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## SOCIOLOGY | RESEARCH ARTICLE

# Effects of ethnicity and gender on youth health

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**Abstract:** This study investigated the effects of ethnicity and gender on the health of young people (14–25 years old) living in Mauritius. Combinations of female and male by four ethnic groups—“Creole”, “Hindu”, “Muslim” and “Mixed”—were used for multivariate analysis of variances. “Mixed” ethnic group consumed most tobacco, alcohol and drugs compared to other ethnic groups. They were also the ones that mostly skipped breakfast and lunch and were found to eat most fast food. Moreover, “Mixed” ethnic group had heard most about HIV/AIDS programmes, but were least satisfied with such programmes and with public hospitals and health services. Females were shown to perceive more physical and mental health issues than did males; although males smoked more cigarettes and drunk more alcohol. However, females consumed more fast food and deep fries and rated public hospitals and sexual and reproductive health services as less good than did males. The findings call for further research on the health of young people living in Mauritius with respect to socio-economic variables in order to promote social justice in the Mauritian society. In addition, this article also emphasises on the need of having a new National Youth Policy for Mauritius, which is long overdue.

**Subjects:** Social Work; Sociology; Sociology & Social Policy

**Keywords:** health; gender; ethnicity; lifestyles; consumption

### 1. Introduction

Youth (14–25 year old) is commonly seen as a critical period for healthy growth and development. Although the majority of young people can make informed decisions about themselves and their

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#### PUBLIC INTEREST STATEMENT

Mauritius is a small island state with a population of about 1.26 million. The youth population (14–25 years old) of the country is estimated to be around 200,000 (about 50% females) representing approximately 16% of the total Mauritian population. Youth has often been characterised as a period that is prone to influences from their social environment. In particular, it is believed that ethnicity and gender (among others) condition youth health lifestyle. Using a lifestyle perspective, this article presents some quantitative analysis of data gathered from 462 young people living in Mauritius. The study shows the effects of gender and ethnicity on some health variables, such as physical and mental health, access to health, food and substance consumption and so on. The findings call for further research and evidence-based youth policies related to the effects of gender and ethnicity on youth health in Mauritius.

future, this critical age range defined as youth has also been characterised as a period that is prone to influences from peers, media, cultural environment and so on. Historically, the focus on youth as a critical and vital period perhaps emerged from a belief that young people required cultivation to grow into adulthood; and/or, on the conviction that the nature of the youth must be controlled by society (Troen, 1985). In particular, healthy growth and development through a healthy lifestyle during youth is considered to be a prerequisite for sound adulthood.

Health is often defined as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity (WHO, 2006). In particular, health is conceptualised as resources for, and also as the most important determinant of well-being (Eurofound, 2012). Given that health cannot be measured directly, like length or weight, the process of its measurement is often based on indirect assessments (McDowell, 2006). For instance, individual's subjective perception on his/her health status is commonly regarded as an essential indicator of his/her health (Hunt et al., 1980). Health lifestyle is also used within health assessment. It is well known that many daily lifestyle practices have direct effects on health outcomes. For instance, unhealthy lifestyles, such as binge drinking and excessive smoking, unhealthy eating, physical inactivity, drug abuse and so on, are generally known to have profound adverse effects on health (Leung & Arthur, 2004).

At global level, several actors have manifested their expressions of commitment to a healthy personal, spiritual, social, mental and physical development of the youth population (United Nations, 2003). At national level, several countries give high priority to the health assessment of its youth population, mainly through health lifestyle, attitudinal and behavioural, studies (Puszka et al., 2015). In particular, several national and international studies on health inequalities have shown that the youth population is affected by the social structural divisions in society (Coleman & Hagell, 2015). In this sense, health inequalities among young people are recognised as an important problem from social justice and human rights perspectives (Oliver et al., 2008). In recent years, social scientists and social epidemiologists have particularly focused their attention on the effects of social and cultural variables, such as ethnicity and gender on the health of individuals (Hernandez & Blazer, 2006). Given that health disadvantages during childhood and youth have profound impact on health during adulthood (Ferraro, Schafer, & Wilkinson, 2016); policy-makers rely on scientific studies for designing evidence-based youth policies and corrective measures.

This article presents and discusses the findings from a small-scale survey on the effects of ethnicity and gender on the health of Mauritian youth. The following section briefly presents the context of the study. Then, the article explains the theoretical background of the research. Then after, it presents the findings and discussion. Before ending with a conclusion, this article briefly outlines a couple of limitations and some implications of this study.

## **2. Context: a brief on the Mauritian society**

Mauritius is a small island state situated in the Indian Ocean, towards north east of Madagascar. The island has a population of about 1.26 million, with about 50% being females. The youth population is estimated to be around 200,000 (about 50% females) representing approximately 16% of the total Mauritian population. In terms of socio-economic development and political stability, Mauritius is considered as one of the most successful country in Africa (Greig, Turner, & D'Arcy, 2011). Over the last few decades, the country's economy has maintained an average GDP growth of about 4% and has continuously tried to reconcile social development with economic development through universal welfare provisions such as free education and free health care for all at all levels (Bunwaree, 2004; Rambaree, 2009).

Mauritius is often described as a "rainbow nation" where different ethnic groups preserve and maintain their ancestral culture, language, tradition and religion. According to Eriksen (1993), a concern to reproduce ethnic boundaries and an urge to remain ethno-religiously "pure" is typical of Mauritian society. The Mauritian Constitution, which has been framed during the British colonial rule, recognises only four main ethnic groups: Hindu, General Population, Muslim and Sino-Mauritian.

