



Health-Seeking Behavior of Adolescents and Youth in West Bengal

Dr. Sayani Patra

West Point School of Education, Bankura, West Bengal, India – 722102

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ABSTRACT

Adolescence is a critical developmental period during which health behaviours and service-use patterns shape trajectories into adulthood, yet adolescents in Indian states such as West Bengal often face multiple barriers to accessing appropriate care. (Basu, 2022; Das, 2006). Studies from rural and urban settings in West Bengal show substantial burden of acute and chronic morbidity, low utilization of government health facilities, and heavy reliance on informal providers, especially among adolescent girls. (Das, 2006). Parallel evidence from Delhi's Madanpur Khadar community demonstrates that peer-led health information centres and youth-focused projects can raise awareness on infections, reproductive health, and substance use but struggle with sustainability, gender norms, and information gaps. (Gupta et al., 2026). Drawing on this evidence, this narrative review synthesizes existing research on adolescent health-seeking behaviour in West Bengal, situates it within India's national adolescent health policy framework, and extrapolates lessons from peer-education models such as the Young Health Program and Rashtriya Kishor Swasthya Karyakram. (Gupta et al., 2026; Jain, 2022; Barua, 2020; "Engagement of Peer Educators from India's National Adolescent Health Programme," 2024). The paper identifies persistent gendered inequities, dependence on non-formal providers, and weak linkage between community-based awareness activities and adolescent-friendly services as key challenges in West Bengal. (Das, 2006; "A Study of the



Functioning of the Adolescent Friendly Health Clinics,” 2022). It proposes a framework for strengthening adolescent health-seeking behaviour that centres peer networks, school–community linkages, and adolescent-friendly health clinics within the broader National Health Mission architecture. (Ministry of Health and Family Welfare [MoHFW], 2026; “Implementation Outcomes of Peer Education Programme,” 2024).

1. Introduction

Adolescents aged 10–19 years constitute a substantial share of India’s population, and their health behaviours are central to achieving several Sustainable Development Goals. (Jain, 2022; Barua, 2020). In West Bengal, as in many other Indian states, adolescents negotiate health decisions in contexts of poverty, gendered power relations, and varying quality of public health infrastructure. (Das, 2006; Basu, 2022). Evidence from rural blocks and smaller urban centres indicates that risk behaviours such as tobacco and alcohol use, inadequate nutrition, and limited knowledge of sexual and reproductive health coexist with constrained service utilization. (Basu, 2022; Das, 2006). At the same time, national policies such as Rashtriya Kishor Swasthya Karyakram (RKSK) and the School Health Programme under Ayushman Bharat emphasize preventive and promotive adolescent health, including adolescent-friendly clinics and peer educators. (MoHFW, 2026; Jain, 2022). Understanding how adolescents in West Bengal actually seek care—and how peer-led and community-based models can support them—is therefore essential for designing contextually grounded interventions. (Gupta et al., 2026; “Evaluating the Impact of a School-Based Youth-Led Health Programme,” 2020). A community-based mixed-methods study in Madanpur Khadar, Delhi, showed that peer educators and a health information centre could significantly improve awareness regarding infections, hygiene, menstrual health, and basic reproductive health among adolescents, while highlighting gaps in rights awareness and sustained service access. (Gupta et al., 2026). That work underscored the importance of youth participation, gender-sensitive approaches, and collaboration with local NGOs and government systems. (Gupta et al., 2026). The present paper draws conceptually on that design and adapts its thematic lens to the context of West Bengal, using published evidence and policy documents rather than primary field data. (Gupta et al., 2026; Jain, 2022). The objectives are: (a) to synthesize evidence on adolescent health-seeking behaviour in West Bengal; (b) to map key barriers and facilitators across gender and setting; and (c) to outline a peer- and community-



centred framework for strengthening adolescent health services in the state. (Das, 2006; Basu, 2022; “A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022).

