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Prevalence and Factors Associated With Alcohol Use in Selected Urban Communities in Ibadan, Nigeria

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Abstract

Nigeria is ranked high among African countries in the consumption of alcohol and the national adult per capita consumption was estimated at 12.3litres. Harmful alcohol use is the sixth leading cause of disability and deaths in Nigeria. This study assessed the prevalence and factors associated with alcohol use in selected urban communities in Ibadan, Nigeria. This community-based cross sectional study was conducted among 500 respondents in two selected urban communities in Ibadan, Nigeria. The World Health Organization STEPS tool was used to collect data on socio-demographic characteristics of respondents and the history of alcohol use. Alcohol users were categorized into *ever consumed, current consumers, consumers within last 12 months, and frequent consumers within 30 days (low, medium, and high consumers*).Chi-square analysis was used to identify factors associated with the different categories of alcohol consumption. The mean age of the respondents was 35.36 ± 12.24 years. Almost one third of the participants (29.0%) reported they had ever consumed alcohol and (13.6%) had consumed alcohol within 30 days prior to the study. Factors significantly associated with the ever-use of alcohol were gender ($p = 0.000$), and income ($p = 0.000$). Current use of alcohol had a statistically significant relationship with male gender ($p = 0.000$). The prevalence of high alcohol use is low in the sample of urban communities studied, and factors influencing include sex, marital status, level of education, income. These results should inform policy decisions to address the alcohol use in urban communities in Southwest Nigeria.

Keywords

alcohol consumers, harmful alcohol use, non-communicable diseases

Alcohol as defined by the World Health Organization (WHO) is "*a psychoactive substance with dependence-producing properties that has been commonly used in many cultures for centuries*".[1] Approximately two billion people use alcohol worldwide with one-third of these users likely to experience alcohol-related disorder.[1,2] According to World Health Organisation,[3] Nigeria is ranked high among African countries in the consumption of alcohol and the alcohol per capita consumption was estimated at 25.5 litres.[3]Harmful consumption of alcohol is considered one of the major five risk factors resulting in diseases, disability and mortality globally,[4,5] and the sixth in Nigeria.[6] Associations between harmful consumption of alcohol and increased risk of cancer, cardiovascular disease, liver cirrhosis, depression, crime, homicide, suicide, HIV/AIDS, failure to accomplish role obligation and absenteeism from school or work has been reported.[7–13] In Nigeria, increase in drink driving accidents are considered major precursors of several deaths and injuries to Nigerians.[14] Currently, diseases that are associated with alcohol use are rising rapidly and this is mostly affecting the low income countries.[15]

In Nigeria, un-recorded alcohol use was projected to be 3.8 litres per capita consumption for adults for the year 2016.[3] The hard line marketing behaviour of principal players and large rate of alcohol drinking as a part of social activities has resulted in strong growth of alcoholic

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consumption in Nigeria[16] which when situated within the Nigeria's population of over 180 million and 3% annual rate projects an increase in the drinking population.[17,18]A national survey on substance use in Nigeria reported urban prevalence of lifetime, 12-month and 30-day alcohol use 41.0%, 32.2% and 25.7% respectively.[19]

Studies have indicated a rapid increase within the last few decades in accessibility, production, importation and use of alcohol across all age groups in Nigeria.[16,18,20,21] The evaluation of various local studies carried out in urban primary health care settings highlights high alcohol intake with antecedent factors that includes being a male gender, increasing age, low educational level and marital status.[22,23] Reports have shown that women consume less alcohol compared to men.[24,25] More alcohol related deaths were attributable to males compared to females, and men have extreme rates (7.2%) of total burden attributed to alcohol than women (1.4%).[16]

Studies carried out in developed countries suggests that low risk pattern of alcohol use could produce high benefits on the effect of some diseases and segments of the population..[26–29] Nevertheless, when alcohol is taken in excess, the benefits of consuming moderate alcohol will disappear, resulting in high risks of non-communicable diseases and a wide range of social problems.[13,30,31] This explains that moderate consumption of alcohol may not be harmful in itself but when misused, the harm outweighs the benefits. This study assessed prevalence and factors associated with alcohol use among adults of two selected urban poor communities in Nigeria.

