Original Research

# PREVALENCE AND DIETARY DETERMINANTS OF ANAEMIA AMONG YOUNG ADULTS AGED 18–25 YEARS: A CROSS-SECTIONAL SURVEY AT A TERTIARY CARE INSTITUTION IN SOUTH INDIA

**Vijayapriya I[1*], Sushmitha S[2], Nandhini G[3], Sowbharanika A[4], Pavithra R[5], Mona N[6]**
[1*]Professor, Department of Biochemistry, Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur.
[2,3,4,5,6]CRMI, Department of Biochemistry, Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur.
**Corresponding Author:** Dr Vijayapriya I
Professor, Department of Biochemistry, Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur

## ABSTRACT

**Background:** Anaemia continues to affect a substantial proportion of young adults in India despite expanding nutrition policy. Local determinants, particularly dietary patterns and the gap between awareness and behaviour, in tertiary-care young-adult populations of South India are not well quantified.

**Objectives:** To determine the prevalence of anaemia and the distribution of haemoglobin levels among young adults aged 18–25 years, evaluate associations between dietary habits and haemoglobin status, identify dietary patterns contributing to low haemoglobin, and assess the level of awareness regarding nutrition and anaemia.

**Methods:** Single-centre, cross-sectional observational survey conducted between January 2024 and December 2024 at a tertiary care institution in South India, enrolling 194 young adults aged 18–25 years. Data was collected through a self-administered Google Form. Analyses used IBM SPSS Statistics v26, chi-square or Fisher's exact tests for bivariate associations, and binary logistic regression for adjusted analysis. $\alpha$ was set at 0.05, two-tailed.

**Results:** Among the 194 participants, the prevalence of anaemia was 45.9% (89/194; 95% CI 39.0–52.9%), with a mean haemoglobin of 11.94 ± 1.78 g/dL. Anaemia was more prevalent in females (54.0%) and was predominantly mild (48.3%) or moderate (50.6%); severe anaemia (1.1%). In multivariable logistic regression, three variables independently predicted anaemia: female sex (aOR 4.47, 95% CI 2.03–9.84; $p<0.001$), low green leafy vegetable intake (aOR 2.29, 95% CI 1.02–5.15; $p=0.046$), and no prior health education on anaemia (aOR 2.62, 95% CI 1.06–6.43; $p=0.036$).

**Conclusion:** Anaemia was common among young adults in this study. Female sex, low green-leafy-vegetable intake, and lack of prior structured health education on anaemia were independently associated with anaemic status, despite uniformly high self-reported awareness.

**Keywords**: Anemia, Young Adults, Dietary Habits, Determinants.

## INTRODUCTION

Anaemia continues to be a major nutritional and public health concern across the world, affecting nearly 1.92 billion individuals. Women in their reproductive years are particularly vulnerable and account for a substantial proportion of the global disease burden [1]. Current estimates indicate that approximately 25–31% of women aged 15–49 years are anaemic worldwide, with the prevalence increasing to 55–70% in many developing and low-and middle-income countries [1,2]. India faces a particularly serious challenge, as evidenced by the National Family Health Survey-5 (2019–21), which reported anaemia among 57.0% of women and 25.0% of men aged 15–49 years [3].

www.ajmrhs.com
eISSN: 2583-7761

Date of Received: 02-05-2026
Date Acceptance: 10-05-2026
Date of Publication: 12-06-2026

The period between 18 and 25 years of age represents a crucial stage in the life course. During these years, individuals encounter increasing academic, professional, and social responsibilities while simultaneously requiring adequate nutrition to support optimal physical and cognitive functioning. For young women, this period also coincides with reproductive maturity, making nutritional adequacy especially important [4,5]. Deficiencies occurring during this stage may adversely affect health, productivity, learning capacity, and future reproductive outcomes.

Among the various causes of anaemia, iron deficiency remains the most prevalent and preventable factor in young adults [4]. Dietary intake plays a decisive role in maintaining iron stores and haemoglobin levels. Traditional Indian diets are largely cereal-based and frequently vegetarian or lacto-vegetarian, resulting in reduced consumption of haem iron, which is more readily absorbed than non-haem iron [6,7]. Inadequate intake of iron-rich foods such as pulses, green leafy vegetables, and fruits further increases the risk of developing iron deficiency and subsequent anaemia [8,9].