2. Context: Adolescents and Health in West Bengal

West Bengal contains a mix of dense urban settlements, peri-urban belts, and rural blocks where adolescents face diverse but overlapping health risks. (Basu, 2022; Das, 2006). A cross-sectional study among high school students in the Amdanga block reported notable prevalence of behaviours such as smoking, alcohol use, and drug addiction, particularly among boys, illustrating the early onset of lifestyle-related risks. (Basu, 2022). Earlier research among adolescent girls in a rural area of West Bengal found acute morbidity in around one-third and chronic morbidity in a smaller but significant minority, indicating a sustained burden of untreated or under-treated conditions. (Das, 2006). Although more than four-fifths of girls sought some form of treatment for acute illness, less than one-quarter used government health facilities, citing non-availability of medicines, distance, and perceived poor quality of care as key deterrents. (Das, 2006). These findings align with broader observations from rural health studies that adolescents often rely on private practitioners, chemist shops, and traditional healers as first-line providers. (“Exploring the Socio-Ecological Factors of Healthcare,” 2025; “Barriers to Access Health Care Services among Rural Adolescents,” 2021). Urban adolescents in West Bengal are influenced by different, though related, structural forces. Studies of urban communities and school-going adolescents point to pressures of academic competition, crowded living conditions, and exposure to substance use within families or neighbourhoods, alongside limited systematic health education. (Basu, 2022; “Assessment of Behavioral Problem among School Children,” 2023). Research on behavioural problems and parental health-seeking in an urban community in the state suggests that even when parents recognize emotional or behavioural issues, help is frequently sought from informal sources before professional services are considered. (“Assessment of Behavioral Problem among School Children,” 2023). These patterns mirror the social determinants observed in Delhi’s Madanpur Khadar settlement, where deprivation, weak sanitation, and gendered mobility constraints shaped both risk exposure and recourse to care. (Gupta et al., 2026).

3. Methods

This paper adopts a narrative review and conceptual synthesis approach rather than reporting new empirical fieldwork. (Barua, 2020). Peer-reviewed articles, reports, and policy documents focusing on adolescent health and health-seeking behaviour in West Bengal were identified through databases and open-access repositories using keywords such as “adolescent,” “health-seeking behaviour,” “West



Bengal,” “adolescent-friendly health clinics,” and “peer education.” (Basu, 2022; Das, 2006; “A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022). Studies from other Indian states were included selectively when they illuminated peer education models, youth-led interventions, or national programme frameworks relevant for the West Bengal context. (Gupta et al., 2026; Jain, 2022; Barua, 2020; “Evaluating the Impact of a School-Based Youth-Led Health Programme,” 2020). Evidence was organized along domains used in the Madanpur Khadar study—general health concerns, patterns of health-seeking, infectious disease awareness, substance use, and reproductive health—while adding a programme and policy domain specific to West Bengal and national schemes. (Gupta et al., 2026; MoHFW, 2026). The synthesis compares rural and urban settings and highlights gendered differences wherever data permit. (Das, 2006; Basu, 2022; “Barriers to Access Health Care Services among Rural Adolescents,” 2021). Drawing on lessons from peer-led projects, including the Young Health Program (YHP) in Delhi and RKSK’s Saathiya peer educators, the paper proposes a conceptual framework for strengthening adolescent health-seeking in West Bengal. (Gupta et al., 2026; “Through the Young Health Program (YHP),” 2022; “Engagement of Peer Educators from India’s National Adolescent Health Programme,” 2024).

4. Findings: Patterns of Health-Seeking Behaviour

General health concerns and everyday morbidity

Across rural and semi-urban settings in West Bengal, adolescents report common problems such as fever, respiratory infections, gastrointestinal complaints, menstrual disturbances, and nutritional deficiencies. (Das, 2006; Basu, 2022). The rural study of adolescent girls documented acute morbidity in roughly one-third of participants and chronic complaints (such as anaemia and musculoskeletal pain) in a non-trivial minority, demonstrating that ill-health is not an occasional event but a recurring experience. (Das, 2006). School-based surveys suggest that lifestyle-related risks, including irregular physical activity and unhealthy diet, coexist with infectious disease risks, amplifying long-term vulnerability. (Basu, 2022). These empirical observations resonate with the lived realities described in Madanpur Khadar, where adolescents identified poor sanitation, unclean toilets, and unreliable waste management as central concerns shaping daily health. (Gupta et al., 2026).

