Ana Aguilera, and Kathryn O'Connell—reviewed this report. Craft Consultancy Co. provided data collection and analysis support. We thank all study participants for taking the time to participate in discussions and for providing key information and valuable suggestions.

**Suggested Citation.** Khera, A. P. Kochar, A. Porwal, M. Kurup, V. Bhaskar, S. Shukla, M. Chaubey, A. Agarwal, R. Golwalkar, A. Aguilera, and K.A. O'Connell. 2022. *Gender, Youth, and Social Inclusion Analysis in Bihar, India*. Washington, DC: EngenderHealth.

## Table of Contents

Table of Contents .....	1
List of Abbreviations .....	2
Executive Summary .....	3
Introduction.....	4
Methodology.....	6
Findings.....	8
Implications .....	18
Recommendations .....	19
References .....	20

## List of Abbreviations

AFHC	Adolescent-Friendly Health Center
AHD	Adolescent Health Day
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
FGD	Focus Group Discussion
FLW	Frontline Workers
GYSI	Gender, Youth, and Social Inclusion
IDI	In-Depth Interview
PE	Peer Educator
RKSK	Rashtriya Kishor Swasthya Karyakram
SRHR	Sexual and Reproductive Health and Rights

## Executive Summary

### Background and Context

In 2014, India's Ministry of Health and Family Welfare launched an adolescent health program called Rashtriya Kishor Swasthya Karyakram (RKSK), targeting adolescents aged 10 to 19 with community-based programming, including peer education, adolescent health days, adolescent-friendly health clinics, and adolescent-friendly clubs. Bihar is the third most populous state in India and it ranks low on many key health indices and high on gender and social inequalities (Census of India n.d.). While the legal age for marriage in India is 18 for girls and 21 for boys, 41% of women ages 20 to 24 in Bihar were married before the age of 18 (MOHFW 2021). Further, 11% of girls aged 15 to 19 in Bihar have delivered a baby or are pregnant (MOHFW 2021). There is a notable shortage of health facilities (MOHFW 2019) and senior secondary and secondary schools (MOSPI n.d.). Further, there is a sizeable gender gap for completion of secondary school in Bihar (MOHFW 2021) and Bihar has the lowest literacy rate of women of all states (MOHFW 2021). In 2017, EngenderHealth launched the TARUNYA project in the Sitamarhi district of Bihar, with support from the David and Lucile Packard Foundation. In 2020, EngenderHealth expanded the scope of TARUNYA to support the government of Bihar in strengthening RKSK in two additional districts.

### Study Methodology

Gender, youth, and social inclusion are critical considerations affecting adolescents' access to health information and services. Recognizing the importance of these issues, EngenderHealth commissioned a study to understand how the gender and youth determinants in Bihar were affecting health service utilization and to determine how the project could better address gender inequality, social inclusion, and adolescent empowerment to maximize project impact. The study team adopted a seven-step approach, which included an assessment of secondary data, collection and analysis of primary data, and triangulation of primary and secondary data to identify key implications and inform future programming. Covering eight villages across two districts in Bihar, Gaya and Sitamarhi, the study team facilitated focus group discussions with adolescents and parents and in-depth interviews with service providers and local influencers in September 2021. The study team analyze data based on four dimensions of power—assets and resources; practices, roles, and participation; knowledge, beliefs, and rights; and legal rights and status—across individual, community, and institutional and policy levels to identify gaps and disparities by district and across and within a set of social categories.

### Findings, Implications, and Recommendations

Based on the findings detailed in this report, the study team identified several key constraints to uptake of adolescent reproductive and sexual health in Bihar, including: limited access to and control over available services, skewed expectations and biased divisions of labor and responsibilities, social norms related to sexual and reproductive health and rights, and prevalence of early and forced marriage. The team has also presented several recommendations for improving health and development outcomes, based on these findings, including: improving agency among adolescent girls, preparing gender-inclusive and gender-sensitive strategies, engaging with parents, and strengthening the peer education approach.

## Introduction

Rashtriya Kishor Swasthya Karyakram (RKSK, National Adolescent Health Programme) is one of the Government of India's flagship programs. Launched in January 2014, RKSK aimed to ensure that adolescents between the ages of 10 and 19 benefit from facility-based care and a sustained peer educator (PE) program (MOHFW n.d. "Adolescent Health"). The core programming principles for RKSK are health promotion and a community-based services in six thematic areas, (1) nutrition, (2) sexual and reproductive health, (3) injuries and violence (including gender-based violence), (4) noncommunicable diseases, (5) mental health, and (6) substance misuse.

In 2017, EngenderHealth launched the TARUNYA project in the Sitamarhi district of Bihar with support from the David and Lucile Packard Foundation. TARUNYA interventions, aimed at the individual, community and structural levels, sought to enhance knowledge and awareness among adolescents. In 2020, EngenderHealth expanded the scope of TARUNYA to support the government of Bihar in strengthening RKSK in two additional districts.

Gender, youth, and social inclusion (GYSI) are critical considerations affecting adolescents' access to health information and services. Recognizing the importance of these issues, EngenderHealth commissioned a study to understand how gender and youth determinants were affecting health service utilization equity in Bihar and to determine how the project could better address gender inequality, improve social inclusion, and empower adolescents to maximize project impact. The results of this analysis are detailed in this report.

The study assessed following:

- Resources and assets available to adolescents from marginalized communities, particularly those related to healthcare (including RKSK health services) and education, including:
  - > Learning and reading comprehension
  - > Access to services and opportunities related to health, education, and income generation
  - > Access to and control over financial resources and services
  - > Access to and utilization of RKSK health services
- Practices, roles, and participation of adolescents related to gender equality, girls' rights, and nondiscriminatory practices promoted at family, school, and community levels
- Knowledge, beliefs, and perceptions related to social norms, gender norms, and adolescent health information
- Knowledge and gender-equitable and nondiscriminatory attitudes of parents and caregivers related to adolescents
- Decision-making power of adolescents and rules that adolescents follow, formally and informally

EngenderHealth engaged Craft Consultancy, a research for development firm, to support this study. Craft Consultancy brings experience conducting studies for RKSK assessments and understands the unique needs of adolescents-focused projects. Craft Consultancy is committed to undertaking high-quality research based on sound methods and rigorous approaches while adhering to the highest ethical standards in order to protect the dignity, rights, and welfare of research participants.

The study team adopted a seven-step approach from EngenderHealth's GYSI Analysis Framework and Toolkit in the design and implementation of this study (see Figure 1).

