RELATIONSHIP BETWEEN DEMOGRAPHIC FACTORS AND LIFESTYLES OF THE PEOPLE OF KADUNA STATE

By

SHEHU, RAHEEM ADARAMAJA
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DECLARATION

I hereby declare that this dissertation for the award of doctor of philosophy in Health Education has been written by me and it is a record of my own research work. It has never been submitted elsewhere for the award of any higher degree or diploma. All sources of publications and other related studies cited in this research have been duly acknowledged through references.

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SHEHU, R.A **Date**
(Researcher)

CERTIFICATION

This dissertation titled "RELATIONSHIP BETWEEN DEMOGRAPHIC FACTORS AND LIFESTYLES OF THE PEOPLE OF KADUNA STATE" meets the regulations governing the award of the degree of Doctor of Philosophy (Ph.D) in Health Education of Ahmadu Bello University, Zaria, and is approved for its contributions to knowledge and literary presentation.

---------- ----------
Dr (Mrs.) C.O. Adegbite Date
Chairman, Supervisory Committee

---------- ----------
Prof. K. Venkateswarlu Date
Member, Supervisory Committee

---------- ----------
Dr. J.A. Gwani Date
Head of Department

---------- ----------
Dean, Postgraduate School Date
Ahmadu Bello University, Zaria.

DEDICATION

To the Almighty Allah for His grace, Mercy and guidance that He bestowed on me throughout the duration of this programme. It is also dedicated to my wife, Hadjia Taibat Raheem Adaramaja and my children Miss Silifat Bukola, Masters Sodeeq Kayode, Abubakar Olushola and Moh'd Nasrudeen Olanrewaju Adaramaja; who shared with me the agonies and stress of both planned and unplanned journeys away from the family during the course of my study.

Finally, the dissertation is dedicated to my father Alhaji Shehu Amosa and my late mother, Madam Kehinde Awele Shehu. MAY HER GENTLE SOUL REST IN PERFECT PEACE (Amen).

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ABSTRACT

The study examined the relationship between demographic factors and lifestyles of the people of Kaduna State. The lifestyle factors of smoking, alcohol consumption, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour constitute the dependent variables. While the demographic characteristics of age, gender, location, socio-economic status, religion, marital and educational status constitute the independent variables. Ex-post facto research design with a 7 x 6 non-experimental factorial sub-design was used. The design afforded the researcher opportunity to juxtapose two or more independent variables in order to study their relationship on the dependent variables.

Stratified and cluster random sampling techniques were used to select samples for the study. A total of 1350 randomly selected respondents were used for the study. A questionnaire, which consists of 55 items on the practice of lifestyle factors, developed by the researcher and pilot tested was used for the study, using Goffman split-half model, a reliability analysis scale of 0.9181 was obtained.

The data collected were statistically analysed using appropriate descriptive and inferential statistics. All the three (3) main hypotheses and six (6) sub-hypotheses were subjected to appropriate statistical analysis. The following results among others shown that:

(1) Age of the respondents is significantly related to smoking and drug habits in Kaduna State.

(2) Socio-economic status is significantly related to alcoholic lifestyle, nutritional habits, drug habits and sexual behaviour of the respondents.

(3) Health problems suffered by the people of Kaduna State are significantly related to their lifestyles.

(4) Rural and urban people in Kaduna State are significantly different in their lifestyles.

Based on the findings of the study the following recommendations among others were made:

1. Since the lifestyle exhibited by an individual does not spring up in a day, health education of children and youths (especially adolescents) should be intensified in the primary and secondary schools in order to make them appreciate the adverse effects of alcohol, drug abuse, smoking, inactivity and indiscriminate sexual behaviour.
2. Kaduna state government should make provisions for more recreational facilities for the promotion and maintenance of positive lifestyles for the people of the state. The communities should also be encouraged to do the same.

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LIST OF ABBREVIATIONS

ANOVA	=	Analysis of variance
B.K.T.	=	Burukutu (Locally Brewed alcohol)
E.U.	=	European Union
F.M.O.H	=	Federal Ministry of Health
HIV/AIDS	=	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
KDSG	=	Kaduna State Government
LEE	=	Low Energy Expenditure
L.G.A.	=	Local Government Area
MAMSER	=	Mass Mobilization for Social Justice and Economic Reliance
NDLEA	=	National Drugs Law Enforcement Agency
NPC	=	National Population Commission
NP+LSD	=	No Participation in Activity and Long Time Sitting Down
P.A	=	Per Annum
S.E.S	=	Socio –Economic Status
SPSS	=	Statistical Package for Social Science
SSP	=	Statix Statistical Package
U.S	=	United States.
WHO	=	World Health Organization.

DEFINITION OF TERMS

The following terms used in this study, are defined to avoid confusion, eliminate inconsistency and enhance understanding of the information presented:

Demographic characteristics: These are the independent variables, namely age, gender, marital status, educational background, location, religious and socio-economic status, which to a large extent determine the individuals adoption of lifestyle factors of smoking, alcohol use, drug abuse, nutrition, inactivity and unsafe sexual practices (dependent variables).

Healthy lifestyle: This refers to the adoption of positive health behaviours of exercise, good diet, non-smoking, non-drinking of alcohol, avoidance of casual sex and drug abuse, which bring about healthy living. Healthy lifestyle help to prevent obesity, high blood pressure, diabetes, stress, spread of sexually transmitted disease including HIV / AIDS and early mortality.

Lifestyle: Lifestyle is the sum total of one's ways of life. Thus, the lifestyle of any society is reflected in their mode of dressing, dietary habits, culture, religions, language and participation in physical activity.

Lifestyle factors: These are the main behavioral factors of concern in this study, which consists of nutrition, physical inactivity, smoking, alcohol consumption, drug abuse and unsafe sexual practices; which are the causes of mortality and morbidity in both developed and developing countries of the world even in Nigeria.

Modifiable risk factors: These are factors found in the environment. They are man-made and are capable of affecting the health and well–being of the individual. They are subject to change from time to time. This include smoking, alcohol consumption, drug abuse and poor nutritional habits.

Mortality: This refers to death rates directly or indirectly resulting from, indulgence in lifestyle risk factors of smoking, alcohol, drug abuse, malnutrition, inactivity and unsafe sexual practices/behaviour.

Non-modifiable risk factors: These are genetic or biological factors from parents to the offspring which can be influence by environmental factors and not subject to modification. They are hereditary and essentially remain the same with the individual, this, dictate the health status, as well as the magnitude and pattern of disability.

Sedentary: This refers to those individual who do not participate in any physical activity during their leisure time and even at work, and in addition spent long time sitting down (No Participation in activity and Long time Sitting Down – NP+LSD).

Unhealthy lifestyle: This implies the adoption and development of negative health behaviour of excessive eating or poor dietary habit, lack of exercise or sedentary, drugs abuse, smoking, casual sex and heavy use of alcohol. They are those habits that are scientifically proven to be harmful to one's health, i.e. they have direct and indirect consequences on the health and well being of the individual. For example excessive eating or loss of appetite may lead to problems of malnutrition.

CHAPTER ONE

INTRODUCTION

1.1 Background To The Study

Lifestyles are patterns of behavioural choices made from the alternative that are available to people according to their socio-economic circumstances and to the ease with which they are able to choose certain ones over others. Lifestyles are the "behaviours of choice" which affect ones fitness and health status. Smoking, diet (both total energy and food type) and alcohol consumption are particularly important in this context. Each of these variables has at least a weak influence upon both fitness and health status in their own right and can potentially confound epidemiological assessments based upon either occupation or patterns of leisure activity.

The individual lifestyles or health habits and behaviours constitute what he does and what he fails to do, ranging from smoking, overeating, inactivity, alcoholism, drug abuse and participation in unprotected sexual relationship. The World Health Organisation (WHO, 1993) reported that there is a strong negative relationship between peoples mortality rates and lifestyle practices. This has serious negative consequences on the nations health status and survival. WHO, further highlighted conditions that promote unhealthy lifestyle practices by individual such as lack of adequate health knowledge, acquisition of misinformation about health matters and development of hazardous lifestyles.

The concept of lifestyle has been identified as a bridge between individual and his immediate environment, reference is then made to healthy and unhealthy lifestyles. An analysis is needed of why the individual adopts unhealthy behaviour as a reaction to

pressures in their daily lives (Lazarus, 1994). The individual adopts a healthy lifestyles by avoiding the risk of breakdown and illness with the help of various health potential variables. They can also be predisposed to unhealthy lifestyles when short – term reactions to stress, such as alcohol, drug abuse, smoking, inactivity, obesity or risk – taking become long term, firmly established patterns of behaviour.

The range of choices available to individual is a function of education, socialization, and financial and other materials resources. People make choices in the context of community norms, social and economic conditions. For people with higher incomes and education the degree of choice is much greater. However, this enhanced capacity does not mean that those who possess knowledge and resources always choose healthier behaviour. Consider Kuwait as an example. High rates of smoking, obesity, physical inactivity and cardio-vascular diseases suggest a culture that does not support healthy living, despite abundant economic resources (Breslow and Breslow, 1993).

Exercise, diet, smoking and alcohol consumption are behavioral factors that are commonly cited as major social determinants of health, especially in later life. A healthy lifestyle can help prevent, for example, weight gain, high blood pressure, diabetes, arthritis, stress and early mortality. The cumulative effects of unhealthy lifestyle begin to produce noticeable differences in the health of older persons who are physically inactive and /or were heavy smokers and consumers of alcohol versus those who were not. Some of the unhealthy lifestyles adopted by most people include excessive eating, lack of exercise, drugs taking, smoking and alcohol among others. Some of these behaviours might also have direct and indirect consequences on the health and well-being of the individual. For instance, excessive eating or loss of appetite may lead to problems of

malnutrition (obesity or undernutrition). Hyperactivity, excitability and restlessness resulting from drug taking may lead to accidents, alcoholism and smoking may lead to other social vices. Fleming (1986) observed that alcohol is used to relieve stress and help the individual to manage a crisis, but in reality, alcohol renders the distressed person less able to cope and prone to accident conditions. Alcohol consumption has been associated with hypertension and obesity in a number of epidemiological studies (Larbi, *et al,* 1983). The effect of alcohol has immediate consequences in terms of behavioral change for the individual and those around him or her. Judgment and coordination are likely to be impaired and reactions are slowed, rendering the person more vulnerable to accident.

Millions of peoples die every year from illnesses caused by environmental pollution, and millions more suffer chronic disabilities such as diminished physical strength and endurance, low intelligence and lack of alertness (WHO, 1993). Within the environment, the poor people suffer most because they have no choice but to face unsanitary living conditions, exposure to infectious organisms and toxic chemicals, and lack of health services. Health effects of exposure to hazardous wastes include cancer, danger to liver, kidney and eyes (WHO, 1998). The food an individual takes are more likely to have an important influence on the lifestyle of such individual than genetic factors, since genetic composition has essentially remained the same.

Lifestyle is generally considered a personal issue. However, lifestyles and social practices or ways of living adopted by individuals which reflect personal, group and socio-economic identities. Although lifestyle reflects individual identity, they are primarily a reflection of the norms and values of the group to which individuals belong.

As lifestyles reflect both individual choice and the norms and values of a particular group or community, promotion of healthy lifestyle should be directed to both the individual and the community. The focus should be more on the community to provide a favourable structural and social environment, which offers healthy alternatives.

In recent times, the terms "western lifestyle" or "modern lifestyle" have become popular. These refers to forms of consumerism, involving particular choice in dress and appearances, food, housing, automobiles, work habits, forms of leisure and other type of status – oriented behaviour.

Healthy lifestyle can be defined as collective patterns of health – related behaviour, based on choices made from available options. This suggests that health is related to choice of lifestyle. Demographic parameters such as age, education, socio-economic and martial status, and lifestyle factors such as smoking, drug abuse, exercise and alcohol consumption, are known predictors of health status. For example, amongst Nigerians adolescents, younger age has shown to be related to poorer mental health, whilst marriage has shown to be associated with better mental health (Asuni, *et al,* 1994). They further submitted that there is scientific evidence to show that pursing a healthy lifestyle can enhance health and life expectancy. Exercise, cessation of tobacco consumption, eating a high-fiber, low-fat diet controlling body weight, and leaning to cope with stress, reduce the risk of heart disease. Health problems associated with alcohol consumption include liver damage, cancers, pancreatitis, diabetes and epilepsy. Alcohol is also a significant factor in motor vehicle injuries and fatalities, falls, drowning and suicide. Tobacco smoking has been associated with diseases like cancers, stroke and thrombosis.

Technological advancement, gender, religion, socialization in relation to the use and abuse of drugs, smoking and alcoholism are some of the factors either within or outside the environment that influence the lifestyle of the people. A combination of socio-cultural, political and economic factors also influences an individual's participation in physical activity, together with his/her fitness and health status (Stephens and Craig, 1990).

World Health Organization, (1999) rated the Nigeria health care system as one of the worst five in the world. i.e. It placed Nigeria health care system in the 187th position out of 191 member countries of World Health Organization. The reasons advanced for this is that there is growing incidence of such non-communicable diseases like hypertension, coronary heart disease, diabetes, Cancer and stress related diseases because the population is living longer and the economically productive age group has changed its lifestyle and consumption pattern.

The 1989 nationwide survey of the non-communicable diseases revealed that 3.5 million of the population have mild hypertension, 1.2 million have moderate and 0.5 million have severe hypertension, the prevalence of hypertension, cardiovascular diseases, the obesity, diabetes and other health related problems due to unhealthy lifestyle is generally estimated at 8-10% for rural and 10-12% for urban areas. The proportion of smokers in the country was 9% and the prevalence of diabetes mellitus was 2.7% (Federal Ministry of Health: National Health Plan 1996-2010 Revised 1998). The report added that poor nutritional habit leading to prevalence of glucose-6-phosphate dehydrogenate has been estimated at 18% and 7% respectively for males and females.

Also, sexually transmitted diseases (STD) and HIV/AIDS due to indiscriminate sexual activities and substance abuse are constituting major public health problems.

This study therefore examined the relationship between demographic characteristics and lifestyles of the people of Kaduna State, with a view to understand the significant relationship they have on people's quality of life.

1.2 Statement Of The Problem

The Webster Third New International Dictionary (1966) views individual's lifestyle as a typical way of life, his attitudes and their expression in a self-consistent manner as developing from childhood. The conceptualizations of lifestyle include the degree of satisfaction of an individuals perceived psychophysiological needs (Dalkey, e*t al*, 1972); and the degree to which the environment is perceived as facilitating or retarding one's functioning capability (Pflaum, 1973). Of significance to both of these views on lifestyles is the role of perception, suggesting that assessment of life quality must include the interpretation of the individual or as Bain (1995) has pointed out "what you see and hear depends on who you are and where you are standing".

The problem of this study as observed, revealed that a lot of Nigerians seems to be practicing unhealthy lifestyles resulting in various health problems, which definitely have its toll on the lifespan of an individual. It was also observed that the practice of unhealthy lifestyles and health related problems cut across different demographic parameters of the people of this country. For instance, the National Health Policy, (1989) has revealed that the lifespan of an average Nigerians at birth is 50years. The Fourth National Development plan of 1981-1985, which put the life expectancy at birth in Nigeria to about 49.5years, corroborated this. Also, the World Health Organization,

(1998) reported that lifestyles are significantly related to lifespan of Americans. Recent happenings shows that most Nigerians do not attain the average life expectancy as identified in the National Health Policy and the Fourth National Development Plan of 1981-1985 due to unhealthy lifestyles.

The following research questions were formulated in order to find answers to the research problems.

1. What factors influence the adoption of lifestyle (s) by an individual?
2. What are the health problems associated with various forms of lifestyles adopted by the people of Kaduna State?
3. Are there any relationship between the environmental factors and lifestyles developed by the people?
4. What are the various lifestyle factors practice by the people of Kaduna State?
5. What influence do the demographic characteristics of the people of Kaduna State have on the adopted lifestyle factors?
6. Why does the individual adopt unhealthy behaviour as a reaction to pressures or frustrations in his daily live?

1.3 Basic Assumptions

This research study is based on the following assumptions:

1.3.1 The life span of an individual is determined by the types of lifestyle adopted by such individual.

1.3.2 An individual with high socio-economic status lives healthier lifestyle than the less privilege individuals.

1.3.3 The environment influenced the people's adoption of lifestyle.

1.3.4 Gender is an important determinant of lifestyle factors among the people of the Kaduna State.

1.3.5 Diseases and health-related problems resulting from poor lifestyles can be avoided by the development and adoption of healthy lifestyle.

1.3.6 Religious belief and doctrines influenced the people's adoption of lifestyle.

1.3.7 The Kaduna State Government of Nigeria is not responsive for the formulation of policies and strategies required, for the development and maintenance of positive lifestyles amongst her citizens, that is, through the provision of recreational facilities.

1.3.8 Problems of unhealthy lifestyles abound in the urban areas of Kaduna State, than in the rural areas.

1.4 Hypotheses

The following main and sub-hypotheses were generated for the purpose of this research.

Main hypothesis one

There is no significant relationship between demographic characteristics of people of Kaduna State and their lifestyles.

Sub-hypotheses

1. There is no significant difference between the adopted lifestyles and age groups of the respondents of Kaduna State.
2. There is no significant difference between the adopted lifestyles and gender of the respondents of Kaduna State.

3. There is no significant difference between the adopted lifestyles and educational status groups of the respondents of Kaduna State.
4. There is no significant difference between the adopted lifestyles and socio-economic status groups of the respondents of Kaduna State.
5. There is no significant difference between the adopted lifestyles and religious background / groups of the respondents of Kaduna State.
6. There is no significant different between the adopted lifestyles and marital status groups of the respondents of Kaduna.

Main hypothesis two

The health problems suffered by the people of Kaduna State does not significantly related to their adopted lifestyles.

Main hypothesis three

There is no significant difference in the lifestyles of urban and rural people of Kaduna State.

1.5 Purpose Of The Study

The purpose of this study was therefore to examine reasons why people adopts various types of lifestyles; assess the influence of age, gender, educational qualification, religion, socio-economic status and marital status on the adopted lifestyles: and effects of those lifestyles on the health of the individual, family and community health.

The following are the objectives of the study:

1. To determine the demographic factors of the study population. These include age, gender, religion, educational status, location, marital status and socio-economic status.

2. To determine the lifestyle factors mostly practice by the people of Kaduna State.

3. To find out the relationship between demographic factors and lifestyles of the people of Kaduna State.

4. To assess the health related problems associated with those lifestyle factors practice by the people of Kaduna State.

5. The study was also interested in examining the differences in the lifestyles of rural and urban people of Kaduna State.

1.6 Significance Of The Study

The outcome of the study is expected to contribute to public awareness on the needs for the adoption of positive lifestyle by the people. These would help to improve people's quality of life and also reduce the cost of health services and untimely death(s).

The study is also expected to make a great contribution towards providing information for the people on factors influencing the adoption of lifestyles (positive health behaviours), which may include avoidance of stressful situation, exercise, balanced diet, moderate sleep, moderate alcohol consumption, avoid smoking and avoidance of unprescribed drugs.

The result of the study is expected to reveal a number of health related problems associated with unhealthy lifestyles. This, according to Jenks (1993) and Agbaoso (1998), includes hypertension, cirrhosis of the liver, cardiovascular diseases, violence tendency or destructive behaviour and accidents. The result of the study would serve as a turning point for the parents, school and business administrators, members of the community and government on how to modify the behaviour of the individuals, especially the youths.

The study will also help the federal government to achieve the goals of National Policy on Education in producing healthy individuals who would build a healthy nation. This might help to reduces manpower wastages and promote good living habits that would enhanced healthy living (lifestyle).

The study is also expected to provide relevant information to employers of labour, Administrators, Government functionaries and parents on reasons why individuals adopts unhealthy lifestyles in reaction to pressures or frustrations in their daily lives which may be detrimental to such individuals and to the society. The knowledge would acquaint the business managers and employers of labour to provide preventive measures with the aim of averting the consequences of such unhealthy behaviours or lifestyles.

1.7 Delimitation Of The Study

The study would be delimited to the following:

- All the Seven (7) identified independent variables (demographic characteristics) that influence or determine the lifestyles of Nigerians: Age, gender, marital status, religion, educational background, location and socio-economic status.
- Lifestyle factors like smoking, heavy use of alcohol, sedentary or inactivity, nutrition (excessive eating), drug abuse and indiscriminate sexual practices (dependent variables).
- All respondents of age 16 years and above, male and female, and of sound mind who are citizens of Nigeria, and resident in Kaduna State as at the time of this study.
- Respondents used for the research were drawn from the three (3) senatorial districts that made up of Kaduna State (Kaduna zone 1, Kaduna zone 2 and

Kaduna zone 3), of which two urban areas and two rural areas each were randomly selected from each zones of the state (Kaduna State).

- The research was also delimited to the consequences of unhealthy lifestyle, as well as differences in the lifestyles of rural and urban people of Kaduna State.

1.8 Limitation Of The Study

This study is likely to have the following limitations, which would be carefully considered while interpreting the results:

Since the study would be using questionnaire as its main instrument for data collection. The researcher may not, however, be available to provide clarification on statements that are not clear to the respondents (where need be). However, efforts will be made to simplify the questionnaire.

The result is based on the perception of the respondents. Because of diversity in languages that exist in the state, the perception of the respondents shall be assessed through the use of interpreters.

As one of the research work on lifestyle of Nigerians in this country, there is a paucity of reference materials in terms of related literature on past relevant works by Nigerian authors.

However, the above limitations will be given adequate consideration while collecting data, and in the analysis and interpretation of the results.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

The purpose of this study was to examine the relationship between demographic factors and lifestyles of the people of Kaduna State. This chapter is on the review of related literature available in textbooks and reputable journals both national and international under the following sub – headings.

2.2 The concept of lifestyle
2.3 Psychological benefits of Active /healthy lifestyle
2.4 Lifestyle factors
2.4.1 Physical inactivity / Sedentary.
2.4.2 Nutrition (Excessive eating).
2.4.3 Smoking
2.4.4 Heavy alcohol use
2.4.5 Drug abuse and misuse
2.4.6 Unsafe sexual practices
2.5 Determinants of lifestyle factors
2.5.1 Residence as a determinant factor
2.5.2 Educational background as a determinant factor
2.5.3 Gender as a determinant factor
2.5.4 Social-Economic Status as a determinant factor
2.5.5 Martial status as a determinant factor
2.5.6 Religion background as a determinant factor
2.5.7 Age as a determinant factor
2.6 Consequences of unhealthy lifestyle(s)
2.7 The role of Government and Community in the promotion and maintenance of healthy lifestyle(s).
2.8 Summary

2.2 The Concept Of Lifestyle

The concept of lifestyle is a useful one when describing and analyzing particular group behaviour. It recognizes the integrated and holistic nature of man's functioning capacity. It considers the relative priority and the unique configuration of values, activities and their interrelationships. It acknowledges the dominance of one interest, which influenced all other activity including social relationships. All of us, consciously or unconsciously, have our own lifestyles, which fit within the general framework of a larger lifestyle. For some, work is the dominant element of their existence; others base their hopes and future in family relationship.

Lifestyle is based upon such factors as individual's personality, cultural heritage, family mode of living, education, income and occupation. A person's lifestyle is a pattern of such individual's behaviours; knowing how an individual with identified lifestyles behaves in one areas of his life provides a strong indication of what he might do in other segments of his life (Burada, 1994).

Harris and Gurin (1985) described lifestyles as a group phenomenon, influenced by a person's participation in various social groups pervades many aspects of life and spills over into many areas of social contact, e.g. work, play, school, family, church, mosque, e.t.c. Lifestyle is seen as the sum total of one's way of life. It conforms to certain personal criteria, which relates to one's basic life security, develops human abilities, and is conducive to the cultivation and humanization of life. Lifestyle may be viewed as one of the ways of understanding living patterns as a unified expression for various sub-cultural, interest group, sexual, family and ethnic ways of life that would make possible the maximum harmony of individual and social interests. It could be viewed as an

integration of the development of human needs and the way of satisfying them. The concept of lifestyles provides a useful understanding of the leisure behaviour of people which may include smoking, alcoholism, excessive eating and sedentary or physical inactive lifestyle.

Lifestyles are neither good nor bad. Society judges their worth and potentials according to their support and maintenance of the social system. Because of this, some lifestyles are seen as highly desirable and virtuous while others are considered destructive or pathological (Douglas, 1978). Alcoholism is in the latter category, for the alcoholic tends to neglect his responsibility to others. He forces society to take care of him, to tolerate his self-destructive behaviour, and to restrict him from activities, which might be of potential harm to others.

Lifestyle is a very broad concept which encompassing a number of human activities. Burada (1994) described lifestyle as patterns of behavioural choices made from the alternatives that are available to people according to their socio-economic circumstances and to the ease to which they are able to choose certain ones over others. Lifestyle patterns developed over decades undergo major modifications, sometime with additional physical, social, financial and environmental difficulties. Evidence shows that people are more likely to have a number of health problems following a series of stressful life events resulting from the difficulties identified above (Franks, 1994).

Agbaoso (1998) and Jenks (1993) reported that the lifestyle of any country or society attests to their way of life, or mode of life or culture of that particular society or people. Thus, the lifestyle of any society is reflected in the mode of behaviour, habits, diet, dressing, language etc of its people. Within the confirms of developed countries,

social theory of lifestyle has been understood as ways of life of the people, their beliefs, rituals and customs. It is seen as what people collectively; "do" in their different ways, in different places and different times (Jenks 1993, Donald 1991; and Agbaoso, 1998).

Lifestyles are ways of living based on identifiable patterns of behaviour which are determined by interplay between an individuals personal characteristics, social interactions, and socio-economic and environmental living conditions. The health and well-being of a community are affected by the social milieu within which people live, thus shifting the focus of our interventions from individuals to the community as a whole. Life conditions, whether social, economic, environmental or biological (genetic), dictate health status, as well as the magnitude and patterns of disability, morbidity and mortality. An epidemiological shift is being witnessed recently due to changes in life conditions, creating a burden of communicable and non- communicable diseases in many countries of the World (WHO, 1998).

Advancement in science and technology in many countries have caused rapid changes in popular lifestyles, which has led to increase in non-communicable diseases. The burden of behaviour-related diseases is expected to be even greater in the future. Urbanization, aging, populations and poverty, for example, aggravate the burden of such diseases in Nigeria.

Lifestyle habits are assumed to be characteristics of a person's way of living, which to the individual has some psychological benefits to him/her, though this habits may change over time (Haveman-Nies, *et al,* 2002). Changes in lifestyle habits probably influenced relations with mortality; at worst, it is possible that

the greatest part of a mortality risk is determined not by baseline lifestyle habits but by former lifestyle habits.

