PUBLIC HEALTH RESEARCH

Perceived Constraints among Adolescent Girls in Accessing Health Care in Assam, India

Pralip Kumar Narzary*

Fakir Mohan University, Balasore, Orissa, India.

**For reprint and all correspondence: Pralip Kumar Narzary, P G Dept of Population Studies, Fakir Mohan University, Vyasa Vihar, Nuapadhi, Balasore - 756 020, Orissa, India.*
Email: pralipkn@gmail.com

ABSTRACT

Accepted 23 August 2011

Introduction Adolescence is a period of transition from childhood to adulthood. The health need of adolescent girls is quite different from other groups of population and has strong policy implications. Study on perceived constraints in accessing health care is quite essential, because it highly affects the future course of action. This study aims to assess the perceived constraints of never married adolescent girls in accessing health care in Assam, India.

Methods This study used the National Family Health Survey 2005-06 data which covered 493 never married adolescent girls in Assam. Percentage distribution, median and inter quartile range were assessed, associations were cross tabulated and logistic regression was applied to assess degree of associations using SPSS 15.

Results In Assam, the most commonly perceived constraints in accessing health care by never married adolescent girls were the concern about availability of the drugs followed by getting money needed for treatment. About 25.8 percent did not perceive any constraint, whereas 74.2 percent of them perceived some constraints, and about 51.4 percent of the girls perceived between zero-two constraint(s). Bi-variate analyses show that perception greatly varies across different groups or segments. Multi-variate analysis shows that mainly wealth index of the household, native language and education of the girls affected the perception of the never married adolescent girls.

Conclusions To remove the perceived constraints, government may manage the entire health care services through which availability, accessibility, affordability, acceptability and quality can be standardized. Further, efforts are also needed to ensure peace and harmony in the state.

Keywords Constraint - health care - adolescent girl - Assam.

INTRODUCTION

Adolescence is a period of transition from childhood to adulthood, which is characterized by rapid physical, biological and hormonal changes resulting into psychosocial, behavioural and sexual maturation, therefore also referred to as period of turbulence. Although physical and biological changes are universal, but the psychosocial and behavioural manifestations are determined by the cultural system[1], hence problems of adolescence should not be universalized. In India, adolescent girl is deprived of adequate health care, good nutrition and opportunity for schooling.[2] Further, onset of puberty implies more restrictions on her movement, fewer interactions with boys and men, and more active participation in household chores[1], largely due to socio-cultural factors[2]. However, types and magnitude of such restrictions vary with every stratum and geographical region.

In India, the health care infrastructures have considerably increased over the last few decades. But, their mere existence or increase in availability of services does not automatically lead to their utilization. Even while ill, some of the individuals do not seek treatment because they perceive their illness to be less severe, or suffer from financial constraints.[3,4] Financial constraints may be perceived on anticipated cost of treatment.[3,5,6] Pandey found that woman's perceptions on the cost of delivery care services, including the cost of going to health facility and stay, contribute to their decisions to seek delivery care.[5] The preference for particular source or system of treatment depends upon the severity of illness, availability, accessibility, affordability and acceptability of health care services. Its utilization also depends upon quality[7,8] availability of drugs and competence of staff [9]. Faith in a particular source of treatment must have been inherited through long period of practical experiences.[10] This may be perceived currently, gained from past experience or heard from others' mouth. Hence, besides the availability, accessibility, affordability, acceptability and quality of health care facilities, there are hosts of individual, household or socio-cultural constraints that affect the utilization of health care services.

Study on perceived constraints in accessing health care is quite essential because perception arises either from past experience or from anticipation, which strongly affects the future course of action. If a woman perceives insurmountable hurdles - which may exist or may not exist in reality or with less/more of severity - she may silently go on suffering from health problems, as such may compel herself to live a morbid life. Later, some may aggravate into serious illness and other related complications. For instance, many women in India suffer from reproductive health problems silently[11], which may be of much more magnitude among the never married adolescent girls. Because, they are neither old enough to tackle the problems on their own, nor are so young to share everything with their parents. They are likely to suffer from reproductive and sexual health problems more silently, because discussing such issues within the family is considered as taboo in India. There is also no denying the fact that the health needs of adolescent girls are different from the adult women. Understanding of these constraints in health care utilization has also crucial policy implications in health systems development. If such constraints are known, policies can be formulated or existing policies can be restructured to overcome such constraints. Therefore, this study aims to assess the perceived constraints of never married adolescent girls in accessing health care in the State of Assam.

