

**MIGRATION STATUS AND ALCOHOL USE IN URBAN POOR COMMUNITIES,
ACCRA, GHANA**

BY

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**Submitted in Partial Fulfillment of the Requirements
for the M.A (Population Studies) in the
Faculty of Social Studies
University of Ghana,
Legon**

September, 2015.



ACCEPTANCE

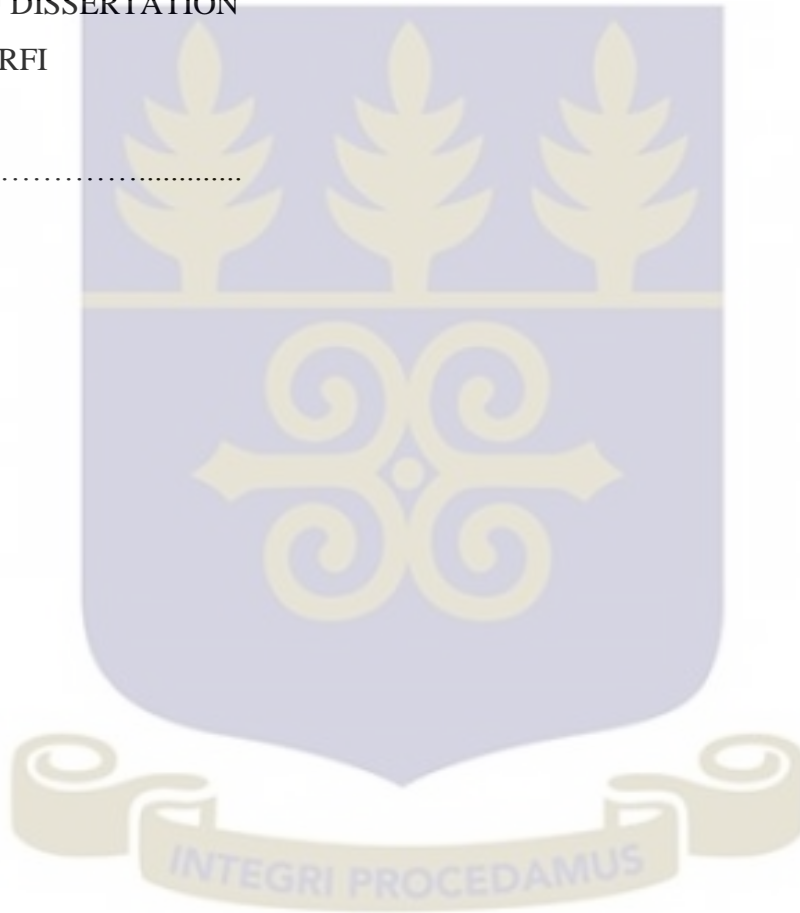
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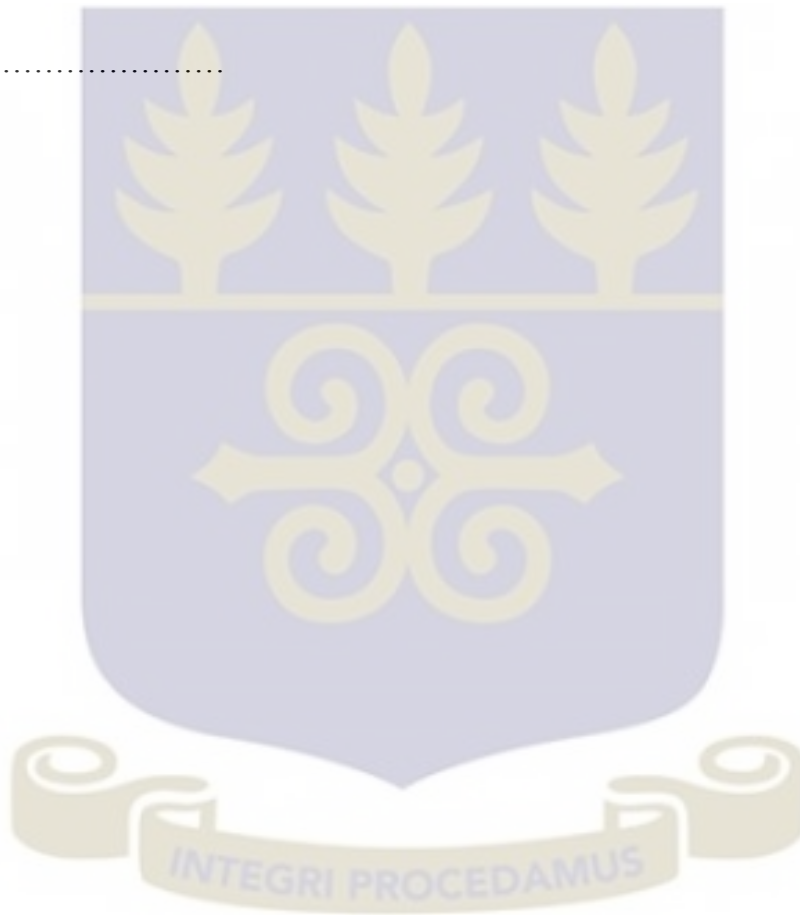
DECLARATION

I hereby declare that, except for references to other people's work which have been duly acknowledged, this is the result of my own research and it has neither in part nor in whole been presented for another degree. I, however, accept responsibility for any errors found in this work.

Signed:.....

DAVID ASAFU-ADJAYE

Date.....



DEDICATION

To my late father, Prince John Kofi Frimpong Asafu-Adjaye, may his soul rest in peace.



ACKNOWLEDGEMENT

I first of all wish to express much gratitude to ALMIGHTY GOD for seeing me through thick and thin in life situations, my fellow M.A. colleagues and the entire PHD students for their immense support during this academic period. Special thanks to my mother, Beatrice Akyeah, Mrs. Mabel Owusu-Debrah, Mrs. Faustina Arthur and Mrs. Mabel Parry for the support given to me throughout my studies.

I am very much indebted to Prof. J.K Anarfi for the patience and time he spent guiding me through the entire dissertation. I equally thank all the faculty members at RIPS for the knowledge they have imparted to me.



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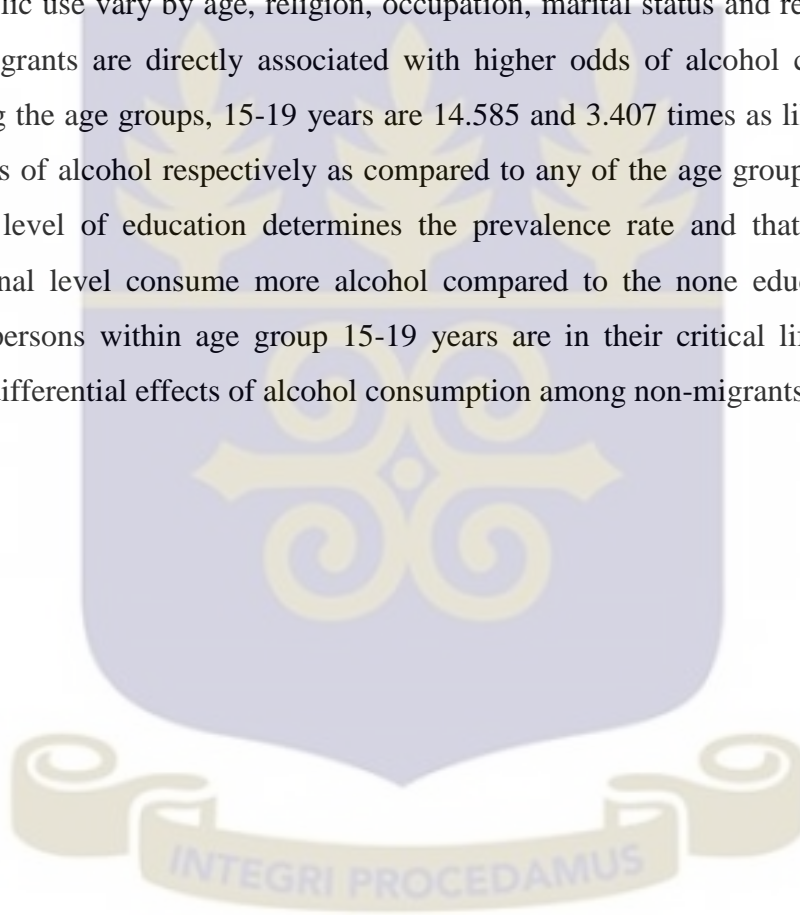
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ABSTRACT

This study scrutinizes the prevalence of alcohol use among migrants and non-migrants and examines whether age, sex, education, occupation, religion, locality and marital status predict alcohol consumption behaviours. Migrants groups include those from all the ten (10) regions of Ghana who have, at the time of the study settled in the three localities. Multinomial regression was estimated using the second round of data collected by the 2011 Urban Health and Poverty Project wave two (EDULINK) in three communities in Accra; (N=915). Results shows that pattern of alcoholic use vary by age, religion, occupation, marital status and region of origin. In addition, non-migrants are directly associated with higher odds of alcohol consumption than migrants. Among the age groups, 15-19 years are 14.585 and 3.407 times as likely to be regular and light drinkers of alcohol respectively as compared to any of the age groups. The study also shows that, the level of education determines the prevalence rate and that respondent with highest educational level consume more alcohol compared to the none educated. I therefore concluded that persons within age group 15-19 years are in their critical life stages that are associated with differential effects of alcohol consumption among non-migrants.



CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Internal migration involves men, women, and children, and includes rural-rural, urban-rural, and urban-urban flows as well as rural- urban movements. Internal migration takes place in large part in response to imbalance between regions of a country, the dominant direction of such migration being dictated by the location bias of employment generating projects. Hence, migration stream will no doubt be directed towards the capital. However, where there is extraction of natural resources such as gold, diamond, crude oil, etc it offers employment and other opportunities. A substantial flow of intra-rural migration is expected as in the case of Ghana, Cameroon, etc.

Migration has been an integral part of Ghana's socio-economic development since time immemorial. The major cause of voluntary movement of population within Ghana, in recent years, is rooted in the initial and growing disparity between and among the regions of Ghana. The causes and consequences of such movement have economic, political, social, and demographic dimensions (Heisel, 1982).

Among the 10 regions of Ghana, Greater Accra and Ashanti regions attract more than half of the migrant population (Ackah and Medvedev, pp4. 2010). A little over half (52 %) of the population aged 7 years and older in Ghana are migrants. Young adults, aged 25 to 29 constitute the largest proportion of migrants. Over four-fifth (89%) of migrants in Accra are from other urban areas. The main impetus for migration in Ghana is family considerations (GLSS Sept, 2008).

In terms of sex, the difference between males and females are marginal except in the rural savannah where proportion of female migrants (47%), is much higher than that of males

(37.6%). Rural forest and Accra have the high proportions of both male and female migrants (GLSS Sept, 2008).

Sex and age differentials with respect to the data provided in the GLSS, 2008, reveal that a comparison of the distribution of all migrants and non-migrants by age group shows the mobility of persons tend to increase with age to age 25-29 and decreases slowly with increasing age.

There are also sex differentials in migration. Generally, there are slightly higher proportions of male in-migrants in the younger age group 10-24 compared to female in-migrants in the same age group. On the other hand, females aged 20 to 34 years constitute a larger percentage of female return migrants than male return migrants in same age group.

Migration research in Ghana has focused on the role of migrants (both internal and international) in the development of Ghana's cocoa industry (Skinner, 1960; Hill, 1961; 1963; 1970; Beals and Menezes, 1970; Thomas, 1973; Peil, 1974; Plange, 1979; Sutton, 1983; Addae-Mensah, 1983; 1985; Arhin, 1988; Cleveland, 1991; Duodu, 2004; Adu, 2005; Abdul-Korah, 2007). Other themes in the research include the evolution of migrant communities, specifically the *Zongos* (Harvey and Brand, 1974; Kpormegbe, 1993; Pellow, 2002; 1991; Schildkrout 1978; Schwimmer, 1980), migrants in what Clark calls 'the market place system' (Clark, 1994; Eades, 1994) and the role of migrants in the development of the mining industry in Ghana (Skinner 1960; Greenstreet, 1972; Thomas, 1973; Peil, 1974; Plange, 1979; Cleveland, 1991). Such focus on migration is due to its demographic, economic and socio-cultural implications not only for the origin areas as well as destination areas but also the actors (migrants) involved.

Many of these studies show that migration in Ghana up to the 1970s was mainly in-migration affecting social organisation, agriculture and population dynamics (Cleveland, 1991).

Substance use, also known as drug abuse, is a patterned use of a substance (drug) in which the user consumes the substance in amounts or with methods which are harmful to themselves or others. The term "drug abuse" does not exclude dependency, but is otherwise used in a similar manner in nonmedical contexts. The terms have a huge range of definitions related to taking a psychoactive drug or performance enhancing drug for a non-therapeutic or non-medical effect. All of these definitions imply a negative judgment of the drug use in question (compare with the term responsible drug use for alternative views). Some of the drugs most often associated with this term include consumption of alcohol, cannabis, cocaine, heroin, inhalant amphetamine type stimulants, prescribed substances, etc.

