**ACCESSIBILITY OF HEALTH INFORMATION ON ALCOHOL AND DRUG ABUSE AMONG THE YOUTH ( A CASE STUDY OF MALE UNDERGRADUATE STUDENTS IN FEDERAL UNIVERSITY LOKOJA)**

**ABSTRACT**

Excessive alcohol consumption has been on the rise globally and Nigeria is no exception, thus making the rise thereof and its adverse effects a public health concern. Various studies indicated that excessive alcohol consumption leads to a great deal of health and social consequences. The main purpose of the study was to determine the information health accessibility, attitudes and practices of youths on alcohol and drug abuse and its effects on their health. The study applied a quantitative approach, using a survey research design, descriptive and exploratory design to obtain data from 383 participants aged 18 – 30 years. A cluster random sampling method was employed, data was compiled and analysed using SPSS version 25. This study found that most of the respondents had a good health information accessibility with more than 67.6% describing the awareness and dangers of alcohol and drug abuse (e.g. stomach ulcers, liver damage and increased risk of motor vehicle accidents). Furthermore, 58.7% of respondents agreed that alcohol is a drug, and 87.7% agreed that 10% of road accidents are alcohol-related. Respondents showed inadequate knowledge regarding the term “standard drink” and the recommended number of standard drinks. Overall, respondents had a good attitude and safe practices towards alcohol consumption and its effects on their health. 71.3% of the respondents indicated that their alcohol consumption was enquired during visits to a health facility. This study, therefore, recommends that there is a need to increase knowledge, improve attitudes and maintain practices towards alcohol consumption and its adverse effects among the youth by creating new platforms to increase awareness and intensify alcohol education. This can be achieved by establishing a multisectoral approach between the Ministry of Health and Social Services (MoHSS), Ministry of Education (MoE) and other relevant stakeholders in Nigeria.

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**CHAPTER ONE**

**INTRODUCTION**

**Background of the study**

The need for health information can be traced back from ancient information societies. History shows how ancient nomadic people needed health information for prevention, care and cure of diseases. Information is used everywhere on daily basis (Savolainen, 2000). Information use may be considered as the effects which information has on individuals and what it does to the person and his/ her problem or situation (Kari, 2007). Information which a user has to access has to address physical and psychological ailments. Denial of access to information marginalizes people's participation in the modern information era (Lor & Britz, 2007). Miescher & Henrichsen (2004:163) traces African history of health provision by relating how among the activities of the Christian missionary societies since 19th century a high value was also placed on 'health and 'hygiene'. The European missionary societies were pioneers in introducing modern medicines to Africa, and played an essential role in the establishment of health systems. After independence, many African countries gave high political priority to the setting up of fair national health systems (Miescher & Henrichsen, 2004:163). Various UN institutions as well as private relief organisations and charities played an important role of this process and continue to do so. In the midst of that attempts were made to suppress use of traditional medicines; how- ever, there are still a lot of people who are continuing to consult traditional healers (Chavunduka, 1999).

Health systems in various countries comprise hospitals, clinics where health information is accessed through channels such as radio, television and social media. It is essential that African health centres make accessible quality health information irrespective of their social status. The South African government (2000) passed the Promotion of Access to Information Act ("PAIA"), No 2 of 2000 gives effect to the constitutional right of access to any information held by the State and any information that is held by another person and that is required for the exercise or protection of any rights. Information is an essential resource for personal development but spread of the information revolution has moved slowly in some African countries. Stakeholders such as government, Non-governmental Organisations (NGOs), research bodies, institutions of higher learning recognise health information as an important resource or asset and for it to be useful, it must be available, accessible, usable, and absorbed by the recipients of the information (Wagacha, 2007).

**Statement of the problem**

Health information, attitudes and practices on alcohol and drugs use and its effects on health may be known, but there are limited published materials in the Nigeria context. Also, there are limited surveillance activities to record alcohol consumption, harm and its impact on health. It is for this reason that public health policies on alcohol consumption needs to be introduced (Rwafa, 2015). There are many reasons why young people start drinking and use drugs, such as to increase self-confidence, escape from personal problems and relieve stress, or overcome a poor self-image, or simply to just get drunk (Berkowitz & Perkins, 1986). The International Alliance for Responsible Drinking (IARD) concurs with consequences of different attitudes towards alcohol use vary, but still do not make it reasonable. Considering that studies indicate that the youth as young as 13 years consume alcohol, and it is not known whether the adverse effects thereof are known; this may put the future generation in a vulnerable state unless steps are taken to control the contributing factors to alcohol consumption and use of drugs. Alcohol consumption and drug abuse, especially in high amounts, can cause a lot of health problems such as anxiety, depression, gastrointestinal disorders, a risk factor for some types of cancers and can lead to death. van Heerden, 2017 mentions that alcohol consumption in Nigeria is a high concern and that there are a few people that are aware of the negative effects of excessive alcohol consumption. In Nigeria, high motor vehicle accident-related deaths at a rate of 66.1% have been linked to alcohol consumption, 68% of deaths are due to liver cirrhosis and prevalence of alcohol use disorder at 5.1%, which is above the regional average of 3.3%. These high rates of alcohol consumption contribute to violence, assault and road traffic accidents (The Nigeria police Force, 2013). While there has been a great deal of research on health systems in Africa, the literature still suffers gaps of addressing marginalised groups who fail to access health information. If health information is not accessible it equates to a failure of an individual to efficiently and effectively improve his quality of life.

**Objective of the study**

This study seeks to assess and describe the Health information status, attitudes and practices of Youths towards alcohol and drug abuse. It is hoped that the conclusions drawn from this study will reveal new and important information that will assist in designing various community education campaigns to educate the public on the effects of high-risk alcohol consumption on their health.

**Specific objectives**

The following are the specific objectives for the study:

1. To assess and determine the health information accessibility status of young adults regarding alcohol and drug abuse.
2. To assess and describe attitudes towards alcohol and drug use among young adults.
3. To assess and describe behavioural practices toward alcohol and drug use among young adults.

**Research Questions**

The following research questions guided this study:

1. What is the health information accessibility status of undergraduate regarding alcohol and drug abuse in Lokoja?
2. What are the attitudes towards alcohol and drug use among undergraduates in Lokoja?
3. What are behavioural practices toward alcohol and drug use among undergraduates in Lokoja?

**Significance of the study**

This study is serving as an alarm blower in creating awareness of risks associated with alcohol and drug abuse, and adverse effects among young adults living in Lokoja, Kogi state. The study will additionally provide baseline information that will serve as a health priority and guide in the health care delivery system. The study findings will be available to stakeholders to assist policymakers and help improve programme implementation.

**Definition of key concepts**

**Alcohol**, according to the Centre of Disease Control and Prevention is defined as an organic compound (scientificicaly named ethanol) which is found naturally in some plants such as corn, potatoes, and wheat.

**Alcohol consumption**, referes to an act of ingesting-typicall orally- a beverage containing ethanol (Collins and Kirouac (2013).

**Young adults**, these are young people from age 19-30 years (Coomer & Hubbard, 2009).

**Chapter layout**

The primary goal of this study was to assess the accessibility of health information on alcohol and drug abuse among youths in Lokoja, Kogi state. This thesis is partitioned into five (5) chapters. Chapter 1, presented an overview of the research process. An introduction to alcohol consumption among the youth from a global perspective as well as in the Nigeria context. Furthermore, the chapter discussed the problem statement, purpose, objectives and significance of this research. Chapter 2 literature review, examining what other scholars have done on the same or similar topic. Chapter 3, covers the research design and methodology of this study. The chapter also gives an overview of the instruments used to collect the data, a description of the sampling method and technique and the analysis used.

Chapter 4, presentation of the study findings. It presents a discussion of the results, similarities, differences and gaps, which are then compared with the literature review. Chapter 5 gives the conclusions and recommendations of the study. Limitations of the study are described as well.

**CHAPTER TWO**

**LITERATURE REVIEW**

**Introduction**

**Conceptual Framework**

Accessibility of health care comprises the following factors, namely availability, financial acces- sibility, geographic accessibility and acceptability (Peters, Garg, Bloom, Walker, Brieger & Rahman, 2008:161). Since people have to access health information it is imperative for this review to adopt the concept of access as used by Buckland (1991:78) who identified the following six aspects of access to information.