Study area

Assam is one of the states in India, which is located in the northeastern corner of the country. This northeastern corner is popularly known as Northeast India. Assam has a geographical area of about 78,438 sq km (Census, 2011)[12], which is about 2.38 percent of landmass of the country. According to 2011 Census, total population of Assam is 3,11,69,272 persons, which is 2.58 percent of national population; has literacy rate of 73.18 against national average of 74.04; sex ratio of 954 against India's 940; and has a density of 397 persons per sq km against 382 in India.[12] One of the most striking features of the State is that it shares international border with Bhutan in the north and Bangladesh in the west, and at the same time shares boundary with other six northeastern states, whereas not only the state, but the entire northeast region is connected to the mainland of India with only 32 km chicken-neck strips of land, for which the region remained somewhat isolated from the country.

Other striking features of the state are that it is the home of a large number of ethnic groups. Many of which have insurgent group(s) and very active students' union to assert their ethnic identity. Some of the insurgent groups are aspiring for separate state within the country, whereas others have gone to the extent of fighting for sovereignty. This has led the state prone to ethnic conflicts and mass population displacement.[13-16] On the one hand, *bandhs*, strikes, protests by insurgent groups or students' unions persist. On the other hand, combing operations of para-military forces keeps continuing on a regular basis. Thus, shooting, killing and bomb blast are frequent incidents in the state. Further, Assam politics is highly governed by illegal immigration issues and also quite sensitive to in-migration from mainland India. Overall, highly volatile socio-political environment has

been prevailing in the state for about last three decades.

METHODS

The entire study is based on the third National Family Health Survey (NFHS-3) data, the collection of which was undertaken all over the country during 2005-06. The NFHS-3 collected data through direct face to face interview (of both *de jure and de facto* women) conducted at the selected households with the help of well-trained investigators. The well-structured bilingual (English and principal native language) questionnaire/interview schedule was used for the purpose. The content and format of the questionnaire were determined through a series of workshops and meetings of experts from various fields and representatives of the data collecting agencies. These representatives trained the individuals involved in data collection in their respective states.[17]

The target sample for each state was fixed at 4,000, 3,000 and 1,500 completed interviews respectively in states with a population (2001 Census) of more than 30 millions, between 5 to 30 million and less than million. However, the target sample for some of the states was increased to facilitate estimation of HIV prevalence. As such, the target sample for the nation as a whole was 125,000 ever married as well as never married women. Within each state, the sample was allocated proportionally to the sizes of the state's urban and rural populations. The survey used a systematic multi-stage stratified sampling design for both rural and urban domains.

The rural sample was selected in two stages. In the first stage, primary sampling units (PSU) of villages were selected through probability proportional to population size (PPS). Random selection of households was followed within each PSU in the second stage. In the urban areas, a three-stage sampling procedure was followed. In the first stage, wards were selected through PPS sampling, followed by random selection of one census enumeration block (CEB) from each ward. In the third stage, households were randomly selected within each CEB. Finally, systematic circular sampling with a random start was adopted to achieve the desired sample size in each PSU or CEB. Thus, in the rural areas, 2001 Census list of villages served as the sampling frame, while the list of wards in urban areas. The NFHS-3 is designed for self-weighting of the urban and the rural domains. This means that all households and individuals in the same domain share a common household weight and individual weight within a household. (Details of NFHSs are available at http://www.nfhsindia.org).

In Assam, the survey completed 3,840 interviews with women (ever married and never married) in the reproductive age group of 15–49 years from 3,437 households, making thereby a 95 percent women's response rate. However, this study retained only the 493 *de jure* resident never married adolescent girls in the age group of 15–19 years as per the requirement. Similarly, Moore *et. al.* also used the NFHS data to study the adolescent marriage and childbearing in India.[18]

In this study, percentage distribution, median and inter quartile range were calculated. Further, data were cross tabulated and logistic regression was applied to assess the degree of associations using SPSS 15.

Variables

Constraints in accessing health care, the dependant variable, was computed by taking eight related variables/questions (Table 1) asked in the survey. Respondents were asked to answer each of these eight questions with options of 'big problem', 'small problem' or 'no problem'. These eight answers were added together to form a composite variable having categories of 'no constraint' and 'some constraints'. It is done so for the convenience of analyses, because girls having all the eight constraints could form only a small group of only 48 cases (9.7 percent). Girls without any of the eight constraints were put under 'no constraint' category while girls having at least one of them were put under 'some constraints' category.

