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Barriers to Access Health Care Services among Rural Adolescent Girls in Raina I Block, Purba Bardhaman, West Bengal

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Abstract

Adolescence in girls is a crucial transition phase during which they experience biological and psychological changes along with changes in social outlook. This phase provides an opportunity to lay the foundation for their future health. But, in rural areas, adolescent girls are often deprived of better nutrition and proper health care guide, resulting in serious health issues like malnutrition, stunting, wasting, and anaemia. Moreover, their access to health care services is subjected to various constraints as infrastructural and societal barriers such as regressive norms, social stigma, gendered family structure, etc. Thus, the present study attempts to explore the perceived barriers that prevent rural adolescent girls from accessing health care services at the micro-level. A community-based cross-sectional study was carried out after randomly selecting 120 adolescent girls in the age cohort of 10-19 years in the Raina-I block of Purba Bardhaman district. The results suggested that societal barriers have a significant influence over health-related decision making. Besides, lack of quality health care services and economic burden are some of the other significant obstacles observed here.

Keywords: Adolescent Girls; Health Care Services; Social Barrier; Social Stigma; Malnutrition; West Bengal; India

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Introduction

Adolescence is regarded as a transitional period of development from childhood to adulthood characterised by rapid physical, emotional and social changes (Singh et al., 1999; Sulakshana et al., 2012). World Health Organization (WHO) considers the age bracket of 10-19 as adolescence. This period is crucial also because adolescent girls attain about half of the adult body weight during this phase (Narzary, 2018; Omigbodun et al., 2010). Thus, adolescence in girls provides an opportunity to lay the foundation of their health and the health of the future offspring that they will reproduce (Abuosi & Anaba, 2019; Mboweni & Sumbane, 2019).

According to Census, 2011, there are 253 million adolescents in India, constituting 21.3 % of its total population. The adolescent population to total population in the rural area is 21.7, which is relatively higher than its urban counterpart. The proportion of male and female adolescents to the total adolescent is 52.7 and 47.3 per cent, respectively. The healthy development of these adolescent populations is trapped energy for a developing country like India. Although the governments have undertaken various schemes and programs for adolescents, these are not targeted holistically and are badly implemented.

Barriers to accessing health care facilities denote the factors that restrict the reach and access of the health care facilities in case of getting ill or as a measure to prevent illness (Aalsma et al., 2016; Chauhan et al., 2015). These barriers are controlled by many factors like lack of freedom to take independent decisions, societal and family norms, etc. (Abuosi & Anaba,2019; Omeire, 2017; Singh et al., 1999). Generally, adolescent girls with self-reported mild symptoms do not seek treatment because of the prevalent stigma and taboos related to their sexuality (Lim et al., 2012; M. L. & Ahmed, 2017). They find it difficult to disclose health ailments due to shame and embarrassment (Mboweni & Sumbane, 2019). These psycho-social barriers act as a significant determining factor in moderating the health-seeking behaviour of adolescent girls (Fuentes et al., 2018; Narzary, 2018). Thus, understanding the barriers to health care facilities is of immense importance to make health care policies more responsive and oriented (Thongmixay et al., 2019). Against this backdrop, the study explores the potential challenges that impede the access and utilisation of health care facilities by the rural adolescent girls in the Raina-I Block of Purba Bardhaman district of West Bengal. The study begins with an introduction presenting the brief context and the outlook of the study. It is followed by a comprehensive literature review that brings the major concepts, trends, and the nature of the research related to adolescent health. A detailed account of the study area and the methodological frame has been presented after that. The different form of barriers is identified and explained by incorporating the results from the field study. Finally, a conclusion has been drawn based on the findings of the study.