However, the ethnic and religious compositions of Mauritius are often reported as follows: *Ethnicity*: Indo-Mauritian 68%, Creole 27%, Sino-Mauritian 3%, Franco-Mauritian 2%; and *Religion*: Hindu 48.5%, Roman Catholic 26.3%, Islam 17.3%, other Christian 6.4%, other .6%, none .7%, unspecified .1% (USAID, 2014). Given its diversity, Mauritius is often regarded a laboratory for ethnic studies (Eriksen, 1997).

In particular, ethnicity is regarded as a fuzzy concept. The term is often used as a group classification, identification and relationships based on a mixture of characteristics such as decent, history, language, religion, culture and tradition. In the case of Mauritius the conceptualisation of ethnicity is even more problematic. For instance, there is constant debate in Mauritius on how the constitution can still consider Creoles (African descends) together with Franco-Mauritians (French descends) under the same ethnic group as General Population, despite them having different history, language, culture and tradition. Moreover, Eriksen (1997) states that religion is an important ethnic marker in Mauritius, where there is not a one-to-one relationship between religious affiliations and ethnic ones; however, there are strong correlations between them. For instance, the ethnic group “Muslim” are linked with “Islam” as religion; and the ethnic group “Hindu” as those having “Hinduism” as religion. In this way, religion is subsumed in ethnicity, and religious labels become markers of certain ethnic groups (Ruane & Todd, 2011). In this sense, ethnicity can therefore have religion as a strong basis for meaning-construction and cohesion in the feeling of community and identity (Kim, 2011). In daily interactions, most Mauritians therefore prefer to identify themselves according to the following ethnic groups rather than the one used in official discourses: Hindu, Muslim, Creole, Sino-Mauritian, Franco-Mauritian and Mixed (Eriksen, 2002).

Ethnicity is commonly reported to play an important role in the identity construction, lifestyles and behaviour of the Mauritian youth (Ng Tseung-Wong & Verkuyten, 2014). As a structure, ethnicity is also regarded as an important determinant in health inequalities (Karlsen & Nazroo, 2002). In fact, socio-economic disparities along ethnic lines are very visible in Mauritius, where the Franco-Mauritians are the elites, the Creoles are the marginalised group and the rest of the ethnic groups form the middle class strata of the society (Boswell, 2006; Bunwaree, 2001; Salverda, 2015). In the case of Mauritius, it is therefore argued that ethnicity and socio-economic class cut across in yielding various forms of health inequalities (Badurally Adam, Mahomoodally, Subraty, & Ramasawmy, 2012; Vos, Gareeboo, & Roussety, 1998).

Furthermore, gender-based inequalities are frequently reported as a hindering factor in the human development of Mauritius. The country is referred as a highly patriarchal society, where gender shapes the opportunities and experiences across one’s life course (Bunwaree, 2004; Gokulsing & Tandrayen-Ragoobur, 2014; Ramtohol, 2010). For instance, Ramtohol (2010) argues that in Mauritius, various spheres such as work, sports and education are dominated and even fully controlled by men. According to the Human Development Report 2014, the gender inequality index of Mauritius was .375 and the country was ranked 72 out of 187 countries globally (UNDP, 2014). The same report also states that women in Mauritius only hold 18.8% of parliamentary seats, 49.4% of adult women have reached at least a secondary level of education compared to 58.0% of their male counterparts; and female participation in the labour market is only 43.5% compared to 74.3% for men (Ibid). Moreover, there are also noticeable gender disparities in the health of men and women in Mauritius. For example, ill-health such as diabetes, heart disease, cerebrovascular disease and cancer together accounted for 62.9% of causes of deaths among women against 56.2% of men’s deaths (Ministry of Finance and Economic Development, 2015).

In a society like Mauritius, it is therefore commonly known that there exist considerable differences in food and substance consumptions and in mortality rates from cardiovascular diseases, between men and women and between different ethnic groups (Badurally Adam et al., 2012; Rambaree, Knez, & Auchoybur, 2012; Vos et al., 1998). Several studies have also pointed out that there exist significant ethnicity- and gender-based inequalities in terms of physical and mental health of young people living in Mauritius (Ministry of Youth and Sports, 2014; Pillay & Bundhoo,

2011; Rambaree & Auchoybur, 2009; Rambaree et al., 2012). Thus, in the case of Mauritius, it becomes imperative to have better understanding on the effects of ethnicity and gender on the health of the young people in order to have more informed national youth policies.

### 3. Theoretical background

Within sociology of health, social structural inequalities are considered as important determinants of health (Dumas, Robitaille, & Jette, 2014). Particularly, medical sociologists focus on the social structural causes of health lifestyles in studying health inequalities. Health lifestyle is often mentioned as a key factor that influences people's health (Leung & Arthur, 2004). In its broad term, lifestyle is associated to habitual behaviours. Cockerham (2000) defines health lifestyle as collective patterns of health-related behaviour that is based on choices from options available to people according to their life chances. Dumas et al. (2014, p. 142), referring to Bourdieu's theory on habitus argue that, "lifestyles are the result of a taste for necessity which implies a form of adaptation to and consequently acceptance of the necessary".

Health lifestyle theory can therefore be used as a perspective to look at the effects of social structural variables on the health of young people living in Mauritius. In particular, health lifestyle theory emphasises on the social structural forces that constraint individual to adopt certain health-related pattern of behaviours and practices. According to this theory, the decisions people make with respect to diet, exercise, smoking, and the like are shaped by social structural variables, such as ethnicity and gender (Cockerham, 2000, 2005). Thus, health lifestyle perspective is commonly used to identify individual characteristics, attitudes and perceptions related substance abuse, eating disorders and access to health services for providing theoretical explanations on health inequalities among different gender and ethnic groups (Dumas et al., 2014; Leung & Arthur, 2004). Indeed, many researchers report that ethnicity and gender are among the most important social structural variables that prevent some young people from having a healthy lifestyle. For instance, Jakab (2012, p. xvii) argues:

Poor health cannot be explained simply by germs and genes. It involves the circumstances in which young people live; their access to health care, schools and leisure opportunities ... It also reflects individual and cultural characteristics such as social status, gender, age and ethnicity.

