International Journal of Technical Research and Applications e-ISSN: 2320-8163,
www.ijtra.com Special Issue 24 (July, 2015), PP. 23-28

HEALTH SEEKING BEHAVIOR AMONG ADOLESCENT STUDENTS IN COASTAL DISTRICT OF SOUTH INDIA

***Abstract*— Objectives: The study was designed to assess the socio-demographic profile, to determine the health seeking behavior and to elicit the socio-demographic factors associated with health seeking behavior among adolescents.**

Methods: The study was a Community based Cross sectional study, carried out during May-June, 2014 among 440 adolescent students studying in 8th, 9th and 10th std at two public & two private High Schools at Mangalore (India). A Pre designed, semi structured questionnaire was used as the tool for data collection. Approval from Institutional Ethics Committee (IEC) & the concerned school authorities were obtained, followed by self-administration of questionnaire and data analysis.

Results: The mean age of our study population of 440 students, was found to be 14.74 with standard deviation of 1.365. 67.3% (34.3% males & 33% females) had various Physical issues and 21.1% population suffered from psychological problems. For the various issues, 47.3% adolescents seek help from their parents, while 39.5% from doctors. 29.8% students considered inconvenient timings as the major hindrance in seeking health care followed by family's perception and lack of privacy in the clinics. 90% of the study population was unaware of the SNEHA clinics run exclusively for adolescents in Karnataka, India.

Conclusion: Unawareness regarding adolescent clinics remained the main focus of our study that emphasized on the fact that newer outreach innovative interventions may be needed to create a sustained demand for services. Further work-up is needed in the field of adolescent health services and made available to them from the ground level itself. The focus must be to make them aware of various health-care facilities for their various problems and issues.

***Index Terms*— Health Seeking Behavior, Adolescents, Students, India**

I. INTRODUCTION

Transition to 'adulthood' from 'childhood' i.e. 10–19 years of age) is Adolescence. The National Population Policy-2000 has recognized adolescents as undeserved vulnerable group in need of health information and services for their betterment. [1] In the WHO South-East Asia (SEA) Region, they constitute 22% of the total population (around 350 million). According to UNICEF, adolescents constitute 21.4% of total Indian population. They are exposed to various risks and vulnerabilities, regarding physical, mental, social and reproductive health.[2] [3] In order to solve their problems, they seek help from family, friends, councilors, primary health centers like SNEHA clinics and ARSH program (Adolescent Reproductive and sexual health) has been introduced in India under RCH-2 programme in 2005.

Every year 2.6 million adolescents die due to preventable causes, maximum (97%) in low & middle socio-economic countries. The causes of death among adolescent girls include irregular menstruation, premature abortion, sepsis etc., whereas among boys, injury-related deaths are the leading causes of deaths in the SEA Region.[4]

There are various barriers mainly in the developing world that prevent poor households from seeking health care such as socio-cultural, lack of knowledge & awareness, financial, distance and language. These barriers lead to low demand for and use of services by affecting all age groups, leading to increased morbidity and mortality among poor [5]. The most fundamental concern is that they either deny or are unaware of problems in him or her. Other reasons include previous unsatisfactory contacts with professional caregivers, cultural attitudes, issues of confidentiality, a belief that nothing or no one can help, lack of knowledge, stigma, embarrassment and socialization. [6] [7]

.

These illnesses impair cognitive development, school attendance and learning capabilities of a child. [8] [9] [10] For these reasons, an important challenge in global health today is to decrease the barriers and increase the availability of child and adolescent health resources. With this background in mind, the current study is designed to determine the various health seeking behaviors among adolescents, since they're most likely to adopt and follow positive health measures in later life. Different socio-demographic factors also tend to have significant influence on the health-seeking behavior of the adolescents. In this study, various socio-demographic factors, health seeking behavior and barriers in seeking health would be determined.

