USE OF SMALL SACHET LIQUOR AMONG ADOLESCENTS IN IBADAN SOUTH-EAST LOCAL GOVERNMENT AREA, OYO STATE

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DEDICATION

This work is dedicated to The Almighty God, who is everything to me.

And to my mother, Mrs. Felicia Omoboja Akinsorotan, who stood by me when I almost gave up hope.

Abstract

The use of alcohol is one of the most irksome risk-taking behaviour among adolescents with its harmful health and social consequences. The availability and affordability of small sachets of liquor has significantly increased access to alcohol within the purchasing power of these adolescents in Nigeria. This study therefore investigated the use of Liquors in Small Sachets (LSS) among adolescents in Ibadan South-East Local Government Area, Oyo state.

A descriptive cross-sectional study was conducted using a three-stage random sampling technique to select 390 adolescents in four communities in Ibadan South-East Local Government Area. A validated 61-item questionnaire and In-depth Interview (IDI) guide were used to collect quantitative and qualitative data respectively. Knowledge on effects of alcohol was measured on a 10-point scale with scores categorized into poor (0-4), fair (5-7) and good (8-10). Perception was assessed on 27-point scale with scores categorized as negative (9-17) and positive (18-27) perceptions. The quantitative data were analyzed using descriptive and inferential statistics at $p<0.05$; while the qualitative data was analysed using thematic approach of content analysis.

The respondents' age was 14.67±2.60 years and 72% were students, 11% were apprentices, while 17.2% were working; majority (72.3%) was Muslims while 26.7% were Christians. Less than half (42.8%) of the respondents live with both parents while 10.0% live independently of any guardian. More than half (53.6%) of the respondents had good knowledge while the students scored higher than the apprentices and workers ($p<0.05$). Many (54.4%) of the respondents had negative perception to LSS; sex, age, school/work status, highest educational qualification and people respondents live with showed a significant relationship with perception, while perception and knowledge had inverse relationship. Half of the respondents had ever taken alcohol, with higher prevalence among males (59.3%) than females (34.9%). Many (31.0%) of the respondents take Pelebe everyday; and there were significant relationships between sex, age, school/work status, knowledge and frequency of use of LSS; and the mean age of onset of alcohol was 12.16±3.03 years. Many (64.0%) of the respondents were introduced to LSS

by their friends and parents, while 28.3% and 27.0% of respondents take Pelebe for perceived health benefits and recreation respectively. Many (42.4%) of LSS users claim it is sold around their school/work premises. This study found an association between LSS use and risky sexual behaviours, about 69% of sexually-active LSS users had unprotected sex. Perception was a significant predictor of LSS use. The participants of the IDI believe that individual differences influence adolescents' responses to alcohol and asserted the effect of alcohol in predisposing adolescents to risky sexual practices.

Sex, age, school/work status, knowledge and perception of liquors in small sachets were variables related to the use of liquors in small sachets among adolescents. Many of the adolescents associated use of liquors in small sachets with heightened sexual performance. Health education strategies such as public enlightenment, peer education and life skills training should be targeted at in-school adolescents as well as out-of-school adolescents and parents.

Keywords: Liquor in small sachet, Alcohol knowledge, Perception, Adolescents

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CERTIFICATION

I certify that this work was carried out by Miss O. Akinsorotan in the Department of Health Promotion and Education, University of Ibadan, Ibadan.

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CHAPTER ONE

INTRODUCTION

Background to the Study

Among adolescents, alcohol is the most widely used and abused drug in the world today (Ukwayi, Ambekeh, Chibuzo and Undelikwo, 2013). There is global concern about drinking trends among young people. Alcohol use by adolescents is a major health concern. Globally, approximately three-fourths of adolescents have tried alcohol by the end of high school (Moreno, Furtner, & Rivara, 2011). The use of alcohol during the teenage and young adulthood years is a common phenomenon in many societies (Reda, Moges, Wondmagegn, & Biadgilign, 2012). For instance, in Europe, alcohol is the third leading risk factor for death and disability in the European Union (EU) after tobacco and high blood pressure. In the United States, alcohol use is the primary contributor to the leading causes of adolescent death (i.e., motor-vehicle crashes, homicide, and suicide) (American Academy of Pediatrics, 2010).

The use of alcohol, tobacco and other substances constitutes one of the most important risk–taking behaviour among adolescents and young adults in secondary schools (Oshodi, Aina, & Onajole, 2010). Alcohol is a psychoactive substance with dependence-producing properties. The use of alcoholic beverages has been an integral part of many cultures for thousands of years (WHO, 2014b). Alcohol is the only psychotropic drug accepted and even encouraged by society, which allows early contact (even prior to 11 years of age) and increases the risk of future dependence (Granville-Garcia A. F., Clementino, M. A., Gomes, M. da N. C., Firmino, R. T., Ribeiro, G. L. A., Siqueira, M. B. L. D., … Siqueira, M. B. L. D. 2014).

Adolescence is a critical period in a young person's development towards adulthood. Adolescence is a time of rapid physiological, psychological and social development, and also a key period for the adoption of alcohol use (Tur, Puig, Pons, & Benito, 2003). For large numbers of youth, it may signify psychological experimentation and risk taking (Reda et al., 2012). A number of theories have linked adolescent development with risk-taking. In a study carried out in Australia, 19.2% of adolescents reported consuming one or more drinks in the previous three months. In Portugal, approximately 50% of adolescents report having experimented with alcohol. In the United States, it is estimated that 4.6% of adolescents

between 12 and 17 years of age have a dependence on alcohol. Studies carried out in Brazil report prevalence values of alcohol experimentation ranging from 48.3 to 71.4% in adolescence, as well as a 27.3% frequency of regular use, 22.1% frequency of drunkenness at some time in life and 8.9% frequency of heavy use (Granville-Garcia et al., 2014).

Alcohol use is a key determinant of physical and mental health and is strongly related to harm among young people (SHORE - Centre for Social and Health Outcomes Research and Evaluation, 2009). It has also been linked to sexual and reproductive health of adolescents. Several investigations has linked alcohol use, especially in cases of continuous/addictive use, to poor sexual and reproductive health outcomes such as multiple sexual partners, unplanned sex, unprotected sex, Sexually Transmitted Infections (STIs) including HIV, unwanted teenage pregnancies, poor maternal and child health (Roy, Roy & Rangari; 2007). The consumption of alcohol carries a risk of adverse health and social consequences related to its intoxicating, toxic and dependence-producing properties (WHO, 2014a). Early initiation in alcohol use is one of the most important predictors of future health, socio-cultural and economic problems (Granville-Garcia et al., 2014). Early-onset drinking among youth is risky for a variety of health and social reasons, including its association with illicit drugs, violence, stealing, driving under the influence, academic problems, feeling depressed, and deliberately trying to hurt or kill oneself (Komro et al., 2004).

Current trends in both consumption and alcohol-related harm suggest today's young adults are emerging into a different alcohol environment than have previous generations (Ikegwuonu & Seaman, 2010). The patterns of use, the users and reason(s) for consumption are changing rapidly, especially among young drinkers (Dumbili, 2013). The alcohol industry increases its sales by creating appealing products for both existing and new, mainly young, drinkers. Alcohol products are designed to be attractive to consumers. Some alcoholic beverages may be ostensibly designed for the young adult market but they also appeal to children and teenagers and therefore encourage the early uptake of drinking (University of Stirling, 2013). Although the minimum drinking age remains 18 years, young people buy and drink alcohol freely in public places. Some of the reasons for this are erosion of communal values, familial socialization and peer influence (Dumbili, 2013).

Young people with limited cash can still drink a lot of alcohol by turning to cheap, high-strength products. Cheap alcohol has been shown to be particularly attractive to harmful and dependent drinkers, binge drinkers and young drinkers. Cheap alcohol is attractive not only to drinkers with limited means but also to drinkers of moderate and even high incomes (University of Stirling, 2013). The most recent means of alcohol packaging found in Lagos, all over Nigeria and even the entire Africa is on the hot drinks like schnapps, chelsea, London dry gin which are packaged in sachet waterproofs (Okonkwo, 2008). In Nigeria today, spirits are available in convenient and affordable nylon packages which has improved the access of students to spirits (Durodola, 2009).

Statement of the Problem

For many years, adolescent alcohol use has been an issue of increasing health (including sexual and reproductive health) and social importance in Nigeria among secondary school students especially with the trend of more adolescents using drugs (Abdu-Raheem, 2013; Chikere & Mayowa, 2011). There have been several studies on prevalence, pattern and psychosocial correlates of alcohol and other psychoactive substance use among adolescent groups in Nigeria (Abdu-Raheem, 2013; Adelekan & Odejide, 1989; Adewuya, 2005; Dumbili, 2013; Durodola, 2009; Ikegwuonu & Seaman, 2010; Oshodi et al., 2010).

Most researches have investigated and assessed adolescents' consumption of alcohol (which covers a wide range of alcoholic drinks of beer, wine, spirit and others). However, it was noted through a review of the studies on alcohol use in Nigeria that there has been a rapid increase in alcohol availability and consumption in recent times with adolescents (Adewuya, 2005). This was further explained by Durodola (2009) as his research findings have drawn attention to the consumption of fruity flavoured spirits packaged in small nylon containers with high alcohol concentration, which has become a very common phenomenon among in-school adolescents.

Research has established that the development of alcohol use and misuse involve a complex interplay of biological, social, familial, peer and other factors which combine to determine rates of alcohol use and misuse in the adolescent population. Consideration of these factors suggests that approaches which focus on regulating the access of young people to alcohol offer the greatest potential for minimizing alcohol misuse in this population (Fergusson &

Boden, 2011). Considering the availability and affordability of these cheap sachets of liquor which has significantly increased access to alcohol within the purchasing power of these adolescents, it is imperative therefore to closely investigate this new trend in the alcohol consumption of adolescents. Besides, quite a number of adolescents out of school are engaged in some economic activities, as they are apprentices and some even take up jobs to engage themselves.

Recently, adolescents drink alcohol in curiosity to achieve pleasure and satisfaction, relaxation from psychological tensions, facilitate socialization, avoiding social pressure from a group, social isolation, family dynamics, low self-esteem, and also for sexual gratification (Adenugba & Ijagbone, 2012). Furthermore, the debilitating effect of continuous use of alcohol by both male and female students on their sexual and reproductive health resulting in continuous rise in prevalence of STIs including HIV, and unstructured population increase resulting from incessant teenage pregnancy are public health issues. These are easily achieved through the use of these sachets of spirit because they are sweet, highly concentrated, easily intoxicates when compared to beer. This growing phenomenon is not just in Nigeria, other African countries have been battered by similar products (Endal, 2012).

As at the time this study was conducted, there very few literatures found on studies that investigated the use of liquors in small sachets by adolescents in Nigeria as compared with those available on alcohol consumption among the same population. Hence, this study sought to find out the use of liquors in small sachets by adolescents, providing insight into the pattern of use of this class of alcohol and the perceptions of the young people it.

Justification for the Study

This study will be useful for providing valuable baseline information in terms of a full description of the profile of the adolescents who use liquor sachets. The provided data for baseline information from this study will be essential for health promotion policies, programmes and strategies, which has great potential for providing a healthier approach to curbing the use of alcohol among adolescents and combating the debilitating effects of the practice. This will give direction to the activities of relevant stakeholders by providing helpful information needed in facilitating the design and implementation of appropriate health

education strategies, targeted at adolescents (both in-school and out-of-school), families, communities, non-governmental organizations (NGOs), policy makers and other concerned individuals/bodies.

The findings of this study will also be useful in providing empirical facts to policy makers in the enactment and/or enforcement of existing laws and policies relating to alcohol consumption. Presently, bars, restaurants, hotels, etc. sell alcohol at any time of the day. There is no policy on 'time', 'day', 'place' and 'who' can sell or buy alcohol, nor is there enforcement of any law that prohibits sellers from selling to alcoholics (Dumbili, 2013; Durodola, 2009). It will also provide insight into adolescent sexual and reproductive health issues and provide vivid cues and directions into the relevant services to be provided to this young population.

Since there is dearth in literature of the assessment and evaluation of the consumption of sachet liquor and its impact on this significant population – the adolescents, this study will hence contribute to literature on the subject matter.

Research Questions

1. How much knowledge do adolescents have on the health consequences of alcohol?
2. What proportion of adolescents use liquor sachets?
3. What is the profile of adolescent drinkers of liquor sachets in Ibadan South-East LGA?
4. Do adolescents in Ibadan South-East LGA engage in sexual risky behaviours?
5. What is the relationship between alcohol and sexual risky behaviours of adolescents in Ibadan South-East LGA?

Objectives

The broad objective of this study was to investigate the use of sachet liquor among adolescents in Ibadan South-East Local Government Area, Oyo state.

The specific objectives of this study were to:

1. Determine the adolescents' knowledge of health consequences of alcohol in Ibadan South-East LGA

2. Identify the proportion of adolescents who use liquor sachets
3. Describe the profile of adolescent drinkers of liquor sachets in Ibadan South-East LGA
4. Assess risky sexual behaviours of adolescents in Ibadan South-East LGA
5. Determine the relationship between alcohol use and sexual risky behaviours of adolescents in Ibadan South-East LGA.

Variables

Independent Variables

The independent variables of this study are: Knowledge of health consequences of alcohol, accessibility to alcohol and sexual risky behaviours.

Dependent Variable

The dependent variable of this study is alcohol use among adolescents.

Definition of Key Concepts

Accessibility: This is interpreted in this study to mean physical availability of sachet liquor. The physical availability of alcoholic beverages refers to the ease or convenience of obtaining alcohol for a low price (Okonkwo, 2008).

Adolescents: This refers to young people whose age fall within the age bracket of 10 – 19years according to the definition by World Health Organization (WHO). In this study, it refers to those in school or out of school including those who are jobless, working and apprentices of trade; and they could be males or females.

Affordability: This concept can be explained as the belief to be within one's financial means; alcohol within the purchasing power of an adolescent (Durodola, 2009).

Alcohol: Alcohol is the ingredient found in beer, wine and spirits that has the capacity to alter the mood, changes the way one feels and could cause drunkenness (Dimelu, Agbo & Igbokwe, 2011). As used in this study, alcohol refers to any brand of beer, wine and spirits including the sachet liquor 'Pelebe'.

Availability: This refers to the concept of an adolescent getting sachet liquor in stores, restaurants, herbal concoction sellers (Oniparaga) and other retail outlets to buy without much difficulty or restriction, while the 'Pelebes' are really handy.

Sachet Liquor: This refers to any brand of alcoholic beverage packaged in small portable water-proof nylon sachets, which mostly contains spirit – a class of alcohol, herbal mixtures in form of bitters, alcoholic medicinal local herbal mixtures (Okonkwo, 2008). For the sake of this study, the street name as used in Nigeria, called 'Pelebe', will be used.

Sexual risky behaviours: Sexual risky behaviours encompass a variety of behaviours including, multiple sexual partners and unprotected sex, which may likely result in contracting HIV/AIDS, unwanted pregnancies and unsafe abortions.

Spirits: These refer to a class of alcoholic beverages whose alcohol content ranges from 40% - 80%, they usually appear colourless and include all drinks in the category of dry gin (Durodola, 2009).

CHAPTER TWO

LITERATURE REVIEW

Adolescents and Youths

Adolescence is one of the most rapid phases of human development. It represents one of the critical transitions in life span and is characterized by a tremendous pace in growth and change that is second only to that of infancy. The World Health Organization (WHO) defines adolescents as those people between 10 and 19 years of age; United Nations defines youths as persons within the age bracket of 15 – 24 years; while WHO finds the overlap of the two categories and defines the young people as people within ages 10 and 24 years which covers for adolescents and youths (WHO, 2014). The World Programme of Action for Youth refers to adolescents as "youth" who are between the ages of 15 and 24, as does the World Bank and the International Labor Organization (ILO) (UNICEF, 2005).

Adolescence is a period of life with specific health and developmental needs and rights. It is also a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire attributes and abilities that will be important for enjoying the adolescent years and assuming adult roles (WHO, 2014); which emphasizes the biological, psychological and sociological changes that define adolescence (Cobb, 2010; UNICEF, 2005). It is a period of transition from childhood into adulthood which is significantly marked by maturity noted by transition from dependence to autonomy in the various spheres of growth and development.

Age is often more appropriate for assessing and comparing biological changes such as puberty, which are fairly universal, than the social transitions, which vary more with the socio-cultural environment. However, it is only one characteristic that delineates this period of development, the definition of adolescence is not solely marked by age boundaries; the biological changes during adolescence do not all start at 10 years or stop at 20 years. Sex and gender also play important roles in the variations in the timing and speed of change among individuals. By sex, adolescent girls tend to reach biologically defined developmental milestones up to two years ahead of adolescent boys; and by gender, expectations and societal

norms differ significantly between adolescent boys and adolescent girls in most societies (WHO, 2014).

Puberty heralds the biological changes, noted by significant changes in physical and sexual characteristics in the body. The growth spurt, which involves rapid skeletal growth, usually begins at about ages 10 to 12 in girls and 12 to 14 in boys and is complete at around age 17 to 19 in girls and 20 in boys. Sexual maturation involves achieving fertility and the physical changes that support fertility. From age 10, girls start experiencing breast budding, then menstruation. For boys, the onset of puberty involves enlargement of the testes at around age 11 or 12 and first ejaculation, which typically occurs between the ages of 12 and 14. The development of secondary sexual characteristics, such as body hair and (for boys) voice changes, occurs later in puberty.

Cognitive competence includes such things as the ability to reason effectively, problem solve, think abstractly and reflect, and plan for the future. At the beginning of adolescence, cognitive abilities are dominated by concrete thinking, egocentrism, and impulsive behavior. The ability to engage in abstract reasoning is not highly developed in most young teens, limiting their capacity to comprehend nutrition and health relationships. Young adolescents also lack the skills necessary to problem solve in an effort to overcome barriers to behavior change and the ability to appreciate how current behaviors can affect future health status (Stang & Story, 2005).

Conflicts over personal choice, including food choices, become increasingly common during this stage of adolescence. Peer groups become more important than family and their influence with regard to making food choices peaks. Coinciding with the increased importance of peer acceptance, the initiation of health compromising behaviors such as smoking, alcohol consumption, using street drugs, and engaging in sexual activities often occurs during middle adolescence. Abstract reasoning skills begin to emerge among most teens during middle adolescence while the late stage of adolescence is characterized by the development of a strong personal identity (Stang & Story, 2005).

Emotional development during adolescence involves establishing a realistic and coherent sense of identity in the context of relating to others and learning to cope with stress and manage emotions. Development of sense of identity during adolescence involves two basic

concepts; self-concept and self-esteem (American Psychological Association, 2002). Self-concept describes the beliefs about one's attributes, roles and goals, and interests, values, and beliefs. In early adolescence, cognitive developments result in greater self-awareness which leads to greater awareness of others, and their thoughts and judgments. Self-esteem is one's thoughts and feelings about one's self-concept and identity. For adolescents, perceived delay in sexual maturation and biological development, especially among males, may lead to the development of poor body image and lowered self-esteem (Stang & Story, 2005).

Peer influence is a dominant psychosocial issue during adolescence, especially during the early stages. Young teens are highly cognizant of their physical appearance and social behaviors, seeking acceptance within a peer group (Stang & Story, 2005). Adolescents depend on their families, their, communities, schools, health services and their workplaces to learn a wide range of important skills that can help them to cope with the pressures they face and make the transition from childhood to adulthood successfully. Parents, members of the community, service providers, and social institutions have the responsibility to both promote adolescent development and adjustment and to intervene effectively when problems arise (WHO, 2014).

Many adolescents face pressures to use alcohol, cigarettes, or other drugs and to initiate sexual relationships at earlier ages, putting themselves at high risk for intentional and unintentional injuries, unintended pregnancies, and infection from sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV). Many also experience a wide range of adjustment and mental health problems. Behavior patterns that are established during this process, such as drug use or nonuse and sexual risk taking or protection, can have long-lasting positive and negative effects on future health and well-being. While adolescence is a time of tremendous growth and potential, it is also a time of considerable risk during which social contexts exert powerful influences (WHO, 2014).

