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Prevalence of Alcohol Use Disorders among Medical Students at Kampala International University Western Campus Bushenyi District, Uganda

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ABSTRACT

Alcohol is the most commonly used psychoactive substance and, globally, causes 1.8 million or 3.2% of all deaths and accounts for 4.0% of the disease burden (WHO, 2007). To determine the prevalence of alcohol use disorders among medical students at KIU-WC Ishaka town, Bushenyi district Uganda. This was a descriptive cross-sectional study conducted to explore the factors influencing alcohol use disorder among medical students at KIU-WC Ishaka-Bushenyi district. The quantitative strategy was used to tabulate numerical data which was presented in pie charts, graphs and tables. Most respondents 45(37.5) were in the age group of 21-23 years and the lowest 12(10%) in the age group of 18-20 years, 75(62.5%) were males and the least 45(37.5%) were females, 35(29.2%) were Baganda with least 15(12.5%) were Iteso. The biggest respondents 45 (37.5%) were Catholics while least 2(1.7%) were Moslems, 75(62.5%) were single while the least 3(2.5%) were divorced from their partners, 45(37.5%) were in BMS 3.1-3.2 while the least of respondents 14(11.7%) were from BMS 4.1-4.2 and the biggest respondents 65(54.2%) were others like students while the least 10 (8.3%) were peasant farmers. From the study findings, 20.8% of the students were not taking alcohol, 79.2% were drinking alcohol, 79.2% and 65% were drinking alcohol harmfully and hazardously while were alcohol dependent. The major contributing factor to alcohol abuse among KIU-WC medical students was social environmental which included stress, peer pressure and social norms. The second contributing factor was environmental like availability, persuasive adverts and local breweries and economic factors like unemployment, loss of job, and high-income status being the least contributing factors.
Keywords: Alcohol, Deaths, Farmers, Students, Peer pressure.

INTRODUCTION

Alcohol is an intoxicating ingredient found in beer, wine and liquor and is one of the most widely used recreational drugs in the world. It is produced by the fermentation of yeast, sugar and starches and it is a central nervous system depressant that is rapidly absorbed from the stomach and small intestine into the blood stream. A standard drink equals 17.7 milliliters of pure ethanol or 354.9mililitres of beer,236.6 millilitres of matt liqor,147.9 milliliters of wine or 44.4mililitres of 80-proof distilled spirits or liquor [1]. Alcohol is the most commonly used psychoactive substance and, globally, causes 1.8 million or 3.2% of all deaths and accounts for 4.0% of the disease burden [2]. Alcoholism is more common in males than females, while cumulative abstinence is more common among females than males due to cultural and biological factors [3]. Attributes such as risk taking, expectancies, sensitivity and tolerance to alcohol, personality characteristics and psychiatric co morbidities, hereditary factors, environmental aspects among adolescents have been pointed as reasons for resumption of alcohol consumption [4]. Alcohol

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consumption and problems related to alcohol vary widely around the world, but the burden of disease and death remains significant in most countries. According to estimates by the World Health Organization [5], there are 2 billion people worldwide who consume alcoholic beverages. When consumed in moderate amounts (up to one standard drink per day for women, and one to two standard drinks per day for men), alcohol consumption has been found to be associated with decreased risk of overall mortality and a number of chronic non-communicable diseases (NCDs), including coronary artery disease, diabetes mellitus, congestive heart failure, and stroke [6]; However, when taken in large amounts, the benefits that mount up from moderate alcohol use are canceled, leading to elevated risks of other NCDs like cancers, injuries, and a wide range of social problems [7].

Of the estimated 2 billion people who consume alcohol globally, almost 80 million have diagnosable alcohol-use disorders, [5]. Uganda has previously been reported to have one of highest levels of alcohol consumption in the East African region, with an annual per capita alcohol consumption of 23.7 liters, [2]. Alcohol consumption is the world's third largest risk factor for disease and disability; in middle-income countries, it is the greatest risk. Alcohol is a causal factor in 60 types of diseases and injuries and a component cause in 200 others. Approximately 4% of all deaths worldwide are credited to alcohol, greater than deaths caused by HIV/AIDS, violence or tuberculosis. Alcohol is also associated with many serious social issues, including violence, child neglect and abuse, and absenteeism in the workplace, [5]. A substantial body of literature has documented alcohol's role as a major risk for chronic disease contributing to the global burden of cancer, cirrhosis, cardiovascular disease and stroke. Together with tobacco use, unhealthy diet and physical inactivity, the injurious use of alcohol was identified as one of the top four risk factors for NCDs globally at the 2011 UN High level meeting on Non-Communicable Diseases (The GLOBE-Issue 3 2012). Globally the detrimental use of alcohol causes considerable public health problems and is ranked the fifth leading factor in premature death and disability in the world (THE GLOBE Issue 3, 2010). The global alcohol per capita consumption for persons aged 15 years or older increased from 6.2 liters in 2014 to 6.4 liters of pure alcohol consumed per year in 2016 [2]. According to the WHO, harmful use of alcohol resulted in three million deaths globally in 2016 [2]. In Uganda, alcohol consumption within school environments has been reported to increase chances of school dropouts, absenteeism and poor academic performance [8]. A study by the Uganda Youth Development Link (2008) indicated that alcohol consumption decreased work productivity, increased road accidents, and increased the risk of unsafe sexual practices. Uganda has one of highest per capita alcohol consumption rates in sub-Saharan Africa, however the prevalence of alcohol use still remains unidentified in many areas especially among university students therefore this research is intended to establish alcohol use prevalence among medical students especially at Kampala International University.

STATEMENT OF PROBLEM

Of the estimated 2 billion people who consume alcohol globally, almost 80 million have diagnosable alcohol-use disorders, [2]. Uganda has previously been reported to have one of highest levels of alcohol consumption in the East African region, with an annual per capita alcohol consumption of 23.7 liters, [2]. As shown in a World Health Organization Publication in 2005, worldwide consumption of alcohol was equal to 6.13 liters of pure alcohol consumed per person aged 15 years and older [2]. According to World Health Organization focal point data, between 10% and 69% ofsuicide committed annually are under the influence of alcohol and between 5% and 10% of parents abusing their children had alcohol abuse disorders. Alcohol consumption was responsible for 4.4% of the global burden of diseases [5]. Alcohol has also been found to be a poisonous substance in many cases when abused, the drug causes depression, anxiety and personality disturbances which are directly related to abuse of alcohol and compromises ones' abilities to learn and remember well [9]. Many studies have clearly demonstrated that alcohol misuse among adolescents is associated with motor vehicle collisions [10], violence and crime, [11], mental health disorders and higher risk of suicide, [12]. Moreover, alcohol use during early adolescence is a risk factor for later alcohol dependence [13]. Alcohol abuse among secondary school is reported to be increasing and there is also high likelihood that a student that uses alcohol goes on to abuse other drugs like marijuana when their bodies get used to alcohol and can no longer produce the desired effect. They may also mix different brands of alcohol of higher alcoholic content. Other issues such as high risk to unsafe sexual practices that lead to HIV/AIDS, early pregnancies and unsafe abortions and accidents are also common among students that use/abuse alcohol in schools [14] Death, disease and injury caused by alcohol consumption have socioeconomic impacts, including the medical costs borne by governments, and the financial and psychological burden to families. The hazardous and harmful use of alcohol also impacts on workers' productivity. Perhaps the biggest social impact is crime and violence related to alcohol consumption, which create significant costs for justice and law enforcement sectors, [5]. In Uganda, alcohol consumption within school environments has been reported to increase chances of school dropouts, absenteeism and poor academic performance [8]. More to that the victims often disengage from school and community activities depriving their peer and communities of the positive contributions they might otherwise have made.