II. MATERIALS AND METHODS

The present Community based Cross sectional study was set up in Mangalore which is the chief port city located in south western Karnataka, lies between the Arabian Sea and the

Western Ghats mountain ranges in India. The study population included adolescent students studying in 8th, 9th and 10th std at various High Schools, which are enrolled under our college for annual school health examination. Taking adequate health seeking behavior among adolescents to be 50% based on assumption, 10% as relative precision and 95% confidence interval, the sample size was found to be 400. Adding 10% as non-response error, the sample size to be studied was 440. Around 15 high schools are enrolled under our college for annual school health examination. After stratifying the schools into public and private sector, four schools were selected taking two schools from each stratum. 110 students from each school i.e. 36 students studying each in 8th and 9th and 38 students in 10th std. were selected randomly. Equal number of boys and girls were selected randomly from each class. Institution Ethics Committee approval was obtained prior to the commencement of the study and permission was obtained from the concerned school authorities. Class teachers of high school were explained about the purpose and importance of the study. Written Informed Consent was obtained from the parent of the study participant after explaining the purpose of the study. This was followed by data collection through self-administration of pre tested, semi structured questionnaire. The questionnaire contains demographic related information, information pertaining to perception & source of information regarding health seeking behavior, practices followed by them, barriers faced by them in the past 12 months. The questionnaire also includes information regarding mental health, social behavior and health facilities available in their locality. The details obtained were entered and analyzed using Statistical Package for Social Sciences (SPSS) version 11.5. Descriptive statistics like mean, proportions and standard deviation were used for expressing the results. For qualitative data, Chi square test was used and *P* value <0.05 was considered statistically significant.

III. RESULTS

A total of 440 adolescents were selected from class 8-10 of the mentioned public and private sector schools. In Table 1, Out of 440 students, 50.9% students were under the age group of 14-15 years followed by 27.8% of 16-17 years. The mean age for our study population was found to be 14.74 with standard deviation of 1.365.

Table 2 shows various socio-demographic profile of 440 students, out of which 397 adolescents i.e. 90.2% lived in Urban area, while rest in Sub-urban and rural areas. Hindus constituted of 65.5% of our study population followed by 27% Muslims. When asked about Father's education status, 43.4% studied till P.U.C, while 5.9% were illiterate. 31.4% of the mothers studied till P.U.C, 11.8% were illiterate and 7.7% studied till graduation. 39.3% of fathers were Professionals by occupation while 27.5% were unskilled workers. 67.3% of mothers of the study population were unskilled workers mainly home-makers.

Table 3 shows information about various health issues that adolescents faced in the past 12 months i.e. correlation between the sex and various health issues faced by them. 67.3% students had various Physical issues like cough, cold, pimples, weight loss/gain, headache, bodyache, etc, out of which 34.3% were male & 33% were females. 21.1% of the total study population had Psychological problems like anxiety, depression, sleep deprivation etc. Sexual problems were faced only by male i.e. 0.7% students, while 0.9% of the boys had issues related to alcohol, smoking and drugs.

Table 4 shows health-care-seeking behavior of 440 students in the last 12 months. For various physical issues, 47.3% adolescents seek help from their parents, while 39.5% from doctors. 10.2% adolescents took help from their parents, 6.4% of people had self-medication for the psychological problems they faced. For social & relational problems, maximum students went to their friends to sort out the issue while for sexual problems, self-medication was the preferred choice.

29.8% students considered inconvenient timings as the major hindrance faced by them in order to seek health care, while issues about family/friends perception, embarrassment/privacy were other main barriers faced by the students as shown by table 5.

Table 6 shows the knowledge and practice of adolescents related to health seeking behavior. 94.5% adolescents took medical help whenever they had any problem, while 1.8% people rarely go to any doctor for their issues. Maximum students i.e. 85.5% didn't avoid going to clinics for their problems. Regarding awareness, 84.6% students didn't know about separate adolescent clinics and 88.6% had never heard about SNEHA clinics. 47.7% adolescents didn't want any changes in the present health care system for adolescents, while 16.1% wanted changes in the health care system.