Nature of Alcohol

Alcohol, with the chemical name – ethanol or ethyl alcohol, is produced by yeast fermentation of the natural sugars in plants, such as grapes (wine), hops (beer), sugar cane (rum), agave (tequila), or rice (saki). The process of fermenting plants to produce alcohol is as old as at least 10,000 years old and it appears to have developed independently in many cultures.

Fermentation is a process that uses yeast or bacteria to change the sugars in the food into alcohol.

According to the literature provided in the Global Status Report on Alcohol and Health, following the history of alcohol consumption, prior to the modern era, fermented alcoholic beverages were known in all tribal and village societies except in Australia, Oceania and North America. In societies where there was no aboriginal alcohol consumption, the encounter with alcoholic beverages was often abrupt and highly problematic. Where alcohol was traditionally consumed, production of alcoholic beverages commonly occurred on a small scale as a household or artisanal activity, particularly when and where agricultural surpluses were available (WHO, 2014b).

The uses and value of alcohol can be categorized based on its physical and cultural properties. Based on its physical properties, an alcoholic drink can defined as a foodstuff, and indeed opaque beer in Africa is a substantial source of nutrition in village societies; another category is as a thirst-quenching drink. Thirdly, alcoholic drinks are also psychoactive. They can be used in moderate quantities to alter mood and they can also be used in larger quantities when the drinker is seeking intoxication (Room, 2013; WHO, 2014b). Alcohol is essentially a drug, it is a primary and continuous depressant and it shows the characteristic action of general anaesthetics, causing sedation. As a result of the depressant activity of alcohol, the safeguarding functions of the brain such as judgment and self-control are the first to be impaired (Durodola, 2009).

Apart from alcohol's physical properties, alcoholic drinks have also often been assigned strong cultural meanings and values – to give diverse examples, as a sacrament, as a source and occasion of stigma, and as a signal of commensality and fellowship (Room, 2013). Drinking alcohol was often considered to be an occasional and communal activity, associated with particular communal festivals. There are many places in the world today where versions of these traditional patterns originating from tribal and village societies persist (WHO, 2014b). In Nigeria, alcoholic beverages play older cultural functions such as pouring spirit and larger beer on the ground to honour ancestors and cultural roles of making profits for his shareholders (Durodola, 2009).

Generally, alcoholic beverages can be broadly categorized into three groups based on their alcoholic content and source, and they are beer, wines and spirits (Dimelu, Agbo, & Igbokwe, 2011; Durodola, 2009; Peltzer & Ramlagan, 2009).

Beer is a low potency alcoholic beverage made by fermenting grains and then extracting the liquid from the mash. It is often produced by combining yeast and malted cereal, such a rye, wheat or barley; which are fermented to produce alcohol and carbondioxide. Beers usually contain 4 to 8 percent of alcohol (Durodola, 2009).

Wine is a relatively low potency alcoholic beverage made by fermenting fruit juices such a grapes, peaches, plums or apricots or other sugary liquid. Wines contain about 10 to 22 percent of alcohol.

Distilled spirits are high potency alcoholic beverages that are made by fermenting grains or fruit juices and then distilling the resulting liquid to reduce its water content and to concentrate its alcohol. They tend to be "harder" or more likely to lead to intoxication than are beer or wine. However some familiar ones in Nigeria are: Calypso (28%), Regal (43%), Chelsea (43%), Schnapps 43%), Schnapps (40%), Apperito (20%)(40%), Apperito (20%) (Durodola, 2009).

It was reported that alcohol beverage preference of a particular area depends on the type of alcoholic beverages produced in the area. For instance beer is preferred in several European and African countries, wine is preferred in the wine producing countries of Europe and spirits are preferred in Eastern Europe, Asia and some island states. On the contrary, scholars have stated that alcoholic beverage preferences of an area are no longer dependent on the type of alcoholic beverages produced in an area due to increasing importation of beverages other than those produced in the area or country. Consumers are increasingly opening up to beverages other than those produced in their country (Dimelu et al., 2011).

Despite the fact that alcohol was not new to the indigenous people, the influence of the Western traders popularised the sale of liquor and facilitated alcohol abuse due to the importation, sale and distribution of trade spirit (Akyeampong, 2010; Dumbili, 2013). This trend was sustained during the colonial era and beyond, leading to the establishment of the first brewery (Nigerian Brewery limited presently known as Nigerian Breweries or NB Plc.) in 1946 with its first brew in 1949 (Dumbili, 2013; Obot, 2000)

Some of the alcohols are traditionally produced at the local level. The traditionally produced alcohols include palm wine, *burukutu, pito, ogogoro* (also known as *kindana)*. These types of local alcoholic beverages produced locally are produced in different sections of the country and beyond (Dimelu et al., 2011; Durodola, 2009; Okonkwo, 2008). Obot, (2000) opined that before the arrival of western factory – made drinks, alcohol consumption was limited to a variety of beverages produced from palm trees and food grains. He further remarked that beer has become the most popular drink in the country, but traditional beverages (palm wine, *burukutu, ogogoro, pito*) are still widely consumed in both rural and urban area. In Ibadan area of Nigeria, the most commonly consumed alcoholic beverages are palm wine which is produced from the sap of the palm tree and beer (Oshodi et al., 2010). Generally, throughout Nigeria native gin distilled from raffia palm wine is popular (Dimelu et al., 2011).

In recent times in many African countries, spirits are packaged and sold in small sachet nylon. In Zambia, it is called tujilijili and it was sold all over the place without any restriction in the country before it was completely banned. The small plastic sachets, containing typically 30 ml of strong liquor was reported to contain about 40% alcohol and it was consumed by all including the young people (Endal, 2012). In Cameroon, whiskey (a class of spirits) are also packaged in small sachets and sold at really low prices everywhere in the republic. It was reported to be manufactured with substandard materials and found to have toxic substances that are dangerous to humans (Muma, 2014).

In Nigeria, spirits are available in convenient and affordable nylon packages, they are sold for as low as N20 (Durodola, 2009). It was reported by Okonkwo, 2008 that another means of alcohol packaging found in Lagos is on the hot drinks like schnapps, Chelsea, London dry gin which are packaged in sachet waterproofs. They are purchased and consumed by everybody, both old and young. However, children and adolescents have no problems obtaining alcohol from any retail outlets, the convenient packaging and affordability allows the students to buy it from anywhere, keep it and drink it unnoticed by teachers, parents or fellow students (Durodola, 2009; Mamman et al., 2014).

Sachet liquor are sold at beer parlours, restaurants, pepper soup joints, motels, stores, supermarkets, some pharmaceutical chemists shops, road-side petty traders, motor parks etc and anybody and at any time can purchase and use (Durodola, 2009). They are sometimes

used by women who mix and sell local herbs called 'Oniparaga' or 'Alagbo' to mix alcohol and herb to make herbal mixtures for managing various ailments, which are then sold to its consumers which include drivers, conductors, National union of Road Transport Workers (NURTW) – agbero, motorcycle riders, young people and some other middle low-income earners of the community (Okonkwo, 2008).

Global, Regional and National Prevalence of Alcohol Consumption

Globally, alcohol consumption has increased in recent decades, with all or most of the increase in developing countries. While alcohol use is deeply embedded in many societies, recent years have seen changes in drinking patterns across the globe: rates of consumption, drinking to excess among the general population and heavy episodic drinking among young people are on the rise in many countries (Chikere & Mayowa, 2011). Considering that beyond health consequences, the harmful use of alcohol inflicts significant social and economic losses on individuals and society at large, the harmful use of alcohol continues to be a factor that has to be addressed to ensure sustained social and economic development throughout the world (WHO, 2014b).

As indicated in the most recent WHO data, globally, individuals above 15 years of age drink on average 6.2 litres of pure alcohol per year, which translates into 13.5 grams of pure alcohol per day. There is however wide variation in total alcohol consumption across WHO regions and Member States. The highest consumption levels continue to be found in the developed world, in particular in the WHO European Region (EUR) and the WHO Region of the Americas (AMR). Intermediate levels of consumption are found in the WHO Western Pacific Region (WPR) and the WHO African Region (AFR), while the lowest consumption levels are found in the WHO South-East Asia Region (SEAR) and particularly in the WHO Eastern Mediterranean Region (WHO, 2014b)

Globally, 50.1% of total recorded alcohol is consumed in the form of spirits, which are also the most consumed beverage type in the WHO South-East Asia and Western Pacific regions (see Figure 4). The second most consumed beverage type is beer, which accounts for 34.8% of all recorded alcohol consumed in the world. It is the most consumed type of beverage in

the WHO Region of the Americas (55.3%). Only 8.0% of total recorded alcohol is consumed in the form of wine (WHO, 2014b).

According to the World Health Organization data in the Global Status Report on Alcohol and Health (2014), the world's per capita alcohol consumption is 6.2 litres per year. The WHO Africa region's per capita alcohol consumption is 6.0 litres a year. This is lower than Europe and the Americas, which consume 10.9 litres and 8.4 litres respectively. The regions that consume the least alcohol are Southeast Asia (3.4 litres) and the Eastern Mediterranean (0.7 litres) (WHO, 2014b).

In WHO African region, countries like South Africa, Nigeria, Namibia and Gabon recorded significantly high per capital alcohol consumption. South Africa's per capital alcohol consumption in litres of pure alcohol is 11.0 litres per year, Namibia and Gabon consume 10.8 litres and 10.9 litres respectively, while Nigeria consumes 10.1 litres per year (WHO, 2014b). In many sub-Saharan African countries like Kenya for example, ever drinking prevalence of up to 15% was found among secondary school students, where some private universities had rates as high as 84%. A particular study from South Africa also reported an alcohol use prevalence of 39.1% among high school adolescents, another one reported 54% (Hoque & Ghuman, 2012), while in southern Ethiopia, a prevalence of 57.7% was found (Reda et al., 2012). Two Ghanaian studies conducted among secondary school students and among nationally- representative samples of in- and out-of-school youth found that the prevalence of lifetime alcohol use was approximately 25% (Kabiru, Beguy, Crichton, & Ezeh, 2010).

Studies in Nigeria have highlighted prevalence rates of alcohol use in different contexts and among different populations ranging from as high as 78% among undergraduate students to as low as 21% among secondary school students. Alcohol prevalence has been sought among male and female students (secondary and tertiary institutions), military officers, tanker drivers, rural settlement dwellers, urban settlement dwellers, etc. Among the studies conducted among secondary school students was one that sought to establish the correlates of alcohol consumption among adolescents in Ibadan North Local Government Area by Adenugba & Ijagbone (2012). The study found a prevalence of alcohol consumption of 37% and established socio-economic status of adolescents' family to be a predictor of alcohol use, and male sex to be a correlate of alcohol use. A study conducted to investigate alcohol and

substance use among secondary school adolescents in Ibadan South-West Nigeria reported a prevalence of alcohol and substance use of 21.4% (Atilola et al., 2013). In the investigation by Durodola (2009), the prevalence was higher (52%), also among secondary school students in Ibadan North Local Government Area.

A study carried out among university male undergraduates by Chikere & Mayowa (2011) indicated a prevalence of 78%. Another research among undergraduates by Onongha (2012) revealed that parents and peer exercise enormous influence on students' alcohol use because they are seen as models, while students with strong commitments to conventional activities such as reading books, sports and religious activities will not want to jeopardize them by engaging in deviant behaviour. The study examined the frequency of alcohol use and found that 42%, 34% and 14.5% of the undergraduate students consume alcohol daily, weekly and monthly respectively.

Odejide, Omigbodun, Ajuwon et al. (2008) in an article called 'Swimming with Crocodiles' sought to gain insight into some of the reasons behind youthful drinking and extreme drinking behaviours in Nigeria. Attention was drawn to the continuous increase in alcohol availability and consumption in the country over years in succession. It was discovered that though peers and parents influenced drinking among the young people, curiosity was the major reason for alcohol consumption. The study in agreement with previous studies affirmed early onset of drinking with a pattern of occasional consumption and problem drinking during weekends and other events that guarantee free drinks. The research also laid emphasis on socioculture environment and lack of enforcement of existing regulations.

Makanjuola et al. (2014) in a study conducted among petroleum tanker drivers in Lagos, Nigeria, discovered that lifetime use prevalence of alcohol was 71.6%, tobacco 69.8% and caffeine 50.9% while the current use prevalence of alcohol was 57.6%. Predictive factors for current drug use were presence of multiple sex partners and previous involvement in road traffic accidents. The use of non-commercial alcohol (such as locally-prepared alcoholic herbal mixtures called 'Paraga'), either alone or together with commercial alcohol, is quite prevalent. A similar study carried out among drivers of commercial vehicles in Calabar, Nigeria, showed that determinants of any alcohol use were history of use by parents, friends and ready availability (Bello et al, 2011).

Alcohol Consumption among Adolescents and Youth

Majority of the Nigerian adolescents ignorantly depend on one form of drug or the other for their various daily activities–social, educational, political, moral etc. Such drugs include: Tobacco, Indian hemp, cocaine, morphine, Heroine, Alcohol, ephedrine, Madras, Caffeine, Glue, Barbiturates, and Amphetamines. Drug use (including alcohol) among youth's and adolescents should be a matter of concern to all Nigerians especially the society, government, school heads, religious leaders, groups and other NGOs (Mamman, Othman, & Lian, 2014). It was however found that in a number of school and college surveys in Nigeria, alcohol use is the most common among students (Abdu-Raheem, 2013; Oshodi et al., 2010)

Adolescents take alcohol for several reasons, but alcohol is taken essentially for pleasure and for overcoming psychological and physical problems (Odejide, 2006). In a study carried out among university students in Owerri by Chikere and Mayowa (2011), reasons given by respondents for alcohol drinking include: makes them feel high (24.4%); makes them belong to the group of "most happening guys" on campus (6.6%); makes them feel relaxed (52.6%) while (16.4%) drinks it because their best friends do.

Many risk factors for alcohol use have been identified in literature over the years in research. Correlates of alcohol use include demographic factors such as gender, age, monthly income, living arrangement, attitudes toward alcohol use, perceived susceptibility of alcohol use, perceived self-efficacy, peer drinking, relatives drinking, accessibility of alcohol, and exposure to either anti-alcohol campaigns or to alcohol advertising as well as ownership of alcohol promotional items (souvenirs such as branded t-shirts, lighters, matches, hats, or sunglasses) (Ikegwuonu & Seaman, 2010; Mamman et al., 2014; Swahn, Ali, Palmier, Sikazwe, & Mayeya, 2011; Swahn, Palmier, & Kasirye, 2013; Tur et al., 2003; Velleman, 2009; WHO, 2014b). Alcohol marketing is one of the major risk factors for alcohol use, it influences youth's attitudes and perceptions about alcohol, which are related to expectancies and intentions to consume alcohol beverages (Durodola, 2009; Swahn et al., 2011)

Current trends in both consumption and alcohol-related harm suggest today's young adults are emerging into a different alcohol environment than have previous generations (Ikegwuonu & Seaman, 2010). Approximately three-fourths of adolescents have tried alcohol by the end of high school (Moreno et al., 2011). According to the National Institute for Health and Clinical

Excellence (2007), alcohol use among children and young people is growing faster than the use of any other drug in the UK and it causes the most widespread problems. Alcohol is also the least regulated and most heavily marketed drug (National Institute for Health and Clinical Excellence, 2007).

As reported in the study of Peltzer and Ramlagan, current (past month) alcohol use has been about 30% (40% among men and 16% among women), which is lower than those reported for other developing countries, e.g. Namibia (men 61%, women 47%), Mexico (men 77%, women 44%), and Thailand (men 77%, women 46%). In South Africa, use of alcohol among various samples among adolescents assessed from 1993 to 2006 found a range of current alcohol use from 21.5% to 62%, likewise binge drinking ranged from 14% to 40%, while hazardous or harmful drinking was only assessed in one sample where 19% was found. Studies with university students in South Africa found from 22 to 80% current alcohol use, between 6% to 43% past month binge drinking and between 17.1% to 58% hazardous or harmful drinking (Peltzer & Ramlagan, 2009).

According to the study conducted by Odekina (2007) on alcohol use among junior secondary school students in Nigeria as cited by Adenuga and Ijagbone (2012), 40% of the students have used alcohol at least once in their life 26% drank an alcoholic beverage to the point of intoxication, 32% had used their own money to buy an alcoholic drink for personal consumption in the past while 48% never had any contact with alcohol. A research conducted among secondary school students in Ibadan North LGA reported 57.5% of the participants to have ever drunk alcohol while 37.2% were still engaged in the consumption of alcohol at that time (Adenugba & Ijagbone, 2012). A study conducted among teenagers in Benin City revealed that 85 per cent were current drinkers and 60 per cent revealed they began to drink from their homes while 79 percent reported that their parents also drink (Dumbili, 2013).

The American Academy of Paediatrics pointed out that when compared with use by adults, alcohol use by adolescents is much more likely to be episodic (binge) and heavy, which makes alcohol use by those in this age group particularly dangerous. Rapid binge-drinking, possibly related to a bet or dare, puts the teenager at even higher risk of alcohol overdose or alcohol poisoning, in which suppression of the gag reflex and respiratory drive can be fatal (American Academy of Pediatrics, 2010).

As identified in the literature within Nigeria context, a sharp contrast from what hitherto existed is the 'alcohol contest' among youths in bars, restaurants, drinking joints, hotels and nightclubs that are strategically located near various schools in Nigeria. This competition is always among boys and the winner is judged based on two standards – 'the ability to drink large a quantity without showing a sign of intoxication and the ability to drink faster than the opponent.' Here, a large sum of money contributed by these competitors or alcohol marketers (especially those that market spirit) is awarded to the fastest drinker or alcohol *macho*. Marketers do this to introduce new products into the market or to promote existing ones that are not receiving enough sales. Though no study has been identified that focused on alcohol competition in the drinking joints in order to document the negative effects, but the fact remains that it contributes to binge drinking which has precarious consequences on human health. Dumbili, 2013 also found that in February 2012, a youth collapsed and died in a drinking competition in Lagos. Among these competitors, alcohol consumption is no longer for *pleasure* as it used to be, but for a *prize* (Dumbili, 2013).

In Zambia, the small plastic sachets, containing typically 30 ml of strong liquor, have become a serious health concern, not just in Zambia but also in a number of African countries the last years. They are sold at really low prices, often in unlicensed bars and often to minors. Local politicians, teachers and headmasters, youth leaders and religious leaders, have on many occasions expressed their concern over youth and even children drinking these strong liquor shots (Endal, 2012). The small and cheap sachet liquor is usually called 'tujilijili' – a local name for cane spirit or other distilled alcohol, packaged in small plastic sachets and it is recorded to have been responsible for significant casualties which has moved the government of Zambia to ban its production and sales (Zambian Dailys, 2012).

As observed by Durodola (2009) in his study among secondary school students in Ibadan North Local Government Area of Oyo state, adolescents are exposed to alcoholic beverages from the alcohol retail outlets located along their routs to and from school especially those sold in small nylon packages (usually called '*pelebe'*) from the 'Oniparagas' and other retail outlets. These adolescents have direct unrestricted access to these drinks and this promotes continuous use. It was also reported in the findings of this study that although beer was the most admired and respected alcoholic beverage, most of the students preferred spirits in small affordable nylon packages. Reasons given for this choice were: small sachet liquor (pelebe) is

cheaper than beer, pelebe could be kept and drunk unnoticed by teachers, parents or fellow students, pelebe is sweet and highly concentrated compared to bitter beer or sour wine, it intoxicates easily and faster compared to beer or wine, and spirit's smell could be easily driven away with peppermint unlike beer. However, the participants emphasized the desire to consume beer as they appreciate the product and all the students who drink spirit still drink beer (Durodola, 2009).

Consequences of Alcohol Use

The harm created by alcohol is immense. According to the World Health Organization (WHO), the consumption of alcohol carries a risk of adverse health and social consequences related to its intoxicating, toxic and dependence-producing properties (WHO, 2014a). The harmful use of alcohol ranks among the top five risk factors for disease, disability and death throughout the world. Statistical Classification of Diseases and Related Health Problems (ICD) 10th revision, WHO, 1992, cited in the Global Status Report on Alcohol and Health pointed out that alcohol is a causal factor in more than 200 disease and injury conditions. It was also reported that drinking alcohol is associated with a risk of developing such health problems as alcohol dependence, liver cirrhosis, cancers and injuries. The latest causal relationships suggested by research findings are those between alcohol consumption and incidence of infectious diseases such as tuberculosis and HIV/AIDS as well as between the harmful use of alcohol and the course of HIV/AIDS (WHO, 2014b).