Literature Review

The contemporary researches on the health of adolescent girls in developing countries have primarily focused on reproductive and sexual health and the nutritional aspects such as malnutrition, stunting, wasting, anaemia and so on(Geary et al., 2014; Mboweni & Sumbane, 2019; Omigbodun et al., 2010; Thongmixay et al., 2019). However, there is a dearth of subjective studies concerning behaviour, attitude, values, etc., which significantly determine health outcomes (Hayrumyan et al., 2020; Lim et al., 2012; Thongmixay et al., 2019). Rural adolescent girls of developing countries like India face an added burden of the societal image concerning their sexuality (Chauhan et al., 2015; M. L. & Ahmed, 2017; Ravi & Kulasekaran, 2014; Sulakshana et al., 2012). The health needs of girls are often paid no heed because it is thought to be something personal to the girls (Aalsma et al., 2016; Mehta et al., 2013). The sheer magnitude of this psycho-social barrier in accessing health needs calls for a serious intervention on multiple fronts.

Poor health is the most prevalent concern among adolescent girls. Poor health during adolescence perpetuates the cycle of poverty

with retarded working efficiency and reinforces the intergenerational under-nutrition (Coker et al., 2010). Hence, the appraisal and redressal of the health issues of adolescents in general and girls in particular are very important for their healthy development (Mboweni & Sumbane, 2019). However, the health need of adolescents is often overlooked because they are believed to be a healthy group (Abuosi & Anaba, 2019; Mehta et al., 2013). Although some of the morbidity and mortality among adolescent girls are hereditary, many are due to preventable causes (Aalsma et al., 2016; Coker et al., 2010). Preventive care of adolescents provides an opportunity to receive information, guidance and counselling related to the health conditions (Mehta et al., 2013). However, the growing adolescent girls do not have adequate and proper knowledge about the physical changes that take shape during this phase (Aalsma et al., 2016; Ray et al., 2011). This renders them vulnerable to various reproductive and sexual diseases like Reproductive Tract Infection (RTI) which have long term implications (Fuentes et al., 2018; M. L. & Ahmed, 2017; Singh et al., 1999).

Adolescent girls in rural areas in particular face dual vulnerability of increased health risks due to prevailing illiteracy, poverty, and restricted societal structure on the one hand and the acute lack of facilities on the other (Chauhan et al., 2015; Geary et al., 2014; Omeire, 2017). There are innumerable prejudiced traditions and regressive customs such as child marriage, dowry, illiteracy, and violence of various forms (Mehta et al. 2013; Singh et al., 2010). In such situations, the health issues of adolescent girls are often enveloped by social stigma and taboos (Fuentes et al., 2018; M. L. & Ahmed, 2017). Furthermore, gender discrimination is conspicuously prevalent in rural societies (Chauhan et al., 2015; Omeire, 2017). Their health needs are often paid less heed and are less likely to be taken to health facilities than boys (Ravi & Kulasekaran, 2014). This ignorant attitude towards girls is due to the various social, economic and religious cause, which includes old age security, financial support, concern for dowry, the security of girl child, property inheritance etc. (Singh et al., 2010; Sulakshana et.al, 2012).

Healthy development and the overall well being of adolescents can be ensured by promoting access to health care facilities (Abuosi & Anaba, 2019; Hayrumyan et al., 2020). It is important not only for the treatment of diseases rather, it may ensure disease prevention, detection at an early stage, and overall better quality of life (Hayrumyan et al., 2020). However, adolescents girls are often deprived of or do not seek health care on time (Abuosi & Anaba, 2019; Singh et al., 1999). The factors responsible for limiting access to health care facilities are lack of health infrastructure, lower awareness level, poor economic background, etc. Some of these barriers are *structural or organisational* in nature, including the unavailability of health care services and personnel, long travelling distances to get health services, etc. (Hayrumyan et al., 2020; Geary et al., 2014). The health facilities in developing countries like India are primarily constrained by such inadequacies and limitations (Ravi & Kulasekaran, 2014; Sulakshana et al., 2012). Even though there have been rapid strides in providing basic and primary health care in last two decades but the rural population is still not getting proper health care (Mehta et al., 2013). This is partly due to the unavailability of health infrastructure like Primary Health Centers (PHC), lack of health personnel, etc. and partly due to the concentration of the secondary and tertiary health facilities in the urban pockets (Khapre et al., 2019). Besides, affordability of recommended medications, waiting time before the consultation, inadequate equipment of facilities influence the health-seeking behaviour in rural areas (Ravi & Kulasekaran, 2014; Omeire, 2017). The quality of available health care services plays a significant role in promoting the health-seeking behaviour of adolescent girls (Mboweni &Sumbane, 2019). It refers to making the health services equitable, accessible, acceptable, appropriate and effective for them (Geary et al., 2014; Lim et al., 2012). Quality health care can be ensured by providing health literacy and awareness, community support, competencies of the health personnel, equity

and non-discrimination and adolescent's participation. It is obvious that the majority of the barriers that they face could be resolved by provisioning an appropriate and quality health care system (Hayrumyan et al., 2020).