Ethnicity has also been found to be associated with risk factors related to health lifestyle (Courtenay, McCreary, & Merighi, 2002; Gottlieb & Green, 1987; Seale, Davis-Smith, & Okosun, 2006; Uphoff, Pickett, Crouch, Small, & Wright, 2016). For instance, it is often reported that the risk of some non-communicable diseases is higher in certain specific ethnic groups of South-Asian descends such as the Hindus and Muslims mainly because of lifestyle risk factors associated with food consumptions and lack of physical activities (Anthony et al., 2012).

Moreover, in almost all societies, men and women have different societal roles imposed on them that lead to different life-chances, life-experiences and lifestyles (Rambaree et al., 2012). WHO (2010) reports that gender-based differences in access to and control over resources, in power and decision-making have implications for women's and men's health status, health-seeking behaviour and access to health care services. For instance, a woman's gender role identity, i.e. the way she views herself vis-a-vis societal gender role ascriptions, can influence her physical and mental health (Littlefield, 2004). In addition, throughout the world men are more likely to adopt binge drinking lifestyle and consequently suffer more from drug- and alcohol-related health problems compared to women (Wilsnack, Wilsnack, & Obot, 2005).

Some researchers argue that there is a need within social science discourses for more scientific study, from a variety of different socio-economic and cultural context, looking at the role of ethnicity and gender on health inequalities among the youth population (Gakidou & King, 2002; Oliver et al., 2008). It is commonly argued that health lifestyle should be seen in relation to the cultural context

of a society with particular focused on local social structural variables (Leung & Arthur, 2004; Tomba, 2012). In the context of Mauritius, health lifestyle is often measured in relation to habits that are relevant to health such as physical activities, diet, smoking, substance consumption. Thus, using the health lifestyle theoretical perspective, this article presents the analysis and discussion on some selected dependent variables, such as physical and mental health, access to health, food and substance consumption and so on, in relation to gender and ethnicity as independent variables among a sample of youth population from Mauritius.

#### 4. Method

##### 4.1. Sample

Data for this study were collected during the period from May 2014 to October 2015 from both rural and urban parts of Mauritius by volunteers, working either as teacher in schools or youth officer in youth centres. A pilot test with 20 questionnaires was undertaken with minor changes made in the final self-administered questionnaire. A stratified sample by sex, ethnicity and location (urban or rural) was designed. Researchers and volunteers followed social research ethical guidelines such as voluntary participation, anonymity in data collection and reporting; and permissions of all the stakeholders involved in the study were sought before the data collection.

##### 4.2. Measures

The following questions/measures related to health issues are included in the present study:

*Physical and mental health:* The items were from Thorlindsson, Vilhjalmsson, and Valgeirsson (1990). Participants were asked to estimate how often they suffered from a number of distresses on a scale ranging from never (1) to almost everyday (4). The physical health items included headache, stomach pains, back pains, dizziness; and the mental health items included anxiety, tension or restlessness, sleeping problems and feelings of sadness or depression.

*Access to health:* The items were from Rambaree et al. (2012). Participants were asked to rate public (government) and private (clinics) hospitals, sexual and reproductive health services for young people on a scale ranging from (1) very poor to (5) very good. They were also asked to rate how often they hear about of HIV/AIDS programmes on a scale ranging from (1) never to (5) always; and how satisfied they are with HIV/AIDS programmes for youth on a scale ranging from (1) very dissatisfied to (5) very satisfied.

*Health risks:* The items were adapted from Currie et al. (2004). Participants were asked to rate their consumption of tobacco (cigarettes), alcohol (beer, wine, liqueurs or spirits) and drugs. For smoking this was done on a scale ranging from 1 (have never tried smoking) to 5 (smoke five or more cigarettes everyday), for alcohol on a scale ranging from (1) never to (5) every week and have been drunk two or three times, and for drugs on a scale ranging from (1) never to (5) almost all time. They were also asked to rate their consumption of food on a scale ranging from (1) daily to (5) never, including following items: you skip breakfast, you skip lunch, you eat fast food, you eat sweets or snacks, you drink soft drinks (gazeuse), you eat deep fries (chips, samosa, etc.), you eat fruit and you drink dairy products (milk, yoghurt, etc.).

##### 4.3. Design

The questionnaire included three genders (Female, Male and Other) and eight ethnicity groups (Sino-Mauritian, Creole, Franco-Mauritian, Hindu, Muslim, Mixed, Other, Don't know). Due to too few participants in each cell of gender by ethnicity grouping, only combinations of female and male by Creole, Hindu, Muslim and Mixed were used for the statistical analyses (see Table 1). Accordingly, 462 (89%) out of 517 participants were included in this study.

IBM SPSS Statistics 22 software was used for the analysis. MANOVAs (multivariate analysis of variances) were calculated, due to several items included in each measure (dependent variable), to

**Table 1. 462 participants included in this study, divided across gender and ethnicity**

|         | Ethnicity |       |        |       | Total |
|---------|-----------|-------|--------|-------|-------|
|         | Creole    | Hindu | Muslim | Mixed |       |
| Gender  |           |       |        |       |       |
| Males   | 14        | 85    | 28     | 15    | 142   |
| Females | 38        | 214   | 59     | 9     | 320   |
| Total   | 52        | 299   | 87     | 24    | 462   |

detect differences in: (1) *General, physical and mental health*; (2) *Access to health* and (3) *Health risks* between females, males and Creole, Hindu, Muslim and Mixed ethnic groups (independent variables).