Use of substance refers to harmful or hazardous use of psychoactive substance including alcohol and illicit drug. (W.H.O.,2011). Historically, psychoactive substance(s) have been used for centuries for various reasons including cultural, religious and recreational purposes. In modern times, scientific advancement leading to pharmacological revolution has produced substances preferable for abuse by the youth. These substance(s) have addictive properties that make them to be abused.

Substance use has become problematic all over the world. Tobacco, alcohol, and illicit substance use continue to result in substantial morbidity and mortality and significant societal economic costs despite considerable efforts to minimize use of licit substances and prevent use of illicit substances. The economic costs of addiction were estimated as \$400 billion yearly in the United States in 1999. In 2002, 4.7 percent of the population reported driving under the influence of an illicit drug and 14.2 percent reported driving under the influence of alcohol at least once during

the past three year. (Galea et al, 2004). Alcohol causes nearly 4 percent of deaths worldwide, more than AIDS, tuberculosis or violence, the World Health Organization (WHO, 2011) warned. For the purpose of this research, alcohol consumption was used for which the data provides information on.

1.2 STATEMENT OF THE PROBLEM

As early as 1979, the W.H.O. initiated a program focusing on alcohol-related problems. This program assessed the impact of alcohol consumption in developing and developed societies and has coordinated dozens of projects and activities that have helped build the evidence, awareness, and support necessary for the development of a global alcohol strategy.

Alcohol use and the related health effects are a global problem and therefore need to be addressed not only by individual nations but also on an international level. For example, the World Health Organization (W.H.O.) noted that harmful alcohol use is the third leading risk factor for premature deaths and disabilities in the world, accounting for approximately 2.5 million deaths worldwide (corresponding to 3.8 percent of all deaths) in 2004 (WHO,2010). Moreover, alcohol use was considered responsible for 4.5 percent of the global burden of disease as measured in disability-adjusted life-years lost in the same year. Given this scope of the impact, the WHO initiated a series of efforts that culminated in the development of a global strategy for reducing the use of alcohol.

In 1997, the WHO also created the Global Information System on Alcohol and Health (GISAH), which currently is hosted and maintained by the Centre for Addiction and Mental Health in Toronto, Canada. This information system compiles the most reliable and updated information in the world on alcohol consumption and related harm by country. It includes and regularly updates

data on recorded alcohol production, on alcohol consumption and related health effects based on national surveys and estimations of unrecorded consumption, and on national alcohol policies and interventions. The database has information from most countries around the world, although many gaps in the validity and reliability of the information remain.

A subsequent study conducted in 2000—the WHO Comparative Assessment of Risk Factors for the Global Burden of Disease—demonstrated that alcohol consumption ranked as the fifth most important risk factor worldwide (Rehm et al. 2003; WHO 2002). Furthermore, alcohol was identified as the leading risk factor in developing countries and the third-leading factor in developed countries. These findings clearly indicated a need for global action regarding alcohol's harmful effects.

An estimated 13 percent of the U.S. adult population was born outside the United States. These diverse migrant populations bring with them the cultural norms related to substance use that exist in their respective countries of origin. As they adapt to life in the United States, they may also be differentially exposed to substance use norms and social challenges (i.e., language barriers, unfamiliar customs, and discrimination). One of the consequences of adapting to new circumstances may be an increased rate of substance use. The heterogeneity of immigrant populations, even among those from the same general regions of the world (e.g., Latin America, Europe), highlights the need to study the factors that may contribute to differential substance use rates. A more comprehensive understanding of the variability among racial, ethnic or minority groups will contribute to the identification of at-risk populations that can be targeted for prevention/early intervention programs.

Today, alcohol use and abuse is a major problem worldwide. Its extent and characteristics however vary from region to region although trends among the youth especially have begun to

converge over these recent years. Alcohol especially, and other related problems are becoming more and more a public health concern. The misuse of alcohol represents one of the leading causes of preventable death, illness and injury. This use is believed to be associated with increasing amounts consumed, frequency of use and groups involved.

Alcohol use problem in Ghana is no different from other countries though there may be variations in the magnitude of the problem. It is difficult to say when it actually became a problem in Ghana but its existence according to educated guesses could be traced as far back as the 1960s' after independence. Currently, use and abuse of drugs have expanded to include the youth. A report in our dailies gives credence to the fact that this menace is on the increase. In the March 16, 2002 edition of the MIRROR, a popular weekly daily in Ghana, it was reported that the Accra Psychiatric Hospital (one of 3 such institutions in the country) has recorded more cases of drug abuse. It stated that "In the past year the facility has recorded as many as 590 drug related cases as against 525 cases in the previous year. The ages of the affected victims ranged from 16 to 60 years"(Lamptey, 2005). This gives evidence that the people mostly affected are the young and strong (fall within the working population of Ghana) who can contribute effectively to the economy of the country. Increasing youth involvement in substance use and abuse is a major threat to national development, family stability and social security.

1.3 RATIONALE OF THE STUDY

A study into relationship between migration and alcohol use and especially at urban poor communities (James Town, Ussher Town and Agbogbloshie) in Accra is considered timely for several reasons. The first is in the area of research. The available literature reveals that, in Ghana much work has been done on all three components of population change, namely, fertility,

mortality, and migration. However, each of these components has often been studied independent of the others. Studies which attempt to investigate the independence of these components are few in Africa. In Ghana, no research has focused on the relationship between migration and alcohol use.

The disinterest shown by researchers in Africa in studies that seek to consider the interactive features among the components of population dynamics prompted Oucho's plea to consider embarking on researches which deviate from treating these components (fertility, mortality and migration) as separate entities,(Kwankye, 1994). It is therefore partly in response to such an appeal and also an attempt at filling such research gap that this study is being conducted. Besides, the study attempts to stimulate research in the area which appears to be abandoned in Ghana.

Secondly, migration as a factor of population distribution has been considered instrumental in the growth of James Town, Ussher Town and Agbogbloshie. Consequently, it has brought many people of diverse ethnic backgrounds to live together. It is thus considered important to examine the issue of how far the congregation of people of varying ethnicity in a sub-urban squatter settlement has affected their substance use (alcohol) behavior, an issue which has been the concern for both government and the public at large.

Furthermore, it is interesting to study a very high natural increase for James Town, Ussher Town and Agbogbloshie. Such a high natural increase attracts research such as the current one which attempts to examine the implications of migration on substance use (alcohol) as pertains to the study area.

1.4 RESEARCH QUESTIONS

1. What is the differential rate of alcohol use among migrants and non-migrants?
2. What is the level of alcohol use among the study population?

1.5 OBJECTIVE

The general objective of the study is to examine the relationship between migration status and alcohol use in urban poor Accra.

The specific objectives of the study are:

- (1) To examine the socio-demographic and socio-economic factors that determine or influence alcohol use in the study area.
- (2) To find out the prevalence rate of alcohol use among migrants and non-migrants
- (3) To highlight the policy implications from the study of the relationship between migration and alcohol use.

1.6 ORGANIZATION OF STUDY

The study is organized into seven chapters. Chapter one focuses on the introduction, which includes the background of the study, statement of the problem, rationale of the study, research question and objectives of the study. Chapter two reviews literature on the harmful use of alcohol, alcohol use as a social norm, acculturation process, intra-cultural diversity, conceptual framework for analyzing migration status and alcohol use, hypothesis, measures used, and definition of concepts. Chapter three covers source of data, sampling design, data analysis and

data limitations. Chapter four, five and six discuss the results and discussion of the study. The final chapter, being chapter seven, summarizes the main findings; whiles conclusions and recommendations were also captured in this chapter.



CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Rising incomes have triggered more drinking in heavily populated countries in Africa and Asia, including India and South Africa, and binge drinking is a problem in many developed countries. Yet alcohol control policies are weak and remain a low priority for most governments despite drinking's heavy toll on society from road accidents, violence, disease, child neglect and job absenteeism.(U.N., 2011).

Approximately 2.5 million people die each year from alcohol related causes, WHO said in its "Global Status Report on Alcohol and Health." (U.N., 2011). The harmful use of alcohol is especially fatal for younger age groups and alcohol is the world's leading risk factor for death among males aged 15-59," the report found. The harmful use of alcohol is especially fatal for younger age groups and alcohol is the world's leading risk factor for death among males aged 15-59," the report found.

Studies conducted over the past 20 years have consistently found lower prevalence of alcohol and drug use among Hispanic immigrants to the US than among US-born Hispanics, a difference presumed to reflect intergenerational change that occurs as migrant groups are incorporated into American society (Alegria et al., 2006; Breslau et al., 2007; Burnam et al., 1987; Grant et al., 2004; Ortega et al., 2000; Vega et al., 1998a). There is evidence to suggest that the transition to high risk for alcohol use begins quickly among migrants, those who arrive as children, (Rumbaut 2004), have *higher* risk for alcohol use than migrants who arrive in the US as adolescents or adults and *lower* risk for alcohol use than US-born Hispanics (Breslau et al).

Burnam et al. (1987) first showed that US born nationals of Mexican ancestry have higher rates of substance use when compared to migrants of Mexican origin. Further studies have confirmed these findings (Alegria et al., 2006; Breslau et al., 2007; Grant et al., 2004; Ortega et al., 2000; Vega et al., 1998a).as cited in G. Borges et al 2012. The scant research in this area suggests that compared to Mexican nationals living in Mexico, Mexican migrants face an increased likelihood of drug use, but contradictory results have been reported for alcohol use (Borges et al., 2011) The alleged differential impact of migration on alcohol and drugs among migrants reported previously (Borges et al., 2011) is puzzling. Two factors may be involved (Babor et al., 2003), substance availability (i.e., the likelihood that one will come into contact with alcohol in a society (Stockwell and Gruenewald, 2001)) and social norms on alcohol and drug use (i.e., the proscriptive and prescriptive, correct use of substances in a given society; Hawks et al., 2002).

2.2 ALCOHOL USE AS A SOCIAL NORM

Social norms are more tolerant for alcohol use in some countries than in others. For instance, alcohol use is more socially accepted in Mexico than in the U.S., with binge and public drinking widely accepted in Mexico (World Health Organization, 2004). On the other hand, the availability of alcohol may not differ between countries, and may even be higher in Mexico for youth due to differences in the legal drinking age and differential enforcement of laws to prohibit underage drinking and sales to minors (Lange et al., 2002) (Borges et al, 2012).

Relocation to the United States is also associated with changes in drinking patterns. Vega et al (2003) relay evidence of these changes in Mexican males. In a study by Caetano and Mora (1988), Mexican men in their native country were found to drink less often but more per occasion than men in the United States. As they adjusted to their new environment, this occasion

drinking combined with the more frequent drinking characteristic of the US culture, “creating a new pattern of regular drinking at higher consumption levels” (Vega et al., 2003). As cited in (McClean et al., pp 10, 2006).

An estimated 13 percent of the U.S. adult population was born outside the United States. These diverse migrant populations bring with them the cultural norms related to substance use (including alcohol) that exist in their respective countries of origin. As they adapt to life in the United States, they also may be differentially exposed to substance use norms and social challenges (i.e., language barriers, unfamiliar customs, and discrimination). One of the consequences of adapting to new circumstances may be an increased rate of substance use.

For many migrant youth, the gradual weakening of parental control and changes in family structure are often accompanied by increasing peer influences. For adolescents, social learning can contribute to the onset of substance abuse behaviors. These new comer youth were likely to have less parental support to avoid risk behavior and most likely to experience peer pressures to engage in risk behavior. Recent migrant youth also report lack of confidence to refuse substances (Blake et al, 2001b). This increasing influence may accelerate their adoption of what they perceive as mainstream behaviors and cultural norms.

The heterogeneity of migrant populations, even among those from the same general regions of the world (e.g., Latin America, Europe), highlights the need to study the factors that may contribute to differential substance use rates. A more comprehensive understanding of the variability among racial/ethnic groups will contribute to the identification of at-risk populations that can be targeted for prevention/early intervention programs.

Rural–urban migration is a major contributor to urbanization in many developing countries. The level of this type of internal migration is increasing in many Asian regions. In the last few

decades Thailand has also experienced a dramatic growth in internal migration, especially from rural areas to Bangkok and its vicinity. Migration to urban areas is an activity undertaken primarily by young adults and characterized by exposure to stressful life events, social difficulties and a reduction in social network and support, with clear potential for deviant behaviours and mental problems. In Thailand, illicit drug use and hazardous and harmful drinking have been identified to be among high priority health issues, which contribute to significant mortality and morbidity among young people. Evidence suggests that the use of illicit drugs, particularly methamphetamine, was reported to be common among Thai adolescents, whereas hazardous/harmful drinking was widespread among young adults.