Organisational or structural constraints do not always control barriers to accessing health services; rather, sometimes, the psychological or perceived barriers are even more influential (Aalsma et al., 2016; Narzary, 2018). These perceived barriers arise either from the societal values imparted to them or from their limited exposure to the knowledge they have (Fuentes et al., 2018). Sometimes, the barriers that adolescent girls believe to be insurmountable may, in fact, not exist in reality or exist in a less severe form (Abuosi & Anaba, 2019; Singh et al., 2010). Furthermore, the *type and severity* of the ailments exert an influence on the choice of accessing health services. Generally, people tend to avoid health services in rural areas when their sickness is mild and less severe. Instead, they resort to self-medication, home remedies or herbal medication, which may sometimes prove detrimental to their health. Only when their symptoms take severe form are pushed to more specialised treatment (Uche, 2017). The *societal stigma* related to the sexuality of adolescent girls stands as the significant psychological barrier in expressing their health needs. Therefore, they are not supposed to discuss openly the issues related to menstruation. As a consequence of this barrier, it often lacks a sound knowledge of menstrual problems (Ray et al., 2011). This affects them immensely as they go on suffering the health problem silently without seeking treatment. Ignoring the health needs in this manner may sometimes aggravate in the form of more serious morbidities (Mboweni & Sumbane, 2019; Narzary, 2018). Thus, the cultural values, attitudes and behaviours significantly moderate the identity of the adolescent girls (Lim et al. 2012; Thongmixay et al. 2019). This subjective sense of culture propels powerlessness, discrimination and prejudice (Singh et al. 2010). Consequently, they hesitate to disclose their health problems.

In rural areas, sociological factors such as economic condition, education, gendered family structure, etc. act as the significant limiting factors to access health care services (Geary et al., 2014; Hayrumyan et al., 2020; Ray et al., 2011). The poor *economic condition* undeniably hinders the prospects of health care seeking. The poorer peoples are reluctant to get health care facilities because their priority is to quench their hunger. Hence, they tend to delay seeing treatments if the symptoms are mild or treatment is costly and time-consuming, impacting their out-of-pocket expenditure (Sulakshana et al., 2012). Moreover, more often than not, the rural areas are devoid of quality specialised health facilities, compounding economic vulnerabilities. The *educational background* of the families determines their knowledge and awareness about the health issues (Singh et al., 2010; Uche, 2017). They are more informed about the health option available at their disposal and tend to avoid resorting to unscientific traditional orthodox treatments such as consulting exorcists (Omeire, 2017). The appraisal and redressal of these barriers that affect the healthcare-seeking behaviour are quintessential to making the care system more oriented and responsive.

The Study Area

Raina-I is the southernmost Community Development (CD) Block in the Purba Bardhaman district of West Bengal State. It is part of the Bardhaman Sadar South Subdivision. Shyamsundar is the head-quarter of this CD Block (Figure 1). It covers an area of 266.07 sq. Km and has a population density of 612 persons /sq. Km (Census, 2011). The capital city of the state, Kolkata, is within reach of 100 km. According to the Census of India 2011, the total population in the block is 173094 persons, out of which 51.1% are males, and 48.9% are females. The region has a sex ratio of 958 and a literacy rate of 80.21%, which are fairly above the national as well as the state average. Hindus (70.72%) and Muslims (28.43%) are the two major communities in terms of religion. The occupational structure of the region comprises the agricultural labourer (51.83%), cultivator

(18.11%), household industry (1.84%) etc. (Census, 2011).

