Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 5 No. 6 (2024): June 2024 Issue
https://doi.org/10.51168/sjhrafrica.v5i6.566
Original Article

KNOWLEDGE, ATTITUDE, AND PRACTICES TOWARDS ALCOHOL ABUSE AMONG MEN AGED (20-45) YEARS IN KILHUBO VILLAGE, NGAMBA SUB COUNTY, BUNDIBUGYO DISTRICT. A CROSS-SECTIONAL STUDY.

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ABSTRACT

Background

This study aimed to assess "Knowledge, Attitude, and Practices on alcohol abuse among men in Kilhubo Village Bundibugyo District." The specific objectives were: to assess knowledge towards alcohol abuse among men aged 20-45 years, to assess attitude towards alcohol abuse among men aged 20-45 years, and to assess practices towards alcohol abuse among men aged 20- 45 years.

Methodology

A cross-sectional study design was used, and the target population was men aged 20-45 years. A sample size of 70 participants was used and data was obtained by using questionnaires, data were entered into, analyzed, and presented information pie charts, tables, and graphs.

Results

Findings from knowledge towards alcohol abuse among me aged 20-45 years revealed that 82%had ever heard of alcohol abuse and knew its side effects, most (65%) knew possible reasons why alcohol is abused outlining some as stress, ready availability, and 34% heard information about alcohol abuse from churches and community events. Regarding results from attitude, 92.9% had a negative attitude, and 76.7% had a positive attitude about alcohol abuse as abusers themselves. Findings from practice revealed that 57.1% drank locally brewed alcohol and 46% drank from bars.

Conclusion

Generally, the researcher concluded that the majority had ever heard of alcohol abuse and knew its side effects, knew possible reasons why alcohol was abused outlining some as stress, readily availability, heard information about alcohol abuse from churches and community events, had a negative attitude, those who had positive attitude alcohol abuse were abusers themselves, drunk locally brewed alcohol and drunk from bars.

Recommendation

The researcher recommended that the Ministry of Health should be in touch with the government together with the community members to increase awareness of the effects of alcohol and its outcomes.

Keywords; knowledge, Attitude, Practices, Alcohol abuse, kilhubo village
Submitted: 2023-07-11 Accepted: 2023-07-21

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INTRODUCTION

Background

Alcohol is the most commonly used psychoactive substance in the world and is one of the leading causes of death and disability worldwide Page, Randy & Hall, P (2009)Globally drinking alcohol causes 1.8 million or 3.2% of all deaths and accounts for 4.0% of the disease burden (Sohi I, 2016). The disease burden related to alcohol use is especially great among low-income populations and countries where alcohol consumption is a common feature of social gatherings and injury rates are high due to the limited implementation of public health policies and prevention strategies (**Monica H. Swahn**, 2011).In addition, alcohol consumption has increased all over the world in the past decade, with the health impact from alcohol striking relatively early in life, it is the leading risk factor for mortality and overall burden of disease in (the 15-59) age group. To exacerbate the conditions, heavy episodic drinking is prevalent among youths in African countries (Swahn MH et Al,2011)

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Ugandans consume more alcohol than their counterparts in any African country. According to the research done by US broadcaster, Cable News Network (CNN); titled "World 10 best drinking countries" Uganda was ranked 8th globally ahead of Germany and Australia at positions 9 & 10respectively.

In Uganda, most alcohol consumers are middle-aged. This is evidenced by research conducted on the prevalence of alcohol consumption among university students where 78% were using alcohol, and about 80% of males used alcohol compared to 75% of females. The study further shows that 92% of the students began drinking before joining university. Alcohol is a uniting factor at this age for persons who have lots of interests in common such as nightlife and extramarital affairs). Alcohol has escalated child abuse, domestic violence, and hygiene-related problems in homes. Since husbands spend much of their household income on alcohol, this has led to economic household security collapse (Ovuga E and Madrama C,2016) Addictions begin at 21 and are highly associated with other stressors and poor coping skills among young people. Alcohol use increases with age in Uganda. Alcohol abuse can result in several medical problems such as alcohol poisoning, unconsciousness, respiratory depression, and sometimes death.

Knowledge about the health and social consequences of alcohol abuse among young people in urban and rural areas is limited due to limited access to information about the interventions by the government and civil society in this regard. therefore, there is a need to step up efforts to educate young people about the dangers of drug abuse. Alcohol abuse is a significant problem among most people and a solution needs to be found. Most people do consume alcohol but barely know the effects it has on them be it short or long-term.