Exposure to mass media index was computed by taking three variables, namely frequency of reading news paper or magazine, frequency of listening to radio, and frequency of watching television. The respondents who were not at all exposed to any of them were considered as 'not exposed', whereas others were considered as 'exposed' to mass media. *Wealth index* was used as available in the NFHS-3. It is an indicator of the level of wealth which was constructed by using 33 household assets and housing characteristics.[17] Each household asset was assigned a weight (factor score) generated through principal component method. The resulting scores were standardized in relation to normal distribution with a mean of zero and standard deviation of one. Each household thus acquired a score for each asset and summation of this score for it was arrived at. Then the sample was divided into five quintiles, each quintile (group) having 20 percent of the household population at the national level, although not necessarily true at the state level.[17]

Scheduled Castes / Tribes: The Constitution of India defines scheduled caste and tribe populations as communities who are scheduled (listed) in the Articles 341 and 342 respectively.[19, 20] Population belonging to scheduled castes are economically backward and socially occupy the lowest rank in

the caste system. Similarly, the essential characteristics of scheduled tribe communities are 1] Primitive traits, 2] Geographical isolation, 3] Distinct culture, 4] Shy of contact with community at large, and 5] Economically backward.[20] On the contrary, *Other Backward Classes* belong to the castes/communities, other than Scheduled Caste or Scheduled Tribe, that are notified as socially and educationally backward by the State or Central Government.[21]

Source of treatment: Govt. /Municipal Hospital, Govt. Dispensary, Community Health Centre /Rural Hospital/Primary Health Centre, Sub-centre, and Other public health facility were grouped under 'government' category. On the other hand, Private Hospital, Private Doctor/Clinic, Private Paramedic, Vaidya/ Hakim/ Homeopath, Traditional Healer, Pharmacy/Drugstore, other private health facility, and home treatment were grouped under 'private' category.

RESULTS

Magnitude of perceived constraints

Result (Table 1) depicted that in Assam never married adolescent girls do not perceive 'getting permission' and 'finding someone to accompany them to visit health care centre' to be problems. The most commonly perceived constraints were the 'concern about availability of the drugs' followed by 'getting money needed for treatment'. The question regarding concern about availability of the drugs comes mainly when a person visits a government health centre; otherwise most of the drugs are easily available in the market. This seems that adolescent girls understood the question of 'availability of drugs' in terms of accessing a government health centre. Although this question did not specify any particular source of care but pertained to 'wherever the woman would seek care'.[13] Of course, if this assumption would be true, the question of high percentage of adolescent girls reporting of 'getting money for treatment' as a serious problem remains unexplained. Because, government health centers are supposed to provide services free of cost. Thus, should it point towards some anomalies existing in the government health services in Assam? However, as the question cannot be explained with the current set of data, it may be left to be answered by other researchers.

Table 1 Percentage distribution of never married adolescent girls according to various perceived constraints in accessing health care services

Perceived constraints	No problem	Small problem	Big problem
a] Getting permission to go	84.1	6.9	9.0
b] Getting money needed for treatment	54.3	16.8	28.9
c] The distance to the health facility	59.2	14.6	26.2
d] Having to take transport	59.7	15.1	25.2
e] Finding someone to go with you	80.3	11.9	7.9
f] Concern that there may not be a female health provider	67.5	18.1	14.4
g] Concern that there may not be any health provider	56.0	20.4	23.6
h] Concern that there may be no drugs available	49.2	18.6	32.2

Result (Table 2) shows that about 51.4 percent of the girls perceived between zero-two constraint(s), 29.6 perceived three-five, whereas 19 percent perceived six or above with an inter-quartile range of four. Further, it is found that about 25.8 percent of the adolescent girls in Assam do not perceive any constraint in accessing health care services, whereas remaining 74.2 percent of adolescent girls perceived at least one or more constraints (Table 3 and 4 last rows). It is quite surprising to see that about 9.7 percent of the adolescent girls perceived all the eight constraints in accessing health care services (result not shown). But, at the national level, only 47.8 percent of the adolescent girls/women (married and unmarried) in the age group of 15-19 years perceived of having at least one problem.[13]

Table 2 Percentage distribution of never married adolescent girls according to the number of perceived constraints in accessing health care services