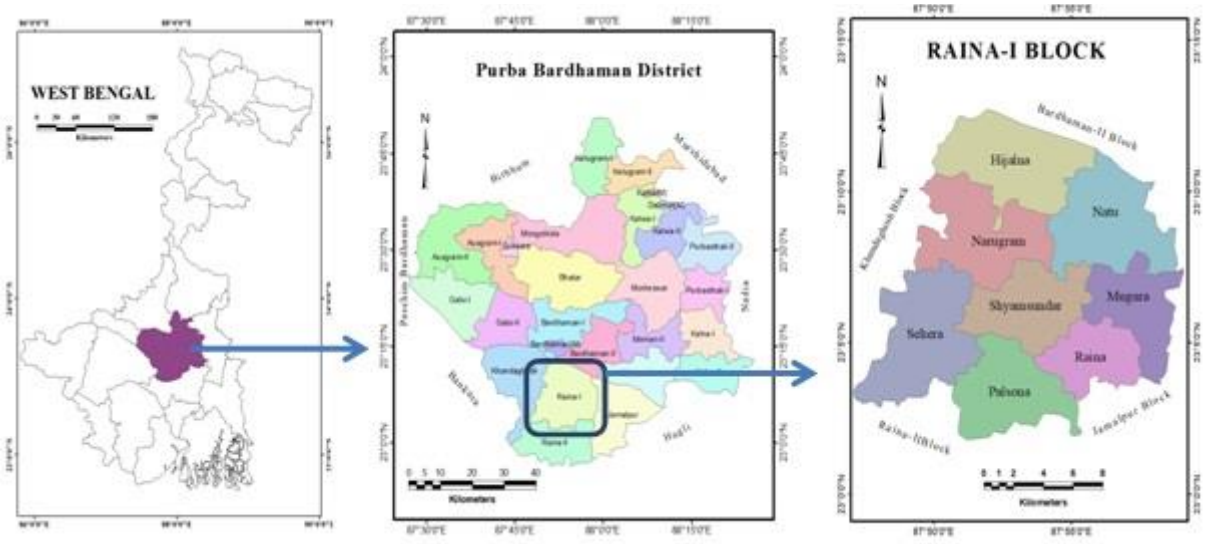

Figure 1: Location of the Study Area
Source: Prepared by the Authors

Methodology

This work is a community based exploratory study for which a sample of 120 adolescent girls of 10-19 age groups has been taken randomly from two villages of Palasan Gram Panchayats, which comes under Raina-I Block. The participants were approached household wise with a semi-structured questionnaire. The questionnaire was framed in the English language; however, the questions were asked in the Bengali language during the interview. The researchers administered the questionnaire schedule. The questions consisted of demographic attributes, socio-economic status, perceived physical and psychological barriers, etc.

Health-Care Facilities in the Region

The available health care in the region comprises governmental as well as private facilities. The government facilities of the first resort are Community Health Centre, Primary Health Centre and Sub-Centre, etc (Table1). However, the nearest town Burdwan serves as the destination for secondary and tertiary care. There are facilities of alternative medicine as well which comprise of Homeopathy, Ayurveda, etc. To fill the gap posed by the lack of governmental facilities, numerous private health care facilities have proliferated in the region. Unfortunately, there is a preponderance of medical practitioners without an MBBS degree or even no degree and traditional faith healers. This highlights the lack of quality primary health care facilities in the absence of which the people seek to rely on such unscrupulous treatment.

Socio-Demographic Profile of the Respondents

A sample of 120 adolescent girls was considered for this study. The respondents belonging to age group 10-14 years and 15-19 years were 42 (35%) and 78 (65%) respectively. The mean age of the respondents was 15.7 years. 60 (50%) of the adolescent girls have studied or are studying in 10th Standard whereas around 12% of the respondents had either primary or no education at all. Most of the adolescent girls in the study were school-going (82.3%) and were unmarried (76.67%). The adolescent girls in the study predominantly belonged to the nuclear family (60.83%). The modal family size of the studied sample households was 5-8 (60%) however; smaller family (29%) is also prevalent significantly. Hinduism (86.67%) is the predominant religion among the participants whilst Islam (13.33%) is the second major religion (Table 2).