General objectives

To assess the knowledge, attitude, and practices towards alcohol abuse among men aged(21-45) years in Kilhubo village, Ngamba sub-county, Bundibugyo district.

The specific objectives of the study were; To assess the knowledge of men towards alcohol abuse in Kilhubo village, Ngambasub county, Bundibugyo district. ii) To assess the attitude of men towards alcohol abuse in Kilhubo village, Ngamba sub-county, Bundibugyo district. iii) To identify the practices of men towards alcohol abuse in Kilhubo village, Ngamba sub-county, Bundibugyo district.

METHODOLOGY.

Study design

The study was cross-sectional in that the characteristics of an individual(s) were described and the information gathered was accurately and precisely measured or in the form of numbers. The study was carried out from 18/12/2022 to 29/01/2023.

Study area

The study took place in Kilhubo village, Ngamba Sub County 8km east of Bundibugyo town council, Bundibugyo district. This is one of the districts in the Western region of Uganda. It has an estimated population of 280000 people with a land of 453.2 (sq. mi), led by the Local Chairperson LCV.

Study population

The study targeted all willing men (20-45 years) of age in Kilhubo village, Ngamba sub-county, Bundibugyo district.

Sample size determination

The following sample size formula for an infinite population was used to arrive at a representative number of respondents(Godden, 2004)

N=z^2*p(1-p)/m^2

Where

N= Sample size for infinite population

Z=Z value (e.g.1.96 for 95% confidence level)

Population proportion(expressed as decimal (0.1(10%) since this would provide a representative sample size).

M=Margin of error at5%(0.05)

In this study, the population was at 5% since there was a problem with funds and time for the study

Therefore,

Z= 1.96

P= 0.05

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M= 0.05

From n=z^2*p(1-p)/m^2

=(1.96*1.96)[0.05(1-0.05)]/(0.05*0.05)N= 70

Therefore, the sample size for this study will be 70 respondents.

Sampling technique

A simple random sampling technique was used to obtain the required sample size of 70 respondents to represent the entire population of men in Kilhubo village, Ngamba Sub County, Bundibugyo district. It is a technique where every man has an equal chance of participating in the study.

Sampling procedure

The number of men in Kilhubo village under the Local Council 1 and other research assistants. The sampling technique was explained to men and each man was given a number to represent him and pieces of paper were labeled with numbers corresponding to the numbers allocated or given to each man.

These pieces of paper were then folded and put in the basin. In the presence of the in charge, research assistants, and some men, the basin containing the pieces of paper was shaken and picked randomly.

Each paper was picked from the basin with the number corresponding to the number given to men forming the sample of the study up to 70.

This was done during the holiday for three weeks

Study variables

Independent variable

Knowledge, Attitude, and Practices of men towards alcohol abuse in Kilhubo village, Ngamba SubCounty, Bundibugyo district.

Dependent variable

Alcohol abuse

Inclusion criteria

This included men (20-45 years) of age who were available for interviews at the time of the study. They consented to be interviewed and participate in the study.

Exclusion criteria

IndividualswhowereresidentsofKilhubovillagebutarebelow 20yearsofageorabove45yearsofage.

Data collection tool

Semi-structured questionnaires with open-ended and closed-type questions were used as the data-collecting tool.

Data collection procedure

A letter of introduction from the Kampala School of Health Sciences was taken and delivered to the LC1.

Copies of the introduction letters were also given to each respondent to indicate that the study was permitted to proceed.

Consent forms were delivered to each respondent to ask for their help for them to participate in the study.

Questionnaires were distributed to each respondent and the way of answering or dealing with the questionnaires was explained to each respondent.

The respondents were then asked to return the answered questionnaires for data collection.

Piloting the study

The respondents in the study area were found out whether they were interested and how they behaved.

Quality control

This was to ensure the reliability and validity of the instrument used to collect data.

Reliability refers to the ability of the instrument to deliver consistent results after repeated trials on the same population, it was ensured through pre-testing of the instrument.

Validity refers to the accuracy with which a study instrument can be able to provide relevant results,

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which will be ensured through proper supervision as well as the judgment of experienced people.