IV. DISCUSSION

Adolescents are a part the care of pediatricians; they have several types of health needs and concerns that cannot be fully met within the adult-oriented care system. Adolescents end up facing a lot of problems those can be dealt only by Adolescent friendly heath care system. In our study, maximum i.e. 67.3% students had various Physical issues like cough, cold, pimples, weight loss/gain, headache, bodyache etc. This result regarding Physical issues is also favored by a cross-sectional study by H.A. El Kahi et al [11] done in Lebanon. Only 21.1% of adolescents had psychological issues as contradicted by a high proportion i.e. 57.2% students in the Lebanese study. 1st

& 2nd semester University students being the study group are vulnerable to various psychological issues as opposed by the study group in our research being 8th to 10th standard school students. Sexual problems were faced only by 0.7% students, while 0.9% had issues related to alcohol, smoking and drugs. Similar low frequency of sexual issues and substance abuse concerns was found in a study conducted among Chinese school students [12] whereas a high proportion was reported in North American and western countries [13] and may in part be explained by the different cultural construct in India, or in China, with regard to such sensitive issues that are considered taboo in India and are thus less openly discussed. Additionally, adolescents tend to underestimate the health risks associated with tobacco and alcohol, and with risky sexual practices; hence need for seeking health services isn't realized by the adolescents.

Faced with different sorts of health concerns i.e physical problems, the young people surveyed tended to seeking help mainly from their peers and other sources of informal help i.e. parents/relatives/self-medication, followed by formal (doctors/health workers). This was also shown in other studies conducted elsewhere [14,15,16]. Our participants particularly showed informal health-care-seeking behavior when it came to psychological, relational and addictive substances issues. Furthermore, they were more likely to forego care for these categories of problems, a tendency that has also been found in a study conducted at Florida [17].

It is also worth noting that when young people sought informal relational help, the choice of the person approached depended on the nature of the health concern. Young people went to their parents when they had physical problems. They were more likely to go to friends for social & relational problems. These observations are similar to results found in Chili [18] and Lebanon [11]. In Switzerland, recourse to family was first in terms of physical problems and to friends for psychological problems [19], whereas adolescents went to their parents for most of the problems in our study.

The common barriers to care reported by our students are inconvenient timings, worry over people's perception, lack of privacy etc., that is similar to those reported in other studies too [19-22], suggesting that these are universal and transcend geographical differences. The majority cited both accessibility and relational barriers. Accessibility and transportation was not a major barrier in the study conducted in Lebanon [11] as contradicted to our study where it is the most important barrier regarding health seeking. This finding indicates that in India there is a need to reassure young adults coming in contact with formal care and to provide more intimacy and certainty of confidentiality than usually provided to adult patients, since young minds tend to be more shy and concerned about their privacy as compared to adults.

Need of Adolescent friendly health services those are involved in Programme design and feedback, properties including short waiting times, affordable fees, trained and empathetic staff on adolescent issues, respect for adolescent, maintains privacy and confidentiality, adequate time for client and provider interaction; is on high demand with respect to the various health issues faced by adolescents. For this, states have various clinics named as 'Maitry' in Maharashtra, 'UDDAN' in Uttarakhand, 'SNEHA' in Karnataka and so on. . These clinics provide routine check-ups at primary, secondary and tertiary levels on fixed days and time to adolescents, married and unmarried, girls and boys during the sessions. When asked about these clinics, around 90% of the adolescents were unaware about the existence of the clinics. Effective implementation of policies and programmes has progressed from the past few years and has led to strengthening of Adolescent Friendly clinics and subsequently the outreach programmes, but still this becomes ineffective since people are unaware of the clinics, their days, timings, services provided and their benefits over general clinics.

V. RECOMMENDATIONS

Unawareness regarding adolescent clinics remained the main focus of our study that emphasized on the fact that newer outreach innovative interventions may be needed to create a sustained demand for services. Further work-up is needed in the field of adolescent health services and made available to them from the ground level itself. The focus must be to make them aware of various health-care facilities for their various problems and issues. There should be an adolescent health education cell for the students to address the issues of adolescent problems. Identification of various problems faced by the adolescents as well as the spectrum of barriers faced by them need to be done at an early stage mainly by the parents and teachers, in order to make an early treatment availability. Incorporating health issues as a part of education, access to health services, correct knowledge about various health seeking activities will lead to improvement in their physical, mental, social and reproductive health and spread of awareness among them.

REFERENCES

1. Department of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India: National Population Policy. 2000. [online](URL:http://mohfw.nic.in/index3.php?lang=1&level=1&linkid=944&deptid=24) Accessed on 27th January, 2014.