**The six aspects are as follows:**

**•Identification:** This means that users should identify a suitable source. Identification of a source includes two-stage process. The first stage includes deciding where to look for a source while the second stage involves identifying a specific source.

**•Availability:** The identified source should be physically accessible to the user. Technology may be used to enhance accessibility of the source. If the identified source cannot be located and made physically available, then another source needs to be identified again and made available.

**•Price to the User:** Price refers to costs that the user must incur for using the service. The costs may be in a form of money, time, effort and discomfort of acquiring the source. Effort relates to a client- patient who struggles to locate information. Discomfort relates to the health worker helping the client-patient to ask a well phrased question. The health worker has to make sure that the information given to the client-patient matches the client-patient's query.

•**Cost to the Provider:** The term cost refers to costs incurred by the providers of service. This involves money and effort borne by public health facility as health service providers.

**•Cognitive Access:** After physical access to a relevant source has been achieved, subsequent condition for successful access is the user's expertise to understand it. In case the user does not understand the source, explanation and education will be required.

**•Acceptability:** There are two related issues involved in acceptability. The first issue is that the user may be reluctant to accept the identified source as credible and reliable. The second issue, the users may not accept the evidence of the source because it is unwelcome in what it signifies and conflicts with other beliefs, a matter of cognitive. For example, a user may understand a source but not accept its validity; such user can hardly be informed by that source. This suggests that credibility as a criterion for becoming informed can be questioned.

Latest definition of access to information by Lor and Britz (2007:390) is that information that is availa- ble should also be affordable, accessible, timely, relevant, readily assimilated, and in languages and contexts users can relate to and understand. But this paper focuses on Buckland's definition of access.

**Health Information Sources**

One cannot doubt that the first prerequisite is well- established health systems to provide health infor- mation sources needed by patients and general public. Health practitioners are key sources for pack- aging health information hence many health clinics hold free health talks. They are also expected to match the query by information seeker with relevant, accurate, comprehensive and complete information. If a user needs information on listeriosis, the health practitioner should not give information on stomach cramps.

Another challenge with sharing health information in many African countries is shortage of health profes- sionals despite having the highest burden of disease. A clear example is that within sub-Saharan African countries, it is widely known that rural communi- ties are the most socio-economically deprived, have the greatest health needs and the poorest access to healthcare (In On AFRICA IOA, 2012). Issue of not having enough health practitioners could be caused by brain drain, health professionals not willing to work in rural areas and challenges to war- torn regions where there is threat to their lives. In terms of addressing brain drain in sub-Saharan Africa, many governments have agreements with Cuba to recruit their doctors. Ghana, for example, employs over 200 Cuban doctors on two-year con- tracts and these doctors serve some of the most remote areas in the country. In case of remote areas the Senegalese Government is currently developing policy to encourage health professionals to remain in areas defined as 'difficult' (Honda, Krucien, Ryan, Diouf, Salla, Nagai & Fujita, 2019).South Africa has introduced Rural Allowance in 2004 and nurses of salaries in Ghana are already high by regional stand- ards, however dissatisfaction by certain sectors were recorded (Kulansa, Dzodzomenyo, Mutumba, Asabir, Koomson, Gyakobo, Agyei-Baffour, Kruk & Snow, 2012; Dithopo, Blaauw, Bidwell & Thomas, 2011).

**Health Practitioners as Sources of Health Information**

The existing health care problems in many parts of African countries are exacerbated by the attitudes of healthcare workers. As a result many patients are faced with unwelcoming healthcare workers who do very little to make patients feel welcome, fuelling levels of patient dissatisfaction (Williams, Baker, Honig, Lee & Nowlan, 1998). A study by Dikotla (2008:80) established that nurses working at Nigeria clinics, in Nigeria are not satisfied about the number of people who visit the clinics on a daily basis to access HIV/AIDS information. Failure to visit clinics was based on patients' attitude towards their health status not being protected. In a study conducted in Uganda, it was discovered that patients had a negative attitude towards seeking healthcare in public facilities because health workers tend to turn away poor women who cannot afford soap, clothes and simple gloves (Kiguli, Ekirap-Kiracho, Okui, Mutebi, Macgregor & Pariyo, 2007). This form of discrimination prevails in spite of constitutions of many African countries (such as South Africa, 1996, Angola; 2010; Kenya, 2010; Morocco, 2011; Zimbabwe, 2013 and Egypt, 2014) making provisions to protect the rights of its patients and discourage any form of discrimination (Shyllon, 2016:76).

**Alternative Health Information Sources**

From the literature reviewed how little has been the about the role of the public libraries in packaging and providing health information at no-cost and in multiple languages. But, in most African countries public libraries are not easily accessible and where they are accessible they are underutilized due to poor reading culture among the communities. In South Africa many public libraries through community engagement projects, visits the local clinics to provide patients with health information which includes information on diabetes and how to manage it. They also target learners in various schools to raise awareness about issues such as HIV/ AIDS, TB, Malaria teenage pregnancy, etc. They also target children and teenagers health information is disseminated through story telling. Lastly, the libraries provide health information through what is called "Do It Yourself" (DIY) programme whereby the marginalized groups such as the unemployed, home based care patients and orphans are loaned some books, watch videos and other sources of information that empower them to manage their health conditions on their own.

In an attempt to match the health information needs of those who rely on traditional health information system, South Africa signed the Traditional Health Practitioner's Act (THPA) of 2007 into law in February 2008 (Nxumalo, Alaba, Harris, Chersich & Gouche, 2011:124). The aim of the act is to "serve and protect the interests of members of the public who visit traditional health practitioners," thus suggesting that South Africa use two parallel health-care systems.

**Credibility of Information Sources**

Generally, information sources should always be credible. This includes health information. So, it is important for end users to know or have the ability to determine whether information source is cred- ible or not. There are criteria that may be used to determine the credibility of health information. According to Anderson, (2019) such criteria include the following:

**Authority -** this criterion determines whether or not the author or agency that created the information has the credentials, academic background or experience to write authoritatively about the topic. Essentially this criterion evaluates if author have a degree related to the topic they addressing. In terms of the agencies, the criterion checks if the agency has a good reputation in the field they are addressing.

**Bias -** this criterion checks if there is a reason to believe that the information provided by the author or agency is slanted or designed to persuade the reader by presenting part of the whole story. Therefore, health information sources should provide objective information.

**Currency -** In terms of currency, the information provided by the source should be current. The date matter because information in some areas and disciplines changes all the time or needs to be up-to-date.

**Indicators of quality -** This criterion looks whether or not the claims made by the source are backed up with documented and cited sources. Most importantly, the cited sources should be of high quality and really cover what they are supposed to.

**Theoretical Framework**

**Social theory**

Social theory by Albert Bandura, suggest that all behaviour is learned through observing the actions of others in an environment. His theory further explains that, just because something has been learned, it does not guarantee a behaviour change. Berkowitz & Perkins, (1986) found that reasons, why people start drinking alcohol, are such as to overcome a poor self- image, relieve stress or simply to just get drunk. Negative social consequences e.g. broken homes, unemployment or poverty are some of the contributing factors to poor self-image.

The theory also explains that behaviour does not necessarily result in change, hence some people who consume alcohol and can recognise when a behaviour (e.g. excessive consumption of alcohol) is destructive can change either change their behaviour or environment and others not (Patock-Packham et al.,2001) in (Essays, UK 2018). This theory assumes that learning is based on responses to environmental and social interaction stimuli.

Interactions of personal factors, certain behaviour and the environment are reciprocal. Therefore, decision-making and actions are influenced daily by people in their environment. Additionally, success in life or failure depends on individuals coping strategies, and self- efficacy will increase resistance towards alcohol consumption or addiction. This can be further associated with alcohol consumption among the youth in a way that explains that people who have a low-esteem level tend to use drinking as a way of escaping reality (Patock-Peckham., et al 2001) in (Essays, UK 2018). Figure 1 below depicts these reciprocal interactions.