In addition to inadequate dietary intake, several common eating practices can negatively influence iron absorption. Consumption of tea or coffee along with meals is widespread in South India. These beverages contain tannins and polyphenolic compounds that significantly reduce the absorption of non-haem iron and may contribute to poor iron status when consumed regularly with food [10,11]. Similarly, irregular eating habits, particularly skipping breakfast, are commonly observed among college students and young adults, potentially leading to insufficient micronutrient intake and compromised nutritional status [12].

Over the past decade, numerous studies conducted among Indian adolescents and college students have explored awareness regarding anaemia and nutrition. Findings suggest that many young adults possess basic knowledge about the causes, symptoms, and prevention of anaemia and are able to identify foods that are rich in iron [13,14]. Nevertheless, knowledge alone does not appear sufficient to ensure healthy dietary behaviour. Several investigations have documented a considerable discrepancy between awareness and actual dietary practices, with anaemia prevalence ranging from 28% to 60% despite relatively high levels of nutritional knowledge [9,13,16]. Female gender, vegetarian dietary patterns, low consumption of green leafy vegetables, and inadequate exposure to nutrition education have consistently emerged as important determinants of anaemia in these populations [5,9,17].

Although evidence regarding anaemia among adolescents and medical students is available, information pertaining to young adults attending tertiary care institutions in South India remains limited. Most existing studies have focused either on undergraduate student populations [13,16] or rural community settings [8,9], leaving a gap in understanding the nutritional profile of the broader young adult population encountered in educational and healthcare institutions. Local evidence is essential for identifying context-specific risk factors, planning targeted nutritional interventions, strengthening health education initiatives, and establishing baseline data for future preventive programmes [18].

Considering these gaps in the literature, the present study was undertaken among young adults aged 18–25 years attending a tertiary care institution in South India. The study aimed primarily to estimate the prevalence of anaemia and describe the distribution of haemoglobin levels within the study population. Secondary objectives included examining the relationship between dietary habits and haemoglobin status, identifying dietary practices associated with reduced haemoglobin levels, and assessing awareness regarding anaemia and nutrition among young adults. As the study employed a descriptive cross-sectional design, analyses were conducted in accordance with the predefined objectives without testing a specific hypothesis.

## METHODS

**Study Design**

This was a single-centre, cross-sectional observational study

**Setting**

The study was conducted at a tertiary care institution in South India. Data collection took place over 12 months from January 2024 to December 2024.

**Participants and Sample Size:**

The study enrolled 194 young adults aged 18 to 25 years. Participants were recruited by convenience sampling. A study invitation containing a link to a self-administered Google Form was circulated through institutional email lists and class group communication channels. Participation was voluntary.

**Inclusion Criteria.**

1. Age 18 to 25 years (completed years) at the time of survey completion.
2. Written informed consent provided through the consent item embedded in the Google Form prior to the questionnaire.

**Exclusion Criteria.**

1. Pregnancy, declared self-reported chronic illness requiring active hospital treatment, or any condition that the participant felt precluded participation.

**Data Collection Tool:**

Data were collected using a structured, self-administered questionnaire deployed on Google Forms. The instrument contained 36 items grouped into demographics (age, gender, residence, occupation), dietary habits (type of diet, frequency of green leafy vegetables, fruits, iron-rich foods, tea or coffee consumption after meals, junk food frequency, meal-skipping), hygiene practices (handwashing before meals, handwashing after toilet use, tooth-brushing, nail trimming), clinical history (presenting symptoms, prior diagnosis of anaemia, iron supplementation, treatment status, chronic illness, worm infestation and deworming), menstrual history (administered to female respondents only: cycle regularity, duration of bleeding, heavy menstrual bleeding), lifestyle (physical activity, sleep duration, smoking, alcohol use), and three awareness items (self-perceived awareness of anaemia, knowledge of iron-rich foods, and prior receipt of health education on anaemia).