Number	Percent	Frequency
0 – 2	51.4	253
3 – 5	29.6	146
6 & above	19.0	94

Total	100.0	493
Median		2.00
IQR		4.00

Individual factors

Hosts of individual factors supposedly affected the perception of never married adolescent girls about constraints in accessing health care services. When we looked into the relationship between age of the respondents and the perceived constraints, there is no clear cut pattern (Table 3), which may possibly be attributed to the misreporting of age to some extent. Because, the number of respondents in each age implies that there are more respondents in even ages. Education is one of the factors which has great bearing in the life of an individual. Hence, it is also expected that education may affect the perception of adolescent girls about the constraints in accessing health care services. It is found that 89.3 percent of illiterate/ primary incomplete adolescent girls, whereas 69.8 percent of girls with primary and above level of education perceived constraints in accessing health care services. It may be due to the fact that educated girls are better informed about the health care system, existing socio-political environment, law and order situation, etc., and as such perceived lesser constraints.

Table 3 Percentage of never married adolescent girls who do not/ perceive constraints by their personal characteristics

Characteristics of Respondents	No constraint	Some constraint	n
Age			
15	29.1	70.9	110
16	19.9	80.1	141
17	24.0	76.0	96
18	33.6	67.4	95
19	25.5	74.5	51
Education			
Illiterate + primary incomplete	10.7	89.3	112
Primary complete & above	30.2	69.8	381
Mass media			
Not exposed	8.7	91.3	46
Exposed	27.8	72.2	447
Native language			
Assamese	35.1	64.9	231
Bengali	18.9	81.1	132
Others	16.2	83.8	130
Total	***25.8***	***74.2***	***493***

Mass media exposes a person to the outside world and widens the horizon of thinking and thus has a greater bearing in the life of never married adolescent girls. About 91.3 percent of the never married adolescent girls having no such exposure perceived some constraints, but only 72.2 percent girls who were exposed to it perceived some constraints in accessing health care services.

As language is an important means of communication, it helps in developing communication skill, thereby playing a vital role in availing a service. Thus, a girl having this skill may be able to discuss her health problems with anybody in general and health care provider in particular in a better manner. It is apparent (Table 3) that compared to Assamese girls, Bengali or other girls perceive more constraints. One of its reasons could be as Assamese language is the predominant language of communication in the state, so never married adolescent girls who are not well versed with Assamese language perceive more constraints in accessing health care facility. Another hidden reason for such reporting may be the existing chaotic law and order situation in the state. It may so happen that non-Assamese adolescents may feel unsecured to venture out in the volatile socio-political environment due to lack of knowledge of Assamese language. Hence, it may be inferred that even if the questions were not asked whether the existing socio-political

environment poses any problem, the same might have got indirectly reflected in the findings.

Household factors

Result (Table 4) showed that in the urban areas about 59.3 percent and in the rural areas about 77.6 percent of never married adolescent girls perceived some constraints in accessing health care services. Such a huge difference may be mainly due to the fact that in the urban areas normally health care centers are easily available, whereas in the rural areas far away from home. Furthermore, in the urban areas transportation facility is good, whereas in the rural areas it is pretty poor.

Table 4 Percentage of never married adolescent girls who do not/ perceive constraints by their household and Head of Household (HH) characteristics

Household & HH characteristics	No constraint	Some constraint	n
Residence			
Urban	40.7	59.3	91
Rural	22.4	77.6	402
Religion			
Hindu	28.9	71.1	349
Muslim	19.3	80.7	109
Others	12.1	87.9	33
Social class			
SC / ST	22.3	77.7	121
OBC	32.2	67.8	114
Others	24.4	75.6	258
Wealth index			
Poorest	2.1	97.9	48
Poorer	19.4	80.6	134
Middle	21.3	78.7	150
Richer	36.8	63.2	95
Richest	50.0	50.0	66
Source of treatment			
Government	23.3	76.7	330
Private	30.7	69.3	163
Age HH*			
Upto 39	18.6	81.4	70
40 – 49	27.6	72.4	180
50 – 59	25.0	75.0	124
60 and above	26.5	73.5	117
Sex HH			
Male	25.2	74.8	420
Female	28.8	71.2	73
Total	***25.8***	***74.2***	***493***

*Note: HH = head of the household; SC= Scheduled Caste; ST= Scheduled Tribe; OBC = Other backward class, * = two missing cases*

From a religious point of view, there were very contrasting variations in perceiving constraints. It was found that lowest (71.1) percentage that perceived constraints were of the Hindu religion, followed by Muslim girls (80.7). However, the highest (87.9) percentage of girls were from other than Hindu and Muslim religions but the result may not be given much emphasis because of the fewer number of observations. The relationship between social class and perceived constraints showed that about 67.8 percent of other backward community girls perceived constraints, whereas 77.7 percent of Scheduled Caste / Scheduled Tribe girls and 75.6 percent of girls belonging to other than these groups perceived constraints.