It is true that lifestyle behaviour can influence an individual's state of health, and individual's state of health can influence their lifestyle choice. Individuals with healthy lifestyle behaviour tend to live longer than others, and that individuals with unhealthy lifestyle behaviour tend to die sooner than others (Branch 1985; Breslow and Breslow 1993; Manton, *et al,* 1991; and Rogers 1995). There are important linkages between lifestyle choice, determinants, and health. The causes of health and diseases are a complex interplay between individuals, social structural factors (i.e, socio-economic status, educational attainment and occupation), cultural factors (i.e, health beliefs of various ethnic communities and peer subcultures), and exposures to particular risk and protective factors. Overlaying these factors are persuasive pressures from the consumer market place and information from diverse sources that may impinge on perceptions of health and risk.

Lifestyle choice is linked to social and environmental determinants of health, which is influenced by human physiology (e.g. the desire for pleasure). The issue of lifestyle choice or concept is a growing societal challenge; there is a broad range of choices of commodities and broad access to immediate pleasurable activities with potentially long term negative outcomes for health (e.g. rich food, drugs, unsafe sex, smoking and alcohol consumption). Tiger (1992) suggests that human beings are motivated to seek pleasure and avoid pain. For instance, the human body finds sweet and fatty foods tasty, becomes easily addicted to certain chemicals (drugs and alcohol), and seeks opportunities to rest. Many healthy behaviors or lifestyles appear to require giving

up pleasure. Again, (Stewart, 1996) observed that people who live in conditions of poverty and / or insecurity are more likely to engage in risk behaviour, such as smoking and unhealthy food choices. The pleasure provided by these activities often serves as a distraction and respite from difficult life situations.

Lifestyle is regarded as the whole way of life of people. It includes their mode of dressing, food habits, customs, religion and language (Agbaoso, 1998). This behaviour and habits of the people have some effect on their health. The adoption and development of positive health behaviours and habits brings about healthy lifestyle, while the adoption and development of negative health behaviours and habits constitute unhealthy lifestyles.

Often people make choices that satisfy multiple and competing personal and family needs. Lifestyle choices are frequently made for purely personal health reason. For example coal miners are acutely aware of the serious health risks of their occupation, but may choose (because of limited education and few available occupational alternatives) to work underground to provide for their families. Also, people with substance abuse often choose to smoke (another substance addiction) as a way of coping with the stress of withdrawal. Given limited resources, smoking may be the only coping mechanism available to them. The case(s) of occupational hazards and substance addiction cited above are examples of unhealthy lifestyle choices.

People maintain lifestyle, which they know, is unhealthy because they meet certain immediate needs. In order to address “unhealthy” lifestyle choices (those that have been scientifically proven to be harmful to one’s health), factors in the broader context of people’s lives must be understood and changed to permit healthier choices.

Personality traits may also influence lifestyle. Personality traits such as optimism and self-efficiency contribute to healthy living. For example, research has shown that people who are optimistic live longer (Mayoclinic, 1999). If individuals do not think well of themselves, or do not feel that their efforts will make a difference, why engage in a healthy lifestyle? The concept of helplessness demonstrates this linkage. "Learned helplessness" suggests that people can be socialized to believed that their efforts will not pay off; that they cannot have any measure of control over their environment (Bandura, 1998; Lazarus and Folkman 1995). If people believe they cannot exercise control over various aspect of their lives, they are unlikely to attempt changes to control their health, or the health of their family or community.

2.3 Psychological Benefits Of Active/Healthy Lifestyle

A multitude of psychological benefits are associated with an active lifestyle (International Society of Sport Psychology 1992; Morgan and Goldson, 1987; Singer, *et al,*, 1993 and Berger, 1996). Accumulating evidences suggests that for members of the general population, planned and structured physical activity is associated with psychological benefits in four broad areas: enhance mood, stress reduction, a more positive self-concept and higher quality of life.

The psychological benefits of healthy lifestyle through active participation in exercise may even be more pronounced in special populations such as individuals who are clinically depressed or anxious, coronary heart disease patients, the elderly and those who have specific diseases. As reported in 1994 Academy of kinesiology and physical education meetings, the course of many illnesses can be changed with the avoidance of

lifestyle factors like smoking, inactivity, unsafe sex, excessive eating and alcohol consumption. These illnesses include coronary heart disease, hypertension, end-stage renal disease, osteoporosis, type II diabetes mellitus, and cancers of the lung, breast and colon, and sexually transmitted diseases including HIV/AIDS (Bain, 1995; Leon and Norstrom, 1995; Shephard, 1995; Spirduso, 1995 and Wood 1994).

Also from a utilitarian approach of decreasing health care costs, it is important for most of us to be physically active. Because of broad-based benefits of exercise, researchers as well as practitioners are searching for ways to increase the number of people who pursue active lifestyles.

Though exercise, good diet, safe sex, avoidance of smoking and alcoholic consumption is associated with healthy lifestyles, but only a small proportion of the population accrue these benefits. Obviously, knowledge (that a particular behaviour has other good or deleterious influences on our health) does not consistently affect our behaviour. Most individuals, for example, are aware that smoking is unhealthy, but many people smoke. A diet high in fat is unhealthy, yet we eat French fries and ice cream. It seems that personal enjoyment, emotional reactions, habit, and convenience are more important determinants of our behaviour than is knowledge about benefits and/or the health consequences.

The promotion and maintenance of healthy lifestyle is the responsibility of an individual, community and the government. To this end, Borg and Kristensen, (2000) suggested the following tips on how to maintain a healthy and active lifestyle.

- Please don't smoke, drink alcohol or use street drugs;
- Minimize prescription drugs;
- Exercise regularly;

- Avoid processed food;
- Avoid sugary drinks and candy;
- Avoid people or situations that consistently bother you;
- Drink plenty of clean water;
- Spend time outdoors regularly;
- Eat small nutritious meals at regular intervals;
- Go to bed and get up at the same time daily;
- Get enough rest and;
- Laugh, play, sing, dance and do something funny every day (Borg and Kristensen, 2000).

2.4 Lifestyle Factors

The major cause of mortality in developed and developing countries of the world, are diseases in which lifestyle plays an important role. The main behavioural or lifestyle factors of concern, namely nutrition, physical activity, smoking, alcohol consumption, drug abuse and misuse, and unsafe sexual practice, are modifiable and are a major focus of national and international health improvement strategies. Changing these factors in the direction of a healthier lifestyle patterns could postpone the age of onset of permanent morbidity, disability and death, and could have a major effect on quality of life (Bush, *et al,* 1990; Verbrugge and Jette, 1994; Haveman-Nies ***et al,*** 2002).

For example, lifestyle factors such as physical activity, dietary habits, smoking and alcohol intake are related to relative weight (Seidell and Flegal, 1997; Lissner and Heitman, 1995; Molarius, *et al*, 1997; and Tremblay, 1999). However, differences often exist between socio-economic groups in such a way that the most privileged often have healthier lifestyle. Because these behavioural factors are potentially modifiable, it is of interest to know whether and to what extent the association between socio-economic status and obesity can be explained by these factors. Molarius

(2003) reported that many lifestyle factors were related to obesity and socio-economic status, only a part of (18-29%) of the association between educational level and obesity could be explained by the measured of lifestyle factors. One possible explanation for the fact that lifestyle factors only partly explain the socio-economic differences in obesity prevalence is that higher socio-economic status subjects may to a greater extent deliberately control their weight.

So far, many studies have focused on the relationship between one-lifestyle factor and survival throughout life. These studies point to the importance of healthy lifestyle behaviours – adhering to a high quality diet, not smoking, and being physically active, for achieving long – term health gains (Havemen-Nies ***et al,*** 2002). This study investigates the relationship between demographic characteristics and modifiable and non-modifiable lifestyle factors and their effects, separately and combine on the lifestyles of Nigerians. The factors under investigation are:

- Physical inactivity (sedentary work);
- Nutrition (Excessive eating);
- Smoking;
- Heavy alcohol use;
- Drug taking (Abuse and misuse);
- Unsafe sexual practices.

2.4.1 Physical Inactivity (Sedentary Lifestyle)

A regular level of physical activity has great potential in improving health and well-being. Health gains from physical activity include enhance mood and self – esteem, improved physical appearance and a substantial reduction of several cancers, premature mortality, obesity, high blood pressure, cardiovascular diseases, non-insulin-dependent diabetes and osteoporosis. Physical inactivity or sedentary lifestyle help to develop one or

all of the above mentioned diseases. Doing more physical activity would probably reduce the risk of diseases also by controlling other risk factors like smoking or dietary fat intake. Of particular interest is the role of physical activity in reducing weight and body fat and the possible subsequent effect on cancer risk reduction. For example, being overweight or obese is associated with an increased risk of hormone-related cancers. Losing weight and body fat reduced circulating levels of estrogen and progesterone, hormones related to breast and colorectal cancer respectively. David (2002) reported a high risk of non-fatal Cardiac Diseases for women in the sedentary control group in comparison to the active group. He added that, regular physical activity has significant benefits for our health and well-being. He suggested that, 30 minutes of moderate activity each day can improve health and reduce the risk of developing certain conditions or diseases. According to him, these 30 minutes can be accumulated in shorter bouts of 10 minutes or more during the course of the day, for example, three 10 minute walks. Moderate activity is good and energetic, but should be at a level at which conversation can be maintained. Physical activity aids cardiovascular and respiratory functions, slows the loss of muscular strength, increase bone mass, aids digestion and bowel functions, promotes sound sleep, and prevents depression.

Bain (1995), Crespo et al (1999) and David (2002) were of the opinion that improving physical fitness or exercise is like quitting smoking from a health stand point, they were unanimous on the importance of participation in physical activity, which include:

- Reduces blood pressure;
- Prevents heart disease, diabetes, some cancers and osteoporosis;

- Fight depression and anxiety;
- Controls obesity, which is linked to premature mortality;
- Boosts the immune system;
- Feel more energetic;
- Have a healthier blood cholesterol level;
- Recover better from a heart attack (should this have occurred) and;
- Feel more confident, happy, relaxed and able to sleep better (Bain 1995; Crespo et al 1999; and David, 2002).

The amount of physical activity needed to maintain a healthy weight, lose weight, and promote good health, including reducing cancer risk, is recommended by various organisations in the United States, to be 30 minutes of moderate physical activity on most days of the week. This level of activity might include walking. Jogging, running, gardening and yard work, or swimming (U.S. Department of Health and Human Services, 1996; Pereira, 1997, Evenson, *et al*, 2002).

The prevalence of obesity continues to increase in Nigeria. The factors that appear to be most responsible are sedentary behaviour patterns and excessive fat in the diet. There is a scarcity of international epidemiological studies assessing the prevalence of sedentary lifestyles (Jose, *et al*, 2003). The definition of sedentary lifestyle is not a simple task. Up to now, the approach to the problem of assessing the prevalence of sedentary lifestyles in populations has faced two important barriers. The first is the lack of a clear and universal definition of a sedentary lifestyle. Some authors (Jose, *et al* 2003) have tried to determined the prevalence of sedentary lifestyles analyzing the numbers of hours that individual spend sitting down in a typical day, or the number of hours expended

walking or in other specific physical activities. A second barrier is that previous studies have not assessed geographical variations across large areas. Bernstein, *et al,* (1999) reported in a cross-sectional study on the prevalence of "Sedentary" in Geneva (Switzerland), and also proposed a new definition for "Sedentary", using a measure of Low – Energy Expenditure (LEE). Another definition of sedentary lifestyle referred to those individuals who did not practice any physical activity during their leisure time and in addition spent long time sitting down (No participation in activities and long time sitting down – NP + LSD). However, attempts to encourage obese individuals to adopt active lifestyle and to maintain low-fat eating have not been very successful in producing significant and long-lasting weight loss. An understanding of the motivational factors that lead to imprudent eating and inactivity may help health and physical education professionals to be more effective in their work with obese individuals.

Motivating individuals to exercise regularly is difficult. Adherence to supervised exercise programs has been reviewed (Dishman and Sallis, 1994; John and Goodrick, 1995). Adherence ranges from 50% to 80% in the first 6 months and then drops to about 50% at the end of one year. Program factors related to drop-out include inconvenience, cost, exercise intensity, lack of opportunity for social interaction and support, inadequate feedback, poor leadership and length of sessions. Relapse data for exercise are limited to reported reasons for drop out, which include lack of time, laziness/tiredness, health problems, perception that physical activity is bored, and perception that physical activity is not needed or the occupation / normal activities provide enough activity (Goodrick, *et al*, 1984; Harris and Gurin, 1985). The perception that physical activity is not needed or that one's daily occupation provide enough, follows the wrong assumption that sedentary

behaviours reduces cardiovascular fitness, leading to reduced felling of energy, making exercise less likely.

Considerable evidence has grown supporting an association between regular physical activity and a decreased risk of premature death and cardiovascular disease (Dishman and Sallis, 1994).

2.4. 2 Nutrition (Excessive Eating)

Nutrition is the entire process by which our bodies absorb and make use of foods; nutrients are those substances in foods that sustain our bodies. Nutrients serve three basic functions: (1) Building and repairing the body tissues; (2) regulating body processes and (3) supplying energy.

Food choice is an important determinant for health. Poor or unbalanced diets as in the case of excessive eating – a lifestyle factor, are risk factors for several chronic diseases. A diet characterized by a high proportion of high-fat dairy foods, fatty containing sugars and by a low proportion of vegetables, fruit, cereals and legumes poses an increased risk of non-communicable diseases, such as cardiovascular diseases and cancer. Controversy continues over cholesterol and how much and what kind of fat to eat. Gerber, *et al,* (2003) reported that diets high in fibre, fruits and vegetables as well as bran cereals, and whole grains help to prevent cancer. The choice of good nutrition is not important only in preventing health problems, but it is a critical part of managing diseases among those who are already infected or sick. The effect of under nutrition on tuberculosis, HIV/AIDS, Cancer and other chronically ill patients is that it increases the added effects of wasting (or losing weight), and consequently, a further

suppression of the immune system. Most illnesses cause a loss of appetite, and medication that need to be taken may cause nausea. Poor food intake reduces the level of nutrients in the body thereby exposing the patients to nutritional health related problems.

Overweight and obesity pose major public health challenges. Excess weight can substantially rise the risk of developing a number of diseases and conditions, including high blood pressure, high blood cholesterol concentration, diabetes mellitus, coronary heart disease, stroke and cancer (Pi-sunyer, 1998). According to him, United States of America spent $99.2 billions in 1995 on medical cost and disability attributable to obesity alone. According to data from the Third National Health and Nutrition Examination survey (1988 – 1994), more than 100 million American adults aged 20 years or older are overweight, and 43 million are obese. In addition, 4,900,000 children aged 6- 17 years are overweight due to their nutritional habits (American Heart Association, 2000). Also, Wamala, *et al,* (1997) found that unhealthy dietary habits were the second strongest factor after reproductive history accounting for socio-economic differences in obesity among middle – aged women.

Ogunsakin, (1999) observed that unhealthy dietary habits adopted or developed by an individual results in various forms of malnutrition with attendant cases of weakened condition, poor health, impaired intellectual development, and low productivity. Nutrition, together with smoking and physical inactivity, is one of the main determinants for cardiovascular disease and cancer. WHO, (1998) estimated that an unhealthy diet and a sedentary lifestyle might be responsible for up to one third of the cases of cancers, and for approximately one third of premature deaths due to cardiovascular disease in Europe. The report added that good nutrition and physical

activity are key determinants for the prevention of obesity, which continues to rise in the European community among children and adults. The problem of obesity which is due to poor nutritional lifestyle is on the increase in Europe with nearly two thirds of men and just over half of women being either overweight or obese (WHO, 1998). This is important, as obesity is major risk factor for many other diseases, which are common in the European Union Communities (EUC) such as coronary heart disease, some cancers, hypertension and diabetes.

The dietary habits or lifestyles adopted by an individual have a major impact on his/her health. The foods that we eat on a daily and weekly basis are major determinants of diseases like obesity, diabetes, high blood pressure, cancer and coronary heart diseases. In Nigeria, many amongst us are undernourished. For example, about 40% of adults admitted to hospital show signs of malnutrition (Asuni, 1974). This can have an impact on recovery rates and length of stay in hospital.

Evidence also shows that in the rural areas of Nigeria, poor nutritional habits results in anemia amongst young women (Asuni, 1974). Anemic mothers are likely to have smaller babies with potentially significant longer – term health consequences. Some of the poor nutritional behaviours are:

- Excess intake of calory foods with less energy output.
- Taking of snacks and Juncks foods, especially soft drinks among the adolescents.
- Strict adherence to food fads and superstitions associated with the choice of food nutrients.

- Binge eating patterns. Binges are often precipitated by negative emotions, and the act overeating seems to relieve the emotional symptoms.
- Restrictive dieting.

Helping individuals to adopt good dietary behaviour or lifestyle is the joint responsibility of Dietians, Health and physical education experts, parents and members of the community. Some dieters find themselves developing binge-eating patterns (Polivy and Herman, 1985; Telch and Agras, 1993). In studies of patients presented for obesity treatment, up to half are found to have frequent eating binges. Bingers report feeling out of control and experiences guilt and self-loathing because of their self-perceived gluttony.

As a result, binges are often followed by period of increased dietary restraint or even fasting. The following lists the basic elements of the recommended approach:

1. Stop restrictive dieting: Psychophysiological rationale is that dieting causes body to conserve fat, dieting may lead to eating dyscontrol, dieting usually lead to ultimate regain.
2. Distinguish between hunger and craving: Identify symptoms of true stomach hunger as opposed to emotional/situational cues to eat.
3. Normalize eating: Three meals a day with snacks helps stabilize appetite and prevents evening binge urges.
4. Gradually reduce fat intake: Gradual reduction allows time for changes in food selection, food preferences and food preparation. Reduces preference for high-fat

foods. Permanent lifestyle change is the goal rather than temporary, non-maintainable caloric reduction (Foreyt and Goodrick, 1995).

The choice of food nutrients like protein, carbohydrate, vitamins, fats and oils, and minerals in the correct proportion would go along way to influence or determine the lifestyles of an individual. Gerber, Roper and Teresa (2003) suggested the following health tips on how to improve ones lifestyle through good nutrition:

- Eat regularly throughout the day;
- Choose nutritious foods that you enjoy eating;
- If you don't feel like eating, try having small amounts often;
- Avoid inappropriate foods (don't have in the house);
- Tell your family and friend about your diet needs so they can support you.
- Keep active;
- Regular exercise promotes health and well-being and help prevent injury (Gerber, *et al*, 2003 pp. 34 - 35).

2.4.3 Smoking

Smoking is another lifestyle factor. People commonly turn to tobacco smoking as a means of dealing with stressful situations. For example, one study 35,000 nurses in the United Kingdom found that smoking was one of the mostly commonly reported ways of coping with stress (Hawkins, *et al*, 1983). The American Cancer society (1986) suggests that the cost of smoking as a lifestyle factors to the U. S. economy has been estimated at $65 billion annually, due to lost of productivity and medical treatment for smoking-related diseases. It contributes to an estimated 350,000 premature deaths each year. The American Heart Association (1986) also notes; "Cigarette smoking is the biggest risk factor for sudden cardiac death: Smokers have between two to four times the

risk of non-smokers". At least 25% of all deaths from Cardiac Disease (CD) are caused by smoking; and in Great Britain, Cancer of the trachea, bronchus and lung rate third as killer diseases of the 1980s among males in the 16 – 64 years age group.

The World Health Organisation (1999) reported that Tobacco smoking was responsible for an estimated 1.2 million deaths in this European Region in 1995 (or about 13% of all deaths). Smoking – related deaths in middle – aged people are responsible for 19 to 23 years of life lost in the WHO European Region.

Children's health is also damaged by smoking: Mothers smoking during pregnancy can negatively affect the weight of new born babies, as well as their childhood and perhaps adult health. Recent data shown that babies of smokers are more likely to die from sudden infant death syndrome than babies of non-smokers (WHO, 1995).

In Nigeria, smoking (Tobacco and India hemp) is the second largest cause of avoidable death after accident, accounting for over 250,000 deaths each year (i.e. deaths resulting from cancer related diseases). It is estimated that 25% of all cancer deaths and 15% of all deaths in the urban cities of Nigeria could be attributed to smoking (Asuni, 1974). In order to curb this epidemic, the Federal Ministry of Health (2000) is actively developing a comprehensive tobacco control policy, which is characterized by a four – stage approach.

- Legislative measures as the backbone of the community in the present and future, for tobacco control activities.
- Support for country – wide smoking prevention and cessation activities is another important element in the tobacco control strategy.

- Mainstreaming tobacco control into a range of other governmental polices (e.g. agricultural policy, taxation policy, development policy)
- Make sure that the pioneering role of the Federal Ministry of Health in rural and urban cities produces an impact beyond making of policies, and allow community participation in tobacco smoking preventive strategies (Federal Ministry of Health, 2000).

The adoption of smoking as a lifestyle begins among young people through experimentation. With so many adult smokers to observe, it is not surprising that young people experiment with smoking. In this case, parents have an important influence on whether or not their children begin smoking. Children learn about adult behaviour through their parents, using them as role models, and may come to associate smoking with being mature. Thus many teenagers see cigarette smoking as a symbol of adulthood. Also, many young people start smoking even though their parents and relatives do not; in many cases, smoking becomes the teenager's gesture of independence from parents and family. Peer influence is extremely important in the adoption and development of smoking as a lifestyle during the teenage and college years.

In our society, cigarette smoking used to be strongly associated with freedom, independence, urbanity, glamour, and sophistication. Advertising campaigns, now restricted to the print media, still represent cigarette smokers as mature, sophisticated and attractive. The male smoker is portrayed as tough, the female as liberated; partygoers still smoke, and so do people in love. Hence, young people (young smokers) see smoking as a good habits (lifestyle). Advertising is losing its power to persuade because antismoking

campaigns have portrayed a truer image of smokers, depicting them as people with unhealthy lifestyle.

Most studies categorized subjects (smokers) into three groups: non smokers, past smokers and current smokers. It is evident from these studies that smokers had a higher risk of mortality than non-smokers, though the mortality risk was higher among middle-age subjects than among older subjects. For those who had quit smoking, the mortality risk varied from an intermediate risk to a non-elevated risk in comparison with non-smokers (Ruigomez, *et al*, 1995; Davis and Moritz, 1994; Sunyer, *et al*, 1998). For example, A 40 –years old man who smoke a packet of cigarette a day die seven years before his non-smoking peer. Smoking is seriously implicated in heart diseases and accounts for many deaths from lung cancer to other cancers.

Andrew, *et al,* (2002) observed that the rate of smoking among women now outnumbered the men, thus, cigarette smoking was associated with short cycles (menstrual cycles) and with irregular cycles. The odds of having irregular cycles were 3.6% among women who smoked more than a pack of cigarette a day compared with non-smokers. This assertion was corroborated by Molarius (2003) when he reported that women were more often smokers than men, except among the elderly.

Smoking increases the risk for all forms of urinary inconsistence and is dependent on the number of cigarettes smoked (Bump and McClish, 1994). They added that, smokers cough more frequently than non-smokers, which may lead to earlier development of stress urinary inconsistency. A smoker's chronic cough may damage structures that support the urethra and vagina and there may also be an association between nicotine and increased bladder contractions, which causes both urge urinary inconsistency and overactive bladder.

2.4.4 Heavy Alcohol Use

Perhaps, a description of alcoholic lifestyle may help in the understanding of his/her ways of life. The alcoholic does live a separate lifestyle from others. His sickness, a compulsion to drink, dictates a well – defined set of defense mechanisms, behavioural patterns and attitudes. Although there is diversity among alcoholics as with all segments of the population, these are related primarily to economic and social factors. For example, the alcoholic member of an affluent family probably exhibits a different set of behaviours as a result of protectiveness of his environment than does the back alley derelict who has been rejected or alienated from family support. But these differences are superficial compared to the commonalities which exist as a result of their compulsion to drink.

The social and behavioural scientists have developed a body of literature related to alcoholism as a social and psychological problem (Douglas, 1978). According to him, sociologists have described the lifestyle pattern, while psychiatrists have focused primarily on the psychodynamics of excessive drinking. They report that there is a definite alcoholic personality syndrome with the characteristics behaviour of compulsiveness, emotional passivity, emotional dependence and destructive tendency. From a sociological perspective, alcoholics tend to develop their own normative patterns seeking the comfort of the alcoholic subculture and permissive behaviour. For them, activities and relationships are measured in terms of their contribution to or interference with the "right to drink" (Douglas, 1978). Drinking is an important element of an alcoholic social activity whether it is at the club, at the poolside, or at the bar. Alcohol is considered a part of their social processes; there is a social expectation to have a cocktail or a beer. When friends get together, they usually "have a few drinks". Many consider the

neighborhood bar as a recreation centre; their central interests are related to the relationships and activities, which take place in that setting.

High alcohol consumption, especially when combined with the practice of drinking to intoxication, leads to a tremendous increase in mortality. Evidence has been accumulating that mortality increased among smokers and heavy users of alcohol (National Institute of Health, 2000; Urho, *et al*, 2002). Alcohol is dependence–producing drug, and this dependence is associated with an increased risk of illness and premature death; drunkenness is also associated with a high risk of injury and death, both to the person who becomes intoxicated and to others. Death rates for chronic liver disease and cirrhosis of the liver is high, of which a significant part is associated with alcohol consumption.

Alcoholism as a lifestyle is characterized by excessive use of alcohol to the point of over dependence or addiction (Asuni, *et al*, 1994). Alcoholism should be differentiated from excessive and heavy social drinking. Excessive drinking goes beyond what is traditional and customary in one's country. Alcoholics are those excessive drinkers whose health or family relationships or work performance are adversely affected by drinking. The alcoholic has, infact, lost the power of choice in the matter of drinking.

For alcohol consumption as a lifestyle factor, the progression from social drinking to alcoholism often follows this course; drinking is first associated with relaxation but then becomes an escape from stress and anxiety and feelings of inadequacy; self control is gradually lost and the person's need for alcohol increases; as control is lost, work, family and social relationships and health are affected. Finally, drinking becomes an end

in itself and anything is sacrificed to ensure a supply of alcohol.

Alcohol is used to relieve stress and help the individual to manage crisis, but in reality, alcohol renders the distressed person less able to cope and prone to accident conditions. Fleming (1986) suggests that there seems to be a strong link between stress, alcohol consumption and accidents. Alcohol consumption have been associated with hypertension and obesity in a number of epidemiological studies (Larbi, *et al,* 1983). Molarius (2003) reported that because alcohol has high caloric density, alcohol intake is usually associated with obesity. In some studies alcohol intake has not been associated with relative weight which might be due to difficulties in measuring alcohol intake accurately (Eisen, *et al,* 1993; Molarius, 2003; Suter, *et al,* 1997). In addition, the association has been found to differ between men and women, with a positive association often found in men but a negative association in women (Hellerstedt, *et al,* 1990). This may be due to the fact that the same cut-off points for alcohol intake have usually been used both for men and women whereas the actual intake is much lower in women than in men.

The effects of alcohol have immediate consequences in terms of behavioural change for the individual and those around him/her. Judgment and co-ordination are likely to be impaired and reactions are slowed, rendering the person more vulnerable to accident (Sutherland and Cooper, 1992). Alcohol consumptions may lead to loss of jobs, cirrhosis of the liver (liver damage) and hypertension. A combination of all these, and many more may lead to premature deaths.