**Haemoglobin Estimation:** Haemoglobin levels were assessed through venous blood sample collection conducted under aseptic conditions by trained healthcare personnel. Approximately 2 mL of venous blood was collected from each participant and analysed for haemoglobin concentration using standard laboratory procedures in the institution's central laboratory. Haemoglobin values were recorded in grams per decilitre (g/dL) and used to determine the anaemia status of the participants according to the relevant World Health Organization (WHO) criteria.

**Variables and operational definitions**

**Primary Outcome** Anaemia (binary) was defined per WHO criteria using sex-specific haemoglobin thresholds: haemoglobin <13.0 g/dL in males and <12.0 g/dL in non-pregnant females [19]. All female respondents were treated as non-pregnant for cutoff application.

**Severity grading** (among anaemic participants):

- Mild anaemia: haemoglobin from 11.0 g/dL up to (but below) the sex-specific cutoff.
- Moderate anaemia: haemoglobin 8.0 to 10.9 g/dL.
- Severe anaemia: haemoglobin <8.0 g/dL.

**Statistical Methods**

Data exported from Google Forms were cleaned in Microsoft Excel and imported into IBM SPSS Statistics version 26 (IBM Corp., Armonk, NY, USA) for analysis. Continuous variables were summarised as mean ± standard deviation when approximately normally distributed (assessed using the Shapiro-Wilk test and inspection of histograms) or as median with interquartile range otherwise. Categorical variables were summarised as counts and percentages.

Prevalence of anaemia, overall and stratified by sex and severity, was reported with 95% confidence intervals computed using the Wilson score method [2,17].

Bivariate associations between categorical exposures and the binary anaemia outcome were tested using the Pearson chi-square test, with Fisher's exact test substituted where any expected cell count was less than 5. For comparisons of continuous variables across the anaemic and non-anaemic groups, the independent-samples *t*-test was used when the normality assumption was met, and the Mann-Whitney U test otherwise.

Adjusted associations were estimated using binary logistic regression, with anaemia (yes/no) as the dependent variable. All a priori specified predictors — female sex, urban residence, low green leafy vegetable intake, low fruit intake, non-consumption of iron-rich foods, tea or coffee after meals, meal-skipping, high junk-food frequency, lack of awareness of anaemia, lack of knowledge of iron-rich foods, and absence of prior health education on anaemia — were entered together in a single model (forced entry; no stepwise selection). Adjusted odds ratios (aOR) with 95% confidence intervals and Wald *p*-values are reported.

All analyses were performed on complete records for the 194 enrolled participants. All statistical tests were two-tailed, with α set at 0.05.

**Ethics**

Institutional Ethics Committee approval was obtained (IECHS/IRC/No 752). Written informed consent was obtained from all participants before enrolment. Participation was voluntary, responses were anonymised at the point of analysis, and no personally identifying information was retained in the analytic dataset.

## RESULTS

**Baseline Characteristics**

The study enrolled 194 young adults aged 18 to 25 years between January 2024 and December 2024. Baseline demographic characteristics are summarised in Table 1. The mean age was 20.4 ± 2.0 years (median 20.0 years), and female-predominant (139; 71.6%). Most participants resided in urban areas (125; 64.4%).

Table 1. Baseline Demographic Characteristics of the Analytic Sample (N=194)

| Characteristic | Value |
|---|---|
| Age (Years), Mean ± SD | 20.4 ± 2.0 |
| Age (Years), Median | 20.0 |
| Gender, N (%) | |
| Female | 139 (71.6) |
| Male | 55 (28.4) |
| Residence, N (%) | |
| Urban | 125 (64.4) |
| Rural | 69 (35.6) |

SD = standard deviation.

**Primary Outcome — Prevalence of Anaemia**

The prevalence of anaemia by WHO criteria was 45.9% (89/194; 95% CI 39.0–52.9%). Mean haemoglobin was 11.94 ± 1.78 g/dL (range 7.0–16.0; median 12.0 g/dL). Anaemia prevalence differed markedly by sex. Among 139 female participants, 75 were anaemic (54.0%, 95% CI 45.7–62.0%), compared with 14 of 55 male participants (25.5%, 95% CI 15.8–38.3%). Among the 89 anaemic participants, anaemia was mild in 43 (48.3%), moderate in 45 (50.6%), and severe in 1 (1.1%); 98.9% of anaemic cases were therefore mild or moderate. (Table 2).