Alcohol has been implicated in the transmission of HIV via unsafe sex in many systematic reviews examining this association. These literature reviews and meta-analyses have varied. Cook and Clark (2005) examined the association between alcohol consumption and sexually transmitted infections (STIs). Baliunas (2010) looked at alcohol consumption and risk for incident HIV. Fischer (2007) and Kalichman (2007) conducted global-level systematic review studies in Africa and sub-Saharan Africa (SSA) respectively. Woolf-King and Maisto(2011) conducted a narrative literature review that included qualitative and quantitative literature on the link of alcohol and high-risk sexual behaviour in sub-Saharan Africa. Pithey and Parry (2009) conducted a descriptive literature review examining studies that quantified the association between alcohol consumption and HIV in SSA. The results included a high risk group category of beerhall patrons and bar and hotel workers. Braithwaite et al., (2007) showed that alcohol consumption impacts negatively on people living with AIDS (PLWA). These reviews and the Braithwaite study, while consistently indicating a strong association, do not provide sufficient

epidemiological evidence of causality between alcohol use and HIV zero-conversion. They only demonstrate that alcohol is an important correlate of sexual risk behaviour in populations.

2.3 ACCULTURATION PROCESS

Through acculturation process, migrants exposed to new values and opportunities begin to adopt the traditions and practices of the dominant culture in the host country. Such changes may involve increased alcohol and drug use, as acculturation may expose foreign born people to social mores more favorable to substance use than those of their native countries. Among Latina women, greater acculturation is associated with higher odds of being a drinker and higher levels of alcohol consumption (Caetano, 1987; Caetano and Medina-Mora, 1988; Marks et al., 1990; Zeng, 2005). Among Latino men, the nature of the relationship between acculturation and drinking is less clear: Studies have suggested positive (Cherpitel, 1999; Marks et al., 1990), negative (Hines and Caetano, 1998; Markides et al., 1988; Neff et al., 1987), and curvilinear (Caetano, 1987; Caetano and Clark, 2003; Polednak, 1997) relationships between acculturation and other drinking outcomes, as well as null results (Alaniz et al., 1999; Caetano and Medina-Mora, 1988; Ye et al., 2005; Zeng, 2005; Zeng, 2007). Simultaneous with the process of changing social mores, acculturating Latinos also may be climbing in socioeconomic status (Zeng, 2005). National studies in the United States have shown that income is an established predictor of drinker status (Dawson et al., 1995; Mulia et al., 2006). Higher socioeconomic status signifies both greater access to alcohol and, in all likelihood, contact with cultural norms favoring a pattern of frequent light drinking (Mulia et al., 2006). Changes in income thus may interact with acculturation's effects to determine the likelihood and amount of drinking. For

those with higher socioeconomic status (and thus who are able to afford frequent light consumption of alcohol, if interested), higher acculturation may be related to higher odds of 11 drinking and higher frequency of consumption. For those with lower socioeconomic status (and thus less likely to be able to afford frequent light consumption), acculturation may not be related to drinking. An interaction between acculturation and socioeconomic status may partially explain the inconsistent findings across prior studies of acculturation's effects on Latino men's drinking. The effects of acculturation on alcohol use by Latinos seem to vary by gender and because other research using the current dataset has focused on Latina women (Zemore, 2005 as cited in Karrike –Jaffe and Zemore, pp. 27, 2008).

Alcohol use literature has established a positive association between linguistic acculturation and higher levels of substance use (Saint-Jean, Martinez, & Crandall, 2008; Szapocznik & Kurtines, 1980, Vega & Gil, 1998). One explanation for this association is that some individuals may experience stress when acquiring a new language and adapt to a new culture; acculturative stress in turn may lead to alcohol use and other health problems (Breslau et al., 2007; Finch, Frank, & Vega, 2004; Turner, Lloyd, & Taylor, 2006). Linguistic acculturation has been also described as an indicator of cultural integration and in turn cultural integration may be more directly connected to certain risk or protective behaviors than linguistic acculturation (Kuran & Sandholm, 2008).

Some studies have found a specific link between acculturative stress and substance use in Latino migrants (Barnes, 1979; Barrett, Joe, & Simpson, 1991; Bonnheim & Korman, 1985, Conway et al., 2007). On the other hand, language isolation has been identified as a possible protective factor against risk and English acquisition has been identified as possible risk factor making the acculturating individuals more vulnerable to the host culture's alcohol use norms, attitudes, and

models of behavior (Gilbert & Cervantes, 1986). In general, attitudes toward substance use are more liberal in the United States than in Latin-American-heritage communities (Escobar, 1998). Epidemiological studies by Borges et al, (2007) have found that among migrants in general and Mexican migrants in particular, longer duration of residence in the United States is associated with higher risk for substance use. Transnational migration is likely to have an effect on substance use among Mexican migrants in native and destination countries. This is particularly important for Mexico because of the large number of Mexican citizens who migrate to work in the United States and subsequently return to Mexico and even larger proportion of Mexicans who benefit from financial remittances sent home by family members working in the United States. In the United States, Mexican migrants have greater access to alcohol and drugs and exposure to more liberal norms of substance use. Those who remain in Mexico and receive remittances have indirect exposure to US norms of substance use through their family members as well as increased access to alcohol and drugs because of the increase in household income. Studies of patients in treatment for drug use disorders in Mexico have found that those with migration experiences consumed a greater quantity and variety of drugs than did patients without migration experience.

Research consistently shows that foreign-born individuals initially demonstrate better health indicators than their native-born counterparts and this is consistent across socioeconomic status and educational attainment. However, with increased time in the United States, the health status of foreign-born individuals tends to deteriorate. Rumbaut (2004) found that, the longer the time and exposure to the United States, the poorer are the physical health outcomes of immigrants and the greater their propensity to engage in a variety of risk behaviors. While newcomers were found to be less likely to engage in substance use than the US-born population, those who had

been in the United States for 10 years or longer reported drug use that was not significantly different from that of the US-born population (SAMHSA, 2004).

2.4 INTRACULTURAL DIVERSITY

Another model, which may be called the intracultural diversity model, emphasizes the diversity of alcohol and other drug use patterns that exist within different immigrant and refugee groups (Gutmann, 1999). It is incorrect to think of a specific drinking pattern as typifying all members of a particular group, and necessary to recognize heterogeneity. Differences in alcohol consumption exist among individuals within a specific group.

Migrants from Japan (62.1 percent) and Korea (53.2 percent) had a higher prevalence of past month alcohol use than migrants from the Philippines (24.1 percent), China (28.4 percent), 13 Vietnam (26.4 percent), and India (26.6 percent). Korean and Japanese prevalence rates were similar to the rates of U.S.-born individuals (SAMHSA, 2005).

Korean migrants had the highest level of weekly alcohol consumption, consuming on average 7.5 drinks per week; migrants from Vietnam had the second highest past month weekly consumption rate of 5.1 drinks per week, followed closely by Filipino and Japanese immigrants at 4.6 and 3.5 drinks per week (SAMHSA, 2005). For most Asian migrant groups, past month weekly alcohol consumption was higher with longer time spent in the United States (SAMHSA, 2005).

Alcohol consumption has been part of human history since antiquity. There are not only numerous biblical examples and ancient myths which refer to alcohol but local oral history and archaeological findings suggests that consumption has been part of African culture, rituals, tradition and custom since “time immemorial”. But the fact of enduring alcohol consumption and

the passing down of this habit through generations does not adequately explain *why* alcohol is consumed. Moreover patterns of alcohol use have changed significantly over time and evidence suggests that the quantity used now is far greater than in earlier times. The WHO estimates that around 2 billion people worldwide consume alcohol (WHO 2004) and there is clearly no single reason why they do or why different people drink to different extents. It is apparent though that drinking is influenced by factors such as genetics, social environment, culture, age, gender, accessibility, exposure and personality (Freeman and Parry, 2006).

Though alcohol has been consumed for thousands of years, the quantity and patterns of alcohol consumption have changed significantly over the past 500 years. The most important of these changes has been the replacement (or in some instances complementing) of traditional and locally produced beverages with industrial beverages – in particular Western-style commercially produced beer (Riley and Marshall, 1999). As a result of this, regular heavy drinking has become a sustainable pattern. Previously alcohol products did not last long – especially in warm climates – and each batch was consumed within a relatively short period of time. The amount of alcohol available was typically limited by the amount of agricultural surplus (Room et al. 2002). Other factors which have substantially affected patterns of drinking in developing countries include urbanization, changes in gender and age roles, and high intensity mass marketing and promotion of alcoholic beverages by mass multinational corporations (Parry, 2000).

In traditional African society the use of alcoholic beverages appears to have been well regulated. Drinking did not occur on a daily basis and people did not drink alone or just for the sake of drinking. Rather, drinking served a communal and ceremonial purpose (Western Cape Department of Economic Affairs and Tourism, 2003). However this changed with the social and economic developments mentioned. Life for black people tended to be extremely hard and many

people turned to drink to alleviate their stress and sorrow. Rates of drinking in countries with the highest consumption are decreasing while the opposite is true of countries with lower consumption (corresponding generally to more developed and less developed countries). It also appears that there is a link between economic prosperity and rising alcohol consumption (e.g. Ireland and the Nordic Countries). Data on country level alcohol consumption is usually measured in terms of “recorded” alcohol derived from formal production and sales - the UN Food and Agriculture Organisation collects annual figures directly from governments around the world –and measured in terms of per capita alcohol consumption (15+) in litres of pure alcohol. The WHO Global Status report on Alcohol 2004 reported on alcohol consumption in 189 countries (WHO 2004). Consumption ranges from Muslim countries such as Iran and Saudi Arabia where no alcohol is consumed (in terms of official production and sales) to Luxembourg and Uganda who consume 17.54 and 19.47 litres of pure alcohol per adult capita respectively. South Africa is the 47th highest consumer with 7.81 litres per capita.

These figures do not, however, include “unrecorded” consumption or the consumption of those who do not drink i.e. excluding adults who abstain from alcohol.

Migration and health is also attracting increasing interest. Badasu (2004) has presented, under internal migration, child care practices among Ewe ethnic migrants in the city of Accra in what she describes as “cases of crisis of care”. Though these cases are unique in their own respect, they reflect together, the general situation of care among migrants and the need to include health perspectives in migration research.

Ghana is not spared in this substance abuse pandemic. A publication in the weekly Ghanaian Spectator (26th September edition 2001) noted that the major drugs abused by adolescents include cannabis, cocaine and heroin. Whereas we have the problem of abuse of socially

accepted substance like alcohol, tobacco and prescribed drugs in recent times, Ghana has been confronted with the abuse of narcotic substances (as cited in Lamptey, 2005).

Further statistics from Ghana Narcotics Board indicate higher arrest rates for cannabis followed by heroin and cocaine. Alcohol use is linked with socio-cultural life of Ghanaians. There are many psychiatric complications associated with chronic alcohol use but unfortunately many do not receive psychiatric attention. Many complications of alcohol abuse find their way to general hospitals. Overall figures also show that there is greater involvement of males in drug-related offences than females. The future wealth and manpower of any country depend on the mental and the physical health of the youth of today. It is therefore important for all countries including Ghana to adopt concrete and appropriate strategies in combating any physical, psychological and socio-medical problem which may affect the youth negatively, (Lamptey, 2005).

In a study looking at the pattern and prevalence of alcohol-impaired driving in Ghana using a random breathalyser survey of drivers, it was found that 21 percent of the drivers who were tested had detectable blood alcohol concentrations. Among these positives, 7.3 percent had blood alcohol concentrations greater than or equal to 80 mg/dl, indicating impaired driving. Alcohol use was more prevalent in middle-aged drivers than in younger or older drivers and was higher among illiterate drivers than literate drivers. A qualitative study looking at the consumption and impact of a locally made alcohol (*akpeteshie*) in the Upper Western Region of Ghana found that *akpeteshie* drinking by both men and women is on the rise, and is increasingly associated with sexual abuse and rape. The findings reveal strong perceptions of the health and economic damage that alcohol is having on the people of the area, (Population and Statistics Division, World Bank, WHO, 2004).

In Ghana about 30 million litres of alcohol is consumed yearly. A survey conducted by the Ghana organisation on Foetal Alcohol Syndrome (GOFAS) estimated that the per capita consumption of Alcohol is 1.5 litres, about 7 million gallons of alcohol consumed annually (Kunnteh, 2008). While studies have shown that greater proportion of alcohol is traditionally consumed by men in Ghana (Luginaah and Dakubo, 2003; Luginaah, 2008), recent decades have fundamental changes in the role of women in Ghana and have brought about marked changes in their attitudes and behaviours toward alcohol (Adusi-Poku, 2011; Badasu, 2004; Oppong, 2004). An urban survey of a random cluster sample of Ghanaians aged 25 years and above from the Greater Accra area of Ghana (total sample size $n = 4733$; males $n = 1857$ and females $n = 2876$) found that 44.5 percent of the total sample do not drink alcohol (40% of males and 47.5% of females).

Women in Ghana are involved in drinking behaviours that pose threat to the health development of the country especially in areas of maternal and reproductive health (Asamoah and Agardh, 2012; Adusi-Poku, 2011); and that the problem of alcohol ingestion extends into the gestation periods of these women, thereby causing teratogenic effects (Adusi-Poku et al, 2013; Asamoah and Agardh, 2012). The suspicion is amplified when a pilot study conducted by GOFAS in three regions of the country; i.e. Greater Accra, Central and Western revealed that 129 out of the 150 women of childbearing age, representing 86%, drunk various types of Alcohol (Opoku-Boakye, 2008).