The impact can be similar to that of the work place i.e. increased absenteeism by students and poor academic performance, increased student turnover as students live to escape rejection; conflict amongst students when depression, anger and aggression are present. Decreased productivity and academic performance and decreased participation in school activities as students must focus on the strategies about ways to deal with physiological effects of substance abuse [14]. Lack of clear national alcohol policy coupled with weak and poorly enforced laws provide fertile ground for increasing the availability and accessibility of drugs and other substances especially alcohol in Uganda. [14]. Therefore, this study tends to investigate the socio-demographic, socio-economic and environmental factors that influence alcohol use among university students, KIU-WC in particular.

Aim

To determine the prevalence of alcohol use disorders among medical students at KIU-WC Ishaka town, Bushenyi district Uganda.

Specific objective

❖ To determine the socio-demographic factors associated with alcohol use disorder among medical students at KIU-WC Ishaka, Bushenyi district Uganda.
❖ To establish the socio-economic factors associated with alcohol use disorder among medical students at KIU-WC Ishaka, Bushenyi district Uganda.
❖ To identify the environmental factors associated with alcohol use disorder among medical students at KIU-WC Ishaka, Bushenyi district Uganda.

Research Questions

i. What is the prevalence of alcohol use disorders among medical students at KIU-WC Ishaka- Bushenyi district Uganda?
ii. What are the socio-demographic factors associated with alcohol use disorders among medical students at KIU-WC Ishaka- Bushenyi district Uganda?
iii. What are the socio-economic factors associated with alcohol use disorders among medical students at KIU-WC Ishaka- Bushenyi district Uganda?
iv. What are the environmental factors associated with alcohol use disorder among medical students at KIU-WC Ishaka-Bushenyi district Uganda?

METHODOLOGY

This chapter entails the different methods that were used in this study to obtain and manage data. it includes details of the research design, study population, sample size, sampling techniques, data collection methods, instruments, data management, data analysis and presentation, ethical consideration, study limitation and dissemination of results.

Study design

This was a descriptive cross-sectional study conducted to explore the factors influencing alcohol use disorder among medical students at KIU-WC Ishaka-Bushenyi district. The quantitative strategy was used to tabulate numerical data which was presented in bar graphs and tables.

Area of Study

The study was conducted in Kampala International University Western Campus which is found along Mbarara-Kasese road, in Bushenyi-Ishaka Municipality South-western Uganda. Bushenyi district is located about 361km in the south west of Kampala (capital city) by road. Ishaka town's coordinates together with the municipality are 0o 32' 40.00''N, 30o 8' 16.00''E (Latitude: 0.544445, Longitude: 30.137778). Kampala International University is a private university in partnership with the government of Uganda for a program of training medical students and different disciplines like education in different levels. It lies approximately 360 kilometers by road, southwest of Kampala, the largest city in the country. The university has approximately 800 students with different classes in which students of different years are trained for a period located for the particular discipline. The area was selected by the researcher because the desired respondents will be easily obtained and it serves a big population and have students from different parts of the country including international students who come from countries like Kenya, Sudan, Tanzania, Zambia, Cameroon etc. The scope of study is wide as many students come from different parts of Uganda like northern, eastern, central and western parts even other countries like Kenya, Nigeria among other.

Study population

The study participants were youth of different gender and religion above the age of eighteen from first to fifth year offering bachelors in medicine and surgery at KIU-WC within the study time and who are eligible.

Sample size determination

The sample size was calculated using the Kish and Leslie formula of 1965 to determine the sample size,

$$n = \frac{Z^2 * P * q}{\partial^2}.$$

Where: n is the sample size.

Z is the standard normal deviation (set at 1.96 for maximum sample at 95% confidence level).

P is the proportion of youth above 18 years abusing alcohol. (p=0.5).

Therefore, q= 1-p

q = 1-0.5, = 0.5

∂ is the proportion of error that the researcher can accept. If 95% is the degree of accuracy, the level of error is 5%. Therefore 0.05 is the level of significance of the study.

By substitution we get:

n= (1.96)²x 0.5x (1-0.5)

        (0.05)²

n = 384.16

nf = $\frac{n}{1+\frac{n}{N}}$

Where: nf is the sample size.

N is the population size of the study area (N=**180** medical students).

Using the above formula, nf= $\frac{384}{1+\frac{384}{180}}$, = ≈**120** participants. Therefore, the sample size for the study was **120**.

Sampling procedures.

Study participants were interviewed through non-purposive random sampling technique and based on their availability during the time of study until the study sample size of 120 respondents is achieved.

Data collection methods

Data collection was done using socio-demographic and clinical factor questionnaires which were written in English language by the investigator during the interview. Structured and non-structured questions (open and close) were also used. Editing, coding, categorizing and summarizing of the answers given by the respondents was done by the principle investigator. Errors and incomplete questionnaires were removed. Diagnosis of Alcohol use disorder was done using AUDIT.

Data analysis

Data was analyzed manually by the help of pen, papers, calculator and then later using Statistical Package for Social Scientist (SPSS) computer program to illustrate the data using figures and pie charts. Subsequently simple numerical data was analyzed by use of descriptive sentences.

Quality control

Data collection instruments were pre tested among medical students before carrying out the study to ensure that the objectives of the study are well met. Adjustments were made which where necessary to improve the checklist.

Ethical consideration

An introductory and permission seeking letter was sought from the office of the Head of the department of research in clinical medicine and dentistry KIU-WC and Dean of students to collect data. Informed consent was obtained from each participant and they were asked to sign a consent form as proof. Confidentiality was strictly observed at all stages of the research. Participant identifiers were removed during data entry and analysis. Participants were informed that their involvement in the study would be voluntary and that they were free to decline if they so wished.

RESULTS

Socio-demographic data of respondents

Most respondents 45(37.5) were in the age group of 21-23 years and lowest 12(10%) in the age group 18-20 years, 75(62.5%) were males and least 45(37.5%) were females, 35(29.2%) were Baganda with least 15(12.5%) were itesot.The biggest number of respondents 45 (37.5%) were Catholics while least 2(1.7%) were Moslems, 75(62.5%) were single while the least 3(2.5%) were divorced from their partners, 45(37.5%) were in BMS 3.1-3.2 while the least numbers of respondents 14(11.7%) were from BMS 4.1-4.2 and the biggest number of respondents 65(54.2%) were others like students while the least 10 (8.3%) were peasant farmers.

Table 1: shows socio-demographic files of respondents. n=120

Bio demographic parameters		Frequency(f)	Percentage (%)
Age:(years)	18-20	12	10
	21-23	45	37.5
	24-26	15	12.5
	27-29	29	24.2
	30-32	19	15.8
	Total	120	100
Sex:	Male	75	62.5
	Female	45	37.5
	Total	120	100
Religion:	Catholic	45	37.5
	Anglican	30	25
	Moslems	2	1.7
	Others	43	35.8
	Total	120	100
Tribe:	Muganda	35	29.2
	Munyankole	20	16.7
	Luo	25	20.8
	Iteso	15	12.5
	Others	25	20.8
Total		120	100

Marital Status:			
	Married	25	20.8
	Single	75	62.5
	Separated	17	14.2
	Divorced	3	2.5
	Total	**120**	**100**

Education Level:		
BMS 1.0-1.2	25	20.8
BMS 2.1-2.2	21	17.5
BMS 3.1-3.2	45	37.5
BMS 4.1-4.2	14	11.7
BMS 5.1-5.2	15	12.5
Total	**120**	**100**

Occupation:		
Business person	30	25
Peasant farmer	10	8.3
Government Worker	15	12.5
Others	65	54.2
Total	**120**	**100**

Table 2: Social factors of study participants.