Sources of care and pathways to treatment

When unwell, adolescents in West Bengal use pluralistic care pathways. (Das, 2006; “Exploring the Socio-Ecological Factors of Healthcare,” 2025). The rural adolescent girls’ study found that over 80%



sought treatment for acute illness, but only about 23% used government facilities, with many turning instead to private practitioners, informal providers, or medical shops. (Das, 2006). Reasons for avoiding government facilities included distance, drug stock-outs, waiting times, and perceptions of low-quality or disrespectful care. (Das, 2006; “Exploring the Socio-Ecological Factors of Healthcare,” 2025). Wider work on rural West Bengal shows that even for adult populations, medicine shops and registered or unregistered rural health practitioners often serve as first points of contact, indicating a pattern that adolescents likely mirror. (“Exploring the Socio-Ecological Factors of Healthcare,” 2025). Qualitative evidence from adolescent-friendly health clinics (AFHCs) in the state suggests that awareness of clinic locations, timings, and confidentiality assurances remains limited, reducing their utilization despite their formal availability. (“A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022). The Delhi YHP experience reflected similar ambiguities: adolescents reported knowing that registered doctors were preferable yet frequently consulted traditional healers or unqualified practitioners (“hakims”) under parental influence and trust. (Gupta et al., 2026). In Madanpur Khadar, many youths saw the NGO-run health information centre as a more approachable and youth-friendly space than formal facilities, underscoring the role of intermediary community platforms in shaping health-seeking. (Gupta et al., 2026).

Awareness of infections and preventive practices

Studies in West Bengal point to partial awareness of major infectious diseases but gaps in depth and breadth of knowledge. (Basu, 2022; Das, 2006). Schoolchildren in rural blocks demonstrate some understanding of the causes and prevention of vector-borne diseases like malaria and dengue, yet confusion about detailed transmission routes and treatment-seeking pathways persists. (Basu, 2022). In the rural girls’ study, adolescents recognized illness episodes but often lacked clear information on which symptoms required prompt medical attention and where appropriate treatment could be obtained. (Das, 2006). In Madanpur Khadar, peer educators trained by an NGO significantly improved adolescents’ knowledge about dengue, malaria, tuberculosis, safe water, and sanitation; however, girls and boys still struggled to name a broader range of infections beyond the project’s curricular focus. (Gupta et al., 2026). This pattern suggests that in West Bengal as well, issue-specific campaigns may raise awareness on selected conditions but leave broader infectious disease literacy and linkage to services underdeveloped. (Basu, 2022; “A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022).



Reproductive health and gendered constraints

Sexual and reproductive health (SRH) remains one of the most sensitive and under-discussed domains of adolescent health in West Bengal. (“Barriers to Access Health Care Services among Rural Adolescents,” 2021; Das, 2006). Studies on rural adolescent school girls highlight low levels of correct knowledge about menstrual hygiene and reproductive tract infections, alongside significant embarrassment and stigma around seeking care. (“Barriers to Access Health Care Services among Rural Adolescents,” 2021). In the rural morbidity study, girls rarely approached formal health services for gynaecological issues, relying instead on home remedies or advice from older female relatives. (Das, 2006). The Madanpur Khadar project documented that while adolescent girls became knowledgeable about menstrual hygiene and the need to consult gynaecologists in case of menstrual problems, they remained largely unaware of legal rights, government schemes, and comprehensive SRH services. (Gupta et al., 2026). Gender norms in that Delhi community limited girls’ mobility, autonomy, and participation in health sessions, with male dominance and parental restrictions frequently cited. (Gupta et al., 2026). Comparable gendered constraints are documented in rural West Bengal, where early marriage, domestic responsibilities, and concerns over family “honour” restrict girls’ access to adolescent-friendly clinics or school-based programmes. (“Barriers to Access Health Care Services among Rural Adolescents,” 2021; “A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022).

Substance use and risk behaviours

Health-risk behaviours such as tobacco, alcohol, and other substance use are visible in both rural and urban adolescent populations in West Bengal. (Basu, 2022; “Assessment of Behavioral Problem among School Children,” 2023). The rural school study reported that smoking, drinking, and drug use were “pretty prevalent,” especially among boys, indicating a need for early preventive interventions. (Basu, 2022). Community-based observations suggest that experimentation with tobacco and locally available intoxicants may begin even in late childhood, often normalized within family or neighbourhood contexts. (“Assessment of Behavioral Problem among School Children,” 2023). The Delhi YHP experience similarly found that adolescents, particularly boys, were well aware of different forms of tobacco and their substitutes but were less equipped to recognize behavioural signs of dependence or pathways for quitting. (Gupta et al., 2026). Peer educators in Madanpur Khadar described instances of very young children using cigarettes and showed both concern and limited strategies for effective intervention beyond verbal persuasion. (Gupta et al., 2026). These parallels suggest that in West Bengal, as in Delhi, adolescent health programmes must move beyond basic awareness of substance harms to skill-building in



refusal, peer support, and accessing de-addiction services where needed. (“Evaluating the Impact of a School-Based Youth-Led Health Programme,” 2020; “Engagement of Peer Educators from India’s National Adolescent Health Programme,” 2024).