While the claims may be confirmed by recent studies in other regions and countries on maternal alcohol consumption (WHO, 2004), extensive empirical research are scanty, mostly based on men, and with unrepresentative sample sizes (e.g. Adusi-Poku, 2011; Asamoah and Agardh, 2012; Luginah, 2008; Luginaah and Dakubo, 2003).

According to the 2003 World Health Survey (total sample size $n = 1943$; males $n = 1085$ and females $n = 858$), the mean value (in grams) of pure alcohol consumed per day among drinkers was 8.0 (total), 10.6 (males) and 5.0 (females).

In a study of 894 senior secondary students in Accra (56.9% female and 43.1% male; mean age of 17.4 years), using a modified version of the Youth Risk Behaviour Survey questionnaire, it was found that the prevalence rate of lifetime alcohol use was 25.1%. Among lifetime users, 46.2% were currently using alcohol. The unrecorded alcohol consumption in Ghana is estimated to be 3.6 litres pure alcohol per capita for population older than 15 for the years after 1995 (estimated by a group of key alcohol experts) (WHO, 2004).

There are limited studies on the migration status of internal migrant and alcohol use in Ghana; specifically, within poor urban communities in Ghana. Studies on migration status focus on international migrant and their alcohol use. However, using the acculturation hypothesis, although there are ethnic and regional differences of internal migrant it is expected that young migrant are at risk of high alcohol use due to the economic and social values they have to adapt. Inability of the internal migrant to secure job and adapt to social values could expose them to stressful situations and at risk of alcohol use.

2.5 CONCEPTUAL FRAMEWORK FOR ANALYSING MIGRATION STATUS AND ALCOHOL USE

The conceptual framework of the study was adopted from a theoretical model which has earlier been advanced in explaining the substance abuse differentials between migrants and non-migrants (Figure 2.1). These differ from one another largely in terms of whether they view the

differentials in substance use as having existed before the migration occurred or as manifested after migration in respect to the Substance use norms of the host population (socialization and adoption models).

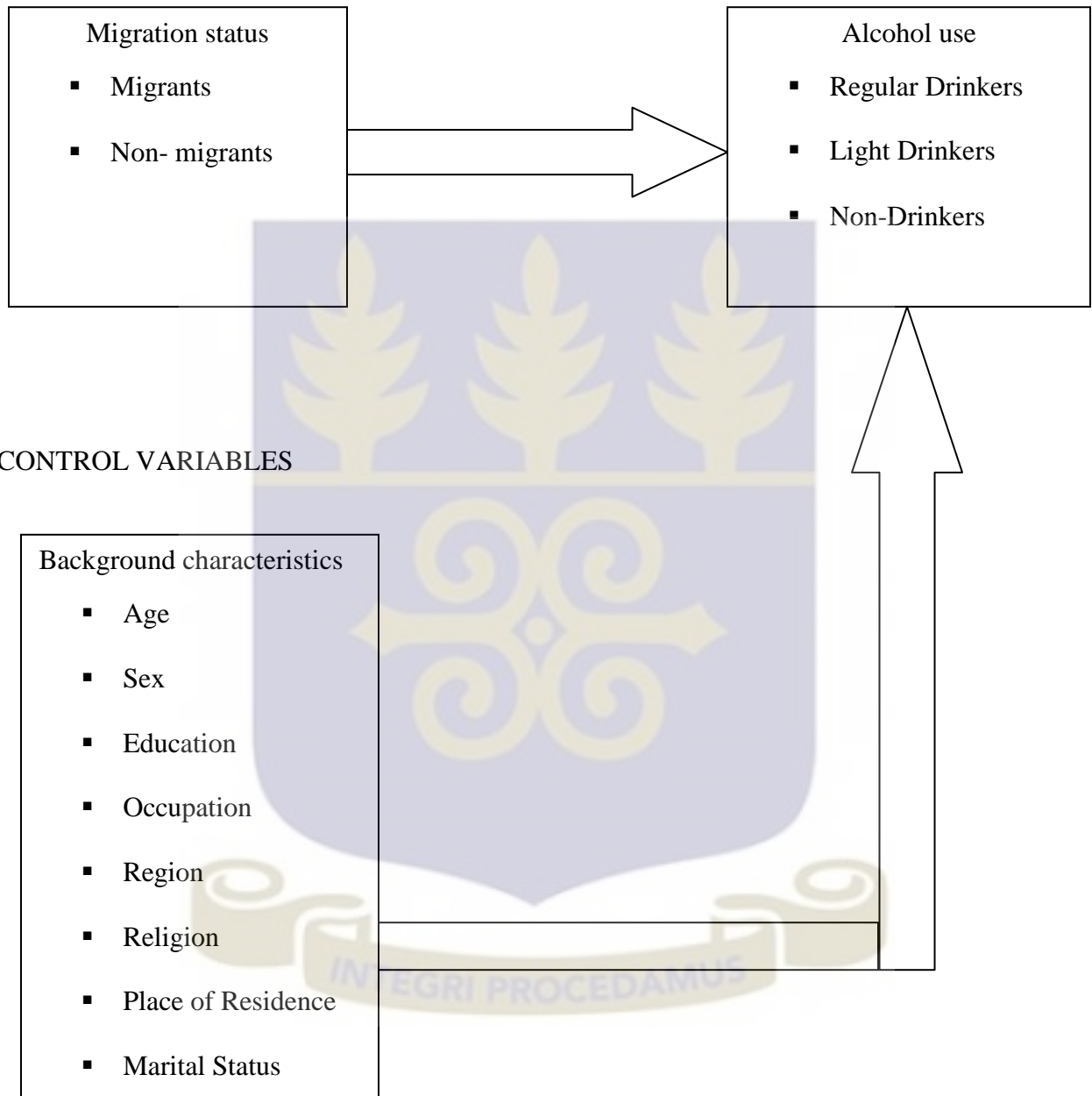
These models are relevant to the current study and are as such, adopted with some modification. Generally, the conceptual framework is underscored by the idea that migrants are usually selected by factors based on some special characteristics such as age, education, and occupation. By this nature of selection, migrants may usually be prepared for lower Substance use even before they move. Consequently, disruptions that take place as a result of change of residence and adjustment of problems at the place of destination make it ideal for migrants to readily adapt to alcohol use prevailing in urban places of residence. In effect, it shows how the migrants conform to alcohol use pattern in most urban areas.

The conceptual framework diagram shows how the independent variables namely Migrants and Non-migrants are connected to the Dependent variable; Alcohol use. Control variables, namely; age, sex, education, region, occupation and place of residence will be controlled to see the effect that migration status has on alcohol use (Religion, is however conceived not to have any influence on Migration).



INDEPENDENT VARIABLE

DEPENDENT VARIABLE



Adopted: Borges et al, 2011.

Figure 2.1 CONCEPTUAL FRAMEWORK SHOWING THE RELATIONSHIP BETWEEN MIGRATION STATUS AND ALCOHOL USE

2.6 HYPOTHESIS

In the light of observation made in the available literature and considering the conceptual framework that has been adopted for the study, it is accordingly hypothesized that:

- (i) Migrants in urban poor communities are more likely to be regular drinkers compared to non-migrants.

2.7 DEFINITION OF CONCEPTS

With respect to migrants and non-migrants, persons who have relocated from other place(s) to their present residence (James and Ussher Towns, and Agbogloboshie) for five (5) years and above will be considered as migrants. And non-migrants are persons who were born and whose place of last residence and eliciting answers of this interview are the same. Also, this study takes into consideration where migrants, mostly lived during the last fifteen (15) years of their lives.

2.7.1 Alcohol

The simplest form of alcohol is methanol, sometimes called “wood alcohol” because it can be produced by fermentation of wood. Other members of this family include glycol (found in anti-freeze for cars), propane and cholesterol, a complicated molecule vital for many bodily functions and which in excess, can cause serious illness such as heart disease (International Centre for Alcohol Policies, 2005).

2.7.2 Age

In a study of by Pitkanen and others, four indicators of the adults use of alcohol were used which were: (1) frequency of drinking, (2) binge drinking (3) cut-down and (4) annoyed. Results indicated that the age of onset of alcohol was predictive of these four indicators in adult life (Pikanen et al, 2005).

2.7.3 Education

Studies indicate that those with more than 12 years of education are twice as likely to be drinkers, than those with less education. On the other hand, for heavy drinkers, about 6 per cent of those with less than junior high school education report heavy drinking compared to 20 percent of college graduates (Ford, 2008).

According to the World Health Organization (2004), a study conducted in India on the role of socioeconomic makers in the prediction of alcohol consumption revealed that the odds of drinking was relatively higher among illiterate women in India than the literates (WHO, 2004).

2.7.4 Occupation

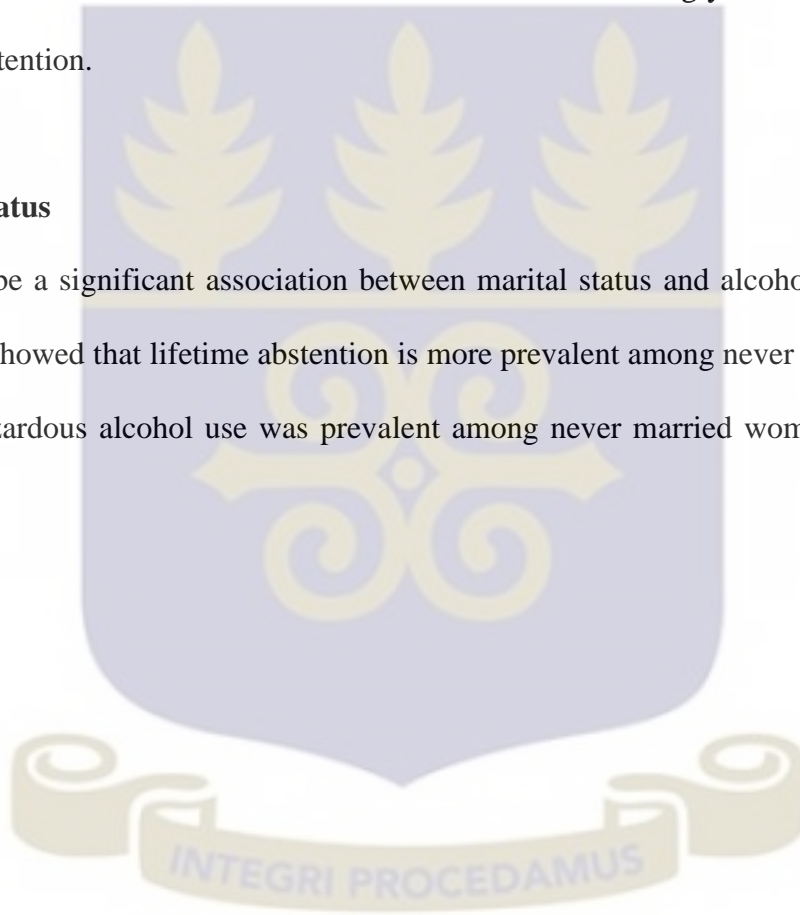
In the study “Alcohol and Occupations”, reviewers found an association between alcohol consumption and the type of occupation. This review showed that the prevalence of alcohol dependence and abuse was high in two high risk industries: construction and transportation (Mandell et al, 2006). Evidence shows that employment in some occupations may be protective against alcohol dependence and also some studies show that women are more likely to during pregnancy if they earn higher income (Ford, 2008).

2.7.5 Religion

Researchers have consistently found positive relations, participation and healthy outcomes across multiple religion and population (Ayers et al, 2009; Amankwa et al, 2012). For instance, in their studies in drinking among Koreans in California, Ayers and colleagues (2009) found that religious beliefs and more conservative views of the Bible were strongly associated with greater likelihood of abstention.

2.7.6 Marital Status

There seems to be a significant association between marital status and alcohol use. A study in urban Tanzania showed that lifetime abstention is more prevalent among never married than ever married. But hazardous alcohol use was prevalent among never married women (Mbatia et al, 2009).



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research techniques and methods used in the study. It focuses on the following areas: data source, research design, sampling design, population and sample size, data analysis, measures and data limitations.

3.2 Source of Data

The study relied on secondary data from the 2011 Urban Health and Poverty Project wave two collected in three communities. This Edulink Urban Health and Poverty Project is a project undertaken by the Regional Institute for Population Studies (RIPS), University of Ghana with collaboration from Southampton University (UK), Cape Coast University (Ghana), University of Ibadan (Nigeria) and Fourah Bay University (Sierra Leone). The aim of the project is to integrate real-life fieldwork into the teaching and learning of population sciences among students and staff in participating African and UK Higher Education Institutions (HEIs). The focus of the data collection was directed towards urban poverty and health. The Project was conducted in three urban poor communities in Accra (James Town and Ussher Town in Ga Mashi and Agbogbloshie). The Edulink Urban Health and Poverty Survey seeks to contribute to knowledge on inequalities in health and human welfare between the urban poor and other sub-groups in Africa and to sensitize local and regional stakeholders on urban poverty and health issues. The survey brings together a variety of research interests in the areas of migration, community and environmental challenges, climate change, reproduction, contraception, child and maternal health, marriage, sexual health and behaviour, fertility preference, HIV/AIDS and other STIs,

adolescent sexual and reproductive health, and nutrition. The Edulink data are collected within a period of 18months interval and it is made up of different waves.

