FACTORS INFLUENCING THE HEALTH-SEEKING BEHAVIOUR OF ADOLESCENT GIRLS IN CHENNAI SLUMS

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Abstract

Adolescent girls are a key asset of our country. Investments in adolescents will have an immediate, direct and positive impact on India's health goals and the achievement of the Millennium Development Goals. This paper explores the health-seeking behaviour of unmarried adolescent girls residing in the underprivileged belt of urban spaces, and analyses the factors that influence such behaviours. Health-seeking behaviour is a sequence of remedial actions that individuals undertake to rectify perceived ill health. It is a positive behaviour which helps the persons to improve their health continuum from negative health to positive health. Given that a significant proportion of the slum dwellers face social burdens and health problems far worse than their non-slum and rural counterparts, and thirty percent of the adolescent girls' population (RAY, Tamil Nadu Slum Clearance Board, 20th July 2015) of Chennai reside in slums, 330 unmarried adolescent girls from 33 slums were selected using Probability Proportional to the Size Linear Systematic Sampling design. In this paper, a social work model for promoting health-seeking behaviour for adolescent girls has been suggested, based on the factors influencing such behaviour.

Keywords: Health-Seeking Behaviour, Adolescent Girls, Influencing Factors, Social Work Model, Slums

INTRODUCTION

Adolescence is a key phase of human development, characterized by rapid biological and psychosocial changes that take place during the second decade of life, affecting every aspect of adolescents' lives from infectious diseases to non-communicable conditions. These changes make adolescence a unique period in a life course in its own right, as well as a significant period for laying the foundations of good health in adulthood. A focus on the adolescent phase of the lifecourse is crucial not only for the unfinished MDG agenda, but also to enhance the quality of human capital of any country. At the same time, however, health problems and behaviours that arise during adolescence affect physical and cognitive development.

Health-seeking behaviour is a sequence of remedial actions that individuals undertake to rectify perceived illhealth. It is a positive behaviour which helps the persons to improve their health continuum from negative health to positive health. In the broadest sense, health seeking behaviour includes all behaviours, associated primarily with establishing and maintaining a healthy physical and mental state; secondarily, deal with any digression from the healthy state; and, tertiarily, reducing the impact and progression of an illness. It involves actions taken by people, in the absence of signs and symptoms, to remain well by improving their state of well-being.

The remarkable capacity of the adolescent brain to change and adapt to experimentation, exploration and risk-taking is more normative than pathological, and has real potential to ameliorate negative developments that took place during the early years of life. This implies that any behaviour adopted during this period can have a great influence in their adulthood. Likewise, initiating health seeking behaviour during adolescence will help pave the way for a better and healthy adulthood.

A LITERATURE REVIEW

A literature review on the current topic being discussed examines the wide spectrum of research in health seeking behaviour and related area. This helps us understand the assessment and description of different variables constituting the research.

Saraswathi Nandhini. R and K. Sathyamurthi's (2017) article, *Adolescent Reproductive Health: Patterns and Practices in the Slums of Chennai* sheds lights on understanding the reproductive health practices of unmarried adolescent girls in slums of Chennai. It identifies a fear of stigma, coupled with insensitivity about the issue in community at large, as major reasons for adolescents not actively seeking health care. The article suggests appropriate alternative therapies as interventions to reduce psychosocial implications, and combat stigma from the community by creating awareness about the need for appropriate health care.

Saraswathi Nandhini and K. Sathyamurthi's (2016) article on the *Wellness of Adolescent Girls in the context of Health Seeking Behaviour An Analytical Approach* points out that about 57% of the respondents in the study involved have poor health seeking behaviour. Of the three components, treatment component shows better health seeking behaviour (21.7%) than the others. The outcome of the study recommended a 'Health Seeking Behaviour Promotion Model for Wellness of Slum-dwelling Adolescent Girls'.

Sathish Kumar and K. Sathyamurthi's (2015) article on *Understanding Adolescent Health in Social Work Perspectives* explains the problems and needs of adolescents from their perspectives. It shows that adolescents' needs, which have not been adequately addressed so far in health schemes, provide opportunities for social work professionals to step in and put remedial measures in place.

Sharanya's (2014) cross-sectional study on the ***Reproductive Health Status and Life Skills of Adolescent Girls Dwelling in Slums in Chennai, India*** reported that 73 percent of respondents experienced menstrual morbidity and 51 percent had symptoms suggestive of reproductive/urinary tract infection. Almost 39 percent attributed shame and insecurity as key barriers that kept them from accessing seeking reproductive healthcare.

CH. K. G. Singh and Madhavi L. H. (2003) in their community based cross-sectional study of 238 adolescent girls aged 15-19 years, found that the prevalence of anaemia was 57.14 percent. Anxiety neurosis was noticed in 5.46% of the girls. The most common menstrual

problem was dysmenorrhoea (28.57%), followed by menorrhoea (0.42%). Other problems mentioned included a fear of dependence in old age (1.26%); being considered as parayadhan (1.26%) and stigma of being born a girl (2.52%).