Economic condition of the household is assumed to be another variable that has great bearing on the behavior of its members. It is found that there is a distinct inverse relationship between wealth index and the perceived constraints (Table 4), as the wealth index improves, percentage of adolescent girls reporting perceiving of constraints reduced. This finding is in line with the uni-variate result (Table 1) that getting money needed for treatment is the second most important problem.

NFHS–3 also collected data on usually from where the household members seek treatment. In Assam, it is found that 76.7 percent of adolescent girls whose household members usually seek treatment from government health centers perceive some constraints, whereas among the other group it is only 69.3 percent. From the frequency distribution (Table 4), it is quite clear that the households in Assam heavily (64.84 percent) depend usually on government health care facilities.

Household head factors

Role of family is very crucial in adolescent behavior.[22] The choice of health provider is also dependant on decision makers generally who could be the head of the household or elder male members, or someone from the community.[8] Hence, an attempt is made here to assess the relationship between characteristics of household head and perception of the adolescent girls. It can be noted that there is no clear link between age of the head of the household and adolescent girls perceiving constraints in accessing health care facilities (Table 4). However, percentage of girls from younger (less than 40 years) household heads perceived highest constraints. It can be justified by saying that younger parents may be protective of their children than the older ones. Result (Table 4) shows that there is huge difference in the percentage of adolescent girls perceiving constraints in accessing health care by the sex of the household-head. About 71.2 percent of girls from female-headed households and 74.8 percent from male-headed households felt constrains. It may happen due to the fact that in female-headed households, girls are supposed to help mothers in various household activities and thus become more self-dependant. Besides, adolescent girls may feel more comfortable in seeking permission from and sharing health matters with mother.

Determining factors

Results of multivariate analysis (Table 5) showed that very few variables have significant impact on the perception of never married adolescent girls in accessing health services. Wealth index of the household, native language and education of the girl are the three factors that significantly affected the perception of adolescent girls. Compared to girls from poorest households, girls from both richer and richest families are less likely to perceive constraints. This is in similar direction with both uni-variate and bivariate results. It signified that richer family can afford to pay for health care services, so girls from those families did not perceive constraints in accessing health care for themselves. Compared to Assamese speaking girls, Bengali or other girls are much more likely to perceive constraints. This is mainly because the girls who are not well versed with Assamese language are not confident of communicating their health problems to the health care provider and so perceive more constraints. Further, compared to illiterate and primary incomplete level of education, girls with primary and above level are less likely to perceive constraints. It means that even a little bit of education can bring in changes in the perception of adolescent girls.

Table 5 Results of binary logistic regression

Independent variable	Dependent variable: Has perceived constraints? ***(Yes = 1, No = 0)***			
	Categories of variable	**β**	**Exp (β)**	**C. I.**
Age	(Cont)	0.032	1.033	0.870 – 1.226
Education	Illiterate & primary incomplete(R)			
	Primary complete & above	-0.763	0.466*	0.212 – 1.024
Mass media	Not exposed(R)			
	Exposed	-0.414	0.661	0.199 – 2.198
Native language	Assamese(R)			
	Bengali	0.752	2.120**	1.138 – 3.951
	Others	0.649	1.913*	0.989 – 3.699
Residence	Urban(R)			
	Rural	0.473	1.547	0.823 – 2.910
Religion	Hindu(R)			
	Muslim	0.341	1.407	0.695 – 2.847
	Others	0.196	1.217	0.359 – 4.121
Social class	SC / ST(R)			
	OBC	-0.131	0.877	0.463 – 1.662
	Others	-0.138	0.871	0.467 – 1.627

Wealth Index	Poorest[(R)]			
	Poorer	-1.469	0.230	0.033 – 1.583
	Middle	-1.484	0.227	0.033 – 1.555
	Richer	-2.025	0.132**	0.019 – 0.938
	Richest	-2.397	0.091**	0.012 – 0.672
Source of treatment	Government[(R)]			
	Private	-0.415	0.660	0.400 – 1.089
Sex HH	Male[(R)]			
	Female	-0.057	0.944	0.506 – 1.762
Age HH	[(Cont)]	-0.010	0.990	0.972 – 1.010
Constant		***3.263***	***26.136***	