3.3 SAMPLING DESIGN

The sampling design consisted of a total of 1160 households from all 29 EAs across the three localities. A breakdown by locality shows that 320 households in James Town, 640 households in Ussher Town and 200 households in Agbogbloshie were selected. An updated version of the listing frame used in the first round of EDULINK was used to sample the 20 additional households. After informed consent was obtained, household interviews were conducted with household members; individual questionnaires were also administered to respondents of ages 15 to 49(females) and 15 to 59(males) years respectively. Out of the total of 915 respondents, Regular drinkers were 144, Light drinkers 412 and Non-drinkers 359. Reference category (RC) was Non-drinkers.

3.4 DATA ANALYSIS

The study uses SPSS version 16 for the data analysis. Various methods were employed in the analysis of the data. These include frequency distributions and simple cross tabulations. In order to examine the relationship between migration status and alcohol use, cross tabulations of the current age group of respondent, religious background, locality of respondents and educational categories were used.

Multiple regression analysis was then taken using alcohol use as the dependent variable and migration status as independent variable. This was done to see the effect of independent variable (migrants and non-migrants) on the dependent variable (alcohol use).

3.5 MEASURES

The study questionnaire based on the EDULINK URBAN HEALTH AND POVERTY PROJECT (Individual Questionnaire) included items related to alcohol use, migration and demographic characteristics, including where the respondents were living at the time of the interview.

Alcohol use variable was re-coded into three variables with one (1) representing Regular drinkers who answered Yes to; Have you ever consumed a drink that contains alcohol?; Have you consume alcohol in the last 30 days?; Light drinkers are respondents who answered Yes to both questions but No to; Now think from now to this same time yesterday, did you consumed alcohol? Non-drinkers were respondents who answered No to all three (3) questions.

With respect to Migrants and Non-migrants, persons who were not born in Greater Accra, but have relocated from other place(s) to their present residence (James Town, Ussher Town and Agboghloshie) are considered as Migrants. Non-migrants are persons who were born within Greater Accra. This was done based on the assumption that residents in Greater Accra may have homogeneous characteristics and hence will be different from those of the other regions.

With the idea of homogeneity, Greater Accra Region was interchanged with Upper West Region from their original numbering placement to the last so as to make Greater Accra Region reference category.

Other covariates analyses included socio-demographic information collected in the Edulink on gender, age, occupation, region, religion, educational attainment, and marital status. Age was re-grouped into five (5) year age group. Thus 1=15-19, 2=20-24, 3=25-29...7=45-49.

Some multichoice answers of religion were re-grouped. Multichoice answer 2=Catholic, 3=Protestants, 4=Pentecostal/Charismatic and 5=Other Christians was re-grouped into

1=Christian. Traditional/spiritual was re-categorized to include Other Eastern Religion, since their counts were very small. No Religion and Islam were maintained.

Occupation was also re-categorized into 1= No occupation (comprises of no occupation, missing system, and Don't know), 2= Professional/Technical/Clerical, 3= Sales and Service, Household and Domestication, and 4= Agriculture (Agriculture-self employed and Agriculture). Skilled Manual, Unskilled Manual and Other were maintained.

Educational attainment was categorized as 1=Primary (comprising preschool and primary), Middle/JHS was maintained, 3=Secondary/Higher (comprising secondary/SHS and Higher), No education (comprising dataset missing from the system).

Two questions in the Edulink data were used to categorized marital status.

1. “Are you currently married or living with a partner?” Respondents who answered to 1= Yes, currently married were considered as Married. Respondents who answered to 2= Yes, living with a partner were considered as living with a partner. And respondents who answered to 3= No, not in the union were considered as Widowed/Divorced/Separated.

2. All respondents who did not answer to the question “What is your marital status?” were never considered as married.

3.6 DATA LIMITATIONS

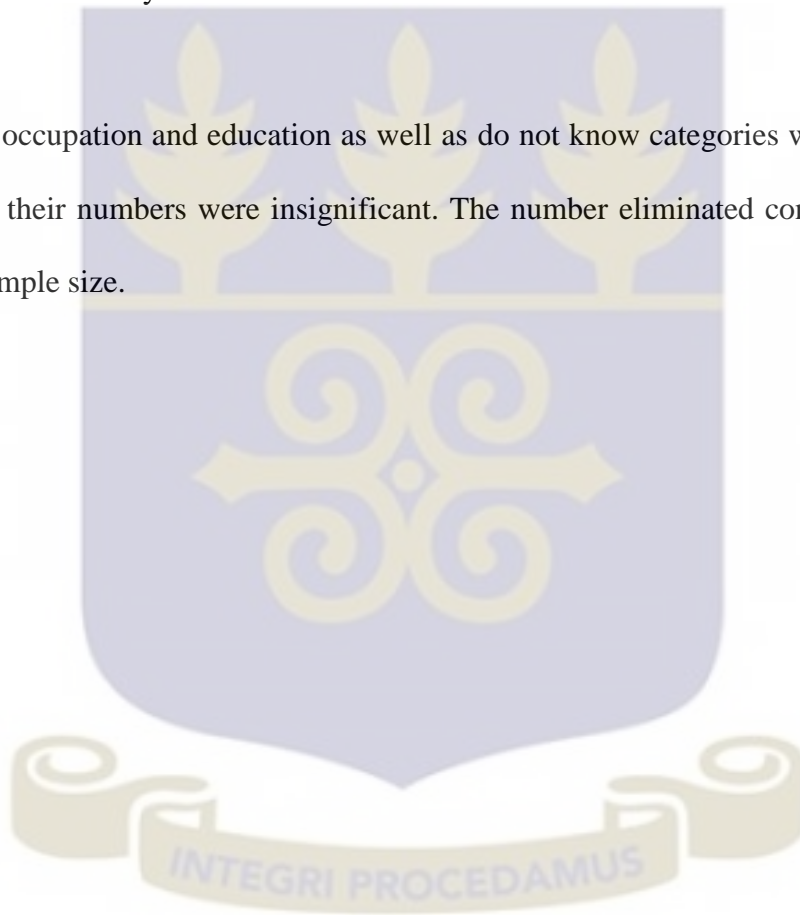
The study is limited in two major respects. First, it does not provide an adequate basis for comparing migrants and non-migrants alcohol use in both rural and urban areas as would otherwise have been expected in many studies on migration and alcohol relationships. By the nature of the data and sample used, the study is limited to what pertains in an urban setting after migration has taken place.

Secondly, all those classified as migrants have an urban place of current residence. The study is consequently silent on the possible impact of rural environment on the alcohol use of an individual who migrates from urban or rural area to sojourn in a rural area.

Thirdly, the dataset did not ask about the frequency of consuming alcohol in the last 30 days. The categorization of alcohol drinkers is without the frequency at which respondents consume alcohol within the last 30 days.

Missing Values

Missing data for occupation and education as well as do not know categories were eliminated in the dataset since their numbers were insignificant. The number eliminated contributed to about 0.005% of the sample size.



CHAPTER FOUR

DEMOGRAPHIC AND OTHER CHARACTERISTICS OF RESPONDENTS

4.1 INTRODUCTION

This chapter deals with the demographic and socio-economic characteristics of respondents to help understand their behaviour towards alcohol use. The chapter describes the characteristics of 915 respondents aged between 15-49 years, taking into consideration their alcohol use. These include age, sex, religion, education, occupation, region, locality, and marital status.

4.2 BACKGROUND OF THE STUDY AREA

Accra is the capital and largest city of Ghana, with an urban population of 1,848,614 according to the 2010 census (Ghana Statistical Service, 2012). Accra is one of the leading and fastest growing cities in Africa, with an annual growth rate of 3.36%. Accra serves as the nation's economic and administrative hub.

The main study areas form part of central Accra. Located directly east of the Korle Lagoon, James Town and Ussher Town are the oldest districts in the city of Accra, and emerged as communities around the 17th century. These districts were heavily developed by the end of the 19th century, and following the rapid growth of the city during the 20th century, they became fishing communities inhabited primarily by the indigenous Ga.

Agbogbloshie is a suburb of Accra. The town covers approximately four acres and is situated on the banks of the Korle Lagoon, northwest of Accra's Business District. About 40,000 Ghanaians live in the area (Ghana Statistical Service, 2012) most of whom are migrants from rural areas. The population of Agbogbloshie consists of economic migrants from northern and rural parts of Ghana.

4.3 Demographic Characteristics of Respondents

4.3.1 Age and Sex of Respondents

Of the sample of 915 respondents, 58.3 percent were females while 41.7 percent were males.

Respondents' ages were between 15-49 years for both sexes. Age group 20-24 constituted the highest number of respondents with 19.1 percent. Percentages for the age groups decreased thereafter for each age group to the least of 9.9 percent for 45-49 years. However, age group 15-19 years were 16.2 percent.

4.3.2 Marital Status

A little over forty percent (41.3%) of the respondents were never married while 22.3 percent were currently married and another 20.8 percent were living together. Respondents who were widowed /separated/divorced were 15.6 percent.

4.3.3 Migration Status

Table 4.2 presents the socio-economic characteristics of respondents. The table reveals that 81.4 percent of respondents in the urban poor communities are non-migrants while 18.6 percent are migrants. Migration can also affect the characteristics of the labour force of the areas of origin and destination. Interest in the extent, causes and selectivity of migration has increased over the years because of social and economic considerations that are of considerable research and policy relevance (GLSS 5, 2008).

Table 4.1 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Age	Number (N)	Percent (%)
15-19	148	16.2
20-24	175	19.1
25-29	161	17.6
30-34	137	15.0
35-39	104	11.4
40-44	99	10.8
45-49	91	9.9
Total	915	100.0
Sex		
Female	533	58.3
Male	382	41.7
Total	915	100.0
Marital Status		
Married	204	22.3
Living Together	190	20.8
Widowed/Separated/Divorced	143	15.6

Never Married	378	41.3
Total	915	100.0
Migration Status	Number(915)	Percent (%)
Migrants	170	18.6
Non-migrants	745	81.4
Total	915	100.0

Source: Computed from Edulink Data, 2011

4.4 Social Characteristics of Respondents

4.4.1 Religion

Table 4.2 indicates that most of the respondents were Christians (80.7%). Respondents with Islamic affiliation were 10.4 percent while respondents with no religion or category labelled no religion were 6.9 percent. Respondents with traditional/spiritual/other were the least of percentages with 2.1 percent.

4.4.2 Educational Level

The educational level of a person is an important variable in the formulation of perceptions and behaviour (Amoah, 2003). Therefore, the educational status of the population was examined. Most respondents in the study were middle/JHS level holders (43.2%). Secondary/ higher educational level were 29.7 percent while respondents with primary educational level were 21.3 percent. Respondents with no education were 5.8 percent. The study anticipated less risky behavior due to possible exposure to knowledge.

4.4.3 Region

A large majority (73.7%) of the respondents were from the Greater Accra Region while the least proportion (0.2%) was represented by the Upper West Region. Eastern and Central Regions were 7.4 and 4.9 percent respectively. These two regions have higher representation in the area mainly because they share geographical boundaries with Greater Accra and are thus closer to the region. Upper West Region which was the least representation may be due to the distance between the two Regions. The high percentage of respondents from Greater Accra goes to confirm GLSS report of the fifth round that about four in every ten (10) residents of this region is an in-migrant (GLSS, 2008).

4.4.4 Locality

Most of the respondents, (50.7%) resides in Ussher Town. James Town was 32.1 percent of respondents as residents while 17.2 percent of the respondents were residents of Agbogbloshie. A study by Escobar et al (2003) stated that the number of outlets in a locality may affect levels of alcohol consumption due to the opportunity cost associated with alcohol (Babor et al, 2003, as cited in Freeman et al, 2006).

Table 4.2 Social Characteristics of Respondents

Religion	Number (N)	Percent (%)
Christian	738	80.7
Islam	95	10.4
Traditional/Spiritual/Other	19	2.1
No Religion	63	6.9
Total	915	100.0
Education		
Primary	195	21.3
Middle/JHS	395	43.2
Secondary/Higher	272	29.7
No Education	53	5.8
Total	915	100.0
Region		
Western	16	1.7
Central	45	4.9
Upper West	2	0.2
Volta	21	2.3

Eastern	68	7.4
Ashanti	17	1.9
Brong Ahafo	19	2.1
Northern	12	1.3
Upper East	41	4.5
Greater Accra	674	73.7
Total	915	100.0
Locality		
Ussher Town	464	50.7
James Town	294	32.1
Agbogbloshie	157	17.2
Total	915	100.0

Source: Computed from Edulink Data, 2011

4.5 Economic Characteristics of Respondents

4.5.1 Occupation

Table 4.2 shows that more than forty percent (42.7%) of the respondents were Sales/services personnel. This was followed by respondents with no occupation with 22.2 percent. 17.6 percent of the respondents were skilled manuals while 8.2 percent were Professional/Managerial/Clerical; and about 6.7 percent were Unskilled manual. Only 1.1

percent of the respondents were into Agriculture. Occupation of the respondents is a reflection of their educational level. Meaning that their chances of working in the formal sector were slim. Perhaps this accounted for the larger proportion of them engaging in sales and services.