Figure 1: Internal principle of Social Cognitive Learning Theory. (SCLT). Source: Nabavi (2011 -2012)

**Neurobiological theory**

The neurobiological system is a sub-discipline of both biology and neuroscience of which cells are organised into functional circuits that process information and mediate behaviour (Science daily, 2019). Drinking alcohol affects the neurobiological system by generating pleasure in the brain and leads to the desire to continuing receiving such pleasure. This theory assumes that people become physiologically dependent on the consumption of alcohol because of drinking it. This may, however, result in the need for increasing amounts of alcohol consumption or regular use to feel its effects, despite negative consequences such as health problems and motor vehicle accidents.

**Genetic theory**

Studies on genetics and alcoholism or alcohol use suggest that relatives of problem drinkers are found to have high rates of alcohol use or abuse (Dick & Foroud, 2015), (Mayfield, Harris, & Schuckit, 2008). However, as much as the theory supports alcohol consumption the amount of alcohol a person can tolerate is highly related to genetics. Developing a tendency to alcohol consumption although may be genetically passed on, other factors such as social and the environmental surrounding plays a role in leading an individual to consume alcohol. Whereas some individuals never take alcohol despite being genetically predisposed (Mayfield, Harris, & Schuckit, 2008).

**Psychological theory**

This theory highlights the idea that people consume alcohol to alter their mood by using their emotions, expectations and cognitions. Alteration of moods by individuals may be that one wants to fit into a crowd of peers at a party for example. On numerous occasions, people feel the need to relax after a long or busy day. The theory further outlines that some people consume alcohol to relieve stress when faced with stressful life situations (Grant, Stewart & Mohr,2009). Literature, however, has not found evidence that proves alcohol consumption and reduction of stress, although a correlation between increased alcohol consumption and increased stress exists.

The theory also explains that behaviour towards alcohol consumption may be linked to the expectations of individuals. For example, an individual may believe to be euphoric after consuming alcohol, especially when feeling emotionally down. Since this individual believes alcohol consumption will restore happiness, they then resort to drinking and this explains the power of expectation in why people consume alcohol.

**Behavioural theory**

This theory is considered a learning theory based on the idea that all behaviours are learned and occurs due to responses through environmental interactions (Cherry, 2019). Cherry (2019) further mentions that, regardless of genetic background, personality traits or internal thoughts, the response in terms of behaviour towards environmental stimuli only requires the right conditioning. The theory explains that reasons for alcohol consumption or a dependent thereof happen through a string of behaviours, namely positive attitude, experimental, regular use, heavy use and dependence or abuse. Initially, there should be a positive attitude about alcohol to begin drinking. Teenagers feel the pressure to keep up with their friends to fit in. As an experiment, they may temporary drink to distract themselves from the pressure and worries of life. This however if continued, then develops into regular use of alcohol. As time goes by regular use turns into heavy use. Over time, to feel the same pleasure because of alcohol, dependence or abuse occurs.

Positive

attitude

Experimental

Regular use

Heavy use

Depedence or

abuse

**Figure 2:** The process of becoming dependent on a drug; Behavioural theory. Source: Kring, Johnson and Neale: Abnormal Psychology,(2010) 11th Edition.

**Prevalence of alcohol consumption among the youth**

Alcohol use being a worldwide problem, not only results in millions of death and diseases but a causal factor to self-inflicted injury and violence as well (World Health Organization, 2004). WHO global status report (2018) states that consumption levels are highest in Europe but African nations suffer the heaviest burden of alcohol-related diseases, injuries and deaths. The report further indicates that from the global population of 15 – 19-year-olds, 26, 5% (155 million adolescents) are current drinkers. In the same study, current drinkers were found to consume an average of 32.8 grams of pure alcohol per day, which is 20% higher (40.0 g/day) in the African Region in comparison to other regions. Globally, there has been an increase in total alcohol per capita consumption (from 5.5 litres of pure alcohol in 2005 to 6.4 litres in 2016).

A survey conducted in American countries, Europe and the Western pacific found that adolescents younger than 15 years were found to be consuming alcohol. The prevalence of alcohol consumption by these 15-year-olds stood at 50 – 70% and a slight difference between boys and girls was observed (World Health Organisation, 2018). Edwards, Marshall, & Cook, (2003) found that extensive research has revealed that a correlation exists between high average consumption of alcohol in a population and incidence of alcohol-related problems. However, (Sherlock & Dooley, 1997) says that not all alcohol abusers develop liver damage. The development of alcoholic cirrhosis in certain people remains unknown. Moreover, liver damage due to alcohol consumption is not related to the type of beverage, but rather due to its content (Sherlock & Dooley, 1997). Therefore, continuous daily intake may be more dangerous than occasional drinking. In a study by (Sommers & Sundararaman, 2007) it has been observed that there is an increase in disability, suicidal incidences, violence and traffic violation among the youth under age 21 who consume alcohol in the United States. The legal age to purchase alcohol is 21; however, it has been found that 20% of alcohol consumed in the U.S is by person’s aged 12- 20-year olds. Approximately 5000 young people per annum age below 21 died as a result of juvenile drinking. The prevalence of alcohol consumption despite having dropped over the years in the U.S, underage drinking remains the prevalent problem than the use of other drugs. In Brazil, 48.3% - 71.4% of adolescents were found to have experienced alcohol use, whereas 27.3% regular users and 8.9% heavy users; despite having a few alcohol prevention programmes in place (Granville-Garcia et al., 2014).

Young adults are more likely to engage in petty crimes and risky behaviours. Alcohol use or abuse mostly tends to be a rising factor in incidences of the aforementioned. (Maciag, 1999) in another study done in the US, cases of criminality and a large portion of AIDS cases are highest reported among young adults, and alcohol-related problems are mostly observed in men (Nolen-Hoeksema, 2004) since woman are found to be drinking less than men. However, both genders may display similar alcohol-related problems.

South Africa (SA) is among the countries from Africa with the highest levels of alcohol consumption in the world, and these levels continue to rise. Initiation of alcohol consumption is from as young as below 13 years old, rating at 12% (Ramsoomar; Morojele, 2012). At 16.6 litres of pure alcohol consumed per drinker per year, 5 5 billion litres (Seggie, 2012) of alcohol annually in SA, a similar pattern is found in Kazakhstan, Mexico, Russia and Ukraine. The prevalence among the youth age 25 and above stood at 32.8 litres of pure alcohol consumption among males and 19.6 litres of pure alcohol in females. This trend continues to rise. In most developing African countries, high rates of alcohol consumption can be found. Whereas adolescents in Zambia, 40.8% are reported to have consumed alcohol in their lifetime, (Swahn, Ali, Palmier, Sikazwe, & Mayeya, 2011).

Alcohol plays a considerable role in society as it is consumed during special occasions, without thinking of the negative consequences thereof. Although not everyone that consumes alcohol may develop related problems (Sherlock & Dooley, 1997), there are some health benefits (Tampah-Naah& Amoah, 2015) and adverse effects when consumed in excess (/Uiras& /Uirab, 2015; van Heerden, 2017; The Namibian police 2013 in (Kalunta-Crumpton et al., 2018). Heim et al., (2004) mention that besides alcohol use having effects on human health, parental and family relationships and work are disrupted as well. Namibia is one of the top 10 countries with a high alcohol consumption rate and ranking at number 5 in Africa (World Health Organization, 2014a). A report on alcohol consumption levels and patterns in Nigeria states that the total alcohol per capita consumption from the age of 15 and above for alcohol drinkers in 2010 stood at 27.7 % (in litres of pure alcohol) for both sexes. There are over 900 registered drinking places found in Windhoek alone (Siiskonen, 1994) thus making alcohol abuse a major problem in Nigeria, where an estimated 53.5% of youths aged 13-30 use alcohol (Barth & Hubbard, 2009). These findings further state that 28.4% of youths use alcohol at least once a week and 6.8% daily. These problems reduce life expectancy, lower productivity; require substantial expenditures for health resources and desolate community life. Despite alcohol burden being a global health problem, there are variations in disease burden between different regions and religions (Babor, 2010).

**Effects of alcohol**

The Centre for Disease Control and Prevention, defines alcohol as an organic substance- scientifically named ethanol which is found naturally in some plants such as corn, potatoes, and wheat. Made up of molecular compounds of carbon, hydrogen and oxygen; alcohol is formed when a hydroxyl group is substituted for a hydrogen atom in a hydrocarbon. Ethanol (the type of alcohol used in beverages is derived from fermenting sugar with yeast).

