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Health Care Seeking Behavior of Rural Adolescents in Bangladesh.

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ABSTRACT
A cross sectional descriptive study titled health care seeking behavior of rural adolescents was carried out with the aim to find out the health care seeking behavior of rural adolescents started from January 2016 to December 2016. About 200 secondary school going adolescents were interviewed with a pre-tested semi structured questionnaire where purposive sampling technique had been adopted for this study. Data were analyzed with the SPSS software (version 21). Out of 200 respondents, 77 (39%) were male and 123 (61%) were female where 126 (63%) respondents were belonged to age group 15-16 years. Among the adolescent girls, 24 (20%) faced problem in their first menstruation and 16 (13%) were facing menstrual problem at that time. Among the adolescent boys, 29 (38%) reported that they faced problem in their first wet dream. Forty eight (24%) respondents reported that this problem affect their daily activity. Ninety six (48%) respondents said that they feel mood off. Among the girls, 70(57%) faced eve teasing, 10 (5%) harassed over phone, 80(40%) abused physically, 40(20%) tortured mentally and 70(35%) abused or tortured in many other ways. Secondary school going students told that 72(55%) shared their problems with parents, friends, health workers and others. Most of them, about 160 (80%) respondents informed or consulted about their problems where adolescent health and consultation services provided. About 136 (85%) respondents went to health-care center in the last 6 months. Those who did not go to health care center told that their economic or financial condition, communication to health care center, family decision to go there, knowledge about the services given in the health center etc. were the main barriers not to avail the health care services. Out of 136 adolescents who went to health care center 99 (73%) respondents reported that they got sufficient health services. Few of them complained that they did not get service satisfactorily because of shortage of health care provider, insufficient medicine, excess patients' pressure etc. According to findings of the study, it have been suggested that secondary school going adolescents need access to health care by creating awareness about their health problems, enhancing health education program, providing accurate health-related information in their text book and legal and moral support from their family, community and society. Most adolescents have limited scope for acquiring knowledge and skills for their self-development and protection. The study findings would assist health planners in designing appropriate health- seeking promotion strategies for secondary school going adolescents for building up a healthy nation in future.

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I. Background :

Around the world, adolescence is a time of opportunities as well as vulnerabilities to risk-associated behaviors that can have lifelong consequences for health and well- being. Numerous World Health Organization (WHO) consultations and studies have confirmed the importance of caring and meaningful relationships, as well as pro- social connections with individuals and social institutions, reducing risks and promoting healthy and positive developmental outcomes. Many researchers and various WHO documents, have also called for more attention to and more research on where, why and how adolescents seek help (i.e. their help-seeking behavior) and the sources of nature of help available to them in their specific contexts (i.e. social supports) Before proceeding, it is important to define the terms that frame this document, particularly "help-seeking behavior" and "social supports." There are few specific, agreed upon definitions of "help-seeking behavior" in the adolescent health and development literature. Furthermore, when referenced, help seeking generally refers to the use of "formal" supports, which we define as health facilities, youth centers, formal social institutions or professional care providers, either in the public or private sector. In many cases, "help-seeking" is used interchangeably with "health-seeking," which generally refers more narrowly to seeking services or remedies for a speailment or illness. In many of the documents cited in the reference, "help-seeking" refers to the use of health and other services in the case of severe or serious mental health issues, including substance use, depression and suicide. In only a few cases in the literature is the term "help-seeking" used in a more

comprehensive way to refer to the use of both form all supports and informal supports, which we argue includes family, kinship networks, friends, traditional healers and/or religious leaders. There are 27.8 million adolescents aged 10-19 years in Bangladesh– 13.8 million girls and 14 million boys– making up about one fifth of the total population. Most adolescents have limited scope for acquiring knowledge and skills for their self- development and protection. The term of biological, social and familial status is the main aspect of the education. But it is highly concern that, the situation of biological status of the secondary school going adolescent is not much specified. All the BDHSs, with exception of 1993/94 collected information on the height and weight especially for the sample women. The data were used to obtain two measures of nutritional status; height; and body mass index (BMI). A woman's height can be used to predict the risk of difficulty during pregnancy, given the relationship between height and pelvic size. The risk of giving birth to low weight babies is also higher among women of small stature. The information demonstrates there has been an improvement in the nutritional status of the adolescents. In the 1996 BDHS over 48 % were underweight (BMI less than 18.5) and in the 2007 BDHS it declined to 32.1%. The amount of adolescents with a BMI greater than 18.5 increased from about 52% to about 68% between 1996 and 2007. Nutritional status of urban adolescents are better than the rural adolescents and youths. Adolescent marriage is common in Bangladesh where about 30% adolescents are married by age 15. In recent years there has been increasing concern about violence against women in general and domestic violence in particular. The results show that 35% of the rural ever married adolescents and 40% of the urban adolescents have experienced some form of physical violence by their husbands in their current or most recent marriage. About 12% and 17% respectively of the urban age groups 15- 19 reported ever having been physically forced to have sex by their husbands when they did not want to. These percentages are higher in the rural areas. The mostly avoided topic of the school going adolescent in Bangladesh is the Health Behavior. They are not interested to discuss about the health seeking behavior among them, that's why they are not concern about different kinds of diseases at the stage of teenage period. We specifically concern that, the different aspects related with the health behavior are always discussed among them in a short term process and most of them fell shy to talk about health. Over 67 percent of adolescent girls are married. This includes 48 percent of girls aged 15-19 years of age. About 50 percent of pregnancies occur by the age of 18 years. Early marriage is a critical issue for adolescent girls. Until recently, the rights and needs of adolescents were largely ignored in Bangladesh. This was especially true in relation to girls, most of whom move straight from childhood to marriage around the time of puberty. They are not informed about their rights, health and gender equality, and they have limited mobility and opportunities to meet and exchange ideas and knowledge among their friends. Health-seeking behavior of a population depends to a great extent on the availability, accessibility and affordability of services of health care providers/facilities in nearby localities. Adolescents are usually uncomfortable discussing private health issues such as sexuality and contraceptives. This study was designed to find out the health care seeking behavior of rural adolescent. We selected this study to find out the health care seeking behavior of rural adolescents.

II. Methods and Materials:

This study was under taken with the objective to find out the health care seeking behavior of rural adolescents, secondary school going students. Study design: It was a Cross-sectional Study which was conducted among secondary school going adolescents. The study has been conducted at Dapunia High School, in Mymensingh. The study period was throughout from 1st January to 31st December 2016 including preparation of the data collection instrument, field testing of instrument, data cleaning, editing, analysis and reporting. Study Population: Study population were rural adolescents (12-19 years) studying at secondary school. The prevalence of the study will be taken as =50%. n=z 2 pq/d2 (1.96)2 0.50(1-.5)/ (0.05)2 =384 Here, n=desired sample size. z=confidence limit (1.96 for 95% confidence level) p=prevalence rate (50%) q=1-p d=Margin of error (set at 0.05) Calculated sample size was 384. Considering the resource constraints this study included 200 respondents. So, the sample size of the study was 200. Data were collected by face to face interview ensuring the privacy and confidentiality of data. Time required for data collection from each individual was about 25-30minutes. Result of the Study**:** In the study the major findings are sketched by- out of 200, 77 (39%) were male and 123 (61%) were female, maximum 126, (63%) respondents belonged to age group 15-16 years. On the other hand, minimum 74, (37%) respondents belonged to age group from 12 to 14 years. The mean age was 14 and median was 15**.** maximum respondents 197 (98%) were Muslims, 2 (1%) were Hindus and the rest (1%) were Christians adolescents. respondents regarding adolescents (Girl) facing problem in their first menstruation. Among 123 respondents, 99 (80%) reported they did not face any problem in their first menstruation and 24 (20%) reported they faced problem in their first menstruation. Distribution of Adolescent (Boys) facing problem in first wet dream, Among 77 respondents, 48 (62%) reported they did not face any problem in their first wet dream and 29 (38%) reported they faced problem in their first wet dream. Distribution of the respondents (girls) opinion according to ever faced eve teasing. majority 70 (57%) of the respondents mentioned they faced eve teasing and 50 (71%) reported they seek help to others respectively.