Factors		Frequency (f)	Percentage (%)
Drinking alcohol:	Yes	95	79.2
	No	25	20.8
Achievements from alcohol drinking:			
Friends		48	50.53
Wife/husband		10	10.53
Job		16	16.84
Others		21	22.1
Age fist drunk alcohol:			
	Before 18	52	54.7
	Above 18	43	45.3
Amount taken per sitting:			
2-3 bottles		28	29.5
1 bottle or less		20	21
4-5 bottles		38	40
Above 5 bottles		9	9.5
Amount spent on alcohol per day:			
Half of what is earn per day		40	42.1
More than what is earn per day		32	33.7
Spent little		23	24.2
Time of start of drinking:			
Very early in the morning		15	15.8
Evenings only		60	63.2
Any time of day		20	21
Sources of alcohol:			
	Small bars	48	50.5
	Individual brewers	12	12.7

	Others	35	36.8
Who takes alcohol:	Father	30	31.6
	Mother	10	10.5
	Siblings	15	15.8
	Others	40	42.1
Time of returning home	Before 12:00 pm	12	12.6
	Beyond 12:00 pm	25	26.3
	Between 7:00pm-12:00am	30	31.6
	Others	28	29.5

Figure 1: response on alcohol intake

n =120
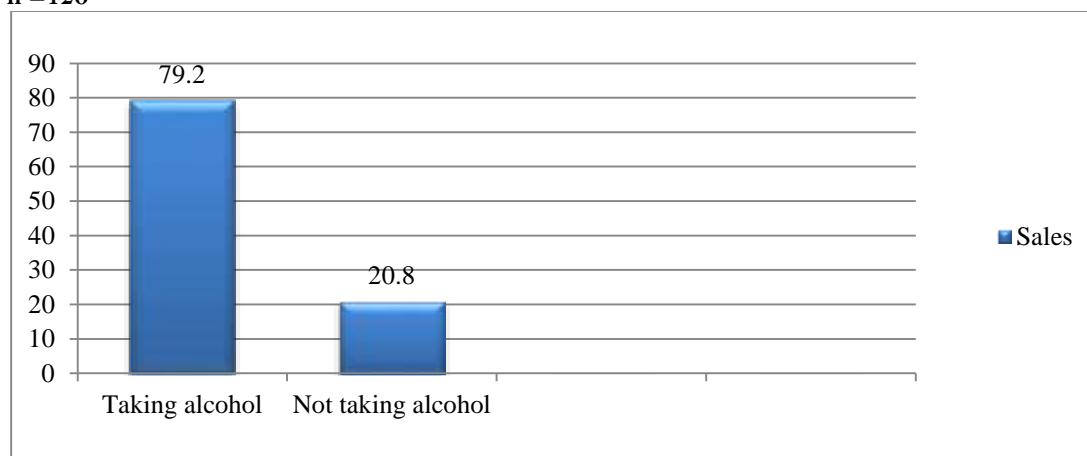
Majority of the respondents 95(79.2%) were taking alcohol while the smallest number 25(20.8%) were not taking alcohol.

Figure 2: Response on reasons for not drinking alcohol. n =25
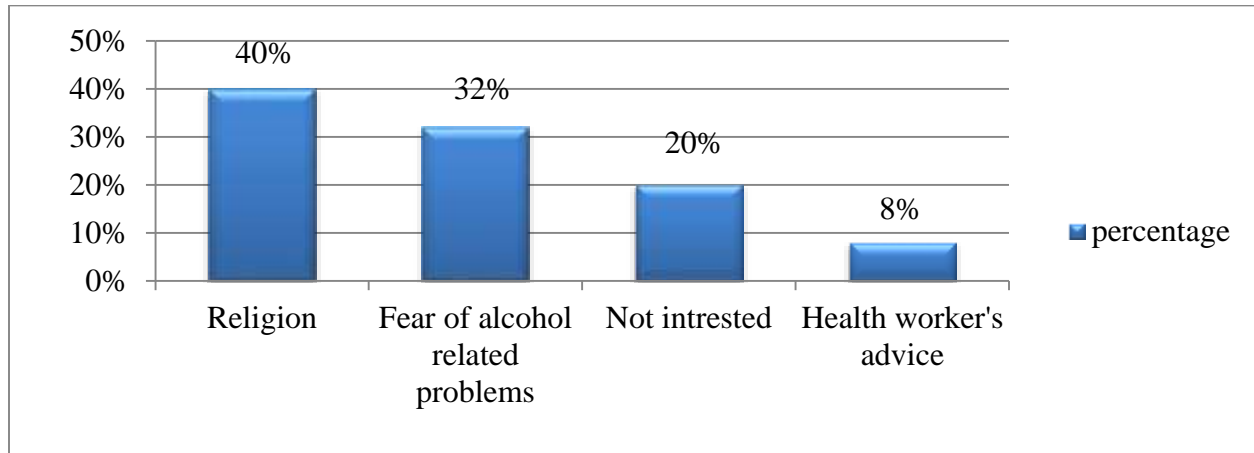
Most respondents 10(40%) were not taking alcohol because of religious reasons while least 2(8%) were not drinking because of health workers' advice.

Figure 3: Response on achievements got from drinking alcohol.
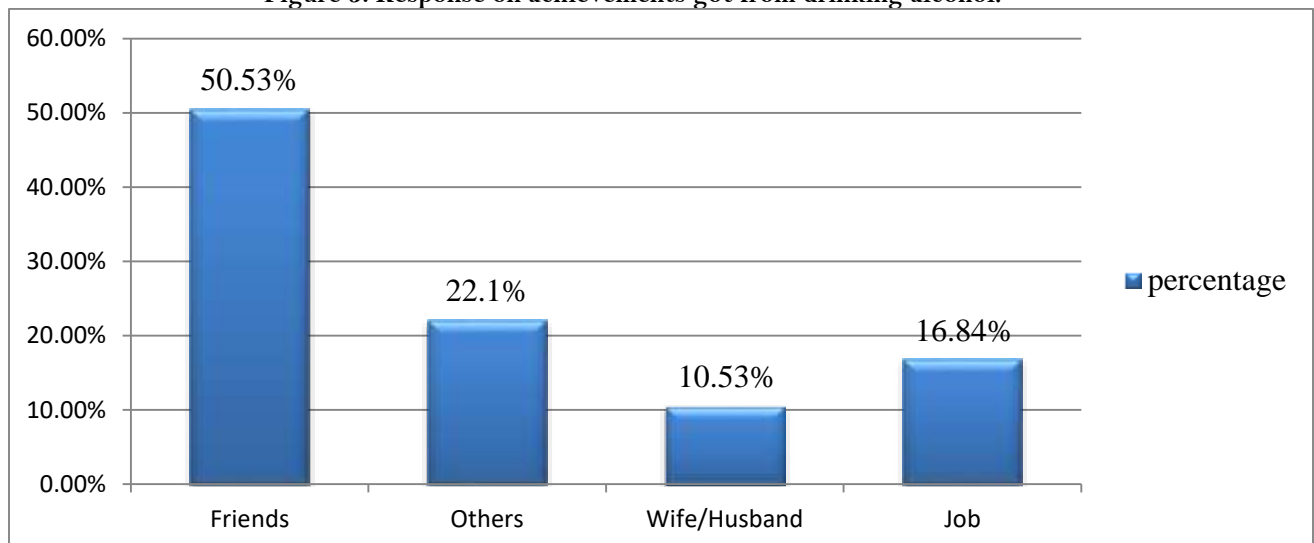
Majority of respondents 48(50.53%) said they got friends while least 10 (10.53%) reported that they got job.

Figure 4: Response on age respondent first drunk alcohol
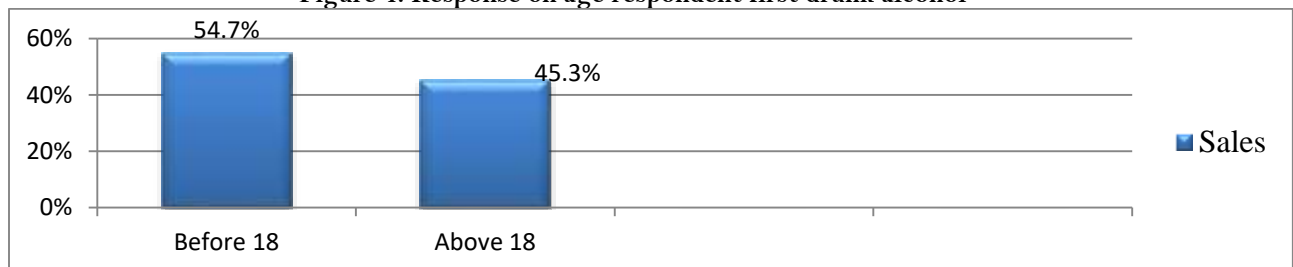
Most respondents 52(54.7%) started drinking alcohol before the age of 18 years while few respondents 43(45.3%) started drinking alcohol when they were above 18 years.