**Figure 1. The Seven Steps of the Study**



**Step 1.** The study team prepared a secondary data collection plan to understand the status of adolescents in the project area in terms of access to and utilization of resources related to sexual and reproductive health and rights (SRHR). The secondary data collection plan included a review of multiple reports from credible data sources, including the Government of India (e.g., Ministry of Health and Family Welfare, Ministry of Statistics and Programme Implementation, and Office of the Registrar General and Census Commissioner), the United Nations, various academic journals, and peer organizations (e.g., CARE, CREA, and the International Center for Research on Women).

**Step 2.** The study team analyzed secondary source materials using EngenderHealth’s GYSI Analysis Framework and Toolkit. This review and analysis highlighted existing challenges in Bihar.

**Step 3.** Based on the analysis of the available literature, the study team summarized key findings.

**Step 4.** The review of secondary data demonstrated stark gender gaps as well as gaps among socioeconomically marginalized groups, which impact the health-seeking behaviors of adolescents and affect their access to quality education and their abilities to make decisions for themselves related to marriage, livelihoods, and other opportunities. Though fragmented data are available about existing inequalities related to SRHR, there is little information about the factors underlying these inequalities and the unique ways in which these inequalities affect adolescents.

#### Highlights from the Literature Review

Bihar is the third most populous state in India and it ranks low on many key health indices and high on gender and social inequalities (Census of India n.d.). More than 40% of children under the age of five are underweight in Bihar (MOHFW 2021). Bihar is also “one of India’s poorest states,” with the lowest per capita net state domestic product among all states (MOSPI n.d.). The state has a low sex ratio (918 females per thousand males) (Barua and Chandra-Mouli 2016) and female infants in rural Bihar have a higher mortality rate than male infants (38 to 34, respectively) (Census of India 2012). The literacy rate of rural women in Bihar is 58%, the lowest rate among the larger states in the country (Barua and Chandra-Mouli 2016). The gender gap is stark at the education level, with only 29% of women in Bihar having completed at least 10 years of education compared to 43% of men (Barua and Chandra-Mouli 2016). At 8.3%, Bihar has one of the highest proportions of women in the age group 18 to 29 years who had experienced sexual violence before the age of 19 (Census of India n.d.).

**Step 5.** Building upon the four dimensions of power defined in EngenderHealth’s GYSI framework (see Figure 2), the study team tailored data collection tools to address study objectives. The team also considered how these tools could be used to collect data to fill the evidence gaps and respond to findings from the literature review.

**Step 6.** The study team analyzed primary data using a coding framework based on the four dimensions of power and cross-cutting power structures at each level of the socioecological model. The team then triangulated data with findings from the literature review to inform further recommendations.

**Step 7.** Lastly, the team identified key implications from the study, including intersectional constraints and opportunities.

**Figure 2. Four Dimensions**



## Methodology

The study team adopted a qualitative approach for data collection. The study covered two districts in Bihar: Gaya and Sitamarhi. The team randomly selected four villages per district, including two marginalized villages in each district. The team used existing government records to identify marginalized villages on the basis of socioeconomic status, availability of amenities, and other developmental indicators (Bihar Mahadalit Vikas Mission n.d.). The team selected other villages using 2011 census data and considering geographic spread.

The study comprised 24 focus group discussions (FGDs) and 44 in-depth interviews (IDIs) with a variety of respondents (see Table 1). The FGDs and IDIs were equally spread across the selected villages in the target districts. Convergent View IRB approved the study protocol and tools. Professional, experienced moderators conducted these FGDs and IDIs in person in September 2021.

**Table 1. Study Composition**

Participant Category	Method	Marginalized Village		Other Village		Per District	Total
		Village 1	Village 2	Village 1	Village 2		
Boys 10 to 14 Years	FGD	1	-	1	-	2	4
Girls 10 to 14 Years	FGD	-	1	-	1	2	4
Boys 15 to 19 Years	FGD	-	1	-	1	2	4
Girls 15 to 19 Years	FGD	1	-	1	-	2	4
Fathers of Adolescents	FGD	-	1	-	1	2	4
Mothers of Adolescents	FGD	1	-	1	-	2	4
Peer Educators (PEs)	IDI	1	1	1	1	4	8
Teachers	IDI	1	1	1	1	4	8
Accredited Social Health Activists (ASHAs)	IDI	1	1	1	1	4	8
Auxiliary Nurse Midwives (ANMs)	IDI	1	1	1	1	4	8
Adolescent-Friendly Health Center (AFHC) Counselors	IDI	1	-	1	-	2	4
<i>Pradhans</i> (Village Leaders)	IDI	-	1	-	1	2	4
Religious Leaders	IDI	1	-	1	-	2	4
<b>Total FGDs</b>		<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>12</b>	<b>24</b>
<b>Total IDIs</b>		<b>6</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>22</b>	<b>44</b>
<b>Overall Activities</b>		<b>9</b>	<b>9</b>	<b>9</b>	<b>9</b>	<b>34</b>	<b>68</b>

### Study Limitations

There were inherent limitations for this study, common with any qualitative research; for instance, that the research could not be extended to wider populations and geographies with the same degree of certainty. Additionally, the primary data collection period was limited (17 to 29 September 2021); therefore, responders may have been influenced by their most recent experiences.

### Considerations for Data Collection

- Informed consent was required for all respondents for their voluntary participation in the study and use of their image and/or voice (photographs and audio recordings). For participants under the age of 18, consent was required from the adolescent as well as a parent or guardian of the adolescent. The team explained the parameters of consent using easy-to-understand terminology in the local language.



- The study team adhered to established COVID safety protocols and considered participants’ safety and comfort a priority during the data collection phase.
- The team maintained confidentiality of personal information and privacy of all respondents throughout the data collection, data processing, and dissemination phases.
- The team followed do no harm principles and established a mitigation plan to address unanticipated risks.

## Data Analysis

Professional transcribers familiar with the local context and dialect transcribed the audio recordings in Hindi and then translated them into English. The study team employed Dedoose software to code the English transcripts using a content analysis method based on the four dimensions of power. Under each dimension, the team analyzed data across each level of the socioecological model (see Table 2) and identified gaps and disparities by district and across and within a set of social categories, such as age, gender, and type of village (marginalized or non-marginalized). Differences observed across these categories are detailed in the findings section of this report.

**Table 2. Data Analysis Framework**

Dimensions and Levels	Individual	Community	Institutional and Policy
Assets and Resources			
Practices, Roles, and Participation			
Knowledge, Beliefs, and Perceptions			
Legal Rights and Status*			

*Note: The legal rights and status dimension was covered only briefly for this study*

## Findings

### Assets and Resources

The study team explored assets and resources primarily related to healthcare and education.