Alcohol remains the main substance abuse in Nigeria (World Health Organization, 2014b). Consumption in different amounts has multiple effects on human beings, and every organ of the body can be affected by alcohol (Babor, 2010), (Barclay, Barbour, Stewart, Day, & Gilvary, 2008). These effects may be short-term, long-term, physical or psychological. Although some are not observed immediately, warning signs should not be ignored, as it may be difficult to reverse the complications.

**Short-term**

Short-term effects associated with alcohol consumption are mostly depending on the amount of alcohol consumed. Slurred speech, lack of coordination, unintentional self-harm, vomiting and driving under the influence of alcohol are some of the short-term effects. Amongst other effects, these can cause extensive harm besides to oneself; there is a direct impact on family, friends and colleagues.

Comprehensive data on alcohol use and problems in Nigeria is evident in suggesting that alcohol use is a widespread phenomenon. According to (World Health Organization, 2014b), a survey conducted in Namibia. Questions based on the Alcohol Use Disorder Identification Test (AUDIT) referring to alcohol-related problems; found that nearly half of the male respondents and one-fourth of the female reported having experienced one of the life problems caused by alcohol such as getting injured, breaking up with friends or spouse.

**Long-term**

Individuals who consume alcohol for a long-term or prolonged period (Babor, 2010) are at risk of developing long-term effects of alcohol. These may include cardiovascular diseases, liver disease, cancers, and nerve damage. The liver is one of the organs most significantly affected, damaged and physically deranged as a result of prolonged use of alcohol (Barclay et al., 2008). Alcohol consumption is the main cause of liver disease in the world; and is responsible for fatty liver, alcoholic hepatitis and cirrhosis (O’Shea, Srinivasan, &Arthur 2010). The severity of liver damage, however, depends on the frequency, strength and dosage of alcohol consumed by an individual, mere consumption does not predispose one to health or social consequences (Tampah-Naah & Amoah, 2015a).

**Physical effects**

Alcohol consumption and abuse thereof has been linked to physical effects such as domestic violence, injuries related to aggressive behaviour and sexual assault (Ramsay et al., 2012). (Barclay et al., 2008) also mentions that alcohol use is responsible for a considerable amount of effects such as an impaired judgement or dysfunctional behaviour that may lead to impaired interpersonal relationships. Other physical effects that may result from alcohol even in small amounts of consumption (Granville-Garcia, AF; Clementino,MA; Gomes,M; Firmino,RT; Ribeiro,G and Siqueiro,MB 2014) are such as weight gain, increased suicide rates, juvenile delinquency, familial conflicts, increase motor vehicle accidents as a result of drink and driving cases as well as illicit drug use.

**Psychological effects**

Psychological effects due to alcohol use are determined by the impact on the human brain. The quantity, frequency of consumption, age at which a person begins drinking and how long they continue to drink negatively affects the psychological wellbeing of human. Difficulty focusing, problems with memory, poor or diminished vision and coordination, depression, increase substance uses are some of the results caused by alcohol consumption and increase thereof.

**Knowledge of alcohol use among the youth**

Young adults are the future of any nation. With alcohol consumption on the rise globally and its effects significantly evident, young adults are a vital group at which health promotion strategies are targeted and hence important in determining their knowledge with regards to alcohol consumption.

In a survey conducted in India, China, and Pakistan on alcohol consumption and perception of community responses and attitudes of young people; it was found that religion for one was a predictor for alcohol consumption among the youth. In China, although awareness of alcohol consumption and its effects are made available, alcohol use is not identified as a major public concern (Heim et al., 2004). However, communities in Pakistan ignore or hide aftermath problems from alcohol use and abuse while in India some respondents revealed that several community members had no understanding of alcohol use effects on health. (Bivol, 2011) observed that age 15 – 24 Moldovan youth consume alcohol, and they do not seem to see a problem with excessive alcohol consumption. This shows that there is low awareness of alcohol use among the youth. Contrary,(Odeyemi, Odeyemi, & Olatona, 2014a) mentions that awareness of alcohol consumption and its effects are known among the youth aged 16 – 30 although some gaps in knowledge exist among some people.

A Nigerian KAP based study on alcohol consumption among medical students revealed that a considerable number (83.3%), the majority of respondents in the study had good knowledge about alcohol. Despite the majority having good knowledge of alcohol, some respondents described alcohol as a stimulant, good for the body and a painkiller. This suggests that there is a need for education to combat alcohol use among the youth. However, a high percentage of respondents reported knowing harmful effects of alcohol such as liver cirrhosis, a risk factor for cancer and 40.4% responded that, regardless of what amount of alcohol is consumed; alcohol remains dangerous to one’s life.

Alcohol is widely available in our societies and exposure to young adults is expected to be high. However, their knowledge of the effects thereof may differ based on gender or educational level. The amount of alcohol consumed by young adults may be associated with their level of education although the same cannot be linked to the behavioural outcome. As reported by (Odeyemi, Odeyemi, & Olatona, 2014b), they found an association between the amount of alcohol consumption and the level of education among participants. However, despite senior students displaying better knowledge of alcohol, the highest prevalence of consumption was amongst them. Meanwhile in a study conducted in Zambia. onlcohol marketing,drunkness, and problem drinking among Zambian youth,found that regardless of alcohol education provided, there was no significant factor related to drunkenness (Swahn et al., 2011).

**Attitudes towards alcohol consumption**

Influence from peers plays a role in the attitude of young adults and alcohol consumption. The study conducted in Nigeria on alcohol knowledge and consumption among medical students in Lagos,found that students who consume alcohol had friends who drink as well . While of those that consume alcohol for fun or on an occasional basis, some did so to make self-feel bold and better when depressed (Odeyemi et al., 2014b). Related to the study in Nigeria, another study also indicate that environmental and social factors influence the commencement of alcohol consumption by young adults (Malčić & Kudumija Slijepčević, 2015).

Having a positive or negative attitude towards alcohol or alcohol consumption can determine the behavioural aspects thereof. This can be linked to a study conducted among nursing and mechatronics students. The study found that nursing students showed a much lower interest in alcohol consumption than the mechatronics students did. Mechatronics students, however, where reported to be behaving irresponsibly while consuming alcohol, although displaying a positive attitude towards alcohol / or alcoholics. The study further explains that differences in knowledge with relations to the student's respective fields of study contribute to their behaviour towards alcohol consumption (Malčić & Kudumija Slijepčević, 2015).

**Practices towards alcohol consumption**

Effects of alcohol, although known by a percentage of young adults misconceptions are playing a role and affecting alcohol practices. Low-esteem levels play a role in the practices of alcohol consumption. Some studies indicated that some individuals view and describe alcohol as a stimulant, depressant, or painkiller (Odeyemi et al., 2014b). People then use alcohol as a way of escaping reality (Patock-Packham et al., 2001) (Essays, UK 2018). Men have been identified to consume alcohol as a coping response, increase confidence and cope with social demands (Tampah-Naah & Amoah, 2015b). Whereas the same study found that women do so for socializing pleasure with peers.

Another report found that young adults consume alcohol to have fun and escape from stress. This leads to risky sexual behaviours in society among peers and significant others. Regardless of these young adults knowing the risks associated with alcohol, “they appear to be unable to stop the practice of alcohol use”(Kafuko & Bukuluki, 2008).

Exposure to alcohol marketing through media has been found to affect alcohol consumption practices. In a Zambian study, the marketing strategy of providing free alcohol to the youth was found to have a significant influence on the drinking behaviour and alcohol-related problems among the youth (Swahn et al., 2011). Similarly, the marketing of alcohol has been associated with early initiation and higher alcohol consumption among the youth (Jernigan, Noel, Landon, Thornton, & Lobstein, 2017). Contrary, IARD argues that banning alcohol advertisement as evidence in reducing NDCs or harmful use of alcohol is inefficient and does not make a compelling case that advertisement leads to harmful drinking. The ready availability of alcohol plays a significant role in the consumption of alcohol among male and female young adults. This can concur with a study done in Namibia that found more than half of the respondents mentioning that alcohol was easily accessible in society (Legal Assistance Centre, 2008).