Table 2: Prevalence and Severity of Anaemia among Study Participants (N = 194)

| Variable | Category | N | % |
|---|---|---|---|
| Overall Anaemia Prevalence | Anaemic | 89 | 45.9 |
| | Non-Anaemic | 105 | 54.1 |
| Haemoglobin Levels (G/Dl) | Mean ± SD | 11.94 ± 1.78 | — |
| | Median | 12.0 | — |
| | Range | 7.0–16.0 | — |
| Anaemia By Sex | Female (N = 139) | 75 | 54.0 |
| | Male (N = 55) | 14 | 25.5 |
| Severity Of Anaemia Among Anaemic Participants (N = 89) | Mild | 43 | 48.3 |
| | Moderate | 45 | 50.6 |
| | Severe | 1 | 1.1 |

**Bivariate Associations between Dietary or Awareness Variables and Anaemia**

Bivariate associations between dietary and awareness predictors and anaemia status are presented in Table 3. Two dietary and awareness-related exposures reached statistical significance: low green leafy vegetable (GLV) intake was associated with higher odds of anaemia (OR 2.13, 95% CI 1.02–4.48; p=0.045), as was the absence of prior health education on anaemia (OR 2.13, 95% CI 1.02–4.48; p=0.045). Female sex showed the strongest unadjusted association (OR 3.43, 95% CI 1.72–6.86; p<0.001). The remaining dietary, lifestyle, and awareness variables, including urban residence, low fruit intake, non-consumption of iron-rich foods, tea or coffee after meals, meal skipping, high junk-food frequency, lack of anaemia awareness, and not knowing iron-rich foods, were not significantly associated with anaemia.

Table 3. Bivariate (Unadjusted) Associations between Demographic, Dietary, and Awareness Variables and Anaemia (N=194)

| Predictor | OR | 95% CI | P-Value |
|---|---|---|---|
| Female Sex | 3.43 | 1.72–6.86 | **<0.001** |
| Urban Residence | 1.16 | 0.64–2.10 | 0.619 |
| Low Green Leafy Vegetable Intake | 2.13 | 1.02–4.48 | **0.045** |
| Low Fruit Intake | 1.60 | 0.74–3.48 | 0.231 |
| Non-Consumption Of Iron-Rich Foods | 1.02 | 0.57–1.85 | 0.937 |
| Tea/Coffee After Meals | 1.17 | 0.66–2.06 | 0.597 |
| Meal Skipping | 0.88 | 0.50–1.54 | 0.648 |
| High Junk-Food Frequency | 0.92 | 0.49–1.71 | 0.788 |
| No Awareness Of Anaemia | 1.20 | 0.40–3.55 | 0.748 |
| Does Not Know Iron-Rich Foods | 1.71 | 0.52–5.58 | 0.376 |
| No Prior Health Education On Anaemia | 2.13 | 1.02–4.48 | **0.045** |

Uor = Unadjusted Odds Ratio; Ci = Confidence Interval. Estimates Obtained by Univariate Binary Logistic Regression with Anaemia as the Outcome.

**Multivariable logistic regression**

In the binary logistic regression model with all candidate predictors entered together (n=194), three variables retained independent associations with anaemia (Table 4): female sex (aOR 4.47, 95% CI 2.03–9.84; p<0.001), low green leafy vegetable intake (aOR 2.29, 95% CI 1.02–5.15; p=0.046), and no prior health education on anaemia (aOR 2.62, 95% CI 1.06–6.43; p=0.036). A borderline non-significant signal was observed for not knowing iron-rich foods (aOR 4.30, 95% CI 0.84–22.02; p=0.080). Urban residence, low fruit intake, non-consumption of iron-rich foods, tea or coffee after meals, meal skipping, high junk-food frequency, and lack of general anaemia awareness were not independently associated with anaemia after adjustment.