Methods

This community-based cross sectional study was conducted among 500 participants in two selected urban poor communities in Ibadan, Nigeria. The study employed a quantitative method of data collection. Findings presented in this paper are nested within a larger community–based cross sectional study which assessed the knowledge, risk factors and preventive practices for non-communicable diseases among residents of two urban communities in Ibadan North Local Government Area of Oyo State, Nigeria.

Procedure

The participants were selected from the total community population by using simple random sampling technique. This was done by randomly selecting the households and from each of the households selected, one respondent was selected the ballot method.

Measures

Collection of data was done using the modified version of WHO STEPS through an electronic data capture tool (ODK collect).[1] Data collected include socio-demographic characteristics of respondents and the history of alcohol consumption. Alcohol consumers were classified into *ever consumed, current consumers within last 12 months, current consumers and frequent consumers within 30 days (low, medium, and high consumers*). In order to get information on the level of alcohol consumption, respondents were asked if they had ever used any alcoholic drink and those with affirmative response were further requested to provide information on current use within last 12 months. Including details of type, frequency and the average quantity consumed per sitting.

Reliability and Validity of the Instruments

A modified version of the WHO STEPS instrument was developed by adopting questions from relevant literature. The modified instrument was subjected to independent, academic peer and expert public health reviews and subsequently pretested among respondents sharing same characteristics with the study participants.

Data Analysis

The collected data was exported to Statistical Package for Social Science (SPSS) version 21.0 for analysis. The exported data was cleaned and analysed using descriptive and inferential statistics (Chi-square). The dependent variables were ever used and current users of alcohol while the independent variables were respondent's socio-demographic characteristics. Determination of relationship in the distribution of alcohol use by categories of participant characteristics was done using chi-square test statistic. The level of statistical significance was determined at $p < 0.05$.

Current users of alcohol were rated low, medium or high alcohol consumers. Respondents rated low were those who reported consuming an equivalent of less than four standard drinks of alcohol on average per occasion (men) and less than two standard drinks of alcohol on average per occasion (women). Respondents rated medium alcohol consumers were those who reported consuming an equivalent of four to six standard drinks of alcohol on average per occasion (men) and two to four standard drinks of alcohol on average per occasion (women). Respondents rated high were those who reported consuming an equivalent of more than six standard drinks of alcohol on average per occasion (men) or an equivalent of more than four standard drinks of alcohol on average per occasion (women). Interviewers quantified the amount consumed in terms of the numbers of standard drinks. World Health Organization defines one standard alcoholic drink as any alcohol drink that contains 10 g of pure alcohol.

Results

Respondents' Demographic Characteristics

Data on alcohol consumption was obtained from 500 respondents. Majority of the population (70.6%) were female, and almost one third (29.4%) were male. The mean age of the participants was 35.36 ± 12.24 years. About half (52.6%) of the participants had completed their secondary school education while almost a quarter (22.0%) completed their tertiary education.

More than half (54.2%) of the participants were considered as younger adults, majority (88.8%) were Yoruba ethnic group and almost equal proportion of Christians and Muslims was reported (51.0% and 49.0% respectively). Majority (64.0%) of the respondents were currently married and almost one third (28.4%) have never been married.

More than half of the respondents (54.8%) reported 2–4 members as their household size, about two-third of participants (65.8%) had lived in the community for about 10 years. Majority of the respondents (72.6%) were self-employed and about half (49.8%) earn the median income naira 20,000 ($48.6) per month (see Table 1).

Table 1. General Demographic Characteristics of Study Sample ($N = 500$).

Variables	Frequency	Percentage
Gender		
Male	147	29.4
Female	353	70.6
Age group		
Youth (18–25 years)	119	23.8
Younger adults (26–45 years)	271	54.2
Older adults (46–65 years)	110	22.0
Education		
No formal schooling	49	9.8
Primary education	78	15.6
Secondary education	263	52.6
College/university education	110	22.0
Ethnic group		
Yoruba	444	88.8
Igbo	26	5.2
Hausa	4	0.8
Others[a]	26	5.2
Marital status		
Never married	142	28.4
Currently married	320	64.0
Not married	38	7.6
Religion		
Christianity	255	51.0
Islam	245	49.0
Years of residence		
10 years or less	329	65.8
11 years to 20 years	75	15.0
21 years to 30 years	60	12.0
More than 30 years	36	7.2
Employment status		
Employed	64	12.8
Self-employed	363	72.6
Unemployed	73	14.6
Monthly income		
No income	34	6.8
20,000 naira ($48.6) or less	217	43.4
More than 20,000 naira ($48.6)	249	49.8
Household size		
1 member	41	8.2
2 to 4 members	274	54.8
5 or more members	185	37.0