The research assistants were trained on how the study was to be conducted, and how to deal with the study tools as well as the respondents when carrying out the study.

Data analysis and presentation

Scientific calculators and manual coding were used. After data analysis, data were presented in the form of tables and graphs. g. bar graphs, as well as pie charts.

Ethical considerations

Before data collection was done, the reason for carrying out the study and its significance to respondents were explained to the respondents. Consent was obtained from the respondents; force was not used to get data from them and was not against their culture. The results of the study showed tithe respondents.

Table 1 shows the distribution of respondents according to their Socio-demographic data.
(N=70)

Variable		Frequency (f)	Percentage (%)
Age	20-25	23	32.9
	25-30	19	27.1
	30-40	16	22.9
	40-45	12	17.1
	Total	70	100
Religious Denomination	Catholic	30	42.9
	Anglican	20	28.6
	Muslim	05	7.1
	Others	15	21.4
	Total	70	100
Marital status	Married	40	57.1
	Single	16	22.9
	Cohabiting	06	8.6
	Divorced	08	11.4
	Total	70	100
Occupation	Employed	30	42.8
	Unemployed	24	34.3
	Self-employed	07	10
	Student	09	12.9
	Total	70	100

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Table 2: The table shows the distribution of respondents according to their knowledge about alcohol abuse.
(N=70)

Response	Frequency	Percentage (%)
Yes	64	92
No	6	8.0
Total	70	100

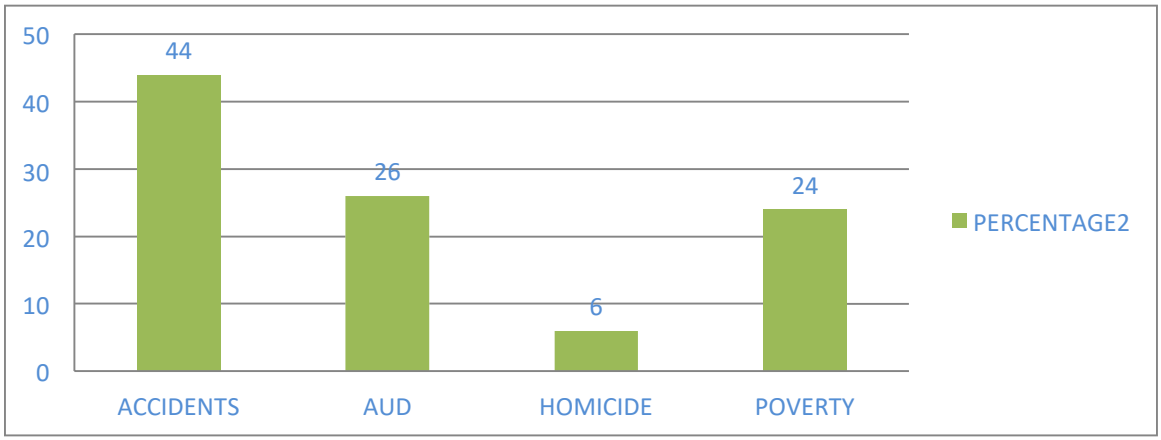
Table 3: The table below shows the distribution of respondents according to where they got information about alcohol abuse.
(N=64)

Variable	Frequency(f)	Percentage (%)
Community events	20	28.6
Television and radio	11	15.7
Church	24	34.3
Friend/ family	15	21.4
Total	64	100

Table 4: Shows the distribution of respondents according to their awareness

Response	Frequency (f)	Percentage (%)
Yes	54	77.2
No	16	22.8
Total	70	100

Figure 1: Shows the distribution of respondents according to health and social consequences associated with alcohol consumption.
(N=70)



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RESULTS

SOCIO-DEMOGRAPHIC DATA

Table 1 shows that most (32.9%) of the respondents were aged between 20-25 years whereas the least (17.1%) were aged between40-45years.

In regard to religious affiliations of respondents, most (42.9%) of the respondents were Catholics whereas the least (7.1%) were Muslims. Table 1 shows that more than half (57.1%) were married whereas the least (8.4%) were divorced currently. Table 1 shows that most (47.1%) of the respondents were unemployed, whereas the least (12.9%) were self-employed.

Knowledge on alcohol abuse among men of Kilhubo Village Bundibugyo District.