Figure 5: Response on Amount of alcohol taken per sitting.
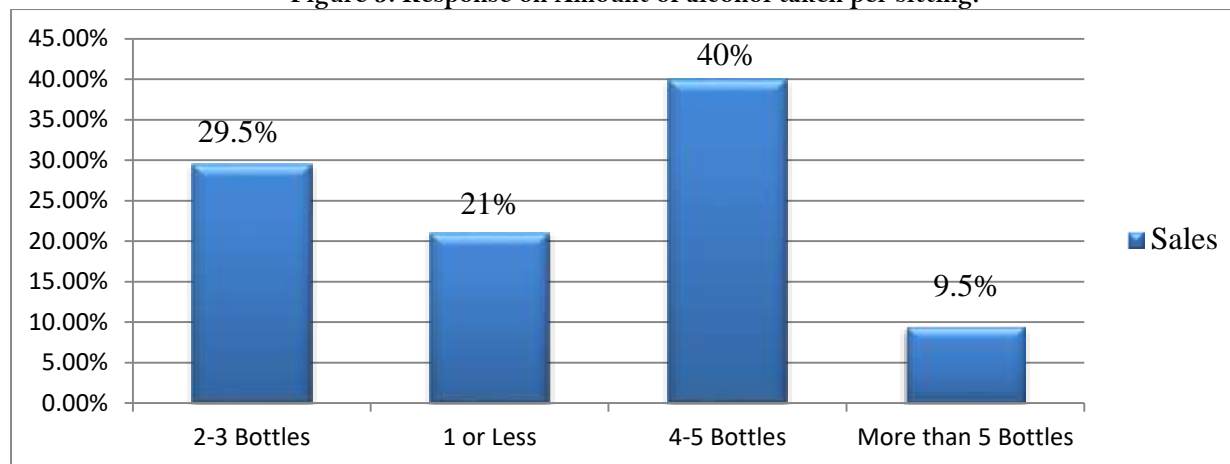
Majority of respondents 38(40%) were taking 4 to 5 bottles per sitting while least 9 (9.5%) was taking more than 5 bottles per sitting.

Figure 6: Response on Amount spent on alcohol per day in every sitting
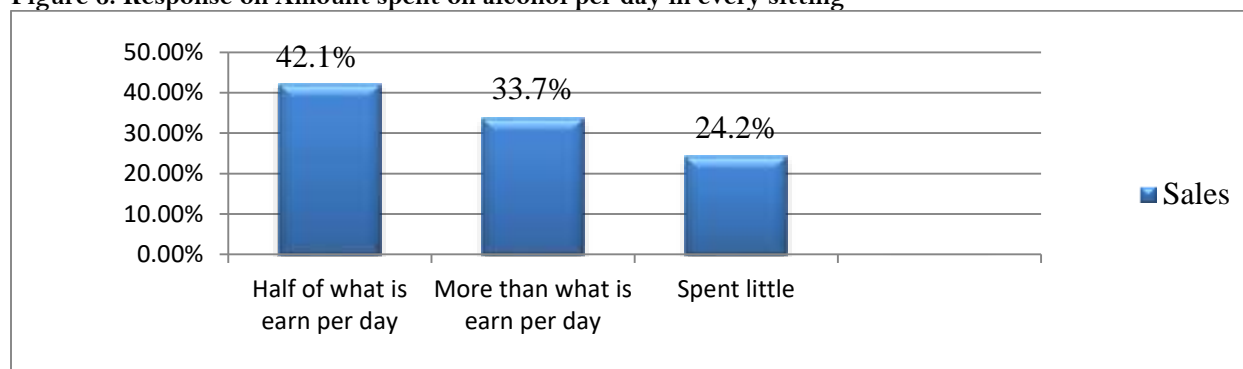
Majority of respondents 40(42.1%) spent half of what they earn per day while least 23(24.2%) spent little.

Figure 7: Response on Source of alcohol.
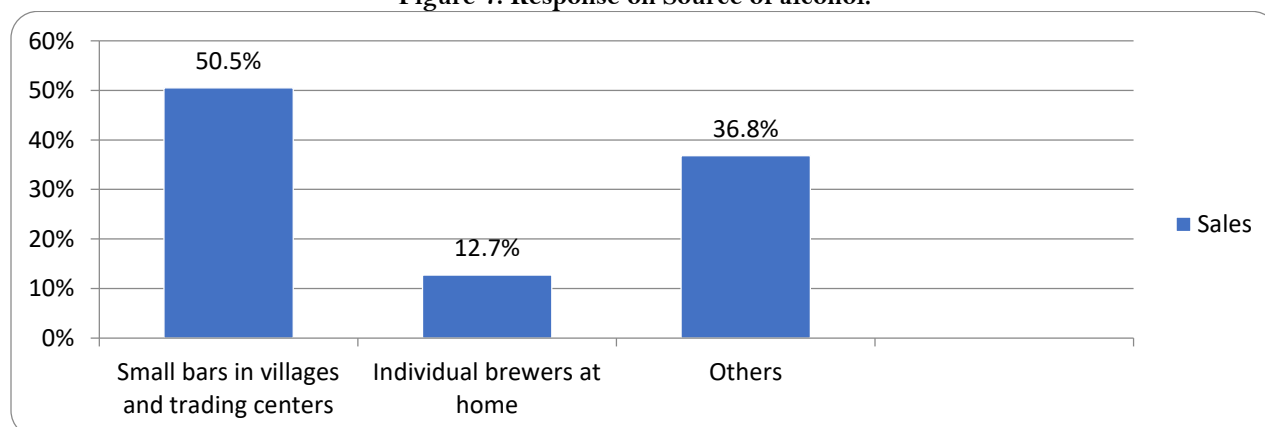
Majority of respondents 48(50.5%) got alcohol from small bars in the village and trading centers while least 12(12.7%) got alcohol from individual brewers at home.
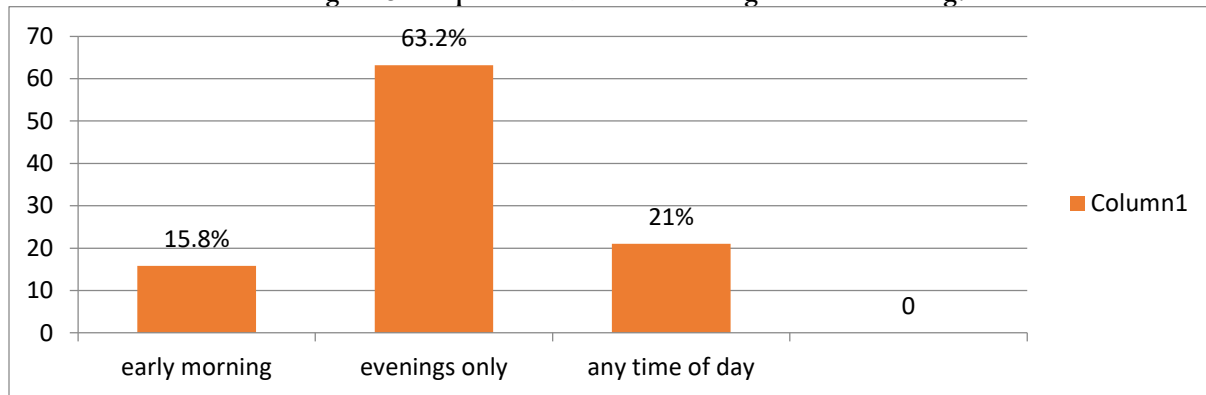
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**Figure 8: Response on the Family members who take alcohol.**
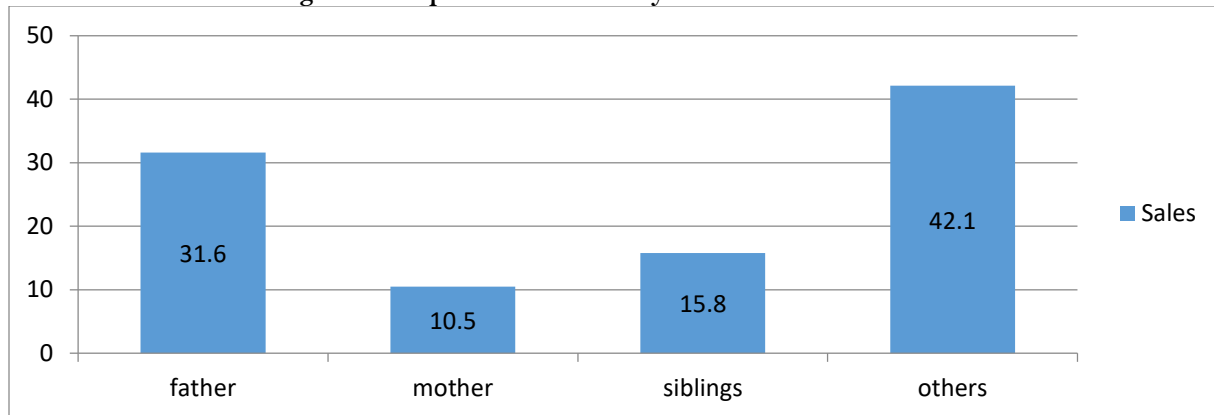
Most respondents 40(42.1%) said others like friends and least 10(10.5%) said mother.

