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A STUDY ON HEALTH, PERSONAL HYGIENE AND NUTRITIONAL STATUS OF RURAL TEENAGE GIRLS

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Nutrition

India is becoming a preferred destination for medical tourism and super-specialty healthcare but it has a long way to go in providing basic healthcare to the people. The persistence of deficits in the health outcomes of a majority of the country's population is rooted in the poor state of public provisioning of healthcare. Public expenditure accounts for a small share in total expenditure on healthcare in India, which reflects the low priority accorded to health sector in the government budgets of the country. When compared to the developed and many developing countries, the share of public expenditure in the country's total expenditure on healthcare appears to be very low for India and, (as per the latest available National Health Accounts of India) it is lower than other Asian countries like China, Malaysia, Sri Lanka, Thailand and Bangladesh. India ranks sixth from the bottom, amongst all countries in the world, in terms of public expenditure on healthcare as a proportion of the Gross Domestic Product (GDP). The Health expenditure; total (% of GDP) in India was last reported at 4.05 in 2010, according to a World Bank report published in 2012. Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

Health Status of India

India‘s health achievements are low in comparison to the country‘s income level. According to UNDP‘s Human Development Report 2010, in a set of 193 countries, while India ranked 119th on the human development, it ranked 143rd in infant mortality rate, 124th in maternal mortality rate, 132nd in life expectancy at birth, and 145th in under-five mortality rate. Scatter plots between Gross National Income across countries and each of the four indicators along with their associated trend lines also indicate that India‘s health indicators are worse than what is expected at India‘s level of income for three of the four indicators.

An important factor contributing to the slow progress in population health in India is the poor access to primary and preventive health care services.3 This is evidenced by the fact that India‘s immunization rates and percentage of births attended by skilled health personnel rank among the worst in the world. The health indicators summarized in various developing regions of the world show that India‘s performance is only better than that of sub-Saharan Africa. Inadequate preventive healthcare services results in high incidence of

deaths from communicable diseases. According to the *Global Burden of Diseases* data published by WHO in 2008, of the total number of deaths in a sample of 192 countries across the world, India accounted for nearly one fourth of the deaths due to diarrhea, more than a third of the deaths due to childhood cluster diseases (many of which are preventable by basic immunization), more than a third of the deaths due to Leprosy, more than half the deaths due to Japanese Encephalitis and about 30 percent of the deaths due to prenatal conditions.

Public Spending on Health

It is believed that an important factor contributing to India's poor health status is its low level of public spending on health, which is one of the lowest in the world. In 2007, according to WHO's *World Health Statistics*, India ranked 184 among 191 countries in terms of public expenditure on health as a percent of GDP. In per capita terms, India ranked 164 in the same sample of 191 countries, spending just about $29 (PPP). This level of percapita public expenditure on health was around a third of Sri Lanka's, less than 30 percent of China's, and 14 percent of Thailand's (WHO, 2010). What is more, public spending on health as a percent of GDP in India has stagnated in the past two decades, from 1990–91 to 2009–10, varying from 0.9 to 1.2 percent of GDP.

While public spending on health care is low, the OOP expenditure by households has been large. In 2007, total expenditure on health in India (public and private) was about 4.1percent of GDP, which was higher than the level in Thailand and around the levels of Sri Lanka and China. In 2007, private spending in India constituted nearly 74 percent of the total spending on health in contrast to 18 percent in the United Kingdom. Nearly 90 percent of this private expenditure in India was in the form of OOP expenditure on health by households (WHO, 2010), a share that is one of the highest in Asia. The high OOP expenditure has put an increasing financial burden on the poorer sections of the population. Data from the National Sample Survey Organization (NSSO) in India indicate that between 1986-87 and 2004, the share of ailments not treated due to financial reasons has increased from around 15 percent to 28 percent in the rural areas. Part of this increased financial burden arises from the fact that the share of visits to private health facilities has increased in recent years. According to the NSSO data, the share of outpatient visits to public facilities has dropped from 25 to 20 percent and for inpatient visits from 60 to 40 percent. Notably, outpatient treatments account for nearly three-fourths of OOP expenditure by households; a large part of this could be reduced through adequate provision of primary and secondary care.

The skewed composition of public spending further reduces its effectiveness. A significant share of the spending is directed toward curative and tertiary health care services as opposed to preventive, primary, and secondary care. According to the latest National Health Accounts data (for 2004-05), about 28 percent of total public expenditure was allocated for tertiary health care services, significantly higher than the target of 10

percent recommended by the National Health Policy of India. Also, an overwhelming portion of the expenditure is for wages and salaries, leaving little for non-salary (complementary) expenses like drugs and other material supplies. The expenditure is particularly skewed toward salaries in some of the poor performing states. For example, wages and salaries constituted around 83 and 85 percent of total health spending in the states of Madhya Pradesh and Orissa—the two states with the worst health indicators.