Table 4. Multivariable Logistic Regression: Independent Predictors of Anaemia (N=194)

| Predictor | Aor | 95% CI | P-Value |
|---|---|---|---|
| Female Sex | 4.47 | 2.03–9.84 | <0.001 |
| Urban Residence | 1.11 | 0.57–2.16 | 0.757 |
| Low Green Leafy Vegetable Intake | 2.29 | 1.02–5.15 | 0.046 |
| Low Fruit Intake | 1.74 | 0.75–4.06 | 0.197 |
| Non-Consumption Of Iron-Rich Foods | 1.10 | 0.57–2.11 | 0.771 |
| Tea/Coffee After Meals | 1.17 | 0.62–2.20 | 0.628 |
| Meal Skipping | 0.90 | 0.48–1.69 | 0.736 |
| High Junk-Food Frequency | 0.75 | 0.38–1.48 | 0.408 |
| No Awareness Of Anaemia | 0.53 | 0.10–2.77 | 0.455 |
| Does Not Know Iron-Rich Foods | 4.30 | 0.84–22.02 | 0.080 |
| No Prior Health Education On Anaemia | 2.62 | 1.06–6.43 | 0.036 |

Aor = Adjusted Odds Ratio; CI = Confidence Interval. All Listed Predictors Entered Into A Single Binary Logistic Regression Model Simultaneously (Forced Entry; No Stepwise Selection), With Anaemia As The Outcome.

## DISCUSSION

The present study identified anaemia as a significant public health concern among young adults attending a tertiary care institution in South India. Female sex, infrequent consumption of green leafy vegetables, and lack of prior structured health education emerged as independent predictors of anaemia. These findings are consistent with the continuing burden of anaemia reported across India despite ongoing nutrition and anaemia-control initiatives [3,17].

The overall prevalence of anaemia in the present study (45.9%) is comparable with findings reported from several Indian populations. Although the global prevalence of anaemia among non-pregnant women is estimated to be approximately 30% [1], considerably higher rates have been documented in India. NFHS-5 reported anaemia among 57.0% of women and 25.0% of men aged 15–49 years [3]. Similar prevalence estimates have been reported from South Indian studies. Selvaraj et al. observed anaemia in 57.2% of women and 39.3% of men, with a substantial proportion failing to meet recommended dietary iron intake [8]. Likewise, Sukumar et al. documented prevalence rates approaching 50% among rural adolescent girls [9]. Furthermore, analyses comparing NFHS-4 and NFHS-5 data have demonstrated limited progress in reducing anaemia prevalence among women of reproductive age, with several districts showing worsening trends over time [17].

However, lower prevalence rates have been reported among medical students and other highly selected educational populations. Salman et al. reported anaemia in 31% of female medical students in Karachi [16], while Shaka and Kufoof documented a prevalence of 28.6% among female medical students in Maharashtra [13]. These differences may reflect variations in socioeconomic status, dietary diversity, health awareness, and healthcare access. The persistence of anaemia in this setting may be linked to dietary patterns characterised by limited intake of haem iron and the widespread consumption of absorption inhibitors such as phytates and tannins [5,10]. The findings support the need for routine screening and early identification of anaemia among young adults attending tertiary healthcare facilities [17].

A pronounced sex disparity was evident in the study, with anaemia affecting more than half of female participants compared with one-quarter of male participants. After adjustment for potential confounders, female sex remained the strongest predictor of anaemia. This observation is consistent with national data and previous regional studies demonstrating a substantially higher burden among women [3,8,17]. Biological factors, particularly menstrual blood loss and increased iron requirements during the reproductive years, provide a plausible explanation for this difference [4,10]. In addition, social and dietary factors may contribute to the persistence of female disadvantage. Previous research has suggested that women often have lower consumption of nutrient-dense foods and may experience gender-related differences in dietary allocation within households [5,6]. Together, these findings reinforce the importance of prioritising anaemia screening and nutritional interventions among young women before pregnancy.

Dietary practices also played a significant role. Participants reporting infrequent consumption of green leafy vegetables had more than twice the odds of anaemia compared with regular consumers. Similar findings have been reported among adolescents and young adults in India, where inadequate intake of green leafy vegetables consistently emerges as a predictor of low haemoglobin levels [8,9]. Green leafy vegetables constitute an important source of non-haem iron, folate, and other micronutrients required for erythropoiesis, particularly in predominantly vegetarian populations [6,7]. The present findings therefore support existing recommendations that encourage regular inclusion of these foods as part of routine dietary counselling. Importantly, in relatively urban and educationally advantaged populations such as the present cohort, low vegetable intake may serve as a direct indicator of poor dietary quality rather than reflecting broader food insecurity.