**Summary**

The researcher did not find any literature based on the Health information accessibility, attitudes and practices towards alcohol consumption, drug abuse and its effects on health in the Kogi state context.

**CHAPTER 3**

**RESEARCH METHODOLOGY**

**Introduction**

This chapter outlines the research methodology used to conduct this study. It covers an overview of areas that are needed to be considered when undertaking research and explains research methods used as well as the rationale for choosing the methodology. The following are defined: research design, study population, sampling, research instruments, data collection, validity, reliability, data analysis and research ethics.

**Research methods and design**

The study applied a quantitative approach, using a cross-sectional descriptive design. The chosen design is appropriate because the collection of data was done at one point in time in a specified population (De Vos, Strydom, Fouche, & Delport, 2011) to assess the knowledge, attitudes and practices of young adults concerning alcohol use and its effects on their health.

**Population**

A study population is the total number of male undergraduate in Federal University, Lokoja state. This study targeted both male in the age group eighteen (18) to thirty (30) years.

**Sample**

Given that financial resources and time was a limitation, sampling was the most feasible way of studying large populations. Sampling is defined as a practical way of collecting data from a smaller portion of the population, which is representative, or having similar characteristics to the defined total population (De Vos, Strydom, Fouche & Delport, 2011). A sample is a subset of the population, which is considered for the actual study (Creswell, 2009).

**Sample size and methods**

Using convenience sampling method, a total of 383 male students from different departments and faculties were randomly selected within a period of one month to voluntarily participate in this study.

**Research instruments**

A structured questionnaire containing closed-ended questions was constructed in English was used as the method of data collection through an interview. The questionnaire is divided into two sections as follow:

Section A consisting of demographic information

Section B captured the health information accessibility, attitudes and practices towards alcohol and drug use and its effects on the health of young adults.

**Data collection**

Participants were randomly selected from the randomly selected departments. This was done by going to department open space and administering the instrument to a cluster of students on different days of the week. Three days of the week was selected for questionnaire distribution. This activity lasted for one month. This was done to elicit information and gather sufficient data required to draw conclusions.

**Data analysis**

Data was exported to Microsoft Excel for cleaning and coding i.e. categorical and numerical data. Data analysis was done using the software Statistical Packages for the Social Sciences (SPSS) version 25. Descriptive quantitative statistics were used to analyse and represent demographic information, e.g. age and sex. Results were summarised and presented in frequencies and percentages for categorical variables, means, median and standard deviation for numerical variables, which showed how many participants fell into each category and converted into graphs using Ms excel to show a visual presentation of data.

Questions on knowledge and attitude were given scores. Scores on each question were awarded as follow: 1 for yes and 0 for no and don’t know answers. Participants who obtained 5 and above out of 10 were regarded as having sufficient knowledge and those scoring less than 5 inadequate knowledge.

A Likert scale was also used scaled on 5 points and totalling 15 marks. Participants who had obtained 7 and above were regarded as having adequate knowledge and those who obtained less than 7 with inadequate knowledge. Responses for questions based on practices were calculated using frequencies and percentages. Figures were created using Ms Excel.

**Research ethics**

Approval to conduct the study was obtained from the department. Also, consent of the male students were obtained prior to participating in the survey.

**Principle of justice:** Participants were selected randomly, giving each individual an equal and fair chance to be part of the study. The researcher did not use any form of coercion, incentives or bribery to lure participants.

**Anonymity and respect for the participant:** Questionnaires were based on anonymity, did not require any identity and cannot be traced back to the participant. An informed consent stated that the study is voluntary, participants were not forced to partake against their wish, and they had the right to withdraw from the study at any point.

**Principle of beneficence and non-maleficence:** The study constitutes non-experimental research, hence no predictable harm or discomfort was inflicted on the participants. Efforts to minimise discomfort by protecting participants’ privacy and ensuring anonymity were made. Informed consent: An informed consent was presented to participants before the study; any clarity concerning the study was done before participating in the study.

**Confidentiality:** All data obtained from this research is kept confidential and only intended for this study, findings will not be linked to any participants. The information provided by the participant is not available to any third parties either than to the researcher and supervisors.

**CHAPTER 4**

**DATA ANALYSIS, RESULTS AND DISCUSSION OF FINDINGS**

**Introduction**

The previous chapter emphasised the study methodology. This chapter will focus on data analysis, results and findings obtained from the study. Data analysis was done using SPSS version 25, and three hundred and eighty-three (383) participants were interviewed. Results of this study are presented under sociodemographic characteristics, health information accessibility levels (adequate and inadequate), attitude (good and negative) and practices on alcohol use and its effects on health. Illustrations are done using tables and graphs.

**Sociodemographic characteristics of the study respondents**

Sociodemographic characteristics refer to those unique attributes of the respondents, which distinguish them into different sets of categories. In this study, however, the results about demographic characteristics including but not limited to the following presented in Table 1 on the following page.

Most respondents were age group 21- 23 (134) and 11.2% age group 24-26 being the lowest represented among the age groups under study. Out of a total of 383 participants, 120 (31.3%) are in year 4, 46.2% are in year 3, 10.4% are in year 2, while 12% are in year 1.

**TABLE 1: SOCIODEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS**

|  |  |  |
| --- | --- | --- |
| **Age group (years)** | **Number of respondents** | **Percentage** |
| 18 - 20 | 118 | 30.8 |
| 21 - 23 | 134 | 35 |
| 24 - 26 | 43 | 11.2 |
| 27 - 30 | 88 | 23 |
| Total | 383 | 100 |
| Highest level of education |  |  |
| Year 4 | 120 | 31.3 |
| Year 3 | 177 | 46.2 |
| Year 2 | 40 | 10.4 |
| Year 1 | 46 | 12 |
| Total | 383 | 100 |

**Health information accessibility of alcohol, drug abuse and its effects on health**

Respondents’ health information accessibility about the effects of alcohol on health was tested with a variety of questions that determined the understanding of alcohol and its effects on health. The findings revealed that there were participants who were not aware of the dangers that alcohol may cause as a result of health information inaccessibility. Most prominent was that 259 participants had responded to being aware of any danger that alcohol may have on health. As illustrated in Table 2, the majority of respondents have access to health information and are aware of the dangers that alcohol and drug abuse has on health as well as reducing the chances of becoming affected.

**TABLE 2:** Accessibility of health information of alcohol and drug abuse

|  |  |  |
| --- | --- | --- |
| **Probing responses** | **Frequency (N)** | **Percentage (%)** |
| Yes | 259 | 67.6 |
| No | 26 | 6.8 |
| Don’t know | 98 | 25.6 |
| TOTAL | 383 | 100 |

**Some of the known dangers of alcohol on health and means of reducing danger effects caused by alcohol consumption**

Following an assessment of respondents’ health information accessibility and awareness of the dangers that alcohol and drug abuse has on health, respondents were asked to name some of these dangers known to them. The findings revealed some of the health dangers caused by alcohol consumption. The most prominent, with 39% was liver damage and 1% of respondents indicated their awareness on alcohol consumption might cause gastritis. Table 3 below shows these responses.

Although the dangers of alcohol on health may be known, the study further assessed whether respondents knew any means of reducing the chances of alcohol effect on health. More than 65% responded to having awareness of reduction measures.

**TABLE 3: DANGERS OF ALCOHOL AND DRUG ABUSE ON HEALTH**

|  |  |
| --- | --- |
| **Dangers of alcohol on health** | **Percentage (%)** |
| Stomach ulcer | 7.0 |
| Gastritis | 1.0 |
| Liver damage | 39.0 |
| Cancer | 3.0 |
| HPT | 3.5 |
| Mental illness | 3.5 |
| Slow response of the nervous system | 13.0 |
| Brain damage | 12.0 |
| Total | 100 |
| Awareness reducing chances of alcohol effects | Percentage (%) |
| Yes | 65 |
| No | 14.4 |
| Don’t know | 20.6 |
| TOTAL | 100 |

Ways of reducing these effects were mentioned as follow: limiting alcohol intake, consume less or abstain from alcohol. Advice peers to stop drinking alcohol and keep track of drinking habits. Consume non-alcoholic drinks, avoid bad company (friends), raise awareness on dangers of alcohol and seek help if cannot stop consuming alcoholic drinks were the means reported by respondents to reduce the adverse effects from alcohol consumption.