5. Discussion

The evidence from West Bengal converges on several themes: high burden of morbidity, pluralistic but often suboptimal care pathways, persistent gender gaps, and underutilization of formal adolescent-friendly services. (Das, 2006; Basu, 2022; “A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022). These patterns resemble the situation observed in Delhi’s Madanpur Khadar, where community-based peer education strengthened awareness yet could not by itself overcome socio-cultural and systemic barriers. (Gupta et al., 2026). Together, these findings suggest that adolescent health-seeking behaviour is shaped by intersecting layers of information, trust, physical access, perceived quality, and gendered social norms. (Das, 2006; “Barriers to Access Health Care Services among Rural Adolescents,” 2021; Gupta et al., 2026). At the policy level, India’s adolescent health strategy under RKSK and school health initiatives under Ayushman Bharat provide a supportive framework that explicitly prioritizes adolescent health promotion, counselling, and access to services. (MoHFW, 2026; Jain, 2022; Barua, 2020). RKSK’s design, with its peer educators (“Saathiyas”), community-based adolescent-friendly clubs, and facility-based AFHCs, recognizes that adolescents often prefer to discuss sensitive issues with peers and trusted local figures. (“Engagement of Peer Educators from India’s National Adolescent Health Programme,” 2024; “Implementation Outcomes of Peer Education Programme,” 2024). Evaluations of youth-led school and community health programmes in India have shown that trained peer educators can improve knowledge, shift attitudes, and modestly influence behaviours when properly supervised and linked to services. (“Evaluating the Impact of a School-Based Youth-Led Health Programme,” 2020; “Through the Young Health Program (YHP),” 2022). However, both the West Bengal evidence and the Madanpur Khadar experience warn that peer-based approaches are not a substitute for accessible, high-quality public services. (Das, 2006; “A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022; Gupta et al., 2026). Adolescents may become more aware of health issues yet continue to rely on informal providers if government facilities remain distant, understaffed, or perceived as unfriendly. (Das, 2006; “Exploring the Socio-Ecological Factors of Healthcare,” 2025). Moreover, without explicit strategies to address gender norms, girls may benefit less than boys from peer networks and health camps, as their mobility and decision-making power are more heavily constrained. (“Barriers to Access Health Care Services among Rural Adolescents,” 2021; Gupta et al., 2026).



6. Implications for Programmes and Policy in West Bengal

Drawing on the reviewed evidence and on lessons from the Young Health Program and RKSK, several implications emerge for strengthening adolescent health-seeking behaviour in West Bengal. (Gupta et al., 2026; “Through the Young Health Program (YHP),” 2022; MoHFW, 2026).

1. **Strengthen adolescent-friendly health clinics and school–clinic linkages:** AFHCs in West Bengal require better visibility, adolescent-friendly infrastructure, and reliable availability of commodities such as sanitary napkins, contraceptives, and essential medicines to become credible options for youth. (“A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022). School health programmes can systematically refer students to nearby AFHCs, integrating health education sessions with clear guidance on where and how to seek confidential care. (Jain, 2022; Barua, 2020).
2. **Institutionalize and incentivize peer education:** Peer networks have shown promise in both Delhi’s Madanpur Khadar and national RKSK initiatives, but sustaining motivation requires structured support, recognition, and potential pathways to economic empowerment. (Gupta et al., 2026; “Engagement of Peer Educators from India’s National Adolescent Health Programme,” 2024; “Implementation Outcomes of Peer Education Programme,” 2024). In West Bengal, peer educators could be drawn from both school and out-of-school adolescents, provided with regular training, and linked to community-based organizations and health staff for supervision and joint activities. (“Through the Young Health Program (YHP),” 2022; MoHFW, 2026).
3. **Address gender norms and empower girls:** Programmes should go beyond information provision to explicitly engage parents, community leaders, and boys in challenging practices that restrict girls’ mobility, education, and access to health services. (“Barriers to Access Health Care Services among Rural Adolescents,” 2021; Das, 2006). Girls-only groups facilitated by female peer educators, combined with safe transport to AFHCs and female providers, can help create supportive environments for discussing menstrual problems, SRH concerns, and mental health. (Gupta et al., 2026; “A Study of the Functioning of the Adolescent Friendly Health Clinics,” 2022).
4. **Integrate substance-use prevention into adolescent health platforms:** Given the documented prevalence of tobacco, alcohol, and drug use among West Bengal adolescents, school and community programmes should include skill-based modules on resisting peer pressure, recognizing early dependence, and accessing counselling or de-addiction services. (Basu, 2022; “Assessment of