In traditional African communities drinking (alcohol consumption as a lifestyle) occurs not only in home after work but also outside the home and at the time of weddings and other special ceremonies. In some areas especially after the harvest and the sale of a cash crop there is heavy drinking for some days or weeks until the money is consumed (Asuni et al, 1994). African alcoholics fall into two main groups. The first are those men and women who have not left the traditional setting. Their drinking was originally in conformity with the custom in their village or community but unlike most of their friends their drinking became more and more excessive and thereby set them apart from most of their neighbours. Even though such men and women with an alcoholic problem might not drink the entire year simply because of the unavailability of alcoholic drinks. However, when the alcohol drink is available they might be the ones who would drink without control and perhaps be drunk much of each day. The other type of African alcoholic is found among men and women who have moved away from the traditional way of life and lived in cities. Such alcoholics may present symptoms of one of the personality disorder or social uneasiness and inability to tolerate tension, or, less frequently, symptoms of a more psychiatric illness.

The sharp increase in the incidence of alcoholic psychosis in Eastern European countries of Italy, France and Spain between 1992 and 1995 provides additional evidence for increasingly high alcohol consumption (WHO, 1999). The average mortality in the EU, although slightly declining, is still about twice as high as the average of the Nordic countries.

While the prevalence of alcoholism in Africa is not known exactly, it is appreciated that it will vary from place to place and it appears to be a substantial problem

which is increasing. In the last few years, scientists have been increasingly study the problem of alcohol in Africa. For example Acuda (1980) wrote on the drinking patterns in Kenya. He concluded that alcohol consumption has increased markedly at all levels, together with a complete change in patterns of drinking behaviour, especially in rural areas. Adomakoh (1974) analyzed 41 cases of alcoholic problems seen in psychiatric hospital and the medical school Teaching Hospital in Accra during 1973. Asuni (1974) also described the pattern of alcohol problems based on 60 cases seem in Neuropsychiatric Hospitals, Aro, Abeokuta, Nigeria between 1964 and 1973. Odejide (1978) reviewed alcoholics admitted into the 500 – bed University College hospital, Ibadan with an annual average admission rate of 10,000 over a 10– year's period 1966 – 75. Oshodin (1981 A) reported on alcohol abuse among high school students in Benin city, Bendel now Edo State. The study found a high rate of alcohol use among the students. Oshodin (1981 B) also studied alcohol use among students in a secondary school in rural areas of Benin district, and found that 18% of the students could be classified as alcohol abusers.

2.4.5 Drug Taking (Abuse And Misuse)

Drugs are chemicals, natural or synthetic, that alter the functioning of the body in some way. Most drugs are designed to relieve pain or to prevent or cure disease. Aspirin, a simple, relatively mild analgesic (Pain Killer), is a drug; heroine, a dangerous and illegal narcotic, is a drug. Between these two extremes are thousands of other drugs, all which alter body functions to various degrees. Drugs in most cases are those substances used to influence human actions to suit reactions of the body. Scientifically, a drug is any

substance other than food, which when taken into the body, by its chemical nature, affects the structure or function of the living organism (Folawiyo 1990).

Drug abuse is the taking of any substance for any purpose other than that for which it is intended, and in any way that could endanger the user's health or ability to function. Legal and illegal drugs are abused by Nigerians (National Drug Law Enforcement Agency, 1998).

The world is presently witnessing an increasing rate of illicit drug consumption. This ugly situation is giving the nations of the world serious concern, hence, concerted efforts are being made to curtail the problem. Drug abuse as a lifestyle is a problem for youths everywhere nowadays.

Many Nigerians are known to have one form of drug related problems. Many secondary school bright, promising young boys and girls have been affected by drug abuse, the lucky one's temporarily while the unfortunate ones for prolong period. Therefore, the usage or trafficking of any illegal drugs must not be permitted on school campuses.

One of the most pervasive problems facing our society today is drug abuse. This exists at all ages, involving both sexes and every socio-economical level and therefore frequently complicating and creating a high – risk situation for the people. The adolescents' even adults are prone to use seduction of drugs and their mood altering capabilities. The use, misuse and abuse, and dependence on psychoactive drugs (caffeine, alcohol, tobacco, other stimulants, depressants and hallucinogenic drugs) by children and young people as well as adults stem from and contribute to emotional and social problems in our society.

MAMSER (1989) observed that despite the side effects and deaths associated with these drugs, the numbers of people using drugs are on the increase. Folawiyo (1990) stated that those attracted to drugs abuse as a lifestyle are those who are bored, cannot enjoy or cannot tolerate stress and frustration. The drugs fit their emotional discontent and remove the necessity to plan, to struggle and to endure. According to him, it is a feeling of existential meaninglessness, which attracts some people to drugs. Oyerinde (1998) opined that most teenagers and adolescents even adults do take drugs while seeking for fame, courage and excuse to hide away from the future.

Falcomer, *et al,* (1970) agreed that those who persist in drug abuse are often ***"dropout"*** of general society. They tend to congregate and to live together, often in very unsanitary conditions. Many turn to be burglaries, panders and prostitution to secure their Fix. Such people feel that they cannot be bothered by the hoodlum routine of life.

Churchhill (1978) writes on drug use among youths. According to him, youths of today have grown up to believe that drugs can provide the answers to their problems. The so – called aggressive drugs like amphetamine; Marjiuana (Indian hemp) and cigarette with the aid of alcohol are for the purpose of killing the fears of the obstacles of their future.

The problems associated with the abuse of drugs are numerous. They are social, medical and psychological that afflicts the consumers(s), his family and the society (Folawiyo, 1990). The social problems include automobile accidents, child abuse, unproductivity at work, assault and murder, suicide attempts, depression, anxiety, psycho-hallucinogenic reactions (like seeing things or hearing voices that do not exist)

aggressive tendencies, argumentative and abusive utterances, nausea and vomiting. The medical problems include ulcer of different types, liver cirrhosis, malnutrition and hepatitis. Infact most organs of the body are affected negatively through the process of drug abuse. Psychologically, drug abuses may suffer from brain and liver damage at sometimes in their lifetime. They tend to neglect their family and the loved ones, and they do not command respect and dignity (NDLEA, 1998). Providing an overview of illicit drug consumption levels and trends in the world is a task which must be approached with caution, due to the differences in the nature and comprehensiveness of data collection system.

It is difficult to make comparisons between countries (WHO, 1998). The use of illicit drugs in the Netherlands among 12 – 18 years olds (13.6%) appears to be higher than in, Greece or Portugal, where it is about (4-5%). Among adults, regular use is considerably lower than occasional use in all cases. Drug misuse is a significant problem in urban cities of Nigeria, with national surveys showing that around a fifth of the population have used an illicit drugs at some point of their lives (Federal Ministry of Health, 2000). Although many will not experience problems with their drug use, drug misuse can have a profound and lasting impact on health and social functioning. A young person who is injecting heroin has about a 14 times risk of death than someone who is not (NDLEA, 1998).

2.4.6 Unsafe Sexual Practices

Unsafe sexual practices or casual sex as a lifestyle factor is characterized with sexual mal – adjustment and sex–related crimes abound in the society. This is supported by the fact that obscene and pornographic materials are on sale everywhere. Thus, sex is

sold and bought openly. Female teenagers boast of what wonders their hip rolling correspondence act could work on men. The average Nigerian male adolescent's gossip is centered on his ladies/ women exploits. This attitude has created a number of sex–related problems in our society. These problems include adultery, prostitution, rape, abortion, illegitimate child, abandonment of newly born babies, the spread of sexually transmitted diseases including HIV/AIDS, intimidating frequency of divorce and sex pervasion (i.e Masochism, sadism, invest, lesbianism, homosexuality, pedophilia and exhibitionism). Casual sex is more common among young adults and high socio-economic status individuals in the cities. This account for high prevalence of HIV/AIDS and other sexually transmitted diseases. A visit to Ibadan, Lagos, Port-Harcourt and Kano among others revealed high incidence of sexual pervasions among the inhabitants. Although, religions and non – governmental organisations are in the fore-front preaching against homosexually, lesbianism and casual sex among the people. This in an attempt to discourage sex – related problems that are abound in our communities.

2.5 Determinants Of Lifestyle Factors

The lifestyle of an individual is influenced by a variety of external and internal factors based on the complex interactions between the individual and his immediate environment. The social environment plays a decisive role in the individual's capacity to maintain and promote their health and to prevent diseases (Adesina, 1990).

Environment is considered of crucial factors in the health and well being of the individuals. Everything within the environment ranging from air, water and chemical products have tremendous impact on the well being of the individual. This does not exclude both the psychological and social environment as well. All these external factors,

both natural (Non – modifiable factors like Genetics) and Man – made (modifiable factors like age, sex, marital status, socio-economic factors, residence, religious and educational background) are capable of affecting health and well-being of the individual.

2.5.1 Residence As A Determinant Factor

Among the modifiable risk factors, residence seems a major determinant of lifestyle, since urban residents have a 1.5 to 4 – fold prevalence of lifestyle factors like smoking, heavy use of alcohol, sedentary lifestyle, drug abuse and misuse, and unsafe sexual practices compared to their rural counterparts (Levitt, *et al,* 1998).

Urban lifestyle in Africa is characterized by changes in dietary habits involving an increase in consumption of refined sugars and saturated fat, and a reduction in fibre intake (Sharma, *et al* 1996; Mennen, *et al* 2000). Majority depends on imported and refined food nutrients with little nutritional values which may have adverse effects on their well-being. Moreover, there is reduction in physical activity with urban lifestyle. The technological and communication advancement do not help matters in this regard. The use of automobiles, telephone facilities, mobile phones, household technological gadgets has substantially increase the sedentary lifestyle of the urban residents. Rural populations rely upon foot walk as a means of transportation and often have intense agricultural activities as their main occupation (Alemu and Lindtjorn, 1995). Rural people therefore have a high physical activity related energy expenditure compared to urban subjects (Singh, *et al* 1989; Heini, *et al* 1991). Thus explaining the higher rates of obesity, hypertension and other cardiovascular disease in the cities. Obesity is at least 7 times higher in urban areas compared to rural areas (Rashid, *et al* 2000).

The higher prevalence of unsafe sexual practice as lifestyle factors in our cities in Kenya, South Africa and Nigeria accounts for the incidence of sexually transmitted diseases and HIV / AIDS in the areas (WHO 1991). It is also important to state categorically that the rates of drug abuse and drug trafficking is more pronounce amongst the urban people than the rural people / inhabitants. Oshodin (1981A) reported the high rates at which secondary school students in Benin City, of Nigeria, consume alcohol as compared to their counterpart in the rural areas. One's place of abode is a significant factor in the determination of adopted lifestyle factors (Smoking, alcoholism, Excessive eating or poor nutritional habits, sedentary lifestyle and unsafe sexual practices).

2.5.2 Educational Background As A Determinant Factor

One's level of education influences both accessibility to information and the ability to process new information; thus individual with a higher level of education often better understand the nature of new technology and its risks. In general, individuals with a higher education are more open to new ideas, which help to modify their lifestyle.

In a study conducted on the distribution and determinants of sedentary lifestyle in the European union by Jose et al., (2003). Individual with a higher educational level (secondary or third level of education) was significantly associated with a lower level of sedentary lifestyle both among men and women. Educational level was markedly associated with sedentary lifestyle in both men and women. Individual with higher educational levels showed lower prevalence of a sedentary lifestyle. This result is consistent with the findings of Crespo, *et al* Heath and Smith (1999) and confirms that education influences health through lifestyle behaviours. Although this correlations is not

entirely understood. The individual's level of education also influences his / her dietary habits (over and under nutrition), and its health implications.

Molarius (2003) reported that obesity was more common among subjects with low education than subjects with higher education. Also, lifestyle habits differed considerably between the educational levels. Those with low education were more often physically inactive, heavy smokers, used more often alcohol and had unhealthy dietary attitudes than those with higher education.

The study also shows that those with middle level education were however, more often heavy alcohol users, smoke and had unhealthy dietary attitudes (among men) than those with low education. What leads to such a premise is a clear recognition and acceptance of the fact that individual's exposure to higher education influences what he eats, smoke, drinks and does in all ramification of his life and those of others around him. Educational background is an important determinant of individual's lifestyle. This follows a phrase ***"the higher you go, the more responsible you are"***. This study is, therefore intends to determine the influences of educational background on the adoption of lifestyle factors like smoking, heavy use of alcohol, sedentary lifestyle, nutritional status, drug abuse and unsafe sexual practices among the people of Kaduna State of Nigeria.

2.5.3 Gender As A Determinant Factor

Lifestyle factors, such as physical activity, dietary habits, smoking and alcohol intake are related to relative weight gain in both men and women (Seidell and Flegal, 1997; Lissner and Heitman, 1995; Molarius et al, 1997; and Tremblay, 1999), Molarius, (2003) reported a prevalence of obesity by gender and age group among his study

population (i.e. 12% of men and 14% of women were Obese). Also, about one – fifth of the study population were reported to be physically inactive, and physical inactivity was most common among young men (25 – 44 years) than women. In Nigeria, it is observed especially in the cities, that heavy use of alcohol and drug abuse are very common among men especially young men than women. Dietary attitudes shows a similar patterns as heavy alcohol use and drug abuse.

Women were more often than men trying to avoid fat food and to eat fiber – rich food. Further differences in health status and lifestyle between men and women have been attributed to gender – specific health and longevity – related behaviours. For example women are more likely than men to describe themselves as non – drinkers and non – smokers, yet are less physically active (Ross and Bird, 1994). Women also tend to be more concerned about health matters and to use health – care system for treatment compare to men (Verbrugge, 1984, MC Donough and Walters, 2001). Gender disparities in health are often linked to differences between men and women in exposure to lifestyle factors.

Women were more often smokers than men, except among the elderly "65 – 74 years (Wagenknecht, *et al* 1990; Molarius, 2003). It is therefore the aim of this study to find out the influence(s) of gender on the choice of lifestyle factors like heavy use of alcohol, nutritional status, smoking, drug habit, unsafe sexual practices and sedentary lifestyle(s) among the people of Kaduna State.

2.5.4 Socio-Economic Status As A Determinant Factor

Socio-economic status (SES) is difficult to assess, particularly across countries or communities with different cultural habits, it is believed to be a significant factor in the determination of individual's lifestyle. The importance of socio-economic status on the practice of physical activity, smoking, heavy use of alcohol and in particular of high-intensity activities during leisure time has been identified in numerous studies (Stephens, *et al* 1985; Ford, *et al* 1991; Pomerleau, *et al* 1997; and Mensik, *et al* 1997). Different reasons can be invoked for this. People with lower socio-economic status are more likely to have manual jobs with higher physical demand. Also the access to some recreational activities may be limited due to their cost. They thereby result in the intake of stimulants (drugs and alcohol) to increase their physical strength for the required energy dispensing. Their counterpart with high socio-economic status has money and other influences to enjoy themselves. Cases of obesity, liver Cirrhosis, HIV/AIDS, hypertension and other Cardiovascular diseases are more rampant among this social group due to their sedentary lifestyle, high consumption of alcohol, poor nutritional habits and unsafe sexual practice or casual sex.

The health of individuals is affected by their social class position. Socio-economic status is positively correlated with understanding health education information, making informed decision about health and health care, access to health care services, health maintenance and healthier lifestyle (Adler, *et al,* 1993; Borg and Kristensen, 2000). These factors contribute to better health and healthy lifestyle of those with higher socio-economic status.

On the other hand, the social production of health shows that psychosocial factors such as social support, economic liability, chronic diseases, and stressful life events influence health and individual lifestyle. For instance, low levels of social integration and socio-economic status can gravely influence a person's moral and adjustment and, hence, their mental and physical health (Mildred, 1990; Rowe and Kahn, 1998). They are also more likely to experience chronic diseases and stressful life events. This may be a serious determinant or impetus for the use of alcohol, tobacco, drugs and poor nutritional habits as a lifestyle.

In terms of psychosocial determinants of health as identified earlier, it is assumed that social support has a positive influence on health in later life, since a person with social support has someone to confide in, get advice from, and depend on (financially). People who receive less social support are more likely to experience depression and mental illness, pregnancy risk (women), and chronic disability (Mildred, 1990). Good social relations can reduce adverse response to stress, belonging to a social group (high socio-economic group) makes people feel cared for, loved and valued.

Therefore, the aim of this study was to examine the influence of socio-economic status (SES) in the adoption of lifestyle factors like smoking, drug abuse, sedentary lifestyle, nutritional habits, unsafe sexual practice or casual sex, and the use of alcohol as lifestyle among Nigerians.

2.5.5 Marital Status As Determinants Factor

The influence of marital status on lifestyle factors have not been extensively research on, but one observed that the use of alcohol, cigarette smoking and drug abuse and misuse are common amongst the teenagers (male and female) than their married

counterparts. Teenagers are seen using stimulants like cocaine, amphetamines, alcohol, India hemp and Caffeine as mood elevator in our cities either to show – case in social functions, to commit social vices or to cover – up some inadequacies.

Marital status has only rarely been included in studies about physical activity, Jose et al, (2003) found that being single was associated with high physical activity levels, eating of fast foods and drug abuse. Also, in a logistic regression model conducted by Steptoe, Wardle and Fuller, (1997), it showed a significantly high level of sedentary lifestyle among widowed and divorced individuals than in the singles.

However, a combination of socio-economic factor with marital status is an important determinants of lifestyle factors among the married couples in Nigeria. Hence, the use of drugs, alcohol, smoking, sedentary, unsafe sexual practices and excessive eating often find a prominent place amongst married individuals with high standard of living and good social support.

This study is however, intends to examine the influence of marital status (single, married, separated, widowed and divorced) in the adoption of lifestyle factors like smoking, drug abuse, sedentary lifestyle, dietary habits, casual sex and the use of alcohol as lifestyle among Nigerians.

2.5.6 Religious Background As A Determinant Factor

Individuals religious background to a large extent determine the adoption of lifestyle as relates to mode of dressing, the use of alcohol, the number (s) of wife/wives to marry and the types of food nutrients to consume by their followers. For instance, Quran chapter 5 verse 90 prohibits the eating of pork meat and intoxicants among the Muslims.

"O you who believe! Intoxicants (all kinds of alcoholic drinks), and gambling, flesh of swine (Pork), and AL-Azlam (arrows for seeking luck or decision) are an abomination of Shaitan's (Satan) handiwork. So avoid (strictly all) that in order that you may be successful (Quran 5 verse 90)".

Although the reason for this prohibition is not known, but one observed that porks contain high cholesterol and proteins, nutrients needed for bodybuilding and repairs. Although, Christianity is a bit silent on drinking of alcohol as a lifestyle, it however, frown at heavy use of alcohol by its adhere (s).

While Islam recommends a dressing code for its followers (male and female) through which they can be recognized, Christianity, however, emphasized modesty in dressing. It could however be observed that both religious frown at laziness or indolence among their followers, it is an indication that sedentary is not 100% encouraged by both religious. Islam and Christianity therefore, as a matter of fact, encourage their followers to work for their living.

This research is aim at finding out how religious (Islam, Christianity, traditional and others) influence the adoption of lifestyle factors like smoking, unsafe sexual practices, heavy use of alcohol, physical inactivity, dietary habits and drugs abuse as lifestyle among their followers in Nigeria.

2.5.7 Age As A Determinant Factor

Age is a well – known determinant of health in later life. At age 70 – 75 years, a high quality diet, non – smoking, and physical activity were positively related to healthy lifestyle in European population (Rogers, 1995). The combination of healthy lifestyle behaviours or factors like good diet, non – drinking, non – smoking, physical activity and avoidance of drug abuse amongst the ages was even more strongly related to long life.

Major causes of mortality in old age and adolescents are diseases in which lifestyle plays an important role. The main behavioural factors of concern, namely nutrition, alcohol consumption, physical activity and smoking are modifiable and are a major focus of national health improvement strategies.

Changing these factors in the direction of a healthier lifestyle pattern could postpone the age of onset of permanent morbidity and disability and could have a major effect on quality of life (Bush et al, 1990). Also a positive lifestyle to health and sex life among the adolescents and adults would help to limit the spread of sexually transmitted disease including HIV/AIDS in our society. It is the focus of this research to examine the influence of age on the adoption of lifestyle factors amongst Nigerians.

2.6 Consequences Of Unhealthy Lifestyle

A number of these consequences had been identified in the course of describing the effect of lifestyle factors on the individuals. Unhealthy lifestyles are responsible for chronic and degenerative diseases. One of the greater concerns in health today is the areas of chronic and degenerative diseases. They account for more than 60% deaths in African (Asuni et al., 1994). The significance of these diseases resulting from unhealthy lifestyle cannot be measured by death alone. The disability, the unhappiness, the emotional, social, economic and family trauma resulting from these diseases cannot be measured by statistics nor dollars and Naira.

Some of the consequences of unhealthy lifestyle of smoking, heavy alcohol use, physical inactivity, unsafe sexual practices or casual sex, drug abuse, and poor dietary habits are as follows:

Physical inactivity or sedentary lifestyle contributes significantly to the occurrences of obesity, cancers, high blood pressure, osteoporosis, diabetes and premature mortality. Considerable evidence has grown supporting an association between physical inactivity and an increased risk of premature deaths and cardiovascular diseases (Dishman and Sallis, 1994).

Poor dietary habits as in the case of excessive eating – a lifestyle factor is a risk factor for several chronic diseases. This includes obesity, overweight and an increased risk of non – communicable diseases like pellagra, Osteoporosis, Goitre, Anaemia, scurvy and various forms of bony malformations.

A diet characterized by a high proportion of fats and fatty meat, may result in too many cholesterol deposition within the veins and arteries resulting into high blood pressure, hypertension, stroke, coronary heart disease and varicose veins. Wamala, (1997) reported that unhealthy dietary habits were the second strongest factor after reproductive health accounting for socio-economic differences in obesity among middle – aged women leading to high mortality and economic lost in America. Also WHO, (1998) and Ogunsakin (1999) reported that poor dietary habits results into poor health, impaired intellectual development, premature deaths, obesity and cardio-vascular disease.

Smoking is another lifestyle factor. Apart from economic lost due to smoking cigarette, smoking is the biggest risk factor for sudden cardiac death. This is in addition to cancer of the trachea, bronchus and lungs. Mothers smoking during pregnancy can negatively affect the weight of newborn babies, as well as their childhood and adult health. Asuni, (1974) found that smoking (tobacco and India hemp) is the second largest cause of deaths after accidents in Nigeria. Smoking is a risk factor in insanity and mental

unconsciousness. Also, cigarette smoking as a lifestyle among females, was associated with short menstrual cycles and irregular cycles (Molarius, 2003).

Alcoholism is another lifestyle, which has adverse effect on the individuals. Although, alcohol is used to relieve stress, but in reality, alcohol renders the distressed person less able to cope and prone to accident conditions. Larbi et al (1983) and Molarius, (2003) observed a close association between alcohol consumption and cases of hypertension, obesity, liver cirrhosis, loss of weight, mental delusion, poor reaction time, premature deaths and physical injuries. Socially, an alcoholic suffers from personality disorders,. Social uneasiness and inability to tolerates others. Many of this presents symptoms of psychiatry illness.

Drug abuse as a lifestyle is a problem common among the youths and adults. Many of our young promising and bright schoolboys and girls have been affected by this lifestyle. Cases of drop – out from schools, automobile accidents, assaults and murders, suicidal attempts, depression, anxiety; these in addition with aggressive tendencies, hallucinogenic reactions, abusive utterances, brain and livers damages are associated with drug abusers.

Most recently, casual / indiscriminate sex has been associated with the spread of HIV / AIDS virus, the most deadly sexually transmitted disease. Unsafe sexual practices as a lifestyle is responsible for cases of unwanted pregnancies and child abandonment that abound in our societies. Adolescents and middle – aged individual are cut – up in cases of sexual perversion like lesbianism, incest, homosexuality, sadism and exhibitionism.

2.7 The Roles Of Government And The Community In The Promotion And Maintenance Of Healthy Lifestyle

Healthy lifestyle promotion is a continuous process of enabling people and institutions to increase control over and improve health. Healthy lifestyle is a people – based approach to health for all, in which the health of the people is the ultimate responsibility of several stakeholders, including non-governmental organizations.

The first step in the movement toward positive health change in any community is to inform resident about health risks and health status issues that need improvement. Informed residents are in a better position to create and maintain positive change. Greater awareness of the urgency to improve lifestyle practices, reduce risk behaviours, and protect the environment contributes to an improved health status of the community.

To achieve better health gains and quality of life, the government should invest in strategic thinking, planning and programming to address the determinants of health in the long term and the risk reduction objectives contributing to reduction of the burden of diseases and mortality in the short and intermediate terms.

The promotion of healthy lifestyle in the community is not limited to what people can do themselves through self – restraint and more disciplined health – related behaviour. It also entails a wide spectrum of solidarity, trust and support in attaining the legitimate aspirations of healthy and responsive social structures and institution of which the health system is but one. The risk factors related to poor nutrition, use of tobacco, alcohol and other drugs, risky sexual behaviour and physical inactivity are abound in our communities, which needs collective efforts and support of all, especially within the health sector.

Promoting and maintaining healthy conditions needs not only government support, but also community commitment. It requires active citizens including women,

and community associations, with experience in all kinds of community activities, to promote various social, economic or environmental agendas in support of healthy lifestyle. Unfortunately, such community groups are either lacking focus or are very few in number in Nigeria in terms of commitment, this has led to an almost total dependence on government efforts and especially those of health sector, which can never be enough.

Government, voluntary and non – governmental organizations should promote health by encouraging positive lifestyles, particularly through capacity – building strategies, and should design effective programme intersections based on health promotion principles and techniques: some of these principles and techniques include:

- Development of a national comprehensive framework to address factors influencing health, ranging from social, economic and environmental determinants to individuals behaviour patterns. The strategy will advocate health – promoting action, such as exercise, balanced diet and abstention from alcohol, drug abuse and tobacco use.
- All government – controlled media should be banned from promotion of unhealthy lifestyle and practices. I.e. pornographic films, smoking and sales of alcoholic substances.
- The school has an important opportunity to promote active health literacy aims at developing healthy lifestyle. The curricula of health, educational, instructional and public information institutions should be re-oriented in a manner that promotes health and encourages healthy lifestyle.
- Governments need to formulate polices to encourage healthy clubs, sports competition, into smoking campaigns and health education campaigns on

healthy lifestyle. Certain legislative and fiscal measures, especially with respect to tobacco control, such as increasing taxation on cigarettes and banning smoking in public offices, prostitution and drugs trafficking be initiated.