#### Access to Healthcare Services and Facilities

##### Individual Level

The proportion of women aged 15 to 24 who use hygienic methods of menstrual protection is lowest in Bihar, at 59% (MOHFW 2021). When asked about their healthcare needs, girls across all age groups mentioned problems faced during menstruation. Girls aged 15 to 19 also mentioned weakness, fatigue, and an inability to focus on studies. Girls in this age group from marginalized villages further reported that they cannot use sanitary pads regularly due to the cost, and noted that they procure sanitary pads at subsidized rates from their local public health center when they are available.

The boys across all age groups did not mention any healthcare issues besides occasional ailments, such as the common cold or fever.

When we asked with whom they feel comfortable discussing personal issues, all adolescents reported a preference for their peers. For in-school adolescents, girls commonly congregate within the school and boys commonly congregate on open school grounds. However, due to COVID-19 restrictions, schools are closed and girls are limited to gathering within each other’s homes where a lack of privacy often prevents such personal discussions.

Bihar has second highest proportion of underweight children under the age of five and similarly ranks high in anemia cases, with 66% of girls and 35% of boys ages 15 to 19 being anemic (MOHFW 2021). When we asked key informants, such as parents and teachers, about adolescents' healthcare needs, those in marginalized villages mentioned that most adolescent girls in their villages are undernourished and weak and that families from lower economic strata are unable to afford the nutritious foods that the girls need. Furthermore, youth across age groups and genders were unaware of the importance of a balanced diet and nutrition during adolescence.

Alcohol addiction and peer pressure for alcohol consumption among adolescent boys was a common issue discussed by parents, local leaders, and frontline health workers (FLWs). Boys aged 15 to 19 similarly reported their peers becoming addicted to alcohol and it affecting their studies and destroying their futures.

"The young boys in this village start consuming alcohol with friends from a very young age. They get addicted to alcohol and lose focus on studies. They get wrecked and spoil their future."

*Father, Gaya*

### Community Level

Accredited social health activists (ASHAs) and auxiliary nurse midwives (ANMs) are cadres of FLWs, or community health workers, in rural India (MOHFW 2007).

When asked about interactions with ASHAs and ANMs, most adolescents cited their family members depending upon these FLWs for primary healthcare needs. However, the adolescent boys aged 15 to 19 also mentioned being hesitant to access services from ASHAs and ANMs because they are women. Similarly, FLWs agreed that adolescent boys are generally shy and are reluctant to discuss health problems, especially adolescent reproductive and sexual health (ARSH) issues, with ASHAs or ANMs. Furthermore, the FLWs explained they are likewise uncomfortable interacting with adolescent boys, as they fear parents accusing them of encouraging their sons to engage in sexual activity by supplying condoms. Hence, they only supply condoms to married boys. However, some of the FLWs in Gaya mentioned parents in their villages contacting them when boys experience issues, such as pain in their genital areas, lumps in their chests, and inadequate physical growth.

"Adolescent boys in our village do not interact with FLWs to discuss their health issues. We hesitate as they are women. We do not discuss personal problems with family members also; we prefer to discuss with our friends when we meet."

*Adolescent Boy (15–19), Gaya*

"I provide condoms to married [boys] only. I don't give it to the young unmarried boys. If we do, their parents will come and accuse us of spoiling their son's life by encouraging wrong habits."

*ASHA, Gaya*

In contrast, adolescent girls frequently visit FLWs to obtain calcium, folic acid, iron, and other supplements. Girls aged 15 to 19 also cited visiting FLWs for advice about menstruation and weakness-related issues and noted that FLWs sometimes distribute sanitary pads at subsidized rates—but the supply is limited and infrequent. However, girls reported feeling shy about disclosing other personal health issues with FLWs, preferring to discuss those issues with their friends or mothers instead. ASHAs and ANMs similarly confirmed that the adolescent girls approach them for problems relating to their menses and noted that they counsel the girls, ask them to use sanitary pads and maintain menstrual hygiene, and sometimes provide referrals to doctors.

The peer education component of RSKS aims to improve adolescents' access to ARSH. Peer educators (PEs) are adolescents aged 15 and 19 from the community. PEs are trained on various components of RSKS to promote positive health behaviors among their peers, including by addressing misconceptions and fears and supporting adolescents in accessing care (MOHFW 2007). However, PEs in both districts have reported various challenges in serving in this role. For instance, PEs from Gaya, reported a lack of support from the community, particularly parents. These PEs noted that parents do not allow their children to participate in peer education sessions because they believe that the PEs discuss sex, contraception, and similar issues that are not socially acceptable. Further, parents blame PEs for negatively influencing their children by providing information that they believe encourages sexual activity. However, when FLWs are supportive, PEs have been able to enlist their assistance in countering these ideas and garnering support from some parents.

“Parents don't allow the girls to come to the sessions. They say that the adolescents would learn on their own when it is time for them to know these things. Mothers of some girls tell me that you don't come to teach good things, but you mislead them and encourage them on wrong path. There are more restrictions on girls. Boys are allowed to go.”

*PE, Gaya*

PEs from both districts also mentioned difficulties in mobilizing adolescents, as many youth do not understand the importance of learning about SRHR. Lockdowns related to COVID-19 compounded challenges in mobilizing adolescents and organizing peer education sessions. However, with support from program staff, counselors, ASHAs, and ANMs in speaking to parents, PEs have been able to improve adolescents' participation in peer education sessions.

RSKS guidelines call for the facilitation of quarterly adolescent health days (AHDs) in every village. The purpose of AHDs is to increase awareness among adolescents, parents and families, and other community stakeholders about the determinants of adolescent health and to improve adolescents' access to preventive and promotive health interventions (MOHFW 2014). FLWs and PEs however cited a lack of adequate time and resources to plan AHDs as the reason for limited participation in AHDs. In Sitamarhi, adolescents aged 15 to 19 noted that they previously attended AHDs at school, but due to school closures related to COVID-19, this was no longer an option and thus, it has been more than one year since AHDs have occurred in their villages. Adolescents of all ages in Gaya similarly could not recall any AHDs being held in their villages and teachers, FLWs, and local leaders confirmed the AHDs had ceased in February 2020 because of the pandemic.

FLWs also cited increased workloads related to COVID-19 (for testing, vaccination drives, and other administrative tasks) as preventing them from devoting adequate time to ARSH. Thus, they have not been able to support peer education sessions and AHDs for more than a year.

### **Institutional and Policy Level**

The public healthcare system in India is organized into primary, secondary, and tertiary levels. At the primary level are sub-centers and primary health centers. At the secondary level, there are community health centers and sub-district hospitals. Finally, the tertiary level consists of medical colleges and district hospitals (Choski et al. 2016).