The nature of public spending has resulted in a grossly inadequate health infrastructure. The number of allopathic doctors, nurses, and midwives in India (when adjusted for their qualification) is less than a fourth of the WHO benchmark. This has led to recourse to unqualified medical practitioners in the rural areas. Besides, the ratio of nurses to doctors in India is extremely unfavorable in comparison to some of the better performing countries. When adjusted for qualification, the ratio of nurses to doctors is about 0.6:1, that is, it is less than one nurse per doctor. In many developed countries this ratio is about 3:1, three nurses to one doctor. The low share of non-salary expenditure has also resulted in inadequate essential drugs at sub-centers (SCs), primary health centers (PHCs) and community health centers (CHCs) – the first three tiers of primary and secondary health care facilities in the rural areas. According to the facility survey conducted by the International Institute of Population Sciences (IIPS) in 2007-08, about 35 percent of the SCs and 30 percent of PHCs had less than 60 percent of the essential drugs required for primary care. Similarly, about a third of the PHCs had less than 60 percent of the basic refrigeration facilities required for primary care.

Research Questions

The investigation was done in order to find out the answers to the following questions. What is the extent of health awareness of the teenage girls? Are the teenage girls aware of the importance of food?

Objectives of the Study

The objectives of the study pertain to

- To assess the extent of the health awareness among the teenage girls
- To assess the degree of knowledge of nutritious food of the teenage girl
- To construct a tool for measuring the knowledge of health awareness and nutritious food

Sample Design

The investigator selected 90 students of XI std from 3 schools of which 45 were Boys and 45 were Girls.

Hypotheses

1. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Type of institution.
2. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Gender.
3. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of locality.
4. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of socio-economic status.
5. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Parental Literacy.
6. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of community.
7. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Medium of instruction

Research Design

The investigator has contemplated to employ normative method (Survey Design) for the study and has chosen by simple random technique. The tool consists of 60 statements. It has high reliability and validity.

Procedure of Data Collection

The following procedures were adopted.

1. The sample was identified.
2. The investigator structured the tools.
3. The tools were administered and data collected.
4. After scoring the obtained data were subjected to analysis and interpretation.
5. On the basis of the inference, it was decided to give suggestions to conduct further research.

The data were collected in person by administering the questionnaire. The respondents were informed that they should poll the opinion freely and frankly without any bias. A warm and healthy atmosphere was created and a good rapport was established.

Statistical Techniques

't' test was employed to find out the significant of difference between the means of variables between sub groups.

Analysis and Report

There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Type of institution

Table 1: Differences due to Type of Institution

Type of institution	N	Mean	SD	"t" value	Significance
Government	30	41.50	7.53	1.15	NS
Govt. Aided	30	43.83	8.12		
Type of institution	**N**	**Mean**	**SD**	**"t" value**	**Significance**
Government	30	41.50	7.53	2.08	NS
Matriculation	30	45.50	7.30		
Locality	**N**	**Mean**	**SD**	**"t" value**	**Significance**
Urban	57	42.69	7.72	1.50	NS
Rural	33	45.20	7.59		
Community	**N**	**Mean**	**SD**	**"t" value**	**Significance**
SC	19	46.55	7.67	1.98	S
NSC	71	42.82	7.78		
SES	**N**	**Mean**	**SD**	**"t" value**	**Significance**
Low	43	42.93	8.35	1.18	NS
High	47	44.86	7.00		
Parental Education	**N**	**Mean**	**SD**	**"t" value**	**Significance**
Low	31	44.21	7.18	0.94	NS
High	59	42.63	8.36		
Medium	**N**	**Mean**	**SD**	**"t" value**	**Significance**
Tamil	60	42.52	7.30	2.28	S
English	30	45.83	6.05		

Findings

1. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Type of institution (Government and Govt. Aided).
2. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Type of institution (Government and Matriculation).
3. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Type of institution (Govt. Aided and Matriculation).
4. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of Gender.
5. There exists no significant difference in the mean scores of Health, Hygiene and

Nutrition status of students of Higher Secondary Class in terms of locality.

6. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of socio-economic status.
7. There exists no significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of parental literacy.
8. There exists significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of community.
9. There exists significant difference in the mean scores of Health, Hygiene and Nutrition status of students of Higher Secondary Class in terms of medium of instruction.

Limitations of the Study

- The concept of health awareness is limited to the basic principles of health.
- Duration of the research period is limited due to paucity of time.
- The study is limited to the students of Sivagangai district.

Conclusion

The investigation has come to the finale of the research. The researcher could find the level of Health, Nutrition and Hygiene are moderate in nature. It would go a long way if the awareness of the learners gets enhanced

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