[a]Others—Akwa Ibom, Benue, Cross River, Delta, Edo, Ibibio, Kogi, Tapa & Non-Nigerian.

Alcohol Consumption

About one third (29.0%)had consumed alcohol either in the past or present, 17.8% reported alcohol consumption within the last one year preceding the survey, 15.8% were current consumer of alcohol and 13.6% were frequent consumers who had taken alcohol within 30 days preceding the study (see Figure 1).

Among the ever consumed alcohol category, beer (68.3%) is the most consumed type of alcohol closely followed by palm wine (62.1%) while spirits and "ogogoro" (local brewed) were the least consumed alcoholic beverage, 25.5% and 17.9% respectively. Majority (63.3%) of current consumers reported to have taken beer and about average (51.9%)% had used palm wine, while 12.6% reported "ogogoro" which is the least type of alcoholic beverage consumed (see Figure 2).

Frequent Alcohol Consumers

About 13.6% of the respondents reported taking alcohol within the last 30 days prior to the study which comprising of 11.6% low consumers, 1.2% medium consumers and 0.8% high consumers (see Figure 3).

Factors Associated With Alcohol Use

Factors found to be associated significantly with ever-consumed alcohol category were gender ($p = 0.000$), and income ($p = 0.000$). More male (53.1%) reported to have ever consumed alcohol compared to female (46.9%) (see Table 2). However, employment status ($p = 0.474$), marital status ($p = 0.522$), religion ($p = 0.319$), years of residence ($p = 0.400$), household size (0.861), level of education ($p = 0.353$) and age ($p = 0.472$) were not statistically associated with alcohol consumption.

Factor that had significant association with non-current alcohol consumers' category was gender. Majority (62.3%) of the non-current alcohol users was female and 37.7% were male. More than half (59.3%) of respondents not currently consuming alcohol were currently married while 30.3% were not.

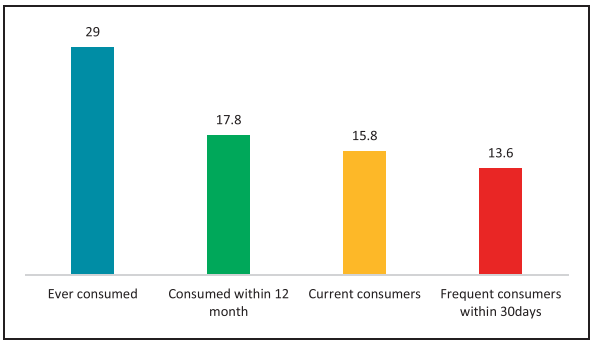

Figure 1. Alcohol Consumption Category.

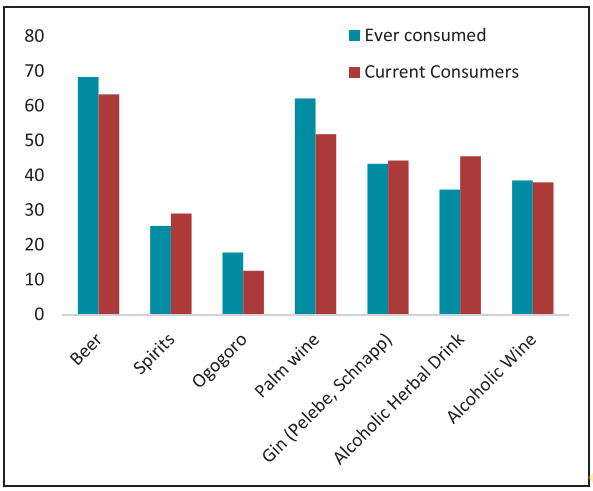

Figure 2. Types of Alcoholic Beverage Consumed.