Much of the research reviewed deals with reproductive health seeking behaviours in largely among married adolescent young women, including health indicators and health risks. These encompass reproductive morbidity, which is inclusive of sexual initiation, menstrual hygiene, dysmenorrhoea, gynaecological problems, early age pregnancy and improper pregnancy spacing, child- bearing, high rates of maternal mortality, family planning, perceived fertility problems, reproductive tract infections and related physical health problems such as backaches. Hardly any studies related to unmarried adolescent girls and their health-seeking behaviour.

RATIONALE AND SIGNIFICANCE OF THE STUDY

The paper attempts to assess the health seeking behaviour of the unmarried adolescent girls residing in Chennai slums, along with the factors influencing such behaviour. The paper contributes to the existing knowledge in social science, in terms of health seeking behaviour in unmarried adolescent girls. It examines the plight of girls living in slums: in the insanitary, unhealthy and dehumanizing living conditions typically characteristics of urban society. The paper considers the promotive, preventive and curative dimensions of health seeking behaviour, with special reference to unmarried adolescent girls, and offers a holistic approach in understanding their health profile. The paper assumes significance, having been designed from a social work perspective. It tries to promote social change, resolve problem in human relationships, empower and liberate unmarried adolescent girls so as to enhance their well-being through utilizing theories of human behaviour and social systems. An attempt has been made to suggest intervention strategies at appropriate levels, which is significant in terms of its reach to the potentially vulnerable sections of the urban society.

MATERIALS AND METHODS

The paper attempts to understand and study the factors influencing health seeking behaviour of unmarried adolescent girls. It involves analytical cross sectional research design with the collection of samples from 330 unmarried adolescent girls residing in the slums of Chennai. The samples are selected from three (north, south and central) regions in Chennai using Probability Proportional to Size Linear Systematic Sampling. Probability proportional to size is a sampling procedure under which the probability of a unit being selected is proportional to the size of the ultimate unity, giving large clusters a greater probability of selection and smaller clusters a smaller probability. Linear systematic sampling involves selecting the same numbers of individuals in a linear order per cluster. In all, 33 slums were selected 14 in North Chennai, 11 in Central Chennai and 8 in South Chennai at random, using cumulative population frequency, with 10 unmarried adolescent girls from each selected slum. All unmarried adolescent girls in the age group of 12 to 19 years were included in the study, and all the married ones are excluded.

A pretested interview schedule was administered by the researcher to collect data. The interview schedule included a set of questions on three profiles - socio-demographic profile, familial profile and health profile in addition to those on health seeking behaviour. Health seeking Behaviour variable is created by combining thirty three items relating to the preventive, promotive and curative factors of such behaviours. These 33 items were computed together and their sum calculated as the value of the health-seeking behavior in question. The levels of the variables were calculated, based on their observed values in terms of health-seeking behaviour. The data was analyzed using the SPSS version 20, and a statistical analysis carried out by applying cross tabulation and factor analysis.

MAIN FINDINGS

The major findings of the health-seeking behaviour of unmarried adolescent girls in Chennai slums are as follows:

a. Socio-demographic Profile:

More than half (54.5%) of the respondents were in early adolescence and less than a third (33.8%) in middle adolescence, while very few (13.6%) were in late adolescence, irrespective of the regions. The strength of late adolescent group is small, since the inclusive criterion of the study was restricted to only unmarried adolescent girls, whereas most of the late adolescent girls in slums were married.

Less than half (44.3%) of the respondents had a middle school education, less than one third (33.6%) had a secondary school education and only eight percent had completed their higher secondary school in the north slums of Chennai region. More than one third (38.2%) had completed secondary and middle school, while very few (16.4%) had completed higher secondary school in central Chennai. In South, more than half (51.3%) of the respondents had completed middle school, while less than one fourth (21.3%) of the respondents had secondary and higher secondary (22.5%) school education.

More than half of the respondents in the slums of north and south Chennai had studied in Government school while half (50%) in the central Chennai slums had done so. One-third (35%) of the respondents in north Chennai slums belongs to scheduled caste and less than one third (30%) belongs to backward and most backward communities. Less than half (40.9%) of the respondents in central Chennai slums belong to the scheduled castes and more than one fourth of the respondents belong to backward community (30.9%) and most backward (27.3%) community. Half (50%) of the respondents in south Chennai's slums belong to the scheduled castes and more than a third (40%) to the backward class community.

b. Health-Seeking Behaviour

A significant percentage (70%) of the respondents showed moderate health seeking behaviour, while it was low (14.2%) and high (15%) with the rest. Among the three regions, adolescent girls

dwelling in North Chennai slums showed better health seeking behaviour than those in central and south Chennai's slums. The high level of health seeking behaviour in adolescent girls in the north region could likely be an outcome of adequate health care services, follow ups through non-governmental organisation, utilization of health benefits, accessibility of health care services in the vicinity, and a greater degree of health awareness.