2. Menna R, Ruck M. Adolescent Help-Seeking Behaviour: How Can We Encourage It? *Guidance & Counselling*. 2004;19(4): 176-83.
3. Rickwood DJ, Braithwaite VA. Social psychological factors affecting help seeking for emotional problems. *Soc Sci Med.* 1994;39(4):563-72.
4. Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, et al. Global patterns of mortality in young people: a systematic analysis of population health data. Lancet. 2009;374:881–92.
5. Kessler RC, Brown RL, Broman CL. Sex differences in psychiatric help-seeking: evidence from four-large scale surveys. J Health Soc Behav. 1981;22(1):49-64.
6. John BN, Chauhan SL, Donde UN, Tryambake VH, Gaikwad NS, Bhadoria V. Reproductive health problems and help seeking behaviour among adolescents in urban India. Indian J Pediatr 2006; 73: 509–513.
7. Barker G. Adolescents, social support and help-seeking behaviour. WHO; 2007. [online] (URL: http://www.who.int/maternal_child_adolescent/documents/9789241595711/en/) Accessed on 27th January, 2014.
8. Balasz et al 1986 and Pollitt 1997 and 2001. In: Alleyne G, Cohen D. Chairs, Health, economic growth, and poverty reduction.
9. Mendez M, Adair L. Severity and timing of stunting in the first two years of life affects performance on cognitive tests in late childhood. J of Nutr, 1999;129:1555-62.
10. Filipino report card on pro-poor services: summary. World Bank, Environment and Social Development Unit, East Asia and Pacific Region. World Bank; 2001. [online](URL:http://www.worldbank.org/socialaccountability_sourcebook/Thematic_SectorAppl/PEM/pem_5.html) Accessed on 27th January, 2014.
11. Afolabi, M. , Daropale, V. , Irinoye, A. and Adegoke, A. (2013) Health-seeking behaviour and student perception of health care services in a university community in Nigeria. *Health*, 5, 817-824. doi: 10.4236/health.2013.55108.
12. Hesketh T, Ding QJ, Tomkins AM. Health and health careseeking behavior of adolescents in urban and rural China. *Journal of Adolescent Health*, 2003, 33:271–274.
13. Coiro MJ, Zill N, Bloom B. Health of our nation's children. *Vital and Health Statistics*, 1994, (191):1–61.
14. Pommier J et al. Self-reported determinants of health service use by French adolescents. International Journal of Adolescent Medicine and Health, 2001, 13:115–129.
15. Booth ML et al. Access to health care among Australian adolescents young people's perspectives and their sociodemographic distribution. Journal of Adolescent Health, 2004, 34:97–103.
16. Pommier J et al. Attitudes à l'égard des soins formels et informels : comparaison d'adolescents français et chiliens [Attitudes regarding the delivery of formal and informal care: comparison of French and Chilean adolescents]. *Santé Publique*, 2002, 14:371–387.
17. Zimmer-Gembeck MJ, Alexander T, Nystrom RJ. Adolescents report their need for and use of health care services. *Journal of Adolescent Health*, 1997, 21:388–399.
18. Florenzano-Urzua R. *El adolescente y sus conductas de riesgo* [*Adolescent risk behaviour*]. Santiago, Ediciones Universidad Catolica de Chile, 1997.
19. Michaud PA et al. Recherche romande sur la santé des adolescents de 15 à 20 ans [Health survey of 15–20-year-old adolescents in French-speaking Switzerland]. *SchweizerischeMedizinische Wochenschrift*, 1993, 123:1883–1895.
20. Elliott BA, Larson JT. Adolescents in mid-sized and rural communities: foregone care, perceived barriers, and risk factors. *Journal of Adolescent Health*, 2004, 35:303–309.
21. Klein JD, McNulty M, Flatau CN. Adolescents' access to care: teenagers' self-reported use of services and perceived access to confidential care. *Archives of Pediatrics & Adolescent Medicine*, 1998, 152:676–682.
22. Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. *JAMA: Journal of the American Medical Association*, 1999, 282:2227–2234.