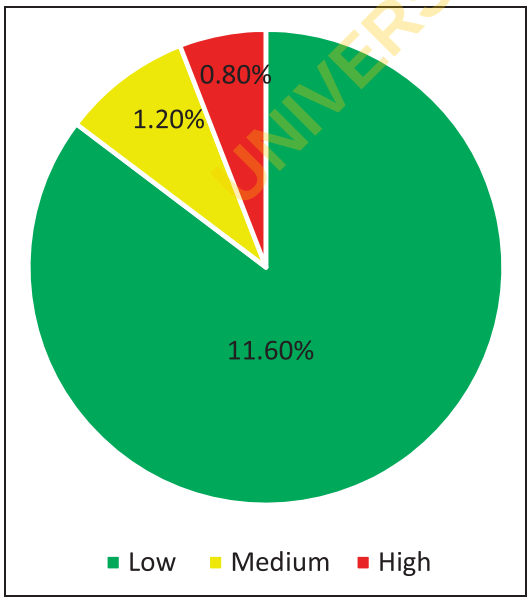

Figure 3. Distribution of Frequent Consumers.

Frequent consumers of alcohol category had a statistically significant relationship with gender ($p = 0.000$), all 100.0% of the high consumers were currently married while same proportion was reported among currently married (50.0%) and never married (50.0%) in the medium consumers' category. Two-third (63.8%) of low alcohol consumers were currently married while one-third (8.6%) have never been married.

Majority (74.1%) of the low consumers were male, medium consumers were females (66.7%) while high alcohol consumers were male (75.0%). The respondents' level of education ($p = 0.723$), employment status ($p = 0.825$), religion ($p = 0.324$), years of residence ($p = 0.766$), household size (0.326), income ($p = 0.516$), marital status (0.534) and age ($p = 0.519$) were not statistically significant.

Discussion

Socio-Demographics

This is the report of a survey in two urban communities to determine prevalence and factors influencing the use of alcohol. Respondents' age cuts across youths to adults. This is similar to report from another study in Uganda that reported that 82.7% of participants were aged 18–49 years.[32]

Prevalence of Alcohol Consumption

Study prevalence of ever consumed participants was 29.0%; this was similar to the report of prevalence 20.3% by Kabwama et al.[32] in Uganda, while frequent alcohol use prevalence of 13.6% in this study was in contrast to 26.8% reported in Kabwana study but in consonance with the current users' prevalence of alcohol of 14% reported by Gureje et al.[10] Studies in urban communities in Africa also reported similar levels of current alcohol use of 22.8% in Uganda,[33] Zambia 23.7%[34] and Nigeria 25.7%.[19] The study showed a difference in the proportions of alcohol use between male and female; this was in consonance with Chukwuonye et al.,[25] who also reported significant differences in the proportions between the genders.

Pattern of Alcohol Consumption

The main alcoholic beverages consumed were beer and palm wine. This finding was consistent with the report from a previous study in Abia State, Nigeria[25] that reported the most common consumed alcohol was beer, followed by gin, and then palm wine. Another cross cultural study by Bennett et al.[35] collaborates report of beer being the first choice of beverage. Majority of frequent consumers were low consumers and this is in consonance with study conducted in Uganda[32] where most current drinking population were low level drinkers.

Table 2. Distribution of Alcohol Consumption According to Selected Socio Demographics.