**Figure 9: Response on Time of starting alcohol drinking.**

Majority of respondents 60(63.2%) were taking alcohol in the evenings only while least 15(15.8%) were taking alcohol very early in the morning.

**Figure 10: Response on Time of returning back from drinking place.**
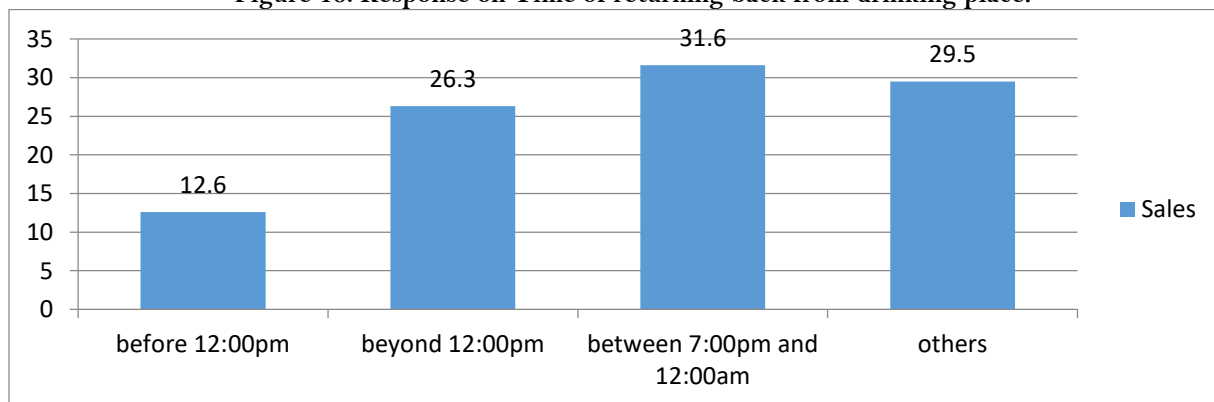
Most respondents 30(31.6%) returned home from drinking place between 7:00 pm – 12:00 am while least 12(12.6%) returned home before 7:00 pm.

**Figure 11: Factors associated with alcohol abuse n=95**
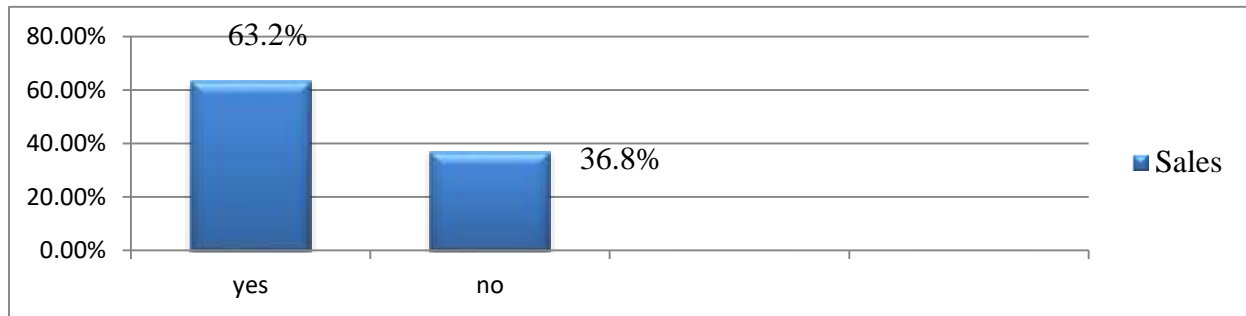
Majority of respondents 60(63.2%) said they were influenced to drink alcohol and least 35(36.8%) reported that they were not influenced to drink alcohol.

**Figure 12: Response on factors that led respondent to abuse alcohol**
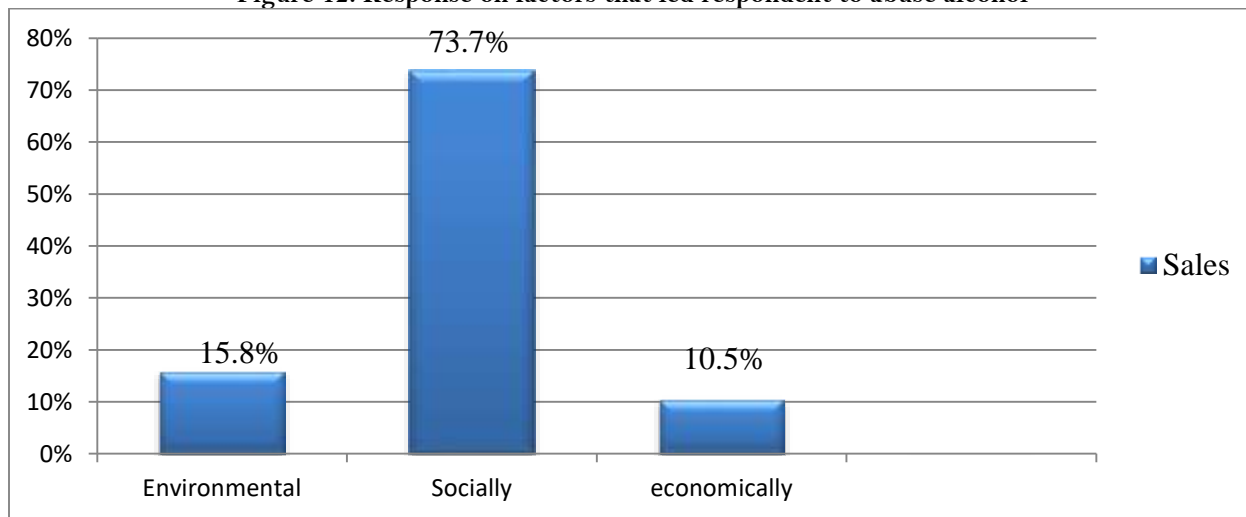
Most respondents 70(73.7%) were influenced by social factors while the least 10(10.5%) were influenced by economic factors.