Alcohol harms health in many different ways. Alcohol is one of the leading causes of illness, injury and death across the world. Globally, the deaths of over three million people every year are attributable to alcohol, more than the annual deaths from HIV/AIDS or tuberculosis. It is a risk factor for liver disease, cardiovascular disease and cancers of the head, mouth, neck, liver, breast and bowel. The Cancer Council of Australia has published a position statement on alcohol and cancer which recommends abstinence from alcohol in order to reduce the risk of cancer. Alcoholic drinks and ethanol are carcinogenic to humans, as the Cancer Council concludes that 'alcohol is clearly one of the most carcinogenic products in common use' (Global Alcohol Policy Alliance, 2011).

It is linked to poor mental health, depression and dependence. It can cause acute toxic poisoning. Among men aged between 15 and 59, alcohol is the leading risk factor for

premature death (University of Stirling, 2013). According to Ukwayi, Ambekeh, Chibuzo and Undelikwo, 2013, academic problems and alcohol use are highly related. It was argued that alcohol has several physiological and psychological effects, which inhibit students' performance as cognitive abilities are affected by even small amounts of alcohol and can persist for a substantial period of time after the acute effects of alcohol impairment disappear. It was also noted that "about a quarter of college students report experiencing difficulty with academics due to alcohol use, including earning low grades, doing poorly on tests and papers, missing class, and falling behind, thereby increasing the rate of dropping out of school (Ukwayi et al., 2013).

Every year in the UK, there are thousands of deaths, hundreds of thousands of hospital admissions and over a million violent crimes linked to drinking alcohol. It is a problem that cuts across the entire population ("Literature Review : Social Supply of Alcohol to Minors," 2009).

In South Africa, a major public health concern is the prevalence of foetal alcohol syndrome (FAS) – a condition caused by mothers drinking during pregnancy, resulting in an incurable birth defect. Tragically, 122 in 1,000 babies are born with this defect in South Africa (compared with just 8 in 1,000 in the US) (Lythgoe, 2013).

The age at which people start regular drinking is predictive of consumption and alcohol-related problems in subsequent years (Centre for Social and Health Outcomes Research and Evaluation, Massey University; 2009). In an article by Danielle, Aliev, Viken, Kaprio and Rose, 2011, it was reported that alcohol use during adolescence may not be just a temporary phase. The more the drinking-related problems an adolescent experienced by age 18, the greater the likelihood that the adolescent would be diagnosed with alcoholism seven years later (at age 25) (Danielle et al., 2011).

Drinking by younger people results in higher levels of harm relative to the same amounts consumed by older people (Centre for Social and Health Outcomes Research and Evaluation, Massey University; 2009). Alcohol consumption at a young age increases the risk of developing alcohol related problems later in life. Those who begin to drink at an early age are at higher risk for injury, illness, long-term alcohol abuse, or even death related to alcohol use

(Moreno MA et al., 2011). Among youth, drinking often coexists with other problem behaviors such as poor academic performance and absenteeism which may impair healthy development and successful transition from adolescence to adulthood (Reda et al., 2012).

It has been reported by researchers that the social harms associated with alcohol are less easy to quantify but some social problems of young adulthood and alcohol are known to co-exist. These include violence and anti-social behavior, unplanned sexual activity and the related problem of sexually transmitted infections, suggesting that societal trends in alcohol consumption and social harm are likely to increase alongside one another (Ikegwuonu & Seaman, 2010).

According to Dumbili, 2013, another major consequence of the changing patterns of alcohol consumption is road traffic accidents due to drunk-driving. This has continued to claim lives yearly in Nigeria and may continue because *drivers are advised to drink responsibly by the brewers rather than to abstain*. Nigeria presently ranks third out of the 10 countries with the highest number of deaths related to road) accidents and the problem may continue due to lack of policy to check alcohol availability, use and misuse (Dumbili, 2013).

Age of initiation of alcohol use cannot be underestimated. The age at which people start regular drinking is predictive of consumption and alcohol-related problems in subsequent years. Drinking by younger people results in higher levels of harm relative to the same amounts consumed by older people and there is also evidence of brain impairment associated with intoxication in the teenage years; including areas associated with making judgments, learning and memory.

The American Academy of Pediatrics (AAP) gathered evidences on the link between the use of alcohol at an early age and future alcohol-related problems. AAP affirms the data from the National Longitudinal Alcohol Epidemiologic Study on the prevalence of both lifetime alcohol dependence and alcohol abuse show a striking decrease with increasing age at onset of use. For those aged 12 years or younger at first use, the prevalence of lifetime alcohol dependence was 40.6%, whereas those who initiated at 18 years were 16.6% and at 21 years was 10.6%. Similarly, the prevalence of lifetime alcohol abuse was 8.3% for those who initiated use at 12 years or younger, 7.8% for those who initiated at 18 years, and 4.8% for those who initiated at 21 years (American Academy of Pediatrics (AAP), 2010).

Alcohol and Risky Sexual Behaviour

Reproductive health of adolescents is central to general health; and it is affected by other aspects of health, particularly the status of health during infancy, childhood and adolescence, lifestyle, nutrition and environment (Roy, et al.; 2007). The emergence of pandemic of HIV infection, increasing rates of STIs, and growing recognition of the importance of gender violence and sexual dysfunction in public health, population explosion due to high birth rate in sub-Saharan Africa, have highlighted the need to focus more explicitly on issues related to adolescent sexual and reproductive health and their well-being (Roy et al.; 2007).

Adolescence is a critical period of rapid physical, biological and psychological development, when 'risky' health behaviours may be adopted, which translates into adventurous practices in all spheres of human endeavours including sexual practices (Morhason-Bello et al., 2008). The sexual development of adolescents is marked by development of secondary sexual characteristics which comes along with strong sexual urges. Following the trend of decreasing on-set of puberty due to improved nutrition and urbanization coupled with the increasing age of marriage, the taming of the sexual urge in period of abstinence till acceptable gratification in marriage has seemingly become more prolonged (Roy et al.; 2007). The social environment provides constant sexual stimulation but the rigidity of social morals may create conflicts leading to anxiety, sexual frustrations, deviant sexual behaviour, promiscuity, casual sexual relations, unwanted pregnancy, teenage motherhood and increases in sex crimes and STDs. The situation can be further complicated by the sex related myths and misconceptions that are prevalent among teenagers (Roy et al.; 2007).

Several studies have demonstrated relationship between alcohol and sexual and reproductive health of adolescents (Asamoah & Agardh, 2012; Morrison, Gillmore, Hoppe, et al. 2003). The link between alcohol use and sex directly has been explained through disinhibiting effect of alcohol. According to alcohol myopia theory, which states that the acute disinhibitory effects of alcohol reduce ability to process complex information (such as long-term goals), thus allowing immediate and salient goals (such as sexual arousal) to influence behavior more strongly (Patrick & Maggs, 2009).

The sexual risk behaviours that are commonly linked with alcohol use are: early sexual activity, unprotected sexual intercourse exposing the adolescent to sexually transmitted

infections (STI) and HIV, teenage pregnancies and sexual intercourse with multiple partners (Lavikainen et al. 2009; Royal College of Physicians (RCP), 2011; Choudhry et al.; Ekpenyong & Aakpege, 2014). Early alcohol use has been closely marked with early onset of sexual activity, and this relationship is stronger for girls than for boys. This explains the resultant decrease in the age of first sexual activity of secondary students across the globe and even in Nigeria. The Nigeria Demographic Health Survey of 2013 (NDHS, 2013) shows that 17 percent of young women and 3 percent of young men age 15-24 initiated sexual activity before age 15, and 52 percent of young women and 19 percent of young men age 18-24 had their first sexual intercourse before age 18.

It was also reported by Morhason-Bello et al. (2008) while describing the sexual behavior of in-school adolescents in secondary schools in Ibadan that 28.3% of the respondents are sexually active and 77.2% of the sexually experienced respondents admitted that their first sexual exposure was unplanned. The method of sexual activity practiced by the sexually experienced respondents were vagina (98.5%), oral (47.2%) and anal (15.2%); and about 40 percent had more than one sexual partner. Okpani et al. (1995) reported 77% among the adolescents in Port Harcourt. He suggested that the increased sexual activity among in-school adolescents in Port Harcourt might be due to rapid urbanization of the city as Nigeria's crude oil operations expand; coupled with the poor socioeconomic background of the indigenous adolescents. This provides insight into the rising prevalence of Sexually Transmitted Infections (STIs), HIV, unwanted/teenage pregnancies and complications of abortions in Nigeria.

Furthermore, alcohol is commonly used as a sex facilitator, a symbol of masculinity, and a means of relaxation, recreation, socializing and improving communication skills. Alcoholic beverages are also used as a facilitator in approaching the opposite sex. "Masculinity" is often linked to the ability to have multiple partners, imbibe alcohol and engage in promiscuous behaviour. Among women, alcohol use increases involvement in risky sexual encounters and sexual victimization, exposing them to the risk of unwanted pregnancies and STIs (WHO/UNAIDS 2005).

Based on alcohol expectancy theory, one of the reasons some secondary school students use alcohol is their expectation that alcohol facilitates sexual drive and sexual affect and decreases

sexual inhibitions. Royal College of Physicians (2011) reported that people feel more confident sexually if they have drunk alcohol. Drinking before sexual contact is therefore often a planned activity that is seen as a necessary precursor to facilitate a sexual encounter happening and can also be used afterwards as an explanation to legitimize the behavior. One of the focus group discussions carried out by Durodola (2009) in his study confirmed that some adolescent boys like to give alcohol to their female sex partners for less pain and increase the fun with some aggression. An analysis of interviews with sexually active women, for example, revealed that about half had used alcohol instrumentally to make sex more likely to occur (Cooper, 2002; Durodola, 2009)

Interventions to Prevent Alcohol Consumption among Young People

Young people's drinking is a major cause for concern for policymakers, communities, parents and many young people themselves; and integrated, planned and implemented prevention system is needed to tackle the excessive alcohol use in young people (Velleman, 2009). Alcohol prevention interventions are developed with the aim of reducing harmful use of alcohol and the alcohol-attributable health and social burden in a population and in society (WHO, 2014b).

Theoretical review of literature on how children learn about alcohol explains how knowledge, attitudes and behavior towards alcohol are formed in young people. It suggests a strong connection between parental and family factors and the developments of attitudes and behaviour towards alcohol; influence of peers, the influence of advertising, the media and wider cultural socialisation processes, the influence of ethnicity, religion and other societal or cultural factors such as sport and other extra-curricular activities on attitude and behavior towards alcohol in young people (Velleman, 2009). This forms the bedrock of intervention strategies in addressing the issue of adolescent alcohol use.

As indicated in the Global strategy to reduce the harmful use of alcohol, sustainable action to reduce harmful use of alcohol requires leadership at the national level, awareness of the issues and commitment. National governments make important decisions about implementation of evidence-based interventions, and their leadership in this area is critical. There were two indicators included in the Global Survey on Alcohol and Health 2012 on leadership, awareness and commitment, and they are: development of national alcohol policies and

presence of awareness-raising activities. Globally, only 66 Member states of the World Health Organization had written national alcohol policies in 2012 and in African region, only 20% (9) of the countries have adopted the national alcohol policies while 36 countries including Nigeria have not adopted the written national alcohol policy (WHO, 2014b).

Regulation of alcohol taxes and prices is another measure in addressing the issue of availability and use of alcohol. As reported by Odejide (2006), economic studies conducted in many developed and some developing regions of the world have demonstrated that increased alcoholic beverage taxes and prices are related to reductions in alcohol use and related problems. Alcohol taxes can be carefully calibrated to incentivise both the manufacture and purchase of lower strength drinks, promoting a shift in market share that delivers an overall reduction in alcohol consumption (Jernigan, 2002; University of Stirling, 2013).

According to the report of University of Stirling (2003), to tackle the primary drivers of alcohol consumption, the most effective way to reduce the harm from alcohol is to reduce the affordability, availability and attractiveness of alcohol products (Jernigan, 2002; University of Stirling, 2013). It is not enough to limit the damage once people are drunk, dependent, ill or dying, there is need to intervene earlier in order to reduce consumption across the entire population; this is primary prevention strategy. Thus, Taxes should be used to raise the real price of alcohol products such that their affordability declines over time (University of Stirling, 2013).

In line with the review of some researches by Jernigan (2002), prevention measures that affect the population level of alcohol consumption are among the most effective ways of preventing alcohol-related problems; and brief interventions have shown to be cost-effective and lead to public health gains, although they have not been broadly utilized in developing societies.

The reduction of physical availability of alcoholic beverages refers to the accessibility which could be total or partial ban of the production and sale of alcohol as experienced in Islamic countries or states. In Nigeria, for example, the sale and consumption of alcohol are prohibited in sharia states e.g., Zamfara, Kano, Sokoto. The State Sharia laws forbid the sale and consumption of alcohol in the state. It could also be in the form of forbidding the location of sales outlets near a school or place of worship (Odejide, 2006; WHO, 2014b). In Zambia, the production and sale of a particular type of alcoholic beverage packaged in nylon sachets

sold cheaply called ‘tujilijili’ was banned in 2012 to control the access and availability of the alcoholic beverage which had wrecked so much havoc in the country (Endal, 2012; “Tujilijili ban,” 2012). Also in Cameroon, due to the alarming consumption rate of alcohol in the country coupled with the observed devastating effects of the practice, the production and sale of liquor sachets have been banned (Muma, 2014).

Reducing accessibility to alcoholic beverages also includes enacting minimum alcohol purchasing age laws. The most common minimum age for legal purchase of alcoholic beverages is 18 years though it varies from ages 16 to 21 years (Odejide, 2006). In Nigeria, the laws exist but they are poorly enforced. It is observed that alcohol is not only sold in unregistered premises, but hawkers of spirits sell around school premises, motor parks and viewing centres in Nigeria. This has made alcohol readily available to in-school adolescents and youths who can afford to buy them (Durodola, 2009).

There have been several intervention programmes to address the issue of adolescent alcohol use. In the United States of America, the First Lady in the White House, Nancy Reagan, the wife of the President Reagan between 1981 and 1989 advocated for prevention of drug abuse in United States following the trend of drug use (Engs & Fors, 1998). The "Just Say No" campaign aimed at middle school/junior high students attempts to reduce drug use by teaching children to "Just Say No to drugs." The name for Mrs. Reagan’s campaign programme was chosen after she met with school children in Oakland. “A little girl raised her hand,” Mrs. Reagan recalled, “and said, ’Mrs. Reagan, what do you do if somebody offers you drugs?’ And she said, ’Well, you just say no.’ ” The phrase caught on, and was eventually adopted as the name for clubs and school anti-drug programs. By 1988 more than 12,000 “Just Say No” clubs had been formed across the country and around the world (Reagan Foundation).

Reagan recruited the Girl Scouts of American and the Kiwanis Club International to help her promote "Just Say No", and over 2000 billboards were created featuring Nancy Reagan’s image and the slogan. "Just Say No" was popularized in the United Kingdom by the BBC-sponsored "Drugwatch" campaign. In 1985, Nancy Reagan hosted two First Ladies Conferences on Drug Abuse for the wives of world leaders, attended by 18 and later 30 fellow First Ladies. She also became the first U.S. First Lady to address the United Nations,

emphasizing the need for the U.S. to curb demand for drugs while developing nations do their part to curb production and exporting of drugs (Reagan Foundation).

The campaign programme was able to achieve a reduction in drug use (cocaine use prevalence dropped from 6.2 percent in 1986 to 4.3 percent in 1987, the lowest level in a decade; also marijuana prevalence among college students dropped from 10% to about 3%) and the passage of anti-drug abuse bill, the "National Crusade for a Drug Free America", into law in 1986.

However, the abstinence or "Just Say No" model for health education has been used for years, primarily in the areas of sexuality and drug education; it has been shown to have minimal effectiveness. It was a campaign programme done without developed curriculum and it could only help mild drug users and not the chronic and hard users (Engs & Fors, 1998).

Another intervention programme for drug use and abuse targeted at the young population is DARE (Drug Abuse Resistance Education). DARE was developed in 1983 as a joint effort between the Los Angeles County (Calif.) School District and the Los Angeles Police Department. In 1986, the U.S. Congress passed the Drug-Free Schools and Communities Act to promote drug abuse education and prevention programs across the country, and DARE spread rapidly, with many school districts adopting it for their students. By 1994, DARE was the most widely used school-based drug prevention program, showing up in all 50 states in the United States and spreading to six foreign countries (Sahin & Karapazarlioglu, 2014).

DARE was initially designed for elementary school students, specifically fifth and sixth graders. Over the years, it has developed curriculum aimed at middle and high school students. The early focus of the program was to inoculate or strengthen children to resist the temptation of drug experimentation and the pressure of peers who want them to engage in drug use. The secondary goals of the program are to build students' social skills and enhance their self-esteem, as these are believed to be linked to adolescent drug use (West & O'Neal, 2004). The DARE curriculum consists of 17 lessons, one for each week, thought by uniformed police officers (Sahin & Karapazarlioglu, 2014).

In Nigeria, the National Drug Law Enforcement Agency (NDLEA) introduced school-based prevention programmes in 1992. The programme was implemented in schools in the form of clubs averse to alcohol use but engaged in creative leisure activities. The goal of the

programmes was to change adolescent's drinking beliefs, attitudes and behavior, relying mainly on providing information about alcohol use/abuse and its related consequences (Odejide, 2006). However, according to researchers, education strategies have not shown to be very effective except when combined with other evidence-based stragegeis as earlier discussed (Velleman, 2009). As discussed by Odejide (2006), according to Parry (2000), education and persuasion aimed at school-going youths should go beyond knowledge and involve resistant skills training and values clarification and should be targeted broadly at life skills rather than narrowly at alcohol. While reasonable time should be given for the training, parallel initiatives should be established for parents and the broader community. There should be general community development programmes such as upgrading infrastructure (e.g., recreational facilities) to encourage alternative activities to drinking.

Theoretical Framework

Social Learning Theory

Social Learning Theory (SLT) focuses on the learning that occurs within a social context (Albert Bandura, 1977). This theory posits that people learn from one another, via observation, imitation, and modeling. People learn through observing others' behavior, attitudes, and outcomes of those behaviors. Most human behavior is learned observationally through modeling: from observing others, one forms an idea of how new behaviours are performed, and on later occasions this coded information serves as a guide for action. Bandura suggested that the environment also reinforces modeling in different ways. First the observer is reinforced by the model. For example a student who changes his or her dress code to fit in with a certain group of students has a strong likelihood of being accepted and thus reinforced by that group. Secondly, the imitated behavior itself leads to reinforcing consequences. Many behaviors that we learn from others produce satisfying or reinforcing results. For example, a student in a multimedia class could observe how the extra work a classmate does is fun. This student in turn would do the same extra work and also receive enjoyment.

Lastly, consequences of the model's behavior affect the observer's behavior vicariously. This is known as vicarious reinforcement. This is where the model is reinforced for a response and

then the observer shows an increase in that same response. Bandura illustrated this by having students watch a film of a model hitting an inflated clown doll. A group of children saw the model being praised for such action. Without being reinforced, the group of children began to also hit the doll. The incidence of substance use among adolescents is high. It has been suggested that alcohol consumption during adolescence is almost always a social experience and a learned behavior (Ench and Stanley, 2004) and which often times takes place in schools.

According to Albert Bandura, 1977:

"Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behavior is learned observationally through modeling: from observing others one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action."

Relating Bandura's postulation to the subject matter of this study, this theory can help explain why in order to gain information or access to opportunities that a peer group provides and enjoy social and emotional support, an adolescent who was never an alcohol user suddenly starts drinking so as to fit into a group of students who share the same characteristics in terms of age and the same sex. Also, receives enjoyment in drinking after observing how members of his peer group have fun when drinking socially.