There is an overall shortage of 11,388 (53%) sub-centers, 1,649 (46%) primary health centers, and 737 (83%) community health centers in Bihar (MOHFW 2019). While Gaya has 261 sub-centers and 72 primary health centers for a population of 3,809,817, this shortage is exacerbated in Sitamarhi, where there are only 91 sub-centers and 18 primary health centers for a rural population of 3,233,076 (MOHFW 2021). Moreover, adolescents, parents, and community members from marginalized villages all noted having to travel to a nearby town or a block to access healthcare as

there are no public health centers in their villages. Study participants from the marginalized village in Sitamarhi further explained they must travel more than 10 kilometers to access care and noted that there are no transportation amenities available to assist them in reaching the health facility.

Our study team explored the implications of these shortages on health-seeking behaviors among families and adolescents. Parents noted that due to the distance, they avoid visiting health facilities and only seek care from these facilities for severe ailments. They also explained that there are some private healthcare providers operating in their villages, but they are expensive and individuals from lower economic strata are prohibited from accessing their services due to the cost.

“There is no government health center in this village. People seek services from private health service providers, but poor people can’t afford [that] and have to go to the government facility 12 kilometers away.”

*Survey Respondent, Sitamari*

In addition to the access challenge related to distance, parents reported that government facilities were frequently not functional. Parents shared examples of traveling to a facility only to return home without accessing services and highlighted the difficulty in revisiting the facility due to distance. Study participants also expressed dissatisfaction with the quality of services at health centers and said there are no doctors or specialists available, thus forcing them to travel to the district hospital for serious illnesses. Parents also mentioned having to purchase medication from private chemists as the medicines are not available at the government facilities.

“The sub-center was open for two months last year and there was a doctor who provided treatment and some medicines but it is closed since then.”

*Parent, Gaya*

“There is a small health center nearby, but no doctor visits the center even for a single day. It is non-functional now and cow dung is being stored there.”

*Survey Respondent, Gaya*

Adolescents of all ages noted they rarely visit health facilities for treatment. Many reported having only visited a health center for early childhood immunizations at the age of two or three and some reported having visited since for treatment of common illnesses such as fever or cold or to accompany younger siblings for immunizations or other family members for curative care.

One factor preventing adolescents from seeking care at health facilities is safety and accessibility. Adolescent girls across age groups and boys aged 10 to 14 both said they are not allowed to travel in public alone, including to visit a health center. Mothers and other elder women in the family usually accompany the children to the health center for treatment.

Under RKSK, adolescent-friendly health clinics (AFHCs) are located in public health facilities to provide a range of clinical and counseling services on diverse adolescent health issues (MOHFW n.d. “Adolescent Friendly”). However, in Gaya, all adolescents aged 10 to 14 and boys aged 15 to 19 years reported being unaware of the location of the AFHCs. Girls aged 15 to 19 from Gaya knew the location, but cited difficulty with access, as it is 10 kilometers away from their homes and their parents would not allow them to visit the AFHC.

“AFHC is 10 kilometers away. I have never been there because parents would not allow us to go there.”

*Adolescent Girl (15–19), Gaya*

In Sitamarhi, the TARUNYA project has supported RKSK program for more than five years and helped ensure that adolescents from this district across gender and age groups are familiar with their local AFHCs. Girls aged 15 to 19 years in Sitamarhi explained that project staff, counselors,

and PEs meet with them regularly, providing SRHR information. This group also confirmed having visited an AFHC recently with a PE and interacting with a counselor. Adolescent boys in Sitamarhi, however, reported not visiting an AFHC as they do not consider health to be an important concern and as they fear stigma if their peers find out that they have visited an AFHC. Sitamarhi adolescents also cited the hours of the AFHCs as being inconvenient and clashing with the school hours.

## Access to Education Facilities, Resources, and Opportunities for Growth

### Individual Level

Bihar has the lowest literacy rate of women (58% overall and 30% among scheduled caste women) and the highest proportion of women aged 20 to 24 who were married before the age of 18 (41%) (MOHFW 2021). The gender gap for completion of secondary school is similarly concerning, with only 29% of women in Bihar having completed 10 or more years of education compared to 43% of men (MOHFW 2021). Yet, most of the adolescents who participated in the study were enrolled in school and respondents agreed that girls in their locality typically continue their studies until grades 10 or 12, and boys continue until they complete college. When discussing their goals, girls reported admiring other girls from their villages who have completed their studies and are working as nurses, teachers, or government staff, while boys shared aspirations of joining the army or police force or working for a bank or in another lucrative position.

However, adolescent girls face a variety of challenges in pursuing their educational goals. Girls aged 15 to 19 explained that parents typically do not allow girls to pursue studies outside their village due to fears of harassment. As a result, girls may only enroll in nearby schools or colleges, but boys can attend schools in the nearby towns or even in Patna, the state capital. Additionally, while there may be local private schools, adolescents noted that parents are more willing to enroll their sons than their daughters, due to the expenses associated with private education. Hence, while some girls (i.e., those with good grades and the support of teachers or other local leaders) have been able to convince their parents to allow them complete grade 12, many girls drop out of school after grade 8 or 10. Adolescents also reported that girls who drop out of school are frequently married early.

“The nearest school after grade 10 is 10 kilometers away from here. Our parents are very scared to send us there. Many girls my age stop school after grade 10 because their parents do not allow them to travel this distance.”

*Adolescent Girl (15–19), Sitamarhi*

Adolescent girls also cited a gender disparity related to the benefits of private tuition and coaching centers, which are only accessible boys due to the cost and parents’ reluctance to invest in girls’ education in this manner. Moreover, girls explained that they rarely receive encouragement or support from teachers or parents, and instead are burdened with household chores that prevent them from studying. Girls that fail to perform well in school as a result of these challenges often lose their motivation to study exacerbating their difficulties in school. Yet, while some boys may be afforded more support—both in opportunities for private tutors and the allowance of time for studies—study participants reported feeling pressured to perform well in school in order to obtain a well-paying job and provide for the family. Adolescents also reported that some boys experience familial pressure to engage in income generating activities before completing their studies and are forced to drop out. Adolescents also noted that other boys may drop out of school due to alcohol addictions or other negative influences.

## Community Level

Due to socialized gender roles in the community, parents feel educating girls is unnecessary, as these girls will eventually marry and be responsible for maintaining a household, rather than for earning income. On the other hand, most parents agree it is important for boys to succeed in school and learn skills that will enable them earn money to support the family.

