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A Study of the Health and Nutritional Status of Indian Youth

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1. Introduction

Health is a basic component of human development. Good health of people of any economy not only increases happiness but also the capabilities and freedom. Therefore, various efforts are being taken from international levels to the local levels to improve healthcare facilities for the people. But it appears that healthcare services either do not reach to the disadvantaged sections or are not accessed by them. There is widespread evidence which proves various types of inequalities such as inequalities across space, gender, age, sex etc. all over the world. For instance many developing countries in Asia such as India, Pakistan, and Bhutan etc. are far behind the all countries including developing countries average in terms of various health indicators like life expectancy at birth, infant mortality, under five mortality rates etc. (Human Development Report 2005). Same is the situation with regard to the expenditure on healthcare. OECD countries, for example, represent only 18 percent of the global population but account for 86 percent of the world's health spending (World Health Report 2010). Therefore, it implies that 82 percent of world's population spends only 14 percent of the total expenditure on health. However, health related inequalities are not only a cross country phenomenon but inequalities persist within the countries also.

2. Objectives of the study and Methodology

In this Study, selected indicators of youth access to maternal health care services, youth health and nutritional status, and the extent to which female youth are subject to domestic violence are discussed. An examination of whether youth are utilizing maternal health care services, such as antenatal and delivery care, is important for several reasons. Key among these reasons are that youth fertility accounts for the majority of all fertility and births to very young mothers are at higher risk of adverse health outcomes than births to older women whose bodies are fully developed. The study also presents data on an oft-ignored aspect of physical, sexual, and mental health of women: freedom from violence. Domestic violence is among the most common forms of violence experienced by women and has been shown to undermine the health and welfare of victims and their children (United Nations, 2006).

3. Relevance of the Study

Indicators of youth health examined in this study include prevalence of sexually transmitted diseases, HIV, diabetes, asthma, tuberculosis and goitre and other thyroid disorders. Indicators of nutritional status include measures based on the body mass index (BMI) of youth calculated from weight measurements taken as part of NFHS-3 and on anaemia status of youth. It is important for the researcher to be familiar with both previous theory and researches published so far in the field of investigation or study. So, in order to assure its familiarity, the researchers have to build upon the accumulated and recorded knowledge of the past. It is focused and directed towards specific purpose and it is also, selective (Krishnaswami, 2005). Literature review will help to determine the background of the concepts taken under the research problem. It also gives the direction to the researchers to carry out the further studies on the right path.

4. Review of Literature:

In the context of the present study, researchers has made efforts for those investigators, researchers, analysts and other who connected with studies related to the status of health directly and indirectly conducted in India and outside such as Adam Wagstaff's study (2000) across nine countries with the help of concentration curves showed that the inequalities in infant and under five mortalities were to the disadvantage of worse off and were statistically significant but the extent of these inequalities varied across countries.

Similar kind of studies in India such as the studies by Rao and Chaudhary ; Davey Smith et.al, Roy et.al etc. also have proved the existence of health related inequalities in India. These inequalities are of several types such as inequalities in expenditure on healthcare; inequalities in access and utilization of healthcare services; inequalities in health status of population etc. However, the present study is concerned mainly with two types of inequalities i.e. inequalities in providing healthcare services measured by expenditure on health by public sector and inequalities in health status of population. Many studies in India have proved these types of inequalities across states, social groups and gender etc. For example, the study by Rao and Chaudhary (2008) analyzed interstate disparities in health spending and worked out equalization system to ensure a fair distribution of resources across states.

Joe and Mishra (2009) also pointed towards the inadequacy of public health spending which necessitated disproportionate out of pocket spending which pushed many people below the poverty line. The incidence of disproportionate out of pocket spending is also noted to be higher in low income states like Uttar Pradesh and Madhya Pradesh which have very low levels of per capita public health spending.

Some other studies which are related to the second type of inequalities i.e. inequalities in the health status of population also shows the geographical, social and gender variations. However, some limitations are associated with these studies, that is, either these studies are related to only few states or are related to only one or two indicators of health status and uses

only one round of National Family Health Survey data.

Davey Smith et.al (2003) study of four states of India, for example, found significant inequalities across socio economic gradient in India but used only anthropometric measures like stunning, underweight and wasting etc. and ignored many other health indicators.