Table 2 shows that almost all (92%) of the respondents had ever heard of alcohol abuse whereas the least (8.0%) had never heard of it.

Table 3 shows that most (34.3%) of the respondents reported that they heard information about Alcohol abuse

from the church whereas at least (15.7%) heard from television and radio stations.

Table 4 shows that the majority (77.2%) of the respondents were aware of ways of reducing the effects of alcohol whereas the minority (22.8%) were not aware of reducing alcohol effects.

Figure 1 shows that most (44.0%) of the respondents reported that alcohol consumption was associated with motor vehicle accidents whereas the least (6%) reported that it was associated with homicide.

The attitude of men towards alcohol abuse in Kilhubo village.

Figure 2 shows that half(50%) of respondents reported that drunkards had more friends than non-drunkards whereas a minority (18.6%) of the respondents were not sure whether drunkards had more friends than non-drunkards or not.

Table 5 shows that the majority (62.9%) of the respondents disagree to put a total ban on alcohol use whereas a minority (37.1%) agreed on fora ban to be put on alcohol use.

Table 5 shows that more than half (52.9%) of respondents reported that alcohol was good for relaxation whereas almost half (47.1%) of the respondents reported that alcohol was not good for relaxation.

Figure 3 shows that almost all (95%) of the respondents reported that they would not advise anyone to drink alcohol whereas the least (5%) reported that they would advise one to drink alcohol.

Figure 2: Shows the distribution of respondents according to their responses to whether drunkards have more friends than non-drunkards. (N=70)

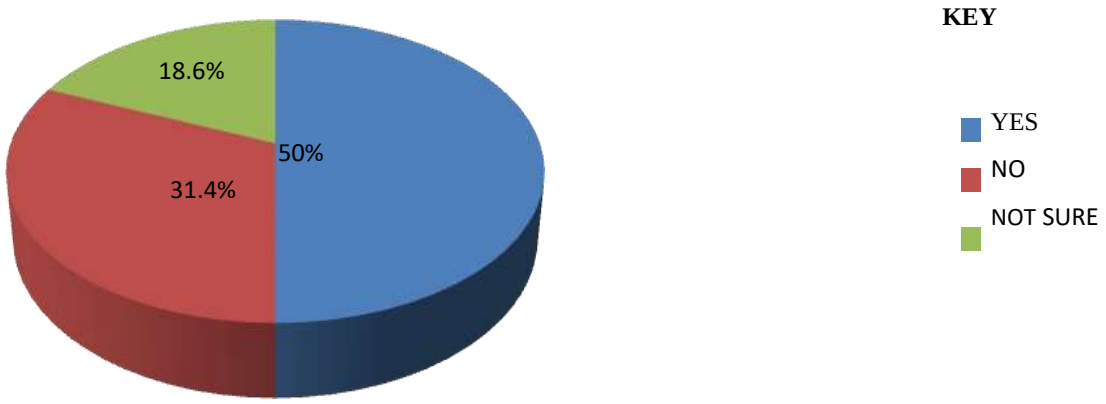

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Table 5: Shows the distribution of respondents according to attitude towards alcohol abuse.
(N=70)

Variable	Responses	Frequency	Percentage (%)
Necessity of placing total ban on alcohol use	Agree	26	37.1
	Disagree	44	62.9
	Total	70	100
Is alcohol good for relaxation	Yes	37	52.9
	No	33	47.1
	Total	70	100

Figure 3: Shows the distribution of respondents according to whether they would advise anyone to abuse alcohol.
(N=70)