## 5. Results

### 5.1. Physical and mental health

#### 5.1.1. Physical health

A main effect of Gender, Wilks  $\lambda = .89$  (4, 433) = 13,  $p < .001$ ,  $\eta^2 = .11$ , showed that females perceived significantly more headache ( $p < .001$ ), stomach ( $p < .001$ ), back pains ( $p < .001$ ) and dizziness than did males (see Figure 1).

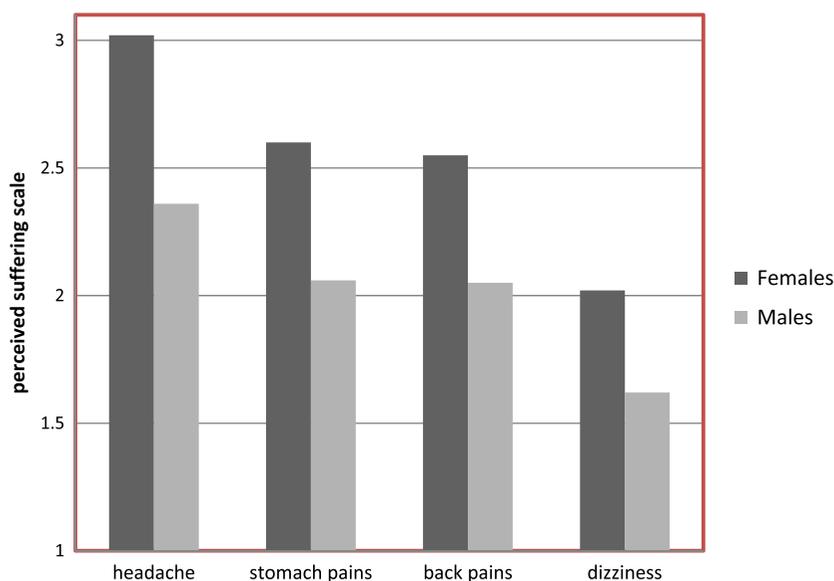
#### 5.1.2. Mental health

A main effect of Gender was obtained, Wilks  $\lambda = .93$  (4, 440) = 8.91,  $p < .001$ ,  $\eta^2 = .08$ , associated with anxiety ( $p < .001$ ), tension/restlessness ( $p < .001$ ), sleeping problems ( $p < .001$ ) and sadness/depression ( $p < .001$ ). As can be seen in Figure 2, Females compared to males were shown to perceive significantly more mental health problems.

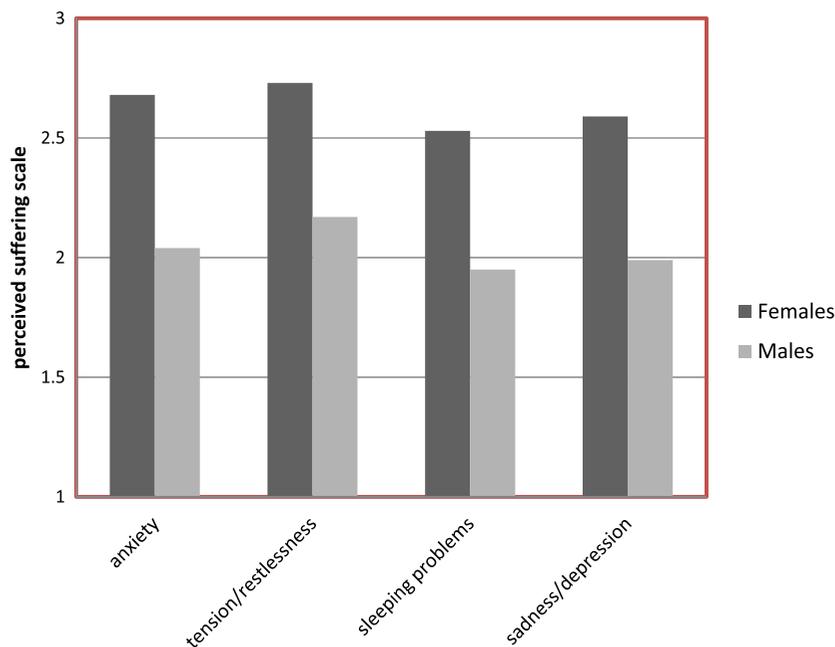
### 5.2. Access to health

Main effects of Gender, Wilks  $\lambda = .96$  (5, 435) = 3.97,  $p < .001$ ,  $\eta^2 = .04$ , and Ethnicity, Wilks  $\lambda = .93$  (15, 1201) = 2.31,  $p < .001$ ,  $\eta^2 = .03$  were shown. The Gender effect was associated with public hospitals ( $p < .001$ ) and sexual and reproductive health services for young people ( $p < .001$ ). As can be seen in Figure 3, males rated higher on both items than did females.