Table 1: Health Care Facilities in the Region	
Health Facilities	**No.**
Community Health Centre	6
Primary Health Centre	11
Primary Health Sub-Centre	34
Maternity and Child Welfare Centre	6
T.B. Clinic	6
Hospital Allopathic	5
Hospital Alternative Medicine	6
Dispensary	19
Mobile Health Clinic	5
Family Welfare Centre	6
Charitable Non-Govt Hospital/Nursing Home	5
Medical Practitioners With MBBS Degree	26
Medical Practitioners With Other Degree	37
Medical Practitioners With No Degree	58
Traditional Practitioners and Faith Healers	54
Medicine Shop	34
Source: Census of India, 2011	

Table 2: Socio-Demographic Profile of the Respondents			
Particulars	**Details**	**Number**	**%**
Age	10-14 years	42	35.00
	15-19 years	78	65.00
Education	Illiterate	2	1.67
	Primary	12	10.00
	Secondary	60	50.00
	Higher Secondary	46	38.33
Marital Status	Married	28	23.33
	Un-Married	92	76.67
Type of Family	Nuclear	87	72.50
	Extended	33	27.50
Family Size	<4	35	29.17
	5-8	72	60.00
	>8	13	10.83
Religion	Hindu	100	83.33
	Muslim	16	13.33
	Other	4	3.33
Caste	General	50	41.67
	OBC	38	31.67
	SC	24	20.00
	ST	8	6.67
Source: Primary Survey, 2020			

Barriers to Access Health Care Facilities

Access the health care facilities by adolescent girls depends on various factors some of which are physical barriers such as unavailability of health care, distance, etc. while others are purely psychological in nature such as social stigma, less freedom to discuss health issues, etc. Hence, an attempt has been made to figure out major barriers under the following heads.

Organisational Barrier

Organisational barriers involve the unavailability of health facilities, lack of doctors and nurses, expensive health services, etc. Distance is a major barrier for rural masses because quality services are found only in urban centres. Besides, the unavailability of transport and poor road make the situation even more complicated (Uche, 2017). It is evident from Figure 2; privacy concern (78.4%) is the most influential barrier that adolescent girls perceive. Besides, the unaffordable health facility (57.6%) and distance of the health centre (48.4%) arethe other major barriers (Figure 2). The majority of the respondents (63%) said that the region's government health facilities are not up to mark. To avail the secondary and tertiary health care, they prefer to go to Bardhaman, the nearest city or Kolkata. Consequently, 30.8% of the respondents delay in availing of health care. 46.3% of the respondents confessed that when they go to the health centre, there is either unavailability of health personnel or lack of medicine or the equipment are inadequate. The necessity of minimising the infrastructural barriers could be understood from the fact that 73.2% of the adolescent conveyed that they would avail the regular check-up if better health care facilities were provided in the nearby health centres to treat the health problem in the initial stage.