Several dietary exposures traditionally linked to iron deficiency, including tea or coffee consumption after meals, meal skipping, and frequent junk-food intake, were not significantly associated with anaemia in the present study. Similar null findings have been reported in some cross-sectional studies where self-reported dietary assessment and limited exposure variability reduce the ability to detect significant associations [12]. Nevertheless, the absence of statistical significance should not be interpreted as evidence of no biological effect. Experimental studies have consistently demonstrated that tea and coffee inhibit non-haem iron absorption through their polyphenol and tannin content [10]. Furthermore, Sadiq et al. reported significantly lower haemoglobin levels and higher anaemia prevalence among habitual tea drinkers [11]. The discrepancy between these findings and the present results may reflect limitations in exposure measurement, including the use of broad categorical variables that do not capture beverage quantity, frequency, or timing relative to meals. Consequently, counselling regarding the timing of tea and coffee consumption should continue to form part of routine nutritional advice [10,11].

Overall, the findings reinforce three important themes in the existing literature. Anaemia remains highly prevalent among young adults despite ongoing national control efforts [3,17]. Women continue to experience a substantially greater burden than men, reflecting both biological vulnerability and social determinants [1,4]. While awareness of anaemia appears widespread, meaningful reductions in prevalence are more likely to be achieved through interventions that target behaviour rather than knowledge alone [14,15,18].

The limitation of the study as it was conducted in a single tertiary care institution using convenience sampling, which may limit generalisability. Dietary information was self-reported and not assessed using a validated food-frequency questionnaire, creating the possibility of recall bias and exposure misclassification. Furthermore, no biochemical markers of iron status, such as serum ferritin or transferrin saturation, were measured; therefore, the specific aetiology of anaemia could not be confirmed.

## CONCLUSION

Anaemia was common among young adults aged 18–25 years in this South Indian tertiary care cohort, affecting nearly half (45.9%) of participants and showing a marked female predominance. Female sex, low green-leafy-vegetable intake, and lack of prior structured health education on anaemia were independently associated with anaemic status, despite uniformly high self-reported awareness. These findings support routine screening of young adults, specific dietary counselling on green-leafy-vegetable intake, and a shift in health-education programmes from awareness-raising toward structured behaviour-change interventions.

## REFERENCES

1. World Health Organization. WHO global anaemia estimates, 2025 edition. Geneva: World Health Organization; 2025. Available from: https://iris.who.int/server/api/core/bitstreams/ffbc07c6-420c-4711-8589-2a7b6f3a3da2/content
2. Stevens GA, Paciorek CJ, Flores-Urrutia MC, Borghi E, Namaste S, Wirth JP, et al. National, regional, and global estimates of anaemia by severity in women and children for 2000–19: a pooled analysis of population-representative data. Lancet Glob Health. 2022;10(5):e627–e639. DOI: 10.1016/S2214-109X(22)00084-5. PMID: 35427520.
3. International Institute for Population Sciences (IIPS) and ICF. National Family Health Survey (NFHS-5), 2019–21: India. Mumbai: IIPS; 2021. Available from: http://rchiips.org/nfhs/factsheet_NFHS-5.shtml
4. Pasricha SR, Tye-Din J, Muckenthaler MU, Swinkels DW. Iron deficiency. Lancet. 2021;397(10270):233–248. DOI: 10.1016/S0140-6736(20)32594-0. PMID: 33285139.
5. Shobha S, Sushma BV, Mahalakshmi SH. Anaemia in India and its prevalence and multifactorial aetiology: a narrative review. Cureus. 2024;16(5):e60737. DOI: 10.7759/cureus.60737. PMID: 38892606.
6. Green R, Mitra AK. Plant-based dietary practices and socioeconomic factors that influence anemia in India. Nutrients. 2021;13(10):3538. DOI: 10.3390/nu13103538.
7. Green R, Pingali P, Hawkesworth S, Khouw I, Whitton C, Davis PA, et al. Dietary patterns in India: a systematic review. Br J Nutr. 2016;116(1):142–148. DOI: 10.1017/S0007114516001598.
8. Selvaraj K, Arumugasamy P, Sarkar S. Burden and determinants of anemia in a rural population in South India: a cross-sectional

study. Anemia. 2018;2018:7123976. DOI: 10.1155/2018/7123976.