**Exploring Knowledge of young adults on alcohol consumption, drug abuse and its effect on their health**

Figure 3 below shows that 39.4% (151) of the respondents strongly agree with the statement, 33.4% (128) Agree, 7.6% (29) neither agree nor disagree and another 19.3% (74) do not know. The category strongly disagrees recorded 0 percentage (0).

Number of response

80 100 120 140 160

60

40

20

0

128

Disagree 1

Agree

74

Do not know

29

Neither Agree, nor Disagree

151

Strongly Disagree 0

Strongly Agree

Response

Figure 3: Responses to the statement “in Lokoja, there are high rates of drunkenness on our streets at night”

Figure 4 below shows that 32.4% (124) of the respondents strongly agree with the statement, 43.3% (166) Agree, 9.6% (37) neither agree nor disagree, 14.1% (54) do not know. The category disagrees and strongly disagree with recorded 0.3% (2).

Number of response

20 40 60 80 100 120 140 160 180

0

166

Agree

Disagree 1

54

Do not know

37

Neither Agree, nor Disagree

124

Strongly Agree

Strongly Disagree 1

Response

Figure 4: Responses to the statement “the current level of alcohol consumption in Lokoja is on an increase”

Figure 5 below shows that 44.9% (172) and 38.9 (149) of the respondents think the government has a responsibility to implement public health measures to address incidences of alcohol use among the youth. Whilst only about 0.3% (1) and 1.0% (4) disagrees and do not think that the government has a responsibility to implement public health measures to address incidences of alcohol use among the youth.

Number of response

20 40 60 80 100 120 140 160 180 200

0

172

Agree

4

Disagree

42

Do not know

15

Neither Agree, nor Disagree

149

Strongly Agree

Strongly Disagree 1

Figure 5: The government and the responsibility to implement public health measures to address incidences of alcohol use among the youth.

Figure 6 below shows that 178 (46.5%) do not think the government is doing enough to reduce alcohol consumption whilst about 115(30%) don’t know whether the government is doing enough in reducing alcohol consumption among the youth.

Strongly Disagree

47

Strongly Agree

22

Neither Agree, nor Disagree

42

Do not know

115

Disagree

131

Agree

26

0

20

40

60

80

100

120

140

Number of response

Response

Figure 6: Government and the reduction of alcohol consumption

Figure 7 below shows that 3.7% (14) of the respondents disagree with the statement, 1.6%

(6) strongly disagree, 4.4% (17) neither agree nor disagree, 2.6% (10) do not know. About

39.7% (152) agreed and another 48.0 %( 184) strongly agreed with the statement.

Number of response

20 40 60 80 100 120 140 160 180 200

0

152

Agree

14

Disagree

10

Do not know

17

Neither Agree, nor Disagree

184

Strongly Agree

6

Strongly Disagree

Figure 7: Regulation of the number of outlets selling alcohol

“Standard drink”

Out of 383 respondents, 52 have heard of the term. The remainder of 265 have not heard of the term and 66 respondents don’t know. Of the men who indicated the maximum recommended number of standard drinks considered safe per week, the median number from the responses was 4. Whereas women’s response median was 2.

**Knowledge of alcohol and standard drink continues**

Table 4 shows that the youth has good knowledge about common diseases that are associated with alcohol intake. These common diseases are such as the effects on the liver, increase the risk of bowel Ca and high MVA incidences. There is limited knowledge about the association between alcohol and high blood pressure, breast cancer, and bowel and alcohol-fatal syndrome in neonates. There is, however, a belief among the population that stomach ulcers are due to high consumption of alcohol.

**TABLE 4: Health Information on alcohol consumption and health effects**

|  |  |  |  |
| --- | --- | --- | --- |
| Consuming alcohol more than the recommended number of standard drinks can lead to: | True (%) | False (%) | Don’t know (%) |
| Liver diseases | 85.4 | 0.0 | 14.6 |
| Stomach ulcers | 89.3 | 0.0 | 10.7 |
| High blood pressure | 27.2 | 0.0 | 72.8 |
| Increase a woman’s risk of breast Ca | 35 | 0.0 | 65 |
| Increase risk of bowel Ca | 95.8 | 0.0 | 4.2 |
| MVA | 100 | 0.0 | 0.0 |
| Alcohol- fatal syndrome | 30.3 | 0.0 | 69.7 |

Table 5 shows that the majority of respondents had limited knowledge of whether any public organisations help or deals with nor protects young adults from excess alcohol consumption.

TABLE 5: DISTRIBUTION OF RESPONDENT’S RESPONSES TO ORGANISATIONS DEALING WITH EXCESS CONSUMPTION OF ALCOHOL AND PROTECTION POLICIES TOWARDS YOUNG ADULTS.

|  |  |  |  |
| --- | --- | --- | --- |
| Probing responses | Yes(%) | No(%) | Don’t know(%) |
| Are you aware of organisations dealing with people who consume alcohol in excess | 78(20.4) | 105(27.4) | 200(52.2) |
| Aware of public policies that protect young people from excess alcohol consumption | 0(0) | 204(53.3) | 179(46.7) |

Table 6 shows that there is good knowledge is observed in the above response from participants with regards to alcohol either regarded as a drug and a known cause of 10% of road accidents. However, the majority did not know the relation between alcohol consumption and an increase in body weight.

**TABLE 6: KNOWLEDGE OF ALCOHOL AS A CONTRIBUTING FACTOR TO PHYSICAL HEALTH AND TRAFFIC ACCIDENTS.**

|  |  |  |  |
| --- | --- | --- | --- |
| Probing responses | Yes(%) | No(%) | Don’t know(%) |
| Aware of alcohol consumption contributes to weight gain | 119(31.1) | 92(24.0) | 172(44.9) |
| Aware that alcohol is a drug | 225(58.7) | 108(28.2) | 50(13.1) |
| 10% of road accidents are alcohol-related | 336(87.7) | 0(0) | 47(12.3) |

Attitudes of respondents towards alcohol consumption and effects on health

As illustrated in Table 7 below, a large proportion of respondents had a positive attitude towards alcohol consumption and its effects. However, there are some negative attitudes found as well.

**TABLE 7: ATTITUDES OF RESPONDENTS` TOWARDS ALCOHOL CONSUMPTION**

|  |  |  |
| --- | --- | --- |
| Variable | Good attitudeN (%) | Negative attitudeN (%) |
| Many people drink to escape from problem, loneliness and depression. | 63(16.4) | 320(83.6) |
| It is safe to drive a car after one or two alcoholic drinks. | 346(90.3) | 37(9.7) |
| All drivers involved in road traffic accidents should have their alcohol levels measured either on the roadside or in the hospital emergency department. | 362(94.5) | 21(5.5) |

Table 8 below shows responses from 346 participants who indicated that they consume alcohol or have been drinking it for the past 4 months. Apart from having had a hangover, the majority of responses were more than those indicated hence observed as a positive attitude towards alcohol consumption. Furthermore, on probing whether alcohol advertising should be associated with people’s image, 93% felt that advertising of alcohol should only be about the product self, and not be associated with people’s image. The remaining percentage of 3.7% doesn’t know.

**TABLE 8: RESPONDENTS FREQUENCY OF OCCURRENCES OF THE FOLLOWING SCENARIOS IN THE LAST 4 MONTHS.**

|  |  |  |
| --- | --- | --- |
| Alcohol use scenarios | Number of responses N | Percentage % |
| Had a hangover | 210 | 54.8 |
| Vomited from drinking alcohol | 105 | 27.4 |
| Driven a car after having several drinks | 37 | 9.7 |
| Drinking and driving | 10 | 2.6 |
| Arrested for driving while intoxicated | 0 | 0 |
| Got in trouble with the law because of drinking | 0 | 0 |
| Lost a job because of drinking or missed work or class | 0 | 0 |
| Got into a fight after drinking | 7 | 1.8 |
| Thought you might have a problem with your drinking | 14 | 3.7 |

Table 9 shows an average of 71.3% support for the clinicians asking about alcohol consumption where there is a connection to the condition of a patient. There is however little support for when clinicians are to ask about alcohol-related questions as part of routine history taking.