**Figure 13: Social factors that led to alcohol abuse. n= 95**
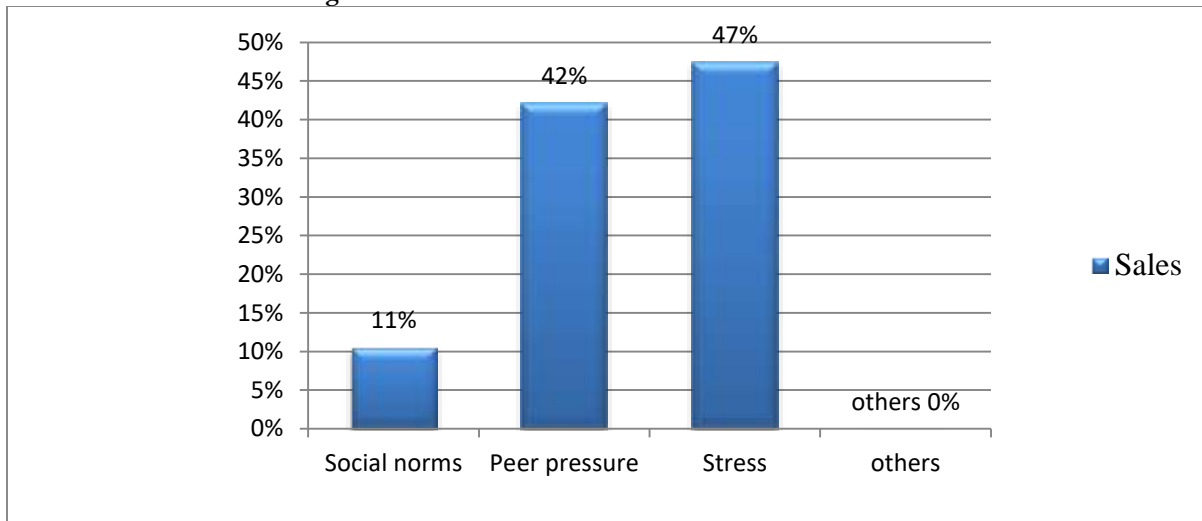
Majority of respondents 45(47.4%) took alcohol because of Stress while the least 10(10.5%) took alcohol because of social norms.

Figure 14: Response on environmental factors leading to alcohol abuse. n=95
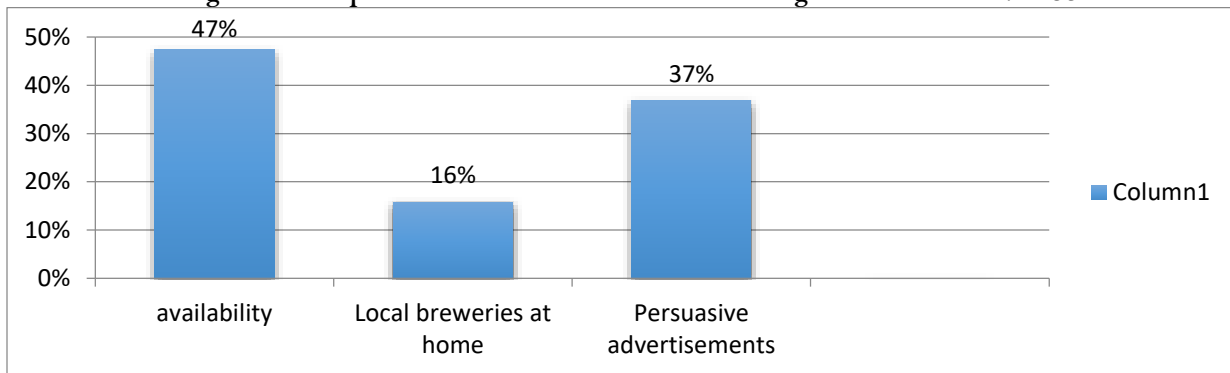
Most respondents 45(47%) reported availability as the environmental factor causing alcohol abuse while least 15(16%) reported local breweries at home as being the factor.

Figure 15: Response on economic factors leading to alcohol abuse.
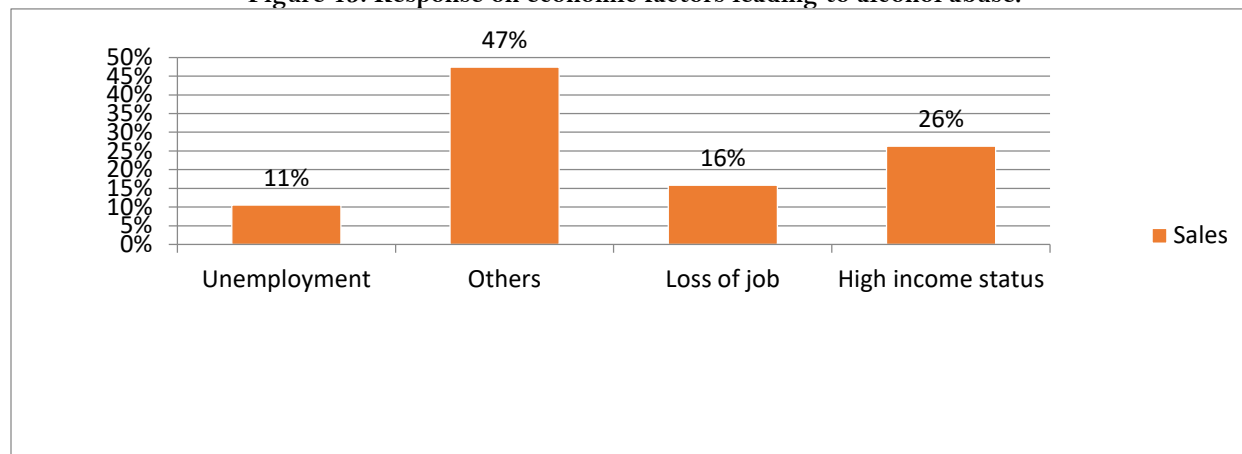
Majority of the respondents 45(47.4%) reported others like boredom while least 10(10.5) reported unemployment.

Effects of alcohol abuse

Table 3: Response on effects of alcohol abuse.

Majority of respondents 60(63.2%) said that alcohol abuse affected them while least 35(36.8%) reported no effects of alcohol abuse, most 20(33.3%) said they had poor performance at school while least 5(8.3%) reported they contracted STDs due to alcohol abuse.

Variables	Frequency(f)	Percentage (%)
Respondents affected by alcohol abuse:		
Yes	60	63.2
No	35	36.8
Total	**95**	**100**

Effects of alcohol on dependent:

n=100

| Contracting STDs	5	8.3
Poor performance in school	20	33.3
Risk sexual behaviors	6	10
Binge drinking	10	16.7
Injuries	10	16.7
Others	9	15
Total	**60**	**100**

Respondents' opinions on alcohol abuse

Figure 16: Response on respondent's opinions on what can be done to reduce alcohol abuse. n= 120
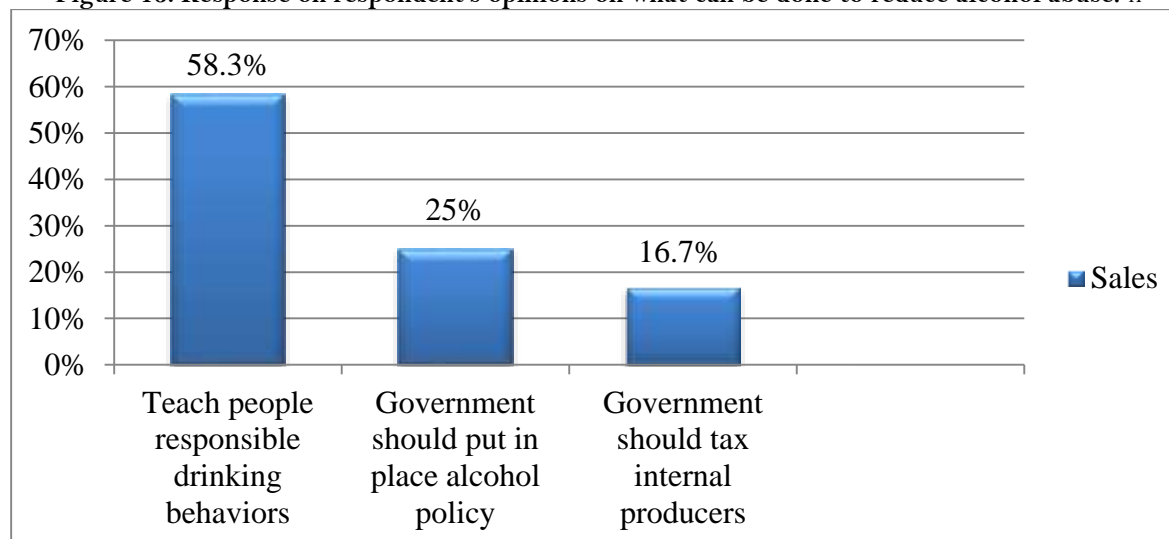

Most respondents 70(58.3%) proposed that people should be taught on responsible drinking behaviors while least 20(16.7%) proposed that government should tax internal producers.