9. Sukumar S, Asha HS, Premkumar PS. The prevalence of anaemia in rural adolescent girls — a cross-sectional study to understand the sociodemographic and dietary determinants in Dharwad District, India. J Family Med Prim Care. 2024;13(7):2641–2647. DOI: 10.4103/jfmpc.jfmpc_46_24. PMID: 39228610.
10. Hurrell R, Egli I. Iron bioavailability and dietary reference values. Am J Clin Nutr. 2010;91(5):1461S–1467S. DOI: 10.3945/ajcn.2010.28674F. PMID: 20200263.
11. Sadiq N, Gul Y, Bilal MM, Afzal M, Mumtaz N, Wahid A. Association between tea drinking and anemia in women of reproductive age: a cross-sectional study from the Mekran division, Balochistan, Pakistan. Cureus. 2024;16(7):e64801. DOI: 10.7759/cureus.64801. PMID: 39156281.
12. Alhalafi AH, Algahtani BS, Abdulkhalik T, Eid HM, Tayeb MMS, Aljabri AA, et al. Haemoglobin status to determine nutritional anaemia and its association with breakfast skipping and BMI among nursing undergraduates of Farasan Island, KSA. J Nutr Sci. 2022;11:e36. DOI: 10.1017/jns.2022.31.
13. Shaka MF, Kufoof L. Prevalence and awareness of nutritional anemia among female medical students in Karad, Maharashtra, India: a cross-sectional study. J Family Med Prim Care. 2019;8(8):2585–2589. DOI: 10.4103/jfmpc.jfmpc_476_19.
14. Roy A, Evers SE, Avison WR, Campbell MK. Indian adolescents' perceptions of anaemia and its preventive measures: a qualitative study. PLoS One. 2024;19(2):e0298032. DOI: 10.1371/journal.pone.0298032.
15. Roy A, Avison WR, Evers SE, Campbell MK. Attention for and awareness of anemia in adolescents in Karnataka, India: a qualitative study. PLoS One. 2023;18(4):e0283631. DOI: 10.1371/journal.pone.0283631.
16. Salman A, Qureshi SA, Azmi MB. Changing trends of anaemia prevalence among female medical students in a metropolitan setting: assessment through self-grading and haematological parameters. Pak J Med Sci. 2020;36(7):1533–1538. DOI: 10.12669/pjms.36.7.2793. PMID: 33235570.
17. Sharma H, Singh SK, Srivastava S. Prevalence and determinants of anaemia among women of reproductive age in Aspirational Districts of India: an analysis of NFHS 4 and NFHS 5 data. BMC Public Health. 2024;24:435. DOI: 10.1186/s12889-024-17912-4. PMID: 38347505.
18. Salam SS, Ramadurg U, Charantimath U, Katageri G, Kavi A, Bellad MB, et al. Impact of a school-based nutrition educational intervention on knowledge related to iron deficiency anaemia in rural Karnataka, India: a mixed methods pre–post interventional study. BJOG. 2023;130(Suppl 3):113–122. DOI: 10.1111/1471-0528.17619.
19. World Health Organization. Guideline on haemoglobin cutoffs to define anaemia in individuals and populations. Geneva: World Health Organization; 2024. Available from: https://www.who.int/publications/i/item/9789240088542

**How to cite this article:** Vijayapriya I, Sushmitha S, Nandhini G, Sowbharanika A, Pavithra R, Mona N, PREVALENCE AND DIETARY DETERMINANTS OF ANAEMIA AMONG YOUNG ADULTS AGED 18–25 YEARS: A CROSS-SECTIONAL SURVEY AT A TERTIARY CARE INSTITUTION IN SOUTH INDIA, Asian J. Med. Res. Health Sci., 2026; 4 (2):849-855.

**Source of Support:** Nil, Conflicts of Interest: None declared.