Table 1: Students of various age groups in different class. (N=440)

Age / Class->	8th	9th	10th	Total
12-13	71 (16.1)	15 (03.4)	0	086 (19.5)
14-15	70 (15.0)	91 (20.6)	63 (14.3)	224 (50.9)
16-17	03 (00.6)	38 (08.7)	81 (18.5)	122 (27.8)
18-19	0	0	08 (01.8)	008 (01.8)
Total	144	144	152	440

Table 2. Socio-Demographic Data of adolescents in coastal district of India. (N=440)

Socio- Demographic Data	Variable	n (%)
Home Place	Urban	397 (90.2)
	Sub-urban	026 (05.9)
	Rural	017 (03.9)
Religion	Hindu	288 (65.5)
	Muslim	119 (27.0)
	Christian	032 (07.3)
	Others	001 (00.2)
Education Status of Father	Illiterate	026 (05.9)
	Primary School	070 (15.9)
	Middle & High School	117 (26.6)
	P.U.C	191 (43.4)
	Graduation	036 (08.2)
Education status of Mother	Illiterate	052 (11.8)
	Primary	088 (20.0)
	Middle & High	128 (29.1)
	P.U.C	138 (31.4)
	Graduation	034 (07.7)
Occupation of Father	Unskilled	121 (27.5)
	Semi-skilled	097 (22.0)
	Skilled	049 (11.1)
	Professional	173 (39.3)
Occupation of Mother	Unskilled	296 (67.3)
	Semi-skilled	055 (12.5)
	Skilled	002 (00.5)
	Professional	087 (19.8)
Monthly Income of Family	<1500	053 (12.5)
	1500-10000	118 (27.9)
	10000-50000	113 (26.7)
	50000-1lacs	139 (32.9)

Table 3: Health Issues faced by the adolescents in past 12 months. (N=440)

Problems	Males (n=220)	Females (n=220)	*P*-value
Physical	151 (68.5)	145 (65.8)	0.281
Psychological	047 (21.4)	046 (20.9)	0.907
Social & Relational	013 (05.9)	017 (07.7)	0.049
Sexual	003 (01.3)	0	0.082

Table 4: Health-care-seeking behaviour in the last 12 months among adolescents. (N=440)

Issues	Parents	Brother -Sister	Other Relative	Friends	Self-Medication	Doctor	Health worker	Teachers	Others
Physical	208 (47.3)	072 (16.4)	011 (02.5)	016 (03.6)	024 (05.5)	174 (39.5)	010 (02.3)	008 (01.8)	015 (03.4)
Psychological	045 (10.2)	010 (02.3)	004 (00.9)	014 (03.2)	028 (06.4)	010 (02.3)	0	005 (01.1)	006 (01.4)
Social & Relational	011 (02.5)	005 (01.1)	004 (00.9)	017 (03.9)	014 (03.2)	002 (00.5)	001 (00.2)	006 (01.4)	007 (01.6)
Sexual	002 (00.5)	0	002 (00.5)	001 (00.2)	005 (01.1)	002 (00.5)	001 (00.2)	004 (00.9)	005 (01.1)
Drugs, Alcohol & Smoking	0	0	0	0	0	0	0	0	0

Table 5: Barriers to accessing formal health-care-seeking behavior in the last 12 months. (N=440)

Barriers in seeking health-care	n (%)
Lack of privacy/Embarrassment	053 (12.0)
Inadequate knowledge about the health services	050 (11.4)
Cost factor	041 (09.3)
Worry over friend's/ family's perception	062 (14.1)
Transportation problems	046 (10.5)
Consent from parents	052 (11.8)
Inconvenient timings	131 9.8)

Table 6: Knowledge and Practice regarding Health seeking among adolescents.(N=440)

Knowledge & Practice	Variable	n (%)
Frequency of Seeking Medical Help	Weekly	002 (00.5)
	Monthly	013 (03.0)
	Yearly	001 (00.2)
	Whenever required	416 (94.5)
	Rarely	008 (01.8)
Avoid Clinics	Yes	068 (14.5)
	No	376 (85.5)
Aware of Clinics exclusively for Adolescents	Yes	068 (15.5)
	No	372 (84.6)
Awareness about SNEHA clinics	Yes	050 (11.4)
	No	390 (88.6)
Need any modifications in Health Care system for Adolescents	Yes	071 (16.1)
	No	210 (47.7)
	Don't know	159 (36.1)