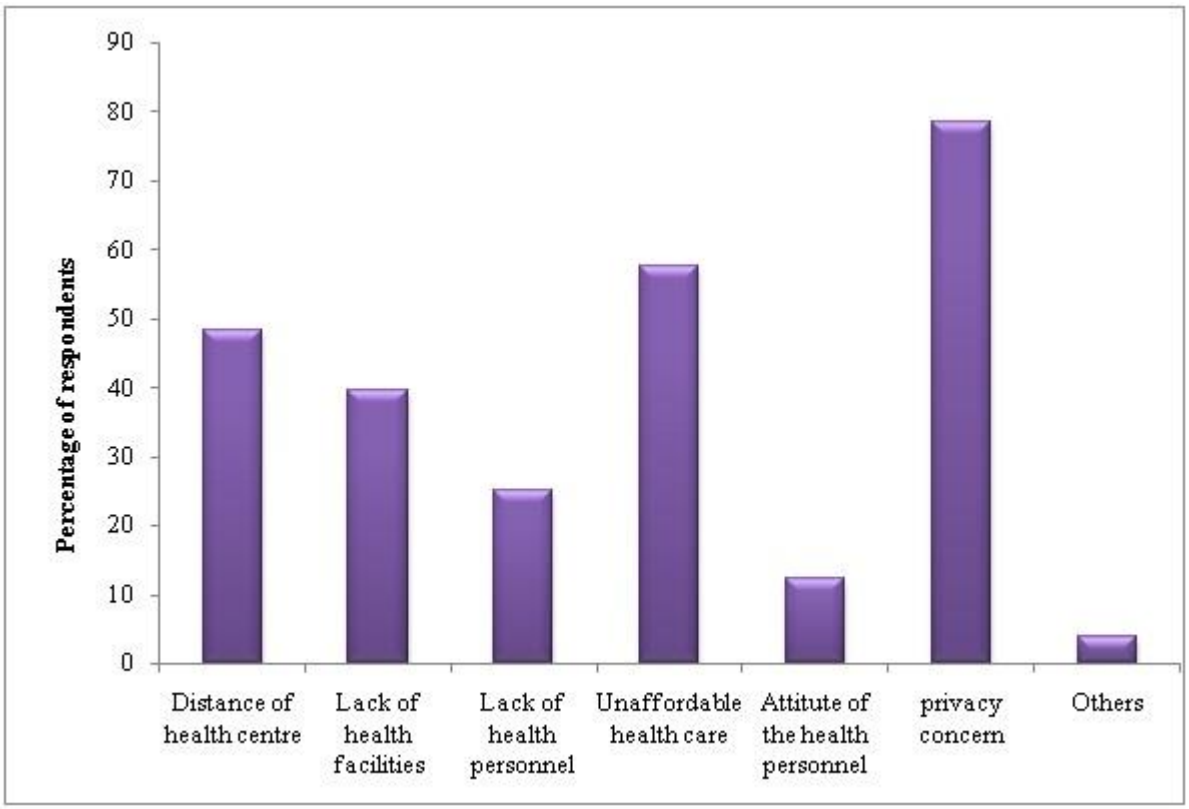

Figure 2: Perceived Organisational Barriers Among the Adolescent Girls
Source: Primary Survey, 2020

Types and Severity of the Problems

In rural areas, when people have mild symptoms, most of the times they tend to avoid the treatment (Chauhan et al., 2015; Sulakshana et al., 2012). It is evident from Table 3; in almost every case, health problems having mild symptoms are overlooked. In the case of mild

fever respondents, either resort to home remedies (22%) or even do not seek treatment (45.1%). Self-medication is the most prevalent mode of treating illnesses such as common cold, cough, fever, minor injuries etc. wherein they buy medicines from the chemist without consulting a doctor. Seeking no treatment is observed most profoundly in case of menstrual problems of mild nature (64.8%). Even in severe cases, they seldom consult a doctor; they either take medicine from a chemist (31.3%) or resort to home remedies (28.4%) of one sort or other.

Table 3: Treatment Seeking Behaviour of Based on Severity of Illness

Types of Illness/ Health Problems	The Severity of Illness (%)	Consult Doctor (%)	Medicine From Chemist (%)	Home Remedies (%)	No Treatment (%)
Cold/Cough	Mild	7.2	43.7	32.4	16.7
	Severe	21.4	62.8	8.3	7.5
Fever	Mild	5.5	27.4	22.0	45.1
	Severe	38.2	58.4	3.4	0.0
Dental Problem	Mild	2.6	12.5	49.3	35.6
	Severe	40.2	44.6	10.4	4.8
Menstrual Problem	Mild	3.4	20.8	11.0	64.8
	Severe	19.6	31.3	28.4	21.7
Respiratory Illness	Mild	8.3	12.2	38.2	41.3
	Severe	68.8	22.4	8.8	0.0
Injuries and Accidents	Mild	1.4	38.4	42.6	17.6
	Severe	77.6	17.2	5.2	0.0

Source: Primary Survey, 2020

Economic Condition

Generally, poorer peoples are reluctant to get health care facilities because their priority is to quench their hunger (Sulakshana et al., 2012). The economic status of the families also determines the educational attainment of the children, which further controls the health-related awareness. The majority of the families (62%) have income less than INR 10000 a month, which means they have very little money to spend on health. Only 34.2% of the family reported that they could avail of secondary and tertiary health care facilities in the nearby town. Avoiding or delaying treatment due to economic reasons is observed among 44.8% of the families. Many families do have insurance cover extended by the state government, but about 25.2% of the family are not aware of the procedure of availing benefit out of it. Furthermore, some people resort to unscientific treatment practices such as consulting exorcists (5%) due to low income.