The reduction in the level of health-seeking behaviour in the central region could be due to the non-utilization of health benefits by the individuals concerned, a stigma in relation to social status, and political conflicts. Adolescents in south Chennai, where awareness on health benefits and government schemes is lacking, showed less health-seeking behaviour. Similarly, there were remarkable differences in the three age groups, with early adolescent demonstrating a higher degree of health seeking behaviour than their middle and late adolescent counterparts. The significant decrease in the level of health seeking behaviour in late adolescents may be caused by the stigma of having to seek treatment for health issues, as well as a lack of awareness on the consequences of not addressing the said issues.

Multiple regression analysis was used to predict the level of health-seeking behaviour. Variables such as region, age, religion, community, income, type of family and number of siblings, frequent illness, protective factors, maintenance of health, stress systems, health expenses, management of health expenses, decisions made to visit health care centres, frequent visits to health care centres and support systems were chosen as intrinsic to this study. The result indicates that higher the scores of the respective independent variables, better the level of the health seeking behaviour. Among the independent variables, community and frequent illness play a predominant role in predicting health- seeking behaviour.

Factor analysis was used to identify meaningful factors from miscellaneous variables, which were selected, based on the results of correlation and regression. Five components were identified using the

Kaiser criterion. The components can represent a liking for the different factors that influence health-seeking behaviour namely: Component 1 Health Benefits, Component 2 Income and Illness, Component 3 Family and Expense Management, Component 4 Environmental Factors, and Component 5 Age & Education.

Bartlett's Test of Sphericity value is less than 0.001, which shows that there exist patterned relationships amongst the variables. The Kaiser-Meyer-Olkin Measure (KMO) of sampling adequacy value is 0.508, showing that the sample is distinct and reliable. When the data were analysed by means of a principal component analysis with varimax rotation, the variables indicate that factorability is good and the residuals indicate that the solution is good. Eight components are produced with an eigen value greater than 1.0.

The health benefits component shows about 27% variance, including variables such as growth monitoring, immunization, health education, health check-ups, sanitary napkins, nutritional counselling, iron and folic acid supplementation, chappals, medicines, support systems, health rights, and the number of siblings. Health benefits such as health education, nutritional counselling, iron and folic acid supplementation, medicines, chappals, health check-ups, growth monitoring, sanitary napkins and immunization showed higher values of communalities with more than 0.70. Thus, these variables showed the most correlation with health-seeking behaviour. The higher the utilization of health benefits, the better the health seeking behaviour. Similarly, the support system, health rights and number of siblings in the health benefit component showed a negative correlation with health-seeking behaviour. It means that the lower the support system and health rights, the higher the level of health-seeking behaviour. This implies that adolescent girls in slums are somewhat pampered to the degree that they can eat pretty much what they please, and as and when they please. Further, the family supports the decisions the girls make, whatever they may be. Prudent decisions taken by adolescent girls in slums must have the support of the family. The number of siblings correlated negatively with health-seeking behaviour implying that the higher the number of siblings, the lower the interest in health seeking behaviour.

The income and illness component shows 11% variance which includes religion, income, and decisions made to visit health care centres, supplementary food, and frequency of illness. The communality value of the frequency of illness (0.834) is higher, showing that the higher the frequent of illness, the greater the health seeking behaviour. Supplementary food and income show a positive correlation with health-seeking behaviour, implying that if there is a decent income and food supplements, health seeking behaviour is positive. Decision-making and religion show a negative correlation in improving health-seeking behaviour. Decisions involving hospital visits are almost exclusively made by the parents of the girls. When these decisions are increasingly made by the respondents themselves, health seeking behaviour may show a positive uptick.

The family and expense management component shows about 10% variance which includes the type of family, frequent visits to hospital, health expense management, and factors inhibiting visits to the health care centre. The type of family and managing health expenses shows a positive correlation with health-seeking behavior, while frequent visits to hospital and factors inhibiting visits to the health care centre show high health-seeking behaviour. This implies that the fewer the visits to hospital and factors influencing these visits, the greater the level of health seeking behaviour.

The environment factors component shows 8% variance which includes the community, type of family, maintenance of the health continuum, and protective factors. The higher the type of family and protective factors involved, the better the health-seeking behaviour. The age and education component shows 6 percent, where both have communalities of more than 0.70. This implies that there exists a correlation between age and education with health-seeking behaviour.

Cross loading is found for decision making, protective factors, community and type of family. The community, decision making and protective factors are split-loaded based on their reliability to a component. The type of family is included in both components, keeping in mind its significance and reliability in both.

