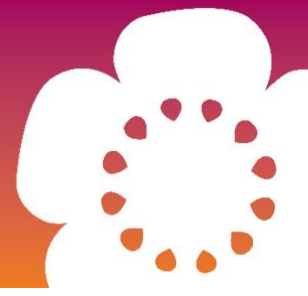


What Adolescents Want: Findings from EngenderHealth's Study of Social Determinants of Adolescent Health and Development in Bihar, India



Background and Context

Development Context in Bihar

Bihar is the third most populous state in India and 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 ages 15 to 19 in Bihar have had a baby or are pregnant, highlighting an unmet need for sexual and reproductive health and rights (SRHR) information and services (MOHFW 2021). There is a notable shortage of health facilities in Bihar (MOHFW 2019) as well as a shortage of secondary and senior secondary schools (MOSPI n.d.). There is also a notable gender gap for completion of secondary school, with only 29% of women in Bihar having completed 10 or more years of education compared to 43% of men (MOHFW 2021). Similarly, Bihar has the lowest literacy rate of women (58% overall, 30% among scheduled caste women) (MOHFW 2021).

EngenderHealth's TARUNYA Project

In 2017, EngenderHealth launched the TARUNYA project in the Sitamarhi district of Bihar with support from the David and Lucile Packard Foundation. This project aims to support the Government of Bihar in strengthening the Ministry of Health and Family Welfare's flagship Rashtriya Kishor Swasthya Karyakram (RKSK) program to improve adolescent health and well-being. Project interventions at the individual, community, and structural levels focus on improving SRHR knowledge and awareness among adolescents. In 2021, EngenderHealth expanded the scope of TARUNYA to two additional districts of Bihar. As a part of this expansion, EngenderHealth commissioned a study to understand the social determinants affect health service utilization equity in Bihar and to determine how the project could better address gender inequality, social inclusion, and adolescent empowerment to maximize project impact. The project held inclusive and participatory consultations with adolescents to better understand the challenges adolescents face and how they want to engage in adolescent health initiatives in their communities.



Adolescent girls participating in health education session

Study and Consultation Overviews

Craft Consultancy conducted a gender, youth, and social inclusion (GYSI) analysis, using a seven-step approach, including 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 24 focus group discussions with adolescents and parents and 44 in-depth interviews with service providers and local influencers. The study team analyzed data based on four dimensions of power across individual, community, and institutional and policy levels to identify gaps and disparities by district and across and within a set of social categories. Professional transcribers familiar with the local context and dialect transcribed and translated the audio recordings. The study team employed Dedoose software to code the transcripts using a content analysis method based on the four dimensions of power defined in EngenderHealth's GYSI Analysis Framework and Toolkit: assets and resources; practices, roles, and participation; knowledge, beliefs, and rights; and legal rights and status. Under each dimension, the team analyzed data across each level of the socioecological model 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).

Summary Findings

Limited Access to Available Services and Facilities

Those living in marginalized villages have limited access to healthcare facilities. Distance to an adolescent-friendly health clinic is a key barrier, especially for girls who experience challenges associated with mobility limitations and unsafe traveling conditions. If the facility is too crowded, adolescents hesitate to access care; and yet, girls also mentioned feeling unsafe accessing care from facilities that they consider too secluded or remote. Girls also reported being uncomfortable discussing personal issues with male counselors, mentors, or doctors; thus, the lack of female providers is another major barrier for girls.

"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."

Peer Educator, Gaya

Adolescent girls face similar mobility issues in accessing education services. When schools were closed due to COVID-19, boys' education continued via private tuition and coaching centers and digital learning, but girls were less able to take advantage of these resources.

Skewed Expectations and Biased Divisions of Responsibilities

Adolescents are unable to prioritize learning about or accessing sexual and reproductive health (SRH) care due to other responsibilities and priorities. Girls generally bear responsibility for household chores while boys are allowed time for studying and engaging in income generating activities. Parents believe girls should prioritize learning domestic

"We focus on our son's education so 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

skills to prepare for marriage, whereas boys should prioritize learning income generating skills so they can earn money for the family.

Social Norms related to SRHR

Health is not a priority for adolescents and parents do not believe children should have access to SRHR information, as they fear learning about SRHR will encourage premarital sex. Community taboos and stigma among parents prevent adolescents from accessing SRHR information from knowledgeable sources. Adolescents are discouraged from discussing SRHR openly and premarital sex is strictly forbidden. Girls who engage in such discussions are considered bad influences, those who interact with boys are labeled as promiscuous, and those who engage in premarital sex risk family honor if they are caught.

“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

Within the health system, community health workers, known as accredited social health activists, and auxiliary nurse midwives are hesitant to discuss SRH with adolescents due to stigma. Further, adolescent boys feel uncomfortable approaching community health workers and auxiliary nurse midwives, who are all women.

Prevalence of Early and Forced Marriage

Girls are viewed as burdens, as they do not earn incomes and are financial drains on their families (for food, education, and dowry); thus, parents are eager to have their daughters marry. Difficulties in finding a suitable match for older girls and social stigmas associated with unmarried women of marriageable age prompt parents to marry their daughters early. Families from lower economic strata and those with multiple daughters feel additional financial pressure to marry their daughters as soon as possible. Those who want to choose their own spouse must elope; however, girls who elope are shunned and no longer receive support from their parents or communities. This is another reason parents marry daughters early—to prevent them from choosing a match and eloping.

Recommendations

Several recommendations for improving health and development outcomes for adolescents emerged from our study.

- ❁ **Improve agency among adolescent girls.** Adolescent girls experience more challenges in accessing health and education resources than adolescent boys, including challenges related to mobility, roles and responsibilities, and social norms and expectations. Therefore, targeted interventions for improving girls' agency and self-efficacy are critical.
- ❁ **Deliver gender-inclusive, age-appropriate services.** Providers must be sensitized to the specific needs of adolescent girls and boys to ensure SRH services are age-appropriate and gender-inclusive. Establishing a cadre of male community health workers could help meaningfully engage adolescent boys but requires funding and support from the state level.

- ❁ **Engage parents and other gatekeepers.** Parents are gatekeepers for adolescents and must be engaged in designing and implementing SRHR initiatives to ensure they will support adolescents' participation. Similarly, elder brothers often assume positions of power over their younger siblings and can serve as enablers or barriers to adolescent health and well-being.
- ❁ **Strengthen the peer education approach.** Peer educators can play an important role in reaching and relating to adolescents but require support—both from service providers and gatekeepers—to be able to combat social stigma and perform their duties effectively.
- ❁ **Support integrated health and development initiatives.** Comprehensive programs that integrate health education and care with vocational skills and career counseling programs may be more appealing to adolescents. Similarly, programs that incorporate exercise and fitness, games, and sports, could keep adolescents interested in programming longer.
- ❁ **Use technology to reach to adolescents.** Leverage available technology, such as WhatsApp groups and telemedicine for consultations, to mitigate access barriers associated with mobility constraints and social stigma.

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