“We focus on our son’s education so that he can get a good job and take care of us in old age. Daughters have to get married and take care of household chores. Studies are not important for them.”

*Mother, Gaya*

## Institutional and Policy Level

Bihar has a massive shortage of senior secondary and secondary schools; data from the 2015–16 school year showed a total 84,236 schools, including approximately 3,900 senior secondary and 3,700 secondary schools (MOSPI n.d.). Further, when schools closed during the COVID-19 lockdown, tuition and coaching centers and online education platforms were the only sources of education for adolescents. As girls have limited access to digital resources and, as previously noted, parents are less likely to invest in girls’ education (with paying for private tuition and coaching), it was significantly more difficult for girls to access education than boys during this period.

When asked about the schools in their locality, adolescents from Gaya explained there was one government school inside the village for students until grade 10 and private schools serving students until grade 12. Adolescents from Sitamarhi reported that the government school and private schools inside their villages only served students until grade eight and that they had to travel more than 10 kilometers to continue studies thereafter.

Additionally, adolescents across the districts also reported being unsatisfied with the quality of teaching in government schools and noted needing to supplement school-based learning with private tuition and coaching centers. There are private tuition and coaching centers within the villages that can support students through eighth grade but for coaching thereafter, adolescents have to travel outside their village.

Scholarships can help families with budget constraints in investing in their daughters’ education. The government of Bihar introduced an initiative in 2006 to support girls in continuing their studies by providing bicycles to grade nine girls. Since 2013, the government of India has steadily expanded the direct benefit transfer initiative to support a variety of development outcomes—including Bihar’s bicycle scheme and other scholarship programs. Adolescent girls in the study reported being aware of these government schemes, but noted they are unaware of what their parents do with money they may receive. Most also said that they have a bicycle at home, but they are unable to use it to travel long distances or to leave their village due to unsafe roads and fears of harassment. Further, they noted that the bicycle is usually shared among siblings, and, since boys are able to attend schools and coaching centers outside of the village, their brothers tend to use it more. According to the teachers, direct benefit transfer schemes can be effective in reducing corruption; however, funds transferred for bicycles, uniforms, and books for girls may be spent by their parents for other items rather than the intended purchases.

## Practices, Roles, and Participation

Prevailing social norms related to gender have a demonstrated impact on the practices, roles, and participation of adolescents across all levels.

## Individual Level

When asked about roles and responsibilities at home, adolescents revealed clear gender differences. Most girls reported engaging in household chores and caring for younger siblings. Adolescent girls aged 15 to 19 also reported engaging in livelihood activities at home, such as sewing, embroidery, and making floral strands and bouquets. In contrast, boys reported studying at home, playing outside with peers, and engaging in outdoor livelihood activities, such as farming and livestock work, to contribute to the household income. Boys also shared being encouraged to learn livelihood skills so that they can contribute to the family income.

“Girls our age manage and clean the house, wash clothes of family members, including brothers, and take care of siblings. Brothers don’t do any work at home. They just go to school.”

*Adolescent Girl (10–14), Sitamarhi*

Mothers and fathers provided similar responses when were asked about roles and responsibilities of adolescent girls and boys. Most of the parents explained that the daughters help their mothers with household chores and the sons help their fathers with livelihood activities.

In poor households, the situation is exacerbated. As both parents work outside of the home, daughters carry the entire burden of household chores. Sons are expected to help with household livelihood activities after school and boys aged 10 to 14 reported that some of their peers are required to drop out of school after grade 10 to obtain full-time jobs, due to household financial constraints.

“The people who feel like going out, they go after 10th grade to work in a factory or something.”

*Adolescent Boy (10–14), Sitamarhi*

School closures related to COVID-19 have also forced girls to stay at home and assume more of the burden of household chores. For instance, adolescents from Gaya discussed how COVID-19 has affected household incomes and as a result shifted responsibilities, particularly for girls. In households where girls had been helping their mothers with chores, these girls may now be responsible for these chores themselves, as their mothers must work outside the home. Adolescent boys reported continuing to help with livelihood activities, but also attending private tuition and coaching centers to compensate for school closures.

This discrimination also impacts girls’ mobility and agency. Girls aged 10 to 14 reported that their parents do not allow them to go out and play, especially with boys, after they begin menstruating. Instead, they are expected spend time at home, helping with household activities. Girls aged 15 to 19 cited similar mobility restrictions prohibiting them from leaving their neighborhoods.

These gender norms, roles, and expectations directly affect adolescents’ attitudes. Girls aged 15 to 19 reported feeling the stressed and burdened by household chores and, as a result, being unable to focus on studies and eventually dropping out of school. Conversely, boys aged 15 to 19 reported feeling pressure to do well in school to be able obtain a good job later that would enable them to contribute to the household income.

“Our parents want us to focus on our studies so that we can grow and earn a lot of money to take care of household expenses.”

*Adolescent Boy (15–19), Sitamarhi*

## Community Level

Prevailing community norms around gender are that women are responsible for household chores and men are responsible for earning an income. Girls are groomed from adolescence for marriage and domestic responsibilities. The community brands girls who do not perform household chores properly as “lazy and useless,” which can make it difficult for them to find a husband. Girls also experience pressure from their communities to marry as soon as they complete grade 10. Parents similarly confirmed that daughters are restricted from going outside in order to protect family honor. In contrast, the expectation from boys is to study well to be able to take care the parents in their old age. Sons are expected to continue the family lineage in future.

“Mothers ask us to do all the household work. If we don’t complete household chores properly, they scold us and call us lazy.”

*Adolescent Girl (15–19), Sitamarhi*

These norms also manifest in decision-making responsibilities at the household level. In one study, as many as 70% young men and 64% young women agreed that a wife should obtain her husband’s permission for most things (IIPS and Population Council 2010). Similarly, study participants across categories agreed that men make the key household decisions. Bihar ranks among the lowest states in India with regard to women’s participation in decision-making around healthcare, major household purchases, and visits to relatives—with only 87% women from rural areas participating in any one of these three types of decisions, whereas in contrast, 99.8% of women in rural Nagaland participated in such decisions (MOHFW 2021).

## Institutional and Policy Level

The study team explored the impact of policy interventions aimed to increase women’s political participation in *panchayati raj* institutions (village councils). Policy changes encouraging women’s participation in panchayat elections and involvement in other local governance structures have motivated some women to work for change in their communities. One respondent, an elected woman representative, noted it took courage to defy gender norms and restrictions imposed by her family members at first, but now she feels confident in working in the community to accomplish governance-related tasks. Further, she is also mobilizing other women to collectively combat harmful traditional practices, such as discrimination and gender-based violence.