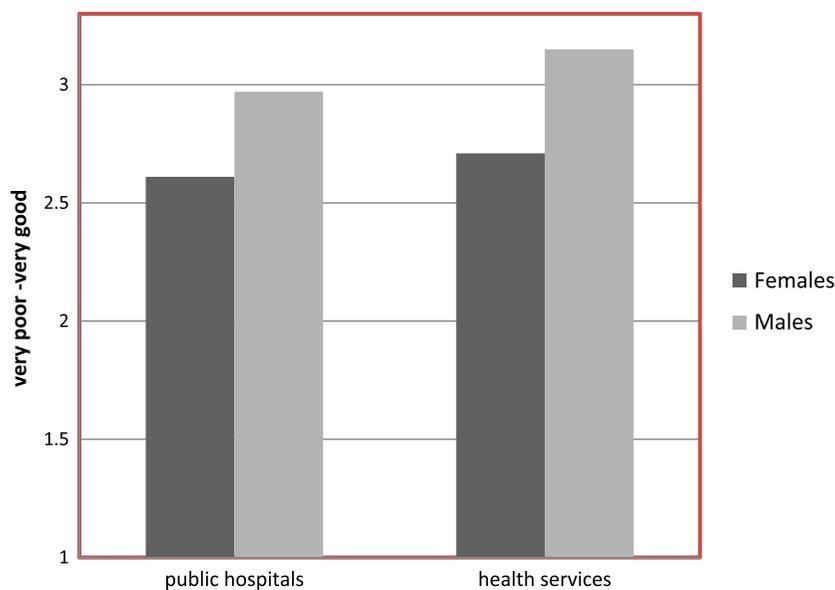
**Figure 1. Mean perceived suffering of headache, stomach and back pains, and dizziness in females and males.**



**Figure 2. Mean suffering of anxiety, tension/restlessness, sleeping problems and sadness/depression in females and males.**



**Figure 3. Mean rating of public hospitals and sexual and reproductive health services for young people, across females and males.**



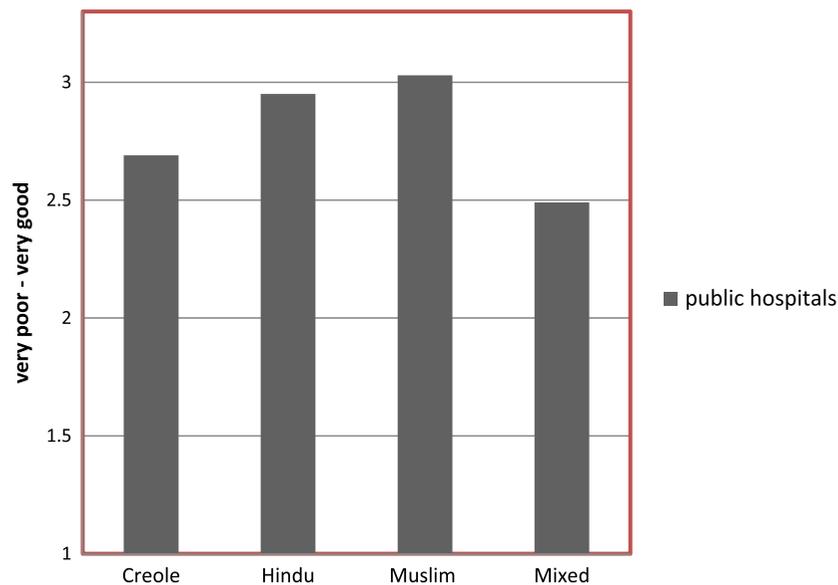
The ethnicity effect was associated with public hospitals ( $p = .05$ ), how often they hear about of HIV/AIDS programmes ( $p = .05$ ), and how satisfied they are with HIV/AIDS programmes for youth ( $p = .03$ ). As can be seen in Figure 4, “Mixed” ethnic group were mostly dissatisfied with public hospitals. They did also hear most about HIV/AIDS programmes but were least satisfied with them (see Figure 5).

### 5.3. Health risks

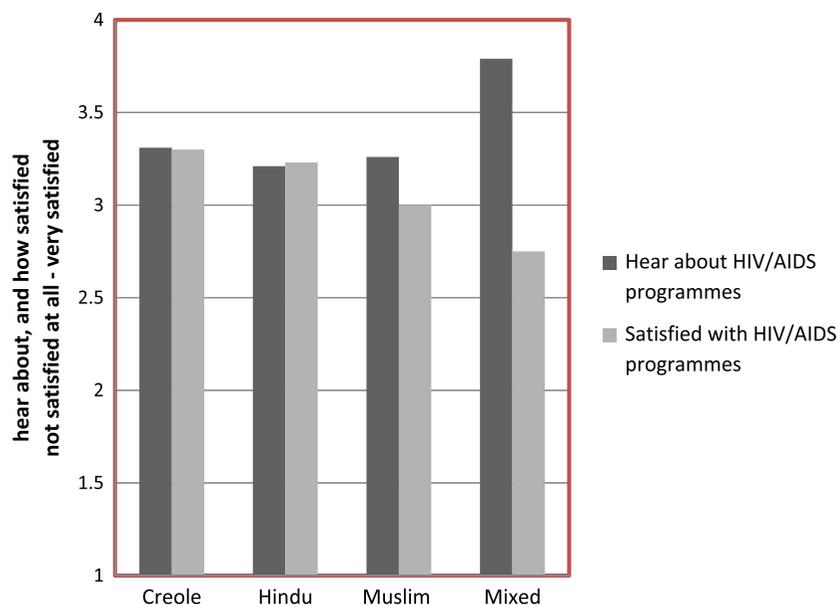
#### 5.3.1. Consumption of tobacco, alcohol and drugs

Two main effects of Gender, Wilks  $\lambda = .94$  (3, 445) = 9.74,  $p < .001$ ,  $\eta^2 = .06$ , and Ethnicity, Wilks  $\lambda = .86$  (9, 1083) = 7.6,  $p < .001$ ,  $\eta^2 = .05$ , were obtained. As can be seen in Figure 6, the Gender effect was