Adolescents ever abused / tortured at home or outside. among 10 (5%) reported over phone, 80 (40%) reported physically, 40 (20%) reported mentally tortured home/outside. 72 (55%) mentioned they shared these problems with others and 58 (45%) of the respondents stated they did not share these problems with others. 36(50%) respondents reported sharing with parents, 18(25%) respondents reported sharing with friends, 7(10%) respondents reported sharing with health worker and 11(15%) respondents reported sharing with cousin and brothers about the problems. 136(85%) stated they went to health care center in the last 6 months. On the other hand 24 (15%) stated they did not go to health care center in the last 6 months. Conclusion :The study conducted at secondary school going rural adolescent who have socioeconomic differentials in health care seeking behavior. Health care seeking behavior and health care utilization is determined by the organization of the health system. Among the respondents, half of the girls who were interviewed said that they were faced eve teasing, among them three-fourth asked help to others. Among all respondents two fifth of adolescents abused/tortured by physically and one fifth tortured by mentally at home/outside. More than half of adolescents who were tortured shared these problems and asked help from parents, friends, health workers. service from health center. Among all respondent maximum adolescents got support from guardian for identification and solving health problem.

NB: Key Words: BDHS, BMI, BSMMU, BBS, EOC, GOB, IPV, MOHFW, MCWC, NIPSOM

1.1 Introduction

Health service is one of the fundamental rights of the people. It is the constitutional liability of the state to ensure adequate health service delivery to the people (Bangladesh Constitution, Artcle-18). However, in the case of Bangladesh, the state is not able to deliver door-to-door health service as yet. There are various reasons responsible for this condition. One of the main reasons is that Bangladesh is an overpopulated country. It is a difficult task for the government to ensure health services for its population of about 160 million people.

The Bangladesh Government (GOB) has shown exemplary farsightedness in creating an overall supportive policy and legal environment to promote adolescent reproductive health. The Constitution of Bangladesh guarantees equal rights for men and women irrespective of caste, creed, and color. All citizens are entitled to equal protection under the law. A number of laws are in places which directly or indirectly dissuade adverse practices. These include the Dowry Prohibition Act, 1980 which provides taking and giving of dowry an offence and punishable by fine and imprisonment; Cruelty to Women (Deterrent Punishment) Act, 1983 which makes punishment by death or life imprisonment for the kidnapping or abduction of women for unlawful purposes, trafficking women or causing death or attempting to cause death or grievous injuries to wives for dowry; the Immoral Traffic Act and the Women and Children Repression(Amendment) Act, 2000 enacted to regulate offences (like sexual harassment, rape, trafficking, kidnapping, dowry) against women; the Child Marriage Restraint Act, 1929 (Amended in 1983) enacted to restrain child marriage and ascertain the legal age of marriage, which is 21 years for boys and 18 years for girls, and the Children Act, 1974 which provides provisions relating to protection and treatment of children and trial and punishment of youth offenders.

The Government of Bangladesh has recognized the importance of ensuring ARH and has incorporated this issue in important national policies. The Population Policy of 2005 has provision of information, counseling and services for adolescents as one of its objectives and outlines a number of strategies for achieving this goal. The Policy addresses the ARH issue not just from the population but also from a development perspective, which is a major breakthrough. The Policy puts special emphasis on providing vocational and non-formal education to both in-school and out-school adolescent boys and girls. (MOHFW).

The National Health Policy of 2000, on the other hand, does not contain any explicit mention of the adolescents or address the ARH issue, though the objectives and strategies are comprehensive enough to encompass the issue. The newly adopted Youth Policy has, as one of its objectives, involvement of youth in issues of national importance such as preventing the spread of HIV/AIDS and drug abuse, and specially mentions the importance of involving members of the society in imparting youth with knowledge about reproductive health.

ARH has so far been mainly a concern of the Ministry of Health and Family Welfare, though other ministries have of recent integrated ARH issues in some of their projects/programmers. Important programmer initiatives undertaken by MOHFW on this issue include steps to train providers on adolescent friendly health services and introduce ARH services in Maternal and Child Welfare Centres (MCWCs) and country wide project under Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM) to prevent the spread of HIV/AIDS among young people. Nutritional supplementation of pregnant mother with iron /folic acid, introducing skilled birth attendants and expansion of Emergency Obstetric Care (EOC) services, initiatives to improve quality of care in government centers are other initiatives which will directly contribute to improving ARH especially of adolescent mothers.

Health is a basic requirement to improve the quality of life. A national economic and social development depends on the state of health. Bangladesh is a mostly rural, developing country of South Asia,

located on the northern shore of the Bay of Bengal, covering 147,570 square km. Health is a basic requirement to improve the quality of life. National economic and social development depends on the status of a country's health facilities. A health care system reflects the socio-economic and technological development of a country and is also a measure of the responsibilities a community or government assumes for its people's health care. The effectiveness of a health system depends on the availability and accessibility of services in a form, which the people are able to understand, accept and utilize. The Government of Bangladesh is constitutionally committed to "the supply of basic medical requirements to all levels of the people in the society" and the "improvement of nutrition status of the people and public health status" (Bangladesh Constitution, Article- 18).

The health service functions were initially restricted to curative services. With the development of modern science and technology, health services emphasize on promotion and prevention rather than curative health care. Yet, a large number of people of Bangladesh, particularly in rural areas, remain with no or little access to health care facilities. It would be critical for making progress in Bangladesh's health services to improve the people's participation in the health sector. The Government therefore seeks to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. However, previous studies on the socioeconomic differentials in the utilization of these services were based on a limited number of factors, focusing either on preventive or on curative modern health services. These studies failed to collect data from adolescent who study in secondary school at rural to examine the socioeconomic differentials in health-seeking behavior.

In this study, an attempt has been made to investigate the health seeking behavior of secondary school going adolescent in Dapunia. Mymensingh Sadar, Mymensingh. Health seeking behavior and health care utilization is determined by the organization of the health system. Health system does not merely represent the structures that provide health care but it encompasses various other elements, which constitute the system as a whole. These are economic conditions, family system, social support network, cultural forces, environmental conditions, political systems and so on, which invariably affect the health care seeking patterns. As for health care system, in almost all the developing countries like Bangladesh, the public and the private health sector co-exit, complementing or conflicting with each other.

Adolescent health seeking is conceptualized as a multi-step process that involves efforts made by adolescents or parents to seek assistance from other people to cope with problems *(Cauce & Srebnik; 2003*). More specifically, individuals must first recognize the problem requiring help, decide to seek help, and actually seek the help they require. Less than half of adolescents with mental health difficulties are estimated to seek professional help or access mental health services *(Bergeron et al., 2005; Merikangas et al., 2011; Unrau & Grinnell, 2005; Verhulst & van der Ende, 1997; Zwaanswijki et al., 2007).* In the Canadian Community Health Survey (CCHS), the overall prevalence of help seeking for individuals with symptoms of mental health problems was 8.3 percent *(Sareen, Cox, Afifi, Yu, Stein, 2005)*. Individuals aged 12 to 19 years old represented 13 percent of those who did not seek help and 8.8 percent of those who sought help *(Sareen et al.).* Other studies with young Canadians (aged 15 to 24 years old) have reported that as many as 25 percent of adolescents seek professional help (Bergeron et al., 2005). However, this means that 60 to 80 percent of adolescents do not seek professional help for mental health difficulties *(Burns et al., 1995; Gould et al., 2002; Schonert-Reichl, 2003).* Help seeking is an important coping behaviour that involves actively seeking out assistance from formal (i.e., professionals) or informal (i.e., family and friends) resources for a problem or concern (Fallon & Bowles, 2001). A consistent finding within the help-seeking literature is that of adolescents' preference to seek informal help (e.g., Wilson & Deane, 2001;
Sherer, 2000; Sullivan et al., 2002). Raviv, Sills, Raviv, and Wilansky (2000) suggest that friends and family provide a reciprocity that minimizes the visibility of the help-seeking process.

Adolescent help seeking models.

There is a consensus within the literature that help seeking models are adult-oriented, and thus, have limited relevance to adolescents' help seeking (Murray, 2005). As such, help-seeking models were devised to acknowledge the important role that family members, the school system, and the larger community play in ensuring that adolescents are given proper care (Cauce et al. 2002). In fact, many 'individual factors' in adult models are characteristics of families when adolescents are in need of help; for example, finances, geographic region, and education (Andersen, 1995).

Murray (2005) asserts that a key limitation of models of adolescent help seeking is that they ignore 'problem legitimization' – a process whereby adolescents view their problems as important due to the reactions of important others. After analyzing 55 qualitative interviews involving hypothetical and actual problems that participants (aged 13 to 14) encountered in their daily experience, Murray found that youth sought help more often for problems that adults treated seriously (e.g., bullying) compared to problems that adults tended to trivialize (e.g., relationship issues). Murray argues that problem legitimization from microenvironments (e.g. family and peer groups) and macro environments (e.g., society) should be considered when considering

adolescent help seeking. Murray's research implies that adolescents may be particularly sensitive about how others will react to their problem as adolescents appear to be more sensitive to judgment and may require adult support to remedy problems. Murray's research is consistent with previous and more recent findings that adolescent difficulties are commonly underestimated or undetected by parents and teachers (Boyles, 2010, Feehan, Stanton, McGee, & Silva, 1990; Levisohn, Rohde, & Seeley, 1998; McGee, Feehan, & Williams, 1996;15Morrissey-Kane, & Prinz, 1999, Raviv, Raviv, Edelstein-Dolev, & Silberstein, 2003; Rutter, Graham, Chadwick, & Yule, 1976; Sayal, Goodman, & Ford, 2006; Stiff man et al., 2004; Trudgen & Lawn, 2011; Zwaanswijk et al., 2007).