Behavioral Problem among School Children,” 2023). Peer educators can be trained not only to convey harms but also to model alternative recreational activities and support peers in quitting, drawing on experiences from youth-led health promotion initiatives. (“Evaluating the Impact of a School-Based Youth-Led Health Programme,” 2020; Gupta et al., 2026).

5. **Bolster research and monitoring of adolescent health-seeking:** Existing studies in West Bengal, while informative, are geographically limited and often focus on either rural girls or school-going adolescents, leaving gaps regarding urban slum youth, out-of-school adolescents, and diverse gender identities. (Das, 2006; Basu, 2022; “Assessment of Behavioral Problem among School Children,” 2023). Mixed-methods designs similar to the Madanpur Khadar study—combining quantitative surveys with focus group discussions and participatory tools—could be applied in multiple districts to map health-seeking patterns more systematically. (Gupta et al., 2026; Barua, 2020). Findings should feed back into district-level planning under the National Health Mission, ensuring that adolescent perspectives are central to resource allocation and service design. (MoHFW, 2026; Jain, 2022).

References

- A Study of the Functioning of the Adolescent Friendly Health Clinics as well as the Awareness and Health Seeking Behaviour among the Adolescents Girls and Boys Attending AFHCs in Rampurhat Health District, West Bengal. (2022). *International Journal of Community Medicine and Public Health*. Retrieved from <https://www.ijcmph.com/index.php/ijcmph/article/view/10232>
- Assessment of behavioral problem among school children and health seeking behavior of parent in selected urban community, West Bengal. (2023). *International Journal of Research - Granthaalayah*, 11(12). <https://www.granthaalayahpublication.org/journals/granthaalayah/article/view/5409/5322>
- Barriers to Access Health Care Services among Rural Adolescents in West Bengal. (2021). *Space and Culture, India*, 9(4). <https://spaceandculture.in/index.php/spaceandculture/article/view/1181>
- Barua, A. (2020). Adolescent health programming in India: A rapid review. *BMJ Open*, 10(6), e036667. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7271491/>



- Basu, R. (2022). A cross-sectional study to assess the prevalence of health behaviors and protective factors among schoolchildren in a rural area in West Bengal. *Journal of Family Medicine and Primary Care*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC9067170/>
- Das, D. K. (2006). Morbidity and treatment seeking behavior among adolescent girls in a rural area of West Bengal, India. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/17444056/>^[3]
- Engagement of Peer Educators from India's National Adolescent Health Programme for the COVID-19 response activities: Qualitative findings from i-Saathiya study. (2024). *BMJ Open*, 14(8), e084416. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11331997/>
- Evaluating the Impact of a School-Based Youth-Led Health Programme in India. (2020). *International Journal of Environmental Research and Public Health*, 17(16), 5860. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7292104/>
- Exploring the socio-ecological factors of healthcare seeking behaviour in West Bengal. (2025). *Journal of Rural Health Services*. <https://www.sciencedirect.com/science/article/pii/S2949856224000394>
- Gupta, A., Antony, B., & Harit, K. (2026). A study on health seeking behavior of adolescents and youths at Madanpur Khadar. *International Innovations & Scholarly Trends Journal*, 2(1), 76–88. <https://doi.org/10.5281/zenodo.18334785>
- Implementation outcomes of peer education programme under India's National Adolescent Health Programme. (2024). *BMJ Open*, 14(10), e085657. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11564149/>
- Jain, N. (2022). Progress and challenges in implementing adolescent and school health programmes in India. *BMJ Open*, 12(5), e047435. <https://bmjopen.bmj.com/content/12/5/e047435>
- Ministry of Health and Family Welfare. (2026). *Adolescent health: Programme overview*. Government of India. <https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=818&lid=221>
- Through the Young Health Program (YHP), Plan India and AstraZeneca are enabling and empowering adolescents. (2022). Plan India. <https://www.planindia.org/media-coverages/through-the-young-health-program-yhp-plan-india-and-astrazeneca-are-enabling-and-empow>