**Figure 4. Mean rating of public hospitals and sexual and reproductive health services for young people, across Creole, Hindu, Muslim and Mixed.**



**Figure 5. Mean rating on how often participants hear about HIV/AIDS programmes and how satisfied they are with HIV/AIDS programmes for youth, across Creole, Hindu, Muslim and Mixed.**



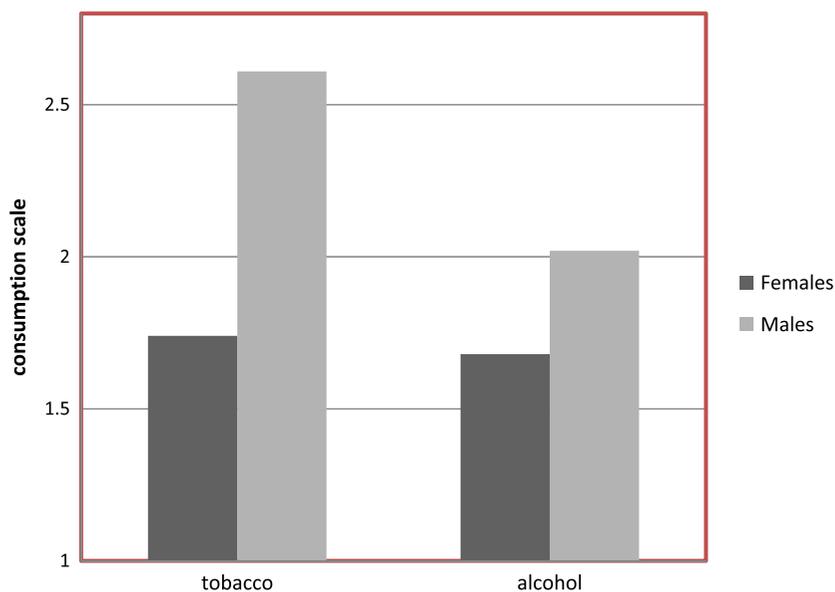
associated with consumption of tobacco ( $p < .001$ ) and alcohol ( $p < .001$ ), showing that males compared to females smoked more cigarettes and drank more alcohol.

The Ethnicity effect was associated with all three items, tobacco ( $p < .001$ ), alcohol ( $p < .001$ ) and drugs ( $p = .02$ ), showing that “Mixed” group compared to other ethnic groups consumed most substances (see Figure 7).

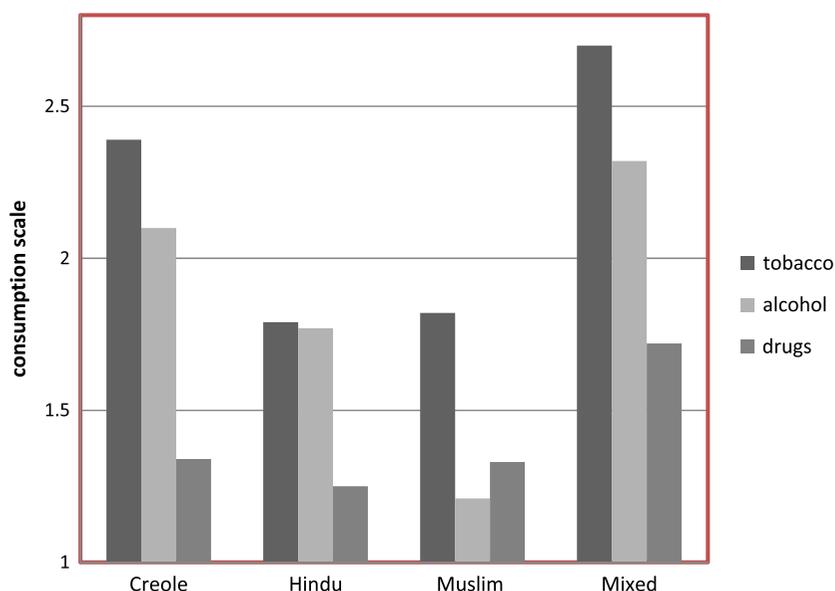
### 5.3.2. Consumption of food

A strong tendency to a main effect of Gender, Wilks  $\lambda = .97$  (8, 423) = 1.8,  $p = .07$ ,  $\eta^2 = .03$ , associated with fast food ( $p = .04$ ) and deep fries ( $p = .03$ ), showed that females consumed more fast food and deep fries than did males (see Figure 8).