Educational Background of the Family

The poorer families in the rural areas are often deprived of quality education which limits their knowledge about health problems. Sometimes the problem they perceive to be less severe may appear as very serious. Furthermore, low educated families have a tendency to impart less education to their children, which increases the incidence of their dropouts (Uche, 2017). About 68% of respondents whose parents have passed 10thstandards or higher affirm that they consult the doctor as soon as they notice any health problem. On the contrary, 32% of the respondent's parents who have education up to primary level considered minor health problems as self healing and do not consult doctor. Besides, mother's education is often linked with the education of her child. It is found that 78.4% of adolescent girls whose mother has education up to 10th or more could openly discuss their health issues in the family.

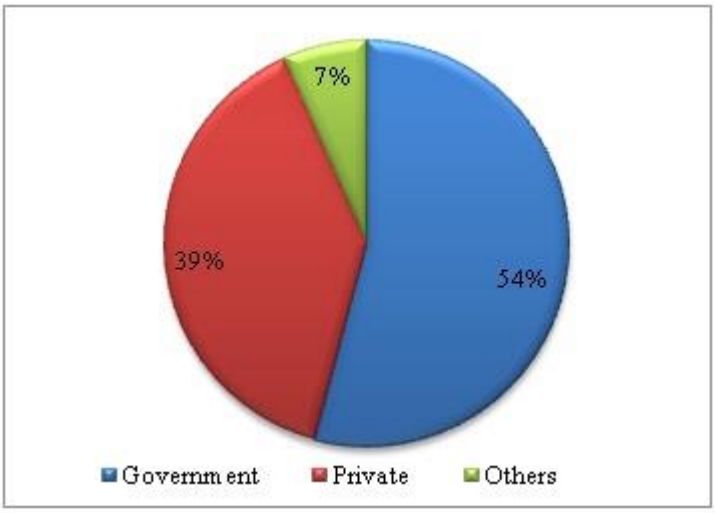

Figure 3: Preferred Health Care Service
Source: Primary Survey, 2020

Usage of Health Care Facilities

The mere availability of health care facilities does not assure its usage by the masses; instead, it is controlled by complex societal and economic factors (Coker et al., 2010). 70.8% of the respondents admitted that they go to the hospital only when their health problem becomes severe. Again, in hospitals' selection, the general tendency is to opt for the governmental services (54%) because it is the cheaper alternatives (Figure 3). The private health care system is equally popular (39%), which provides relatively better health care. To avoid out of pocket expenditure, people prefer to get medicine from a chemist (48.6%) without consulting doctors. Consulting cheaper alternatives such as traditional medicines, herbal remedies, etc., is followed by 13.2% of the respondents. A minuscule portion (17%) of the respondents in the region opts for the specialist doctor only in critical situations. About 70% of respondents go to the hospital when their health problems become severe. It is thus evident that the general tendency of the respondents regarding the usage of health care facilities is not satisfactory.

Societal Stigma Related to Health Issues of Girls

Stigma related to health of adolescent girls in general and menstruation in particular stands as a potent barrier in accessing health care services (Uche, 2017). Adolescents are not supposed to discuss their health issues openly and are paid no heed (M. L., K. & Ahmed, 2017). The majority of the adolescent girls (76.4%) admitted that they do not feel comfortable discussing menstruation disorder and related problems. They prefer to speak to their mother rather than their father. They like to discuss among the peer groups (82.8%). 27.6% of respondents confessed that they had a menstrual problem, but they did not disclose it due to embarrassment.

Source of Health-Related Information

The available information to people usually depends on the educational level and the economic status of the family. Sometimes, the reach of government machinery is not effective enough to disseminate health information to the masses. Friends (72.8%), Family (80.8%) and School (53.4%) are the three most preferred sources of health pieces of information among adolescent girls. On the other hand, T.V. as a medium of getting health information is preferred by 28% of the respondents. However, the role of health workers (16%) as disseminators of health information is not preferred much. Besides, social media (19.4%) is also gaining popularity as a source of health related informations (Figure 4). It may thus be highlighted that reach of health workers such as need to be enhaced so as to impart right information.