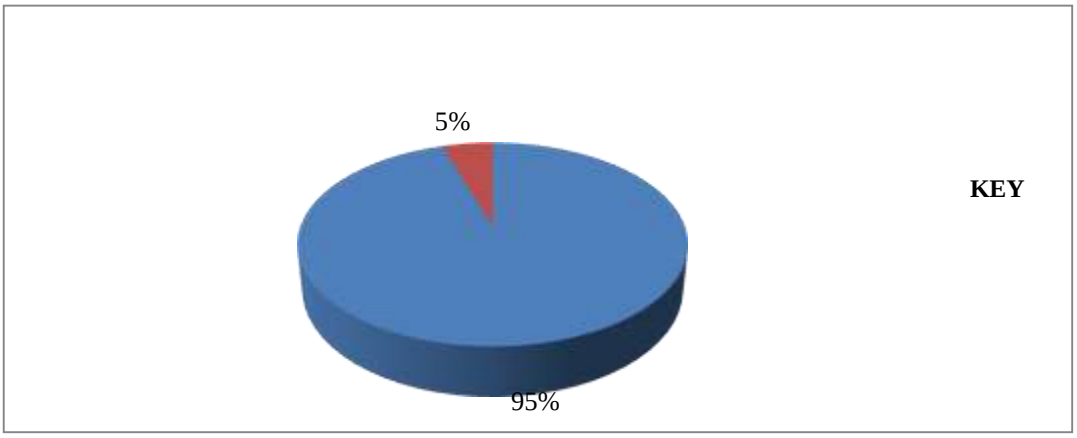

Figure 4: shows the distribution of respondents according to whether they have ever taken alcohol
(N=70)

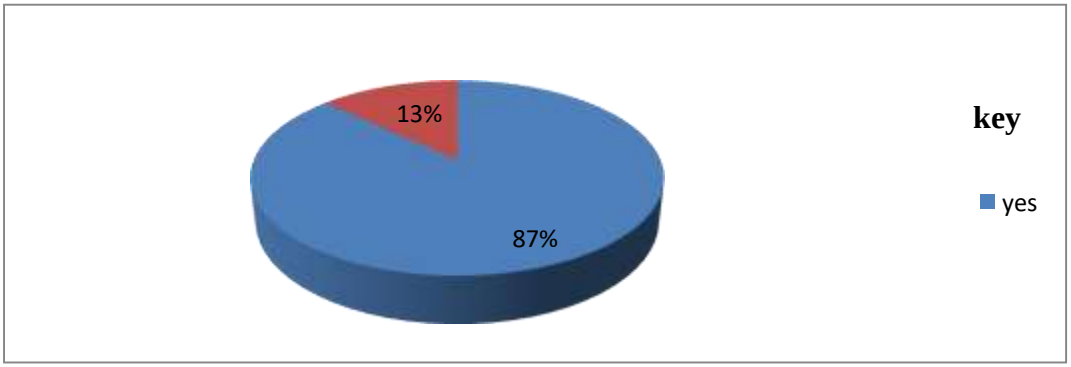

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Table 6: Shows the distribution of respondents according to different practices toward alcohol abuse
(N=70)

Variable		Frequency(f)	Percentage (%)
Age of first drink of alcohol.	10-11 years	08	14.2
	11-14 years	19	27.1
	15-18 years	30	42.9
	Older than 18 years	13	18.6
	Total	70	100
Number of days of taking alcohol in 30 days	1-10 days (low)	20	28.6
	11-20days (moderate)	25	35.7
	21-30 days (high)	15	21.4
	Had no drink containing alcohol (very low)	10	14.3
	Total	70	100
Type of alcohol usually taken	Beer	17	24.3
	Wine	05	7.1
	Local waragi	40	57.1
	Other types	08	11.5
	Total	70	100

Figure 5: shows the distribution of respondents according to places they go for drinking alcohol.
(N=70)