- The health and well–being of a community are affected by the religious and spiritual teaching in the social milieu within which people live. Islamic and Christian teachings favour solidarity, good conduct, cleanliness, healthy bodies and minds, avoidance of harming oneself or others and love. Caring for others, especially the weak, the poor and the needs is a must in religions teaching. Making use of such teachings in our communities leaves much to be desired.
- Encouragement of the comprehensive development of local communities and support for them in attaining their basic needs through self – reliance are practical approaches for the introduction of healthy lifestyles in the community. The basic development needs which will help to prevent a stressful life situations should be provided in the home, places of work, schools and in the community as a whole

2.8 Summary Of Literature Review

This chapter review literature on the relationship between demographic characteristics and lifestyles of the people of Kaduna State. Lifestyle is seen as an individuals' typical way of life, attitudes and expression in a self – consistent manner as developing from childhood and influence by modifiable and non – modifiable factors that are found within and outside the environment. This concept of lifestyles was also viewed

as a way or manner of living or behaving that is deemed elegant or in accord with fashion: a fashionable luxurious mode of living. This go down to explain reasons why teenagers and adults saw drinking, smoking, drug abuse, eating of imported and canned foods and casual sex as a fashionable ways of life.

The individual's lifestyle behaviour can influence his state of health, and individual's state of health can influence lifestyle choice. Branch (1985); Breslow and Breslow (1993); Manton et al., (1991); and Rogers, (1995), were of the opinion that individuals with healthy lifestyle tend to live longer than others, and that individuals with unhealthy lifestyle tend to die sooner than others. Healthy lifestyle consists of those positive health behaviours of regular exercise, good diet, non – smoking, non – drinking, avoidance of casual sex and drug abuse, which brings about healthy living. Healthy lifestyle helps to prevent weight gain, high blood pressure, stress, early mortality and the spread of HIV/AIDS. On the other hand, unhealthy lifestyles are those negative health behaviours that had been scientifically proven to be harmful to one's health. They have direct or indirect consequences on the health and well being of individuals. These include poor dietary habits or excessive eating, lack of exercise or sedentary, smoking, casual sex and heavy use of alcohol. The implications of unhealthy lifestyle are enormous these includes problems of malnutrition, obesity, liver cirrhosis, cardiac diseases, HIV/AIDS, accidents, untimely deaths and many others.

The health and well – being of a community are affected by the social milieu within which they live. Thus, life conditions, whether social, economic, environment or biological dictate individual's health status, as well as the magnitude and patterns of disability, morbidity, and mortality.

The review also highlighted that changes in culture and technology in many countries, Nigeria inclusive have caused rapid changes in popular lifestyles, which had led to an increasing incidence of chronic non – communicable diseases. The main behavioural or lifestyle factors of concern examined in this study are nutrition, physical inactivity, smoking, alcohol consumption, drug abuse and unsafe sexual practices.

A regular level of physical activity has great potential in improving health and well – being. Health gain from physical activity include enhanced mood and self - esteem, improved physical appearance; prevent premature mortality, high blood pressure and cardio – vascular disease. Sedentary lifestyle or physical inactivity help to develop one or all of the above mentioned diseases. David (2002) reported a high risk of non – fatal Cardiac Disease for women and divorcee in the sedentary control group in comparison to the active group. A moderate level of walking, jogging, gardening / farming, swimming or yard work most days of week would help to prevent health related problems associated with sedentary. The review also highlighted some programme factors related to drop – out from physical activity or exercise. This includes time constraint, cost, exercise intensity, lack of opportunity for social interaction and support, inconvenience, length of sessions and poor leadership.

Nutrition is the second lifestyle factor examined in this study. Nutrition is defined as the process by which our bodies absorb and make use of food nutrients. The choices of food nutrients by an individual seriously determine the state of health of such individual. Poor or unbalanced diet as in the case of excessive eating or abstinences from eating constitutes risk factors for several chronics diseases. A poor nutritional habit is the major cause of over weight, obesity and diabetes. This fact was corroborated by Ogunsakin

(1999) who reported that unhealthy dietary habits adopted by individuals results in various forms of malnutrition's with attendant cases of weakened condition, poor health, impaired intellectual development and low productivity. Poor nutrition, together with smoking and physical inactivity, is one of the main determinants for cardio vascular diseases and cancer. The dietary habits or lifestyle adopted by an individual have a major influence on his / her health. The food we eat on a daily and weekly basis are the major determinants of diseases. Asuni et al., (1974) observed that about 40% adults and children admitted to hospital in Nigeria in 1973, showed signs of malnutrition. They also reported that a poor nutritional habit in the rural areas of Nigeria results in anaemia amongst young women. And that anaemic mothers are likely to have smaller babies with potentially significant longer – term health consequences.

Helping individuals to adopts good dietary behaviour or lifestyle is the joint responsibility of dieticians, health and physical education professionals, parents and members of the community. The choice of food nutrients like protein, carbohydrate, vitamins, fats and oils, and mineral salts in the correct proportion is influence by both demographic and environmental factors which invariably determine the lifestyles of an individuals.

Smoking is another lifestyle factor reviewed in this chapter, people commonly turn to tobacco smoking as a means of dealing with stressful situations. The American Heart Association (1986) noted that "***Cigarette smoking is the biggest risk factor for sudden cardiac deaths"*** Smokers have between two to four times the risk of non – smokers. Corroborating this fact, the Word Hearth Organisation (1999) reported that Tobacco smoking was responsible for an estimated 1.2 million deaths in the European

Region in 1995 (or about 13% of all deaths). In Nigeria, smoking (Tobacco and Indian Hemp) is the second largest cause of avoidable deaths after accidents, accounting for over 250,000 deaths each year i.e. deaths resulting from cancer related diseases (Asuni, 1974). According to him, about 25% of all cancer deaths and 15% of deaths in the urban cities of Nigeria, could be attributed to smoking. The adoption of smoking as a lifestyle begins among young people through experimentation. Children learn about adult behaviour through their parents and peer groups, using them as role models and may come to associate smoking with being mature. Thus, many teenagers see cigarette smoking as a symbol of adulthood. Peer influence is extremely important in the adoption and development of smoking as a lifestyle. Cigarette smoking used to be strongly associated with freedom, independence, urbanity, glamour and civilization among the smokers. Most studies categorized smokers into three groups: Non – smokers, past smokers and current smokers. It is evident from these studies that smokers had a higher risk of mortality than never smokers, though the mortality risk was higher among middle – age subjects than among the older subjects. For those who had quit smoking, the mortality risk varied from an intermediate risk to a non – elevated risk in comparison with never smokers (Ruigomez ***et al,*** 1995: Davis and Moritz 1994; and Sunyer et al 1998).

Alcoholism as a lifestyle is characterized by excessive use of alcohol to the point of over dependence or addiction (Asuni ***et al,*** 1994). Alcoholism should be differentiated from excessive and heavy social drinking. Excessive drinking goes beyond what is traditional and customary in one's community. Alcoholics are those excessive drinkers whose health, family relationship or work performances are adversely affected by drinking. A description of alcoholic lifestyle may help in the understanding of his/her ways of life. The alcoholic does live a separate lifestyle from others. His sickness, a

compulsion to drink, dictates a well- defined set of defense mechanisms, behavioural patterns and attitudes. For them, alcohol is a necessity and drinking, a compulsion. All activities and relationships are measured in terms of their contribution to or interference with the ***"right to drink"*** (Donglas, 1978). Drinking is an important element of alcoholic social activities whether it be at the club, at the poolside, or at the bar. Alcohol is a dependent producing drug, and this dependence is associated with an increased risk of illness and premature death. Drunkenness is also associated with a high risk of injury and death, both to the person who becomes intoxicated and to others. Alcohol consumptions may lead to loss of jobs, cirrhosis of the liver and hypertension. The effects of alcohol have immediate consequences in terms of behaviuoral changes for the individual and those around him/her. Judgment and co-ordination are likely to be impaired and reactions are slowed, rendering the person more vulnerable to accident (Sutherland and Cooper, 1992).

Drug abuse is another lifestyle factors examined in this chapter. Drug abuse is the taking of any substance for any purpose other than that for which it is intended, and in any way that could damage the user's health or ability to function. The National Drugs Law Enforcement Agency (1998) reported that Nigerians abuse legal and illegal drugs. The use, misuse and abuse, and dependence on psychoactive drugs by children and young people as well as adults stem from and contribute to emotional and social problems in our society. Folawiyo (1990) observed that those attracted to drugs (drug abuse as a lifestyle) are those who are bored, cannot enjoy or cannot tolerate stress and frustrations. The drugs fit their emotional discontents and remove the necessity to plan, to struggles and to endure. According to him, it is a feeling of existential meaninglessness, which attracts some people to drugs. The problems associated with the abuse of drugs are numerous.

This includes automobile accidents, child abuse, unproductively at work, assault and murder, suicide attempts, depression, hallucinogenic reactions, aggressive tendencies and abusive utterances. Other problems include ulcer, malnutrition, hepatitis, brain and liver damage and family neglect.

Casual sex or unsafe sexual practice as a lifestyle is more common among young adults and high socio-economic status individuals. Casual sex as a lifestyle is characterized by sexual mal-adjustment and sex – related crimes. This account for the high prevalence of HIV/AIDS and other sexually transmitted diseases.

The lifestyle of an individuals is influenced by a variety of external and internal factors based on the complex interactions between the individuals and his environment. The review examined the influence of demographic characteristics like age, gender, marital status, religion, educational background and socio-economic factors in the choice of lifestyle factors (smoking, drinking of alcohol, drug abuse, unsafe sexual practices, poor nutritional habits and sedentary lifestyle) as reported by different authors and writers. For example, Jose ***et al,*** (2003) reported that individual with a higher educational level was significantly associated with a lower level of sedentary lifestyle both among men and women.

The influence of individuals' educational background was reported by Molarius (2003), who stated that obesity was more common among subjects with low educational background than subjects with high educational background.

The influence of gender on lifestyle choice was also reported by Molarius (2003), he reported a prevalence of obesity by gender and age among his study population (i.e. 12% of men and 11% of women were obese). In Nigeria, especially in the cities, one observed a prevalence of heavy use of alcohol and drugs among men, especially young men than women.

The influence of other demographic characteristics like socio-economic status, age, martial status and religious were also reviewed. This in addition to various diseases or consequences of unhealthy lifestyles adopted by the people. This has already been discussed in relations to each of the lifestyle factors.

Finally, the review also highlighted the roles of government and the community in the promotion and maintenance of healthy lifestyle. This include adequate information, proper planning, inculcating healthy lifestyle into the school curricula, banned advertisement of cigarette and alcohol in print and electronic media, good legislation and involvement of both non – governmental and religious organisation in the campaign against unhealthy in our society.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The purpose of this study is to examine the relationship between demographic factors like age, gender, religions, socio-economic status, location, educational background, marital status and lifestyles of the people of Kaduna State. This chapter is therefore, concerned with the research design, the population, the sample, the sampling techniques, the instrument, validation of the instrument, pilot study, scoring and analysis, and the statistical techniques/methods used in the study.

3.2 The Research Design

As the purpose of this study is to examine the relationship between demographic factors and lifestyle of the people of Kaduna State, ex-post-facto research design was used, because the information required was already available. In this design a 7 x 6 non – experimental factorial sub– design was used. Thus, the lifestyle factors of smoking, alcohol consumption, drug use, physical inactivity or sedentary lifestyle, excessive eating and unsafe sexual behaviour constitute the dependent variables. While the demographic characteristics of age, gender, socio-economic status, marital status, location, educational background and religions constitutes the independent variables.

The non – experimental 7 x 6 factorial design is a scientific investigation in which an investigator examine the influence of increase or change in one or more independent variables and observed the dependent variables for variation concomitant to the increment or changes of the independent variables though in a non – experimental setting (Kerlinger, 1975). Thus, factorial design afforded the researcher opportunity to juxtapose

two or more independent variables in order to study their relationship on the dependent variables. Information on the seven (7) demographic characteristics of the respondents (independent variables) was compared with the six (6) selected lifestyle factors (dependent variables) of the people of Kaduna State as shown in paradigm I.

	LIFESTYLE FACTORS					
DEMOGRAPHIC CHARACTERISTICS	Smoking	Alcohol consumption	Excessive eating	Sedentary lifestyle	Drug abuse	Unsafe sexual behaviour
Age						
Gender						
Educational background						
Religions						
Socio-economic status						
Marital status						
Location						

Paradigm 1: 7 x 6 Research Design

3.3 The Population

The population for this study consist of all individuals age 16 years and above living in both rural and urban areas in Kaduna State of Nigeria. Because of diversity of the rural areas in different societies, definitions of rural and urban vary. Olawoye (1994) was of the opinion that some researchers used a combination of characteristics to distinguish between rural and urban settings. This include:

- Population size and /or density: rural low, urban high;
- Predominant occupations: Farming or petty trading in the rural area, specializations in the urban area;
- Personal attitudes and opinions of the people: rural sense of "we" belonging, interaction in the urban area is complex, they have sense of "I".;
- Races: rural areas are homogeneous, urban areas are heterogeneous;
- Forms of social control: rural informal, urban formal;
- Presence of social amenities like water, roads, schools, electricity, communication facilities and others: In rural areas those facilities are absent or not adequate, in urban areas facilities are present and adequate to certain degree;
- Death rate: Higher death rates in the rural areas, especially for infants and children under five, as comparable medical facilities found in the urban areas are not available to most rural inhabitants;
- In addition, the rural people are more likely to hold on longer to the traditional ways of doing things, since their exposure to innovations is less frequent and less intense than the exposure of the urban people (Olawoye 1994)

Based on the above distinguishing characteristics, towns and villages in Kaduna state were categorized into rural and urban areas as shown in table 3.1. It is also

important to note that Kaduna State like any other states of the federation is divided into three (3) senatorial districts or zones.

Table 3.1: Rural and urban areas in the three (3) senatorial zones of Kaduna State

1.	**KADUNA ZONE 1**			
		URBAN AREAS		**RURAL AREAS**
	a.	Zaria city	a.	Makarfi
	b.	Sabon – Gari	b.	Soba
	c.	Ikara	c.	Hunkuyi
	d.	Saminaka	d.	Kundan
	e.	Samaru	e.	Basawa
	f.	Tundun wada	f.	Tukutuku
	g.	Wusasa	g.	Hanwa
	h.	Jaji	h.	Line zomo
			i.	Ja'ama
			j.	Palladan
			k.	Kwangila
	KADUNA ZONE 2			
		URBAN AREAS		**RURAL AREAS**
	a.	Kaduna North (Kawo, Mando, Tundun Wada, Angwa Sanusi, Angwa Rimi, Malaali, Kabala West, Kurmin – Mashi, Angwa Sunday)	a.	Giwa
	b.	Kaduna South (Makira, Kakuri, Nasarawa, Barnawa. Television, Sabon-Tasha).	b.	Shika
	c.	Birni – Gwari	c.	Buruku
	d.	Dankade	d.	Udawa
			e.	Kuriga
			f.	Kachia
		KADUNA ZONE 3		
		URBAN AREAS		**RURAL AREAS**
	a.	Kafancha	a)	Gida waya
	b.	Zonkwa	b)	Godo godo
	c.	Zagon-kataf	c)	Fadan kashi
	d.	Samaru – Kataf	d)	Kagarko
	e.	Manchok	e)	Kagoro
	f.	Katcha	f)	Kateri
	g.	Kwoi	g)	Kagoma
	h.	Gantu	h)	Nok
			i)	Chori
			j)	Kasuwa magani
			k)	Izom
			l)	Angwa Rimi
			m)	Jagindi
			n)	Ka matan

3.4 The Sample

Two rural and two urban areas from each of the three (3) senatorial zones of the state were selected at random to draw the samples for this study. Thus, a total of six (6) urban areas and six (6) rural areas were selected at random from where the samples for this study were drawn. All respondents (16 years and above) living in Kaduna state at the time of the study served as subjects for this investigation irrespective of gender, socio-economic status, location, religions, marital status and educational background. In addition, 150 respondents each from the six (6) urban areas and 75 respondents each from the six (6) rural areas were involved. Thus, a total of 1350 samples/respondents were used for the study.

3.4.1 Sampling Techniques

Stratified random sampling technique was used to select the required sample for the study. In the first stage, Kaduna State was divided into three (3) strata represented by the three (3) senatorial districts/zones of the state. In the second stage, two urban and two rural areas were randomly selected from each of the three (3) senatorial districts/zones giving a total of six (6) rural and six (6) urban areas used for the study. The three (3) senatorial district headquarters of Zaria, Kaduna and Kafancha of the state formed the nuclei of the study. Cluster sampling technique was also used to select drug addicts, heavy tobacco users, drunkards, sedentary individuals and prostitutes. However, a total of 450 respondents each from the three (3) senatorial zones were randomly selected for this study. Altogether, a total of one thousand, three hundred and fifty (1350) copies of questionnaire farms were distributed, 450 copies to each of the three (3) senatorial zones.

3.5 The Instrument

The instrument used in this investigation to collect data was the questionnaire designed and developed by the investigator tagged "Questionnaire on Relationship between Demographic factors and Lifestyles of the people of Kaduna State (QRDLKS)". The instrument was also used as an interview schedule / focused group discussion for non – literate and addicted respondents. The instrument is described below.

3.5.1 Development Of The Instrument

The instrument on the relationship between demographic factors and lifestyles of the people of Kaduna State is an inventory form designed by the investigator (**Appendix A**). The instrument consisted of 55 statements relating to personal information, with sections on practices of lifestyle factors like smoking, physical inactivity, use of alcohol, drug abuse and misuse, nutritional habit and sexual behaviour of the people of Kaduna State. The respondents are requested to respond to the alternatives provided in the research instrument as it applicable to them (Kerlinger, 1975; Best and Kahn, 1989; and Babbie, 1990).

The instrument is divided into two parts (I and II). Part I of the instrument focused on the demographic information such as age, gender, location, income level, religions, marital status and educational qualification.

Part II of the instrument elicited information from the respondents on different aspects of the practices of lifestyle factors, frequency of its practice, reasons for the adopted lifestyles, consequences or health related problems of unhealthy lifestyle and whether practices of lifestyle factors is common amongst the rural people than urban people of Kaduna State.

3.5.2 Validation Of The Instrument

The face validity of the instrument was determined by distributing the copies of the questionnaire to five (5) jurors who are professional experts selected from the departments of Economics, Sociology, Community Medicine and Physical and Health Education of Ahmadu Bello University, Zaria; to vet the questionnaire. On the basis of their suggestions and recommendations, necessary modifications were made in the draft questionnaire, after which a questionnaire for pilot testing was prepared.

3.5.3 The Pilot Study

In order to determine the internal consistency and reliability of the questionnaire, a pilot study was conducted. In this pilot study, a total of 120 respondents were randomly selected from urban and rural areas of Kaduna State. These respondents were not expected to be part of the samples for the main study. The questionnaire was administered to the literate respondents and translated for the non-literate respondents by a research assistant (an interpreter) who was fluent in Hausa language. Thereafter, the responses of the latter group were recorded in the questionnaire forms by the researcher. The former group who could read and understand English language filled the questionnaire by themselves, which were then returned to the researcher. The data thus collected was statistically analyzed to determine the internal consistency and validity of the instrument. In the procedure, Goffman split–half reliability model was used through the Statistical Package for Social Science (SPSS). Thus a reliability analysis scale of alpha value of 0.9181 was obtained, which showed that the instrument was consistent and valid.

In addition, all items in the questionnaire were item analyzed to determine the discrimination index and the facility index of each item. As there were no wrong and right answers, only facility index was used in this pilot study. Any statement that had a facility index of between 30% and 70% was accepted (Mukherjee, 2002). Only statement numbers 15 and 54 could not meet these criteria, and were therefore discarded. All other items were accepted, and the final questionnaire that was prepared included all other items.

3.6 Scoring And Analysis

The final draft of the questionnaire after the pilot study, was administered on the respondents with the appropriate instructions on how to respond to the statements. The data collected were statistically analyzed

Each statement is assigned a numerical score (ordinal). The raw scores of the respondents were coded on data sheets and punched on the computer cards. The total score was interpreted as representing the respondents' attitude on the lifestyles factors towards the statement under investigation. The scoring nature of the questions did not permit the direct application of a parametric procedure like the usual Analysis of Variance (ANOVA), but rather the Kruskal – Wallis one-way ANOVA was applied. i.e. The Kruskal-Wallis one way non-parametric method is designed for the type of scoring of items (ordinal scoring) used in this study.

3.7 Administration Of The Questionnaire

The investigator was personally involved in the distribution of questionnaire and conduct of interview schedule/focused group discussion for the addicted respondents and non– literate respondents. However, this was done with the assistance of research

assistants and interpreters who are fluent in various local languages that exists in the state. Thus, a total of 450 copies of the questionnaire were administered to each of the three (3) senatorial districts/zones in Kaduna State.

3.8 Statistical Techniques

The data collected from the respondents during the investigation were analyzed by using the Statistical Package for Social Science (SPSS) for student t-test, chi-square and spearman rank order and Statix Statistical Package (SSP) for Kruskal-Wallis one-way ANOVA at the Institute for Agricultural Research (IAR) Computer Centre, Ahmadu Bello University, Zaria. The statistical techniques that was used to analyzed data for this study are:

1. Descriptive statistics of frequencies, percentages, means and standard deviations was used to analyzed the demographic data that emanated from the study.
2. A 7x6 factorial analysis of variance with a combination of spearman rank-order of correlation coefficient and Kruskal-Wallis one –way ANOVA was used to test the relationship and differences between demographic factors and lifestyles of the people of Kaduna State.
3. Chi- square (x^2) and spearman rank-order of correlation coefficient was used to analyzed the significant relationship between the health problems suffered by the people of Kaduna state and their lifestyles.
4. Student t-test was used to test the significant difference in the lifestyle of urban and rural people of Kaduna State.
5. Both 0.01 and 0.05 alpha levels of significant was used for the statistical tests of significance.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

The purpose of this study was to find out the relationship between the demographic factors and lifestyles of the people of Kaduna state. To achieve this purpose, the data collected in this study were statistically analyzed to test the hypotheses posed in the study, the results are presented and discussed in this chapter.

4.2 Demographic Characteristics

Before the results are presented according to the hypotheses stated in the study, overviews of the study areas, lifestyles patterns and possible health problems location by location with the demographic characteristics of the respondents are analyzed. The results are shown in tables 4.1 to 4.3. This is in addition to the respondents' responses to each of the items on the questionnaire as presented in **appendix E**.

Table 4.1: The six (6) Rural and Six (6) Urban Areas With The Numbers of Samples Randomly Selected And used for the Study.

Senatorial zones	Rural Areas	No of Samples	Urban Areas	No of Samples
Zone 1 Headquarter: Zaria	1. Ja'ama 2. Kwangila	75 75	1. Zaria city 2. Samaru	150 150
Zone 2. Headquarter: Kaduna	3. Giwa 4. Buruku	75 75	5. Kawo and Mando 6. Birni Gwari	150 150
Zone 3. Headquarter: Kafancha	5. Kagoro 6. Kagoma	75 75	7. Kafancha 8. Kwoi	150 150
Total		450		900

Table 4.1 shows the towns and villages used for the study. It also reveals that 75 respondents each were randomly selected from the six (6) rural areas of Ja'ama,

Kwangila, Giwa, Buruku, Kagoro and Kagoma that are for the study. The table further reveals that 150 respondents each were randomly selected from the six (6) urban areas of Zaria city, Samaru, Kawo and Mando, Birni Gwari, Kafancha and Kwoi that are used for the stud. In all, 450 rural people and 900 urban residents were randomly selected and used for the study.

Table 4.2 Lifestyle patterns and Common Health Problems Location by Location.

Senatorial zones	Locations	Lifestyle patterns in order of preference	Health related problems
Zone 1	Ja'ama Kwangila Zaria city Samaru	Sexual behaviour Drug habit Alcoholic lifestyle Smoking Nutritional habit Physical inactivity	Sexually transmitted diseases, violence depression, anxiety, redness of lip. accident, personality disorder, problems of adjustment, malnutrition, obesity, lost of appetite e.t.c.
Zone 2	Giwa Buruku Kawo and mando Birni Gwari	Drug habit Alcoholic lifestyle Sexual behaviour Smoking Nutritional habit Physical inactivity	Depression, violence, liver problem, accident, social uneasiness, STDs, abortion, cardiac diseases, lung problem, loss of appetites, overweight, obesity, high blood pressure e.t.c
Zone 3	Kagoro Kagoma Kafancha Kwoi	Alcoholic lifestyle Sexual behaviour Smoking Drug habit Physical inactivity Nutritional habit	Accident, problems of adjustment, teenage pregnancies, STD, cough, lung problem, violence, depression, obesity, malnutrition, loss of appetite

Table 4.2 gave an overview of lifestyle patterns in order of commonalities and health related problems of the adopted lifestyles location by location. The table reveals that the use of the drugs to enhance performance, alcohol consumption and indiscriminate sexual behaviour top the list of those lifestyle factors (unhealthy lifestyle) mostly practiced by the respondents in Kaduna State. Sedentary lifestyle, smoking and poor nutritional habit occupies the rear three (3) positions among the unhealthy lifestyles practiced by the respondents in Kaduna State. The table also presented health related problems of the adopted lifestyles location by location.

Table 4.3 Demographic Characteristics of Respondents

S/NO.	CHARACTERISTICS	FREQUENCY	PERCENTAGE
1.	**Age:**	261	19.3
	16-20 years	289	21.4
	21-25 years	236	17.5
	26-30 years	225	16.7
	31-35years	155	11.5
	36-40 years	85	6.3
	41-45 years	63	4.7
	46-50 years	36	2.7
	51 years and above		
2.	**Gender:**		
	Male	1038	76.9
	Female	312	23.1
3.	**Religion:**		
	Islam	549	40.7
	Christianity	703	52.1
	Traditional	27	2.0
	Others	71	5.3
4.	**Marital Status:**		
	Single	676	50.1
	Married	614	45.5
	Widowed	9	0.7
	Divorced	16	1.2
	Separated	35	2.6
5.	**Highest Educational Qualification:**		
	Postgraduate	151	11.2
	First degree [HND]	198	14.7
	Diploma / NCE	363	26.9
	Secondary school	423	31.3
	Primary school	81	6.0
	Adult Education	20	1.5
	Quranic Education	70	5.2
	Craftman / Apprenticeship	27	2.0
	Traditional form of education	17	1.3
6.	**Income Level (socio-economic Status)**		
	Above A million Naira P.A.	49	3.6
	N500,000 – N999,000 P.A.	119	8.8
	N100,000 - N499,000 P.A.	247	18.3
	N 50,000 - N 99,000 P.A.	338	25.0
	Less than N 49,000 P.A	447	33.1
	No Response	150	11.1
7.	**Location:**		
	Rural area	450	33.3
	Urban area	900	66.7

TOTAL NUMBER OF RESPONDENTS USED: 1350

The table shows that out of a total of 1350 respondents used for the study, majority (n=289, 21.4%) were within the age range of 21-25years. Most of them are male respondents (n=1038, 76.9%); religion played significant role in this perspective, since researcher and his assistants were not allowed to meet with females (women in purdah) in Muslims dominated areas of Kaduna State.