Table 4.3 Economic Characteristics of Respondents

Occupation	Number (N)	Percent (%)
No occupation	203	22.2
Professional/Managerial/Clerical	75	8.2
Sales and Service	391	42.7
Agriculture	10	1.1
Skilled Manual	161	17.6
Unskilled Manual	61	6.7
Other	14	1.5
Total	915	100.0

Source: Computed from Edulink Data, 2011

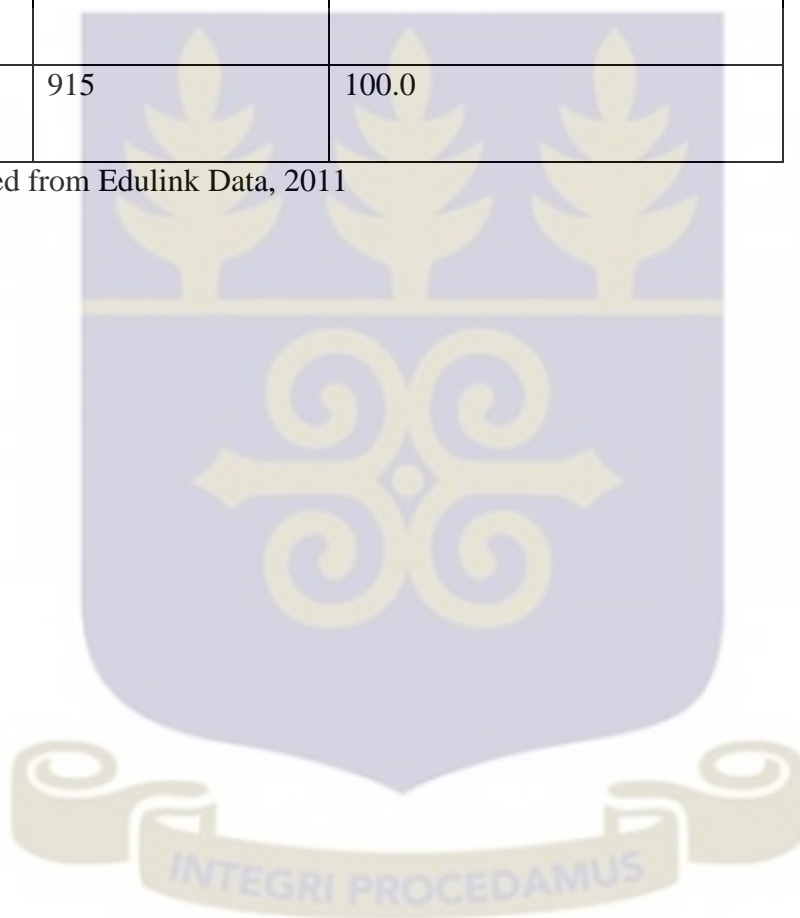
4.6 Alcohol Status

In terms of contextual determinants of smoking and alcohol use, area-level social and economic disadvantage may be associated with a greater likelihood of the use of cigarettes and alcohol (Galea et al, 2004). Table 4.2 further reveals that, 45 percent of the respondents were light drinkers while 15.7 percent were regular drinkers. Non-drinkers were 39.2 percent

Table 4.4 Alcohol use of Respondents

Alcohol Status	Number (N)	Percent (%)
Regular Drinkers	144	15.7
Light Drinkers	412	45.0
Non-drinkers	359	39.2
Total	915	100.0

Source: Computed from Edulink Data, 2011



CHAPTER FIVE

DISTRIBUTION OF DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS AND ALCOHOL USE AMONG RESPONDENTS.

5.1 Introduction

In this chapter the relationship between the dependent and independent variables are discussed. As indicated earlier there are many factors that affect alcohol use; but for the purpose of this study only the socio-demographic factors are discussed, as the EDULINK data would not allow a discussion of other factors. The demographic factors are first related with alcohol use for any associations; whilst the social and economic variables are then discussed.

5.2 Distribution of Demographic factors among Respondents

5.2.1 Age and Alcohol use

Generally, Table 5.1 revealed that, respondents had lower in-take of alcohol consumption at the lower age group of both regular and light drinkers. For example, proportion of respondents who were regular drinkers of alcohol increased with age from a minimum of 2.7 percent at age group 15-19 to 26.9 percent at age group 35-39, where it took a V-shape to 45-49 years (27.5%). Light drinkers had a higher proportion of the initial alcohol consumption compared to regular drinkers and also increased from the initial age group 15-19 years (29.7%) to age group 25-29 (50.9%), from where it began to decrease in 35-39 years (40.4%). Thereafter, alcohol consumption increased to the last age group, 45-49 years (53.8%). Unlike regular and light drinkers, majority of the respondents abstained from alcohol consumption in the initial age group 15-19 (67.6%). Thereafter, abstention decreased to age group 35-39 years (32.7%), increased at 40-44 and again decreased in the last age group 45-49 years (18.7%). This indicated a rough inverse proportional relationship between alcohol use and age of respondents (P value= 0.000). This did not

confirmed the study by Nguyen et al, (2012) which found the prevalence of drinking alcohol among adolescents aged 15–19 years and young adults aged 20–24 years in Hanoi were relatively high, especially among males and/or young adults and the current drinking rate of 36 percent.

Table 5.1 Percentage Distribution of Age and Alcohol use among Respondents

Age of Group Respondents	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
15-19	2.7	29.7	67.6
20-24	8.6	49.7	41.7
25-29	14.9	50.9	34.2
30-34	20.4	46.0	33.6
35-39	26.9	40.4	32.7
40-44	20.2	45.5	34.3
45-49	27.5	53.8	18.7
$X^2=97.326$	P value=0.000		

Source: Computed from Edulink Data, 2011.

5.2.2 SEX AND ALCOHOL USE

Table 4.3 shows that both males and females had higher proportions of light drinking than regular drinkers. For instance, males and females were 44.2 percent and 45.6 percent proportions as light drinkers respectively, compared to 19.1 percent and 13.3 percent as regular drinkers. The proportions of abstinence or non-drinkers for males and females were substantial with 36.6

percent and 41.1 percent respectively. This indicates an insignificant association between the sex of the respondents and alcohol use.

Table 5.2 Percentage Distribution of Sex and Alcohol use among Respondents

Sex	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
Female	13.3	45.6	41.1
Male	19.1	44.2	36.6
$X^2=5.946$	P value=0.51		

Source: Computed from Edulink Data, 2011.

5.2.3 MARITAL STATUS AND ALCOHOL USE

The result indicated that respondents who were living together were the highest proportion of light drinkers. For instance, more than half (54.2%) of the respondents who were living together were light drinkers while less than 20 percent (18.9%) of the same category were regular drinkers. Again, respondents who were non-drinkers and were living together were more than 25 percent (26.8%). Respondents who were widowed/ separated/ divorced were the highest proportion of regular drinkers with 25.2 percent.

More than half (51.7%) of the respondents of the same category were light drinkers while the least of abstention from alcohol consumption were the widowed/ separated/divorced with 23.1 percent. Respondents who were married were more than 40 percent (43.1%) as the highest proportion as light drinkers while 18.6 percent were regular drinkers. 38.2 percent of the respondents who were married abstains from alcohol consumption.

The never married were the highest of non-drinkers with 52.1 percent. This reflected on the proportions of regular and light drinkers with 9 and 38.9 percent respectively.

There is a significant association between alcohol use and marital status of the respondents (P value=0.000). This is consistent with Mbatia who found a higher prevalence of alcohol use among ever married urban Tanzanian women than never married women (Mbatia, 2009).

Table 5.3 Percentage Distribution Marital Status of and Alcohol use among Respondents

Marital Status	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
Married	18.6	43.1	38.2
Living Together	18.9	54.2	26.8
Widowed/Separated/Divorced	25.2	51.7	23.1
Never Married	9.0	38.9	52.1
$X^2=62.649$	P value=0.000		

Source: Computed from Edulink Data, 2011.

5.2.4 MIGRATION STATUS AND ALCOHOL USE

Migration status is significantly associated with alcohol use (P=0.001). Table 4.3 indicated that, higher proportion (47.1%) of non-migrants were light drinkers while 16.5 percent were regular drinkers. For migrants, higher proportions were non-drinkers (51.8%) with 12.4 percent as regular drinkers. 36.4 percent of non-migrants were non-drinkers while 35.9 percent of migrants were light drinkers. This may be that non-migrants have highly qualified employment positions with higher disposable income than migrants.

This is contrary to a study done by Ngeyun et al (2012), which revealed that, the prevalence of drinking is higher among rural migrants (41%) than non-migrants (31%). However, this is because of male drinkers and not true for females.

Table 5.4 Percentage Distribution of Migration Status and Alcohol use among Respondents

Migration Status	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
Non-Migrants	16.5	47.1	36.4
Migrants	12.4	35.9	51.8
$X^2=13.752$	P value=0.001		

Source: Computed from Edulink Data, 2011.

5.3 Distribution of Social Factors and Alcohol use

5.3.1 RELIGION AND ALCOHOL USE

Of the respondents who were regular drinkers, the highest proportions of 25.4 percent were respondents with no religion. This was followed by respondents of Traditional/Spiritual/ Others and Christians with 21.1 percent and 16.3 percent respectively. The least of the proportions of regular drinkers were respondents with the Islam background (4.2%). The pattern of order of proportion of regular drinkers was not different from light drinkers. In this instance, the proportions were higher than regular drinkers. Proportion of respondents who were Islam and mainly abstained from regular drinking increased their alcohol consumption (31.6%) at light drinking. So were the other religious sects; no religion, 47.6 percent; Tradition/Spiritual/Other (47.4%); Christians, (46.5%). The pattern of order did not reflect on non-drinkers although abstention for alcohol consumption was the highest for respondents with Islam background

(64.2%). This may be due to their strict abstinence from alcohol use. This is followed by respondents who were Christians (37.3%), Tradition/Spiritual/Others (31.6%) and no religion (27.0%). This study, however found a significant relationship between alcohol use and religion of the respondents as a confirmation of other researches. (P value=0.000).

Table 5.5 Percentage Distribution of Religion and Alcohol use among Respondents

Religion	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
Christian	16.3	46.5	37.3
Islam	4.2	31.6	64.2
Traditional/Spiritual/Other	21.1	47.4	31.6
No Religion	25.4	47.6	27.0
$X^2=35.031$	P value=0.000		

Source: Computed from Edulink Data, 2011.

5.3.2 EDUCATIONAL LEVEL AND ALCOHOL USE

Respondents with primary educational level were 17.4 percent of the regular drinkers while light drinkers were 43.6 percent. This was followed by respondents with Secondary/Higher educational level (15.8%) and Middle JHS (15.4%). Both respondents of Middle/JHS and Secondary/Higher level were light drinkers with 46.3percent each as the highest proportion. The same educational levels abstained from alcohol consumption with 38.2 and 37.9 percent while regular drinkers of the same level of educational attainment were least with 15.4 and 15.8 percent.

Respondents with no education were the highest proportion of non-drinkers with 55.7 percent. Light drinkers of the same educational level were 34.0 percent while regular drinkers were 11.3 percent. Most research on education and alcohol use have found increasing levels of education relating to higher prevalence of alcohol use; because of the fact that the educated tend to have less children and fewer family responsibilities (IAS, 2008). This indicates an insignificant relationship between alcohol use and religion of the respondents (P value=0.391).

Table 5.6 Percentage Distribution of Educational level and Alcohol use among Respondents

Educational Level	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
Primary	17.4	43.6	39.0
Middle/JHS	15.4	46.3	38.2
Secondary/Higher	15.8	46.3	37.9
No Education	11.3	34.0	55.7
$X^2=6.291$	P value=3.91		

Source: Computed from Edulink Data, 2011.

5.3.3. REGION AND ALCOHOL USE

Respondents from the Volta Region were the highest proportion of regular drinkers with 19 percent followed by Greater Accra, Eastern, BrongAhafo, and Central Regions with 17.5 percent, 13.2, 11.8, and 11.1 percent respectively. Respondents from Western and Upper West Regions did not have any body as regular drinker.

Respondents from Ashanti Region were the highest of light drinkers with 53.7 percent. This was followed by respondents from Central (53.3%), Greater Accra (46.4%), Western (43.8%) and Eastern (39.7%) regions respectively. Respondents from Upper West Region continued with abstinence from alcohol consumption by 0.0 percent.