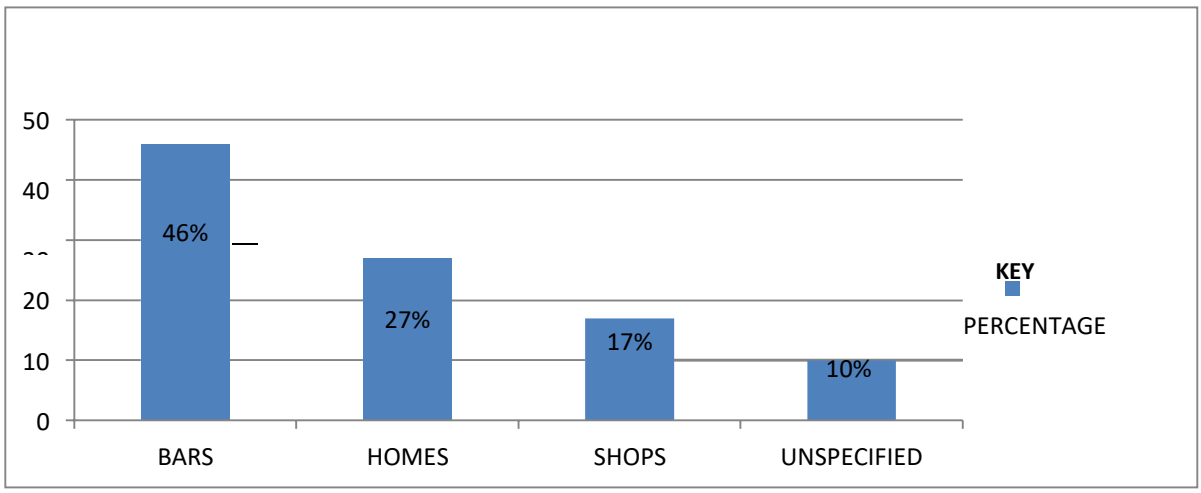

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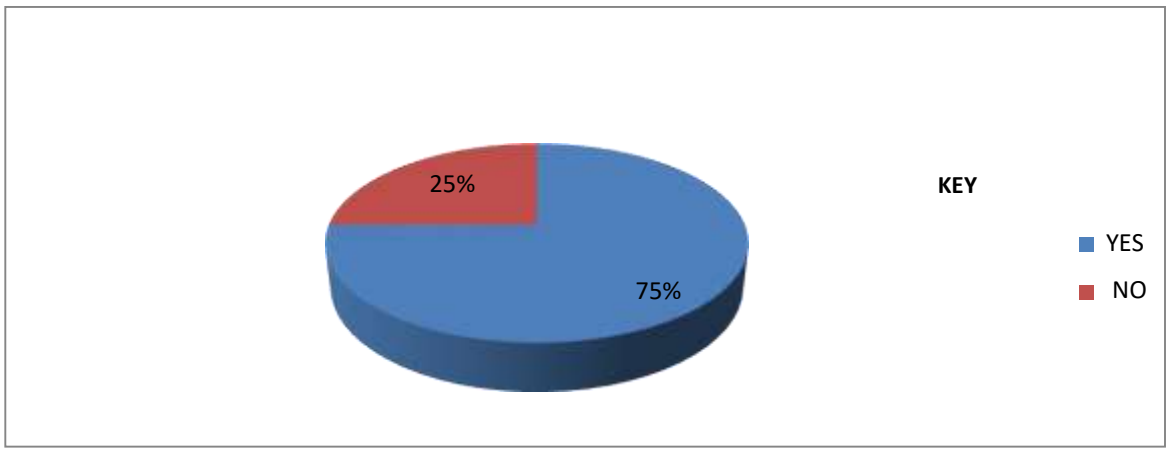
Figure 6: shows the distributions of respondents according to responses towards quitting alcohol drinking. (N=70)



Practices of men towards alcohol abuse in Kilhubo village.

Figure 4 shows that the majority (87%) of the respondents had ever taken alcohol in their lives whereas the minority (13%) had never taken alcohol all their lives.

Table 6 shows that most (35.7%) of the respondents had a high rate of consumption of alcohol in 21-30 days whereas the least (14.3%) never took alcohol in the last 30 days.

Table 6 indicates that most (42.9%) of the respondents reported that they drank alcohol for the first time at the age of15-18years whereas the least (14.2%) at the age of 11-13 years.

Table 6 shows that more than half (57.1%) of the respondents consumed more local waragi whereas a minority (7.1%) took wine

Figure 5 shows that most (46%) of respondent's drink alcohol from bars whereas the least (10%) drink from unspecified places.

Figure 6 shows that the majority (75%) of respondents accepted to quit alcohol whereas the minority (25%) was not sure of whether to quit or continue drinking.

Discussion

Knowledge towards alcohol abuse among men aged (20-45) years in Kilhubo village Bundibugyo District.

According to findings in this study, most of the respondents (82%) had ever heard of alcohol abuse and knew its effects for example road accidents, family wrangles, and breakups, poverty, sex abuse, alcohol use disorder, liver cancer, and cirrhosis. This means that most of the respondents knew what alcohol abuse was. These findings were in line with results from the study conducted by Deepa Gopi Deepa (2017) on the effectiveness of structured teaching programs' Knowledge and Attitude towards alcohol abuse among adolescent boys who reported that (91.31%) of the (542) respondents knew. on alcohol abuse.