Note: [(Cont)]= Continuous, [(R)]=Reference, HH=head of the household

DISCUSSION

Result showed that most of the problems which adolescent girls perceived were from supply side. Out of the three personal or household factors (getting permission, getting money and finding someone to accompany) only getting money needed for treatment was perceived as constraints by the adolescent girls. However, this is also another way related to programme factor, because it indirectly shows the inadequacies in the supply of services for which perceived cost is high. Perception may come from own past experience, word of others' mouth, or observation, etc., and most of the time such perception turns out to be true. So, the government agencies have lots of room to improve upon the quality of health care services in Assam. In the study area, the percentage of never married adolescent girls perceiving constraint is comparatively much higher than the national level. This might indirectly reflect the other constraints which are actually not asked in the NFHS-3, such as the existing highly volatile socio-political environment which hinders lots of people from going out of home, either due to strike, combing operation of para-military forces, killings, etc. As such, besides improving the health care infrastructure, ensuring peace and harmony in the state is of utmost importance.

There is a great scope to nurture the perception of adolescence in accessing health care through education and mass media. Education is an impetus to all round development, whereas mass media mainly audio-visual has the capacity to mould the lifestyle of adolescence completely. Hence, government should expedite ongoing programmes which are aimed at achieving universal education. Assam is a state having multiple of ethnic groups speaking varieties of dialects with Assamese as the main language of communication across people of different communities. However, various organizations from different ethnic groups do not accept Assamese language and try to push forward their own language or dialect, as Hindi is not whole heartedly accepted in some parts of India. Further, people living in remote villages and who are uneducated normally do not have the knowledge of Assamese or other language, which again stands as perceived or real hindrance in accessing health care facilities. Of course, pretty high percentage of people in Assam, especially educated and people having regular interaction with other ethnic groups like para medical staffs, normally are multi-lingual. However, there must be some element of reality in the perception of adolescence. The inhibition of adolescence regarding language problem should be removed through mass media programmes informing that health care providers are well versed in various languages too, and accordingly knowledge of native dialects should be considered while appointing the health care providers.

There is no denying the fact that in India all the best services like education, mass media, transport, communication or health care, etc., are concentrated in the urban areas. Health seeking involves both direct and indirect costs. People in the urban areas have the whole range of services from which they can choose as per their economic capability. For example, in the urban areas one has the option of availing public transport, or hiring vehicle at wide range of costs to access health centers. Similarly, they have the option of availing services from general to extremely specialized centers. But in the rural areas, normally people do not have options to choose from, they have to depend upon available services. Therefore, normally people in the rural areas and poorer segments perceive more constraints and prefer to suffer silently. And, it is more so in case of adolescent girls. In India, although about seventy percent of the population lives in and almost all the natural resources come from rural areas, not even half of the services are available in these areas. Realizing such discrepancies and the need for improvement in health care services in the rural areas, National Rural Health Mission (NRHM) has been initiated in the country in 2005 in a very big way. After its existence for about five years, some improvements in health care facilities are apparent, but complete success is yet to be experienced.

People from each socio-economic stratum have their own belief, traditions and reliance on particular health care services. Some depend on modern whereas others still rely on traditional health care system. Further, in India, choice of particular source, type, place, etc., of health care depends mainly on the head of the household. Constraints associated with accessing heath care services vary with its source. To avail services from government health centers, normally people have to wait for long hours in uncongenial surroundings mainly due to shortage of manpower. Further, generally people perceive government health centers as dirty, having no medicine and with unfriendly para medical staff. But as poor people have difficulty in paying for the private services, they have no other choice but to look for government facilities. But due to compelling circumstances, sometimes poor people also go for private services by spending hard-earned money and as such perceive more constraints. However, the situation can be changed by initiating timely changes / improvements in the services provided by the government. Furthermore, government may better think of managing the entire health care services, with equal emphasis on availability, accessibility, affordability, acceptability and the quality, and can make agonies of poor people lighter.

CONCLUSION

Perception of never married adolescent girls regarding constraints in accessing health care for them is one of the relatable public health problems, which governs present and future courses of action alike. To overcome their subdued perception towards accessing health care, health care infrastructure may be enhanced in the state and the girls may be educated about comparative availability, accessibility, affordability, acceptability and quality of health services across different sectors and systems of care through mass media. Above all, efforts are also needed to ensure peace and harmony in the state.