CONCLUSION

The findings from the paper can be concluded by proposing a health-seeking behaviour model for unmarried adolescent girls in slums as an outcome of this study. The implementation of the model through social work practice can effectively bring desirable changes in the health-seeking behaviour of adolescent girls.

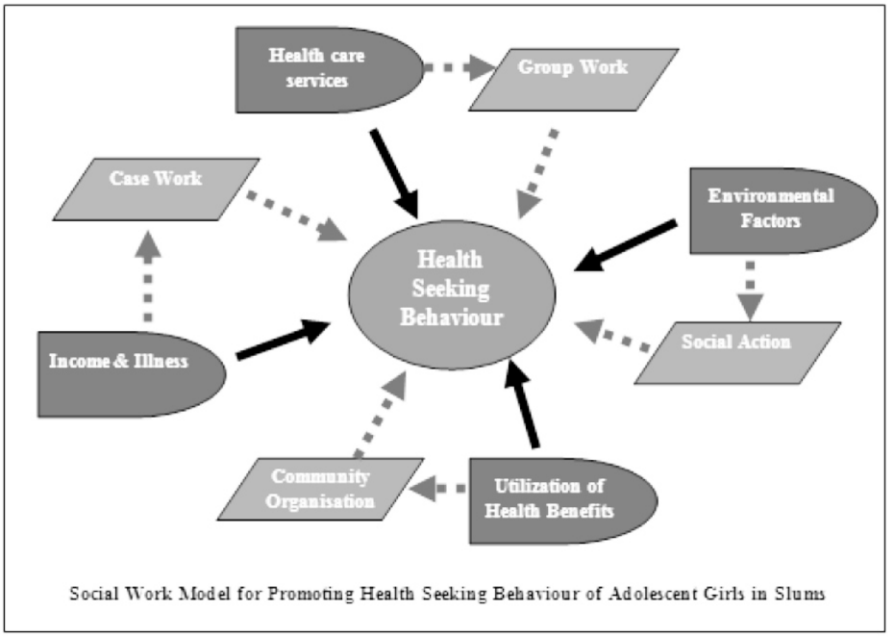

Figure 4.4.1 A Social Work Model for Promoting the Health-Seeking Behaviour of Unmarried Adolescent Girls in Slums

The model depicts factors influencing health-seeking behaviour and the social work methods that promote such behaviour. The four factors that influence health-seeking behaviour are income and illness, health care services, utilization of health benefits, and environmental factors. The income and illness factor includes the frequency of illness, income of the family, and decisions made in regard to treatment. These issues can be overcome through social case work in identifying the problem; referring the respondents to the nearest health services, based on affordability; and by enhancing their decision-making skills with reference to health. Most importantly, follow-up services using a problem-centred approach can promote health-seeking behaviour.

Health care services include frequent visits to health care centres, but there are factors that restrict such visits, including the management of the centres. This can be countered by group work, using target oriented groups to explain public health care services and its cost effectiveness, which can help respondents manage their health expenses effectively. Community organization can help emphasize the use of health benefits, their purpose and significance, and make respondents aware of them.

Environmental factors include the type of family, community, number of siblings, religion, support systems, health rights, maintenance of health and protective factors, all of which play a significant role in influencing health-seeking behaviour. These factors includes several independent and dependent elements, where the application of a single social work method may not be effective as when a combination of case work, group work and community organisation can be used. Social action, one of the secondary methods of social work, can be utilized to health rights protection, maintain a healthy physical environment, and enhance protective factors with reference to religion and community, as well as the type and size of family which, in turn, will help promote health-seeking behaviour.

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KMO and Bartlett's Testa		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy		.508
Bartlett's Test of Sphericity	Approx. Chi-Square	1061.608
	Df	406
	Sig.	.000

Components	Health Benefits	Income & Illness	Family & Expense Management	Environmental Factors	Age & Education
Age					.759
Education					.799
Religion	-.727				
Community			-.445	.443	
Income		.645			
Number of siblings	-.584				
Frequent visits			-.524		
Decisions about hospital visits	.487	-.711			
Supplementary foods		.733			
Growth monitoring	.773				
Immunization	.705				
Health education	.852				
Health check-ups	.788				
Sanitary napkins	.763				
Nutrition counseling	.849				
IFA supplements	.813				
Chappals	.799				
Other medicines	.808				
Frequency of illness		.834			
Health maintenance				-.531	
Protective factors		-.413		.618	
Support systems	-.554				
Health-inhibiting factors			-.576		
Health rights	-.623				
Eigenvalue	7.824	3.456	2.836	2.223	1.824
% of variance	26.98	11.92	9.78	7.67	6.29
Cumulative variance	26.98	38.89	48.67	56.34	62.62