From the study findings, results showed that the majority (65.5%) knew possible reasons why alcohol is abused outlining some as peer pressure, boredom, the ready availability of alcohol, unemployment, and stress. The World Health Organization defines an adverse drug reaction (ADR) as „a response to a medicinal product which is noxious and unintended and occurs at doses normally used in humans (Canberra,2022) for the prophylaxis, diagnosis, or therapy of disease, or for modification of physiological function (Julie Samyde, 2016). Adverse effects usually predict hazards from future administration and warrant prevention, specific treatment, alteration of dosage regimen, or withdrawal of the product. Since 2012, the definition has included reactions occurring as a result of error, misuse, or abuse, and suspended reactions to medicines that are unlicensed or being used off-label in addition to the authorized use of a medicinal product in normal doses. (Jacoline C Bouvy, 2015)

Adverse drug reactions (ADRs) remain a major public health concern for most policymakers, clinicians, and

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patients because they impact treatment adherence and increase healthcare costs and mortality. ADRs may range from mild to life-threatening, with short or long-term effects of which the ADR will necessitate linkage for that specific drug of assault. ADRs are broadly defined as Type A reactions which refer to augmented reactions that are dose-dependant and Predictable based on the pharmacology of the drug. Type B reactions Bizarre reactions that are idiosyncratic and not predictable based on the pharmacology (Sumeshni Birbal, 2016) The ADR might also occur even after the correct utilization of medications, such that there has been a range of factors, which either predispose or contribute to the development of ADR (WA Adedeji, 2013)

Globally occurrence of ADRs is multifactorial. These factors include the irrational utilization of medications, poor patterns of medication prescriptions, promotional activities and

campaigns considered by the pharmaceutical industries, the inadequate access to objective resources of information, and unhealthy pharmaceutical practices (Marc L Berger, 2014) The ADR might be predicted and related to dose, time (delayed reactions), withdrawal reactions, and the unexpected reactions due to the failure of treatment. (Mai Fujimoto, 2014)

In sub-Saharan Africa, the need for Monitoring ADRs has been important in Africa concerning chronic illnesses notably HIV/AIDS. The prevalence of HIV infections and the usage of antiretroviral therapy gave more to the relevance of pharmacovigilance over the years. Although Africa contributes to 69% of the world's patients, are on ARVs. (Yohanna Kambai Avong, 2018) There is little information as to what extent adverse drug reactions (ADRs) influence patients‟ health-related quality of life. From a pharmacovigilance perspective, capturing and making the best use of this information remains a challenge (Sieta T de Vries, 2019) even though Africa registers an average of 6.3% of total hospital admissions are a direct result of adverse drug reactions. (Appiah, 2012)

Appropriate reporting and capturing of ADRs across all the spans of service delivery is essential for reducing the risk of morbidity and mortality following the administration of drugs., healthcare professionals need to achieve competence in the handling of ADRs within the clinical practice not only for the safety of patients but also for the monitoring of drug safety level at the level of the population (Rike van Eekeren, 2018)

One of the studies superficially hinted that some of Uganda's healthcare workers were unfamiliar with formal pathways for reporting ADRs with about 16.6% underreporting rate linked to inadequate knowledge, attitude, and practices towards Adverse Drug Reaction reporting by healthcare service providers at Mulago National Referral and Teaching Hospital with a variety of factors cited to deter healthcare workers from reporting ADRs including inadequate knowledge about the reporting, fear of extra workload, failure to differentiate clinical symptoms from ADRs, among several other factors (Katusiime et al, 2015).

Therefore, it is important to determine the possible causes of the underreporting by Health professionals. This study aims to evaluate the Knowledge, Attitudes, and practices of

Adverse Drug Reaction Reporting among Health Professionals in Aiveen Pharmacies in the Central division of Kampala District.

From the study findings above, results showed that most(34.3%)of respondents received information about alcohol abuse from churches and community events. This means that community elders and leaders plus church leaders play a big role in informing and condemning alcohol use and abuse. This study is in disagreement with the study conducted by Prudence Mafa et al (2019) in South Africa on alcohol consumption patterns among high school youths where results showed that most(61.47%) of the 450 respondents got information about alcohol abuse from the internet and lectures.

Attitude towards alcohol abuse among men (20-45) years in Kilhubo village Bundibugyo District.