Figure 17: Response on respondent's opinions on time to start drinking alcohol.
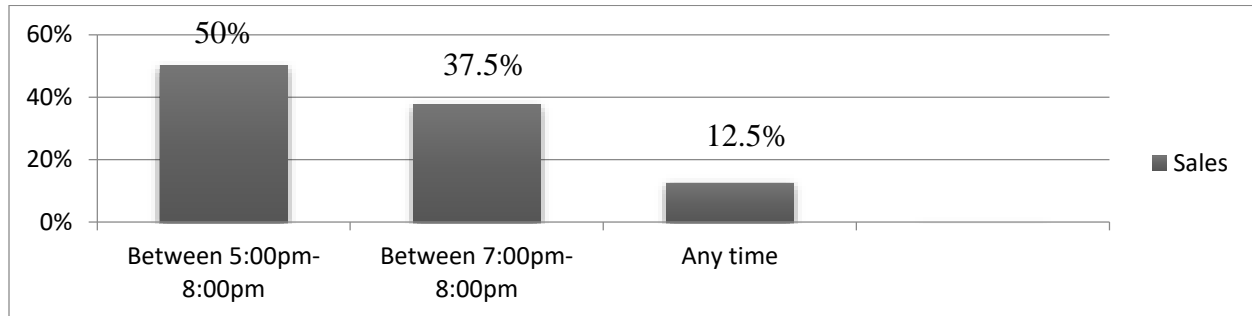
Majority of respondents 60(50%) proposed drinking should start at between 5:00pm to 8:00pm while least 15(12.5%) proposed that drinking should begin any time.

Figure 18: Response on respondent's opinion on time to stop drinking alcohol.
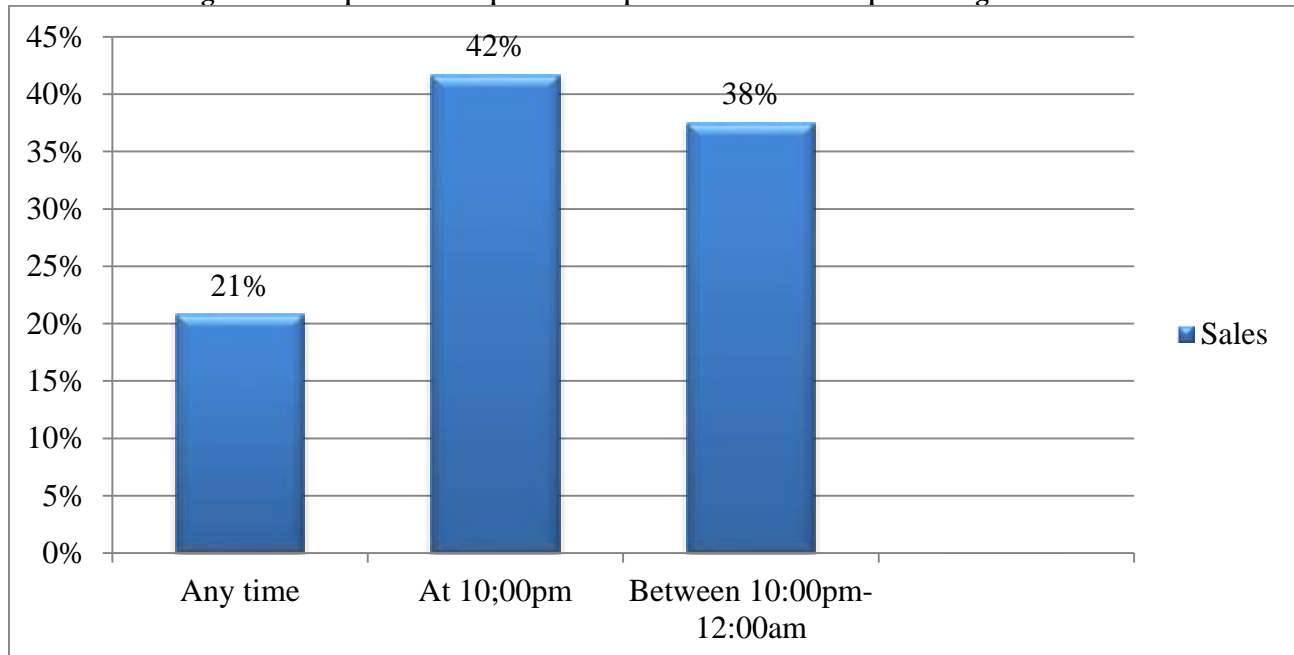
Majority of respondents 50(41.7%) proposed drinking should stop between 10:00pm-12:00 mid night and least 25(20.8%) proposed drinking should stop any time.

**Figure 19: Response on respondent's opinion on legal age limit to start drinking alcohol. n = 120**
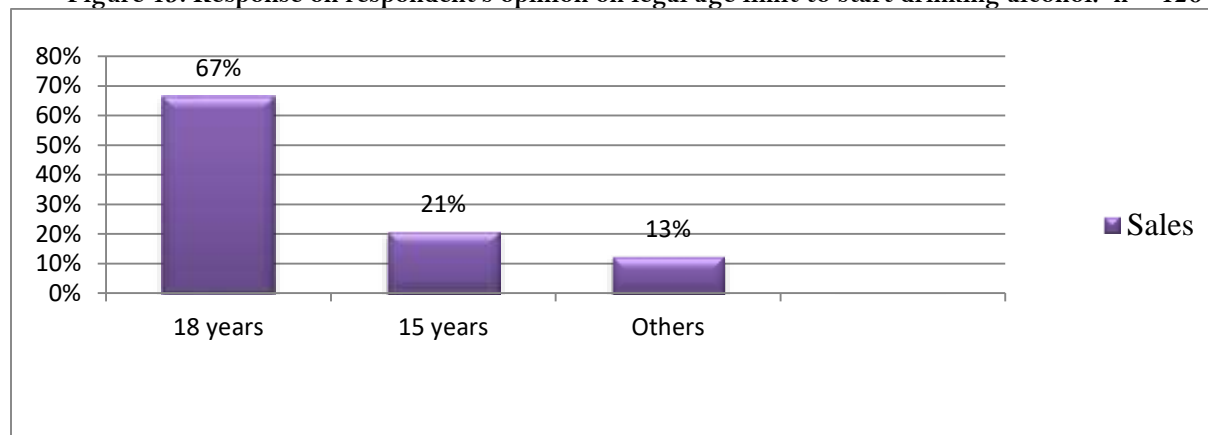
Most respondents 80(66.7%) proposed that the legal age limit to start drinking alcohol should be 18 years and least 15(12.5%) proposed others like according to sex and being in school.

Audit
65% of the respondents scored 8 and above upon AUDIT analysis indicating that there's association with harmful or hazardous drinking whereas 35% scored 13 and above indicating alcohol dependence.