The table further reveals that majority of the respondents (n=703, 52.1%0 were Christians especially among the southern Kaduna inhabitants. Also, majority of the respondents (n=676, 50.1%) were singles, while most of the respondents can be classified as being literates since the respondents (n=1135, 84.1%) claimed to have obtained secondary education and above. Majority of the respondents (n=447,33.1%) submitted that their annual income level is less than N49, 000.00, which implies that majority are living below average income level set for the developing countries of the world, by the World Health Organization of 1998. Finally, the table shows that a total of 450 respondents were randomly selected from the rural areas, while 900 respondents were randomly selected from the urban areas of the study area (Kaduna State).

4.3 Hypotheses Testing

Testing main hypothesis one

There is no significant relationship between demographic characteristics of the people of Kaduna State and their lifestyles.

In order to find out whether there is no significant relationship between demographic characteristics (age, gender, religions, marital status, location, educational background and socio-economic status) of the people of Kaduna State and their lifestyles (smoking, alcohol, sedentary, nutritional habit, drug habit and sexual behaviour), the data collected were analysed by using spearman rank-order correlation coefficient.

Table 4.4: Spearman' rho showing relationship between

Demographic factors and lifestyles of the people of Kaduna State.

	LIFESTYLE FACTORS					
DEMOGRAPHIC FACTORS	**Smoking habit**	**Alcohol lifestyle**	**Sedentary lifestyle**	**Nutritional lifestyle**	**Drug habit**	**Sexual Behaviour**
Age						
Correlation coefficient	-.150**	-.028	-.045	.047	-.124**	-.040
significant (2-tailed)	.000	.298	.099	.086	.000	.141
N	1350	1350	1350	1350	1350	1350
Gender						
Correlation coefficient	-.027	-.016	-.105**	.025	.086**	.044
significant (2-tailed)	.327	.549	.000	.368	.000	.109
N	1350	1350	1350	1350	1350	1350
Religion						
Correlation coefficient	.065*	.175**	.071**	-.043	-.124**	-.040**
significant (2-tailed)	.017	.000	.009	115	.000	.141
N	1350	1350	1350	1350	1350	1350
Marital Status						
Correlation coefficient	-.044**	.048**	.030**	.077**	.000**	.002**
significant (2-tailed)	.105	.076	.277	.005	.996	.933
N	1350	1350	1350	1350	1350	1350
Location						
Correlation coefficient	-.058*	-.142**	-.103**	-.047	-.163**	-.117**
significant (2-tailed)	,034	.000	.000	.084	.000	.000
N	1350	1350	1350	1350	1350	1350
Educational Status						
Correlation coefficient	.042**	.096**	-.046**	.131**	.044**	102**
significant (2-tailed)	.123	.000	.091	.000	.108	.000
N	1350	1350	1350	1350	1350	1350
Socio-economic Status						
correlation coefficient	.005**	.096**	.000**	.178**	.093**	-.013**
significant (2-tailed)	.849	.000	.987	.000	.001	.629
N	1350	1350	1350	1350	1350	1350

** Correlation is significant at the .01 level (2-tailed)

* Correlation is significant at the .05 level (2-tailed)

A careful examination of the table shows that there are two (2) basic inferences that can be deduced from the table.

1. Inference I:

Demographic characteristics and lifestyle factors are significantly related in the following ways:

(i) Age is significantly related to smoking and drug habits of the respondents at 0.01 alpha level.

(ii) Gender is significantly related to sedentary lifestyle and drug habit of the respondents at 0.01 alpha level.

(iii) Religion is significantly related to smoking habit at 0.05 alpha level, and significantly related to alcoholic lifestyle, sedentary lifestyle, drug habit and sexual behaviour of the respondents at 0.01 alpha level.

(iv) Marital status is significantly related to smoking habit, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour of the respondents at 0.01 alpha level.

(v) Location (rural and urban) are significantly related to smoking habit of the respondents at 0.05 alpha level, and significantly related to alcoholic lifestyle, sedentary lifestyle, drug habit and sexual behaviour of the respondents at 0.01 alpha level.

(vi) Educational status is significantly related to smoking, alcoholic lifestyle, sedentary lifestyle, nutritional lifestyle, drug habit and sexual behaviour of the respondents at 0.01 alpha level.

(vii) Socio-economic status is significantly related to smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour of the respondents at 0.01 alpha level of significance.

2. Inference II

Significant relationship does not exist between demographic factors and lifestyles of the people of Kaduna State.

(i) Significant relationship does not exist between age and alcoholic lifestyle, sedentary lifestyle, nutritional habit and sexual behaviour of the respondents at both 0.01 and 0.05 alpha levels of significance.

(ii) Significant relationship does not exist between gender and smoking habit, alcoholic lifestyle, nutritional habit and sexual behaviour of the respondents at both 0.01 and 0.05 alpha levels of significance.

(iii) Nutritional habit is not significantly related to respondents' religion at both 0.01 and 0.05 alpha level of significance.

(iv) Significant relationship does not exist between location (rural and urban) and nutritional habit of the respondents at both 0.01 and 0.05 alpha levels of significance.

Sub-hypothesis I

There is no significant difference between the adopted lifestyles and age groups of the respondents in Kaduna State

In order to find out whether there is no significant difference between the adopted lifestyles (smoking habit, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour) and age groups of the respondents in Kaduna State, the data collected were analysed by using Kruskal-Walli one-way ANOVA in the following order:

(a) Significant difference does not exist between the age groups and smoking habit of the people of Kaduna State.

(b) Significant difference does not exist between the age groups and alcoholic lifestyle of the people of Kaduna State.

(c) Significant difference does not exist between the age groups and sedentary lifestyle of the people of Kaduna State.

(d) Significant difference does not exist between the age groups and nutritional habit of the people of Kaduna State.

(e) Significant difference does not exist between the age groups and drug habit of the people of Kaduna State.

(f) Significant difference does not exist between the age groups and sexual behaviour of the people of Kaduna State.

It is important to note that the age range of the respondents are classified into the following groups.

Group 1	-	16-25 years to include individuals within age ranges 16-20 years and 21-25 years (n=550).
Group 2	-	26-35 years to include individuals within age ranges 26-30 years and 31-35 years (n=461).
Group 3	-	36-45 years to include individuals within age ranges 36-40 years and 41-45 years (n=240).
Group 4	-	46 years and above to include individuals within age ranges 46-50 years and 51 years and above (n=99).

TABLES 4.5 (1) Summary of Kruskal-Wallis one way ANOVA on

The differences between the adopted lifestyles and age groups of Respondents in Kaduna State

Lifestyle factors	Source	DF	SS	MS	F-Ratio	P. value	Remark
Smoking & Age groups	Between Within	3 1346	4.727 1.741	1.576 1.294	12.18	0.0000	Significant
	Total	1349	1.789				
Alcoholic lifestyle & Age groups	Between Within	3 1346	5.286 1.937	1.762 1.439	1.22	0.2990	Not significant
	Total	**1349**	**1.942**				
Sedentary lifestyle & Age groups	Between Within	3 1346	5.101 2.009	1.700 1.493	1.14	0.3322	Not significant
	Total	**1349**	**2.015**				
Nutritional habit & Age groups	Between Within	3 1346	6.800 2.030	2.273 1.508	1.51	0.2093	Not significant
	Total	**1349**	**2.030**				
Drug habit & Age groups	Between Within	3 1346	7.725 1.890	2.575 1.404	18.34	0.000	Significant
	Total	**1349**	**1.967**				
Sexual behaviour & Age groups	Between Within	3 1346	9.457 2.028	3.152 1.507	2.09	0.0977	Not significant
	Total	**1349**	**2.038**				

Df = K-1 = 4-1=3, F-Critical = 2.60, P<0.05.

= N-4 = 1350-4 = 1346.

Table 4.5 (II): Differences in the age groups and Mean Ranks of the Adopted Lifestyles.

Age groups	Sample size	Mean rank for smoking	Mean rank for alcoholic	Mean rank for sedentary	Mean for rank for nutritional	Mean rank for drug habit	Mean rank for sexual behaviour
16-25 years	550	746.7**	695.8	695.4	662.2	754.5*	703.4
26-35 years	461	629.4	650.4	665.7	665.0	598.9	642.0
36-45 years	240	626.7	673.0	669.0	700.4	610.4	675.0
45 years and above	99	613.0	685.7	626.5	717.9	751.4*	676.2
Total	**1350**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**

Table 4.5 (I) shows that the F-calculated for alcoholic lifestyle (1.22), sedentary lifestyle (1.14), nutritional habit (1.51) and sexual behaviour (2.09) were less than the critical value of 2.60 with degrees of freedom 3 and 1346 at 0.05 alpha level of

significance. Therefore, the null hypotheses that says there are no significant differences in the adopted lifestyles of alcoholic lifestyle, sedentary lifestyle, nutritional habit and sexual behaviour of the respondents and their age groups were accepted. This implies that significant difference does not exist between the adopted lifestyles (Alcoholic lifestyle, sedentary lifestyle, nutritional lifestyle and sexual behaviour) of the respondents and their age groups.

The insignificant difference or lack of significant difference observed in the adopted lifestyles of alcoholic lifestyle, sedentary lifestyles, nutritional habit and sexual behaviour of the respondents and their age groups is due to the fact that the mean ranks of all the age groups as the case of alcoholic lifestyle and age groups; sedentary lifestyle and age groups; nutritional lifestyles and age groups and sexual behavour and age groups of the respondents are closely related as presented in table 4.5 (II) above. This means that age does not influence respondents consumption of alcohol, participation in physical activity, nutritional habit as well as sexual practices.

The table 4.5 (1) also reveals that the F-calculated for smoking (12.18) and drug habit (18.34) were greater than the critical value of 2.60 with degrees of freedom 3 and 1346 at 0.05 alpha level of significance. Therefore, the null hypotheses that says there are no significant differences in the adopted lifestyles of smoking and drug habit of the respondents and their age groups were rejected. This implies that significant differences exist between the adopted lifestyles (smoking and drug habit) of the respondents and their age groups.

As it is indicated from table 4.5 (II) above, individuals within age group 16-25 years (n=550) possessed a high mean rank of 746.7, an indication that they smokes more than people of other age groups in Kaduna State. Also, a careful examination of table 4.5

(II) shows that drug abuse and misuse is common among individuals within age group 16-25 years (n=550, mean rank = 754.5) and age group 46 years and above a(n=99, mean rank 751.4). Tendency to feel high among peer groups and geriatric health problems may account for the reasons why drug use, abuse and misuse is common among adolescents / young adults and old people respectively.

Sub-hypothesis II

There is no significant difference between the adopted lifestyles and gender of the people of Kaduna State.

In order to find out whether there is no significant difference between the adopted lifestyles (smoking habits, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour) and gender of the respondents in Kaduna State, the data collected were analysed by using student t-test.

(a) Significant difference does not exist between gender (male and female) and smoking habit of the people of Kaduna State.

(b) Significant difference does not exist between gender (male and female) and alcoholic lifestyle of the people of Kaduna State.

(c) Significant difference does not exist between gender (male and female) and sedentary lifestyle of the people of Kaduna State.

(d) Significant difference does not exist between gender (male and female) and drug habit of the people of Kaduna State.

(e) Significant difference does not exist between gender (male and female) and drug habit of the people of Kaduna State.

(f) Significant difference does not exist between gender (male and female) and sexual behaviour of the people of Kaduna state.

Tables 4.6: Summary of Means, standard Deviations, standard Errors and t-values of Differences between adopted lifestyles and Gender of the respondents in Kaduna State.

Lifestyle factors	Gender	No of cases	Means	S.D.	S. E	Df	Cal. t-value	Critical value	Remark
Smoking	Male Female	1038 312	4.9094 4.7596	3.817 4.042	0.118 0.229	1348	0.60	1.96	Not sign
	Total	**1350**							
Alcoholic lifestyle	Male Female	1038 312	7.9017 7.2596	6.044 5.593	0.188 0.317	1348	1.67	1.96	Not sign
	Total	**1350**							
Sedentary lifestyle	Male Female	1038 312	8.0032 8.6002	2.707 2.691	0.084 0.153	1348	3.43	1.96	Sign
	Total	**1350**							
Nutritional habit	Male Female	1038 312	15.9094 16.0609	4.304 4.607	0.134 0.261	1348	-0.54	1.96	Not sign
	Total	**1350**							
Drug habit	Male Female	1038 312	7.1657 8.1250	5.650 5.449	0.175 0.308	1348	-2.65	1.96	Sign
	Total	**1350**							
Sexual behaviour	Male Female	1038 312	9.4971 9.7276	4.134 4.521	0.128 0.266	1348	-0.84	1.96	Not sign
	Total	**1350**							

Df = N- 2 = 1350 –2 = 1348, critical value = 1.96, P. < 0.05.

Table 4.6 shows that the calculated t- value = 1.96, P. <0.05. Smoking habit (0.60), alcoholic lifestyle (1.67), nutritional habit (-0.54) and sexual behavour (-0.84) of the respondents were less than critical / table value of 1.96 with a degree of freedom 1348 at 0.05 alpha level of significance. Therefore, the null hypotheses that says there are no significant difference in the adopted lifestyles of smoking, alcoholic lifestyle, nutritional habit and sexual behaviour were upheld. This means that significant difference does not exist between the adopted lifestyles (smoking, alcoholic lifestyle, nutritional habit and

sexual behavour) and gender of the respondents in Kaduna State. This implies that gender of the respondents does not influence the respondents smoking habit, alcoholic lifestyle, nutritional habit and sexual behaviour of the people of Kaduna State. A visit to southern parts of Kaduna State and state would clearly testify to the fact that both gender were actively involve in alcohol consumption. However, a slight increase is found among men than women as shown in their means in table 4.6 above. Also, majority of the respondents (Cut across gender) submitted that they feed on local foods everyday of the week (Pap & Akara, Tuwo Masara, Gari, Yams, Rice, Beans and other cereal products). The insignificant difference observed in gender and their sexual behaviour is due to the fact that both gender were actively involve in indiscriminate sexual behavour.

Table 4.6 also reveals that the calculated t. value for sedentary lifestyle (3.43) and drug habit (-2.65) were greater than the critical value of 1.96 with a degree of freedom 1348 at 0.05 alpha level of significance. Therefore, the null hypotheses that says there are no significant differences in the adopted lifestyles of sedentary lifestyle and drug habit of the respondents and their gender were rejected. This implies that significant differences exist between the adopted lifestyles (sedentary and drug habit) and the gender of the respondents in Kaduna State.

As it is indicated from table 4.6 above, sedentary lifestyle is common among the female respondents than their male counterparts. The difference in their means of 8.0032 for males and 8.6002 for females as presented in the table is a pointer to this direction. Also, the female respondents irrespective of age, religion, culture and socio-economic background involve in drug abuse, trafficking and misuse than their male counterparts. This is shown in their mean of 8.1250, which is greater than the mean of their male counterparts of 7.1657.

Sub-hypothesis III

There is no significant difference between the adopted lifestyles and educational background of the respondents in Kaduna State.

In order to find out whether there is no significant differences between the adopted lifestyle (smoking habits, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour) and educational background of the respondents in Kaduna State, the data collected were analysed by using Kruskal-Wallis one-way ANOVA. It is important to note that the educational status of the respondents are classified into the following groups:

(a) Tertiary to include postgraduate, first degree, Higher National Diploma (HND), Nigerian Certificate in Education (NCE) and Ordinary National Diploma (OND) holders (n=712).

(b) Secondary to include Grade II, SSCE, NECO and NAB TEB holders (n=423).

(c) Primary to include first school leaving certificate and Adult literacy certificate holders (n=101).

(d) Others to include Quranic Education, Craftmen / Apprenticeship and traditional form of education (n=114).

The Kruskal-Wallis one-way ANOVA is presented in the following order:

(a) Significant difference does not exist between the educational status groups of the respondents and their smoking habit.

(b) Significant difference does not exist between the educational status groups of the respondents and their alcoholic lifestyle

(c) Significant difference does not exist between the educational status groups of the respondents and their sedentary lifestyles.

(d) Significant difference does not exist between the educational status groups of the respondents and their nutritional habit.

(e) Significant difference does not exist between the educational status groups of the respondents and their drug habit.

(f) Significant difference does not exist between the educational status groups of the respondents and their sexual behaviour.

Tables 4.7(1) Summary of Kruskal-Wallis One Way ANOVA on the Difference Between the Adopted Lifestyles and Educational Status groups of Respondents in Kaduna State

Lifestyle factors	Source	Df	SS	MS	F-Ratio	P. value	Remark
Smoking & Educ. SG	Between Within	3 1346	2.010 1.768	6.701 1.314	5.10	0.0018	Sign
	Total	**1349**	**1.789**				
Alcoholic lifestyle & Educ. SG	Between Within	3 1346	4.134 1.901	1.378 1.412	9.76	0.000	Sign
Sedentary lifestyle & Educ. SG	Between Within	3 1346	1.533 1.999	5.109 1.485	3.44	0.0163	Sign
	Total	**1349**	**2.015**				
Nutritional habit & Educ. SG	Between Within	3 1346	4.651 1.990	1.550 1.479	10.49	0.0000	Sign
	Total	**1346**	**2.037**				
Drug habit & Educ. SG	Between Within	3 1346	1.631 1.951	5.438 1.449	3.75	0.0107	Sign
	Total	**1346**	**1.967**				
Sexual behaviour & Educ. SG	Between Within	3 1346	2.807 2.010	9.356 1.493	8.27	0.0004	Sign
	Total	**1349**	**2.038**				

Df = K –1 = 4-1 =3, F-critical = 2.60, P. < 0.05
= N-4 = 11350-4 = 1346, Educ. S.G = Educational Status Groups

Table 4.7 (II) Differences in the educational status groups and mean ranks of the adopted lifestyles

Educ. Status groups	Sample size	Mean rank for smoking	Mean rank for alcoholic	Mean rank for sedentary	Mean rank for nutritional	Mean rank for Drug habit	Mean rank for sexual behaviour
Tertiary	712	670.9	650.4	693.0	636.8	668.6	644.8
Secondary	423	647.3	658.7	662.2	680.6	648.0	677.5
Primary	101	690.6	851.1	570.5	739.0	759.0	793.3
Others	114	795.3	738.7	708.5	842.1	746.4	755.6
Total	**1350**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**

A careful examination of table 4.7 (I) shows that the F-calculated for smoking (5.10), alcoholic lifestyle (9.76), sedentary lifestyle (3.44), nutritional habit (10.49), drug habit (3.75) and sexual behaviour (8.27) were greater than the critical value of 2.60 with degrees of freedom 3 and 1346 at 0.05 alpha level of significance. Therefore, the null hypotheses that says there are no significant differences in the adopted lifestyles of smoking, alcoholic lifestyle, sedentary lifestyle, nutritional lifestyle, drug habit and sexual behaviour of the respondents and their educational status groups were rejected. This means that significant differences exist between the adopted lifestyles (smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour) of the respondents and their educational status groups. The interpretation of this is that educational status groups of individuals influenced his/ her smoking habit, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour.

Table 4.7 (II) reveals that individuals within educational status group classified as others (Quranic education, Craft men / Apprenticeship and Traditional form of education n = 114) possessed a high mean rank of 795.3. This means for one reason or the other, the group smokes more than the other groups. The table further reveals that alcohol consumption is more common among the individuals within educational status groups classified as primary (n=101, mean rank = 851.1) and others (n=114, mean rank = 738.7). This implies that these two groups (primary and others) consume more alcohol than the other two groups (tertiary and secondary). Also, the table shows a high mean rank of 708.5 for individuals classified as others, an indication that they assumes more sedentary lifestyle than the other groups. While individuals classified as primary shown a decline mean rank of 570.5, an indication that they are more physically active in their daily routine.

The significant difference observed in the nutritional habit and educational status groups of the respondents is further confirmed in the way the mean ranks of the groups were sparsely spread, with high mean rank found among the individuals classified as others (n=114, mean rank 842.1) declining along the line of educational attainment with low mean rank found among the individuals classified as tertiary (n=712, mean rank 636.8). This means that the choice and selection of food nutrients is significantly influence by ones level of education.

Table 4.7 (II) further reveals that educational status group of an individual influenced the way and manner in which such individual abuse and misuse drugs. Individuals classified as Others and primary possessed high mean ranks of 746.4 and 759.0 respectively, while the more knowledgeable ones (tertiary and secondary) possessed low mean ranks of 668.6 and 648.0. This means that the use and abuse of drugs by individuals is influenced by one's level of education.

A careful examination of table 4.7 (II) shows that individuals classified as primary (n=101) possessed a high mean of 793.3, an indication that half-baked or ill informed individuals are dangerous in their indiscriminate practices of sexual related activities. The same could also be said of those classified as others, their own predicament could be understood because they are not informed about sexual related activities in a school setting. The low mean rank found among the individuals classified as tertiary is a pointer to the fact that education influenced ones level of indiscriminate sexual practices / behaviour.

Sub-hypothesis IV

There is no significant difference between the adopted lifestyles and socio-economic status of the respondents in Kaduna State.

In order to find out whether there is no significant difference between the adopted lifestyles (smoking habits, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour) and socio-economic status of the respondents in Kaduna State, the data collected were analysed by using Kruskal-Wallis one-way ANOVA. The respondents are classified into the following socio-economic status groups.

Group O - No response (N=150)

Group 1 - Individuals earning above one million Naira per annum (n=49)

Group 2 - Individuals earning between N500, 000 – N999, 000 per annum (n=119)

Group 3 - Individuals earning between N100, 000 – N499, 000 per annum (n=247).

Group 4 - Individuals earning between N50, 000 –N99, 000 per annum (n=338)

Group 5 - Individuals earning less than N49, 000 per annum (n=447).

The Kruskal- Wallis one-way ANOVA is presented in the following order.

(a) Significant difference does not exist between the socio-economic status groups of the respondents and their smoking habit.

(b) Significant difference does not exist between the socio-economic status groups of the respondents and their alcoholic lifestyle.

(c) Significant difference does not exist between the socio-economic status groups of the respondents and their sedentary lifestyle

(d) Significant difference does not exist between the socio-economic status groups of the respondents and their nutritional habit.

(e) Significant difference does not exist between the socio-economic status groups of the respondents and their drug habit.

(f) Significant difference does not exist between the socio-economic status groups of the respondents and their sexual behaviour.

Tables 4.8(I): Summary of Kruskal-Wallis one Way ANOVA on The Differences Between The Adopted Lifestyles and Socio-Economic Status Groups of the Respondents in Kaduna State.

Lifestyle factors	Source	DF	SS	MS	F. Ratio	P. value	Remark
Smoking & S.E. S Groups	Between Within	5 1344	3.584 1.753	7.168 1.304	5.50	0.0001	Sign
	Total	**1349**	**1.789**				
Alcoholic lifestyle & S.E.S Groups	Between Within	5 1344	5.210 1.890	1.042 1.406	7.41	0.0000	Sign
	Total	**1349**	**1.942**				
Sedentary lifestyle & S.E.S. Groups	Between Within	5 1344	5.838 1.956	1.168 1.455	8.02	0.0000	Sign
	Total	**1349**	**2.015**				
Nutritional habit & S.E.S Groups	Between Within	5 1344	3.425 1.947	1.721 1.449	15.61	0.0000	Sign
	Total	**1349**	**2.037**				
Drug habit & S.E.S. Group	Between Within	5 1344	8.178 1.885	1.636 1.403	11.66	0.0000	Sign
	Total	**1349**	**1.967**				
Sexual behaviour & S.E.S. Groups	Between Within	5 1344	2.040 2.017	4.081 1.501	2.72	0.0188	Sign
	Total	**1349**	**2.038**				

DF = k-1=6-1=5, F-critical = 2.21, P.<0.05

= N-6 = 1350-6=1344, S.E.S = Socio-Economic Status

Table 4.8 (II): Differences in the Socio-Economic Status Groups and Mean Ranks of the Adopted Lifestyles.

Socio-Economic Status Groups	Sample size	Mean rank for smoking	Mean rank for alcoholic	Mean rank for sedentary	Mean rank for nutritional	Mean rank for drug habit	Mean rank for sexual behaviour
No response	150	567.5	525.7	556.7	547.3	523.1	605.9
Above ₦ 1million	49	722.5	669.3	788.7	413.1	715.4	755.9
N500,000-N999,000	119	792.0	761.2	645.8	655.9	810.9	747.8
N100,000-N499,000	247	675.9	638.7	689.0	677.6	594.0	670.9
N50,000-N99,000	338	689.0	695..5	691.4	667.4	704.4	699.2
Less than N49,000	447	665.2	708.9	647.2	757.5	709.4	655.4
Total	**1350**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**

A careful examination of table 4.8 (I) shows that the F-calculated for smoking (5.50), alcoholic lifestyle (7.41), sedentary lifetysle (8.02), nutritional habit (15.61), drug habit (11.66) and sexual behaviour (2.72) were greater than the critical value of 2.21 with degrees of freedom 5 and 1344 at 0.05 alpha level of significance. Therefore, the null hypotheses that says there are no significant differences in the adopted lifestyles of smoking, alcoholic lifestyle, sedentary lifestyle, nutritional lifestyle, drug habit and sexual behavior of the respondents and their socio-economic groups were rejected. This means that significant difference exist between the adopted lifestyles (smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour) of the respondents and their socio-economic status groups. The interpretation of this is that socio-economic status groups of an individual influenced his / her smoking habit, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual practices.

Table 4.8 (II) shows that individuals within socio-economic status group 2 (N500,000-N999,000, n=119), possessed a high mean rank of 792.0. This implies that, the group tends to smoke more than the other groups. The table also reveals a high rate of alcohol consumption among the same socio-economic status group 2. However, the socio-economic status groups 5 (less than N49, 000, n = 447) were also found to be significant in the way they consumer alcohol, especially the locally brewed alcohol called "Burukutu". A high mean rank of 708.5. is a pointer to this direction.

The table further shows that individuals within socio-economic status group 1 (Above N 1 million per annum, n = 49, mean rank = 788.7) are more sedentary than other groups. I.e. This group (Group 1) does not involve much in physical activity that is more intensive. They enjoin more pleasure because of their wealth than other groups.

The significant difference observed in the nutritional habit and socio-economic status groups of the respondents is further confirmed in the way the mean ranks of the groups were sparsely spread with high mean rank found among the individuals in S.E.S group 5 (n=447, mean rank = 757.5) and the lowest mean rank found among the individuals in S.E.S. group 1 (n=49, mean rank = 413.1). This significant difference should be interpreted very consciously because S.E.S. could only explain about one percent of various in the nutritional habit of the respondents in the study area.

The S.E.S. groups of the respondents influenced the way and manner in which they abuse and misuse drugs. Table 4.8(II) shown the rate of drug use along the line of S.E.S. to be a V-shape model in which the rate of drug abuse is high among the privilege and rich individuals declined at S.E.S group 3 and again increase among the less privilege individuals (Groups 4 and 5).

Table 4.8 (II) further shown that individuals within S.E.S groups 1 and 2 are significantly different in their sexual behaviour (n=49 mean rank 755.9 and n= 119, mean rank 747.8). Wealth, influencers and dignities attract opposite sex to individuals within these socio-economic status groups, thereby influenced their sexual behaviour negatively.