**Figure 6. Mean consumption of tobacco and alcohol in females and males.**



**Figure 7. Mean consumption of tobacco, alcohol and drugs in Creole, Hindu, Muslim and Mixed.**

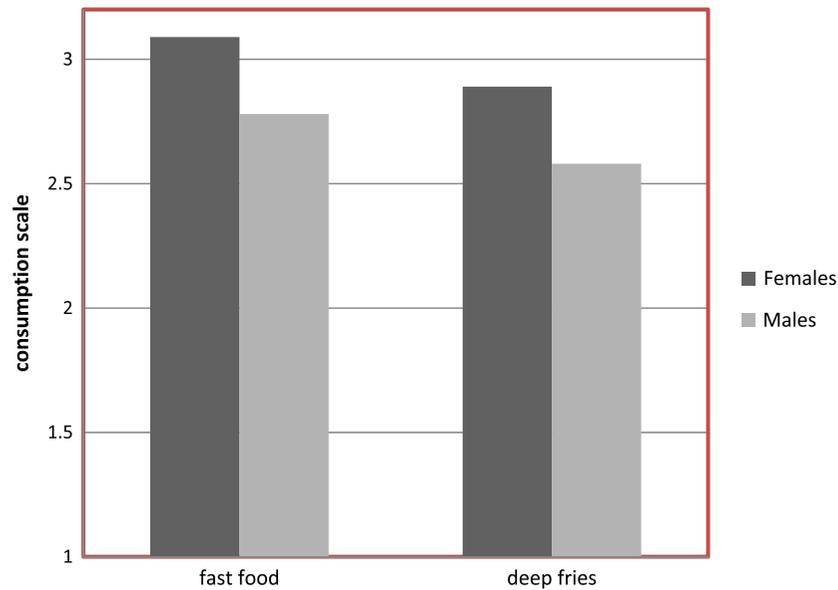


A main effect of Ethnicity, Wilks  $\lambda = .92 (24, 1227) = 1.53, p = .05, \eta^2 = .03$ , was obtained, associated with skip breakfast ( $p = .05$ ), skip lunch ( $p < .01$ ) and eat fast food ( $p = .04$ ). As can be seen in Figure 9, “Mixed” ethnic group compared to others, mostly skipped breakfast and lunch and were shown to eat most fast food.

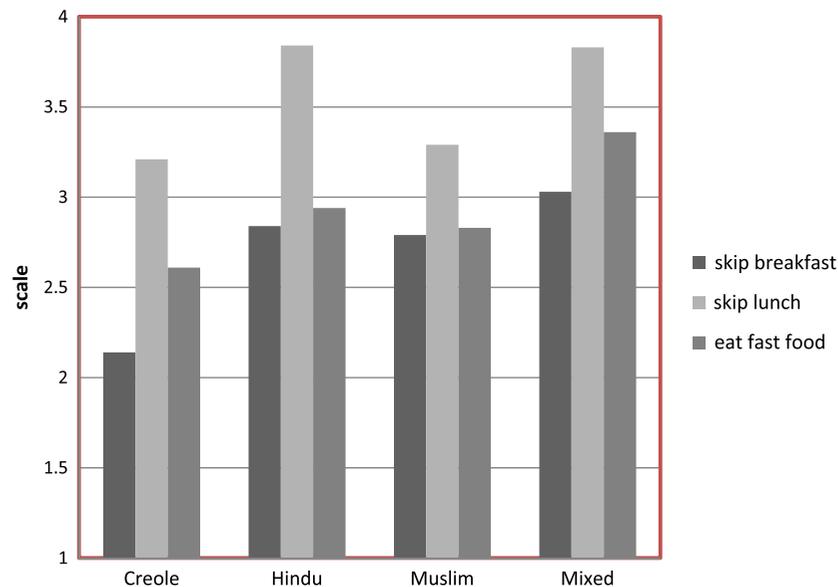
### 6. Discussion

The aim was to investigate effects of ethnicity and gender on health of young people living in Mauritius. Concerning ethnicity, it was found that “Mixed” ethnic group consumed most tobacco, alcohol and drugs compared to other ethnic groups. Young people from the “Mixed” ethnic group were also the ones that mostly skipped breakfast and lunch and were shown to eat most fast food. It is well known that different ethnic groups have different level of tolerance towards health life-styles. For instance, alcohol consumption is not accepted at all in most Muslim families (Neumark, Rahav, Teichman, & Hasin, 2001). In the case of Mauritius, studies have mentioned that there are more social and behavioural pressures and constraints among young people from “pure” ethnic

**Figure 8. Mean consumption of fast food and deep fries in females and males.**



**Figure 9. Mean consumption of food, associated with you skip breakfast, you skip lunch and you eat fast food in Creole, Hindu, Muslim and Mixed.**



groups compared to “Mixed” one (Eriksen, 1997; Nave, 2000; Ng Tseung-Wong & Verkuyten, 2014, 2015). This factor could perhaps explain the findings related to the health lifestyles of young people from “Mixed” ethnic group in Mauritius. However, this possible explanation should be confirmed with further empirical evidence from more appropriately designed studies.

Moreover, “Mixed” ethnic group had heard most about HIV/AIDS programmes but were least satisfied with them, as well as with public hospitals and health services. The Mauritian health care system is based on a mixture of public and private provision. Free health care provided by the public hospitals are normally regarded as inferior quality compared to the fee-paying private hospitals (Kassean & Juwaheer, 2010). There is a noticeable class disparity between those using the public, compared to those using the private health care services in Mauritius. As mentioned earlier, previously carried out studies have reported that “Mixed” ethnic group in Mauritius constitutes often members from higher class strata of the society (Eriksen, 1997; Nave, 2000). In many societies, members from higher strata have healthier lifestyles and more access to health care services and

information (Espelt et al., 2008). Thus, the interaction between class and ethnicity could perhaps explain the finding on least satisfaction of the “Mixed” group with public hospitals and health services. This is another issue that future research needs to explore further.

Concerning gender, females were shown to perceive more physical and mental health issues than did males; although that males smoked more cigarettes and drunk more alcohol. It could be that females reported more physical and mental health issues than males because of biological reasons such as menstruation. However it is commonly known that in patriarchal societies, females do suffer more from structural inequalities that result in ill-health. As UNFPA (2010, p. 19) argues:

Women suffer from mental health disorders, such as depression and anxiety, at higher rates than men due to risk factors related to gender roles and to negative life experiences and events related to reproductive health.

Within patriarchal societies like Mauritius, gender places females far more than males in situations where they have little control over their health lifestyles, which in turn explain the higher level of physical and mental health issues among females (WHO, 2010). According to some feminists, females usually have more responsibilities and fewer opportunities for relaxation compared to males; and therefore, that could account for females having more mental and physical health issues (Becker, 2010; Nussbaum, 2000; Rambaree et al., 2012).