Lastly, drinks alcohol because the friends he is imitating are always being motivated for their drinking habits not minding the risk involved. This motivation could be in the form of shouting, hailing and praising or inviting such a person to chair a party. Adolescents observe the drinking motives of their peer group observe the rewarding consequences obtained by their peer group and then model the motives displayed by their peers. For example, those who go out with friends who drink for social motives might also learn to drink for the same motives themselves due to observation and imitation of these peer motives.

It is also important to note that reinforcement and punishment influences the extent to which an individual performs an action. In other words, it influences the rate at which youths drink. This means that an adolescent who is punished in school or at home for drinking alcohol will not stop that action but reduce the frequency at which he drinks. Nigeria is a country where millions of people do not have the usual or socially acceptable amount of money or material

possession where only a few people are comfortable. As a result, adolescents who are inflicted by this crisis who have friends who drink and at the same time are rich, try to learn their behavior. The reason is to gain their approval and also have a portion of these resources from their friends.

The six (6) basic concepts of social learning theory are described below.

- Reciprocal determinism: Social learning theory explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioural and environmental influences. This points to the fact that as the environment largely determines or causes behavior, the individual uses cognitive processes to interpret both the environment and his/her behavior.
- Environment: Social learning theory argues that much of what a person knows or observes comes from environmental resources such as television, parents, peers, the neighbourhood and books. This means that what a person observes powerfully influences what s/he does; also, a person's behavior influences his environment. The environment is made up of factors that are physically external to the person and opportunities for social support. The physical environment includes size of a room, the proximity of alcohol retail outlet to an adolescent's house or school, the proximity of the school or house to a motor park, the ambient temperature or the availability of certain foods.
- Observational Learning: This is the central theme in social learning theory, it is also referred to as vicarious learning. It is a behavioural acquisition that occurs by watching the actions and outcome of others' behavior within the environment. The observer will imitate the model's behavior if the modeled behavior is rewarded, when the model if punished, the observer is less likely to reproduce the same behavior.
- Reinforcement: This can be vicarious when the learner sees the model meeting with a positive outcome for his/her behavior which the observer finds attractive or desirable, such as talent, intelligence, power, good looks, popularity, etc. however, a distinction exists between an observer acquiring a behavior and performing a behavior. Through observation, the observer can acquire the behavior without performing it; but in future

times, if there is an incentive to do so, the observer may then display (perform) the behavior. Bandura classified observational learning into four (4) steps:

- ✓ Attention to the model, thereby observing the behavior
- ✓ Retention of what was observed
- ✓ Reproduction of the behavior observed
- ✓ Reinforcement of the behavior

This process is influenced by characteristics of the model, such as how one likes or identifies with the model, and also by the characteristics of the observer, such as the observer's expectations or level of emotional arousal. Attention and retention account for acquisition of a model's behavior while production and reinforcement controls the performance.

- Self-efficacy: It is a perception of one's own capacity for success in organizing and implementing a pattern of behviour that is new, based largely on experience with similar actions or circumstances encountered or observed in the past. It is the person's confidence in performing a particular behavior. Self-efficacy increases through information, encouragement, modeling and practice.
- Expectations: It is the anticipatory outcome of a behavior, and it consists of the values that a person places on a given outcome. Bandura noted that external or environmental reinforcement was not the only factors that can influence learning and behaviour, he described the intrinsic reinforcement as a form of internal reward, such a pride, satisfaction, and a sense of accomplishment. This emphasis on internal thoughts and cognitions such as perception helps connect learning theories to cognitive development theories.

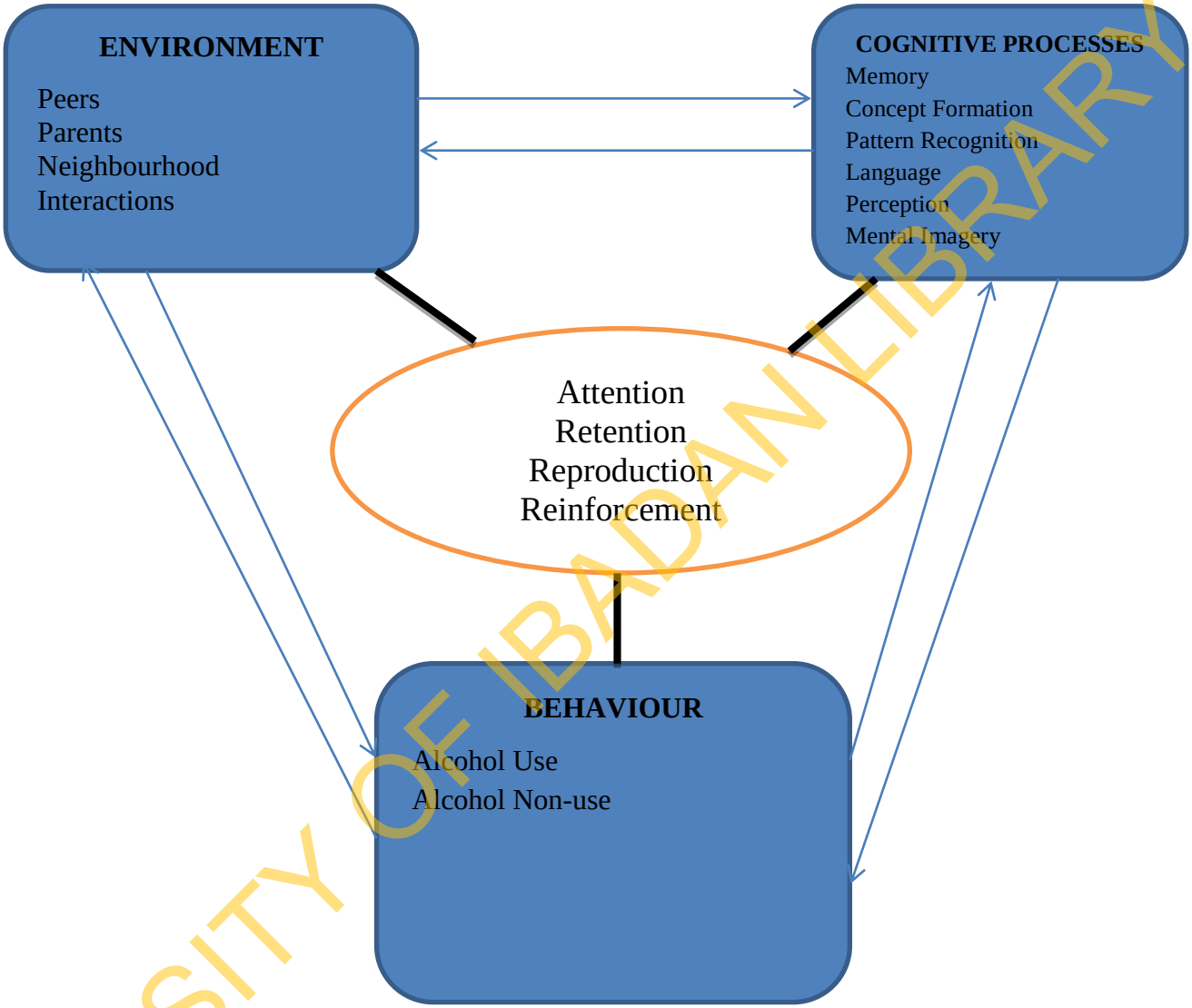
By application, the concept of modeling is accounted for by asking questions on their exposure to alcohol such as parents and relatives, bosses at work, senior apprentices/colleagues, friends in and out of school, neighbours, media advertisements, etc. Questions 29, 30, 35 and 36 on the questionnaire (see appendix 1) address this. These constitute the observational learning sources for the adolescents within the context of alcohol use and pattern of use.

The noted environmental factors which have potential for facilitating alcohol use among the adolescents include the social and commercial environments within the context of availability and accessibility. The social environments refer to the social permissiveness of alcohol availability and use while the commercial environments encompass the alcohol retail outlets to which adolescents are exposed, the mass media facilities, regulations and policies. Questions 38, 39 and 40 assess this issue.

The characteristics of the drinkers which is a significant factor in observational learning is accounted by the objective of describing the profile of the drinkers in terms of age, sex, religion, family type, etc. Section A of the questionnaire accounts for the socio-demographic variables of this study. The internal reinforcement which represents the adolescents' cognitive factors consists of the knowledge of consequences of alcohol and the perception of the adolescents to alcohol use.

The tenets of social learning theory are also used to guide the framing of questions in the in-depth interview (IDI) guide. The IDI discussion guide would help to investigate the perceptive value and expectations associated with 'pelebe' use, probe into the experienced effects of its use and also investigate the link between alcohol use and adolescents' sexual and reproductive health issues.

Figure 2.1 CONCEPTUAL FRAMEWORK: SOCIAL LEARNING THEORY



CHAPTER THREE

METHODOLOGY

Study Design

This study was descriptive cross-sectional survey. It was conducted in Ibadan South-East LGA to investigate the prevalence of emerging practice of the consumption of small sachet liquor among adolescents in Ibadan South-East Local Government Area, Oyo state.

Study Area

This study was carried out in Ibadan South-East local government area. Ibadan South-East LGA is situated in Ibadan metropolis and it was created on 27th August, 1991 following the nationwide broadcast of May 3rd 1989 when the then President and Commander in Chief of the Armed forces, General Ibrahim Babangida announced the creation of additional One Hundred and Fifty-Nine (159) Local Governments all over the Country.

Ibadan South East Local Government is one of the five Local Governments that was carved out of the defunct Ibadan Municipal Government (IMG). The Local Government maintains the Headquarters of the defunct IMG which is historically situated at the centre of Ibadan land on the top of Mapo Hill. It is divided into twelve (12) political wards for easy administration; and its population as at the most recent population census in 2006 was 122,756 (National Population Commission, 2010).

It is bounded in the West by Ibadan South West Local Government, in the East by Ibadan North East Local Government, in the North by Ibadan North Local Government, in the South by Oluyole Local Government. The Local Government covers an area of about 80.537 hectres of land.

This LGA accommodates some of the core slum areas in Ibadan such as Mapo, Eleta, Elekuro, Odinjo, Oke Oluokun, Kobomoje among others. These areas are highly densely populated with inadequate or no access to infrastructure and social amenities like roads, potable water, hospitals, etc. Some of the most prominent monuments in Ibadan, Mapo Hall, are located in the local government area; the palace of the monarch, Olubadan of Ibadan land together with the City Central Mosque and the popular market, ‘Oja Oba.’

Majority of the people that live within the Local Government are traders, artisans and drivers of commercial vehicles. There are markets such as Owode market at Odo-Oba, Ile Titun market, Fowl market at Old Molete part among others. There are many petty traders who sell alcohol and cigarette at motor parks, bus stops, along the streets, the crannies of the communities. Many of the male adults are engaged in businesses like commercial driving, tailoring, welding, trading among others; while the women are involved in trading in markets and streets, tailoring and some are civil servants.

Study Population

The study population consists of adolescents (aged 10 – 19 years) who are students, workers, and apprentices within Ibadan South-East local government area as at September, 2014, the period which the data for this study was obtained.

Sample Size

In a research on correlates of alcohol consumption conducted among adolescents in Ibadan North LGA, 57.5% had ever drank alcohol and 37.2% are current users of alcohol (Adenugba & Ijagbone, 2012).

From this research, the average percentage of alcohol use was derived as follows:

$$\frac{57.5\% + 37.2\%}{2} = 47.4\%$$

Therefore, the mean value is 47.4%

Using Kish and Leslie Formula, the sample size for this study will be:

$$n = \frac{Z^2 pq}{d^2}$$

Where n = sample size

Z = 1.96, (level of significance of 5% (1.96))

P = 47.4% (0.47)

q = 1-p = 1 – 0.47 = 0.53

d = 5% (Difference)

$$n = \frac{1.96^2 x\ 0.47\ (0.53)}{0.05^2}$$

n = 383

However, in making provision for non-response and sifting out the uncompleted and inadequately filled questionnaires, the sample size was increased to 420. Out of the 420 questionnaires, 390 were completely filled and used for this study, making the total sample size for this study 390.

Instrument

A 61-item interviewer-guided structured questionnaire was used for quantitative data collection. The instrument was divided into six (6) sections: sections A, B, C, D, E and F (See Appendix I). Section A consisted of questions for documenting the demographic characteristics and the general profile of Pelebe users; Section B contained questions for determining the level of knowledge of the effects of Pelebe. Section C contained questions addressing the pattern of use of Pelebe among the adolescents while section D focused on the accessibility to Pelebe. Section E contained questions that address the perception of adolescents on Pelebe and section F contained questions that sought to establish the sexual risky behaviours.

In-depth interview (IDI) and questionnaire was used for data collection (See Appendix II). The five (5) In-depth interviews were conducted in the selected four (4) communities in the local government area, probing into the pattern of Pelebe use by the adolescents, their knowledge and perception of Pelebe, the perceived effects of Pelebe and to identify the relationship between alcohol use and sexual risky behaviours.

Sampling Method

Three-stage sampling procedure will be used as stated below:

- Sampling of the Local Government Area: Simple random sampling through the use of ballot was used to select Ibadan South-East Local Government Area (LGA) from the five (5) LGAs in Ibadan metropolis which consist of Ibadan North, Ibadan North-East, Ibadan North-West, Ibadan South-East and Ibadan South-West.

- Sampling of Ward and Communities: One third of the twelve (12) wards were randomly selected in Ibadan South-East LGA, i.e. four (4) wards were selected for the study. The four (4) were selected using simple random sampling through the use of ballot. Simple random sampling was also used to select one area in each ward for the study.

The Table 3.1 shows the classification of areas in Ibadan South-East local government into political ward as adapted by Oyediran & Ogundiran (2013) sourced by Ibadan South-East Local Government, 2012. Using this list of wards and communities, the randomly selected wards and communities are presented in Table 3.2

Table 3.1: List of Wards and Communities

Ward Number	Ward Name	Areas Covered by the Ward
1	Mapo	Oke Dada, Ogunmola, Oleyo, Oja Oba and Oderinlo
2	Oja Oba	Oja'ba Kure, Isale Ijebu, Idi Arere, Omiyale, Ita Koto and Lako
3	Oranyan	Ita Agbaakin, Kobomoje, Oranyan, Kobiowu and Esu Awele.
4	Kobomoje	Kobomoje, Odo Okun, and Ogundepo Area
5	Idi Aro	Labo, Eleta Olukoyi, Ita Ege. Idi Aro and Agbongbon
6	Elekuro	Labo, Elekuro, Asanike, Ayedaade and Modina
7	Orita Aperin	Orita Aperin, Oniyere, Adesola and Tafa Adeoye Area
8	Odinjo	Odinjo, Eleta, Olomi and Oyapidan
9	Kudeti	Oke Ado, Kudeti, Olunloyo, Adelabu Adebiopon and Anirin
10	Oke Oluokun	Oluokun, Oke Ola, Owode, Olomi, Odo Oba and Sanyo
11	Molete	Oke Odo, Molete, Idi Arere, Kudeti, Yejide, Bode, Odo Oba, Elere, Osungbade, Kereru and Sanyo
12	Felele	Felele, Orita Challenge, Olorunsogo, Scout Camp Falana Petrol Station and Adelabu Shopping Complex Area

Source: Ibadan South-East Local Government, 2012.

Table 3.2 – List of Selected Wards and Communities

Ward Number	Ward Name	Areas Covered by the Ward
2	Oja Oba	Idi Arere
4	Kobomoje	Kobomoje
7	Orita Aperin	Orita Aperin
11	Molete	Molete

- Sampling of Respondents: A simple random sampling was used in selecting the street in the community for the administration of the questionnaires. The investigator got to the central location of each selected community, spinned a bottle; and wherever the head of the bottle points to at the end of the spin was the area in the community where research respondents were recruited from. On the selected street or area is combed to recruit one hundred and five (105) adolescents found by proxy, who are willing to participate in the study in each of the four (4) -selected community to make up the total sample size.
- Sampling for the IDI: The four (4) communities used for the quantitative sampling was also used for the qualitative IDI sampling. The IDI was conducted with five (5) adolescents from each community; five (5) males through purposive sampling, thereby selecting identified 'Pelebe' users who were willing to participate in the interview.

Inclusion/Exclusion Criteria

Inclusion

- The study participants were adolescents who were residing or working within the selected communities and were within the age bracket of 10 – 19 years.

Exclusion

- People whose ages are less than 10 years or more than 19 years
- Visitors who are within the age bracket of 10 – 19 years but do not reside or work within the selected communities who are passing-by or on transit.
- Adolescents whose parent/guardian did not give permission to participate in the study.

Method of Data Collection

Approval to conduct this study within the specified Local Government Area was taken from Ministry of Health through the Ethics Review Committee (See Appendix III). This approval from the Ministry was taken to the Local Government Chairman for recommendation to the community heads of the selected communities. With the Local Government Chairman's recommendation for the research, the investigator explained the nature of the research including the issue of voluntary consent and confidentiality to the school authorities and

sought for permission with the community heads to provide required essential support and resources.

Given due official permission to conduct the research, the investigator introduced the purpose of the research to the prospective participants in simple and comprehensible explanations for informed consent. The selection process was also duly explained to the adolescents including the aspect of voluntary participation. After these have been done, the investigator then commenced the selection process, after selection of participants, the participants were then given the written consent forms for them to read again before giving their consent. The consent forms and the questionnaire were made available also in Yoruba language for the adolescents who are out-of-school or any of them who was more comfortable with the Yoruba version. Only the adolescents who gave voluntary and informed consent by signing or thumb printing the consent forms participated in the research.

The questionnaires were interviewer-administered through face-to-face administration, with initial introduction and clarification of possible ambiguity while confidentiality was ascertained. The questionnaires were collected after completion of all items; the filled questionnaires were checked for completeness.

Before the commencement of the in-depth interview, the selected participants were duly informed of the purpose of the research, their voluntary participation and consent; and the confidentiality of information received from them which were strictly for the purpose of the research. A digital voice recorder was used for collecting data and the interviews were timed.

Validity and Reliability

Prior to administration of instruments, the instruments were subjected to standardization procedure of validity and reliability. Validity describes the ability of an instrument to accurately measure the intended construct, while reliability describes the ability of an instrument to consistently elicit similar responses or result from different but similar population of respondents.

The validity and reliability of the instruments were established by conducting a pre-test among 10% of minimum sample size with a draft of the questionnaire in a similar location, Beere, in Ibadan North LGA which has similar characteristics with the study area to determine its consistency and accuracy.

Reliability of the questionnaire was determined by subjecting it to use of Cronbach Alpha statistical test. Cronbach's alpha is a measure of internal consistency, that is, how closely related a set of items are as a group. A reliability coefficient of 0.5 and above is said to be reliable, however, the reliability coefficient of the 59-item scale was 0.63. The instruments were subjected to face validity done by experts in the field of Public Health research.

Some revisions were made based on the results of the analysis of the pre-test. Five (5) items in the socio-demographic section addressing the issue of socio-economic status were removed because they were not accurate indicators and they were viewed as unnecessary; and one (1) item asking for the highest educational qualification was added. Option 'Just once' was added to question 26; also added were option 'Alone' to question 35 and options 'At corners/hidden places' and 'Anywhere' to question 36. Question 41 was revised from 'Does anybody try to stop you from taking Pelebe, who' to 'Has anybody tried to stop you from taking Pelebe? If yes, who?' Question 64 – 'What do you use to prevent pregnancy with your sexual partner? in the pre-test questionnaire was replaced with question 61- 'If yes, why did you use condom?'

Data Management and Analysis

The data collected was checked for completeness and accuracy in the field. Serial number was assigned to each questionnaire for easy identification and for correct data entry and analysis. The data was entered and analysed using SPSS statistical tool Version 20.0.

For the knowledge scale, correct responses to each item were given a point each while wrong responses were given no mark. The total maximum obtainable score was 10 and 0 point was the minimum. The scores were further categorized into poor (0 – 4), fair (5 – 7) and good (8 – 10).

Similarly, for the perception scale, the responses to the 9 attitudinal statements were presented in three-likert scale format; respondents were provided with options of 'Agree', 'Not sure' or 'Disagree' to choose from. Each positive response was awarded three points each, responses of 'Not sure' were given two points each, while responses of 'Disagree' were given one point each. The maximum obtainable score was 27 points and the minimum was 9 points. The perception scores were also categorized into negative perception (9 – 17 points) and positive perception (18 – 27 points)

The IDIs were recorded on digital audio recorder and the recordings were transcribed using first person narratives. The transcribed interview excerpts were analysed using thematic method of content analysis as pertinent quotations that clearly captured the concepts and themes being conveyed in each question were noted and compiled.