Adolescence is the most crucial stage in the life of human beings. This transitory period between childhood and adult is marked by the maximum number of physical changes that an automatically result to an extremely disturbed mental state as well. Apart from the general issues faced by the adolescents at this stage, health acquired major factors for them. Adolescence refer to the period between 10 and 19 years, is important formative time which to a large extend, shapes the future course of boys and girls lives. Although this process of growth is physical the person is also on the way to be becoming intellectually and emotionally nature. During puberty, young people become physically mature and capable of producing offspring. Accompanying rapid changes in body size and proportions are changed in physical features related to sexual functioning. Some, called primary sexual characteristics, involve the reproductive organs like ovaries, uterus, and virgin in female. Others, called secondary sexual characteristics, are visible on the outside of the body and serve as additional signs of sexual maturity, for example, in the life of adolescent girls breast development, widen of hip, appearance of underarm and pubic hair are taken place. Menstruation is the most visible changes among female puberty usually begin with the budding of the breasts and the growth spurts. Menarche typically happens around 19 years. During social development, adolescents spent more time with peers. Friends become more important. An adolescent is no more ego-centric or selfish. They want to mound his behavior according to the norms of the society. The social circle of an adolescent is very wide. Here they become interested in opposite sex. Sexual development also reaches its peak during adolescence. The adolescent is sexually mature. At this stage the young boys and girls follow in love with themselves. They are keen to made friendship or establish even sexual relationship with members of the opposite sex.

1.2 Justification of the Study

School going rural adolescents in Bangladesh does not know about their changing behavior and psychological and physical conditions adequately. The traditional constraints surroundings growing girls rob them of a healthy and natural adolescence, early marriage; dangerous pregnancy and huge responsibility for domestic work are their usual fate. On the other hand, boys have a little knowledge about changing physical conditions as a result they go to brothel or see pornography. So they can fall in dangerous sexual diseases. They have an attraction to the opposite sex and sometimes they do immoral or illegal activities. Girls are treated as a burden devoid of basic rights even their family. Discrimination prevails in every sphere of education, nutrition, health care facilities, freedom of movement, social intercourse. Puberty is a transitory period of life when a child turns into adult and rate of facing various needs is greater than other periods of life. They face various problems like health hazards, malnutrition, mental problems etc. In order to know the health situation of adolescent girls and boys we selected this topic for conducting research. Gathering information regarding the demand, problem, existing system of services would encourage the adolescent and their family to be conscious about these. Information on health-seeking behavior of cases in the group is crucial. However in Bangladesh to date, no studies into the health seeking behavior of school going adolescent at Dapunia, Mymensingh Sadar, Mymensingh available. Because they have differing background characteristics and there is also variation in some of the determinants of health-seeking behavior, the applicability to the group of the available findings is also limited. In view of this, this study is designed and conducted to provide some information on health-seeking behavior of rural adolescent particularly school going adolescent at Dapunia, Mymensingh Sadar, Mymensingh. The findings could assist health planners in designing appropriate health-seeking promotion strategies. People of rural are often less consciousness about health seeking behavior of school going adolescents. As it affects their life style, it is rational to explore the health seeking behavior of them and the study will help the planners & policy makers to take necessary actions for improving the health seeking behavior & reduce adverse consequence.

1.4 Research Question

What is the health care seeking behavior of rural adolescents?

1.5 Objectives of the Study:

General Objective

To find out the health care seeking behavior of rural adolescents.

Specific Objectives

1. To find out the adolescent health problems.
2. To find out the available health service for adolescents.
3. To identify the factors related to health care seeking behavior of adolescents.
4. To determine the socio-demographic characteristics of the respondent.

1.6 Key Variables:

A. **Variables related to adolescent health problems:**

- Menstrual problem
- Nutritional deficiency
- Wet dream
- Early and unwanted pregnancy
- Mental health
- Accident, violence and sexual abuse

B. **Variables related to available health services:**

- Clinic
- Doctor's chamber
- Medical Hospital
- Family planning clinic/Family welfare centre (FWC)

C. **Variables related to factors for identifying health seeking behavior:**

- Accessibility of health center facility in terms of time spent
- Availability of transportation
- Attitude of health care staff
- Cost of service
- Family decision
- Long distance of health center

D. **Variables related to socio-demographic characteristics:**

- Age
- Sex
- Religion
- Education of parents
- Occupation of parents
- Family income
- Family size
- Housing condition
- Daily expenditure

1.7 Operational Definitions:

1. Health Care Seeking Behavior: Health care seeking behavior is the first step towards the cure of any health problem. Health care seeking behavior is the prevention, treatment management, preservation of mental & physical wellbeing through the services offered by medical & health professions.

2. Health: Health refers to the better functioning of body and mind and absence of any infections disease. A state of well-being that takes into account an individual's physical, mental, and emotional vitality and desires health, a bodily state in which all parts are functioning properly. Also refers to the normal functioning of a part of the body.

3. Behavior: According to Wikipedia, behavior refers to the actions or reaction of an object or organism, usually in relation to the environment. Behavior can be conscious or unconscious, overt or covert and voluntary or involuntary.

4. Health Behavior: Any actions undertaken by an individual, which have the potential to influence health (e.g. diet, smoking, physical activity, consulting with health care professionals) Health behavior reflects a person's health beliefs.

5. Adolescent: Unmarried girls / boys who reads in class vi to x age ranges is 10-19 years.

6. Menstrual problem: Adolescent who face different health problem during their menstruation like lower abdominal pain, profuse bleeding, scanty bleeding, vomiting, irritation and itching in vulva/ vagina, desquamation and soreness in inner part of vulva/vagina and others.

7. Wet dream: Wet dream is a process of adolescent boys when semen's produce and secret from body.
8. Sharing: Person discussed tropics with others. In this context adolescent discuss problems with-others.

III. Methods and Materials

This study was under taken with the objective to find out the health care seeking behavior of rural adolescents, secondary school going students. For achieving the objectives mentioned above, this study was carried out systematically and the methodology mentioned below:

2.1 Study design:
It was a Cross-sectional Study which was conducted among secondary school going adolescents.

2.2 Study place:
The study has been conducted at Dapunia High School, in Mymensingh.

2.3 Study Period:
The study period was throughout from 1st January to 31st December 2016 including preparation of the data collection instrument, field testing of instrument, data cleaning, editing, analysis and reporting.

2.4 Study Population:
Study population were rural adolescents (12-19 years) studying at secondary school, who were willing to participate in this study.

2.5 Respondent Selection Criteria:

Inclusion criteria

- Respondent who are adolescent (12-19 years) and studying at secondary school.
- Willing to participate.

Exclusion criteria

- Adolescent who are severe ill.
- Not willing to participate.

2.6 Sampling Method:
Purposive sampling method was adopted for the descriptive part of the study.

2.7 Sample size:
Statistically the following formula was used to calculate sample size (Daniel, 1991; Kothair, 1985).
The prevalence of the study will be taken as =50%.

$n=z^2pq/d^2$

$(1.96)^2\ 0.50(1-.5)/\ (0.05)^2$

=384

Here,
n=desired sample size.
z=confidence limit (1.96 for 95% confidence level)
p=prevalence rate (50%)
q=1-p
d=Margin of error (set at 0.05)
Calculated sample size was 384. Considering the resource constraints this study included 200 respondents. So, the sample size of the study was 200.

2.8 Data Collection Techniques:
Initially informed written consent was obtained from each respondents following introducing and informing about purpose, objectives and procedures of the study. Data were collected by face to face interview ensuring the privacy and confidentiality of data. Time required for data collection from each individual was about 25-30 minutes.

2.9 Data Collection Tools:
Data were collected by semi- structured questionnaire.

2.10 Data Collection Procedure:
At the beginning of data were collected, permission from concerned authorities of mentioned institute. The pretesting was carried out at Civil Aviation High School, which was helpful for finalizing the questionnaire. After finalization of the questionnaire getting permission from school authority then data were collected from mentioned Secondary High School. The purpose of the study was explained in details to respondents. After the verbal consent as per selection criteria of the study, data were collected from the respondents through face to

face interview. Questions were asked in Bengali. The respondents were given full assurance on some ethical point of view that under no circumstances any part of the interview will be disclosed to any unauthorized person. Collected data were checked and verified at the end of work.