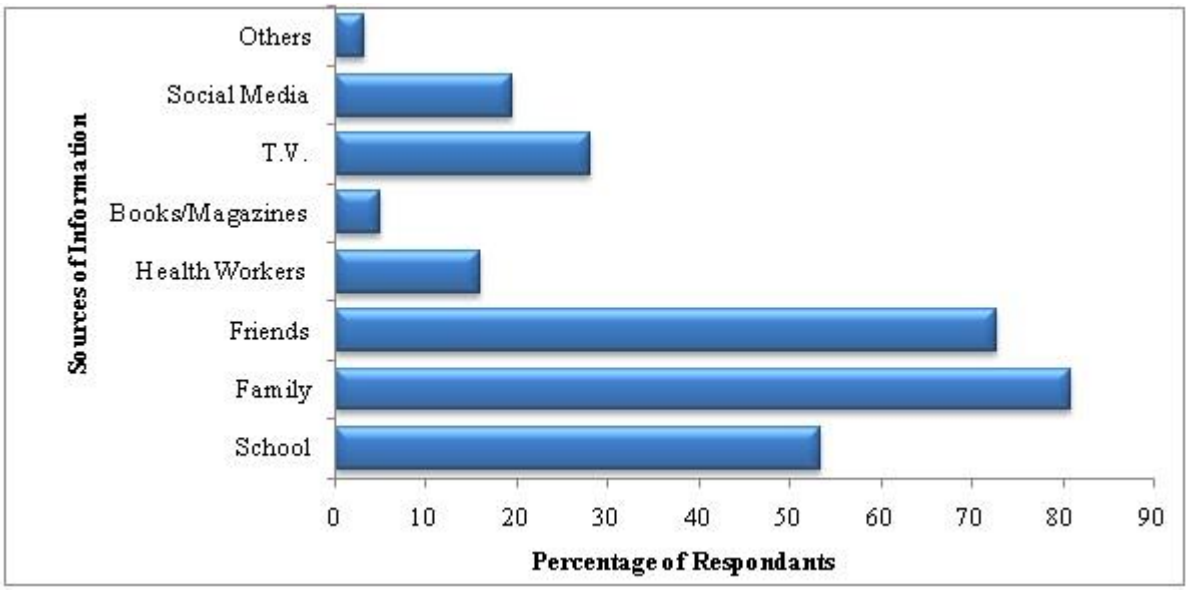

Figure 4: Preferred Source of Healthcare Information
Source: Primary Survey, 2020

Conclusion

It is obvious from the discussion that access to the health care services by adolescent girls in the study area depends on numerous factors such as unavailability of treatment, distance to the health centre, lack of health personnel, illiteracy, economic burden, etc. Concern for privacy is the major determining factor in ignoring health among them. They do not disclose and continue to bear the health problem due to embarrassment. It is observed that they tend to delay their health need in the hope that the problem is not so serious. Besides, there is general propensity to hide the problems related to menstruation. Although several adolescent's health related schemes have been launched—Rashtriya Kishor Swasthya Karyakram (RKSK), Kishori Shakti Yojana (KSY), Nutritional Programme on Adolescent Girls (NPAG), Balika Samridhi Yojana, Weekly Iron and Folic Acid Supplementation, National AIDS control Programme etc. However, these schemes lack proper implementation and are not targeted holistically. Thus, better provision of health facilities along with community awareness on the health of adolescent girls is essential to foster sound health and overall well-being.

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Conflict of Interest

There is no conflict of interest regarding research, authorship and the publication of this study.

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Author Contribution Statement

Mousumi Dholey and Dr. Sumana Sarkar have conceptualised the research and methodology. The first author, Mousumi Dholey, was involved in collecting data through field survey, analysis of data and preparation of tables, maps and charts and framing the initial draft of the manuscript. The second author, Dr Sumana Sarkar, supervised the research work and assisted in shaping the final draft of the manuscript after editing and reviewing it.