The same issue of inequalities in health and nutrition is addressed in detail by Roy et.al (2004). The analysis has clearly brought out the extreme inequalities persisting across various caste groups even after controlling for socio economic background. Similarly William Joe and other's (2008) study of all the 29 states across India also shows inequalities in child health by employing the measures of concentration curves etc. to the National Family Health Survey third round data. But the study is limited to only one round data and does not allow inter temporal comparisons.

Thus, having all these things in mind the government of India has launched a new massive health policy known as National Rural Health Mission in 2005 with the objectives of raising public spending on health; providing access to primary healthcare services for rural poor; universal access for women and children; seeing a concomitant reduction in infant mortality rate, maternal mortality rate etc. and revitalizing local health traditions etc.

Keeping the initiatives taken by government like National Rural Health Mission in mind and al so keeping in view the commitment which Ministry of Health and Family Welfare has made through its National Health Bill 2009 i.e. Right against discrimination in access to health services etc. on the grounds of sex, class, monetary or other economic status, place of birth, age, marital status etc.

5. Conclusion and discussion:

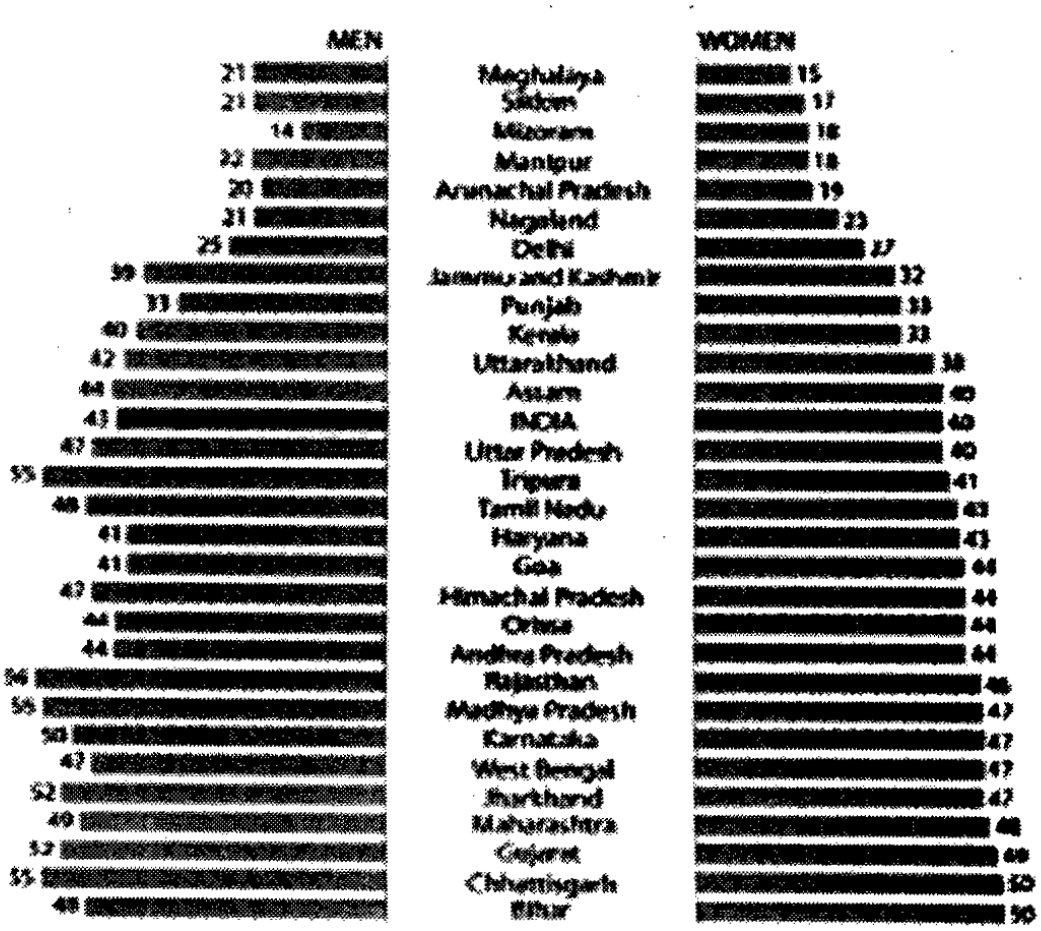
The Body Mass Index (BMI), estimated from the height and weight measurements of individuals, is a widely accepted measure of nutritional status. Based on the BMI, women and men are classified as abnormally thin if their BMI is less than 18.5; overweight or obese if their BMI is 25 or more; and normal if their BMI is 18.5 or higher but less than 25. Persons with a BMI which is less than 18.5 are usually classified as having chronic energy deficiency. Table shows that among youth, 44 percent of women are abnormally thin and 4 percent are overweight or obese; only about half have a BMI in the normal range. Compared with female youth, male youth are slightly more likely to be abnormally thin, but slightly less likely to be overweight or obese.