2.11 Statistical Analysis:
At the end of the data collection, individual questionnaire was edited through checking and rechecking to see whether it was filled completely and consistently. Then the data were entered in to the computer with the help of software SPSS program version 21, then data were analyzed.

2.12 Ethical Implication:
The study was done through collection of data using questionnaire. Neither any intervention nor any invasive procedures was undertaken. However, the research protocol was approved by the ethical committee of the National Institute of Prevention and Social Medicine (NIPSOM), under the Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh, before starting the study ethical clearance was taken from the BSMMU for conducting the study. Before initiation of the interview detailed study related information were read out and explained in a printed handout. They were informed of their full right to participate or refuse to participate in the study. Informed consent was taken from all the respondents. By providing proper privacy, sensitive questions were asked. The researcher also assured the respondents that the data collected through this study would be used to guide the service providers and policy makers for determining the health care seeking behavior of rural adolescents. A complete assurance was given to them that all information provided by them would not be published or exposed anywhere. Their participation and contribution will be acknowledged with due respect. After completion of these procedures the interview was started with their due permission.

2.13 Limitations of the Study
The study encountered the following limitations:

- The study only one cover selected area. A small number of secondary school going adolescent had been selected for data collection. As a result, some important cases had been excluded who can provide more realistic information for this study.

- The respondents were selected following purposive sampling technique and the sample size determined proportionately and by the time limitation.

- The sample of this study may be biased because all respondents were selected from the population by using non- probability sampling techniques.
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IV. Result of the Study

In the findings of the study, efforts have been made to present the data and their analysis in tabulated and graphical format. The data shown and analyzed the table are collected directly by using Interview questionnaire. The major findings of the study are sketched below.

4.1 Socio-demographic characteristics of study population:

Table-1: Distribution of the respondents by their sex.
n=200

Sex	No. of Adolescent	Percent
Male	77	39
Female	123	61
Total	**200**	**100**

Table-1 shows distribution of respondents according to sex, out of 200, 77 (39%) were male and 123 (61%) were female.

Table- 2: Distribution of the respondents by their age.
n=200

Age	No. of Adolescent	Percent
12 to 14	74	37
15 to 16	126	63
17 to 18	00	0
Total	200	100

Above table shows distribution of the age of respondents. Out of the total 200 respondent's maximum 126, (63%) respondents belonged to age group 15-16 years. On the other hand, minimum 74, (37%) respondents belonged to age group from 12 to 14 years. The mean age was 14 and median was 15.

Table-3: Distribution of the respondents by religion.
n=200

Religion	Frequency	Percent
Muslim	197	98
Hindu	2	1
Christian	1	1
Total	200	100

The above table indicates that maximum respondents 197 (98%) were Muslims, 2 (1%) were Hindus and the rest (1%) were Christians out of 200 adolescents.

Table- 4: Distribution of the respondents according to family type.
n=200

Type of Family	Frequency	Percent
Nuclear	154	77
Joint	45	22
Extended	1	1
Total	200	100

Respondents' family type is shown in table 4. Majority 154 (77%) of the respondents were from nuclear families, 45 (22%) from joint families and only one (1%) was from extended family.

Table- 5: Distribution of the respondents according to living accompaniments.
n=200

Living accompaniments	Frequency	Percent
Mother	16	8
Both	152	76
Others (Grandmother, Aunt)	32	16
Total	200	100

Table 5 shows the status of adolescent according to living accompaniments. Out of 200 respondents, Majority 152 (76%) respondents were living with both i.e. father and mother, 16 (8%) respondents were living with only mother and rest 32 (16%) respondents were living with others (Grandmother, Aunt).

Table-6: Distribution of respondents according to House type.
n=200

Type of House	Frequency	Percent
Kancha house	8	4
Pacca house	40	20
Semi pacca house	40	20
Tin made house	112	56
Total	200	100

Table 6 shows type of adolescent's house. It was found that among the respondents 4% lived in kancha house, 20% lived in pacca house, 20% lived in semi pacca house and 56% lived in tin made house.

Table-7: Distribution of the respondents according to their father's education
n=200

Education of fathers	Frequency	Percent
Illiterate / Non formal education	76	38
Primary	68	34
SSC	36	18
HSC	20	10
Total	**200**	**100**

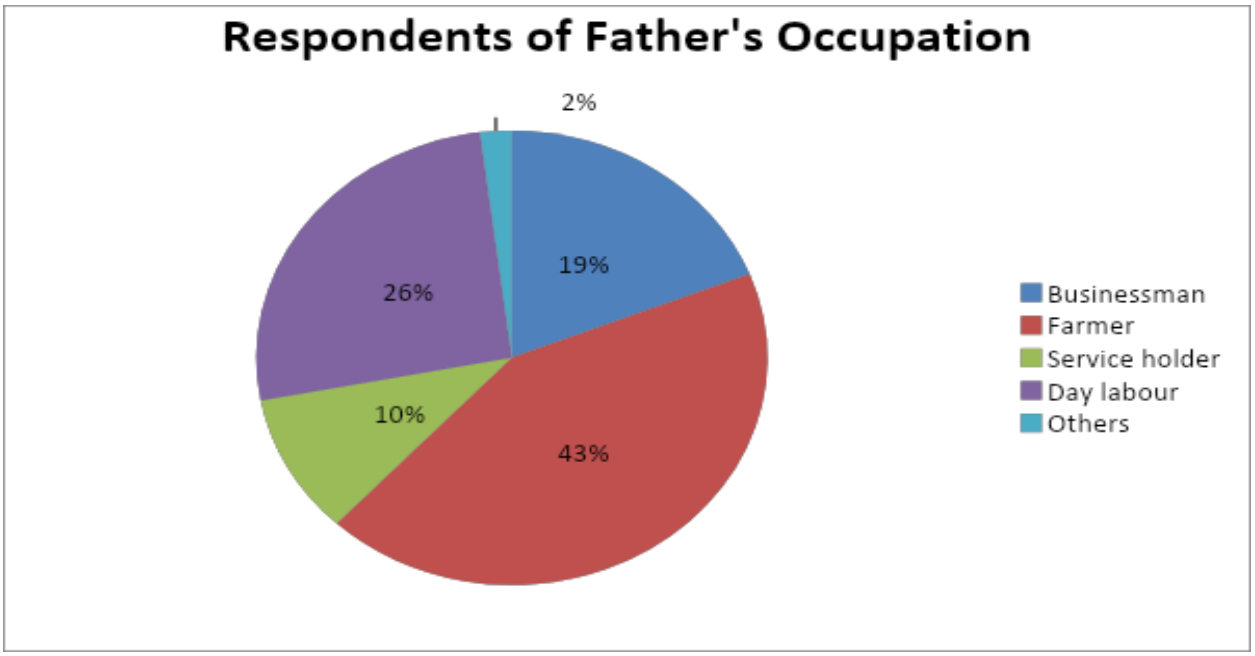
Educational status of the adolescent's father is shown in table 7. Out of 200 respondents 76 (38%) reported illiterate / non formal education, 68 (34%) reported primary level, 36 (18%) reported SSC level and 20 (10%) reported HSC level.

Table-8: Distribution of the respondents according to their mother's education.
n=200

Education of mothers	Frequency	Percent
Illiterate / Non formal education	72	36
Primary	56	28
SSC	60	30
HSC	12	6
Total	**200**	**100**

Educational status of the adolescent's mother is shown in above table, where 36% mentioned their mother were illiterate / non formal education, 30% said SSC level , 28% reported primary level and 6% reported HSC level respectively.

Figure-1: Distribution of the respondents according to father's occupation.
n=200



Above figure shows that 86 (43%) of the respondents fathers occupation were farmers, 52 (26%) were day labors, 38 (19%) were businessmen, 20 (10%) were service holders and 4 (2%) were others (rickshaw puller and butcher).

Table -9: Distribution of the respondents according their mother's occupation.
n=200

Occupation of mothers	Frequency	Percent
Housewife	196	98
Service holder	4	2
Total	**200**	**100**

Considering mother's occupation of adolescents, the above table shows, 196 (98%) respondents' mother occupation were housewife and 4 (2%) were service holders.

Table-10: Distribution of the respondents according to monthly family income.
n=200

Monthly family Income (in taka)	Frequency	Percent
Up to 3000	15	8
3001-5000	37	18
5001-8000	17	9
8001-10000	50	25
10001- 15,000	40	20
15001 and above	41	20
Total	**200**	**100**

Above table shows that 25% respondent's monthly family income had 8001-10000 taka, 20% had 15001-Above taka, 20% had 10001-15000 taka, 18% had 3001-5000 taka, 9% had 5001-8000 taka and 8% had up to 3000 taka.