## Knowledge, Beliefs, and Perceptions

### Individual Level

In Bihar, 11% of adolescent girls aged 15 to 19 have a baby or are pregnant, highlighting an unmet need for SRHR information and services (MOHFW 2021). Lack of knowledge and awareness about the importance of SRHR-related information among adolescents and their parents hinders uptake of ARSH services.

Adolescents of all ages reporting not having time to learn about SRHR. Girls aged 15 to 19 reported being preoccupied with household chores and boys in same age group reported being busy with studies and livelihood activities—neither group felt ARSH was an important enough issue to include in their routine. Girls and boys aged 10 to 14 were neither aware of the benefits of SRHR nor interested in seeking SRHR information. Restricted mobility, especially among girls, as previously discussed, further hinders access to ARSH care.

Parents similarly stated that SRHR information is irrelevant for their children. They explained that children would learn about SRHR on their own when they grow up, thus it is not important to provide such information to adolescents at a young age. Further, parents noted that SRHR is a taboo topic and should not be discussed with adolescents as such discussions could negatively



influence their children. Therefore, few parents allow their children to participate in SRHR activities. However, in Sitamarhi, where the TARUNYA project has been supporting RKSJ for more than five years, more adolescent girls aged 15 to 19 are accessing ARSH care.

### Community Level

Adolescent girls aged 15 to 19 noted that girls who discuss SRHR are considered bad elements in the community and parents instruct their children not to interact with such girls. Boys also make fun of and harass such girls. Therefore, girls are unable to discuss SRHR openly and any such conversations occur within

close friends groups only. Similarly, outspoken girls are perceived as rebellious, so girls must be docile to be deemed socially acceptable. Further, the community perceives adolescent girls who interact with boys as promiscuous; thus, to protect family honor, parents prohibit their daughters from entering public spaces where such interactions may occur.

Boys however reported discussing SRHR topics openly among friends and peers—but usually in a fun, joking manner. According to ASHA and ANMs, girls are generally less informed about SRHR issues than boys, but boys' SRHR knowledge is clouded with misinformation and myths.

Parents asserted that premarital sex is forbidden in the community and that discussing SRHR with adolescents would lead to premarital sex. The ramifications are more severe for girls than boys—girls who engage in premarital sex, and their families, risk being ostracized by the community, whereas boys will receive a warning. In such cases, the girl's family is forced to find a boy outside their village who does not know what has occurred to marry the girl and the girl is forced to marry and relinquish any further support from her parents or community.

### Institutional and Policy Level

When asked if they provide SRHR information to adolescent girls and boys, teachers stated that they do not discuss these topics as they are not trained in this area and thus lack the skills to do so. Teachers also reported feeling shy about discussing SRHR in front of boys and believe that male teachers should provide such information to boys separately.

FLWs (including ASHAs, ANMs, and counselors) are trained to provide SRHR information to adolescents. However, ASHAs and ANMs reported that their focus is on serving pregnant and lactating women and young children and that they rarely have time to support RKSJ activities. When ASHAs and ANMs are able to prioritize ARSH activities, they must contend with various challenges, including the disinterest of adolescents, mobility limitations imposed on adolescents,

“There is no need to provide SRHR-related information to adolescents at this young age. They may get into wrong practices such as premarital sex. Nobody provided this information to us, but we knew about it when time was right. Similarly, they will get to know about these things automatically when they need to know.”

*Mother, Gaya*

“We tell our daughters not to talk about sex, boys, and similar topics. They will get distracted and get into wrong influence. The villagers spread rumors about such girls.”

*Mother, Sitamarhi*

“Boys don't talk to us about SRHR topics, they speak to each other and exchange all misinformation and myths regarding sex and use of condoms.”

*ANM, Sitamarhi*

“We feel shy talking about SRHR in class in front of boys. We should get training about it and male teachers should talk to boys.”

*Teacher, Gaya*

stigma in the community, and their own discomfort in interacting with adolescent boys. Further, ASHAs, ANMs, and counselors all reported being unable to interact with adolescents or conduct SRHR awareness sessions for the last two years due to COVID-19 restrictions.

## Legal Rights and Status

### Individual Level

The legal age for marriage in India is 18 for girls and 21 for boys. Yet, Bihar has highest proportion of women (41%) aged 20 to 24 who were married before the age of 18 (MOHFW 2021). More than half of married persons (64% of boys and 68% of girls) met their spouses for the first time on their wedding day (IIPS and Population Council 2010).

Adolescents reported that parents decide when their children will marry and make arrangements for whom they will marry. Adolescents are aware of the legal age of marriage, but explain that parents begin discussing their daughters' marriage prospects when they turns 16; for sons,

"We can't tell that we don't want to marry. There are three to four sisters at home. They have to get all the siblings married. So parents will get us married quickly."

*Adolescent Girl (15–19), Gaya*

these conversations begin when the sons are between 25 and 30 years of age. Adolescent girls also reported that those with many siblings are often married earlier, so their parents may be sure of marrying of younger siblings. These girls similarly noted that when girls drop-out of school they may also be married early. Adolescent girls aged 15 to 19 explained that their opinion about when and who to marry is irrelevant, while boys explained they have the opportunity to submit their consent before a match is finalized. Both adolescent girls and boys aged 15 to 19 asserted that adolescents who want to choose their spouse must elope, as parents and the village elders do not approve of such love matches. Further, if an underage girl and boy elope, they must hide until they are of legal age, otherwise the community will force them to separate.

Parents also acknowledge the law related to age of marriage in India; however, they explained feeling responsible for finding spouses for their children and therefore begin searching for grooms for their daughters when they turn 16 as they fear losing a good match if they wait longer. Further, parents acknowledged that as girls do not contribute to the household income, they are a financial burden and parents must rush find husbands for them. The situation for girls from lower socioeconomic strata is particularly precarious, as parents marry daughters even earlier as they cannot afford their education and care.

"Parents think that the girl child is a burden. They want to get them married soon and feel relieved."

*Adolescent Girl (15–19), Sitamarhi*

### Community Level

Despite being illegal, the dowry system remains prevalent in rural areas of Bihar—with expectations of the bride's family giving cash, jewelry, household items, and a vehicle to the groom's family. One PE reported there is a high demand for dowry and parents think of their daughters as burdens that they must marry quickly.

"There is a lot of dowry demand here. The poor parents have to give Rs.100000 and one vehicle as well as gold jewelry. They have to take loan for dowry."