Cigarette and alcohol consumption has always been lower among females compared to males, mainly because of gender norms (Hunt, Hannah, & West, 2004; Wilsnack et al., 2005). In most patriarchal societies, females are not expected to smoke and consume alcohol; and their behaviour in relation to substance use is more controlled and sanctioned than that of males by parents and other control agents of society. Such reasoning could therefore explain the differences in consumption of cigarette and alcohol between young males and females in Mauritius.

However, females were found to consume more fast food and deep fries than did males. This part need to be researched further, as other studies have found mixed results in terms of eating habits of males and females in Mauritius. For instance, Badurally Adam et al. (2012) reported that, fruit and vegetable intake among adults in Mauritius was not related to gender. Whereas, Ranjana, Mahomoodally, and Ramasawmy (2013) found that there were significant differences between the eating habits of males and females in Mauritius. In Mauritius very few secondary schools give males the opportunity to study about food and nutrition through “Home Economics” classes, which in many schools are offered to females only (Oogarah-Pratap, 2007). Therefore, one possibility could be that females from this sample have more knowledge related to, or simply have been more conscious in reporting about diet and nutrition; and therefore responded more carefully about unhealthy eating such as fast food and deep fries, compared to males.

Furthermore, females rated public hospitals and sexual and reproductive health services as being less good than did males. In many societies, young females are prime users of sexual and reproductive health services. In the case of Mauritius, given that females suffer more from physical and mental health, they are therefore more likely to use health services. Within the African context, WHO (2012) reports that because of gender, females have limited access to sexual and reproductive health care services; and when they do have access to such services, in many cases the health professionals are not adequately prepared to address gender specific health needs of women. Such statement could perhaps explain why young Mauritian females rated public hospitals and sexual and reproductive health services as less good than did males.

The above-mentioned findings corroborate with several previous studies. In studying the health of students from the University of Mauritius, some researchers found that gender could explain most of the significant differences in terms of health between males and females (Pillay & Bundhoo, 2011; Rambaree & Auchoybur, 2009; Rambaree et al., 2012). For instance, studying the sources of stress

among university students in Mauritius, Pillay and Bundhoo (2011) reported that females were significantly more affected than males mainly because of gender disparities. Despite females reporting more mental health issues, the Health Statistics Report 2013 of Mauritius indicate that males are ten times more likely to be admitted to hospitals for mental and behavioural disorders due to use of alcohol (Ministry of Health and Quality of Life, 2015). In a study carried by the Ministry of Youth and Sports in Mauritius, it is reported that 66.2% of young people ever smoked and males were approximately three times more likely to have ever smoked, consume alcohol and drugs; as well as, girls were more likely to skip breakfast on weekdays (Ministry of Youth and Sports, 2014).

### 7. Limitations and implications

The findings of this study should be considered with two limitations. Firstly, neither gender variables (such as gender roles) nor ethnic variables (such as ethnic relations) have been investigated qualitatively through in-depth interviews in this study. Secondly, the study has also not measured all variables related to health lifestyles and therefore generalisation in this sense should be made with cautions. Nevertheless, this study presents sufficient empirical evidence that shows significant differences in the effects of gender and ethnicity on the health of young people living in Mauritius.

The findings and discussion therefore call for further research on the effects of socio-economic variables on the health of the young people in Mauritius. Further empirical studies need to explore the differences in health attitudes, behaviour and practices of the “Mixed” ethnic group relation to others in the Mauritian society. Further studies in Mauritius need to look at the effects of gender norms/roles/relations on the health lifestyles of the young people. Such data are crucial in designing evidence-based youth policies.

The National Youth Policy (NYP) document available in Mauritius has expired in the year 2014 (Refer to Ministry of Youth and Sports, 2009). Currently, youth workers in Mauritius rely on the National Youth Survey (NYS), entitled “Determinants of Youth Behaviour in Mauritius”, undertaken in 2014 (Refer to Ministry of Youth and Sports, 2014) for formulating their action plans. Despite ethnic-based inequalities being a major national problem in Mauritius (Bunwaree, 2001; Greig et al., 2011), neither the NYP 2010–2014 nor the NYS of 2014 considered this particular issue. However, the NYP 2010–2014 recognised and acknowledged gender as being a major problem in tackling inequalities among the youth in the Mauritius. Whereas, the NYS 2014 only reported the effects of gender on the youth in Mauritius, but did not make any recommendation in this sense.

In particular, policy-makers in Mauritius need to focus more attention on means and strategies for tackling the existing health inequalities based on gender and ethnicity among the youth population in Mauritius, in order to have a fair society for all. Social justice has been a central element in the socio-economic development of Mauritius (Stiglitz, 2011); and it should remain a key component in the progress of the society. Marginalisation based on gender and ethnicity has been a major problem in Mauritius for many years now (Bunwaree, 2001). It is therefore imperative for Mauritius to have clear policy guidelines for tackling health inequalities among the youth population; and such guiding principles need to appear in an up-to-date National Youth Policy, which is long overdue.

### 8. Conclusion

Young people in societies like Mauritius have different life opportunities and experiences because gender and ethnicity. From the health lifestyle theoretical perspective, it could be argued that social structural forces constraint young men and women from different ethnic group to adopt certain health pattern(s). Consequently, youth in Mauritius are exposed to different degrees and types of health inequalities. This article concludes that there are significant differences in the effects of gender and ethnicity on the health of young people living in Mauritius. Mauritian policy-makers need to focus more attention and resources in tackling such structural differences in order to continue making a better society for all. In this context, the need for an up-to-date National Youth Policy document is felt.

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