This continuous abstinence of alcohol consumption by respondents from Upper West Region made them to be 100 percent non-drinkers. The other two Regions, Northern (78.9%) and Upper East (66.7%) from the northern part of Ghana showed that majority of respondents who hail from there abstained from alcohol consumption. The high incidence of alcohol abstinence could be attributed to respondents with Islam background since the three northern regions are predominantly Muslim. Greater Accra Region was the least of non-drinkers with 36.1 percent. There is a significant relationship between alcohol use and where the respondents are born (P value=0.013).

Table 5.7 Percentage Distribution of Regions and Alcohol use among Respondents

Regions	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
Western	0.0	43.8	56.2
Central	11.1	53.3	35.6
Upper West	0.0	0.0	100.0
Volta	19.0	33.3	47.6
Eastern	13.2	39.7	47.1
Brong Ahafo	11.8	35.3	52.9
Northern	5.3	15.8	78.9
Upper East	8.3	25.0	66.7

Ashanti	9.8	53.7	36.6
Greater Accra	17.5	46.4	36.1
$X^2=33.940$	P value=0.013		

Source: Computed from Edulink Data, 2011.

5.3.4. LOCALITY AND ALCOHOL USE

Table 4.3 revealed that Ussher Town had the highest proportion of light drinkers (47.4%). The same locality was the highest proportion of regular drinkers with 16.8% while 35.8 percent of the respondents abstained from alcohol consumption. James Town was the second highest proportions for regular and light drinkers with 16.7 percent and 43.2 percent respectively. About 40 percent of the respondents from James Town abstained from alcohol consumption. The highest of non-drinkers were respondents from Agbogbloshie with 47.8% while less than half (41.4%) were light drinkers. Respondents who were regular drinkers and were from Agbogbloshie were the least of regular drinkers with 10.8 percent. There is no significant association between alcohol use and locality of the respondents. (P value=0.073).

Table 5.8. Percentage Distribution of Locality and Alcohol use among Respondents

Locality	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
Ussher Town	16.8	47.4	35.8
James Town	16.7	43.2	40.1
Agbogbloshie	10.8	41.4	47.8
$X^2=8.561$	P value=0.073		

Source: Computed from Edulink Data, 2011.

5.4 Distribution of Economic Factor and Alcohol use

5.4.1 OCCUPATION AND ALCOHOL USE

Table 4.3 presents the relationship between respondent's occupation and alcohol consumption. The findings are rather surprising. While 17.3 percent of respondents who were Professional/Managerial/Clerical were regular drinkers, respondents whose occupation was Agriculture constituted the highest of regular drinkers with 30 percent. The least of respondents of regular drinkers were respondents with no occupation (4.4%)

This same pattern was observed for respondents who were light drinkers. Respondents whose occupation constituted Agriculture were 60 percent of light drinkers, the highest among the categories. This was followed by Professional/Managerial/Clerical, (50.7%). In line with expectation, respondents with no occupation comprise the least of the light drinkers (36%). Not surprising, 59.6 percent of respondents who had no occupation constituted the highest proportions of non-drinkers. Respondents whose occupation was other followed with 42.9 percent. The least of non-drinkers (10%) were respondents whose occupation was Agriculture. There is a significant relationship between occupation and alcohol use among the respondents in urban poor communities (P value= 0.000). The negative association in other studies, perhaps, may be attributed to the fact that formally employed persons, often attempt to adopt coping strategies, including the ingestion of alcohol (Moore et al, 1997; Ovuga and Madrum, 2006).

Table 5.9 Percentage Distribution of Occupation and Alcohol use among Respondents

Occupation	Regular Drinkers (%)	Light Drinkers (%)	Non-Drinkers (%)
No Occupation	4.4	36.0	59.6
Professional/Managerial/Clerical	17.3	50.7	32.0
Sales and Service	17.1	48.8	34.0
Agriculture	30.0	60.0	10.0
Skilled Manual	23.0	42.2	34.8
Unskilled Manual	21.3	49.2	29.5
Other	14.3	42.9	42.9
$X^2=61.198$	P value=0.000		

Source: Computed from Edulink Data, 2011.



CHAPTER SIX

INFLUENCE OF MIGRATION STATUS, BACKGROUND CHARACTERISTICS ON ALCOHOL STATUS.

6.1 INTRODUCTION

The previous chapter used univariate and bivariate analysis to examine the relationship of each of the selected independent variables and distribution of respondents' alcohol use behaviours. It was realized that there is a significant association between some independent variables such as age, religion, migration, occupation and marital status and alcohol use in the study areas (Ussher Town, James Town and Agboghloshie). However, a bivariate association between two variables does not necessarily imply a significant causal relationship between them, because in real life situation more than one independent variables operate to influence the dependent variable (Kristiana, 2009).

It was therefore important to carry out a statistical analysis which incorporated more than one independent variable at a time. The most suitable analytical technique was the Multinomial Logistic Regression analysis, which allowed the exploration of the effect of different independent variable on a dependent variables with more than two categories corrected for other independent variables (Tabachnick and Fidell, 2007 as cited in Kristiana, 2009). In this study, Multinomial Logistic Regression model was used to determine the factors affecting alcohol use among migrants and non-migrants in urban poor, Accra. This chapter discusses the results or output of the multinomial logistic regression. Table 5.2 displays results from the multinomial logistic regression model used to examine the association between the independent variables and alcohol use.

Table 6.1 Multinomial Logistics Regression of Alcohol Use among Migrants in Urban Poor**Accra.**

Variable								
	Nagelkerke R-squared=0.250							
	Regular Drinkers				Light Drinkers			
	β	S.E.	Sig	Exp(β)	β	S.E.	Sig	Exp(β)
Migration Status								
Migrants	0.021	0.367	0.955	1.021	-0.406	0.262	0.121	0.666
Non-Migrants(RC)	0			1.000	0			1.000
Age Group								
15-19	2.680	0.699	0.000	14.585	1.226	0.418	0.003	3.407
20-24	1.343	0.618	0.030	3.830	0.829	0.273	0.002	2.292
25-29	1.638	0.629	0.009	5.146	0.739	0.309	0.017	2.093
30-34	1.777	0.642	0.006	5.909	0.512	0.338	0.130	1.669
35-39	2.196	0.671	0.001	8.985	0.470	0.381	0.217	1.601
40-44	1.760	0.678	0.009	5.813	0.497	0.372	0.182	1.643
45-49(RC)	0			1.000	0			1.000
Occupation								
No Occupation	1.010	0.961	0.293	2.747	0.305	0.625	0.625	1.357
Professional/Managerial/Clerical	0.978	0.534	0.067	2.660	0.468	0.333	0.161	1.597
Sales and Service	1.194	0.435	0.006	3.301	0.540	0.241	0.025	1.716

Agriculture	1.715	1.278	0.179	5.559	1.435	1.125	0.202	4.201
Skilled Manual	1.148	0.457	0.012	3.151	0.199	0.273	0.466	1.220
Unskilled Manual	1.524	0.592	0.010	4.592	0.968	0.403	0.016	2.633
Other(RC)	0			1.000	0			1.000
Marital Status								
Married	0.437	0.355	0.218	1.549	0.367	0.262	0.162	1.443
Living Together	0.736	0.336	0.029	2.087	0.786	0.239	0.001	2.195
Widowed/Separated/Divorced	1.067	0.383	0.005	2.908	0.884	0.299	0.003	2.422
Never Married(RC)	0			1.000	0			1.000
Religion								
Christian	-0.646	0.418	0.122	0.524	0.367	0.262	0.162	1.443
Islam	-2.548	0.676	0.000	0.078	0.786	0.239	0.001	2.195
Traditional/Spiritual/Other	-0.429	0.807	0.595	0.651	0.884	0.299	0.003	2.422
No Religion(RC)	0			1.000	0			1.000
Sex								
Male	0.787	0.247	0.001	2.196	0.280	0.175	0.110	1.323
Female(RC)	0			1.000	0			1.000
Regions								
Western	- 17.325	3010.89	0.995	2.993	-0.187	0.583	0.749	0.830
Central	-0.561	0.611	0.359	0.571	0.260	0.404	0.521	1.296
Upper West	- 16.978	0.000		4.232	-18.018	7350.9	0.998	1.496

Volta	-0.399	0.707	0.572	0.671	-0.733	0.551	0.184	0.480
Eastern	-0.556	0.483	0.250	0.573	-0.233	0.336	0.489	0.792
Brong Ahafo	-0.642	0.890	0.470	0.526	-0.413	0.599	0.491	0.662
Northern	-1.130	1.176	0.337	0.323	-1.390	0.726	0.056	0.249
Upper East	-1.444	1.230	0.241	0.236	-1.028	0.788	0.192	0.358
Ashanti	-0.855	0.669	0.202	0.425	0.060	0.415	0.886	1.061
Greater Accra(RC)	0			0.000	0			1.000
Educational Level								
Primary	0.782	0.552	0.157	2.186	0.464	0.380	0.222	1.591
Middle/JHS	0.740	0.538	0.169	2.096	0.623	0.366	0.089	1.865
Secondary/Higher	0.875	0.566	0.122	2.399	0.744	0.389	0.056	2.105
No Education(RC)	0			1.000	0			1.000
Locality								
Ussher Town	0.177	0.422	0.675	1.193	0.000	0.276	0.999	1.000
James Town	0.038	0.427	0.929	1.039	-0.193	0.278	0.489	0.825
Agbogbloshie(RC)	0			1.000	0			1.000

Source: Computed from Edulink, 2011.

6.2 Factors influencing Alcohol use among Respondents

6.2.1. Migration Status

Table 5.2 indicates that migrants were 1.021 times as likely as non-migrants to be regular drinkers relative to non-drinkers. On the other hand, migrants are 0.666 times likely to be light drinkers compared to non-migrants. This could be explained by the fact that non-migrants often have the highly qualified employment positions with higher disposable income compared to

migrants (Madsen et al, 2005). Migrants are negatively associated with alcohol use, thereby making migrants alcohol consumption lesser than non-migrants.

6.2.2. Age

Age was a significant predictor of alcohol use. Generally, respondents within all age groups had a higher likelihood of being regular drinkers compared to those within the age group 45-49 years. Those within the age group 15-19 years were 14.585 times as likely as those of the age group 45-49 to be regular drinkers of alcohol. Again, the respondents of the 15-19 age groups were 3.407 times as likely to be light drinkers compared with those within age group 45-49. This finding could be as a result of peer pressure found to have the strongest association with smoking and alcohol drinking (Nguyen et al, 2012).

6.2.3. Occupation

Though at the bivariate stage occupation was significant predictor of alcohol use, with the introduction of, control variables at the regression stage respondents with no occupation, professional/managerial/clerical and agriculture were not statistically significant. The highest of the odd ratios 5.559 being agriculture, indicated that respondents were about 5.559 times as likely as those who work as other to be regular drinkers. Light drinkers who had the highest of odd ratio also agriculture were 4.201 times as likely to be light drinkers as compared to respondents with other.

6.2.4. MARITAL STATUS

Both living together and widowed/separated/divorce were the only marital status category which showed a statistical significant relationship with alcohol use at the regular drinkers. In either case, the odd ratio of widowed/ separation/divorced showed 2.908 times as likely to be regular drinkers as compared to the never married. Similarly, respondents living with partner and widowed/ separation/divorced were the categories of marital status that showed a significant relationship at the light drinkers stage. The table showed that the respondent alcoholic beverage was 2.422 times as likely to be light drinkers as compared to the never married.

6.2.5. RELIGION

Islam showed a significant relationship between alcohol at the regression stage (P value=0.000). Respondents who were Traditional/Spiritual/Other were 0.651 times likely to be regular drinkers than respondents with no religion. With respect to light drinkers, Islam and Traditional/spiritual/other had significant relationship with alcohol. Traditional/Spiritual/Others continue to be 2.422 times as likely to be light drinkers as compared to respondents with no religion. There are two explanations for the negative association of religiosity and alcohol use. Firstly, some religious faiths explicitly prescribe good health habits and prohibit many unhealthy lifestyles including alcohol use, and secondly, most faith groups teach that the body is a temple for the soul and that it should be treated with respect and appreciation (George et al, 2002; Ayers et al, 2009).

6.2.6. SEX

Respondents who are males were 2.196 times as likely as females to be regular drinkers. This same category as the light drinker's level was 1.323 times as likely as females to be light drinkers. Although Sex did not show any significance at the bivariate stage, at the regression stage and specifically with regular drinkers, it showed a significant relationship between alcohol and males. This supports Griesler and Kandel whose study indicated that substance use, including alcohol greatly differ by gender (Griesler and Kandel, 1998, as cited in Marsiglia et al, 2010).

6.2.7. REGION

Results from the multinomial logistic regression model as depicted in Table 5.2 indicate that, there is no association between respondents' region and alcohol use. Generally, respondents from the various regions were likelihood of being regular drinkers as compared to those of Greater Accra. Respondents from Western and Upper West regions were 2.993 and 4.232 respectively times as likely also to be regular drinkers as compared to Greater Accra. Similarly, respondents from the regions were likely to be light drinkers with the exception of Central, Upper West and Ashanti regions who were 1.296, 1.496 and 1.061 respectively times likely to be light drinkers as compared to respondents from Greater Accra.