Table- 11: Distribution of the respondents according to monthly expenditure of family.

n=200

Monthly Expenditure (in Taka)	No. of Adolescent	Percent
Up to 3000	31	16
3001-5000	46	23
5001-8000	18	9
8001-10000	55	27
10001- 15,000	38	19
15001 and Above	12	6
Total	200	100

The above table shows that out of the total 200 respondents 55 (27%) had monthly family expenditure 8001-10000 taka, 46 (23%) had 3001-5000 taka, 38 (19%) had 10001-15000 taka, 31 (16%) had up to 3000 taka, 18 (9%) had 5001-8000 taka and 12 (6%) had 15001 and above taka.

Table-12: Distribution of the respondents according to daily expenditure that they got from family.

n=200

Amount (BDT)	No. of Adolescent	Percent
5	12	6
10	68	34
15	4	2
20	72	36
30	20	10
50	20	10
60	4	2
Total	**200**	**100**

Considering adolescents got money for daily expenditure, above table shows that among 200 respondents 72 (36%) got 20 taka, 68 (34%) got 10 taka, 20 (10%) got 30 taka, 20 (10%) got 50 taka, 12 (6%) got 5 taka, 4 (2%) got 15 taka and 4 (2%) got 60 taka.

Table -13: Distribution of the respondents according to transport use to come to School.

n=200

Transport	Frequency	Percent
Bus	8	4
Auto rickshaw	28	14
Rickshaw/van	28	14
By foot	136	68
Total	200	100

The above table shows using transportation to come to school. Among 200 respondents, 136 (68%) came to school by foot, 28 (14%) came by Auto rickshaw, 28 (14%) came by Rickshaw/Van, and 8 (4%) came by Bus respectively.

4.2 Health Problems at Adolescent Stage:

Table-14: Distribution of the respondents regarding adolescents (Girl) facing problem in their first menstruation.

n=200

Facing problem in their first menstruation	Frequency	Percent
Yes	24	20
No	99	80
Total	**123**	**100**

Above table shows adolescents (girls) facing problem in first menstruation. Among 123 respondents, 99 (80%) reported they did not face any problem in their first menstruation and 24 (20%) reported they faced problem in their first menstruation.

Table- 15: Distribution of the respondents (girl) regarding facing any menstrual problem at present.

n=123

Facing any menstrual problem at present	Frequency	Percent
Yes	16	13
No	107	87
Total	123	100

Above table shows adolescents (girls) facing menstrual problem at present. Majority 107 (87%) of the girls mentioned they did not face any problem and whereas16 (13%) reported they faced problem respectively.

Table-16: Distribution of Adolescent (Boys) facing problem in first wet dream

n=77

Facing problem in first wet dream	No. of Adolescent (boy)	Percent
Yes	29	38
No	48	62
Total	77	100

Above table shows adolescents (boys) facing problem in first wet dream. Among 77 respondents, 48 (62%) reported they did not face any problem in their first wet dream and 29 (38%) reported they faced problem in their first wet dream.

Table-17: Distribution of Adolescent (Boys) facing problem for wet dream at present.

n=77

Facing problem for wet dream at present	Frequency	Percent
Yes	23	30
No	54	70
Total	**77**	**100**

The above table shows that adolescents (boys) facing problem for wet dream at present. Among 77 respondents, 54 (70%) reported they did not facing any problem at present and 23 (30%) reported they faced problem respectively.

Table -18: Distribution of the respondents regarding problems affecting their daily activity.
n=200

Problems affecting their daily activity	Frequency	Percent
Yes	48	24
No	152	76
Total	**200**	**100**

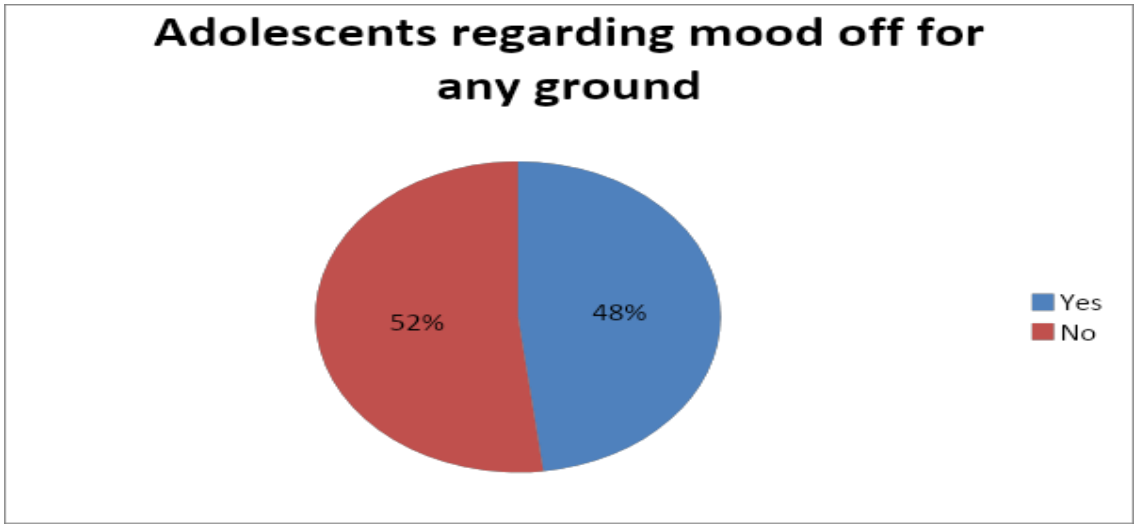
Above table reveals that problems affecting adolescent's daily activity. Among 200 respondents, 152 (76%) reported problems not affecting their daily activity and 48 (24%) reported problems affecting their daily activity respectively.

Table-19: Distribution of the respondents regarding having any other physical problem.
n=200

Having any other physical problem	Frequency	Percent
Yes	52	26
No	148	74
Total	**200**	**100**

Above table shows that majority 148, (74%) reported they had no other physical problem, whereas 52, (26%) reported they had other physical problem.

Figure-2: Distribution of the respondents regarding feeling mood off for any ground.
n=200



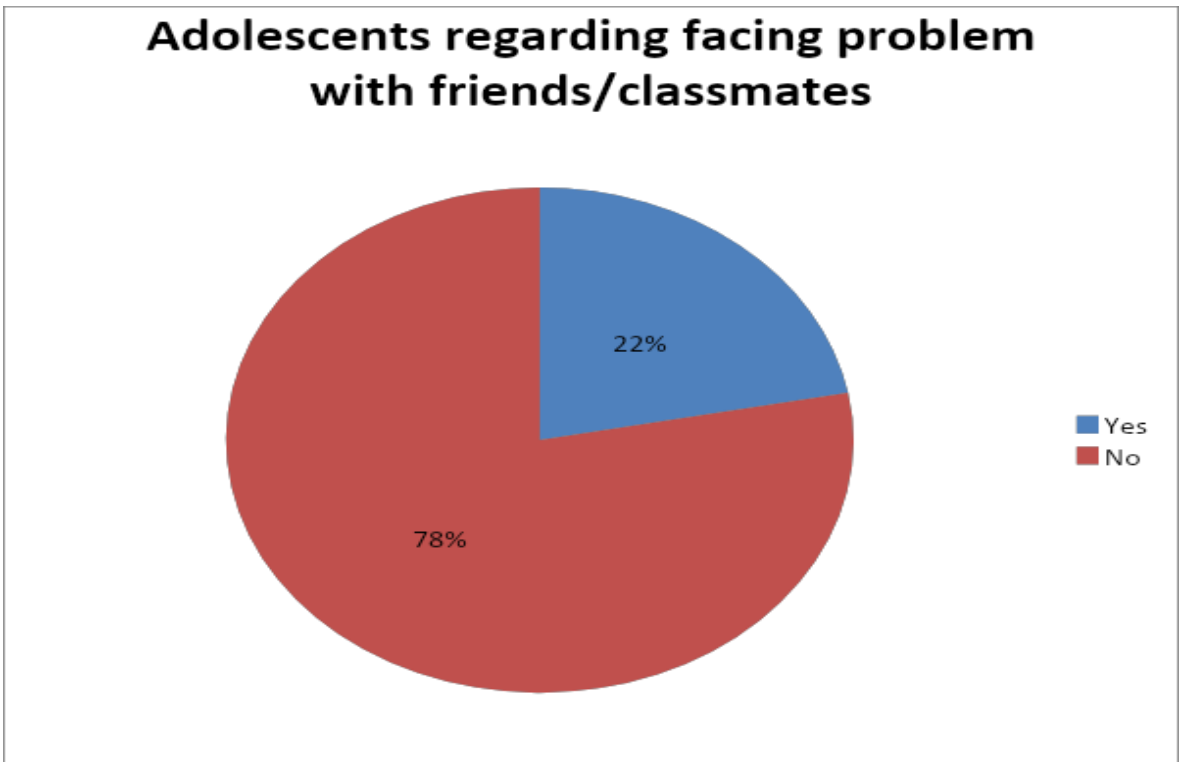
Above pie chart has been shown that adolescent feeling mood off for any ground. Among 200 respondents, 104 (52%) reported they did not feel mood off and 96 (48%) reported they felt mood off for different ground respectively.