Ethical Considerations

Approval for the study was obtained from the Ethical Review Committee of Oyo State Ministry of Health (See Appendix III). The respondents' consent was obtained after provision of adequate, clear and complete information about what the study entails. Permission to carry out the study was also obtained from the heads of the communities.

A written informed consent was obtained, though it did not require the names of the participants but require their signatures and date. They were informed that participation was voluntary and that data collected would be used mainly for research purposes. Anonymity and confidentiality of responses was ensured.

The participating students who are at work were not allowed to miss work while participating in this study; neither were adolescents at home disturbed from performing the duties/chores assigned to them.

It was made clear to the prospective participants that they had the right to decide whether to participate in the study or not. However, any adolescent could also decide to withdraw participation in the study at any time in the course of the study without any loss of benefits.

A strict confidentiality of all information collected from the study participants was maintained by ensuring a restricted accessibility to the data. The data was only handled by the researcher, the supervisor and the data analyst, while these individuals were aware of the utmost confidentiality of the data collected. This was reinforced by non-disclosure of identity of the study participants.

CHAPTER FOUR

RESULTS

The findings from this study are presented in this section, and are organized into the following subsections: socio-demographic characteristics, knowledge about the effects of alcohol, pattern of pelebe use, accessibility to pelebe, perceptions on pelebe and sexual behavior.

Socio-demographic Characteristics

The basic socio-demographic characteristics of the participants are presented in Table 4.1. There were three hundred and ninety (390) respondents who participated in this study with 241 (61.8%) males and 149 (38.2%) females. There were equal number of respondents who fell within the early (10 – 14years) and late adolescence (15 – 19 years), i.e. 195 adolescents were within the age bracket 10 – 14 years and 195 adolescents were also within the age bracket 15 – 19 years. The mean age of the respondents was 14.67±2.60 years with a range of 10 – 19 years. Of the total respondents in this study, 280 (71.8%) were students in schools, 43 (11%) were apprentices while 67 (17.2%) were working. Majority (72.3%) of the respondents practice Islam while 26.7% and 1% practice Christianity and traditional religion respectively.

Table 4.1 – Socio-demographic Characteristics (n=390)

Characteristics	No.	%
Sex		
Males	241	61.8
Females	149	38.2
Age Groups*		
10 – 14 years	195	50.0
15 – 19 years	195	50.0
School/Work Status		
In-school	280	71.8
Apprentice	43	11.0
Working	67	17.2
Highest Educational Qualification		
No qualification	62	15.9
Primary school	165	42.3
Junior secondary school	143	36.7
Senior secondary school	20	5.1
Religion		
Christianity	104	26.7
Islam	282	72.3
Traditional	4	1.0
Family type		
Monogamy	201	51.5
Polygamy	189	48.5
Birth Order		
First born	104	26.7
Middle born	202	51.8
Last born	77	19.7
Only child	7	1.8
People Respondents Live with		
Parents	167	42.8
Grandparents	56	14.4
Single Parent	114	29.2
Relatives	14	3.6
Independent	39	10.0

*Mean age of respondents = 14.67±2.6

Knowledge of Effects of Alcohol

A 10-item scale was used to test for knowledge of the participants on the health effects of alcohol. The questions asked ranged from the immediate consequences of alcohol on health to long term accumulative effects of alcohol on health, causing health defects or deteriorating health conditions; and also on academic and work performance of adolescents. The result shows that there is generally a good knowledge of alcohol effect among the adolescents in the study area as shown in Table 4.2.

Among the 10 questions asked, one of the questions in which a fewer percentage got the question wrong is 'Any alcohol is a drug' where only 57.7% of the respondents agreed that this is true while 42.3% claimed it is false. This is the question that had the highest percentage of wrongs. Another question is 'Alcohol use cannot affect students' performance at school in any way' where 35.9% asserted this to be true while 64.1% asserted it to be false. On the question 'Alcohol use overtime can make people not to remember things easily', only 69.5% of the respondents affirmed it to be true.

The remaining seven (7) questions had more than 70% of the respondents getting it right which indicates a fairly good knowledge as the mean knowledge score was 7.36±1.99. The respondents' total score was categorized into poor (0 – 4), fair (5 – 7) and good (8 – 10) knowledge (See details in figure 4.1).

Table 4.2 – Proportion of Respondents with Correct Knowledge of the Effects of Alcohol

Statements	No.	Percentage
Any alcohol is a drug	225	57.7
Alcohol drink is dangerous to health	311	79.7
It is not possible for alcohol use to lead to the damage of the liver	290	74.4
It is not possible for alcohol use to worsen any health condition	280	71.8
Alcohol use can cause diabetis or even cancer	280	71.8
Alcohol use makes one get so used to drinking that one cannot function normally without taking it	278	71.3
Alcohol use overtime can make people not to remember things easily	271	69.5
Alcohol use cannot affect student's performance at school in any way	250	64.1
Alcohol use can make someone aggressive and violent	338	86.7
Alcohol use can make someone lose control of oneself	347	89.0

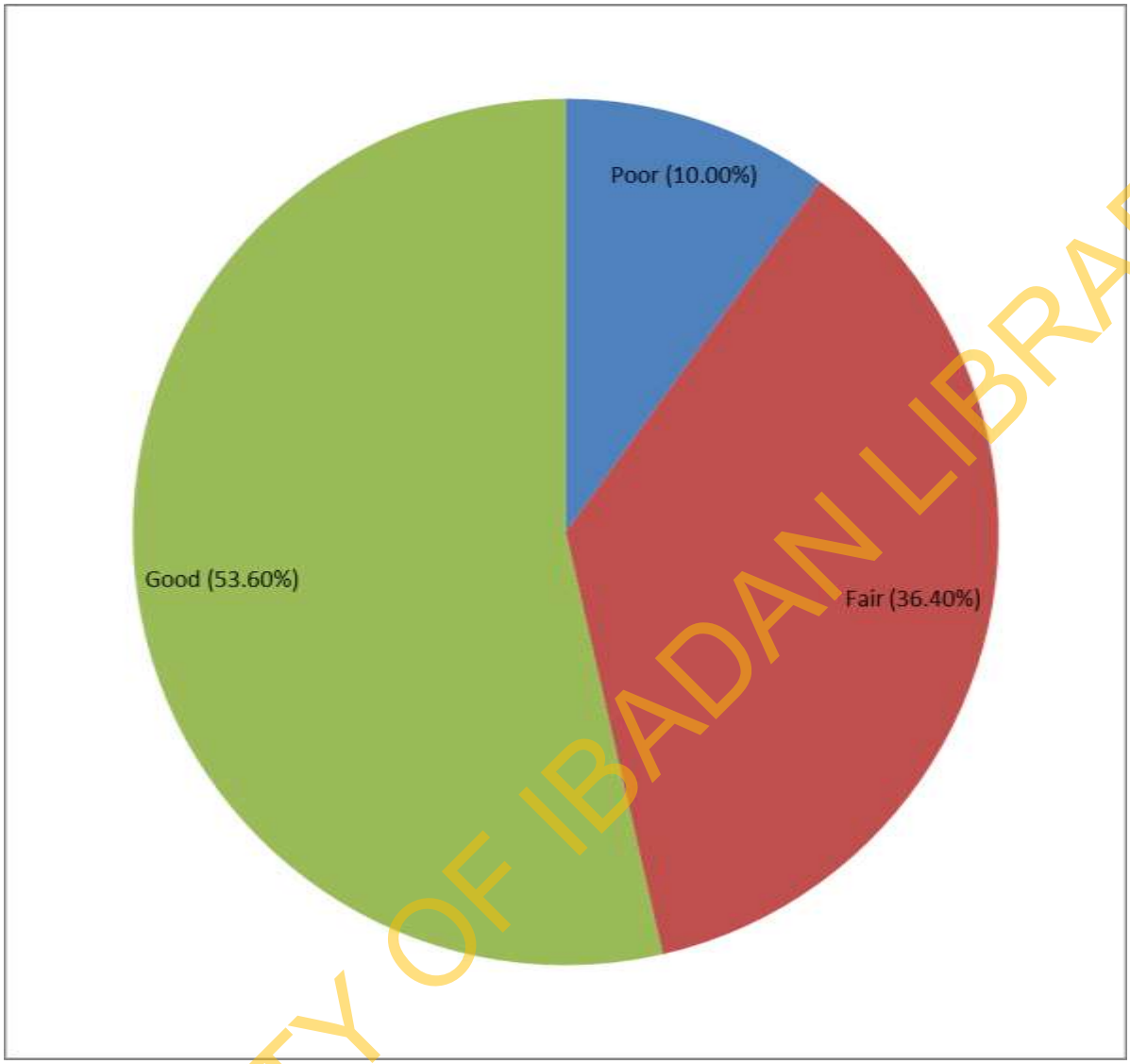


Figure 4.1 – Categorization of Respondents on Knowledge Scores

Knowledge and Socio-demographic Characteristics

This section centres on comparisons of participants' mean knowledge scores on the 10-point scale on health effects of alcohol use was done by sex, age groups, school/work status, highest educational qualification, religion, family type, birth order and guardian.

With regards to the sex of the respondents, as shown in table 4.3, the mean knowledge score for the male respondents was 7.29±2.02 while for female is 7.46±1.96 ($p > 0.05$) with no significant difference. Also, the mean knowledge score for the respondents in the early adolescence (10 – 14 years) was 7.46±1.92 while for respondents in late adolescence (15 – 19 years) was 7.26±2.08 ($p > 0.05$) with no significant difference.

Table 4.3 also shows the comparisons of participants' mean knowledge scores by school/working status which indicates that the respondents in school had the highest mean knowledge score of 7.56±1.90 followed by the apprentice who had 6.98±2.01 and the least is the working class with mean score of 6.78±2.28 ($p < 0.05$) with significant difference between the groups. The table is also indicating that the respondents whose highest educational qualification was primary school leaving certificate had the highest mean knowledge score in the group of 7.61±1.91, followed by those with Junior secondary school with 7.40±2.04, then those with Senior secondary school with 7.15±2.03; and the least are those with no educational qualification who had mean score of 6.66±2.03 ($p < 0.05$)

Using the religion of the respondents to compare their mean score on knowledge of alcohol health effects, table 4.3 shows that the Christians scored highest on the knowledge test with mean score of 7.53±1.97, followed by Muslims with mean knowledge score of 7.31±1.97 and then the traditional religion with 6.25±4.35 ($p > 0.05$) with no significant difference.

The comparisons of the respondents' mean knowledge scores based on their family type in table 4.3 shows a very little difference between participants from monogamous and polygamous families with 7.35±1.99 and 7.37±2.02 respectively at ($p > 0.05$) no significant difference.

With regards to birth order, as shown in Table 4.3, the last borns had the highest mean score of 7.57±2.21, followed by the middle born which had 7.43±2.02, the 1st borns with 7.10±1.81 and then the only child with 6.86±1.35 ($p > 0.05$) of no significant difference.

The table also shows that respondents who live with single parent had the highest mean knowledge score (7.90±1.99), followed by relatives (7.64±1.78), grandparents (7.45±1.82), parents (7.14±1.96) and lastly those who are independent (6.49±2.15) with significant difference ($p < 0.05$).

Table 4.3 – Comparisons of Respondents' Mean Knowledge Scores by Demographic Factors (n=390)

Demographic Factors	No.	$\bar{x}$	f-value or t-value	p-value	level of significance
Sex					
Male	241	7.29±2.02	-0.81	0.42	p>0.05
Female	149	7.46±1.96			
Age group					
10-14	194	7.46±1.92	0.98	0.33	p>0.05
15-19	196	7.26±2.08			
School/Work Status					
In-School	280	7.56±1.90			
Apprentice	43	6.98±2.01	5.11	0.006	p<0.05
Working	67	6.78±2.28			
Highest Educational Qualification					
No Qualification	62	6.66±2.03			
Primary School	165	7.61±1.91	3.56	0.01	p<0.05
Junior Secondary School	143	7.40±2.04			
Senior Secondary School	20	7.15±2.03			
Religion					
Christianity	104	7.53±1.97			
Islam	282	7.31±1.97	1.07	0.345	p>0.05
Traditional	4	6.25±4.35			
Family Type					
Monogamy	201	7.35±1.99	0.003	0.953	p>0.05
Polygamy	189	7.37±2.02			
Birth Order					
First Born	104	7.10±1.81			
Middle Born	202	7.43±2.02	1.12	0.34	p>0.05
Last Born	77	7.57±2.21			
Only Child	7	6.86±1.35			
People Respondents Live With					
Parents	167	7.14±1.96			
Grand parents	56	7.45±1.82			
Single parents	114	7.90±1.99	4.75	0.001	p<0.05
Relatives	14	7.64±1.78			
Independent	39	6.49±2.15			

Findings from IDI

The qualitative aspect of this study sought to investigate the knowledge of the participants on the effects of alcohol and specifically, 'Pelebe'. When the interview participants were asked what they know about the health benefits and usefulness of Pelebe, many of the participants asserted that Pelebe gives strength, increases one's energy level, and is used to fight cold; some said they are used to take drugs and even to mix herbal concoctions for illnesses, used to get sound sleep. A typical expression of one of the participants is articulated in the following comments:

- *You see really, they could use it to take drugs, mix concoction for charm for someone and so using the charm involves taking the Seaman. Others might not know, they will just see him taking the alcohol with some herbs and he won't tell them. Another reason is that most people might have been using with herbal concoction for a long time and they've gotten used to it, when others just see him taking it all the time, they could start imitating him and just start taking it without knowing what that person is using it for or the purpose it serves, and such person will even be taking more than the person being imitated. for me, its usefulness for me is for cold, such that when I'm cold and I take it, I feel better, when I take it, it just excites me and it makes me feel good, you know, since the day I was advised to take it and I consented, I've been enjoying it.*

Some bad effects of pelebe were reported by the respondents. Many of the participants know that alcohol use can make someone aggressive and violent, making someone lose control of oneself especially when the person is drunk. The notable consequences of alcohol as reported by the respondents are sicknesses, poor academic performance, restlessness, violence, injury and accident. Here are the typical statements to portray these:

- *You see, for students, some people who are students, when they take it continuously, they could be dull….. as his brain is getting dull, his sight will be getting blurred such that whatever assignment is given to him, he will be asking his mates what the teacher is saying or doing.*
- *It damages the intestines, it can cause all sort of problems in the body, it causes sickness. For some people, someone who has taken pelebe could just be walking on*

the road and hit a motorcycle or fall into the gutter, or dash his foot against stone and die, those are the causes.(Dire)

- *If you ask that woman over there, when she says I'm too restless, it is the cause*

Perception of Liquors in Small Sachets ('Pelebe')

Table 4.4 shows respondents perception about 'pelebe'. The respondents were presented with nine (9) statements which articulate positive opinions about the use of pelebe to which they were requested to indicate agree, undecided or disagree. Agree had the highest point while disagree had the lowest point, thus, the higher the total score, the more positive a respondent's perception towards the use of pelebe and vice versa.

Using the mean score of 17.96±4.58 to group the respondents into those that have negative and positive perception, Table 4.5 shows that 55% and 45% of the respondents have negative and positive perception respectively of the adolescents' use of pelebe. The statement that had the highest percentage of positive view is 'Pelebe helps one to have some confidence to do or say certain things in the public', where 75.9% of the respondents agree to. The other statement which also had a high percentage of positive view (74.6%) is 'Pelebe makes people bold enough to do certain things they would not have been able to do.' However, the statement with the highest percentage of negative view which was collectively refuted by 73.3% of the respondents is 'Any adolescent who does not drink pelebe will not become a strong man.' Another statement with 69% of the respondents disagreeing to it is 'Pelebe clears one's eyes,' while the statement that elicited the highest percentage of undecided (23.6%) from the respondents is 'Pelebe makes sex fun' (see Table 4.4 for details)

Table 4.4 Proportion of Respondents with Negative and Positive Perception on 'Pelebe'

S/N	Indicators	Negative		Positive	
		N	%	N	%
45	Pelebe is fun, it makes people feel good or happy	128	32.8	228	58.5
46	Pelebe makes people bold enough to do certain things they would not have been able to do	81	20.8	291	74.6
47	Pelebe helps one to have some confidence to do or say certain things in the public	81	20.8	296	75.9
48	Pelebe is good for celebration	211	54.1	167	42.8
49	Pelebe is necessary after a day's hard work	228	58.5	135	34.6
50	Pelebe strengthens a young person	200	51.3	151	38.7
51	Any adolescent who does not drink Pelebe will not become a strong man	286	73.3	72	18.5
52	Pelebe clears one's eyes	269	69	102	26.2
53	Pelebe makes sex fun	135	34.6	163	41.8

Table 4.5- Categorization of Respondents' perception of 'Pelebe' Using the Mean Perception Score

	N	%
Negative Perception	212	54.4
Positive perception	178	45.6
Total	**390**	**100.0**

Comparisons of respondents' mean perception scores were made by the socio-demographic variables. The comparison by sex showed that the male respondents had a significantly higher mean perception score than the females as presented in Table 4.6. In the same vein, the older respondents in the late adolescence group had significantly higher perception score than those in the early adolescence.

The comparisons made by school/work status in Table 4.6 also identified the respondents in the working class to have a higher perception of pelebe which translates into a more positive perception of use of pelebe than those in school or even the apprentice. The table also identifies the respondents with the highest educational qualification of Senior Secondary Certificate to hold the highest mean perception score which indicates a positive perception of the use of pelebe.

Furthermore, the comparisons made in Table 4.6 by religion and family type shows that there is no significant difference between the perception scores of the respondents by their religion and family type; that is, whether they were Christian or Muslim was not significantly linked with their perception of the use of pelebe. Similarly, the family type of either monogamy or polygamy had nothing to do with the perception of the respondents.

Moreover, the birth order of the respondents had no significant relationship with their perception of use of pelebe as presented in Table 4.6. Conversely, as presented in the same table, the respondents' guardians had a very significant relationship with their perception of the use of pelebe as those who are independent, that is, respondents who stay alone without guardians had the highest positive perception of pelebe use compared to others. This is closely followed by respondents who stay with relatives and then those with grandparents (see details in Table 4.6).

However, relating the perception of the respondents about the use of pelebe with their knowledge on its health effects, the higher the knowledge of the respondents on the health effects of alcohol, the more negative their perception of pelebe ($r = -0.227$; $p < 0.001$) (see Table 4.7).