Fig: 20. Audit response. n=95
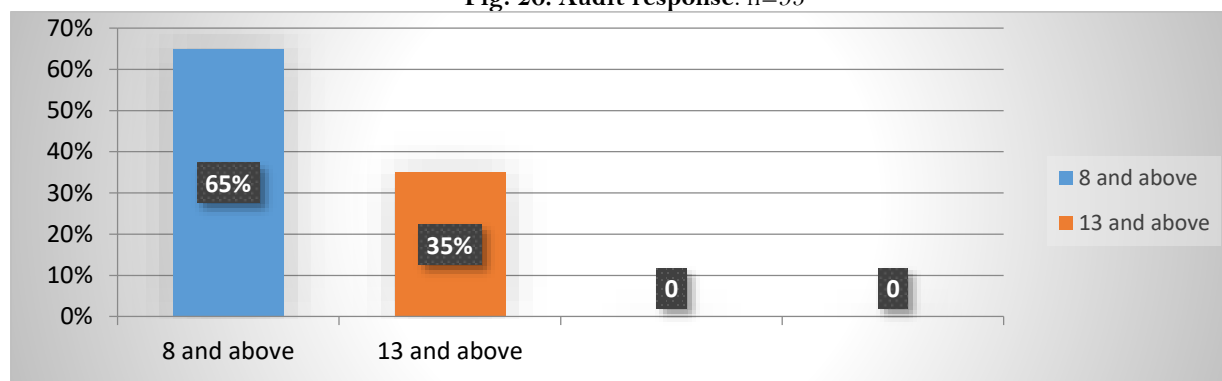
DISCUSSION
A descriptive cross-sectional study was conducted on 120 respondents for one week from15th to 21st October 2022. It was done to determine the factors associated with alcohol abuse and its effects on KIU medical students, however only 95 respondents where abusing alcohol and 25 were not.

Demographic data
This study has found out that the majority of respondents 37.5% were in the age range 21-23 years while least 10% were in the age range of (18-20) years which is in line with the research that was done which stated that alcohol consumption increases with age (NSDUH, 2013). Majority of respondents 62.5% were male and least 37.5% were females. The dominant tribe 29.2% were baganda because they are the ethnic group there and least 12.5% being itesot. Majority of respondents 37.5% were Catholics and least 1.7% being Muslim. 75% were single and least percentage, 3% divorced. This could be due to Promiscuity nature of student. Majority of them, 54.2% were others like students, house wives and least, 8.3% being peasant farmers. Most respondents 37.5% were in BMS 3.1-3.2 and least, 11.7% being in BMS 4.1-4.2.

Characteristic of respondents:
79.2% of respondents were taking alcohol and least 20.8% were not. 50.53% were drinking because they got friends, few 10.53% were drinking because they got a wife or husband. This might be because friends tend to kill boredom and give company as was also found by [15], also cited in the research by Bran [16], which stated that youth are more likely to increase their frequency and levels of substance use with that of their peers while others just drink to

relieve stress. Most respondents 54.7% started drinking alcohol before 18 years and least started above 18 years. This is in line with the research which stated that women and men who brew alcohol introduce children as young as 8years to drinking alcohol [17-21]. It is true that mothers ask these children to sell for them alcohol so in the process they start testing it and later become used. Most respondents 40% were taking 4-5 bottles of alcohol per sitting and least 9.5% more than 5 bottles. 42.1% of the respondents were spending half of what they earn per day on alcohol and least percentage, 24.2% spent little. Every day payment that they always receive half of it is taken to alcohol and little is left for upkeep. 50.5% of them would get their alcohol from small bars while least, 12.7% from individual brewer. Youth are always attracted to places where there is music and friends that's why they prefer small bars as drinking places [18-21]. Most respondents 42.1% reported others like friends, spouses drink alcohol while least 10.5% said their mothers. These men say they forget their problems after taking alcohol especially when with friends. Higher percentages 63.2% were taking alcohol in the evening, 21% any time of the day and least 15% very early in the morning. Most students tend to take alcohol in evening when they've finished lectures and most of them feel stressed. High number of them 31.6% was returning home from drinking places between 7:00pm-12:00am, 12.6% were returning before 12:00pm. 7:00pm-12:00am is a more convenient time for students to return home since they'll have to get ready for the following days lectures and programs.

Factors associated with alcohol abuse

Higher percentages 63.2% were influenced to drink alcohol with social factor carrying the highest percentage 73.7%, environmental factors carrying 15.8% and economic factors caring the least 10.5%.

Social factors:

Stress, 47% was the major cause of alcohol abuse among medical students at KIU. Academic stress like retakes, failure, exams, the busy lecture schedules and poor coping skills to academic demands contributing most.Peer pressure, 42% was the second common cause of alcohol abuse among medical students at KIU. The need to belong to a social group, to feel needed cause most of the students to conform to the groups' norms and thus end up abusing alcohol with time. Social norms, 11% was one of the least social factors contributing to alcohol abuse. Students usually are occupied with academic programs which make them have less time for ceremonies, parties and thus social norms contributing less.

Environmental factors:

The availability of alcohol near the campus and hostel settings contributed highly (47%) to KIU medical student alcohol abuse. The proximity of the alcohol outlet to the students provided easy access and thus abuse of alcohol. Persuasive advertisements and marketing on bill boards, radios, TV station among others contributed 37% of alcohol abuse among the students. Local breweries at home was the least (16%) environmental cause of alcohol abuse among the students. This could be due to the fact that medical students spend most of their time at school than at home.

Economic factors:

Others factors like having no family to cater for, sustained money supply from families contributed 47% of the cause of alcohol abuse whereas unemployment being the least contributing factor (11%). Students get money from their family members, relatives inform of pocket money and upkeep therefore they tend to have no sense of responsibility thus spending anyhow.

EFFECTS OF ALCOHOL ABUSE ON THE YOUTH

Majority of them 63.2% were affected by alcohol abuse while least 36.8% were not. This could be due to ignorance on responsible drinking. Most respondents 33.3% reported poor performance at school since most of the time during the day they can be having hang over from alcohol thus failing to concentrate in class. However least, 8.3% of the students reported to have contracted STDs like syphilis, gonorrhea, HIV among others since most of them engage in sexual activity without protective measures.

Respondents opinion on alcohol abuse

This involved both the alcohol abusers and those who don't abuse alcohol. 58.3% of the respondents suggested that people be taught responsible drinking behavior whereas least, 16.7% suggested that the government should tax internal producers of alcohol. 50% said drinking should start between 5:00pm-8:00pm while others, 12.5% said drinking can start anytime. 41.7% said the stoppage of alcohol intake hould be between 10:00pm-12:00am while 20.8% said anytime. 66.7% were of the view that legal age limit to start drinking should be 18 years whereas 12.5% were of the view that to start alcohol intake should be dependent on one sex and academic status.

Audit response

This involved those who use alcohol where 65% scored 8 and above implying that 65% were involved in harmful and hazardous use of alcohol whereas 35% scored 13 and above implying 35% were likely to be alcohol dependent.

Conclusion of the study findings

From the study findings,20.8% of the students were not taking alcohol, 79.2% were drinking alcohol, of the 79.2%, 65% were drinking alcohol harmfully and hazardously while 35% were alcohol dependent. The major contributing factor to alcohol abuse among KIU-WC medical students was social environmental which included stress, peer pressure and social norms. The second contributing factor being environmental like availability, persuasive adverts and local breweries and economic factors like unemployment, loss of job, high income status being the least contributing factors. The effects of alcohol abuse were poor performance at school, binge drinking, injuries and risky sexual behaviors.

RECOMMENDATIONS

Through the university administrators, MOH, and the government, students should be further educated and sensitized through health talks, radios, TV channels and seminars about the short and long term effects alcohol abuse and responsible alcohol intake. The government should also put and strengthen strict alcohol policy that will limit the age, level and time of drinking alcohol.

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