Table-20: Distribution of the respondents regarding facing problem with parents
n=200

Facing problem with parents	Frequency	Percent
Yes	23	12
No	177	88
Total	**200**	**100**

Above table reveals that among 200 respondents, 177 (88%) reported they did not face any problems with parents, 23 (12%) reported they faced problem with parents respectively.

Figure-3: Distribution of the respondents regarding facing problem with friends / classmates
n=200



Above figure shows that majority adolescents 157 (78%) reported they did not face any problems with friends/classmates and 43 (22%) reported they faced problem with friends/ classmates.

Table- 21: Distribution of the respondents (girls) opinion according to ever faced eve teasing.
n=123

Opinion on faced eve teasing	Frequency	Percent
Yes	70	57
No	53	43
Total	**123**	**100**

Above the table shows that majority 70 (57%) of the respondents mentioned they faced eve teasing and 53(43%) reported they did not faced ever eve teasing respectively.

Table -22: Distribution of the respondents regarding seeking help to others n=70

Seeking help to others	Frequency	Percent
Yes	50	71
No	20	29
Total	**70**	**100**

Above table shows that among 70 respondents, 20 (29%) reported they did not seek help to others and 50 (71%) reported they seek help to others respectively.

Table-23: Distribution of the Adolescents ever abused / tortured at home or outside. n=200

Opinion on tortured	No. of Adolescent	Percent
Physically	80	40
Mentally	40	20
Over phone	10	5
No	70	35
Total	**200**	**100**

Above table shows that among 200 respondents, 10 (5%) reported over phone, 80 (40%) reported physically, 40 (20%) reported mentally tortured home/outside, On the other hand, 70 (35%) reported they did not ever abused/tortured.

Table- 24: Distribution of the respondents according to sharing the problem with others. n=130

Sharing the problem with others	Frequency	Percent
Yes	72	55
No	58	45
Total	**130**	**100**

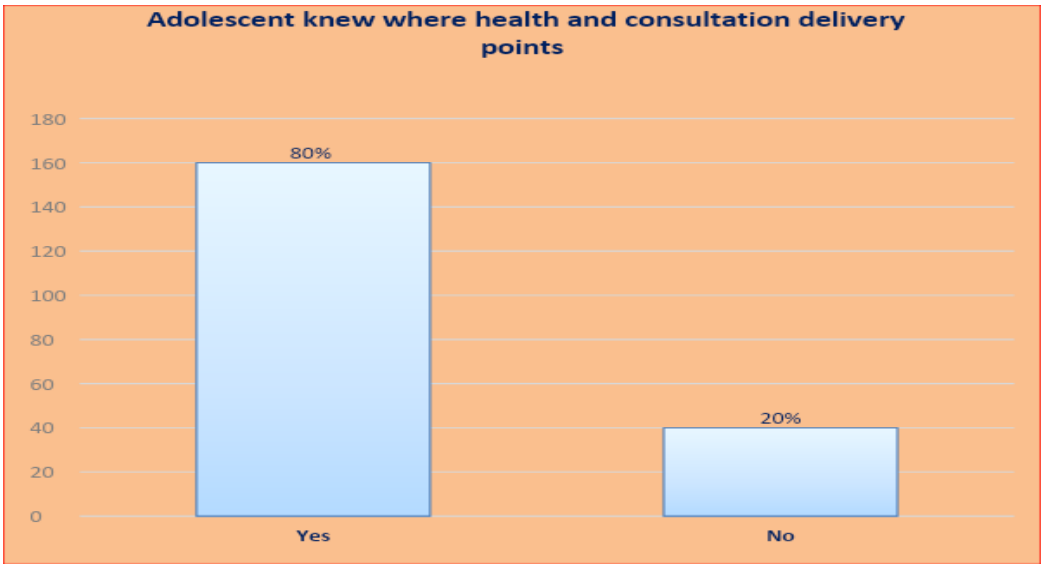
Above table shows 72 (55%) mentioned they shared these problems with others and 58 (45%) of the respondents stated they did not share these problems with others.

Table -25: Distribution of the respondents regarding sharing the problems with different persons. n=72

Sharing the problem with different persons	Frequency	Percent
Parents	**36**	**50**
Friends	**18**	**25**
Health worker	**7**	**10**
Others (Brother, Cousin)	**11**	**15**
Total	**72**	**100**

Above table shows that 36(50%) respondents reported sharing with parents, 18(25%) respondents reported sharing with friends, 7(10%) respondents reported sharing with health worker and 11(15%) respondents reported sharing with cousin and brothers about the problems.

Figure-4: Distribution of the respondents' knew where adolescent health and consultation delivery points. n=200



Above figure demonstrates that among 200 respondents, 40 (20%) informed they did not knew where adolescent health and consultation services provided and 160 (80%) reported they knew where adolescent health and consultation services provided respectively.

Table-26: Distribution of the respondents regarding went to health care center in the last 6 months. n=160

Went to health care centre in the last 6 month	Frequency	Percent
Yes	136	85
No	24	15
Total	160	100

Out of 160 respondents, 136(85%) stated they went to health care center in the last 6 months. On the other hand 24 (15%) stated they did not go to health care center in the last 6 months.

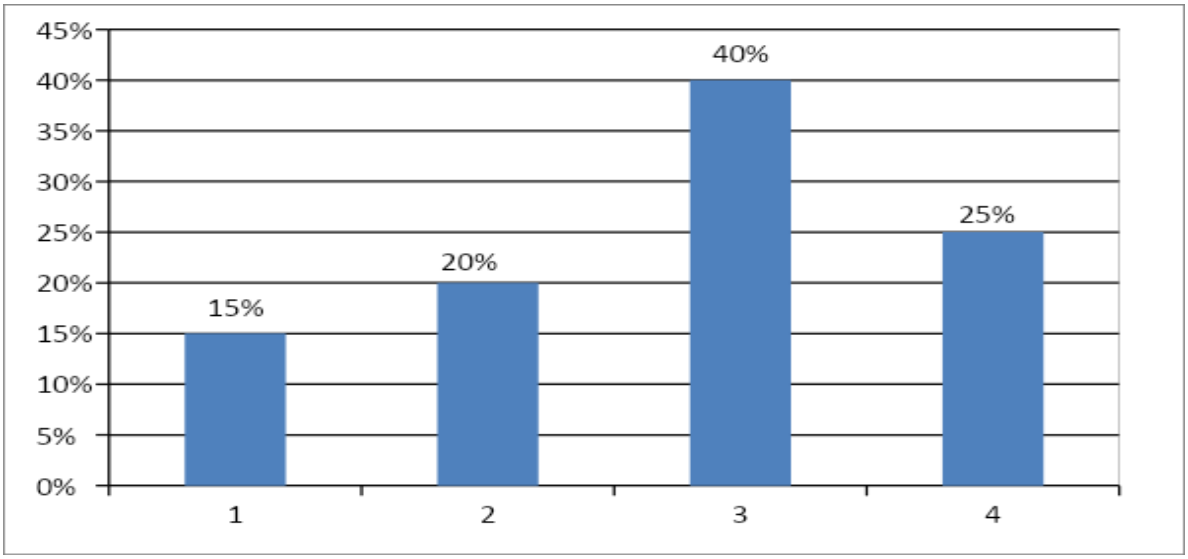
Table-27: Distribution of respondents reasons for not going to medical center in the last 6 month. n=24

Reasons for not going to medical center.	Frequency	Percent
Economic crisis	10	40
Communication problem	2	10
Family decision	5	20
Need money to get health service	3	12
Long distance of health center	1	5
Fear	1	6
Busy with his study	2	7
Total	**24**	**100**

Above table shows that 2 (7%) respondents reported busy with his study, 10 (40%) respondents reported economic crisis, 1 (5%) respondents reported long distance of health center, 1 (6%) respondents reported fear, 5 (20%) respondents reported family decision, 2 (10%) respondents reported communication problem, 3 (12%) respondents reported need money to get health service as reasons for not going to medical/ health care center in the last 6 months.

Figure-5: Distribution of the respondents regarding type of health care center where adolescents went in the last 6 month.

n=136



Above figure shows that 21(15%) respondents stated community clinic/ family welfare center, 54(40%) respondents stated Upazilla Health Complex/ District Hospital, 27 (20%) respondents stated doctor's chamber, 34(25%) respondents stated traditional healer/village doctor/ quack stated health care center where adolescent went in the last 6 months.