Sub-hypothesis V

There is no significant difference between the adopted lifestyle and religions background of the respondents in Kaduna State.

In order to find out whether there are no significant differences between the adopted lifestyles (smoking habit, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour) and religions background of the respondents in Kaduna State, the data collected were analysed using Kruskal-Wallis one-way ANOVA. The respondents were classified into the following groups based on their religious affiliations / beliefs.

Group 1 - Islamic religion (n=549)

Group 2 - Christianity religion (n=703)

Group 3 - Traditional religion (n=27)

Group 4 - Others (n=71).

The Kruskal-Wallis one-way ANOVA is presented in the following order:

a. Significant difference does not exist between the religion groups of the respondents and their smoking habit.

b. Significant difference does not exist between the religion groups of the respondents and their alcoholic lifestyle

c. Significant difference does not exist between the religion groups of the respondents and their sedentary lifestyle.

d. Significant difference does not exist between the religion groups of the respondents and their nutritional lifestyle

e. Significant difference does not exist between the religion groups of the respondents and their drug habit.

f. Significant difference does not exist between the religion groups of the respondents and their sexual behaviour.

Tables 4.9(1): Summary of Kruskal-Wallis One Way ANOVA on the Differences Between the Adopted Lifestyle and Religion Groups of the Respondents in Kaduna State.

Lifestyle factors	Source	DF	SS	MS	F-Ratio	P. value	Remark
Smoking & Religion	Between Within	3 1346	1.157 1.673	3.857 1.243	31.03	0.0000	Sign
	Total	**1349**	**1.789**				
Alcoholic lifestyle & Religion	Between Within	3 1346	8.034 1.862	2.678 1.383	19.36	0.0000	Sign
	Total	**1349**	**1.942**				
Sedentary lifestyle Religion	Between Within	3 1346	6.717 1.947	2.239 1.447	15.48	0.0000	Sign
	Total	**1349**	**2.015**				
Nutritional habit & Religion	Between Within	3 1346	8.591 2.028	2.864 1.507	1.90	0.1258	Not sign
	Total	**1349**	**2.037**				
Drug habit & Religion	Between within	3 1346	8.254 1.885	2.751 1.400	19.65	0.0000	Sign
	Total	**1349**	**1.967**				
Sexual behaviour & Religion	Between Within	3 1346	1.618 2.022	5.392 1.502	3.59	0.0133	Sign
	Total	**1349**	**2.038**				

Df = k – 1 = 4-1 = 3, F-critical = 2.60, P. <0.05

= N-4 = 1350-4=1346,

Table 4.9 (II): Differences in the Religion Groups and Mean Ranks of the Adopted Lifestyle.

Religion Groups	**Sample size**	**Mean rank for Smoking**	**Mean rank for Alcoholic**	**Mean rank for Sedentary**	**Mean rank for Nutritional**	**Mean rank for Drug habit**	**Mean rank for Sexual behaviour**
Islam	549	679.8	612.6	665.9	701.4	639.0	655.1
Christianity	703	628.0	691.1	649.8	651.2	665.6	677.8
Traditional	27	930.1	949.1	782.4	682.4	945.5	664.9
Others	71	1015.8	902.9	963.6	710.3	953.4	815.0
Total	**1350**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**

A careful examination of table 4.9(I) shows that the F. calculated for smoking (31.03), alcoholic lifestyle (19.36), sedentary lifestyle (15.48), drug habit (19.65) and sexual behaviour (3.59) are greater than the critical value of 2.60 with degrees of freedom 3 and 1346 at 0.05 alpha level of significance. Therefore, the null hypotheses that says there are no significant differences in the adopted lifestyles of smoking, alcoholic lifestyle, sedentary lifestyle, drug habit and sexual behaviour) of the respondents and their religion groups. The interpretation of this is that religion group of an individual influenced his / her smoking habit, alcoholic lifestyle, sedentary lifestyle, drug habit and sexual behaviour. i.e. some religion doctrines or affiliations allows open display of alcohol/beer, use of drugs and sexual practices especially during festivals and other ceremonies. Other religious prohibits the use of drugs, alcohol and indiscriminate sexual practices among its adherents.

The table further shows that the F-calculated for nutritional habit (1.90) is less than the critical value of 2.60 with a degree of freedom 3 at 0.05 alpha level of significance. Therefore, the null hypothesis is accepted. This means that there is no significant difference between the nutritional habit of the respondents and their religions affiliations / groups. The implication of this is that despite the religions teachings and prohibition of certain foods i.e. pork meat for the Muslims, beer and alcohol for the Muslims and Christianity, the nutritional lifestyle of the respondents does not significantly different across religion inclinations / doctrines.

Table 4.9 (II) shows that the traditional believers (n=27, mean rank 930.1) and individuals that failed to specify their religions affiliation (n=71, mean rank 1015.8) were significantly different in their smoking habit at 0.05 alpha level of significance. The two

groups (Traditional and others) possessed high mean ranks of 930.1 and 1015.8 respectively. An indication that they smokes more than those who profess the Christian and Muslim faiths. The table also reveals a high rate of alcohol consumption among the two groups (Traditional n=27, mean rank 949.1; others n=71, mean rank 902.9) than other two religion groups (Islam and Christianity). This is because their faiths (Traditional and others) permit open display of wines, beers and alcohol during festivals and other ceremonies. Significant difference was also observed in the sedentary lifestyle, drug habit of the traditional believers and those who failed to specify their religion beliefs as presented in table 4.9 (II).

The table further shows that the individuals categorized as others i.e. Those who failed to specify their religious inclinations possessed a high mean rank of 815.0, an indication that they are significantly different in their sexual behaviour.

Sub-hypothesis VI

There is no significant difference between the adopted lifestyles and marital status of the respondents in Kaduna State.

In order to find out whether there are no significant differences between the adopted lifestyle (smoking habits, alcoholic lifestyle, sedentary lifestyle, nutritional status, drug habit and sexual behaviour) and martial status of the respondents in Kaduna State, the data collected were analysed by using Kruskal-Wallis one-way ANOVA.

The respondents were classified into the following groups of marital status.

Group 1	-	Single (n=676)
Group 2	-	Married (n=614)
Group 3	-	Widowed (n=9)
Group 4	-	Divorced (n=16)
Group 5	-	Separated (n=35)

The Kruskal-Wallis one-way ANOVA is presented in the following order.

(a) Significant difference does not exist between the marital status groups of the respondents and their smoking habit.

(b) Significant difference does not exist between the marital status groups of the respondents and their alcoholic lifestyle.

(c) Significant difference does not exist between the marital status groups of the respondents and their sedentary lifestyle.

(d) Significant difference does not exist between the marital status groups of the respondents and their nutritional habit.

(e) Significant difference does not exist between the marital status groups of the respondents and their drug habit.

(f) Significant difference does not exist between the marital status groups of the respondents and their sexual behaviour.

Table 4.10(1): Summary of Kruskal-Wallis One Way ANOVA on the Differences Between the Adopted Lifestyle and Marital Status Groups of the Respondents in Kaduna State.

Lifestyle factors	Source	DF	SS	MS	F-Ratio	P. value	Remark
Smoking & Religion	Between Within	4 1345	1.792 1.771	4.480 1.316	3.40	0.0090	Sign
	Total	**1349**	**1.789**				
Alcoholic lifestyle & Marital status	Between Within	4 1345	1.591 1.927	3.648 1.433	2.55	0.0375	Sign
	Total	**1349**	**1.942**				
Sedentary lifestyle & Marital status	Between Within	4 1345	8.889 2.006	2.222 1.491	7.49	0.0014	Sign
	Total	**1349**	**2.015**				
Nutritional habit & Marital status	Between Within	4 1345	2.176 2.015	5.440 1.498	13.63	0.0061	Sign
	Total	**1349**	**2.037**				
Drug habit & Marital status	Between within	4 1345	2.199 1.945	5.497 1.446	3.80	0.0046	Sign
	Total	**1349**	**1.967**				
Sexual behaviour & Martial status	Between Within	4 1345	4.299 1.995	1.075 1.483	7.25	0.0000	Sign
	Total	**1349**	**2.038**				

Df = k – 1 = 5-1 = 4, F-critical = 2.37, P. <0.05

= N-5 = 1350-5=1345,

Table 4.10(II): Differences in the Marital Status Groups and Mean Ranks of the Adopted Lifestyle.

Religion Groups	**Sample size**	**Mean rank for Smoking**	**Mean rank for Alcoholic**	**Mean rank for Sedentary**	**Mean rank for Nutritional**	**Mean rank for Drug habit**	**Mean rank for Sexual behaviour**
Single	676	697.1	661.3	664.6	648.8	682.4	684.6
Married	614	642.6	680.5	684.8	694.4	653.3	645.0
Widowed	9	611.1	634.6	929.7	676.8	627.3	632.3
Divorced	16	823.1	689.5	579.2	632.5	929.9	808.6
Separated	35	785.8	867.4	701.8	878.8	827.4	985.9
Total	**1350**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**	**675.5**

A careful examination of table 4.10 (I) shows that the F- calculated for smoking (3.40), alcoholic lifestyle (2.55), sedentary lifestyle (7.49), nutritional habit (13.63), drug habit (3.80) and sexual behaviour (7.25) were greater than the critical value of 2.37 with degrees of freedom 4 and 1345 at 0.05 alpha level of significance. Therefore, the null hypotheses that says there are no significant differences in the adopted lifestyles of smoking, alcoholic lifestyle, sedentary lifestyle, nutritional lifestyle, drug habit and sexual behaviour of the respondents and their marital status groups were rejected. This means that significant differences exist between the adopted lifestyles (smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behavour) of the respondents and their marital status groups. The implication of this is that martial status groups of an individual influenced his / her adopted lifestyles.

Table 4.10 (II) revealed that divorced (n=16) and separated (n=35) individuals possessed high mean ranks of 823.1 and 785.8 respectively. This means that for one reason or the other the two groups (divorced and separated) smokes more than the other groups (Single, married and widowed). The table further reveals that alcohol consumption is more common among the separated individuals with a high mean rank of 867.4. An indication that the separated individuals are significant different in their alcoholic lifestyle.

The table (4.10-II) had shown a high mean rank of 929.7 for the widowed individuals, an indication that they assume more sedentary lifestyle than other groups. Long hours of mourning via sitting down and complete inactivity during grief period may account for the difference. The table further shows that the nutritional habit of the separated individuals (n=35, mean rank 878.8) is significantly different from other groups of martial status found in Kaduna State.

The divorced (n=16) and the separated individuals (n=35) consumes more drugs and participate more in indiscriminate sexual practices than other groups as presented in table 4.10 (ii). The two groups possessed high mean ranks of 929.9 and 827.4 for drug habit, and 808.6 and 985.9 for sexual behaviour respectively.

Testing main hypothesis two

The health problems suffered by the people of Kaduna State are not significantly related to their adopted lifestyles.

In order to find out whether the health problems suffered by the people of Kaduna State are not significantly related to their adopted lifestyles of smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour. The data collected were analysed using spearman rank-order (rho) correlation coefficient and chi-square (x^2) test.

Table 4.11: Spearman 'rho showing the relationship between health problems and lifestyles of the people of Kaduna State.

	LIFESTYLE FACTORS						
HEALTH PROBLEMS		**Smoking habit (1)**	**Alcoholic lifestyle (2)**	**Sedentary lifestyle (3)**	**Nutritional lifestyle (4)**	**Drug habit (5)**	**Sexual behaviour (6)**
1. Cough, cancer, lung problem Redness of the lip, cardiac disease. 2. Liver problem, accident, Hypertension Obesity, poor coordination, personality and social disorder 3. High blood pressure, overweight Diabetes, depression, obesity. 4. Loss of appetite, cardiovascular diseases, malnutrition 5. Hallucinogenic reaction, anxiety, liver damages, violence 6. HIV/AIDS, STDs, Abortion, Rape Teenage pregnancy	Corrl: coeff. Signi (2 tailed)	.487** .000 1350	.650** .000 1350	.100** .000 1350	.343** .000 1350	.548** .000 1350	.59** .000 1350

** Correlation is significant at the 0.01 level (2 tailed)

* Correlation is significant at the 0.05 level (2 tailed)

Table 4.11 shows that the hypothesis is significant at 0.01 alpha level of significance. Therefore, the null hypothesis that says that the health problems suffered by the people of Kaduna State are not significantly related to their adopted lifestyles is rejected. The inferences that can be deduced from the table are as follows:

(a) Health problems suffered by the people of Kaduna State are significantly related to their smoking habit.

(b) Health problems suffered by the people of Kaduna State are significantly related to their alcoholic lifestyle.

(c) Health problems suffered by the people of Kaduna State are significantly related to their sedentary lifestyle.

(d) Health problems suffered by the people of Kaduna State are significantly related to their nutritional habit

(e) Health problems suffered by the people at Kaduna State are significantly related to their drug habit.

(f) Health problems suffered by the people of Kaduna State are significantly related to their sexual behaviour.

In order to test the validity of results generated through the spearman rank-order correlation coefficient, the data collected were also analysed using chi-square (x^2) test.

Tables 4.12: Chi-square (x^2) showing the Relationship between Health's Problems and Smoking Habit of the Respondents

Questions	Yes	%	No	%	No response	%	Total	x^2
Do you smoke?	417	30.9	895	66.3	38	2.8	1350	
2. Do you experience any of these difficulties in smoking?								
(a) Cough	166	12.3						
(b) Cancer	71	5.3						
(c) Lung problem	50	3.7						
(d) Redness of lip	77	5.7						
(e) Cardiac diseases	41	3.0						
(f) All of the above	62	4.6						
(g) Others	3	0.2						
(h) No response	880	65.2						
Total	1350	100					1350	885.36

$x^2 = 885.36$, df =14, critical value = 23.68, $P< 0.05$

Table 4.12 shows that the calculated x^2 value of 885.36 is greater that the critical value of 23.68 at 0.05 alpha level of significance. Therefore, the null hypothesis that says health problems suffered by people of Kaduna State are not significantly related to their smoking habit is rejected. This means that health problems suffered by people of Kaduna State are significantly related to their smoking habit.

Table 4.13: Chi-square (x^2) Showing the Relationship between Health Problems and Alcoholic Lifestyle of the Respondents

Questions	Yes	%	No	%	No response	%	Total	x^2
Do you drink alcohol smoke?	653	48.4	649	48.1	48	3.6	1350	
2. Do you experience any of these difficulties in alcohol consumption?								
(a) Liver problem	97	7.2						
(b) Accident	97	7.2						
(c) Problems of adjustment	108	8.0						
(d) Obesity	64	4.7						
(e) Personality disorder and social uneasiness	210	15.6						
(f) All of the above	35	2.6						
(g) Others	9	0.7						
(h) No response	730	54.1						
Total	1350	100					1350	796.32

$x^2 = 796.32$, df =14, critical value = 23.68, $P< 0.05$

A careful examination of table 4.13 shows that the calculated x^2 value of 796.32 is greater than the critical value of 23.68 at 0.05 alpha level of significance. Therefore, the null hypothesis that says health problems suffered by the people of Kaduna State are not significantly related to their alcoholic lifestyle is rejected. This means that health problems suffered by the people of Kaduna State are significantly related to their alcoholic lifestyle.

Tables 4.14: Chi-square Showing the Relationship between Health Problems and Sedentary Lifestyle of the Respondents

Questions	Yes	%	No	%	No response	%	Total	x^2
1. Do you participate in physical exercise?	1160	85.9	156	11.6	34	2.5	1350	
2. Do you experience any of these difficulties due to physical inactivity?								
(a) High blood pressure	256	19.0						
(b) Cardio vascular disease	52	3.9						
(c) Obesity and overweight	220	16.3						
(d) Diabetes and cancer related disease	79	5.9						
(e) Depression, anxiety and uneasiness	249	18.4						
(f) All of the above	44	3.3						
(g) Others	31	2.3						
(h) No response	419	31.0						
Total	1350	100					1350	57.64

$x^2 = 57.64$, df =14, critical value = 23.68, $P< 0.05$

Table 4.14 shows that the calculated x^2 value of 57.64 is greater than the critical value of 23.68 at 0.05 alpha level of significance. Therefore, the null hypothesis that says health problems suffered by the people of Kaduna State are not significantly related to their sedentary lifestyle is rejected. This implies that health problems suffered by the people of Kaduna State are significantly related to their sedentary lifestyle or physical inactivity.

Table 4.15: Chi-square (x^2) Showing the Relationship between Health Problems and Nutritional Habit of the Respondents

Questions	Yes	%	No	%	No response	%	Total	x^2
1. Do you planned your diets?	825	61.1	418	31.0	107	7.9	1350	
2. Do you experience any of these difficulties due to nutritional habit?								
(a) Loss of appetite	366	27.1						
(b) Gross underweight	100	7.4						
(c) Obesity and overweight	237	17.6						
(d) High blood cholesterol and diabetes	96	7.1						
(e) Cardio vascular diseases	76	5.6						
(f) All of the above	47	3.5						
(g) Others	11	0.8						
(h) No response	417	30.9						
Total	1350	100					1350	83.74

$x^2 = 83.74$, df =14, critical value = 23.68, $P< 0.05$

Table 4.15 shows that the calculated x^2 value of 83.74 is greater than the critical value of 23.68 at 0.05 alpha level of significance. Therefore, the null hypothesis that says health problems suffered by the people of Kaduna State are not significantly related to their nutritional habit is rejected. This means that the health problems suffered by the people of Kaduna State are significantly related to their nutritional habit.

Table 4.16: Chi-square (x^2) Showing the Relationship between Health Problems and Drug Habit of the Respondents

Questions	Yes	%	No	%	No response	%	Total	x^2
1. Do you take drugs to enhance your performances?	697	51.6	569 .	42.1	84	6.2	1350	
2. Do you experience any of these difficulties due to drug habits?								
(a) Violence	119	8.8						
(b) Hallucinogenic reactions	93	6.9						
(c) Depression and anxiety	151	11.2						
(d) Liver damage	94	7.0						
(e) Lack of interest	59	4.4						
(f) Educational set back	78	5.8						
(g) All of the above	41	3.0						
(h) Others	1	0.1						
(i) No response	714	52.9						
Total	1350	100					1350	520.53

$x^2 = 520.53$, df =16, critical value = 26.30, $P< 0.05$

Table 4.16 shows that the calculated x^2 value of 520.53 is greater than the critical value of 26.30 at 0.05 alpha level of significance. Therefore, the null hypothesis that says health problems suffered by the people of Kaduna State are not significantly related to their drug habit is rejected. This means that the health problems suffered by the people of Kaduna State are significantly related to their drug habit.

Table 4.17: Chi-square (x^2) Showing the Relationship between Health Problems and Sexual behaviour of the Respondents

Questions	Yes	%	No	%	No response	%	Total	x^2
1. Do you use condom?	729	54.0	508	37.6	113	8.4	1350	
2. Do you experience any of these difficulties due to physical inactivity?								
(a) Sexually transmitted diseases	164	12.1						
(b) Abortion	136	10.1						
(c) Child abandonment	106	7.9						
(d) Rape	47	3.5						
(e) Teenage pregnancy	101	7.6						
(f) All of the above	37	3.7						
(g) Others	9	0.7						
(h) No response	750	55.6						
Total	1350	100					1350	141.51

$x^2 = 141.51$, df =14, critical value = 23.68, $P< 0.05$

Table 4.17 shows that the calculated x^2 value of 141.51 is greater than the critical value of 23.68 at 0.05 alpha level of significance. Therefore, the null hypothesis that says health problems suffered by the people of Kaduna State are not significantly related to their sexual behaviour is rejected. This implies that the health problems suffered by the people of Kaduna State are significantly related to their sexual behavour.

Summary of findings of main hypothesis two

a. Health problems suffered by the people of Kaduna State are significantly related to their smoking habit.
b. Health problems suffered by the people of Kaduna State are significantly related to their alcoholic lifestyle.
c. Health problems suffered by the people of Kaduna State are significantly related to their sedentary lifestyle / physical inactivity.

d. Health problems suffered by the people of Kaduna State are significantly related to their nutritional habit.

e. Health problems suffered by the people of Kaduna State are significantly related to their drug habit.

f. Health problems suffered by the people of Kaduna State are significantly related to their sexual behaviour.

Testing main hypothesis three

There is no significant difference in the lifestyles of urban and rural people of Kaduna State.

In order to find out whether there is no significance difference between the lifestyles of urban and rural people of Kaduna State, the data collected were analysed using student t-test. The respondents were classified into the following groups:

Group 1 - Rural people of Kaduna State (n=450)

Group 2 - Urban people of Kaduna State (n=900).

The student t-test is presented in the following order:

(a) Rural and urban people of Kaduna State are not significantly different in their smoking habit.

(b) Rural and urban people of Kaduna State are not significantly different in their alcoholic lifestyle

(c) Rural and urban people of Kaduna State are not significantly different in their sedentary lifestyle.

(d) Rural and urban people of Kaduna State are not significantly different in their nutritional habit.

(e) Rural and urban people of Kaduna State are not significantly different in their drug habit.

(f) Rural and urban people of Kaduna State are not significantly different in their sexual behaviour.

Tables 4.18: Means, Standard Deviation, Standard Error and t-Value of difference between the Smoking Habit Of Rural and Urban People of Kaduna State.

Type of dwelling	No of cases	Mean	S.D	S.E.	DF	Calculated t-value	Critical value
Rural	450	5.3400	4.214	0.199	1348	3.13	1.96
Urban	900	4.6422	3.664	0.122			
Total	1350						

$P < 0.05$

Table 4.18 shows that the calculated t-value of 3.13 is greater than the table value / Critical value of 1.96 at 0.05 alpha level of significance. Therefore, the null hypothesis that says rural and urban people of Kaduna State are not significantly different in their smoking habit is rejected. This means that significant difference exist in the smoking habit of rural and urban people of Kaduna State.

Tables 4.19: Means, Standard Deviation, Standard Error and t-Value of difference between the Alcoholic Lifestyle of rural and Urban People of Kaduna State.

Type of dwelling	No of cases	Mean	S.D	S.E.	DF	Calculated t-value	Critical value
Rural	450	9.0022	5.911	0.279	1348	5.52	1.96
Urban	900	7.1289	5.869	0.196			
Total	1350						

$P < 0.05$

A careful examination of table 4.19 shows that the calculated t-value of 5.52 is greater than the table value of 1.96 at 0.05 alpha level of significance. Therefore, the null hypothesis that says rural and urban people of Kaduna State are not significantly different in their alcoholic lifestyle is rejected. This implies that significance difference exist in the alcoholic lifestyle of rural and urban people of Kaduna State.

Table 4.20: Means, Standard Deviation, Standard Error and t-Value of difference between the Sedentary Lifestyle of Rural and Urban People of Kaduna State.

Type of dwelling	No of cases	Mean	S.D	S.E.	DF	Calculated t-value	Critical value
Rural	450	8.8222	2.739	0.129	1348	3.47	1.96
Urban	900	8.2822	2.672	0.089			
Total	1350						

$P < 0.05$

Table 4.20 shows that the calculated t-value of 3.47 is greater than the critical value of 1.96 at 0.05 level of significance. Therefore, the null hypothesis that says rural and urban people of Kaduna State are not significantly different in their sedentary lifestyle or physical inactivity is rejected. This means that significant difference exist in the sedentary lifestyle of rural and urban people of Kaduna State.

Table 4.21: Means Standard Deviation, Standard Error and t-value of difference between the Nutritional Habit of Rural and Urban People of Kaduna State.

Type of dwelling	No of cases	Mean	S.D	S.E.	DF	Calculated t-value	Critical value
Rural	450	16.2311	4.323	0.204	1348	1.70	1.96
Urban	900	15.8011	4.396	0.147			
Total	1350						

P < 0.05

A careful examination of table 4.21 shows that the calculated t-value of 1.70 is less than the critical value of 1.96 at 0.05 alpha level of significance. Therefore, the null hypothesis that says rural and urban people of Kaduna State are not significantly different in their nutritional habit is accepted. This means that there is no significance difference in the nutritional habit of rural and urban people of Kaduna State.

Table 4.22: Means, Standard Deviation, Standard Error and t-Value of difference between the Drug Habit of Rural and Urban people of Kaduna State.

Type of dwelling	No of cases	Mean	S.D	S.E.	DF	Calculated t-value	Critical value
Rural	450	8.6222	5.655	0.267	1348	5.78	1.96
Urban	900	6.7700	5.498	0.183			
Total	1350						

P < 0.05

Table 4.22 shows that the calculated t-value of 5.78 is greater than the critical value of 1.96 at 0.05 level of significance. Therefore, the null hypothesis that says rural and urban people of Kaduna State are not significantly different in their drug habit is

rejected. This implies that significant difference exist in the drug habit` of rural and urban people of Kaduna State.

Table 4.23: Means, Standard Deviation, Standard Error and t-value of difference between the Sexual behaviour of Rural and Urban people of Kaduna State.

Type of dwelling	No of cases	Mean	S.D	S.E.	DF	Calculated t-value	Critical value
Rural	450	10.2622	3.887	0.183	1348	4.41	1.96
Urban	900	9.1944	4.344	0.145			
Total	1350						

P < 0.05

Table 4.23 shows that the calculated t-value of 4.41 is greater than the critical value of 1.96 at 0.05 level of significance. Therefore, the null hypothesis that says rural and urban people of Kaduna State are not significantly different in their sexual behaviour is rejected. This means that significant difference exist in the sexual behaviour of rural and urban people of Kaduna State.

Summary of findings of main hypothesis three

(a) Significance difference exists in the smoking habit of rural and urban people of Kaduna State.

(b) Significance difference exists in the alcoholic lifestyle of rural and urban people of Kaduna State.

(c) Significance difference exists in the sedentary lifestyle of rural and urban people of Kaduna State.

(d) There is no significant difference in the nutritional habit of rural and urban people of Kaduna State.

(e) Significance difference exists in the drug habit of rural and urban people of Kaduna State.

(f) Significant difference exists in the sexual behaviour of rural and urban people of Kaduna State.

Table 4.24: The Practices of Lifestyle factors by the Respondents in Kaduna State.