Table 4.6 – Comparison of Respondents' Mean Perception Scores by Demographic Factors (n=390) $\underline{x}$

Demo	N		f-value or t-value	p-value	level of significance
Sex					
Male	241	18.45	2.70	0.007	p<0.05
Female	149	17.17			
Age group					
10-14	194	16.76	-5.33	0.000	p<0.05
15-19	196	19.15			
School/Work Status					
In-School	280	17.05			
Apprentice	43	19.79	22.07	0.000	p<0.001
Working	67	20.58			
Highest Educational Qualification					
No Qlf	62	17.13			
Pry Sch	165	17.53			
JSS	143	18.43	4.24	0.006	p<0.05
SSS	20	20.75			
Religion					
Christianity	104	18.02			
Islam	282	17.87	1.24	0.291	p>0.05
Traditional	4	21.50			
Family Type					
Monogamy	201	17.48	4.52	0.34	p>0.05
Polygamy	189	18.48			
Birth Order					
First Born	104	17.99			
Middle Born	202	18.10	0.33	0.804	p>0.05
Last Born	77	17.51			
Only Child	7	18.29			
People Respondents Live With					
Parents	167	17.60			
Grand parents	56	17.91			
Single parents	114	17.32	6.62	0.000	p<0.001
Relatives	14	18.07			
Independent	39	21.38			

Table 4.7 – Correlation between Perception of Pelebe and Knowledge of Effect of Alcohol

	Perception	Knowledge
Perception	1	-0.227
Sig 2-tailed		0.000
Knowledge	-0.227	1
Sig 2-tailed	0.000	

Findings from IDI

In the qualitative study, one of the issues discussed in the in-depth interview is the perception of the respondents on the use of Pelebe. Majority of the respondents believe that individual differences in body make-up act as an interplay in the response to alcohol; then they went further to stress the fact that pelebe makes people bold and aggressive enough to fight, gives strength, disagreed to the fact that pelebe clears one's eyes. In the view of the respondents, moderate use of alcohol is good for adolescents; it is excess use of alcohol that poses dangers and threats to the well-being of young people. Below are some of the statements made by the respondents:

- *Individuals differ in body capacity, some people's body can tolerate…., It is too much drinking that is dangerous,*

However, one of the respondents was of the opinion that bottled spirit is more concentrated and toxic than the sachet spirit even though both products are from the same manufacturer. He said:

- *The bottled dry gin intoxicates faster that the sachet one, it is the same content but the bottle dry gin intoxicates faster than the sachet…. they differ in strength, their works are different, it is just like say you want to buy big coke and small coke, the sugar contents/quality are different too. Pelebe does not really intoxicate, it is only when too much is taken that one can be drunk. One would take like 10 sachets before one can be drunk, whereas the bottle sold for N150 can intoxicate and make one drunk; this is why adolescents like the sachets*

One other respondent disagrees with the claim that Pelebe is used as/for medicine, and said:

- *My own view is that it is not possible to use pelebe as a medicine to cure fever*

A few respondents agreed that pelebe makes sex fun because it improves sexual performance. Some explained the way they use spirit in sexual intercourse and how it works for them. A little elaboration was made on the danger of inappropriate use of condom under the influence of Pelebe. The comments of the respondents are:

- *Some people consume it to strengthen them during sexual intercourse. I have a neighbor who sends me to get for him whenever he wants to have sex with his girlfriend; they sometimes call it 'Mokole' (something for sustaining erection)*

Pattern of Use of Liquors in Small Sachets ('Pelebe')

The pattern of 'Pelebe' use as described in this study was introduced by the identification of users of alcohol. As presented in Table 4.8, half (195) of the respondents had ever consumed alcohol while the remaining half who had never taken any alcoholic drink skipped the other questions in this section. Out of the 195 respondents who have ever taken alcohol, 84.1% (164) are current users of alcohol and 15.9% (31) are not current users. Also of the 195 respondents that have ever taken alcohol, 175 (89.7%) have ever taken 'Pelebe' and out of the 175 that has ever consumed 'Pelebe', 154 (88%) are current users.

The prevalence of 'Pelebe' use varies across the sex of the respondents as shown in Figure 4.1. However, the overall prevalence of current users of 'Pelebe' was 39.5%. According to the result of this study, the mean age of onset of alcohol was 12years (12.16±3.03) as the ages at first alcohol ranged from 5 to 19 years. By age, 47.2% of the late adolescence (15 – 19 years) respondents were current users while 31.8% of early adolescents (10-14) were current users of 'Pelebe' (see details in Table 4.9); and figure 4.2 shows the prevalence by sex. Comparing current users by school/work status, majority 32.5% (91) of the the In-school respondents were current users of 'Pelebe', 53.5% (23) of the Apprentice respondents were users of 'Pelebe' and 59.7% (40) of the Working respondents were users (see details in Table 4.9).

The mean age of first use of alcohol by males and females were 12.41 ± 2.87 and 11.50 ± 3.38 years respectively ($p > 0.05$) (Table 4.10).

Table 4.8 – Pattern of Alcohol Use by Sex Using Chi-Square

	Male (n-241)	Female (n-149)	Total	P
Ever use of alcohol	143 (59.3%)	52 (34.9)%	195	<0.0001
Current use of alcohol	122 (50.6)%	42 (28.2%)	164	> 0.005
Ever use of 'Pelebe'	127 (52.7%)	48 (32.2%)	175	> 0.005
Current use of 'Pelebe'	114 (47.3%)	40 (26.9%)	154	> 0.005

Table 4.9 – Current Use of 'Pelebe' by Sex, Age Group and School/Work Status (n=390)

	Use of 'Pelebe'		Total
	YES	**NO**	
Sex			
Male	114	127	**241**
	(47.3%)	(52.7%)	
Female	40	109	**149**
	(26.8%)	(73.2%)	
Age Group			
10-14	62	133	**195**
	(31.8%)	(68.2%)	
15-19	92	103	**195**
	(47.2%)	(52.8%)	
School/Work Status			
In-School	91	189	**280**
	(32.5%)	(67.5%)	
Apprentice	23	20	**43**
	(53.5%)	(46.5%)	
Working	40	27	**67**
	(59.7%)	(40.3%)	

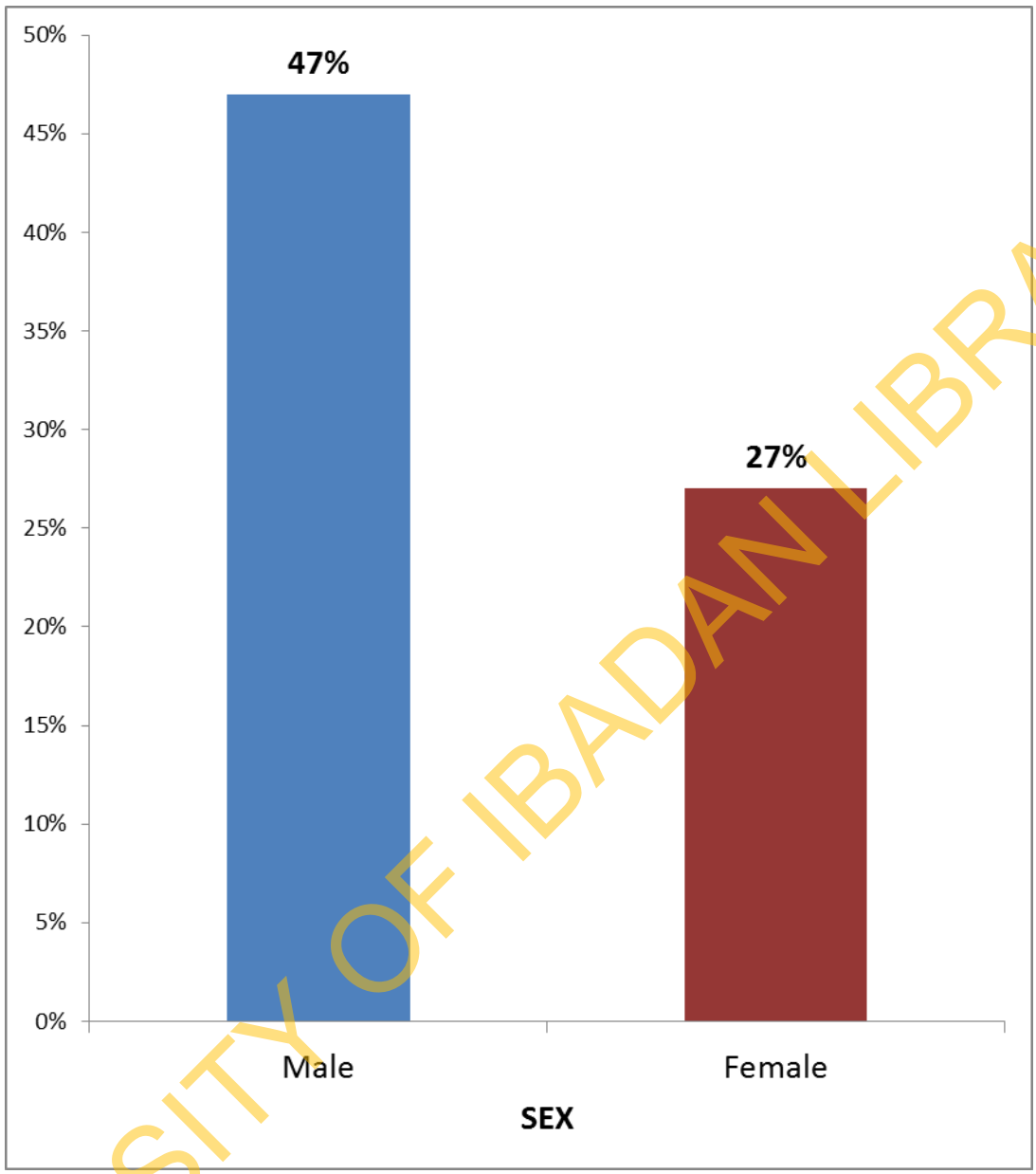


Figure 4.2: Prevalence of 'Pelebe' use by sex

Table 4.10 – Comparison of mean age at first use of alcohol among respondents by sex

Sex	No	Mean Age	Std. Deviation	df	t-value	p-value
Male	143	12.41	2.87			
Female	52	11.50	3.38	193	1.86	0.065

Table 4.11 shows the respondents who have ever used alcohol according to their guardian status at Chi-square value of 33.92 ($p < 0.001$). Out of 167 respondents who live with their parents, about 37% (62) are ever users of alcohol, half of those who stay with grandparents are ever users of alcohol, those who live with single parent report 60%. For those who live with relatives and those who live independently, ever users of alcohol are 42.9% and 79% respectively. Respondents who live alone with no guardian have the highest proportion of ever users of alcohol which is followed by those who live with single parent.

However, about 71% and 89% of the wards of parents and grandparents who have ever taken alcohol respectively are current users of 'Pelebe', 81% of the wards of single parent, 66.7% of those who live with relatives, while about 93% of adolescents who are independent are ever user of alcohol (Table 4.12).

Table 4.11 – Ever use of alcohol by people respondent lived with

	Ever Use of Alcohol		Total
	Yes	**No**	
People Respondents Live with			
Parents	62	105	**167**
	(37.1%)	(62.9%)	
Grand Parents	28	28	**56**
	(50.0%)	(50.0%)	
Single Parent	68	46	**114**
	(59.7%)	(40.3%)	
Relatives	6	8	**14**
	(42.9%)	(57.1%)	
Independent	31	8	**39**
	(79.5%)	(20.5%)	
Total	**195**	**195**	**390**

Table 4.12 – Current Users of Alcohol by People Respondents Stay with

	Current Use of Alcohol		
	YES	**NO**	**Total**
People Respondents Live with			
Parents	44	18	**62**
	(71.0%)	(29.0%)	
Grandparents	25	3	**28**
	(89.3%)	(10.7%)	
Single Parent	55	13	**68**
	(80.9%)	(19.1%)	
Relatives	4	2	**6**
	(66.7%)	(33.3%)	
Independent	29	2	**31**
	(93.5%)	(6.5%)	
Total	**164**	**31**	**195**

When the respondents were asked for their most preferred brand of 'Pelebe', 61 (34.7 %) reported Seaman Schnapps, 56 (32.4%) reported Regal dry gin, 17 (9.7%) for Chelsea and 17 (9.7%) for Sarbina. The other drinks reported at low frequencies are Blackwood, Strong Bull, Best, Alomo, Calypso, and Eagle, which made up 24 (13.6%) (Table 4.13, and see the picture of some of the common brands of liquors in small sachets in Appendix IV). However, the respondents gave different reasons for their choice of brand which varied from no reasons, efficacy, taste, public ideology to addiction. The reasons classified under efficacy are related to the perceived worth, value, ability, usefulness or effectiveness of the brand as compared with other brands. Respondents who attributed their preference to taste claim that their preferred brand is pure and natural, soft in the mouth, creamy and some just likes the taste. The public ideology describes the choice of brands as a result of what people belief or say about the brand, such as it is old, people say it is the best, it is herbal, etc., while reason labeled as addiction is the claim of 'just being used to this band'.

Table 4.13 also shows brand preference of the respondents by sex. It shows that almost equal number of males take Regal and Seaman while more females take Seaman than Regal. Also, a lot more males than females take Chelsea while more females take Sarbina than males. Figure 4.3 shows some of the brands of liquors in small sachets found in the communities.

Table 4.14 shows that 33.1% of the respondents were initiated into drinking by their friends, followed by parents (31.3%) and then the respondents themselves (18.4%).

Table 4.13 – Brand Preference of alcohol sachet by Sex

Brand	**Sex**		**Total**
	Male	Female	
Seaman	43	18	61
Regal	42	14	56
Others	18	6	24
Chelsea	16	1	17
Sarbina	8	9	17
Total	**127**	**48**	**175**

Figure 4.3 – Brands of Liquors in Small Sachets

Table 4.14 – Initiators of adolescents into drinking

Initiators to alcohol	N	%
Self	30	18.4
Parent	51	31.3
Friends	54	33.1
Sibling	10	6.1
Neighbour	11	6.7
Boss	7	4.3
Total	**163**	**100**

Frequency of 'Pelebe' Use

By sex, the highest percentage of male respondents takes 'Pelebe' everyday (34.4%) while the highest percentage of female respondents take 'Pelebe' once a week (34.8%) with Chi-square value of 10.42 ($p < 0.05$) (Table 4.15).

By age, respondents in early adolescence reported the highest frequency of once a week (32.4%) while those in late adolescence was highest on everyday frequency of use (38%) with chi-square value of 11.88 ($p < 0.05$).

By school/work status, respondents who are working take 'Pelebe' more frequently than any other category. A good majority (71%) of working respondents take 'Pelebe' every day, while for those who are in-school, 31% take 'Pelebe' once a week, 24% rarely, 18% twice a week and 14% every day. For the apprentice, 33% take every day, while 25% take once a week and another 25% take twice a week (Chi-square value of 50.21, $p < 0.001$).

Comparing the mean knowledge scores of respondents by the frequency of 'Pelebe' use in Table 4.16, the respondents who have taken 'Pelebe' just once have the highest mean score on knowledge (7.79±1.85), while the respondents who take 'Pelebe' everyday have the lowest mean score on knowledge (6.11±2.43) with f-value of 3.29 ($p < 0.05$). This indicates that the higher the respondents' knowledge of health effects of alcohol, the less frequent they take 'Pelebe'.

Table 4.15 – Frequency of Use by Sex, Use and School/Working Status (n = 171)

Frequency of Use	Everyday	Once a week	Rarely	Twice a week	Just once	Total
Sex						
Male	43 (34.4%)	27 (21.6%)	23 (18.4%)	25 (20%)	7 (5.6%)	**125**
Female	10 (21.7%)	16 (34.8%)	9 (19.6%)	4 (8.7%)	7 (15.2%)	**46**
Age Group						
10-14	15 (21.1%)	23 (32.4%)	12 (16.9%)	11 (15.5%)	10 (14.1%)	**71**
15-19	38 (38.0%)	20 (20.0%)	20 (20.0%)	18 (18.0%)	4 (4.0%)	**100**
School/Work Status						
In School	15 (14.3%)	33 (31.4%)	25 (23.8%)	19 (18.1%)	13 (12.4%)	**105**
Apprentice	8 (33.3%)	6 (25.0%)	4 (16.7%)	6 (25.0%)	0 (0.0%)	**24**
Working	30 (71.4%)	4 (9.5%)	3 (7.1%)	4 (9.5%)	1 (2.4%)	**42**
Total	**53**	**43**	**32**	**29**	**14**	**171**

Table 4.16 – Comparison of mean knowledge scores among respondents by frequency of 'Pelebe' Use by Current Users

Frequency of 'Pelebe' Use	N	Mean Knowledge score	Std. Deviation	df	f-value	p-value
Just once	14	7.79	1.85			
Rarely	32	7.59	1.83	4		
Once a week	43	7.26	2.13			
Twice a week	29	6.97	2.42	166	3.29	0.013
Everyday	53	6.11	2.43			
Total	**171**	**6.96**	**2.27**	**170**		

Table 4.17 shows the quantity of sachets of 'Pelebe' recently consumed by respondents. It is indicated in this study that majority of the respondents (60.7%) consumed one (1) sachet of liquor per time or as at the last time of consumption, while the highest number of sachets taken was fifteen (15). The mean quantity of sachets last consumed was 2.66±2.9.

Comparing the quantity of 'Pelebe' consumed among respondents by sex, age and school/work status in Table 4.18, the findings show that males take more than the females. The mean quantity taken by male was 2.97±3.10 while the females take 1.79±1.76 with t-value of 2.34 ($p < 0.05$).

Also by comparison of the mean quantity of 'Pelebe' last consumed by the respondents by age, respondents in late adolescence consumed more than those in early adolescence, 1.75±1.70 for early and 3.32±3.32 for late adolescence at t-value of 3.57 ($p < 0.001$).

Comparing the mean quantity of 'Pelebe' consumed by the respondents by school/work status, the working class of the respondents consumed most of the three categories. The mean quantity consumed by in-school respondents was 1.54±1.33, apprentice was 2.75±2.11 and the working class was 5.29±4.0 with a significance difference between the mean with f-value of 35.43 ($p < 0.001$).

Table 4.17 – Quantity of 'Pelebe' Last Consumed

	Frequency	%
1	99	60.7
2	16	9.8
3	11	6.7
4	4	2.5
5	7	4.3
6	6	3.7
7	4	2.5
8	8	4.9
10	4	2.5
12	3	1.8
15	1	0.6
Total	**163**	**100**

Table 4.18 – Comparison of mean quantity of 'Pelebe' consumed among respondents by sex, age and school/work status

	N	Mean Quantity	Std. Deviation	df	t-value	p-value
Sex						
Male	121	2.97	3.10	161	2.34	0.021
Female	42	1.79	1.76			
Age Groups						
11-14	68	1.75	1.70	161	-3.57	0.000
15-19	95	3.32	3.32			
School/Work Status						
In-school	98	1.54	1.33	2	35.43	0.000
Apprentice	24	2.75	2.19			
Working	41	5.29	3.99	160		

Table 4.19 shows that about 42% (67) of the respondents who take alcohol have parents who also take alcohol, out of which 54 (80.6%) are fathers. However, Table 4.20 reveals that, of all the respondents whose parents initiated into drinking, 64% of the respondents have parents who drink alcohol at Chi-square value of 18.25 ($p < 0.05$).

Table 4.19 – Parental Alcohol Use

	YES	NO	TOTAL
Parents' use of alcohol	**67 (41.6%)**	**94 (58.4%)**	**161**
Parents who use alcohol			
Father	**54 (33.5%)**	**107 (66.4%)**	**161**
Mother	**6 (3.7%)**	**153 (96.3%)**	**161**
Both parents	**7 (4.3%)**	**154 (95.6%)**	**161**
Respondent buys alcohol for parent	**43 (64.2%)**	**24 (35.8%)**	**67**

Table 4.20 – Initiators of Alcohol of respondents by Parental Alcohol Use

	Alcohol Use of Parents		
Initiators of Alcohol	**YES**	**NO**	**Total**
Self	9(31%)	20(69%)	29
Parents	32(64%)	18(36%)	50
Friends	20(37%)	34(63%)	54
Siblings	3(33%)	6(67%)	9
Neighbor	3(27%)	8(73%)	11
Boss	0	7(100%)	7
Total	**67**	**93**	**160**

Figure 4.4 shows the time of the day when 'Pelebe' is usually taken which reveals that about 51 (32%) of those who responded to this question take 'Pelebe' anytime of the day while another 27% take it in the evening.

According to Table 4.21, majority (57.6%) of the respondents drink 'Pelebe' with their friends/peers while 25.9% drink 'Pelebe' alone. Table 4.22 shows that 43.7% of the respondents drink 'Pelebe' at home while 13.9% drink in corners/hidden places. Table 4.23 reveals the reasons why the respondents take 'Pelebe'. 28.3% of the respondents claim to take 'Pelebe' for health-related benefits, 27% take it for recreation, 17.6% take it to improve their performance, 13.8% take it in emulation of those who drink alcohol, 11.9% take it for no known reason while 1.3% takes it for religious rites.