**TABLE 9: APPROPRIATENESS OF THE HEALTHCARE PROFESSIONALS/CLINICIANS ASKING ABOUT ALCOHOL CONSUMPTION**

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol and health-related scenarios | Appropriate N (%) | Not appropriateN (%) | Don’t know N(%) |
| If I feel the issue they were dealing with was related directly to the amount of alcohol I drink, e.g. addition | 361 (94.3) | 8 (2.0) | 14(3.7) |
| If they believe the issue they were dealing with could be related to the amount of alcohol I drink, e.g. high blood pressure | 258 (67.4) | 103 (26.9) | 22(5.7) |
| If they believe the treatment they prescribed would be affected by the amount of alcohol I drink, for example prescribing drugs that interact with alcohol | 257 (93.2) | 7 (1.8) | 19 (5) |
| Part of routine history taking | 116 (30.3) | 240 (62.7) | 27(7.0) |

**Exploring the practices of young adults on alcohol consumption and its effect on their health.**

A total number of 346 (90.3%) out of 383 respondents reported to have consumed alcohol in their lifetime, and only 37 (9.7%) have never drunk alcohol. Respondents who consume alcohol reported to mostly consume beer, wine, whiskey and ciders.

From the 9.7% of those that have never consumed alcohol, mentioned that their main reasons for not doing so were:

* Lack of interest in alcohol
* Fear of the dangers and alcohol-related effects
* Born-again Christianity

The majority of both male and female reported that the age at which they initially commenced consuming alcohol was at 16 and 18 years.

The majority of the main reason why young adults started consuming alcohol was due to peer pressure, with influence from an adult being the least reported.

**TABLE 10: REASONS FOR CONSUMING ALCOHOL**

|  |  |  |
| --- | --- | --- |
| Variable | Frequency | Percentage |
| Peer pressure | 103 | 29.8 |
| curiosity | 257 | 74.3 |
| Because you felt “like it” (bored) | 16 | 4.6 |
| Influence of an adult | 7 | 2.0 |

**The number of times consuming an alcoholic drink?**

Figure 8 below shows that the majority of the respondents (141) indicated that they consume 4 or more drinks containing alcohol in a week and that only 37 of the respondents have never taken a drink containing alcohol.

Number of response

160

140

120

100

80

60

40

20

0

37

Never

54

Once a month or less

75

2 to 4 times a month

76

2 to 3 times a week

141

4 or more times a week

Figure 8: The number of times respondents consume a drink containing alcohol in a week.

Table 11 below shows the practices of alcohol by the respondents. On a typical day, 28.9% indicated that they have 1 or 2 drinks while 8.1% indicate 10 or more drinks. The majority of the respondents indicated that they have six or more units of alcohol on one occasion monthly while the majority of respondents indicated that they drank alcohol at a licenced place in the last four months.

TABLE 11: PRACTICES OF ALCOHOL CONSUMPTION BY YOUTH

|  |  |  |
| --- | --- | --- |
| Variable | Frequency | Percentage (%) |
| On a typical day, how many drinks containing alcohol do you have: |  |  |
| 1 or 2 | 100 | 28.9 |
| 3 or 4 | 94 | 27.2 |
| 5 or 6 | 91 | 26.3 |
| 7 to 9 | 33 | 9.5 |
| 10 or more | 28 | 8.1 |
| How often do you have six or more units on one occasion: |  |  |
| Less than monthly | 44 | 12.7 |
| monthly | 183 | 52.9 |
| weekly | 58 | 16.8 |
| daily | 61 | 17.6 |
| Place where you drank alcohol in the past 4 months |  |  |
| in a licenced premise | 109 | 31.5 |
| restaurant | 77 | 22.3 |
| club | 56 | 16.2 |
| field | 59 | 17.0 |
| home | 45 | 13.0 |
| elsewhere, where (name place) | 0 | 0 |

Figure 9 below shows that the majority of respondents (242) indicated that they had purchased alcohol from elsewhere either than from a supermarket.

No

242

Yes

104

0

50

100

150

Number of response

200

250

300

Response

Figure 9: Number of respondents who have purchased alcohol from a supermarket in the last 4 months.

Table 12 below shows that the natural behaviour of purchasing less when prices are higher is followed. This negative relationship is observed in table 4.10 above, as the percentage of alcohol price increase, the purchasing of alcohol decreases. It will take at least a 50% increase in the alcohol price to change the purchasing behaviour of the respondents. About 30.5% of the population would not change their behaviour at a 10% price hike.

TABLE 12: ALCOHOL PRICING AND PURCHASING BEHAVIOUR

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alcohol price cenarios | The amount of alcohol I buy will decrease substantially% | The amount of alcohol I buy will decreaseslightly % | The amount of alcohol I buywould not change% | The amount of alcohol I buy would increaseby % | Don’t know% |
| If the price of alcoholwere to increase by 50% | 75.7 | 24.3 | 0 | 0 | 0 |
| If the price of alcoholwere to increase by 25% | 62.1 | 37.9 | 0 | 0 | 0 |
| If the price of alcoholwere to increase by 10% | 24.8 | 23.2 | 30.5 | 0 | 21.4 |

**Summary**

This chapter presented the quantitative data generated by the study. Results of the study were presented in the form of tables and figures.

**CHAPTER 5**

**DISCUSSION, CONCLUSION AND RECOMMENDATION**

This chapter serves to consider the findings of the study outlined in chapter four. The study found that the health information accessibility and behaviours of the youth in Lokoja, Kogi state can be described under distinct themes; attitudes, perceived harm, personal knowledge and perceptions of education (awareness). The findings of the survey are generalisable to the population of the youth sampled. The findings will be discussed in this chapter in light of previous research, and relevant literature pertaining to this study.

Alcohol and drug abuse is often associated with fun, curiosity and in some instances, peer pressure, home setting, drinking to fit in, ignorance of the effect of alcohol on health, boredom and ignorance are some of the factors that influence the attitudes and use of alcohol and drugs by youth. The perceived attitudes towards alcohol are that it has a positive influence on confidence and increase the chances of having fun, and therefore, perceived ‘normal’ behaviour, which in turn promotes the use by suggesting it is acceptable (SixSmith and Nic Gabhainn 2008). These findings highlight the normalised attitude towards alcohol use among the youth. However, young people can experience health and social problems, including relationship problems, accidents and involvement in a crime as a result of alcohol use (Kiely and Barry, 2002). Respondents were aware of the impact of heavy drinking on their health.

In the context of the health information accessibility of alcohol and drug abuse, the study revealed that a large proportion of the respondents had adequate health information accessibility and were aware that excessive drinking caused dangers to their health with 39% indicating liver damage as one of the dangers. The good knowledge of alcohol by respondents was expected considering that alcohol is widely available and the level of education by the majority of respondents. Similar to studies done in Namibia and Zambia, good health information accessibility have been reported among the youth (Odeyemi et al., 2014b), (Swahn et al., 2011). It would appear that despite the knowledge of the dangers associated with alcohol, the escalating use of alcohol is evident as most of the respondents indicated that they consumed 4 or more alcoholic beverages per week. This links with the health belief model (Becker 1974) where behaviour is dependent upon the perception that it will or will not lead to harm.

In the context of education and awareness, the respondents were aware of the negative effects of alcohol but were however unaware of the recommended number of drinks allowed for male and female per day. This could be attributed to a lack of drugs and alcohol education, and that in some cases that it was either not well delivered or did not meet their needs. The fact that alcohol is easily available to the youth should mean that education on alcohol should too be easily accessible and available. This, however, requires enhancing the capacity of those delivering it to challenge attitudes and move beyond information giving and scare tactics, in line with best practice. This study, therefore, highlights the need for a multifaceted approach to programmes to reduce early alcohol use.

**CONCLSION**

The study found that the majority of the respondents had access to health information and were aware of the dangers associated with excessive use of alcohol and drugs. However, the use of alcohol and drugs among the youth in Lokoja, remains a significant problem. It is, therefore, suggested that a new approach and different strategies rather than education alone needs to be introduced to combat the destructive practices of young adults and alcohol use (Swahn et al., 2011).