S/No	Lifestyle factors	Total Respondents admitting practicing it	%	Total respondents not practicing it.	%	No Response	%	Total	%
1.	Smoking habit	417	30.9	895	66.3	38	2.8	1350	100
2.	Alcoholic lifestyle	653	48.4	649	48.1	48	3.6	1350	100
3.	Physical activity (Participate in physical exercise)	1160	85.9	156	11.6	34	2.5	1350	100
4.	Nutritional habit (planned nutrition)	825	61.1	418	31.0	107	7.9	1350	100
5.	Drugs to enhance performance	697	51.6	569	42.1	84	6.2	1350	100
6.	Sexual behaviour (protective sex)	729	54.0	508	37.6	113	8.4	1350	100

Table 4.24 shows the practices of lifestyle factors by the respondents in Kaduna State. The table reveals that 417 respondents (30.9%); 653 respondents (48.4%), 697 respondents (51.6%) and 156 respondents (11.6%) are actively involves in smoking, alcohol consumption, use of drugs to enhance performance and sedentary lifestyle

respectively. Also, 418 respondents (31.0%) and 508 respondents (37.6%) concord that they do not planned their diets and involves in un protective and indiscriminate sexual practices. The table reveals the practices of those lifestyle factors in order of preference as follows:

1. Use of drugs to enhance performance 697 respondents representing 51.6 percent.
2. Alcohol consumption 653 respondents representing 48.4 percent.
3. Unprotective and indiscriminate sexual behaviour 508 respondents representing 37.6
4. Nutritional habit (unplanned diet) 418 respondents representing 31.0 percent.
5. Smoking habit 417 respondents representing 30.9 percent.
6. Sedentary lifestyle 156 respondents representing 11.6 percent.

4.4 Discussion

4.4.1 Relationship between Demographic Characteristics and Lifestyle of the People of Kaduna State.

This study revealed significant relationship between age cum smoking and drug habit. While the rate of smoking was shown to decrease with age, the rate of drug use was shown to be a u-shape in which the rate of drug use declined after 25 years of age and again increase after 50 years of age. This significant relationship should be interpreted very consciously because age could explain only about one percent of variance in the rate of smoking and drug abuse, although it supported the finding of WHO (1999). According to which most of the life lost between 19-25 years of age were due to smoking related diseases in the WHO European region.

On the relationship between age and drug habit, Churchill (1978) and WHO, (1998) submitted that youths of today have grown to believe that drugs can provide answers to their problems. Hence, the need for the use, abuse and misuse of drugs like amphetamine, marijuana, cocaine and Heroine among others. WHO, (1998) further observed the use of illicit drugs in the Netherlands among individuals within age group of 12-18years (13.6%) appears to be higher than in Greece or Portugal, where it is about 4 - 5%. The risk of drug abuse among adolescents and young adults was also observed by NDLEA, (1998) when it was reported that a young person who is injecting heroine has about a 14 times more risk of deaths than someone who is not.

The finding that gender is significantly related to sedentary lifestyle and drug habit of the respondents, is corroborated by the submission of Molarius (2003) who reported a prevalence of obesity due to physical inactivity by gender and age group among his study population (i.e. 12% of men and 14% of women were obese). About one-fifth of the study population were reported to be physically inactive, and physical inactivity was most common among young men (25-44 years) than women. Seidell and Flegal, (1997), Lissner and Heitman (1995), Molarius et al, (1997) and Tremblay (1999) observed that physical inactivity, smoking, drug abuse and alcohol intake are related to relative weight gain in both men and women. The finding that gender is related to drug habit among the people of Kaduna State is in agreement with the submission of Folawiyo, (1990) who observed especially in Nigeria cites, that heavy use of alcohol and drug abuse are very common among men especially young men than women.

Location (rural and urban) was also found to be significantly related to smoking, alcoholic lifestyle, sedentary lifestyle, drug habit and sexual behaviour of the respondents

in Kaduna State. Urban people practiced this unhealthy lifestyle than the rural population. This finding was in accordance with the submission of Levitt, Katzenellenbegan, Bradshaw, Hoffman and Bonnici, (1998) in their report, urban residents have a 1.5 to 4-fold prevalence of lifestyle factors like smoking, heavy use of alcohol, sedentary lifestyle, drug abuse and misuse and indiscriminate sexual practices compared to their rural counterparts. Corroborating the relationship between location and sedentary lifestyle, Alemu and Lindtjorn, (1995) reported that rural populations rely upon foot walk as a means of transportation and often have intense agricultural activities as their main occupation, while there is reduction in physical activity with urban lifestyle. The authors further reported that technological and communication advancement does not help matters in this regard. The use of automobiles, telephone facilities, mobile phones, household technological gadgets has substantially increase the sedentary of the urban residents. On residence and sexual behaviour, the World Health Organization (1991) reported high prevalence of indiscriminate sexual practices in our cities in Kenya, South African and Nigeria, which accounts for the incidence of sexually transmitted diseases and HIV/AIDS in the areas. Oshodin (1984) reported the high rates at which secondary school students in Benin city, Nigeria, abuse drugs and consume alcohol as compared to their counterparts in the rural areas, was in concomitant with the finding that significant relationship exist between residence and alcoholic lifestyle. Ogunbiyi (2002) also lay credence to the fact that significant relationship exist between the rural and urban women of Kaduna State in their cultural opinion as regard their lifestyle.

The finding that educational status of the respondents is significantly related to alcoholic lifestyle, nutritional habit and sexual behaviour was supported by Molarius,

(2003) who reported that obesity was more common among subjects with low education than subjects with high educational status. According to him, lifestyle differed considerably between the educational levels. Those with low education were more often physically inactive, heavy smokers, used more often alcohol and had unhealthy dietary attitudes than those with high education. The existence of poor nutritional habits, alcoholic lifestyle and indiscriminate sexual practices among low educational status groups classified as primary and others amongst the subjects in Kaduna State, as presented in table 4.7(I) and 4.7(II), are consistent with the findings of Crespo, *et al* (1999) and confirms that education influences health through lifestyle behaviours.

The finding that socio-economic status of the respondents is significantly related to alcoholic lifestyle, nutritional and drug habits is in conformity with the studies of Stephens, *et al*, (1985); Pomerleau, *et al*, (1997) and Mensik, *et al,* (1997) who reported the influence of socio-economic status on the use of tobacco, alcohol, refined diets and stimulant drugs. According to them, cases of obesity, liver cirrhosis, HIV/ AIDS, hypertension and other cardio vascular diseases are more rampant among high socio-economic status group due to their sedentary lifestyle, high consumption of alcohol, poor nutritional habits and indiscriminate sexual practices.

The finding that religion groups of the respondents is significantly related to smoking, alcoholic lifestyle, sedentary lifestyle and drug habit concord with the submission of Ogunbiyi (2002) who reported that significant relationship exist between religion and lifestyle of rural and urban women of the same study area (Kaduna State).

Qur'an chapter 5 verse 90 prohibits all kinds of alcoholic drinks, eating of pork meat and other intoxicants among the Muslims. Corroborating the differences between religion and lifestyles of the people, the findings of sub-hypothesis 5 as presented in tables 4.9(I) and 4.9(II) affirmed that individuals classified as traditionalists and those who failed to specify their religion's affiliations involved more in unhealthy lifestyle than their Christians and Muslims counterparts.

4.4.2 No Significant Relationship between Demographic Factors and Lifestyle of the People of Kaduna State

The finding that no significant relationship exist between age and alcoholic lifestyle, sedentary lifestyle, nutritional habit and sexual behaviour is a clear testimony to the fact that the production and consumption of alcohol (local Burukutu) cut across all age groups especially amongst the respondents in Southern parts of Kaduna State. It is a fact that anyone under the influence of alcohol is bound to sexually misbehave. Rogers (1995) submitted that age is not significantly related to the practice of some lifestyle factors, as individuals within age group 70-75 years are found practicing healthy lifestyles of high quality diet, non-smoking and physical activity among the European population.

The finding that significant relationship does not exist between gender and the practice of lifestyle factors like smoking, alcoholic lifestyle, nutritional habit and sexual behaviour of the respondents in Kaduna State as presented in Sub-hypothesis 2, is not in conformity with the submission of Verbrugge (1984), Mc Donough and Walters, (2001) that gender disparities in health are often linked to differences between men and women in exposure to lifestyle factors. Also, the finding was not in accord with Molarius (2003)

who reported a prevalence of obesity by gender and negatively skewed to women among his study population (12% of men and 14% of women were obese). On smoking, a contradictory report was also found in Andrew, *et al,* (2002) when they observed that the rate of smoking among women now out numbered men, thus, cigarette smoking was associated with short and irregular menstrual cycles in women. The reason for these contradictories is not known, it is however open for further research to find out why significant relationship does not exist between gender and some lifestyle factors like smoking, alcoholic lifestyle, nutritional habit and sexual behaviour.

The separated individuals (i.e. those that live away from their spouses) and the divorced are found to be significantly difference in their alcoholic, smoking and sexual behaviour. Corroborating this finding, Jose et al (2003) found that being single was associated with high physical activity levels, eating of fast foods and drug abuse. Also, the widowed are found to be significantly different in their sedentary lifestyle owning to long hours of mourning via sitting down and complete inactivity during grief period. Steptoe, *et al*, (1997) lay credence to this finding in a logistic regression model conducted, the result shown a significantly higher levels of sedentary lifestyle among widowed and divorced individuals than in singles.

The test of spearman rank-order of correlation coefficient between socio-economic status and smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour was found to be significantly related as revealed in Table 4.4. In line with the finding of this study, Ford, *et al*, (1991) invoked many reasons for the differences;(1) people with low socio-economic status are more likely to have manual jobs with higher demand, (2) Access to some recreational activities may be

limited due to their cost; and (3) the intake of stimulants (drug and alcohol) to increase physical strength for the required energy. On the other hand, their counterparts with high socio-economic status has money and other influences to enjoy themselves. Adler Boycee *et al*, (1993); Borg and Kristensen, (2000) were however held a contrary opinion, according to them, the health of an individual is affected by their social class position. Socio-economic status is positively correlated with understanding health education information, access to health care services, health maintenance and healthier lifestyle.

4.4.3 Health Problems Suffered by the people of Kaduna State are Significantly Related to their Lifestyles

The results of the spearman rank-order correlation coefficient and chi-square as presented in table 4.11, revealed that health problems suffered by the people of Kaduna State are significantly related to their lifestyle. This finding is in agreement with the report of Ogunbiyi, (2002) who stated that there is a significant relationship between disease conditions suffered and the lifestyles of rural and urban women in Kaduna State. Talking about health problems and lifestyles, Asuni *et al* (1994) reported that unhealthy lifestyle account for more than 60% deaths in Africa, apart from being responsible for a number of Chronic and degenerative diseases. On the relationship between health problems and sedentary lifestyle or physical inactivity, Dishman and Sallis, (1994) submitted that sedentary lifestyle contributes significantly to the occurrences of obesity, cancers, high blood pressure, osteoporosis, diabetes and premature mortality. On the association between nutritional habit and health problems, WHO (1998) and Ogunsakin (1999) reported that poor dietary habits result into poor health, malnutritional diseases, impaired intellectual development, premature deaths, obesity and cardio-vascular

diseases. Larbi et al (1983) and Molarius, (2003) observed a close association between alcohol consumption and cases of hypertension, obesity, liver cirrhosis, loss of weight, mental delusion, poor reaction time and physical injuries. The submissions of these authors is in concomitant with the finding that lifestyle factors are significantly related to health problems suffered by the people of Kaduna State. On health problems and drug habit, Folawiyo (1990) and NDLEA, (1998) documented a number of problems associated with the abuse and misuse of drugs. The problems include automobile accidents, child abuse, assault and murder, suicide attempts, depression, anxiety, hallucinogenic reactions, aggressive tendencies, liver problems, ulcer of different types, brain damage and abusive utterances. Indiscriminate sexual practices or behaviour is also associated to the problems of sexually transmitted diseases including HIV/AIDS.

4.4.4 Rural and Urban People are Significantly Different in their Lifestyles

The finding that significant difference exists between rural and urban people in their smoking, alcohol, drug habit, sedentary and sexual behaviour is not unexpected as Adesina (1990) postulated that environment is considered a crucial factor in the health and well being of the individual. He was of the opinion that physical and social environment plays a decisive role in the individuals choice of lifestyle factors. Thus, individuals in the urban areas are likely to drink more alcohol, smoke more cigarettes and Indian hemp, use more stimulant drugs and involve more in indiscriminate sexual behaviour to deal with stress occasioned by both physical and social environment. WHO (1993) reported an association between lifestyle and environmental problems occasioned by unhealthy lifestyle. According to WHO (1993) millions of people die every year from

illnesses caused by unhealthy lifestyle in the environment, with more than 70% recorded in cities in Great Britain, Portugal, Sweden, Kenya, South African and Nigeria.

The finding that there is no significant difference in the nutritional habit of rural and urban people of Kaduna State as presented in table 4.54 is supported by the findings of Asuni, (1974); Sharma, *et al*, (1996); Mennen, *et al*, (2000). While Asuni, (1974) reported that evidence shows the prevalent of poor nutritional habits in the rural areas resulting in aneamia amongst young women in Nigeria; Sharma, et al (1996); and Mennen et al (2000) submitted that urban lifestyle in Africa is characterized by poor dietary habits involving an increase in consumption of refined sugars, saturated fat, imported and refined food nutrients with little nutritional values which may have adverse effects on their well-being. The contradiction in the reports of the authors cited above, lay credence to the finding of this study that there is no significant difference in the nutritional habit of rural and urban people of Kaduna State.

4.4.5 The Practice(s) of Lifestyle factors Amongst Respondents in Kaduna State.

The result on table 4.58 revealed the practices of lifestyle factors by the people of Kaduna State. The use of drugs to enhance performance, alcohol consumption and indiscriminate sexual behaviours top the list of those lifestyle factors (unhealthy lifestyle) mostly practiced by the respondents in Kaduna State. Sedentary lifestyle, smoking and poor nutritional habit occupies the rear three (3) positions among the unhealthy lifestyles practiced by the respondents in Kaduna State. This is in accordance with the report of World Health Organization (1999) that rated Nigeria health care system in the 187th position out of 191 member countries, and postulated that diseases associated with unhealthy lifestyles accounted for between 8-10% health related problems in the rural

areas and 10-12% in the urban communities of Nigeria. A visit to government and private health institutions in Kaduna State shows a large number of individuals suffering from diseases relating to unhealthy lifestyle of smoking, alcohol consumption, sedentary lifestyle, poor nutritional habit, drug habit and indiscriminate sexual behaviour.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The purpose of this chapter was to summarize the study, draw conclusion from the findings and make appropriate recommendations that will help to improve and develop healthy lifestyles among the people of Kaduna State in particular and Nigeria in general. The chapter is organized according to the following sub-headings: introduction, summary, conclusions and recommendations.

5.2 Summary

The influence of demographic factors like age, gender, religion, socio-economic status, marital status, location and educational background on the adopted lifestyles, and effects of those lifestyles on the health of the individuals, family and community health had been documented both nationally and globally. Millions of people die every year from illnesses caused by unhealthy lifestyles. Although lifestyles, is considered a personal issue, it however reflects individual identity, as well as a reflection of the norms and values of the group to which individuals belong. In Nigeria, for example, the 1989 nationwide survey of health related problems due to unhealthy lifestyle revealed that 3.5 millions of the population have mild hypertension, 1.2 million have moderate and 0.5 million have severe hypertension. The prevalence of hypertension, cardiovascular diseases, obesity, diabetes, personality disorders and social uneasiness and other health related problems due to unhealthy lifestyle is generally estimated at 8-10% for rural and 10-12% for urban communities. The reports identified poor nutritional habits, smoking,

heavy alcohol consumption, sexually transmitted diseases (STDs) and HIV/AIDS due to indiscriminate sexual behaviour and substance abuse as constituting major public health problems for the citizens. This study therefore, examined the relationship between demographic factors and lifestyles of the people of Kaduna State.

To achieve this purpose, a questionnaire was developed which consists of 55 items with sections on demographic characteristics and the practice of lifestyle factors like smoking, physical inactivity, alcohol consumption, drug abuse and misuse, nutritional habit and sexual behaviour (**See Appendix A**). In order to validate the instrument, five (5) jurors from the Departments of Community Medicine, Economics, Sociology and Physical and Health Education of Ahmadu Bello University, Zaria, vetted the instrument for face validity after which a pilot study was conducted to further determine the internal consistency and reliability of the questionnaire. Using Goffman split-half reliability model through Statistical Packages for Social Sciences (SPSS), a reliability analysis scale of 0.9181 was obtained. On the basis of the result the final questionnaire was prepared.

The questionnaire was administered on a total of 1350 respondents randomly selected from six (6) urban and six (6) rural areas across the three (3) senatorial zones/districts of Kaduna State. The data thus collected were statistically analyzed by using descriptive statistics of frequencies, percentages, means and standard deviations to analyze the demographic data that emanated from the study. A 7x6 factorial analysis of variance with a combination of spearman rank-order of correlation coefficient and Kruskal-Wallis one-way ANOVA was used to test the relationship between demographic factors and lifestyles of the people of Kaduna State, as well as differences that exist

between demographic status groups and the practices of lifestyles factors by the respondents. Chi-square (x^2) and spearman rank-order was used to test the significant relationship between health problems suffered by the people of Kaduna State and their lifestyles. Lastly, student t-test was used to test the significant difference in the lifestyle of urban and rural people of Kaduna state. In all, three (3) main hypotheses and six (6) sub-hypotheses were tested. The study revealed that:

(i) - Age is significantly related to smoking and drug habits of the respondents in Kaduna State at 0.01 alpha level. i.e. The adolescent / young adults (16-25years) and the old people 51 year and above smoke and involve more in drug abuse and misuse than people of other age groups.

(ii) – Gender is significantly related to sedentary lifestyle and drug habit of the respondents in Kaduna State at 0.0.1 alpha level. i.e. Sedentary lifestyle is common among the female respondents than their male counterparts. Also, the female respondents irrespective of age, religion, culture and socio-economic status involve more in drug abuse, trafficking and misuse than their male counterparts in Kaduna State.

(iii) – Educational status of the respondents is significantly related to smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour in Kaduna State at 0.01 alpha level. i.e. Ones level of educational attainment influence his / her smoking , alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour of the respondents in Kaduna State.

(iv) – Socio-economic status of the respondents is significantly related to smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug habit and sexual behaviour of the respondents in Kaduna State at 0.01 alpha level. i.e. Socio-economic of an individual influence his /her lifestyles.

(v) – Religion groups of the respondents is significantly related to smoking, alcoholic lifestyle, sedentary lifestyle, drug habit and sexual behaviour at both 0.01 and 0.05 alpha level of significances. i.e. Some religions permit open display of those lifestyles during festival and social gatherings (Traditional and others), while others prohibit their adherents from drinking, drug habit and indiscriminate sexual behaviour (Islam and Christianity).

(vi) Significant difference were also found in the marital status of the respondents and their lifestyles. i.e. Marital status group of an individual influence his/her adopted lifestyles of smoking, alcoholic lifestyle, sedentary lifestyle, nutritional habit, drug abuse and sexual behaviour. As the divorced and separated individuals smokes, consume more alcohol and participate in indiscriminate sexual behaviours than other groups of martial status. Also the widowed assume more sedentary lifestyle than other group due to long hours of mourning via sitting down and complete inactivity during grief period among the respondents in Kaduna state.

(vii) Rural and urban people of Kaduna state are significantly different in their lifestyles that is individual in urban areas drink more alcohol/beer, smoke more cigarettes and Indian hemp, use more stimulant drugs and involve more

in indiscriminate sexual behaviour to deal with stress occasioned by both physical and social environment than their rural counterparts.

(viii) Health problems suffered by the people of Kaduna state i.e, cough, redness of the lip, hypertension, obesity, poor coordination, cardiac diseases, diabetes, depression, liver damage, violence, abortion, teenage pregnancies and sexually transmitted diseases are significantly related to their smoking habit, alcoholic lifestyle, drug habit, sedentary lifestyle, nutritional habit and sexual behaviour.

(ix) Gender of the respondent does not influence respondent's smoking, alcoholic lifestyle, nutritional habit and sexual behaviour in Kaduna state. As both gender were actively involved in alcohol consumption especially among respondents of Southern parts of Kaduna state, both (male and female) submitted that they feed on local foods everyday of the week and a drunk individual is bound to sexually misbehave.

(x) Insignificant difference is found in the adopted lifestyles of alcohol consumption, sedentary lifestyle, nutritional habit and sexual behaviour of the respondents on their age groups in Kaduna state. This means that age does not influence respondents consumption of alcohol, sedentary lifestyle, nutritional habit as well as sexual behaviour.

(xi) Drug habit (use of drug to enhance performance), excessive alcohol/beer consumption and Unprotective or indiscriminate sexual behaviour constitutes the three (3) lifestyle factors (unhealthy lifestyles) mostly practiced by the people of Kaduna state.

5.3 Conclusions

On the basis of the results obtained in chapter 4 and in view of the limitations of the study, the following conclusions are drawn.

i. Although, age of the respondents is found to be significantly related to smoking and drug habit, individuals within age groups (16-25years old) smoke more than people of other age groups in Kaduna state. Geriatric health problems, violence and tendency to feel high among peer groups account for the reasons why drug problems are common among old people and adolescents/young adults respectively.

ii. Significant relationship is found not to exist between the age groups and alcoholic lifestyle, nutritional habit and sexual behaviour. This is because alcohol consumption, poor nutritional habit and indiscriminate sexual behaviour know no limit across the ages of the people of Kaduna state.

iii. Alcoholic lifestyle and unsafe sexual behaviour are found not to be significantly related to gender (male and female). A visit to places like Kafancha, Kwoi, Zonkwa, Kagoro, Fadan Kagoma and Gantu in the southern parts of Kaduna state, and Samaru–Zaria, Kwangila, Mando, Kawo and Buruku in the northern parts of the state would clearly testify that both gender are actively involve in the production and consumption of alcohol (Local Burukutu). It is a fact that anybody that is drunk is bound to sexually misbehave.

iv. Alcoholic lifestyle, smoking habit, sedentary lifestyle or physical inactivity, drug problems and indiscriminate sexual behaviour is found to be significantly

related to places of abode of the respondents (rural and urban). It could be concluded that people in the urban areas smokes, drinks, involve more in drug abuse and indiscriminate sexual practices than the rural people.

v. Unhealthy lifestyle of smoking, alcohol consumption, drug abuse and indiscriminate sexual practices cut across both socio-economic status groups and educational status groups as both literates including highly educated persons and illiterates are found in the act of smoking, drinking, indiscriminate sexual practices/behaviour and indulgence in drug abuse in Kaduna state. Similarly, the rich individuals and the poor are not left out.

vi. Health problems suffered by the people of Kaduna state, which takes its toll on productivity, reduce life expectancy and huge budgetary allocations are self-inflicted. They can be prevented through the adoption of positive or healthy lifestyles of adequate exercise, cessation of smoking and alcohol intake, good dietary habit, non-indulgence in drug abuse and misuse and safe sexual behaviour.

5.4 Recommendations

On the basis of the findings of the study, the following recommendations are made to reduce likely health problems associated with unhealthy lifestyles and improve quality of life among the people of Kaduna State in particular and Nigeria in general.

1. Since the lifestyle exhibited by an individual does not spring up in a day, health education of children and youths (especially adolescents) should be

intensified in the primary and secondary schools in order to make them appreciate the adverse effects of alcohol, drug abuse, smoking, inactivity and indiscriminate sexual behaviour.

2. Also, to discourage smoking, alcohol consumption and the use of stimulant drugs among teenagers and young adults (16 – 25 years old individuals), the sales of cigarettes, alcohol and hard drugs should be banned within and around the school premises. The counseling unit of our schools (secondary and post-secondary schools) should be more alert to their responsibilities by giving qualitative guidance and counseling to the students. Parents and guardians should also assist in this regard.

3. Kaduna state government should make provisions for more recreational facilities for the promotion and maintenance of positive lifestyles for the people of the state. The communities should also be encouraged to do the same.

4. Since socio economic status influences people's lifestyles, the government should endeavour to improve the socio economic level of the people as well as provide opportunities for people to enhance their socio economic level through education and retraining.

5. Religions and community leaders as well as the opinion leaders should be involved in the crusade against unhealthy lifestyle choices.

6. Public Health Education should be intensified to improve people's awareness of the consequences of unhealthy lifestyles with the aim of encouraging them to make right decisions and choices.

5.5 Recommendations For Further Studies

In the course of this research, the researcher came across several issues affecting the lifestyles of the people. These issues are listed below for future research.

1. Attempts should be made to investigate the relationship between lifestyle factors and diverse ethnics in the state.
2. Future researchers should be encouraged to investigate the relationship between adopted lifestyles and occupational hours or stress of workers in Kaduna state.
3. An all-inclusive investigation be conducted on the relationship between gender and lifestyle factors like smoking, alcohol and sexual behaviour.
4. The significant difference between the lifestyle of adolescents in the rural and urban areas of Kaduna state is also a subject of future investigation. This is important to curb incessant cases of violence, destructive tendencies and the rate at which youths in the State are used to front communal and ethnics crises.
5. Adults who have adopted some unhealthy behaviours should be studied to find out if they will recommend such to their associates especially their children.

5.6 Contributions To Knowledge

1. Among the contributions made from this study are the influences of the seven (7) demographic characteristics (age, gender, educational background, religion, socio- economic status and marital status) on the adoption of lifestyle factors.

2. Most diseases found among respondents in Kaduna state are self-inflicted and could be prevented through the adoption of positive lifestyles of good nutrition, cessation of alcohol, smoking and non indulgence in drug abuse and misuse.

3. Physical and social environment (location) play significant role in the respondents adoption of lifestyle factors as observed among respondents in Kaduna state.

4. The study also established the influenced of religion groups on individual's choice of lifestyle factors. i.e. The faith we profess has influence in our smoking, alcoholic lifestyle, sedentary lifestyle and drug habit; such that an open display of such habits is not spiritually condemned, while some other faiths does not permit an open display of such habits.

5. Socio-economic status groups influenced the respondents adoption and practices of lifestyle factors like alcohol consumption, drug habit, sedentary lifestyle and indiscriminate sexual behaviour.

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APPENDIX A

DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION
FACULTY OF EDUCATION
AHMADU BELLO UNIVERSITY, ZARIA

QUESTIONNAIRE ON RELATIONSHIP BETWEEN DEMOGRAPHIC FACTORS AND LIFESTYLES OF PEOPLE OF KADUNA STATE

This questionnaire has two parts. Part I contains statements on demography. You are requested to tick (√) the appropriate alternative that best describes your opinion for each statement.

Part II contains statements on lifestyle factors. It elicits information on the practice of lifestyle, reasons why people adopt lifestyles and health problems associated with each lifestyle factors. Please tick (√) the appropriate column that best represents your opinion against each statement.