Table: Nutrition status of Adults: Percentage of women & men age 15-25 with specific body Mass Index (BMI) Level (2005-06)

Background characteristic	Body mass index (BMI) in kg/m² — Women* <18.5 (thin)	Women* ≥18.5 and <25.0 (normal)	Women* ≥25.0 (overweight or obese)	Women* Total	Number of women	Men <18.5 (thin)	Men ≥18.5 and <25.0 (normal)	Men ≥25.0 (overweight or obese)	Men Total	Number of men
Age										
15-19	44.6	50.8	2.4	100.0	32,154	56.1	40.2	1.7	100.0	12,254
20-24	40.7	53.4	5.9	100.0	18,612	35.5	59.8	4.7	100.0	11,211
Marital status										
Never married	44.0	50.5	5.6	100.0	22,336	49.1	47.9	3.1	100.0	19,397
Ever married	41.7	53.8	4.5	100.0	18,429	38.8	57.7	3.4	100.0	4,068
Residence										
Urban	38.1	53.2	7.7	100.0	12,845	42.4	52.0	5.6	100.0	8,600
Rural	44.3	51.4	2.3	100.0	27,919	50.1	48.2	1.7	100.0	14,864
Education										
No education	47.7	50.9	1.4	100.0	9,922	47.0	52.0	1.1	100.0	2,251
<5 years complete	48.6	49.3	2.1	100.0	2,928	46.0	50.1	1.3	100.0	1,753
5-9 years complete	46.0	50.3	3.7	100.0	15,725	54.1	44.2	1.7	100.0	10,350
10 or more years complete	37.4	51.6	6.9	100.0	12,191	39.0	55.3	5.7	100.0	8,870
Wealth index										
Lowest	51.3	47.8	0.9	100.0	6,715	58.5	41.2	0.5	100.0	3,298
Second	50.9	48.0	1.1	100.0	7,801	52.0	47.3	0.7	100.0	4,359
Middle	45.4	52.3	2.3	100.0	8,795	49.9	48.8	1.4	100.0	5,115
Fourth	40.9	54.5	4.6	100.0	8,812	44.7	52.0	3.3	100.0	5,421
Highest	34.1	56.0	9.9	100.0	8,543	36.7	58.1	5.2	100.0	5,286
Total age 15-24	44.1	52.0	4.0	100.0	40,766	47.3	49.6	3.1	100.0	23,465
Total age 25-49	30.7	51.6	17.7	100.0	71,015	35.9	50.4	13.7	100.0	42,277

* Excludes pregnant women and women with a birth in the preceding 2 months.

Figure 1 Percentage of Youth who are Abnormally Thin by State



Source : National Family Health Survey, 2005-06

Male and female youth are more likely than adults age 25-49 to be abnormally thin and much less likely to be overweight or obese. Only about a quarter of men age 25-49 are too thin, compared with almost half of men age 15-24; for women, the differential is also large but smaller than it is for men. Notably too, among those age 25-49, women are more likely than men to be abnormally thin; among youth, as already noted, men are more likely than women to be abnormally thin.

Among youth, adolescents are more likely than older youth to be abnormally thin. The differential by age is particularly large for boys. More than half (58%) of adolescent boys and 47 percent of adolescent girls are too thin, compared with 36 percent of men and 41 percent of women age 20-24. Youth in rural areas are more likely than youth in urban areas to be abnormally thin and less likely to be overweight or obese. As can be expected, the likelihood of having a BMI less than 18.5 generally declines with education and wealth and the likelihood of being overweight/ obese increases. There is large interstate variation in the proportion of youth who are abnormally thin (Figure 1). The proportion of youth who are abnormally thin varies for women from 15 percent in Meghalaya, to 50 percent in Chhattisgarh and Bihar, and for men it varies from 14 percent in Mizoram to 56 percent in Rajasthan. Youth, both female and male, are least likely to be abnormally thin in all of the Northeastern states, except Assam and Tripura, compared with youth from all other states in the country. However, the states with the highest proportion of female youth in the abnormally thin category are not all the same as those with the highest proportion of male youth in the abnormally thin category. Notably, in most states the proportion of male youth who are abnormally thin is higher than the proportion of female.

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