**Recommendations**

The study makes the following recommendations:

1. MoHSS, MoE, Public health policy developers, and other NGOs to work together and target education, new policy initiatives, and awareness initiatives to emphasise dangers and / adverse effects that alcohol consumption has on society. As well as prevention strategies aimed at both sensible drinking and harmful use of alcohol.
2. MoHSS could introduce and implement routine screening for alcohol-related problems as part of routine history taking to help identify any rising addictions or health-related effects.
3. More workshops should be conducted to educate students on all aspects of alcohol use and abuse.

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ANNEXURE : Questionnaire

Age?

18 – 20  21 – 23

24 – 26  27 – 30

Highest level of in school? Year 1

 Year 2

Year 3

Year 4

SECTION B: Knowledge on alcohol

Are you aware of any dangers that alcohol may have on your health?

|  |  |
| --- | --- |
| Yes |  |
| No |  |
| Don’t know |  |

…if Yes

What are some of the dangers that you know?

…if No or Don’t know go to question 7

Of these dangers, can you reduce the chances of becoming affected?

|  |  |
| --- | --- |
| Yes |  |
| No |  |
| Don’t know |  |

…if Yes, how

To what extent do you agree with the following?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree | Don’t know |
| In Windhoek, there are high rates of drunkenness on our streets at night | 5 | 4 | 3 | 2 | 1 | 0 |
| The current level of alcohol consumption in Windhoek is on an increase | 5 | 4 | 3 | 2 | 1 | 0 |
| The government has a responsibility to implement public health measures to address incidences of alcohol use among the youth | 5 | 4 | 3 | 2 | 1 | 0 |
| The government is doing enough to reduce alcohol consumption | 5 | 4 | 3 | 2 | 1 | 0 |
| The government should reduce the number of outlets selling alcohol | 5 | 4 | 3 | 2 | 1 | 0 |

Have you heard of the term “Standard Drink”?

|  |  |
| --- | --- |
| Yes |  |
| No |  |
| Don’t know |  |

A “standard drink” is a term used to measure the amount of alcohol in a drink.

Regular beer= about 5% alcohol Malt liquor=about 7% alcohol Wine=about 12%alcohol Shot of distilled spirits (gin, rum, tequila, vodka, whiskey) = about 40% alcohol

What is the maximum recommended number of standard drinks considered safe to be consumed in a week by man and woman?

Man  Don’t know

Woman Don’t know

For the following statements, can you tell me whether you think they are true, false or don’t know?

|  |  |  |  |
| --- | --- | --- | --- |
| 10.1. Consuming alcohol more than the recommended number of standard drinks can lead to: | True | False | Don’t know |
| …. liver diseases | 1 | 2 | 0 |
| …. stomach ulcers | 1 | 2 | 0 |
| …. high blood pressure | 1 | 2 | 0 |
| …. increase a woman's risk of breast cancer | 1 | 2 | 0 |
| …. increase the risk of bowel cancer | 1 | 2 | 0 |
| …. motor vehicle accidents | 1 | 2 | 0 |
| …alcohol – fatal syndrome in neonates | 1 | 2 | 0 |

Are you aware of any organisation that helps/deals with people that consume alcohol in excesses?

|  |  |
| --- | --- |
| Yes |  |
| No |  |

Don’t know

Are you aware of any public policies that protect young adults from alcohol access/ consumption

|  |  |
| --- | --- |
| Yes |  |
| No |  |
| Don’t know |  |

[Tick (√) in the appropriate box]

Alcohol consumption contributes to weight increase.

|  |  |
| --- | --- |
| Yes |  |
| No |  |
| Don’t know |  |

Alcohol is a drug.

|  |  |
| --- | --- |
| Yes |  |
| No |  |
| Don’t know |  |

About 10% of fatal road accidents are alcohol-related.

|  |  |
| --- | --- |
| Yes |  |
| No |  |
| Don’t know |  |

Attitudes towards alcohol:

To what extend do you agree or disagree with the following?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Strongl y agree | Agre e | Neither agree nor disagree | Disagre e | Strongl y disagre e | Don’ tkno w |
| Many people drink to escape from problems, loneliness and depression. | 1 | 2 | 3 | 4 | 5 | 0 |
| It is safe to drive a car after one or two alcoholic drinks. | 1 | 2 | 3 | 4 | 5 | 0 |
| All drivers involved in road traffic accidents should have their alcohol levels measured either on the roadside or in the hospital emergency department | 1 | 2 | 3 | 4 | 5 | 0 |
| It is safe to drink alcohol in moderation even during pregnancy | 1 | 2 | 3 | 4 | 5 | 0 |

Indicate the number corresponding to the frequency of the occurrences in the box beside if you currently drink alcohol or have been drunk in the past 4 months.

|  |  |
| --- | --- |
| Had a hangover |  |
| Vomited from drinking |  |

|  |  |
| --- | --- |
| Driven a car after having several drinks |  |
| Drinking and driving |  |
| Arrested for driving while intoxicated |  |
| Trouble with the law because of drinking |  |
| Loss a job because of drinking/ missed work/class |  |
| Got into a fight after drinking |  |
| 9Thought you might have a problem with your drinking |  |

In your opinion, should alcohol advertising only be about the product itself or should alcohol advertising be allowed to associate with people’s image?

|  |  |
| --- | --- |
| Only about the product |  |
| Allowed to associate with peoples’ image |  |
| Don’t know |  |

In each of the following circumstances, please indicate if you feel it is appropriate or not for health care professionals to ask you about the amount of alcohol you drink.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Appropriate | Not appropriate | Don’t know |
| If I feel the issue they were dealing with was related directly to the amount of alcohol I drink,e.g. addiction | 2 | 1 | 0 |
| If they believe the issue they were dealing with could be related to the amount of alcohol I drink,e.g. high blood pressure | 2 | 1 | 0 |
| If they believe the treatment they prescribed would be affected by the amount of alcohol I drink, for example prescribing drugs that interact with alcohol | 2 | 1 | 0 |
| Part of routine history taking | 2 | 1 | 0 |

Practices:

Have you ever drunk alcohol?

Yes  No 

…if Yes

18.1 What kind of alcohol do you have? [More than 1 answer]

…if No,

18.2. What is the main reason?

At what age did you start consuming alcohol?

Why did you start consuming alcohol?

|  |  |
| --- | --- |
| Peer pressure |  |
| Curiosity |  |
| Because you felt “like it” (bored) |  |
| Influence of an adult |  |

How often do you have a drink containing alcohol?

|  |  |  |
| --- | --- | --- |
| Never |  | Skip to question no 27 |
| Once a month or less |  |  |
| 2 to 4 times a month |  |
| 2 to 3 times a week |  |
| 4 or more times a week |  |

On a typical day, how many drinks (units) containing alcohol do you have?

|  |  |
| --- | --- |
| 1 or 2 |  |
| 3 or 4 |  |
| 5 or 6 |  |
| 7 to 9 |  |
| 10 or more |  |

How often do you have six or more units on one occasion?

|  |  |
| --- | --- |
| Less than monthly |  |
| Monthly |  |
| Weekly |  |
| Daily or almost daily |  |

In which, if any of these places have you drank alcohol in the past 4 months?

|  |  |
| --- | --- |
| In a licenced premise |  |
| Restaurant |  |
| Club |  |
| Field |  |
| Home |  |
| Elsewhere, where (name place) |  |

Have you purchased alcohol in a supermarket at all in the past 4 months?

Yes No

Can you tell me how much of an impact, if at all, the following would have on the amount of alcohol you currently buy in supermarkets?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alcohol price cenarios | The amount of alcohol I buy would decrease substantially | The amount of alcohol I buy would decrease slightly | The amount of alcohol I buy would not change | The amount of alcohol I buy would increase | Don’t know |
| If the price of alcohol were to increase by 50% | 5 | 4 | 3 | 2 | 1 |
| If the price of alcohol were to increase by 25% | 5 | 4 | 3 | 2 | 1 |
| If the price of alcohol were to increase by 10% | 5 | 4 | 3 | 2 | 1 |

The end, thank you!