Table-28: Reasons for going to health care Center in the last 6 months.

n=136

Reasons for going to health care center	Frequency	Percent
Physical problem, eg. Fever, headache, diarrhoea, dental problem etc.	83	61
Mental problem	15	11
Immunization	16	12
Family planning methods	3	2
Menstrual problem	19	14
Total	**136**	**100**

Above table indicates that 83(61%) respondents reported physical problem, 16(12%) respondents reported immunization, 15(11%) respondents reported mental problem, 3(2%) respondents reported family planning methods and 19(14%) respondents reported menstrual problem.

Table-29: Distribution of the respondents which kinds of health facilities were provided from health care center.

n=136

Services	Frequency	Percent
Iron tablet	20	15
Treatment of menstrual problem	34	25
Adolescent counseling	37	27
Personal hygiene	25	18
Health education	20	15
Total	136	100

Above table shows that among 136 respondents, 20 (15%) reported delivery of iron tablet, 20 (15%) reported health education, 37 (27%) reported adolescent counseling, 25 (18%) reported personal hygiene, 34 (25%) reported treatment of menstrual problem.

4.3 Services of Health Care Centre:

Table-30: Distribution of the respondent opinion regarding getting sufficient health services from health care Centre.

n=136

Getting sufficient health services	Frequency	Percent
Yes	99	73
No	37	27
Total	136	100

Above table shows that majority 99 (73%) of the respondents mentioned they got sufficient health services whereas 37 (27%) reported they did not get sufficient health services from health care center.

Table -31: Distribution of the respondents' opinion regarding reasons for getting Insufficient health facilities from health care center.

n=37

Reasons for getting insufficient health service	Frequency	Percent
Shortage of health care provider	15	40
Shortage of medicine	7	20
Busy of health personnel	4	10
Too many patients were there	11	30
Total	37	100

Above table shows that 11(30%) respondent reported too many patients there, 7 (20%) respondent reported shortage of medicine, 15(40%) respondent reported shortage of health care provider, 4(10%) respondent reported busy of health personnel opinion regarding reasons for getting insufficient health facilities from health care center.

Table- 32: Distribution of the respondents opinion regarding solved the health problems.

n=136

Opinion for solved the health problems	Frequency	Percent
Yes	95	70
No	41	30
Total	**136**	**100**

Above table shows that among 136 respondents, 95 (70%) stated health problems were solved and 41 (30%) stated health problems were not solved.

Table- 33: Distribution of the respondent's opinion satisfaction on treatment.

n=136

Opinion satisfaction on treatment	Frequency	Percent
Yes	78	57
No	58	43
Total	136	100

Above the table shows majority 78 (57%) of the respondents stated that they were satisfied on treatment whereas 58 (43%) reported they were not satisfied on treatment.

Table-34: Distribution of the respondents regarding getting support from guardian regarding identification and solving health problem.
n=200

Getting support from guardian	Frequency	Percent
Yes	122	61
No	78	39
Total	200	100

Out of 200 respondents, 122 (61%) stated they got support from guardian regarding identification and solving health problems and 78 (39%) stated they did not get support from guardian regarding identification and solving health problem.

Table -35: Reasons for not getting support from guardian about identification and solving health problem.
n=78

Reasons for not getting support from guardian	Frequency	Percent
Economic problem	35	45
Lack of awareness	16	20
Not allowed to go to health center alone	8	10
Guardians are busy in their household works	19	25
Total	78	100

Above table shows that 19 (25%) respondents reported guardians were busy in their household works, 35 (45%) respondents reported economic problem, 16 (20%) respondents reported lack of awareness, 8 (10%) respondents reported not allowed to go to health center alone reasons for not getting support from guardian about identification and solving health problem.

Table-36: Distribution of the respondents regarding influencing factors for adolescent's health.
n=200

Factors	Frequency	Percent
Financial insolvency	110	55
Lack of proper education	50	25
Lack of proper nutrition	16	8
Lack of information about health care service	24	12
Total	**200**	**100**

Above table shows out of 200 respondents, 110 (55%) respondents reported financial insolvency, 50 (25%) respondents reported lack of proper education, 24 (12%) respondents reported lack of information regarding health care service, 16 (8%) respondents reported lack of proper nutrition, influencing factors for adolescent's health.

V. Discussion

School going rural adolescents in Bangladesh does not know about their changing behavior and psychological and physical conditions adequately. There are 27.8 million adolescents aged 10-19 years in Bangladesh, 13.8 million girls and 14 million boys making up about one fifth of the total population. Most adolescents have limited scope for acquiring knowledge and skills for their self-development and protection. The findings of the study could assist health planners in designing appropriate health-seeking promotion strategies.

The study was under taken "To find out the health care seeking behavior of rural adolescents" The assessment and findings are discussed below-

Out of 200 respondents, 77 (39%) were male and 123 (61%) were female where maximum respondents belonged to age group 15-16 years [126 (63%)] and minimum respondents belonged to age group from 17 to 19 years [74 (37%)]. Among all respondents 197 (98.5%) were Muslims, 2 (1%) were Hindus and the rest 1 (0.5%) were Christians. Majority [154 (77%)] of the respondents were from nuclear families, 45 (22.5%) from joint families and only one (0.5%) was from extended family. On the other hand 152 respondents were living with both i.e. father and mother, 16 respondents were living with only mother and rest 32 respondents were living with others

It was found that among the 200 respondents 8 (4%) had kancha house, 40 (20%) had pacca house, 40 (20%) had semi pacca house and 112 (56%) had tin made house. . Among respondents 76 (38%) expressed their father illiterate, 68 (34%) reported primary level, 36 (18%) reported SSC level and 20 (10%) reported HSC level. Among all adolescent's 36% mentioned their mother were illiterate / non formal education, 30% said SSC level primary level, 28% reported primary level and 6% reported HSC level. .

Father's occupations of respondents were 86 (43%) were farmers, 52 (26%) were day labours, 38 (19%) were businessmen, 20 (10%) were service holders and 4 (2%) were others and mother's occupations were196 (98%) were housewife and 4 (2%) were service holders. Out of the total 200 respondents 50 (25%) had monthly family income 8001-10000 taka, 41 (20%) had 15001-Above taka, 40 (20%) had 10001-15000 taka, 37 (18%) had 3001-5000 taka, 17 (9%) had 5001-8000 taka and 15 (8%) had up to 3000 taka. On the other side 55 (27%) had monthly family expenditure 8001-10000 taka, 46 (23%) had 3001-5000 taka, 38 (19%) had 10001-15000 taka, 31 (16%) had up to 3000 taka, 18 (9%) had 5001-8000 taka and 12 (6%) had 15001 and above taka. Considering adolescents get money for daily expenditure table 16 it was shown that among 200 respondents 156 (78%) got 5 to 25 taka, 40 (20%) got 25 to 50 taka and 4 (2%) got more than 50 taka.

It can be known, no study has directly been conducted on health seeking behavior of secondary school going adolescent in Mymensingh. But it can be mentioned here the findings of some studies related a bit to this study indirectly. Most of the physical changes occur during puberty. Physically they turn into adulthood quickly but their mental changes slower than that of physical changes. Social aspects of adolescence, health condition in adolescence, problem in adolescence, familiar attitude towards the problems of adolescent and the various aspects of adolescence is yet to get considerable attention because of which ground reality of their important issue is little known.

A large number of adolescent girls suffer from malnutrition. The prevalence of malnutrition is found to be markedly higher among female children compared with male children over one half of adolescent girls are stunted and more than one-third of adolescent girls in rural areas are wasted. Adolescent girls" suffer from Iron, Iodine and Vitamin- A deficiency. Forty-three (43) percent of adolescent girl's suffer from iron-deficiency Anemia (Barkat et. al., 2003**)**.

Available information suggests that about 30 percent adolescent Bangladeshi female are already mothers and another 6 percent are pregnant with first child **(** Barkat et. al., 2003**)**. This study it was found, 56 (28%) were not suffering from anemia, 20 (10%) reported they were suffering from anemia and rest 124 (62%) did not know

Bangladesh's adolescent's population was estimated at about 28 million in 2000. With a total population of about 130 million adolescents comprise 22 percent of total population, (Barkat et. al., 2003**)**. The predominantly traditional and conservative nature of Bangladeshi society demands that young unmarried adolescent girls are modest and at least in theory shared from sexuality and reproductive health knowledge. This combined with low levels of education; create an environment of misunderstanding regarding reproductive and sexual health. Soon after the onset of menstruation adolescent girls particularly in rural areas are married off, the social taboo regarding menstruation is so high that young adolescent girls and their mothers usually don't share their experience and knowledge of menstruation. That research study carried out both in rural and urban areas of Bangladesh, found that out of 132 girls between the ages of 10-14 only 34% knew of menstruation before experiencing it and as a result it was often experienced with mental trauma.