Findings from this study showed that the majority (92.9%) of the respondents had a negative attitude toward alcohol abuse as they would not advise anyone to use alcohol. This means that most respondents were against alcohol use and were not current alcohol users. This study is in line with the study conducted by Oluwadera Marcus et al (2022) on factors influencing alcohol consumption among students of Emmanuel Aloyande College, results showed that more than half (56.9%) of respondents perceived alcohol as not good.

Findings from this study showed that most (76.4%) of the respondents who had positive attitudes toward alcohol abuse were abusers themselves. This means that many people who use alcohol or have friends and family members who abuse alcohol to a larger extent don't think alcohol

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is bad or harmful. This is in agreement with the study conducted by Risa Takahashi et al (2017)on the correlation of alcohol consumption in Western Kenya, results showed that attitude towards alcohol intake was positively associated with current alcohol drinking status and with high-risk alcohol consumption.

Practices towards alcohol abuse among (20-45) years.

From the study findings above, more than half (57.1%) of respondents who used alcohol drunk locally brewed waragi. This is because the local waragi was readily available as it was made within the community and was cheaper compared to other spirits and beers. This was in line with the study conducted by Brian Barasa Masaba(2017) on alcohol abuse practices among residents of Busia Town in Kenya, where results showed that most(46.37%)of the respondents also drank locally made alcohol because it was cheap in the locality.

From the study findings above, the results showed that the majority (57.9%) of the respondents were married by the time of the study. This means that alcohol abuse was high among married men and this led to increased family neglect, poverty, wrangles, and breakups in the locality. this was in line with the study conducted by Marietta Mutindi (2016) on alcohol abuse effects am households in Kenya, where results showed that most (31.25%) of respondents were married individuals and a minority (4.5%) were single.

Conclusion

Findings from knowledge towards alcohol abuse among me aged 20-45 years revealed that 82%had ever heard of alcohol abuse and knew its side effects, most (65%) knew possible reasons why alcohol is abused outlining some as stress, ready availability, and 34% heard information about alcohol abuse from churches and community events

Regarding results from attitude, 92.9% had a negative attitude, and 76.7% had a positive attitude about alcohol abuse were abusers themselves

Findings from practice revealed that 57.1% drank locally brewed alcohol and 46% drank from bars.

Generally, the researcher concluded that the majority had ever heard of alcohol abuse and knew its side effects, knew possible reasons why alcohol was abused outlining some as stress, readily availability, heard information about alcohol abuse from churches and community events, had a negative attitude, those who had positive attitude alcohol abuse were abusers themselves, drunk locally brewed alcohol and drunk from bars.

Study limitation

Fund to support the study was a big limitation in that a large amount of information or data was not accessed.

Recommendations

The government and policy developers, put and enforce strict laws governing prices and places supposed to sell alcohol.

To community members, devise other effective ways of information delivery on alcohol drinking rather than only using church and community events.

Fellow young adults should be used to carry messages to other men since many talk to their friends and family on issues regarding alcohol.

The Ministry of Health should carry out community sensitization about alcohol abuse to ensure adequate knowledge.

Acknowledgement

First and foremost, l thank the almighty, for the gift of life, and good healthy, and for blessing me throughout this course.

My special thanks go to my supervisor Mrs.Nabukenya Sharifah, for the technical support and guidance through the research project.

Especially, I especially thank the chairman of LCI Kilhubo village Mr.Kasoro Alex for allowing me to carry out the study in his area.

My sincere appreciation also goes to the men of Kilhubo village Ngamba sub-county Bundibugyo District for your participation in the study.

I also acknowledge the administration and staff of Kampala School of Health Sciences, especially Mr.Mubangizi Prosper, Mr.Atukuuma Cliffe, and Nabukenya Sharifah among others for the academic experience you shared with me.

To my best friends and classmates; Baluku Godfery, Kyobe Timothy, Katumba Noah, Lamunu Mercy, Kissa Joy,

Twafuna Sherina, and Tigawalana Zephania among others for the advice and words of encouragement plus the good times we shared since the course began.

Abbreviations and Acronyms

CNN: Cable News Network

HOD: Head of Department

MOH: Ministry of Health

NGO: Non-Governmental Organization

KAP: Knowledge, attitude, and practices

UDHS: Uganda Demographic and Health Survey

WHO: World Health Organization

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Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 5 No. 6 (2024): June 2024 Issue
https://doi.org/10.51168/sjhrafrica.v5i6.566
Original Article

Publisher details

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