*Survey Respondent, Sitamarhi*

Parents expressed a concern that if a girl delays marriage, that girl will begin talking to boys, fall in love, and run away from home—which would lead to a loss of honor for the family in the community. And, this loss of honor would make it difficult for parents to find good matches for their other children. Parents also shared that they believe finding a suitable match for daughters

becomes more difficult as they become older. They explained that families with unmarried daughters of marriageable age constantly face speculation from the community about their daughters' characters. Parents admitted to arranging marriages for underage children due to these community pressures.

### **Institutional and Policy Level**

Despite laws to prevent early marriages, societal pressures still lead to early marriage. Adolescents explained that while they may be aware of these laws, they do not know how to seek support in cases of forced and early marriage. Parents, who are also familiar with these laws, still arrange marriages of underage girls and boys, but must be discreet to prevent interference—including from local nongovernmental organizations, panchayati raj institutions, or community leaders—who might otherwise try to stop the marriage. In some cases, these stakeholders intervene after an underage marriage has occurred, forcing the bride and groom to live separately until they are of legal age.

“We are aware of the law in India which allows marriage only after 18 years of age for girls. But there are many girls in our village who get married before 18 years of age. We don't want to get married before 18 years of age. But we don't know how to defy our parents and go against them. We need support to convince this to our parents.”

*Adolescent Girl (15–19), Gaya*

## **Implications**

The study team observed several key constraints to providing ARSH services in the target districts.

### **Limited Access to and Lack of Control over Available Services and Facilities**

- Those living in marginalized villages have limited access to healthcare facilities. This includes not having quality healthcare facilities within their villages and not being able to travel to health facilities in nearby areas due to inadequate road infrastructure and lack of transportation options.
- Adolescent girls face mobility constraints that hinder access to health and education services. Most girls are not allowed in public spaces, including healthcare facilities, unchaperoned due to concerns related to safety and family honor.
- During the pandemic, when schools were closed, boys continued to study through private tuition and coaching centers and digital learning methods, but girls had limited opportunities for taking advantage of these resources.

### **Skewed Expectations and Biased Divisions of Labor and Responsibilities**

- Generally, girls bear the responsibility of household chores while boys are allowed time for studying and engaging in income generating activities.
- Parents believe girls should prioritize learning domestic skills to prepare for marriage whereas boys should prioritize learning skills that will enable them to earn money for the family.
- Adolescents—boys and girls—are unable to prioritize learning about or accessing ARSH care due to other responsibilities and priorities.

### **Social Norms related to SRHR**

- Community taboos prevent adolescents from discussing SRHR-related topics openly and with knowledgeable sources, such as ASHAs and ANMs.
- ASHAs and ANMs are hesitant to discuss ARSH with adolescents due to social stigmas around SRHR more broadly and adolescent boys feel uncomfortable approaching ASHAs and ANMs, because they are all women.

- Health is not a priority for adolescents, nor do parents feel children should have access to SRHR information. Parents fear that children who learn about SRHR will engage in unacceptable behaviors, such as premarital sex.

### **Prevalence of Early and Forced Marriage**

- Girls are viewed as burdens, as they do not earn income and are a financial drain with costs for food, education, and eventually a dowry; thus parents are eager to have their daughters marry to be relieved of this financial responsibility.
- It can be difficult to find a suitable match for girls as they age and families with unmarried daughters of marriageable age constantly face speculation from the community regarding their daughters' characters. Thus, parents wish for daughters to marry early.
- Families from lower socioeconomic strata and those with three or more daughters feel additional layers of pressure to marry their daughters to alleviate financial and social pressures.
- Inter-caste marriages and love-match marriages are not socially acceptable. Those who wish to choose their own spouse must elope; girls who elope in this manner are shunned and no longer receive support from their parents or communities. Parents marry daughters early to prevent them from choosing a match and eloping—and dishonoring the family.

## **Recommendations**

The study team presents several recommendations for improving health and development outcomes based on the findings included herein.

### **Improve Agency among Adolescent Girls**

Adolescent girls experience more challenges in accessing health and education services and opportunities than the adolescent boys, including challenges from related to limited mobility, gender-biased roles, and social norms and expectations. Therefore, targeted interventions for reaching adolescent girls and improving their agency and self-efficacy are critical.

### **Prepare Gender-Inclusive and Gender-Sensitive Strategies**

To ensure healthcare is age-appropriate and gender-inclusive, ASHAs, ANMs, and other FLWs and facility-based staff must be sensitized to the specific needs of adolescent girls and boys and have resources to best reach these populations. Further, establishing a cadre of male FLWs would help meaningfully engage adolescent boys, but requires funding and support from the state level.

### **Engage with Parents**

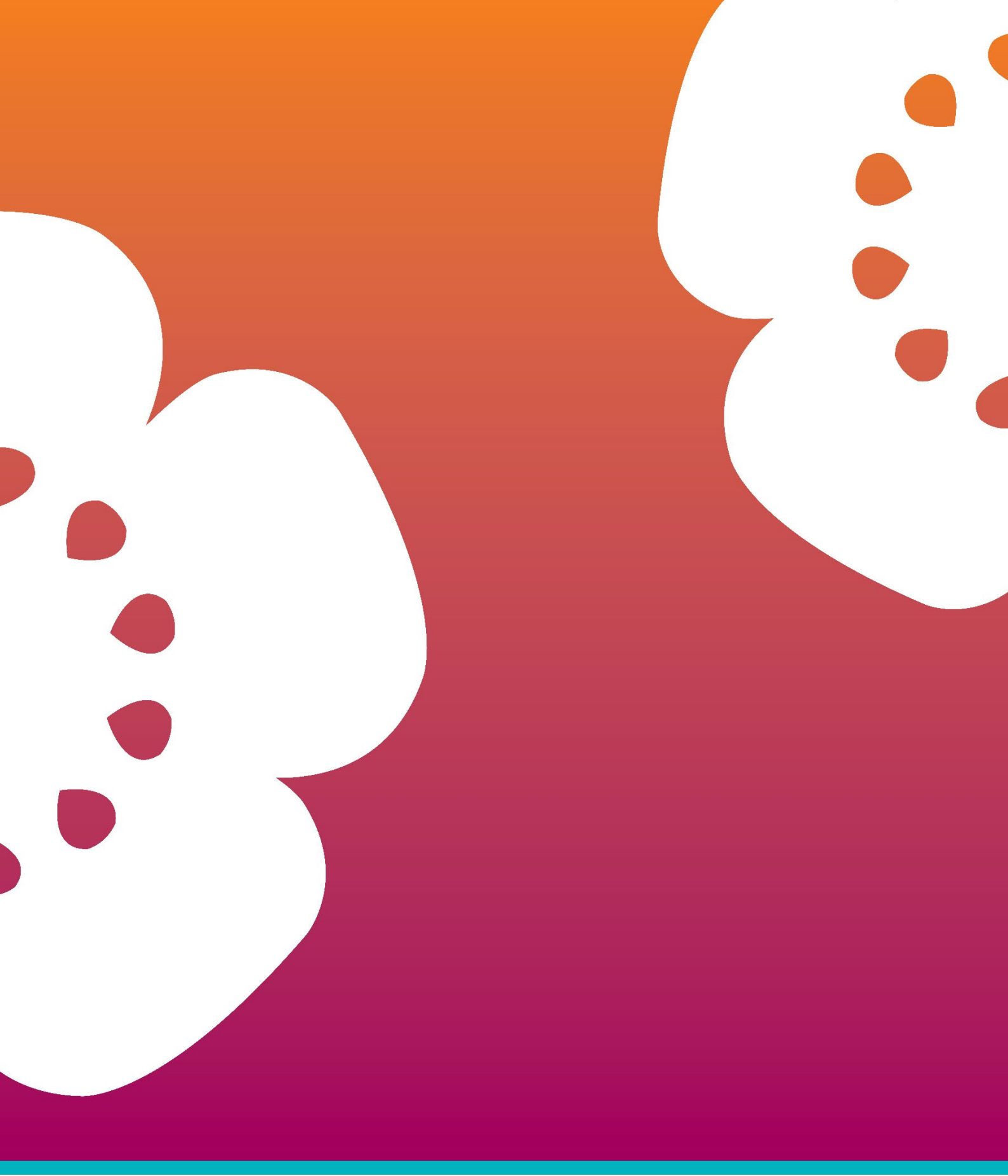
Parents are gatekeepers for their children and must be engaged in designing and implementing initiatives for adolescents, if adolescents are to be allowed and supported in participating.