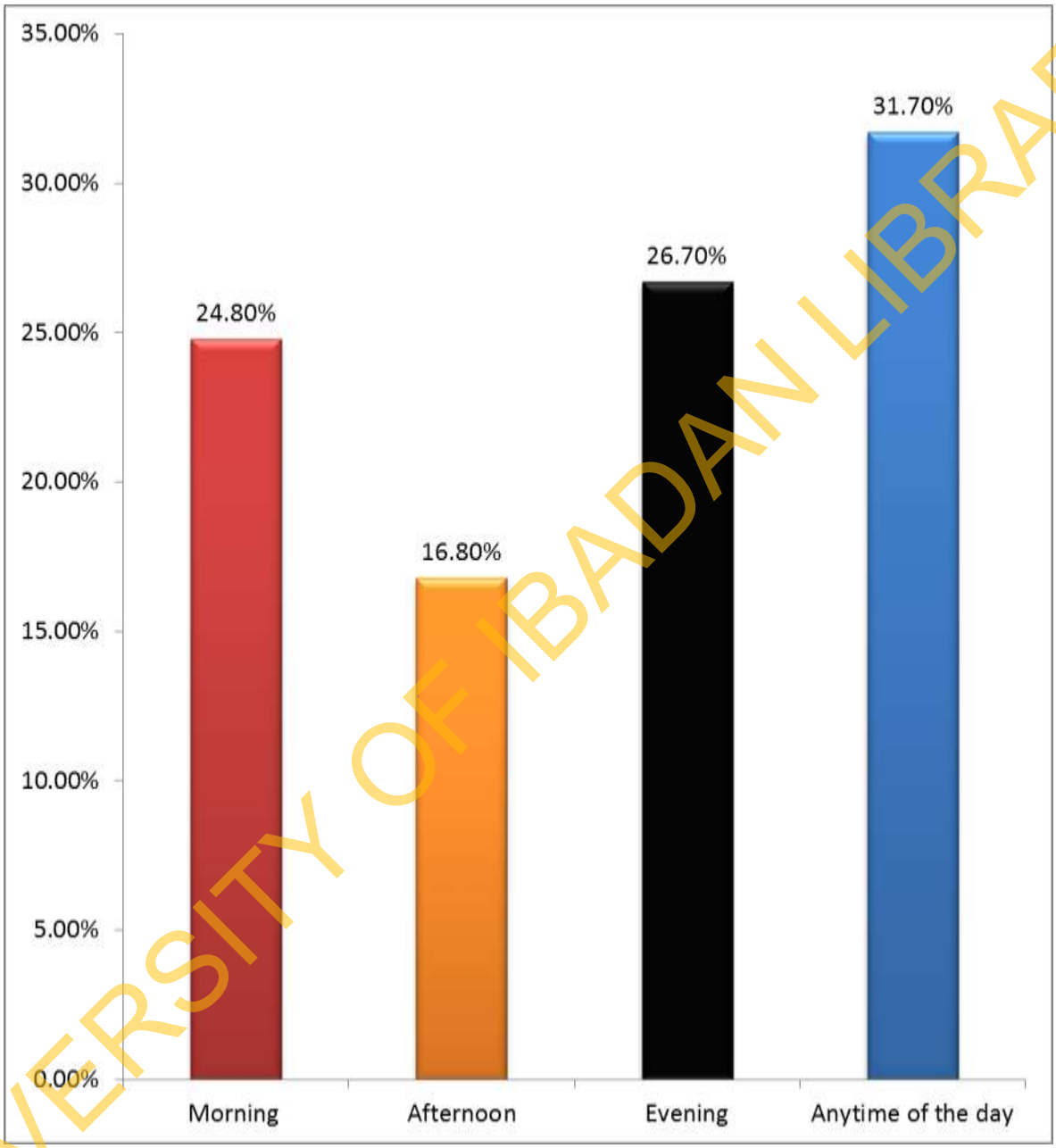


Figure 4.4: Time of the day when 'Pelebe' is taken

Table 4.21 – Respondents' drinking partners

	N	%
Parents	12	7.6
Friends	91	57.6
Siblings	8	5.1
Senior in school/work	1	0.6
Boss	1	0.6
Neighbours	4	2.5
Alone	41	25.9
Total	**158**	**100**

Table 4.22 – Places where respondents drink

Place of drinking	N	%
At home	69	43.7
In school/work	3	1.9
At bars/joints	20	12.7
At parties	7	4.4
In friend's house	6	3.8
On the street	12	7.6
At corners/hidden places	22	13.9
Anywhere	19	12.0
Total	**158**	**100**

Table 4.23 – Reasons for taking 'Pelebe'

	Frequency	**%**
Perceived Health Benefits	45	28.3
Recreation	43	27.0
Improved performance	28	17.6
Emulation	22	13.8
No reason	19	11.9
Religious rites	2	1.3
Total	**159**	**100**

Predictors of 'Pelebe' Use

The result as presented in Table 4.24 shows that perception is the only determinant of 'Pelebe' use among the study population. The higher the perception of the respondents, the more likely they are to use ''Pelebe'.'

Table 4.24 – Logistic Regression Model of 'Pelebe' Use by Sex, Age, Parental Alcohol, Knowledge and Perception

Explanatory Variables	B	df	CI	P
Sex Female Male (RC)	0.11	1	0.20 – 6.14	0.897
Age Groups 15 – 19 10 – 14 (RC)	- 0.97	1	0.07 – 2.18	0.277
Parental Alcohol Use YES NO (RC)	2.24	1	0.99 – 88.06	0.051
Knowledge	0.07	1	0.58 – 1.48	0.755
Perception	0.23	1	0.79 – 0.98	0.028

Findings from IDI

This study also sought to understand the pattern of 'Pelebe' use among the interview participants. Questions were asked as regards the prevalence of 'Pelebe' use among adolescents, how they started taking it, where they usually take it, if they have ever been drunk and why adolescents take 'Pelebe'. The participants were of the opinion that ''Pelebe'' is a very common phenomenon among adolescents and many more males take 'Pelebe' than females and some of them were first given by their father. It was reported by many of these participants that 'Pelebe' is being sold close to their school and that students take 'Pelebe' in school, one even claim to take it in class. Likewise, some teachers were reported to be taking 'Pelebe' in school.

- *Well, the little time I've spent in Ibadan here, I know people drink 'Pelebe' a lot, like Seaman, Sabrina, Regal, etc. They are even much that I myself can't name everything, even my biological father do drink it, that I even tell myself that this 'Pelebe' of a thing is getting too much. Like now, I know somebody in my house that can finish two cartons of dry gin on a spot.*

The following are some of the expressions of the participants that describes the prevalence of 'Pelebe' use among adolescents when asked the question 'how common is the use of 'Pelebe' among adolescents around you':

- *Consumption of 'Pelebe' is high here, as they consume it at parties, there is no place in Ibadan which you wouldn't find 'Pelebe'. It is very rampant and highly consumed by people; about 9 of 10 adolescents consume 'Pelebe' in this area. The males consume 'Pelebe' more than the females do, some females consume much too, but not as much as the males.*

From the responses of the interview, there appeared to be a corroboration of the point expressed in the quantitative study on the most preferred brand, as majority of the respondents in the interview reiterated that Seaman and Regal are very common. Some of the participants were first given by their father to take medication or even taste. Here are some of the participants' expressions:

- *Well, …… but I love Seaman and Regal.*

- *I was 9 years old then, I don't take it before, but when my dad sent me to buy it for him, he then gave me a little of it, then I slept off. I woke up feeling tipsy and my sight was blurred. The next time I took it, I was with my dad, and he asked me if I would take alcohol and I told him yes, then he sent me to buy two. He took one and I took one*

Something was noteworthy in the discussions of some participants; this is the role their teachers played in making statements about alcohol. Some of the participants claim that the teachers who are to be the watchmen against alcohol use in school are also found taking alcohol; this provides cover for the drinking students. Here are the explanations:

- *About school ehn, one Uncle taught me English, there is another one for Yoruba, When I'm coming in the morning, they give me money to buy for them. And when he is teaching us, he puts them on the table and start taking it. One day, I asked that Uncle that, 'this Seaman you send me to buy for you, what are the benefits of these drinks?' he now said when he finishes his class, he takes it, he won't feel hunger pangs…. Sometimes, when he wants to give us classwork, he will first take Seaman or Regal, when he finishes writing on the board and he turns to face us, he would have been covered with sweat, ...Then I used to say I won't take Seaman, but eventually, I now take it, I even still took it yesterday.*
- *Very well, they take it, students who go to the bush take it a lot, and even some teachers take it secretly so that students will not know. Like my teacher now, he takes it, he takes it, only if caught with it by students, however, not all students see it with him or know that he takes it.*

Some of the participants gave reasons for taking 'Pelebe', majority of the views of the participants pointed to peer influence while one other opinion attributes drinking to getting intoxicated for violence and to catch fun. Below are some of the expressions of the participants:

- *For some people, seeing me holding it like this and I invite them to taste it, if he tastes it and sees that this thing is okay, they too will go and buy because they know that taking a little from me is not like having their own. That is why some people take it.*

- *Some take it to get intoxicated and drunk, some for violence and it affects them while we take it for enjoyment.*

As discussed in the in-depth interview, some of the participants provided insight into the places adolescents drink 'Pelebe'. The notable places reported by the participants are bushy areas in schools, 'drinking and smoking joints'; however, very few participants claim to take 'Pelebe' in the classroom because of the cover of a drinking teacher and home. Here are the expressions of the participants:

- *You see, me, I can take mine in class because I have a backup, our Uncle, who takes it such that he won't be able to perceive the smell, he will think he himself was the one that opened it, I take mine in class. But my friends, when they go for break, that's when they take it. But for me, I don't hide it, it is in class I take it, because nobody will chastise me.*
- *It is taken at joints, if we go over to that school now, they are many, those who smoke weed, those who drink rubbish, such and such are many there……*
- *Yes, they take it in school during break, they don't go outside the school o, it is still within the school. They go to hidden places or bush, they don't take it in class.*

A very few participants affirmed that there are light contests on 'Pelebe' drinking among adolescents which come in form of daring and bets. Here are some comments in that regard:

- *Yes, we experienced that before, some set of people were about to consume alcohols and they place a curse on themselves that anyone who doesn't take out of it would suffer the curse.*
- *Yes, there is; maybe at parties, they compete. If they are adults, they can give out cars or money like in club house. For the young people, it is more of betting, like drinking the spirits in bottles. We contribute money among friends, put the money together, and buy the drinks and gifts. If you lose your money today, all you need to do is to brace up for another time so you can win. We do this anytime we like, when we have money.*

Accessibility to 'Pelebe'

The various means by which the respondents get 'Pelebe' was examined, and a large majority (88%) claim to buy 'Pelebe'. Some get it from friends, home while only one respondent claim to get it from work (see Table 4.25 for details).

However, figure 4.5 shows the documentation of the places/spots where the respondents buy 'Pelebe', for those who buy. The table shows that about 45% of the respondents bought the last 'Pelebe' in retail shops, followed by 26.6% buying from the liquor (or local herb sellers) called '*Oniparaga'*

In the investigation of the source of money used in purchasing 'Pelebe', 41.3% of the respondents purported that the money used to buy 'Pelebe' is from their income and 39.2% claim it is from their pocket money, while the remaining report that it is from money given as gifts (Table 4.26). In buttressing this viewpoint, the money source for 'Pelebe' was observed in relation to the respondents' school/work status as presented in Table 4.27. With a Chi-square value of 36.18 ($p < 0.001$), the finding shows that 45% of in-school respondents take from their pocket money to buy 'Pelebe' while 32% of them use money given to them as gift to purchase the drink. However, some of the in-school respondents also make some money from hawking and sales made for their parents/guardians. Whereas, for the respondents in the working class, 75% of them buy 'Pelebe' from their income, while those who are apprentices have equal proportion of pocket money and income.

Table 4.28 describes the possible restraints to respondents' access to 'Pelebe'. The respondents were probed on the existence of any advise/warning to stop their 'Pelebe' consumption. About half (52.3%) of those who responded to that question claim not to be hindered by anybody. For those who asserted being checked, majority of those who try to discourage their consumption of 'Pelebe' are family members; mother accounts for about 24.3%, spouses/boy/girlfriends account for almost 15%, while religious leaders account for just 2.7%.

Table 4.25 – Respondents' means of acquiring 'Pelebe'

	Frequency	%
I buy	141	88.1
I get from friends	10	6.3
I get at home	8	5.0
I get it at work	1	0.6
Total	**160**	**100**

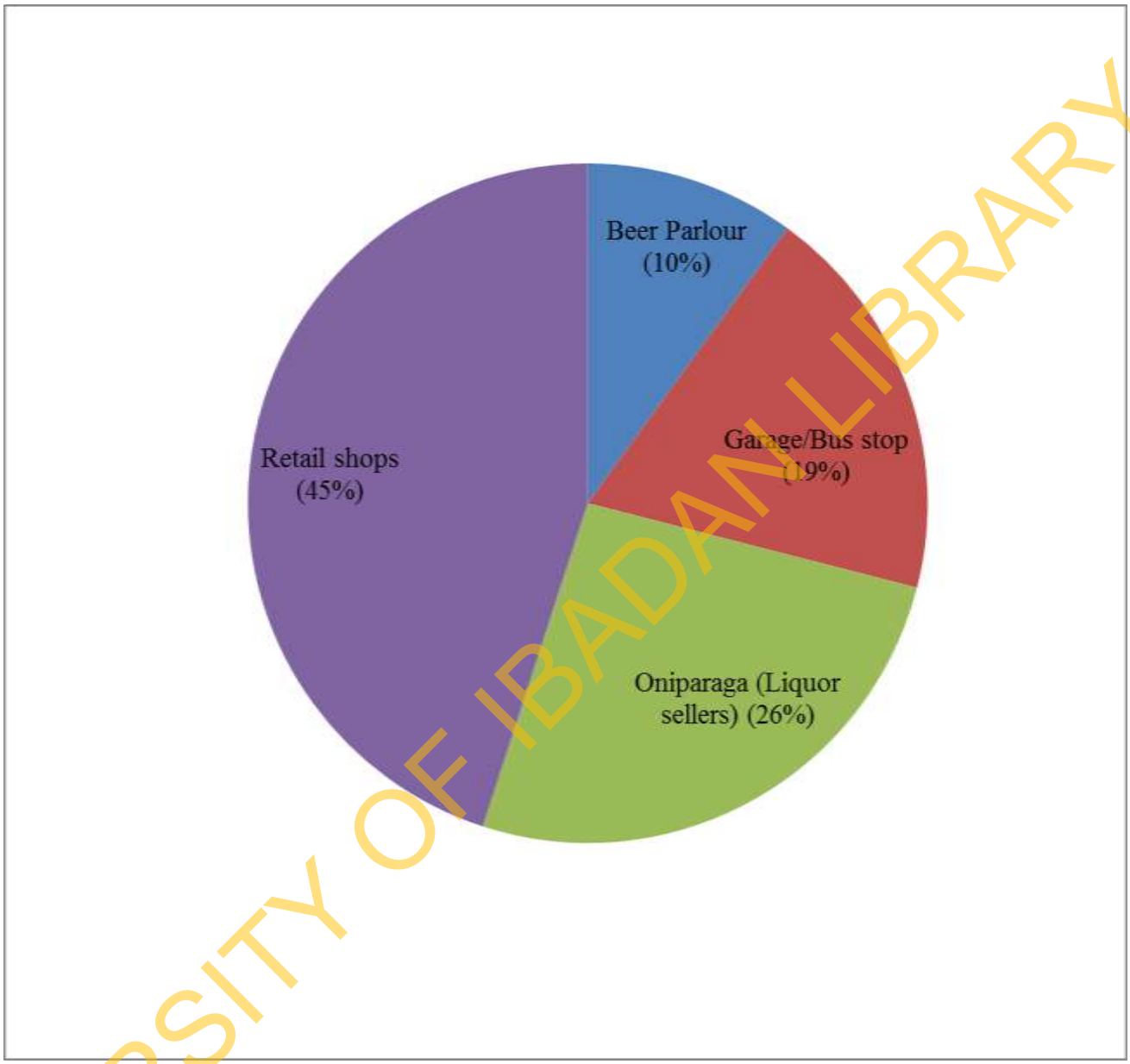


Figure 4.5 – Places where respondents purchase 'Pelebe'

Table 4.26 – Respondents source of money to buy 'Pelebe'

	Frequency	**%**
Pocket money	56	39.2
Income	59	41.3
Gifts	28	19.6
Total	**143**	**100**

Table 4.27 – Source of money for 'Pelebe' by school/work status

	School/Work Status			
	In school	**Apprentice**	**Working**	**Total**
Money Source				
Pocket money	37	10	9	56
	(66.1%)	(17.9%)	(16.1%)	
Income	19	10	30	59
	(32.2%)	(16.9%)	(50.8%)	
Gifts	26	1	1	28
	(92.9%)	(3.6%)	(3.6%)	
Total	**82**	**21**	**40**	**143**

Table 4.28 – Restriction on use of 'Pelebe' by relevant stakeholders

	Frequency	%
YES	74	47.7
NO	81	52.3
Total	**155**	**100**
If yes, by who		
Mother	18	24.3
Father	9	12.2
Elder siblings	7	9.5
Religious leaders	2	2.7
Parents	5	6.8
Uncle/Aunt	2	2.7
Spouse/boy/girlfriend	11	14.9
Neighbor	9	12.2
Friends	11	14.9
Total	**74**	**100**

The respondents' weekly spending on 'Pelebe' is described in Table 4.29. It is categorized into three (3): N100 and below – light spenders; N100 – N500 – average spenders; above N500 – heavy spenders. The table shows that 47% of the male respondents who buy 'Pelebe' are light spenders while 72% of the female respondents are light spenders (more details in the table). The table also relates the weekly spending with respondents' age groups and it reveals that 76% of respondents in early adolescence who buy 'Pelebe' are light weekly spenders while only 38% of respondents in late adolescence are light weekly spenders. The result shows that majority (76%) of the in-school respondents spend about N100 and below on a weekly basis on 'Pelebe', about 53% of apprentice respondents spend between N100 and N500, while equal proportion of working respondents spend heavily and averagely on 'Pelebe' on a weekly basis.

Comparing the availability of 'Pelebe' around work/school environment, 42% of the respondents reported sales of 'Pelebe' around their school/work environment; and to ascertain those of school environment and those of work environment in Table 4.30, 35% of in-school respondents affirm the claim that 'Pelebe' is sold around their school premises while about 63% and 48% of apprentice and working respondents asserts that 'Pelebe' is sold around their work place.

Table 4.29 – Weekly Spending by Sex, Age and School/Work Status (n = 137)

	N100 and below	N100 – N500	Above N500	total
Sex				
Male	51 (47.2%)	34 (31.5%)	23 (21.3%)	108
Female	21 (72.4%)	5 (17.2%)	3 (10%)	29
Age Groups				
10 – 14	39 (76.5%)	11 (21.6%)	1 (1.9%)	51
15 – 19	33 (38.4%)	28 (32.6%)	25 (29.1%)	86
School/Work Status				
In-school	60 (76.9%)	12 (15.4%)	6 (7.7%)	78
Apprentice	6 (31.6%)	10 (52.6%)	3 (15.8%)	19
Working	6 (15%)	17 (42.5%)	17 (42.5%)	40

Table 4.30 – Sales of 'Pelebe' in school/work environment

	Sales of 'Pelebe'		
	YES	**NO**	**Total**
School/Work Status			
In-school	33	61	94
	(35.1%)	(64.9%)	
Apprentice	15	9	24
	(62.5%)	(37.5%)	
Working	19	21	40
	(47.5%)	(52.5%)	
Total	**67**	**91**	**158**

Sexual Behaviour

The respondents were asked some questions to elicit responses identifying sexual risk behaviours that will categorize them based on sexual activity, multiple sex partners and unprotected sex.

Figure 4.6 shows the percentage of the respondents who are sexually active. By sex, of the 119 who are sexually active 88 are males, out of which 14 (15.9%) are in their early adolescence and 74 (84.1%) are in their late adolescence while 31 are females, out of which 7 (22.6%) of them are in their early adolescence and 24 (77.4%) are in their late adolescence (see Table 4.32).

Table 4.33 shows that only 19% of the in-school adolescents are sexually active while 65.7% of those working are sexually active. Table 4.34 reflects the respondents who have more than one sexual partner in the last three months, and those that have just one sexual partner within the same period. Table 4.35 indicates that 34% of sexually active in-school adolescents have multiple sexual partners while 40.9% of working respondents have multiple sexual partners.