In this research it was found, out of 123 adolescent (girl), 99 (80%) reported they did not facing any problem in their first menstruation and 24 (20%) reported they faced problem in their first menstruation. Moreover 107 (87%) adolescent (girl) respondents reported they did not facing any problem for menstruation at present and 16 (13%) adolescent (girl) respondents reported they faced problem for menstruation at present.

Adolescent girls suffer due to discrimination and lack of awareness. (UNICEF, 2002); adolescent appear to be poorly informed with regard to their own sexuality, physical well-being, health and bodies. Whatever knowledge they have, moreover, is incomplete and confused. Low rate of educational attainment, limited sex education activities and inhabited attitudes towards sex contribute to this ignorance (Barkat et. al., 2003).

On the other hand among 77 adolescent (boys) respondents, 48 (62%) reported they did not facing any problem in their first wet dream and 29 (38%) reported they faced problem in their first wet dream. Furthermore 54 (70%) adolescents (boy) reported they did not facing any problem and 23 (30%) adolescent (boys) respondents reported they faced problem at present. Among 200 respondents, 152 (76%) reported these problems not affect their daily activity and 48 (24%) reported these problems affect their daily activity. Among all respondents, 148 (74%) reported they had no other physical problem and 52 (26%) reported they had other physical problem. Other side 104 (52%) reported they did not feel mood off and 96 (48%) reported they felt mood off for different ground. Out of 200 respondents, 177 (88%) reported they did not face any problems with parents and 23 (12%) reported they faced problem with parents; and 157 (78%) reported they did not face any problems with friends/classmates and 43 (22%) reported they faced problem with friends/ classmates**.**

This research found that majority 57% of the respondent girls mentioned they were faced eve teasing and 43% reported they did not face eve teasing. These eve teasing may hamper adolescent (girls) career and affect their daily activity such as anxiety, depression and suicidal tendency. Among the girl adolescents who were suffered eve teasing 71% sought help to others for their problems.

Among 200 respondents, 10 (5%) reported they were abused/tortured over phone, 80 (40%) reported they were abused/tortured physically, 40 (20%) reported they were abused/tortured mentally at home or outside. On the other hand, 70 (35%) reported they did not ever abused/tortured. Among the adolescent who were tortured 72(55%) stated they share these problems with others and 58 (45%) reported they did not shared these problems with others. Furthermore 36 respondents reported sharing with parents, 18 respondents reported sharing with friends, 7 respondents reported sharing with health worker and 11 respondents reported sharing with cousin about the problems

In another research the help seeking behavior revealed that 110 (64.3%) girls and 80 (42.3%) boys sought help/care for their health problems. However, only two boys and two girls had consulted a doctor for the same. Dr. Afrin Ahmed Clara found on her research that most of the adolescent get reproductive information from TV/ Radio. She shows 16.2% adolescent get advice from MBBS doctor. Her research indicates 41% adolescent faced barriers from indecision. The most common source for the consultation for the reported problems among boys was friends (47.6%) while among girls it was mother (63.6%). Other common sources for consultation among boys were mothers (13.8%), both mother and father (17.5%) and only father (10%) while among girls other sources were friends (20.7%), sister (3.6%) and cousin (3.6%). Consultation with a doctor any time before the survey was 26.5% among boys and 36.3% among girls. While consulting a physician a family member accompanied the girls more often (69%) than the boys (46%), $p<0.05$(Rajesh Kumar, et al, 2008),

In this research it was found, out of 200 respondents, 40 (20%) informed they did not know where adolescent health and consultation services provided and 160 (80%) reported they knew where adolescent health and consultation services provided. Out of them, 136 (85%) stated they went to medical/ health care center in the last 6 months. On the other hand 24 (15%) stated they did not go to medical/ health care center in the last 6 months. Moreover who did not go to health care center among them 2 (7%) respondents reported busy in his study, 10 (40%) respondents reported economic crisis, 1 (5%) respondents reported long distance of health center, 1 (5%) respondents reported fear, 5 (20%) respondents reported family decision, 2 (10%) respondents reported communication problem, 3 (12%) respondents reported need money to get health service and as reasons for not going to medical/ health care center in the last 6 months. Besides, these 21 (15%) respondents stated community clinic/ family welfare center, 54 (40%) respondents stated Upazilla Health Complex/ District Hospital, 27 (20%) respondents stated doctor's chamber, 34(25%) respondent stated traditional healer/village doctor/ quack as type of health care center where adolescent went in the last 6 months. As the reasons for going to medical/ health care center in the last 6 months, 83(61%) respondents reported physical problem, 16 (12%) respondents reported immunization, 11% (15) respondents reported mental problem, 2% (3) respondents reported family planning methods .

Among 200 respondents, 20 (15%) reported delivery of iron tablet, 20 (15%) reported health education, 37 (27%) reported counseling, 25 (18%) reported personal hygiene, 34 (25%) reported treatment of menstrual problem and services provide for adolescent from health care center.

Among all respondents, 99 (73%) reported they got sufficient health services and 37 (27%) reported they did not get sufficient health services from health care center. Out of them 11 (30%) respondent reported too many patients were there, 7 (20%) respondent reported shortage of medicine, 15 (40%) respondent reported shortage of health care provider, 4 (10%) respondent reported busy of health personnel as reasons for getting insufficient health facilities from health care center. Furthermore 95 (70%) stated health problems were solved and 41 (30%) stated health problems were not solved. Among all respondents, 78 (57%) were satisfied on treatment and 58(43%) were not satisfied on treatment. (Ibanga Ekong, 2015) found his research that rural girls 12.5% girls were unpleasant experience at a health center. On the other hand 122 (61%) stated they got support from guardian regarding identification and solving health problem and 78 (39%) stated they did not get support

from guardian regarding identification and solving health problem. Out of them 19 (25%) respondents reported guardians were busy in their household works, 35 (45%) respondents reported economic problem, 16 (20%) respondents reported lack of awareness, 8 (10%) respondents reported not allowed to go to health center alone as reasons for not getting support from guardian about identification and solving health problem. Among 200 respondents, 16 (8%) respondents reported lack of proper nutrition, 110 (55%) respondents reported financial insolvency, 24(12%) respondents reported lack of information regarding health care service, 50 (25%) respondents reported lack of proper education as influencing factors for adolescent's health.

(Boltena et.al.2005) found that 70.4% university students seeking medical care as well as for student in need of sexual health counseling (72.2%) regardless of age, gender, self-related health, and rural/ pre-urban residence status. However, barriers differed within the various strata. In this research (85%) school going rural adolescents seeking health care and various factors differ health seeking behavior and differ getting health among the adolescents.

5.1 Conclusion

Health service is one of the fundamental rights of the people. In this study, an attempt has been made to investigate the health seeking behavior of secondary school going adolescent at Dapunia, in Mymensingh Sadar, Mymensingh. The study conducted at secondary school going rural adolescent who have socioeconomic differentials in health care seeking behavior. Health care seeking behavior and health care utilization is determined by the organization of the health system. Among the respondents, half of the girls who were interviewed said that they were faced eve teasing, among them three-fourth asked help to others. Among all respondents two fifth of adolescents abused/tortured by physically and one fifth tortured by mentally at home/outside. More than half of adolescents who were tortured shared these problems and asked help from parents, friends, health workers. Among all respondent maximum adolescent suffer from physical problem, adolescents who knew where health care center among them maximum adolescents went in the last 6 month and maximum get sufficient health service from health center. The adolescents who were not getting sufficient health facilities said that it was because of shortage of health care provider, shortage of medicine, busy of health personnel, too many patients were there. Most of them expressed financial insolvency as influencing factors for adolescent's health. Among all respondent maximum adolescents got support from guardian for identification and solving health problem.

5.2 Recommendations

The study findings and selected a lead to make following recommendation:

i. The access to health care secondary school going adolescents should be improved by enhancing preventative interventions, and making services physically accessible to teenagers.
ii. To create awareness, respective authority should take necessary attempt for enhancing health education, serving nutritious foods and provided accurate health-related information which would make a difference.
iii. Government agencies should develop policies, provide funding, and implement programs that can help efforts to improve their health.
iv. Information should be disseminated by using multiple methods including written formats such as text-books.
v. Health/family planning workers at all levels should be trained about the special health needs of adolescent girls.
vi. Information and adolescent-friendly services should be improved to out-of-school and in-school of adolescents and it is high time to introduce adolescent club where they can share their views and problem with each other.

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