6.2.8. EDUCATIONAL LEVEL

Educational level had no significant association with alcohol use. From Table 5.2, respondents within the educational level were generally above 2.0 times to be regular drinkers. Specifically, secondary/higher had the biggest of odd ratios, (2.399) which respondents were as likely to be

regular drinkers as compared to respondents with no education. Respondents who were light drinkers and had an educational level of Secondary/Higher had significant association with alcohol consumption. On the whole, respondents were likely to be light drinkers, especially with respondents who had Secondary/Higher educational level, having 2.105 times as likely to consume alcohol as compared to respondents with no education.

6.2.9. LOCALITY

Table 5.2 indicates that locality had an insignificant association with consumption of alcohol. Respondents from Ussher Town and James Town had likelihood of 1.193 and 1.039 times respectively as likely to be regular drinkers and light drinkers as compared to Abgobgloshie. This gives an indication that, it does not matter the location of the respondents and thus, despite the location, they may be prone to alcohol status.

6.3. Testing Hypothesis

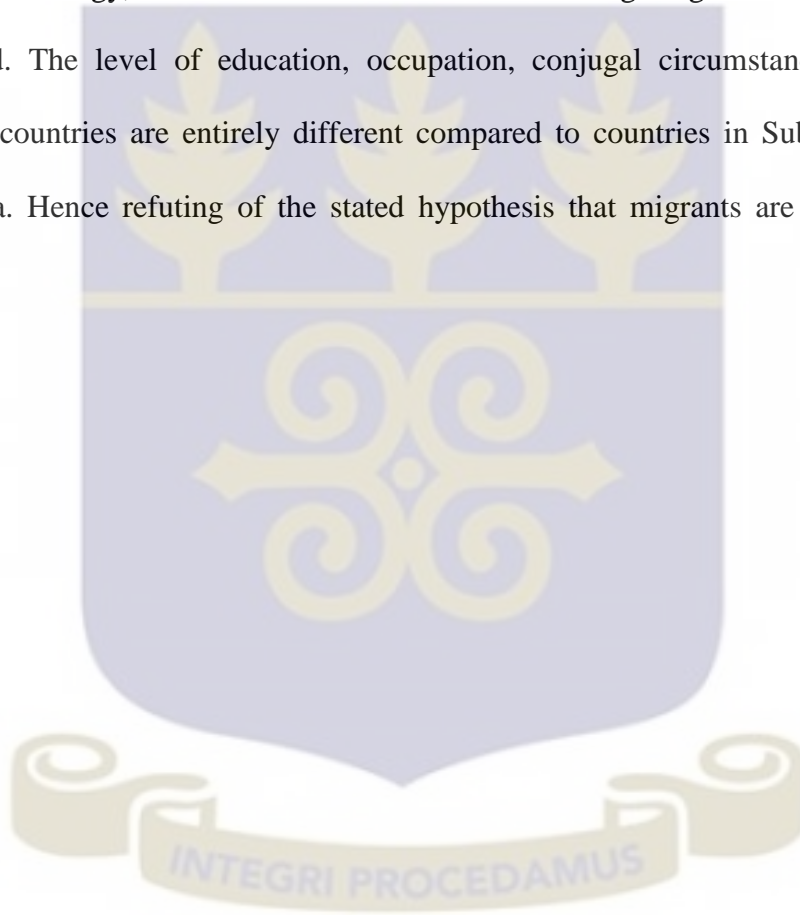
While these findings are consistent with some studies (Ngugen et al, 2011; Borges et al, 2012), they contradict most literature (Garcia V, 2008; Karriker-Jaffe and Zemore, 2009) which showed a significant association between age, occupation, marital status, sex and alcohol use among migrants at the multivariate stage.

From the hypothesis stated and from the analysis made, migrants are not more likely to be regular drinkers compared to non-migrants. The differences in the results might be due to the methodology and settings of this study.

(1) Unlike most studies, (e.g. Barros et al, 2007) and also constrained by the nature of the

availability of alcohol data, the outcome variable in this study (alcohol use) was in three categories; Regular, Light and Non-drinkers. This study was unable to differentiate the type of alcoholic beverages (i.e., beer, wine, and liquor) consumed, the frequency and pattern of consumption; or investigate the consequences of drinking among migrants. This is likely to have an effect on the outcome of the hypothesis.

(2) Besides methodology, most works on alcohol use among migrants were done in the developed world. The level of education, occupation, conjugal circumstances and drinking culture in these countries are entirely different compared to countries in Sub-Saharan Africa, especially Ghana. Hence refuting of the stated hypothesis that migrants are at higher risk of alcohol use.



CHAPTER SEVEN

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

7.1 Summary of Findings

The study was conceived against the background of rapid urbanization in Ghana as a result of large volumes of migration directed mainly to the few large cities in the country. Acknowledging a situation of high rural-urban migration, the study was born out of the idea that large streams of rural-urban migration could have disastrous consequences for the country if migrants especially of rural origin were to maintain their urban places of residence.

The choice of locality (James Town, Ussher Town and Agboghloshie) for the study was mainly due to its cosmopolitan nature. Besides, it is recorded that 40,000 Ghanaians live in the area (Ghana Statistical Service, 2012).

The study has an umbrella objective of investigating into the extent to which migrants differ from non-migrants in the study area in the overall use of alcohol. Among other things, it aimed at filling a research gap.

The findings in the study are many and varied. It was observed that, migrants are 18.6 percent of the respondents as against non-migrants of 81.4 percent. Females account for more than half (58.3%) of the respondents. There is also a greater share of young adults aged 20-24 years relative to other age groups. Large shares of the respondents are sales and service personnel.

Almost all of the respondents (43.2%), however were found to have acquired Middle/JHS and Secondary/Higher education and about 22.3 percent of the respondents were found to be currently married and 41.3 percent of respondents were never married.

7.2 Objective one: Demographic and socio-economic factors affecting alcohol use.

To achieve this objective, bivariate and multivariate analysis was used. The bivariate analysis was based on tests of association (chi-square tests) and the multivariate analysis was based on multinomial regression analysis. The study showed that at the bivariate stage, almost all the socio-economic and demographic factors are significantly associated with alcohol use. The only exceptions were sex, education and locality. However, in the multivariate analysis stage, only age, occupation, marital status, religion and sex were significantly associated with alcohol use: when nine predictor variables were fitted in the model, at 0.005 significant level.

7.3 Objective two: Prevalence of alcohol use among migrants and non-migrants

- Previous studies have largely found that migrants face significant psychological and social stress because of unstable living conditions, changes in lifestyle, social alienation, insecure employment, poor working conditions, long working hours, and adapting to a new environment. Both population- and laboratory-based studies confirm that these social stresses are linked to health risk behaviours, particularly an increased urge to smoke and drink (Johnson et al, 2002; as cited in Nguyen et al, 2012).

The overall alcohol consumption or uses of non-migrants were found to be higher than that of migrants in the study area. The total alcohol consumption for migrants was 58.3 percent (Regular drinkers, 12.4%; and Light drinkers, 35.9% combined) with Non-drinkers being 51.8%. Whereas total consumption of alcohol for non-migrants were 63.6percent (Regular drinkers, 16.5%; and Light drinkers 47.1%) with Non-drinkers 36.4 percent. This is inconsistent with Borges et al (2010) which found that lifetime prevalence of alcohol use was higher among migrants than non-migrants

.

7.4 Policy implementation and Recommendations.

The study has relevant policy implications not only for the study area but the nation as a whole. This is on account of the problems that massive non-migration and alcohol consumption poses to the socioeconomic life of the people. In order for such a research to benefit the nation, it is necessary to look at it from the national perspective rather than a focus on pockets of the country.

The study shows higher prevalence of alcohol consumption among non-migrants. This prevalence poses non-migrants the risk of diseases or alcohol syndromes associated with alcohol consumption. Consequently, sensitization against alcohol consumption is needed to deter non-migrants and in general, people, from alcohol consumption behaviours. The study has shown that, the level of education determines the prevalence rate and that, respondents with Secondary/ Higher educational level consumes more alcohol compared to no educated at the bivariate and multivariate analyses.

The lower prevalence and less likelihood among the no educated may be attributed to fact that migrants might not be in an employment with higher disposable income to consume more of alcohol, as such abstention is higher.

The government of Ghana, through the ministry of Health and Ghana Health Service should embark on intensive national sensitization exercise against alcohol use and its implication; so as to reduce the prevalence rate.

There is also the need to develop a comprehensive national policy that would help educate the public about the negative effects of alcohol. The national policy would help design effective and more importantly a comprehensive data on alcohol. Together with the private sector, the development of a national draft policy would seek to prevent and minimize alcohol related harms to individuals and families. The draft should also aim at developing and implementing a

transparent self-regulatory system by which the alcoholic beverage industry would ensure that production, promotion and marketing of its products were consistent with the requirement and meet international standards.

7.5 Conclusion

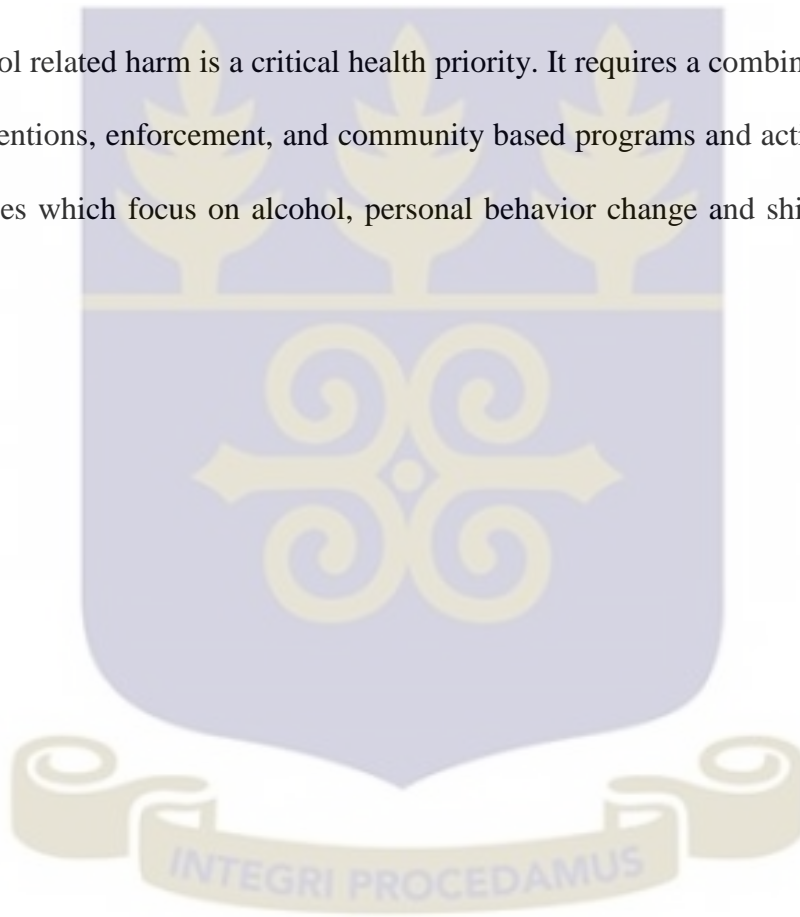
The expansion of alcohol production and consumption in Ghana over recent decades has been followed by a predictable increase in both acute and chronic problems resulting from alcohol use, and the increase is likely to accelerate in the future. Ghana urgently needs to develop a comprehensive national alcohol policy based on the experience of other countries and on WHO recommendations. It can do so by adopting measures aimed at controlling overall alcohol consumption (a population-based approach) as well as measures intended to reduce risky behaviours (a high-risk approach). The restriction of alcohol advertisement, taxation of alcoholic beverages, the setting of a legal age for drinking and policies against driving when drunk will have a significant impact on the frequency of alcohol-related problems.

The economic and political reforms currently taking place in Ghana are aimed at striking a balance between economic development and public health and between short-term and long-term alcohol control strategies. For this effort to succeed, a public health focus must be adopted now, along with long-term alcohol control policies. Both will eventually pay off politically and economically. In this process, Ghana could benefit from the experiences of other countries, such as the Kenya, Republic of Korea and Thailand, that have implemented WHO's global strategy to reduce the harmful use of alcohol.

Findings from the study not only enrich our knowledge of health risk behaviours of drinking alcohol among migrants and non-migrants in Ghana, but also the health risk behaviours of

migrants from rural areas—an emerging population in the urban areas of many developing countries in general and Ghana in particular. At first glance, drinking is more common among non-migrants as compared with migrants in the city. But taking the volume or percentage of alcohol for each group of respondents into consideration, health risk knows no boundary of persons irrespective of socio-economic stand of individuals.

Preventing alcohol related harm is a critical health priority. It requires a combination of legal and regulatory interventions, enforcement, and community based programs and actions, better health and social services which focus on alcohol, personal behavior change and shifts in community attitudes.



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