### **Strengthen the Peer Education Approach**

PEs can serve an important role in reaching and relating to adolescents; however, they need support—both from healthcare workers, such as ASHAs and AMNs, as well as parents and community leaders—to be able to combat social stigma and perform their duties effectively.

## References

- Bandyopadhyay, M. and R. Subrahmanian. 2008. *Gender Equity in Education: A Review of Trends and Factors*. Brighton, UK: Consortium for Research on Educational Access, Transitions, and Equity (CREATE). [sro.sussex.ac.uk/id/eprint/1866/](http://sro.sussex.ac.uk/id/eprint/1866/).
- Barua, A. and V. Chandra-Mouli. 2016. "The TARUNYA Project's Efforts to Improve the Quality of Adolescent Reproductive and Sexual Health Services in Jharkhand State, India: A Post-Hoc Evaluation." *International Journal of Adolescent Medicine and Health* 29 no. 6 (June). doi: 10.1515/ijamh-2016-0024.
- Bihar Mahadalit Vikas Mission. n.d. Homepage. (website). <https://www.mahadalitmission.org>.
- Census of India. 2012. *Annual Health Survey Bulletin 2011–12: Bihar*. New Delhi: Census of India. [www.censusindia.gov.in/vital\\_statistics/AHSBulletins/files2012/Bihar\\_Bulletin\\_2011-12.pdf](http://www.censusindia.gov.in/vital_statistics/AHSBulletins/files2012/Bihar_Bulletin_2011-12.pdf).
- Chokshi, M., B. Patil, R. Khanna, S.B. Neogi, J. Sharma, V.K. Paul, and S. Zodpey. 2016. "Health Systems in India." *Journal of Perinatology* 36 no. S3 (December): S9–S12. doi: 10.1038/jp.2016.184.
- Khokar, A., S. Garg, and N. Bharati. 2005. "Determinants of Reasons for School Drop-Outs Amongst Dwellers of an Urban Slum in Delhi." *Indian Journal of Community Medicine* 30 no. 3 (January): 92–93. doi: 10.4103/0970-0218.42858.
- International Institute for Population Sciences (IIPS) and Population Council. 2010. *Youth in India: Situation and Needs 2006–2007*. Mumbai: IIPS. [www.popcouncil.org/uploads/pdfs/2010PGY\\_YouthInIndiaReport.pdf](http://www.popcouncil.org/uploads/pdfs/2010PGY_YouthInIndiaReport.pdf).
- Ministry of Health and Family Welfare (MOHFW). n.d. "Adolescent Friendly Health Clinics." New Delhi: MOHFW (website). [www.nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1247&lid=421](http://www.nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1247&lid=421).
- MOHFW. n.d. "Adolescent Health (RKSK)." New Delhi: MOHFW (website). [www.nhm.gov.in/index1.php?lang=1&level=2&sublinkid=818&lid=221](http://www.nhm.gov.in/index1.php?lang=1&level=2&sublinkid=818&lid=221).
- MOHFW. 2021. *National Family Health Survey (NFHS–5) 2019–21: Compendium of Fact Sheets*. New Delhi: MOHFW. [rchiips.org/nfhs/factsheet\\_NFHS-5.shtml](http://rchiips.org/nfhs/factsheet_NFHS-5.shtml).
- MOHFW. 2019. *Rural Health Statistics 2018–19*. New Delhi: MOHFW. [main.mohfw.gov.in/sites/default/files/Final%20RHS%202018-19\\_0.pdf](http://main.mohfw.gov.in/sites/default/files/Final%20RHS%202018-19_0.pdf).
- MOHFW. 2014. *Rashtriya Kishor Swasthya Karyakram Operational Framework: Translating Strategy into Programmes*. New Delhi: MOHFW. [nhm.gov.in/images/pdf/programmes/RKSK/RKSK\\_Operational\\_Framework.pdf](http://nhm.gov.in/images/pdf/programmes/RKSK/RKSK_Operational_Framework.pdf).
- MOHFW. 2007. *Guidelines on Accredited Social Health Activists*. New Delhi: MOHFW. [nhm.gov.in/images/pdf/communitisation/task-group-reports/guidelines-on-asha.pdf](http://nhm.gov.in/images/pdf/communitisation/task-group-reports/guidelines-on-asha.pdf).
- Ministry of Statistics and Programme Implementation (MOSPI). n.d. Homepage. New Delhi (website). [mospi.gov.in/](http://mospi.gov.in/).
- Office of the Registrar General and Census Commissioner, India (Census of India). n.d. *Bihar Population 2011–2022*. New Delhi (website). [www.census2011.co.in/census/state/bihar.html](http://www.census2011.co.in/census/state/bihar.html).



For more information, please visit [www.engenderhealth.org](http://www.engenderhealth.org).