REFERENCES

1. UNFPA. Adolescents in India. A profile. 2003. UNFPA for UN System in India. http://www.whoindia.org/LinkFiles/Adolescent_Health_and_Development_(AHD)_UNFPA_Country_Report.pdf (Accessed 15/06/2011).
2. Sharma Shubhangna, Nagar Shipra and Chopra Goldy. Health Awareness of Rural Adolescent Girls: An Intervention Study. J Soc Sci. 2009, 21(2): 99–104.
3. Patel PB, Trivedi KN, Nayak SN and Patel Priyanka. Health seeking behaviour of peri-urban community of Chandkheda. National Journal of Community Medicine 2010, 1 (1): 35–36.
4. Keith Tones. Health promotion, health education and the public health. Oxford Textbook of Public Health. Fourth Edition. Oxford University Press. 2004.
5. Pandey Neelanjana. Perceived Barriers to Utilization of Maternal Health and Child Health Services: Qualitative Insights from Rural Uttar Pradesh, India. Paper for oral presentation at Annual conference of Population Association of America 2011. http://paa2011.princeton.edu/download.aspx?submissionId=111751 (Accessed on 03/05/2011).
6. McCombie SC. Treatment seeking for malaria: a review of recent research. Soc Sci Med. 1996, 43:933–945.
7. Jain M, Nandan D and Misra SK. Qualitative Assessment of Health Seeking Behaviour and Perceptions Regarding Quality of Health Care Services among Rural Community of District Agra. Indian Journal of Community Medicine 2006, 31 (3): 140–144.
8. Neelima A and Reddy AS. People's perspectives on health care services in rural Andhra Pradesh: An epidemiologic study. Social Change 2006, 39 (2): 257–269.
9. Fomba S,Yang Y, Hua Z, Liu Q, Xiao PM. Patient's Utilization and Perception of the Quality of Curative care in Community health Centers of the Fifth Commune of Bamako. Indian Journal of Community Medicine 2010, 35(2): 256–261.
10. Narzary Pralip Kumar and Narzary Birphung. Treatment seeking behavior of Tuberculosis among Boro tribe in India. Stud. Tribes Tribals, 2005, 3(2): 129–132.
11. International Institute for Population Sciences and ORC Macro. National Family Health Survey (NFHS-2), 1998–99: India. Mumbai, IIPS. 2000.
12. Govt. of India. Population Census 2011. http://www.census2011.co.in/ (Accessed 22/08/2011).
13. Goswami Uddipana. Internal Displacement, Migration, and Policy in Northeast India. Working papers, No. 8, East West Centre, Washington, 2007.
14. Bhaumik Subir. Insurgencies in India's Northeast: Conflict, Co-option and Change. Working Papers, No.10 East West Centre, Washington 2007.
15. Narzary Pralip Kumar. Hidden truth of ethnic clash between Boro Tribe and Santhals in Assam. Stud. Tribes Tribals 2006, 4 (1): 57–62.

16. Nath Lopita. Migrants in Flight: Conflict-induced internal displacement of Nepalis in Northeast India**.** Peace and Democracy in South Asia 2005, 1 (1): 57–72.
17. International Institute for Population Sciences and Macro International. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai, IIPS. 2007.
18. Moore Ann M, Singh Susheela, Ram Usha, Remez Lisa and Audam Suzette. Adolescent Marriage and Childbearing in India: Current Situation and Recent Trends. New York: Guttmacher Institute, 2009.
19. Government of India. Scheduled Castes and Scheduled Tribes. Ministry of Home Affairs. http://censusindia.gov.in/Metadata/Metada.htm#2h (Accessed 20 Aug, 2011).
20. Government of India. Introduction. Ministry of Tribal Affairs. http://tribal.nic.in/index2.asp?sublinkid=542&langid=1 (Accessed 20 Aug, 2011).
21. Government of India. Welfare of Backward Classes - About the Division. Ministry of Social Justice and Empowerment. http://socialjustice.nic.in/aboutdivision4.php (Accessed 19 August, 2011).
22. Rahmah MA and Shahraniza B. Risk taking behaviour among early adolescents in Johor Bahru and its associated factors. Malaysian Journal of Community Health 2008, 14(2): 24–30.