PART I

1. Age: what is your age?

   (a) 16-20 years [ ] (b) 21-25 years [ ] (c) 26 - 30 years [ ]

   (d) 31-35 years [ ] (e) 36-40 years [ ] (f) 41-45 years [ ]

   (g) 46-50 years [ ] (h) 51 years and above. [ ]

2. Gender:

   (a) Male [ ] (b) Female [ ]

3. Religion:

   (a) Islam [ ] (b) Christianity [ ] (c) Traditional religion [ ]

   (d) Others (specify)_____

4. Marital Status:

(a) Single [ ] (b) Married [ ] (c) Widowed [ ]

(d) Divorced [ ] (e) Separated [ ]

5. Location:

(a) Rural area [ ] (b) Urban area [ ]

6. Ethnicity:

(a) Hausa [ ] (b) Fulani [ ] (c) Jaba [ ] (d) Garje [ ]

(e) Nupe [ ] (f) Yoruba [ ] (g) Igbo [ ]

(h) Others (Specify)_____

7. Education background: Please indicate your highest educational qualification.

(a) Postgraduate [ ] (b) Bachelor's Degree / HND [ ]

(c) Diploma / N.C.E. [ ]

(d) Ordinary level certificate (Grade II, SSCE, NECO; NABTEB) [ ]

(e) Primary school certificate [ ] (f) Adult literacy [ ]

(g) Quranic education [ ] (h) Apprenticeship/ craftsman [ ]

(i) Traditional form of education [ ]

8. Income level:

(a) Above 1 million Naira per annum [ ]

(b) N500,000.00 –N999,000.00 per annum [ ]

(c) N100,000.00 – N499,000.00 per annum [ ]

(d) 50,000.00 – N99,000.00 per annum [ ]

(e) Less than N49,000.00 per annum [ ]

PART II

The practice of lifestyle factors

9. Do you smoke?

   (a) Yes [ ] (b) No [ ]

10. If yes, how will you quantify your smoking habits interms of numbers of cigarette sticks smoked per day?

    (a) 1-5 sticks per day [ ] (b) 6-10 sticks [ ]

    (c) More than 1 packet per day [ ] (d) Occasional smoker [ ]

11. Do you experience any of these difficulties in smoking?

    (a) Cough [ ] (b) Cancer [ ] (c) Lung problem [ ]

    (e) Redness of the lip [ ] (f) Cardiac diseases [ ]

    (g) All of the above [ ]

    (h) Others (specify)_____

12. Please indicate, reason (s) that made you to adopt smoking as a lifestyle.

    (a) To deal with stressful situations [ ]

    (b) To demonstrate freedom and independence [ ]

    (c) As a form of experimentation [ ]

    (d) Urbanity and sophistication [ ]

    (e) As a symbol of adulthood [ ]

13. Will you like to give up smoking?

    (a) Yes [ ] (b) No [ ]

14. If yes, what reason (s) would make you give up smoking as a lifestyle?

    (a) Ill health [ ] (b) Expense [ ] (c) Fear of ill health in future [ ]

(d) Special pressure / to please someone else [ ]

(e) Pregnancy [ ] (f) Just wanted to give up smoking [ ]

15. Smoking is common amongst the urban populace than the rural people.

(a) Yes [ ] (b) No [ ]

Physical activity

16. Do you participate in physical exercise?

(a) Yes [ ] (b) No [ ]

17. If yes, how frequently do you participate in physical exercise?

(a) Everyday of the week [ ] (b) Twice a week [ ]

(c) Thrice a week [ ] (d) More than three (3) times a week [ ]

18. How will you describe your participation in physical activity?

(a) Casual [ ] (b) Moderate [ ] (c) Intensive [ ]

(d) Very intensive [ ]

19. Which of these physical activities do you do?

(a) House work [ ] (b) Games [ ] (c) Gardening/Farming [ ]

(d) Walking [ ] (e) Physical [ ] (f) Others (specify)

_____

20. Please, indicate reason (s) that made you to adopt participation in physical activities as a lifestyle.

(a) Improve physical appearance [ ]

(b) Reduce stressful situation (depression and anxiety) [ ]

(c) Enhance good blood circulation [ ]

(d) Control obesity and overweight [ ]

(e) Aids digestion and bowel functions [ ]

(f) Prevent heart related diseases [ ]

(g) All of the above [ ]

(h) Others (Specify)_____

21. Do you experience any of these difficulties due to physical inactivity?

(a) High blood pressure [ ] (b) Cardiovascular diseases [ ]

(c) Obesity and overweight [ ]

(d) Diabetes and cancer related diseases [ ]

(f) Depression, anxiety and uneasiness [ ]

(g) Others (specify)_____

22. Physical inactivity is common among the urban people than the rural people.

(a) Yes [ ] (b) No [ ]

Alcohol consumption

23. Do you drink beer / alcoholic beverage?
(a) Yes [ ] (b) No [ ]

24. If yes, how will you quantify your drinking habits interms of numbers of alcohol / beer bottles consumed per day?

(a) 1-5 bottles per day [ ] (b) 6-12 bottles per day [ ]

(c) More than 1 carton per day [ ] (d) Occasional drinker [ ]

(e) Free drinker [ ]

25. How frequently do you drink alcohol / beer?

(a) Everyday of the week [ ] (b) Twice a week

(c) Thrice a week (d) More than three (3) times a week [ ]

26. Please, indicate reason(s) that made you to adopted drinking of alcohol / beer as a lifestyle?

(a) For relaxation purpose [ ] (b) To deal with stressful situations [ ]

(c) Drinks only during weddings and other special ceremonies [ ]

(d) As a form of experimentation and symbol of adulthood [ ]

(e) Urbanity and sophistication [ ]

(f) All of the above [ ]

(g) Others (specify) _____

27. Do you experience any of these difficulties in Alcohol / beer consumption?

(a) Liver problem [ ]

(b) Accident, injury and death of fellow drinker(s) [ ]

(c) Problems of adjustment with the immediate environmental and work place [ ]

(d) Hypertension, obesity and poor coordination [ ]

(e) Personality disorder, social uneasiness and inability to tolerate tension [ ]

(f) All of the above [ ]

(g) Others specify)_____

28. Will you like to give up drinking of alcohol / beer?

(a) Yes [ ] (b) No [ ]

29. If yes, what reason(s) would make you give up drinking of beer / alcohol?

(a) Ill health [ ] (b) Expense [ ] (c) Fear of ill health in future [ ]

(e) Special pressure / to please someone else [ ]

(f) Just wanted to give up drinking of beer / alcohol [ ]

(g) Others (specify) _____

30. Alcohol / beer consumption is common amongst the urban people than the rural people

(a) Yes [ ] (b) No [ ]

Drug abuse and misuse

31. Do you take drugs to enhance your performance?

(a) Yes [ ] (b) No [ ]

32. If yes, what type of drugs do you take?

(a) Paracetamol, Aspirin, Panadol and others [ ]

(b) Cocaine, Nicotine, [ ]

(c) Alcohol, Valium, Indian hemp, Phenobarbital [ ]

(d) Phencyclindine (P.C.P. – Angel dust), D-Lyserge and peyote. [ ]

33. How frequently do you take them?

(a) Every day of the week [ ] (b) Once a week [ ]

(c) Twice a week [ ] (d) Thrice a week [ ]

34. Do you experience any of these difficulties in drug abuse and misuse?

(a) Violence tendency [ ]

(b) Hearing and seeing things that are not real (hallucinogenic reactions) [ ]

(c) Depression and anxiety [ ]

(d) Problems of malnutrition and liver damage [ ]

(e) Lack of interest in one's job [ ] (f) Educational setback [ ]

(g) All of the above [ ]

(h) Others (specify)_____

35. Please, indicate reason(s) that made you to adopt drug abuse and misuse as a lifestyle?

(a) To deal with stressful situations [ ]

(b) As a form of experimentation and symbol of adulthood [ ]

(c) To demonstrate freedom and independence [ ]

(d) To enhance my study and work performance [ ]

(e) Urbanity and sophistication [ ] (f) All of the above [ ]

(g) Others (specify)_____

36. Will you like to give up drug abuse and misuse as a lifestyle?

(a) Yes [ ] (b) No [ ]

37. If yes, what reason (s) would make you give up during abuse and misuse?

(a) Ill health [ ] (b) Expense [ ] (c) Fear of all health in future [ ]

(d) Special pressure / to please someone else [ ]

(e) Just wanted to give up drug abuse and misuse [ ]

(f) Others (specify)_____

38. Drug abuse and misuse is common amongst the urban people than the rural people.

(a) Yes [ ] (b) No [ ]

Nutritional habits

39. How many times do you eat a day?

(a) Once a day [ ] (b) Twice a day [ ] (c) Thrice a day [ ]

(d) More than three (3) times a day [ ]

40. Do you consciously planned your diet?

(a) Yes [ ] (b) No [ ]

41. If yes, give example of food you eat for

(a) Breakfast_____

(b) Lunch_____

(c) Supper_____

42. Think about the things you eat, would you say that your diet is

(a) As healthy as it could be [ ] (b) Quite good, but could improve it. [ ]

(c) Not very healthy [ ] (d) Don't know [ ]

43. Do you experience any of these difficulties in your nutritional habits?

(a) Loss of appetite [ ] (b) Gross underweight (undernutrition) [ ]

(d) Obesity and overweight (over nutrition) [ ]

(e) Cardiovascular diseases and cancer [ ]

(f) Others (specify)_____

44. If yes, what reason(s) would make you to adopt good nutritional habit?

(a) Ill health [ ] (b) On doctors' advice [ ]

(c) Fear of ill health in future [ ]

(d) Special pressure to please someone else [ ]

(e) Just wanted to give up bad nutritional habit [ ]

46. Please, indicate reason(s) that made you to adopt poor nutritional habit as a lifestyle?

(a) Availability of food [ ] (b) Emotional factors and love of food [ ]

(c) Tendency to increase body weight [ ] (d) Economic reasons [ ]

(e) Tendency to meet up with ones daily energy expenditure [ ]

(f) To deal with stressful situations and anxiety [ ]

(g) Others (specify)_____

47. Poor nutritional habit as a lifestyle is common amongst the urban people than the rural people.

(a) Yes [ ] (b) No

48. Please, tick any of these if you take

(a) Too much salt [ ] (b) Too much calcium [ ]

(c) Too much fat [ ] (d) Too much carbohydrate [ ]

(e) All of the above [ ] (f) None of the above [ ]

Unsafe sexual practice

49. Do you use condom during sexual intercourse?

(a) Yes [ ] (b) No [ ]

50. If yes, how often do you use condom?

(a) Once a while [ ] (b) Frequently [ ]

(c) Every time I have sex [ ] (d) Do not believe in condom [ ]

51. How many love partners do you have?

(a) My spouse or fiancé only [ ]

(b) More than one but less than three (3) partners [ ]

(c) Not more than four (4) partners [ ]

(d) I don't know their numbers [ ]

52. Do you experience any of these difficulties in your adoption of unsafe or free sexual practices?

(a) Sexually transmitted diseases excluding HIV/AIDS (i.e. Gonorrhea, Syphilis and vaginal infections. [ ]

(b) Abortion [ ]

(c) Abandonment of newly born babies and illegitimate child [ ]

(d) Rape and public assault [ ] (e) Teenage pregnancy [ ]

(f) All of the above [ ]

(g) Other specify)_____

53. Will you like to give up unsafe sexual practice as a lifestyle?

(a) Yes [ ] (b) No [ ]

54. If yes, what reason(s) would make you to abandon unsafe sexual practice.

(a) Ill health [ ] (b) Fear of ill health in future [ ]

(c) Social and economic reasons [ ] (b) Just wanted to give up bad habit[ ]

(e) Special pressure / to please someone else. [ ]

55. Please, indicate reason(s) that made you to adopt unsafe sexual practice as a lifestyle?

(a) Environmental reason [ ]

(b) To deal with stressful situations and anxiety [ ]

(c) To demonstrate freedom and independence [ ]

(d) All of the above [ ]

(e) Others (specify)_____

APPENDIX B

AHMADU BELLO UNIVERSITY, ZARIA –NIGERIA
DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION
(OFFICE OF THE HEAD OF DEPARTMENT)

Vice Chancellor: Professor Abdullahi Mahadi, BA, (Hons) Ph.D (ABU) FIAMN, CDA.
Head of Department: Dr. J.A Gwani, B.Sc, M.ED, Ph.D (ABU)

Telephone: 069-51466, 50692/7
Telegrams: UNIBELLO ZARIA

Our Ref: Ph.D/EDUC/28178/2001-2002

Your Ref: ---------- Date: 22/08/2003

1. Prof. P. S. singha (Dept. of Community Medicine, ABU, Zaria)
2. Dr. (Mrs.) Clara Ejembi (Dept. of Community Medicine, ABU Zaria)
3. Prof. Moses Awogbade (Dept of Sociology, ABU, Zaria)
4. Dr. A. Garba (H.O.D. Economic Dept., ABU, Zaria)
5. Dr. C.E. Dikki (Dept. of P.H.E., ABU, Zaria.)

Dear Sir,

REQUEST TO VET A QUESTIONNAIRE

Mall. Shehu Raheem Adaramaja is a Ph.D student in this department. In Partial fulfillment of requirement of his Doctoral Programme in Health Education, he is conducting a research on "Relationship between demographic factors and lifestyles of the people of Kaduna State".

In this regard, he has prepared the questionnaire, which contains 2 parts. Part I is on demographic information, Part II contains several sections on practice of lifestyle factors, reasons for the adoption of those lifestyles and consequences of unhealthy lifestyles.

In view of your exceptional experience, expertise and leadership in this field, you have been chosen as one of the juror (s) to Vet the questionnaire, which is attached herewith.

Please, go through the questionnaire very critically and make your suggestions to enhance the face validity and the reliability of the instrument.

Your anticipated co-operation in this regard is highly appreciated.

(Signed 22nd August, 2003)
Dr. (Mrs.) Comfort O. Adegbite
Major Supervisor

(Signed 22nd August, 2003)
Prof. K. Venkateswarlu
Second Supervisor

APPENDIX C

CONSENT LETTER FOR THE COMPLETION OF QUESTIONNAIRE

DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION FACULTY OF EDUCATION AHMADU BELLO UNIVERSITY ZARIA

4th May, 2004.

Dear Respondents,

QUESTIONNAIRE ON RELATIONSHIP BETWEEN DEMOGRAPHIC FACTORS AND LIFESTYLES OF THE PEOPLE OF KADUNA STATE.

I am a doctoral student in the Department of Physical and Health Education of Ahmadu Bello University, Zaria.

I am currently conducting research on relationship between demographic factors and lifestyles of the people of Kaduna State; in partial fulfillment of the requirement of my doctoral programme.

I therefore solicit for your assistance by completing the attached questionnaire purposely designed for the study.

Your co-operation is highly appreciated.

Yours faithfully,

Shehu, R.A.

APPENDIX: E

RAW DATA

PART 1: Demographic Characteristics NO OF RESPONDENTS: 1350

S/No	Characteristics	Frequency	Percentage
1.	**Age**		
		261	19.3
	16-20 years	289	21.4
	21-25 years	236	17.5
	31-35 years	225	16.7
	36-40 years	155	11.5
	41-45 years	85	6.3
	46-50years	63	4.7
	51 years and above.	36	2.7
2.	**Gender**		
	Male	1038	76.9
	Female	312	23.1
3.	**Religion**		
	Islam	549	40.7
	Christianity	703	52.1
	Traditionalist	27	2.0
	Others	71	5.3
4.	**Marital status**		
	Single	676	50.1
	Married	614	45,5
	Widowed	9	0.7
	Divorced	16	1.2
	Separated	35	2.6
5.	**Location**		
	Rural	450	33.3
	Urban	900	66.7
6.	**Educational Qualification**		
	Postgraduate	151	11.2
	First degree / HND	198	14.7
	Diploma /NCE	363	26.9
	Secondary	423	31.3
	Primary	81	6.0
	Adult education	20	1.5
	Quranic Education	70	5.2
	Craftsman/Apprenticeship	27	2.0
	Traditional form of Education.	17	1.3
7.	**Income level**		
	No response	150	11.1
	Above A million	49	3.6
	N500, 000 – N999, 000	119	8.8
	N100, 000 – N499, 000	247	18.3
	N 50,000 – N 99,000	338	25.0
	Less than – N49, 000	447	33.1

PART II: THE PRACTICE OF LIFESTYLE FACTORS			
A. SMOKING			
8.	**Do you smoke?**		
	Yes	417	30.9
	No	895	66.3
	No response	38	2.8
9.	**If you smoke, no of sticks per day**		
	1-5 sticks	149	11.0
	6-10 sticks	179	13.3
	More than 1 packet	73	5.3
	Occasionally	63	4.7
	No response	885	65.6
10.	**Do you experience any of these difficulties due to smoking**		
	No response	880	65.2
	Cough	166	12.3
	Cancer	71	5.3
	Lung problem	50	3.7
	Redness of lip	77	5.7
	Cardiac diseases	41	3.0
	All the above	62	4.6
	Others (specify)	3	0.2
11.	**Reasons for smoking**		
	No response	892	66.1
	To deal with stressful situations	223	16.5
	Freedom and independence	73	5.4
	As a form of experimentation	73	5.4
	Urbanity and sophistication	23	1.7
	As a symbol of adulthood.	66	4.9
12.	**Will you like to give up smoking?**		
	No response	749	55.5
	Yes	452	33.5
	No	149	11.0
13.	**If yes, what reason(s) would make you give up smoking?**		
	No response	835	61.9
	Ill health	143	10.6
	Expense	34	2.5
	Fear of ill health in future	157	11.6
	Special pressure / to please someone else.	70	5.2
	Pregnancy	21	1.6
	Just wanted to give up smoking	90	6.7
14.	**Smoking is common amongst the urban people than the rural people**		
	No response	259	19.2
	Yes	834	61.8
	No	257	19.0
B. SEDENTARY LIFESTYLE			
15.	**Do you participate in physical exercise?**		
	No response	34	2.5
	Yes	1160	85.9
	No	156	11.6
16.	**If yes, how frequent?**		
	No response	149	11.0

	Everyday of the week	491	36.4
	Twice a week	309	22.9
	Three times a week	223	16.5
	More than three(3) times a week.	178	13.2
17.	**How will you describe your participation in physical activity?**		
	No response	98	7.3
	Casual	392	29.0
	Moderate	499	37.0
	Intensive	144	10.7
	Very intensive	217	16.1
18.	**Which of these physical activities do you do?**		
	No response	90	6.7
	House work	262	19.4
	Games	468	34.7
	Gardening / Farming	244	18.1
	Walking	141	10.4
	Physical leisure activities	125	9.3
	Others (specify)	20	1.5
19.	**Reason(s) that made you to participate in physical activity?**		
	Improve physical appearance	402	29.8
	Reduce stressful situations	160	11.9
	Improve blood circulation	264	19.6
	Control obesity and over weight	142	10.5
	Aids digestion	48	3.6
	Prevent heart diseases	174	12.6
	All of the above	133	10.0
	Others (specify)	27	2.0
20.	**Do you experience any of these difficulties due to sedentary lifestyle?**		
	No response	419	31.0
	High blood pressure	256	19.0
	Cardiovascular diseases e.g. chest pain, breathing problem.	52	3.9
	Obesity and overweight	220	16.3
	Diabetes	79	5.9
	Depression, anxiety and uneasiness	249	18.4
	All of the above	44	3.3
	Others (Specify)	31	2.3
21.	**Sedentary lifestyle is common amongst the urban people than the rural people**		
	No response	74	5.5
	Yes	874	64.7
	No	402	29.8
	C. ALCOHOL CONSUMPTION		
22.	**Do you drink alcohol / beer?**		
	No response	48	3.6
	Yes	653	48.4
	No	649	48.1
23.	**If yes, how may bottles of beer / Alcohol do you consumed per day?**		

	No response	657	48.7
	1-5 bottles	155	11.5
	6-10 bottles	108	8.0
	More than a cartoon	70	5.2
	Occasionally	253	18.7
	Free drinker	107	7.9
24.	**How frequently do you drink alcohol / beer?**		
	No response	694	51.4
	Everyday of the week.	167	12.4
	Twice a week	207	15.3
	Three (3) times a week	179	13.3
	More than three (3) times a week	103	7.6
25.	**Reason (s) for drinking beer / alcohol**		
	No response	657	48.7
	For relaxation purpose(s)	313	23.2
	To deal with stressful situations	85	6.3
	Drinks only during ceremonies	151	11.2
	As a symbol of adulthood	44	3.3
	Urbanity and sophistication	36	2.7
	All of the above	58	4.3
	Others (Specify)	6	0.4
26.	**Do you experience any of these difficulties due to alcoholic lifestyle?**		
	No response	730	54.1
	Liver problem	97	7.2
	Accident	97	7.2
	Problems of adjustment with immediate environment and work place.	108	8.0
	Obesity and poor coordination	64	4.7
	Uneasiness and inability to tolerate tension	210	15.6
	All of the above	35	2.6
	Others (Specify)	9	0.7
27.	**Will you like to give up drinking of alcohol / beer?**		
	No response	585	43.3
	Yes	577	42.7
	No	188	13.9
28.	**If yes, what reason(s) would make you give up drinking of beer / alcohol?**		
	No response	702	52.0
	Ill health	136	10.1
	Expense	118	8.7
	Fear of ill health in future	161	11.9
	Special pressure / to please someone else.	127	9.4
	Just wanted to give up drinking of beer /alcohol	105	7.8
	Others (specify)	1	0.1
29.	**Alcohol / beer consumption is common among the urban people than the rural people**		

	No response	291	21.6
	Yes	769	57.0
	No	290	21.5
D. DRUG HABIT			
30.	**Do you take drugs to enhance your performance?**		
	No response	84	6.2
	Yes	697	51.6
	No	569	42.1
31.	**If yes, what type of drugs do you take?**		
	No response	583	43.2
	Paracetamol, Aspirin, Panadol and others	514	38.1
	Cocaine and Nicotine	80	5.9
	Valium, Indian hemp, phenobardital	131	9.7
	Phencyclidine (p.c.p-Angel dust)	42	3.1
32.	**How frequently do you take them?**		
	No response	586	43.4
	Everyday of the week	209	15.5
	Once a week	231	17.1
	Twice a week	184	13.6
	Thrice a week	140	10.4
33.	**Do you experience any of these difficulties in drug abuse and misuse?**		
	No response	714	52.9
	Violence	119	8.8
	Hallucinogenic reactions	93	6.9
	Depression and anxiety	151	11.2
	Problems of malnutrition's and liver damage	94	7.0
	Lack of interest in one's job.	59	4.4
	Educational set back	78	5.8
	All of the above	41	3.0
	Others (specify)	1	0.1
34.	**Reason(s) that made you to adopt drug abuse and misuse as a lifestyle**		
	No response	659	48.8
	To deal with stressful situations	260	19.3
	To demonstrate freedom and independence	86	6.4
	As a symbol of adulthood	78	5.8
	To enhance my study and work performance	176	13.0
	All of the above	91	6.7
35	**Will you like to give up drug abuse and misuse as a lifestyle?**		
	No response	565	41.9
	Yes	588	43.6
	No	197	14.6
36	**If yes, what reason(s) would make you give up drug abuse and misuse?**		

	No response	732	54.2
	Ill health	154	11.4
	Expense	48	3.6
	Fear of ill health in future.	217	16.1
	Special pressure / to please someone else.	63	4.7
	Just wanted to give up drug abuse and misuse.	136	10.1
37.	**Drug abuse and misuse are common among the urban people than the rural people?**		
	No response	302	22.4
	Yes	828	61.3
	No	220	16.3
E. NUTRITIONAL HABIT			
38.	**How many time do you eat a day?**		
	No response	78	5.8
	Once a day	69	5.1
	Twice a day	253	18.7
	Three (3) times a day	760	56.3
	More than three (3) times a day	190	14.1
39.	**Do you consciously planned your diet?**		
	No response	107	7.9
	Yes	825	61.1
	No	418	31.0
40.	**If yes, give examples of food you eat for** (a) Break fast (b) Launch (c) supper **Response** More than 20 different foods were identified for break fast, launch and supper. On the averagePap & Akara, Tea & bread and Rice & Beans were identified for breakfast. Tuwo Masara, yams, Gari and Amala were mentioned for both launch and supper. This was in addition to some other numerous local foods identified by the respondents.		
41.	**Think about what you eat, would you say that your diet is:**		
	No response	72	5.3
	As healthy as it could be	537	39.8
	Quite good, but could improve it	437	32.4
	Not very healthy	146	10.8
	Do not know	158	11.7
42.	**Do you experience any of these difficulties in your nutritional habit?**		
	No response	417	30.9
	Loss of appetite	366	27.1
	Gross underweight (undernutrition)	100	7.4
	Obesity and overweight	237	17.6
	High blood cholesterol and diabetes	96	7.1
	Cardiovascular diseases	76	5.6
	All of the above	47	3.5
	Others (specify)	11	0.8
43.	**Will you like to improve on your nutritional habit?**		

	No response	82	6.1
	Yes	1101	81.6
	No	167	12.4
44.	**If yes, what reason(s) would make you to adopt good nutritional habit?**		
	Ill health	229	17.0
	On doctor's advice	367	27.2
	Fear of ill health in future	317	23.5
	Special pressure./ to please someone else	72	5.3
	Just wanted to give up bad nutritional habit	177	13.1
	No response	188	13.9
45.	**Reason(s) that made you to adopt poor nutritional habit as a lifestyle**		
	No response	253	18.7
	Availability of food	230	17.0
	Emotional factors and love of food	219	16.2
	Tendency to increase body weight	207	15.3
	Economic reason(s)	322	23.9
	Daily energy need	77	5.7
	To deal with stressful situations	29	2.1
	Others (specify)	13	1.0
46.	**Poor nutritional habit is common among the urban people than the rural people**		
	No response	108	8.0
	Yes	600	44.4
	No	642	47.6
47.	**Please, tick any of these if you take**		
	No response	143	10.6
	Too much salt	110	8.1
	Too much calcium	54	4.0
	Too much fat	142	10.5
	Too much carbohydrate	425	31.5
	All of the above	131	9.7
	None of the above	345	25.6
F: SEXUAL BEHAVOUR			
48.	**Do you use condom?**		
	No response	113	8.4
	Yes	729	54.0
	No	508	37.6
49.	**If yes, how often do you use condom**		
	No response	348	25.8
	Once a while	158	11.7
	Frequently	187	13.9
	Every time I have sex	327	24.2
	Do not believe in condom	330	24.4
50.	**How many love partners do you have?**		

	No response	140	10.4
	My spouse or finance only	635	47.0
	More than one but les than four (4) partners	198	14.7
	Not more than four (4) partners	157	11.6
	I don't known their numbers	220	16.3
51.	**Do you experience any of these difficulties in your sexual behaviour?**		
	No response	750	55.6
	STD-HIV/AIDS	164	12.1
	Abortion	136	10.1
	Child abandonment	106	7.9
	Rape and public assault	47	3.5
	Teenage pregnancy	101	7.6
	All of the above	37	2.7
	Others (specify)	9	0.7
52.	**Will you like to give up unsafe sexual practice?**		
	No response	285	21.1
	Yes	774	57.3
	No	291	21.6
53.	**If yes, what reason(s) would make you to abandon unsafe sexual practice?**		
	No response	438	32.4
	Ill health	179	13.3
	Fear of ill health in future	303	22.4
	Social and economic reasons	195	14.4
	Just wanted to give up bad habit	167	12.4
	Special pressure / to please someone else.	68	5.0
54.	**Reason(s) that made you to adopt unsafe sexual practice as a lifestyle**		
	No response	422	31.3
	Environmental reason(s)	303	22.4
	To deal with stressful situations.	206	15.3
	As a symbol of freedom and independence	306	22.7
	All of the above	84	6.2
	Others (specify)	29	2.1