Variables	Ever consumed %	Non-current consumers %	Frequent consumers		
			Low %	Medium %	High %
Gender					
Male	53.1*	37.7*	74.1*	33.3*	75.0*
Female	46.9*	62.3*	25.9*	66.7*	25.0*
Age group					
Youth	26.9	23.4	31.0	16.7	50.0
Adult	53.8	55.8	48.3	83.3	50.0
Middle	19.3	20.8	20.7	0.0	0.0
Education					
No formal schooling	7.6	7.8	8.6	0.0	0.0
Primary education	14.5	11.7	20.7	0.0	0.0
Secondary education	58.6	62.3	50.0	83.3	75.0
College/university education	19.3	18.2	20.7	16.7	25.0
Marital status					
Never married	29.7	31.2	27.6	50.0	0.0
Currently married	64.8	64.9	63.8	50.0	100.0
Not married	5.5	3.9	8.6	0.0	0.0
Employment status					
Employed	11.0	11.7	12.1	0.0	0.0
Self-employed	71.7	74.0	69.0	66.7	75.0
Unemployed	17.2	14.3	19.0	33.3	25.0
Income					
No income	4.8*	6.5	1.7	16.7	0.0
20,000 ($48.6) or less	31.7*	32.5	29.3	33.3	50.0
More than 20,000 ($48.6)	63.4*	61.0	69.0	50.0	50.0
Religion					
Christianity	54.5	53.2	55.2	83.3	25.0
Islam	45.5	46.8	44.8	16.7	75.0
Years of residence					
10 years or less	66.9	66.2	63.8	83.3	100.0
11 to 20 years	17.9	18.2	19.0	16.7	0.0
21 to 30 years	9.7	7.8	13.8	0.0	0.0
More than 30 years	5.5	7.8	3.4	0.0	0.0
Household size					
1 member	8.3	7.8	10.3	0.0	0.0
2 to 4 members	56.6	50.6	62.1	50.0	100.0
5 and more members	35.2	41.6	27.6	50.0	0.0

*$p \leq 0.05$.

Factors Influencing Alcohol Consumption

Frequent Consumer category was associated significantly with male gender which is in consonance with finding from previous studies conducted in Nigeria.[10,18] Association of frequent alcohol consumers with male gender could be as a result of the notion that use of alcohol among men is linked with masculinity.[36] This study found a significant association between participants that had ever consumed alcohol and gender and Income this is in line with report from a previous study by Lasebikan and Ola.[18] However, contrary to the study the findings from our study reported no association between ever consumed alcohol, marital status and education of the participants but there was significant association between non-current consumer and gender.

Conclusions and Recommendations

Findings highlight low prevalence of alcohol use among respondents in these two urban communities. Antecedent factors include gender, marital status, level of education and income, which should inform policy decisions to address alcohol use in urban settings in Nigeria. Prevalence and pattern of alcohol consumption across geopolitical regions, socio-cultural and urban-rural settings in Nigeria should be explored, to assess any disparity. Also, generalization of the prevalence of alcohol consumption from this study to the entire urban population is not advised, because there are diverse socio cultural characteristics of the Nigerian population. Hence, further research involving other cultural population is required. Public health researchers and practitioners

who work at community levels should advocate for support from policy makers to implement educational activities geared towards prevention of harmful alcohol consumption. These educational activities should adopt evidence-based alcohol prevention research and practice. Also education should be targeted at community settings where men congregate.

Study Limitation and Strength

A major strength of the study was the modified use of the homogenous WHO STEPS tool in the assessment of alcohol consumption. Therefore, findings from this study could be related with those from other countries with similar or comparable methodology. The results of this survey should however be inferred in light of certain limitations. This study was based on a cross-sectional study design and this excludes extrapolation to underlying relationship of antecedent factors examined and alcohol use.

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Yetunde O. John-Akinola, MPH, PhD, is an academic and researcher with research interests in public health including prevention of non-communicable diseases, and especially in translating evidence-based research into practice and policy. Her interests also includes school health promotion, young people's health and wellbeing, child and women's health research. Yetunde has been extensively involved in research and her work has been published in scholarly and peer-reviewed journals. She has presented at both National and International conferences.

Mojisola Oluwasanu, MPH, PhD, is a researcher and academic with interest in implementation science and non-communicable diseases (NCDs) prevention especially the behavioral and policy interventions which influence the modifiable risk factors and its implication on the growing burden of NCDs in developing countries. In addition, she is interested in testing the feasibility, acceptability and effectiveness of HIV prevention approaches and models for the prevention of NCDs.

Oladimeji Oladepo, PhD, MPH, FRSPH (UK), is a professor of Public Health and a globally recognized leader in the field of Public Health. Professor Oladepo is highly experienced and have core competencies in implementation research and evidence-base interventions (programmes and policies) with formative, process and summative evaluation components embracing mix -methods with outcome translation of evidence to policy within four domains: Communicable Diseases, Non- Communicable Diseases, M-Health and Diagnostic and Treatment tools of major poverty-related diseases of poverty, Reproductive Health and Global Health and Health Systems Strengthening.