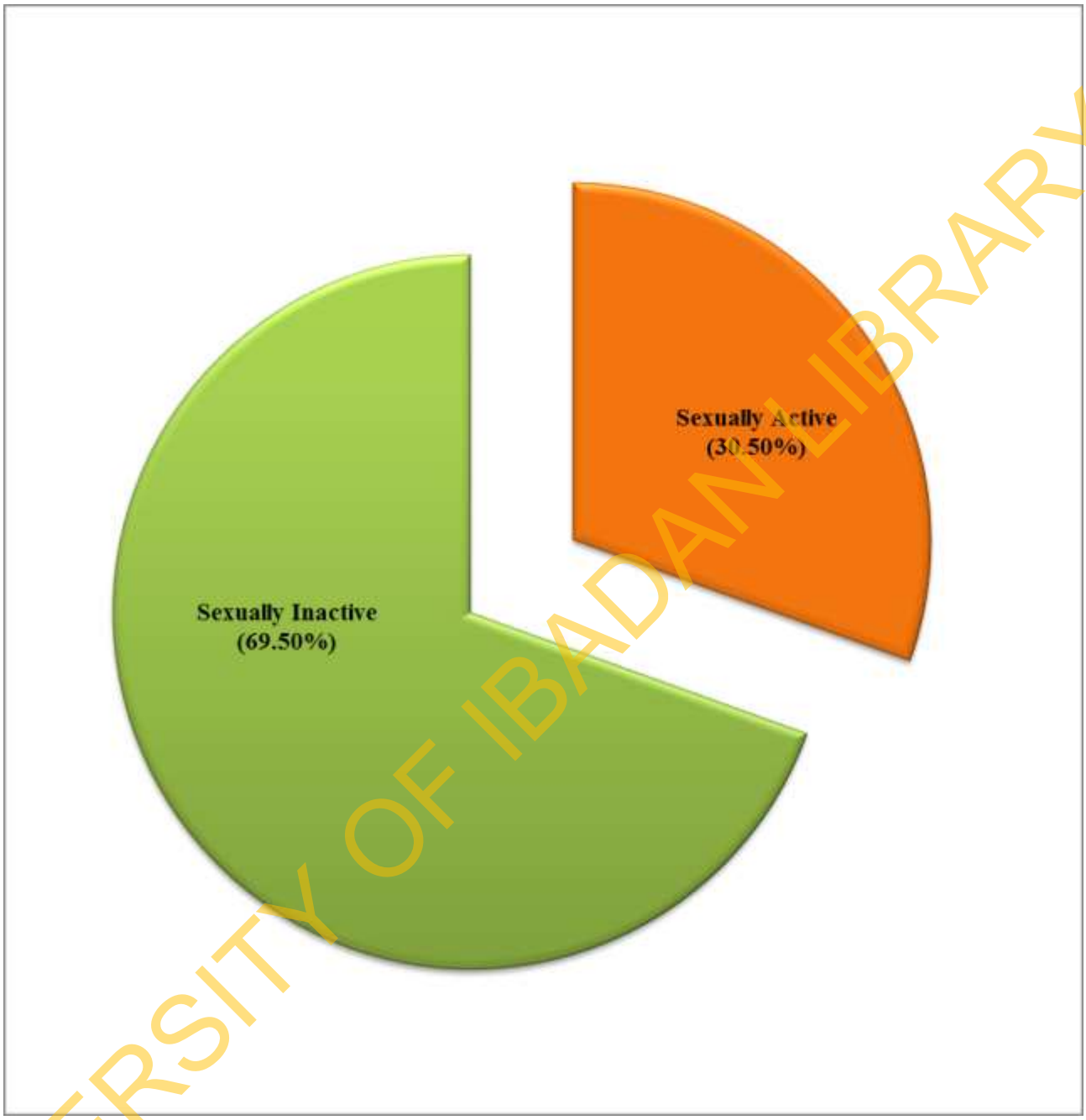


Figure 4.6: Respondents' Sexual Activity

Table 4.31: Use of Alcohol and Sexual Activity

	Sexual Activity		Total
	YES	**NO**	
Alcohol Use			
Yes	83 (50.6%)	81 (49.4%)	**164**
No	5 (16.1%)	26 (83.9%)	**31**
Total	88 (45.1%)	107 (54.9%)	**195**
Use of 'Pelebe'			
Yes	77 (50%)	77 (50%)	**154**
No	5 (23.8%)	16 (76.2%)	**21**
Total	82 (46.9%)	93 (53.1%)	**175**

Table 4.32 – Sexually Active Respondents by Sex and Age

	Age Groups		Total
	10 – 14	**15 – 19**	
Sex			
Male	14 (15.9%)	74 (84.1%)	88
Female	7 (22.6%)	24 (77.4%)	31
Total	**21**	**98**	**119**

Table 4.33 – Sexually Active Respondents by School/Work Status

	Sexually Active		
	YES	**NO**	**Total**
School/Work Status			
In-school	54 (19.3%)	226 (80.7%)	280
Apprentice	21 (48.8%)	22 (51.2%)	43
Working	44 (65.7%)	23 (34.3%)	67
Total	**119**	**271**	**390**

Table 4.34 – Respondents with Multiple Sexual Partners

	N	%
YES	54	48.2
NO	58	51.8
Total	**112**	**100.0**

Table 4.35 – Multiple Sexual Partners by School/Work Status

Educational Status		Multiple sexual partner		
		YES	NO	**Total**
	In-school	18 (34.0%)	35 (66.0%)	**53**
	Apprentice	8 (38.1%)	13 (61.9%)	**21**
	Working	18 (40.9%)	26 (59.1%)	**44**
Total		**44**	**74**	**118**

Table 4.36 shows that 33.6% of the sexually active respondents took alcohol before sex while 63% did not use condom in the last sexual episode. Table 4.37 further explains the reasons why those who used condom did indicating that 35 respondents out of the 44 who used condom in the last sex used condom for protection from diseases/infections.

Table 4.38 reveals that 68.8% of the respondents who took 'Pelebe' in the last one month did not use condom in their last sexual episode (tested with Chi-square, $p>0.05$). Furthermore, 75% of respondents who took alcohol before sex did not use condom (see Table 4.39).

Table 4.36 – Alcohol use of the sexually active respondents during their last sexual episode and condom use.

	YES	NO	Total
Use of alcohol before sex	40 (33.6%)	79 (66.4%)	119
Use of alcohol by sex partner before sex	18 (15.1%)	101 (84.9%)	119
Use of condon during last sex episode	44 (37%)	75 (63%)	119

Table 4.37 – Reasons for Condom Use in the last Sexual Episode

Reasons	N	%
Protection	35	79.5
Prevent Pregnancy	7	15.9
Sexual Arousal	2	4.5
Total	**44**	**100.0**

Table 4.38 – 'Pelebe' Use and Safe Sex

	Use of condom during last sex episode		
	YES	NO	**Total**
Current 'Pelebe' Use			
YES	24 (31.2%)	53 (68.8%)	**77**
NO	4 (80%)	1 (20%)	**5**
Total	**28**	**54**	**82**

Table 4.39 – 'Pelebe' use before sex and condom use in last sexual episode

	Use of condom in the last sexual episode with sexual partner		
	YES	NO	**Total**
Use of alcohol before sex with your partner			
YES	10 (25.0%)	30 (75.0%)	**40**
NO	34 (43.0%)	45 (57.0%)	**79**
Total	**44**	**75**	**119**

Findings from IDI

In the qualitative study, some of the participants discussed the use of ‘‘Pelebe’’ for improving sexual activity. The participants believe the alcohol gives extra energy for sexual pleasure and they are also aware of the effects of the ‘Pelebe’ in putting them at risk of improper use of condom. Below are some of their expressions:

- *You know what, for me, I have one ‘Iya Sule’ in my area when I go to her that I want to have sex with my girl, she will give me ‘Opa eyin’ (herbal concoction for pile). When I feel the concoction is not working, to be sincere, I sometimes take Regal, because I know that Regal will make me high and aroused to perform well. I might be conscious but I might lose some consciousness. But that thing I’m doing can’t be like I’m unconscious, for me, if I take it, my sight will be blurred, the girl I’m having sex with will look like 2 or 3 sometimes, but I will know where I’m focused to go or penetrate, that’s for me (Sola)*
- *Ah, it is not controllable anymore, because when you have taken it, even as you are now for example, when you take it and sit, the alcohol will initially throw you off balance such that if you look out straight, you won’t be able to tell if it is day or night, your body will shiver or jack. If it is Regal that has stayed long on the shelf, that one is past tense, but if it is a fresh one, that is very sharp, one’s body will sway and if you want to use condom, by the time you pick it, it won’t be as though you haven’t taken anything in setting the condom. And some girls like this thing we are talking about too, such that they will be asking her if you have taken it or not, and some persons may not want to wear it before his girlfriend, he will go to the bathroom, take Regal, do what he had to do and go back to the task, go in to the girl. And when he goes into the girl, the work starts conscientiously, that is all.*
- *Some persons are not wise, it should be worn before taking Regal, but some people will have taken the Regal, lose control and just wear the condom anyhow and not use it appropriately. When the girl now comes back with pregnancy, he will start defending himself that after all, he used condom during the sexual episode. He didn’t know that as it was soothing him, so was he firing the more. You know with the Regal he has taken, his energy would have been boosted such that the girl will be wondering*

why this boy is not tired and forcefully push him away that since he had started for 5mins and so on, you have not got up, she won't know that he had taken something.

As regards giving a sexual partner alcohol before sex, some of the participants that answered this question feel boys don't usually give their girl, but girls could give their boyfriends alcohol before sex for better performance:

- *You see, what you are saying, it is for a girl who is already aroused that can give the guy and say, 'take my boyfriend so that in the evening, work can start'. They say,.. elders say, 'penis is boasting, vagina is boasting, they will both meet on the bed for the battle'. If she gives him, it means she is already more prepared for him than he is, for her to give him to use it. That is exactly how it is.*

One participant related the issue of sexual risky behavior with HIV infection and unwanted pregnancy together with the ripple effects of the consequences on career and family. He said:

- *Some people are not smart, because some boys are such flirts that they don't remember that HIV is on the rampage, a person might be wise to use condom, another person does not….. another might even be infected with HIV and infect the girl, even some girls who are HIV positive will not tell the boy and that is why we are being told to protect ourselves with condom. But for me, if I want to have sex with a girl and I already have my Regal with me, I will think about it, the way I want to go about it, I won't drink more than my system can cope with, such that will not affect me so much as I want to enjoy the girl. For someone else, he may not think so much and may take too much and lose control, when he is done, his eyes gets clear, if he has encountered trouble, he won't know and the girl will not want to tell him except when the issue of pregnancy arises, he will now become sober. Being sober, he won't know what to do, it could be that having impregnated the girl, he is jobless or in school or an apprentice. But he has just put the girl in trouble. For me, I will think through the consequences, how I will not take troubles home to my parents, so that they will be happy with me, and so on, that is my take.*

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

Socio-demographic Characteristics of Study Participants

This study was community based; hence, the participants, males and females were drawn from the community. The males and females made about 62% and 38% respectively of the study population; which is similar to the sex structure of the population in the study conducted by Amiegheme (2013) where the male to female ratio in the study was 62% to 38%.

The age distribution of the participants was from 10 to 19 years and the age group distribution of early adolescence (10 to 14 years) and late adolescence (15 to 19 years) was equal. The study participants were also identified by their school/work status and the findings revealed that majority of the participants were students in primary and secondary schools, while there were also apprentice and working adolescents in the study.

As regards the guardian the participants live with, the distribution cuts across both parents, single parent, grandparents, relatives and those who are independently staying alone; with the majority living with both parents. However, it is evident in this study that many of the participants were under-aged with respect to the issue of alcohol use and should therefore not be found with alcohol or even abusing it.

Knowledge on Effects of Alcohol

Most of the study participants are quite knowledgeable of the effects of alcohol especially when it is abusively used in excess. Many of them are conscious of the fact that alcohol use could predispose an individual to being knocked out, violence and aggression, and various forms of illnesses. However, a lot of participants are unaware that any alcohol is a drug and also that alcohol use can affect students' performance at school in some ways. This is strongly related to the fact that they believe some measure of alcohol is healthy irrespective of the age of the drinker.

As reported by Adenugba and Ijagbone (2012), Research suggests that from the age of about 12 or 13 years, young people are similar to adults in their ability to identify and evaluate possible consequence of engaging in risky behavior. Alcohol is commonly sold in different

forms, types, brands and sizes including the small sachet liquor – 'Pelebe' without restriction of place, time and age of buyer in almost every nook and cranny of Ibadan metropolis and used by many people, both old and young. Use of 'Pelebe' has become a common phenomenon (Oshodi et al., 2010; Mamman, 2014) such that the effects are easily observed and noted by young people in the society, especially in areas where people live so close together. This is partly responsible for the awareness of the effects of alcohol.

Durodola (2009) also reported a high level of awareness of the consequences of alcohol among secondary schools in Ibadan North LGA. In the study, it was established that many in-school adolescents were aware that alcohol abuse can cause some health problems and were able to state some of the consequences of alcohol abuse. According to the findings of the study, parents, school teachers, doctors/health care providers and the mass media were the four topmost sources of information about the consequences of alcohol abuse among the students. It was affirmed in agreement with previous investigators that the home is the major source of information about the effects of alcohol use among young people (Durodola, 2009).

In the findings of this study, the person an adolescent lives with appeared to have significant relationship with their level of knowledge; with participants living with single parent scoring highest on the scale of knowledge of effects of alcohol. This could be explained in light of an assumption that more single parents probably take alcohol than married parents; hence, the adolescents take cues from their single parents. Hoque and Ghuman (2012) found out in their study that adolescents who resided in one-parent households were more likely to participate in risk behaviours, such as using alcohol. However, fifty-two percent of adolescents in one-parent households are 2.5 times more likely to report non-use of alcohol if they are actively involved in community activities. Next to the participants of single parents on knowledge score are the participants who are independently living alone. This could be explained in Velleman's (2009) view which established that there is some evidence that a combination of family- and child-focused approaches might work well on how children and young people learn about and behave towards alcohol.

The knowledge of effects of alcohol was highest among in-school adolescents as compared with apprentice and working participants. This could be as a result of the students' access to a more reliable source of information and education on alcohol; and also enlightenment through

the process of prohibition of alcohol use in schools. Though the prohibition of alcohol use in schools is not effectively implemented as some respondents in the in-depth interview revealed some loopholes in the school system, the little done by the educational authorities has yielded a better alcohol awareness among students than apprentice and working respondents who are not in formal institutions. As argued by Durodola (2009), drug and alcohol use education is not promoted in Nigerian schools, National Agency on Food and Drug Administration Council (NAFDAC), National Drug Law Enforcement Agency (NDLEA) and the Police do not enforce alcohol-related laws and regulations effectively.

The increase in awareness of effects of alcohol could be explained by the change in the trend and pattern of alcohol use in the present modern Nigeria as compared with the pre-colonial times. As noted in Dumbili (2013), in traditional Nigerian society, alcohol consumption was gender and age based; it was mainly consumed by adult males in social engagements and customs and tradition regulated production and consumption of locally made alcoholic drinks. Though young people in a few communities were permitted to drink, this was usually in the presence of adults who monitored the quantity they consumed. Alcohol consumption was not a daily affair and it was restricted for use in religious rituals, marriage ceremonies, kingship enthronements, cultural festivals, child naming, etc. that happened in intervals. However, nowadays, consumption is no longer solely regulated by custom and tradition of the people and it is no longer reserved for social gathering or entertainment of a guest alone. The patterns of use, the users and reason(s) for consumption are changing rapidly, especially among young drinkers. A sharp contrast from what hitherto existed is the 'alcohol contest' among youths in bars, restaurants, drinking joints, hotels and nightclubs that are strategically located near various schools in Nigeria.

In this study, the findings revealed that the males are little more knowledgeable than the females; also the participants in late adolescence scored higher on the knowledge scale than those in early adolescence, and also Christians scored higher than Muslims, although the differences are not statistically significant. Amosun, Ige & Ajala (2010) was of the view that religion is not a determining factor of substance abuse between Muslim and Christian students as these students would have different reasons for drug abuse. This is also in-line with the result of the investigation of Atilola et al., (2013), which affirms that majority of the factors that were independently associated with adolescent use of alcohol and other substances in the

current study were personal factors like older age, male gender, and self-reported poor academic performance.

Perception of 'Pelebe'

How people view alcohol and its effects also influences their drinking behavior including whether they begin to drink and how much. An adolescent who expects drinking to be a pleasurable experience is more likely to drink than one who does not (Adenugba & Ijagbone, 2012). Many of the participants in this study had positive perception towards the use of 'Pelebe'. The National Institute on Alcohol Abuse and Alcoholism (2006) indicated that beliefs about alcohol are established very early in life, even before the child begins elementary school (15). The institute also reported that before age 9, children generally viewed alcohol negatively and saw drinking as bad, with adverse effects. By about age 13, their expectancies shifted, becoming more positive. It also indicated that adolescents, who drank the most, also placed the greatest emphasis on the positive and arousing effects of alcohol.

Many of the participants still believe that 'Pelebe' makes people feel good and happy, it is good for celebration, and that 'Pelebe' makes sex fun. According to Chikere and Mayowa (2011) who the reasons why young people take alcohol, the respondents gave some reasons why they currently use alcohol and these included: to enhance sexual pleasure, to *feel high* and to feel more sociable; and this was particularly linked to alcohol advertisement. Durodola (2009) discussed the beliefs and attitudes related to alcohol as a product of the influence of advertisement; as majority of the secondary school students who were the participants in that study were of the opinion that alcoholic beverage advertisement had ever influenced them to drink. Obot and Ibanga (2002) also noted that advertisers are involved in the subtle marketing of the health benefits of alcohol. Onongha (2012) discovered in a study conducted among young people in Osun State University that some of the participants believed that consumption of alcohol irrespective of the number of bottles consumed increases one's desire for sex, which in most cases could be unprotected.

This study revealed an inverse correlation between perception and knowledge. The more knowledgeable the participants, the more negative their perception is towards the use of 'Pelebe'. The participants also differ in perception based on their sexes; the males had more

positive perception than the females on 'Pelebe'. Equally, the older participants were more positive in perception of 'Pelebe' than the younger ones. These call for serious work to be done in broadening the knowledge of adolescents in modifying their belief and use of 'Pelebe'.

Pattern of 'Pelebe' Use

Exactly half of the participants in this study had taken alcohol at least once, while about 39% were current users of 'Pelebe'. This is similar to previous studies on adolescent alcohol use in Nigeria which has established that alcohol use is very common among adolescents in the country. Atilola et al. (2013) conducted a study on adolescent alcohol and substance use among a cohort of school-going adolescents in Nigeria. The results showed that about 21% of the adolescents had used alcohol or any other substance in the preceding 12-months. This is also in agreement with the findings of Adenugba & Ijagbone (2012) and Oshodi et al. (2010). However, Durodola (2009) reported a little higher prevalence of about 50% also among secondary school adolescents. Also in South Africa, Hoque & Ghuman (2012) reported more than half (54%) of the adolescents had consumed alcohol at some time in their life.

According to the findings of this current study, majority of adolescents who live independently of parents/guardian are current users of 'Pelebe', followed by those of single parents and those who live with grandparents. This finding supports the assertion of previous researchers who have linked family structure with alcohol use/abuse among young people. Hoque & Ghuman (2012) also support the various reports that lower levels of alcohol use among adolescents in two-parent families than among adolescents in single-parent families have been found in researches.

The mean age of onset of 'Pelebe' in this study was 12 ± 3.03 years with the ages ranging from 5 to 19 years. This is higher than the mean age of onset of alcohol (11.05 ± 3.7 years) reported by Durodola (2009). The age range of onset of alcohol is however a little wider than the findings of previous findings (Durodola, 2009; Obot, 1999; Odejide et al., 2008). Zucker and Gomberg (1996) stated that the average age when teenagers first try alcohol is 13 years for girls and 11 years for boys, thus indicating that boys are more liable to come in contact with alcohol before their female counterparts. Many of the participants identified Seaman and

Regal as their preferred brand of 'Pelebe', while majority made their choices for reasons of efficacy of the brand, many had no reasons at all, and some for reason of taste of the brand.

Most of the participants take 'Pelebe' every day, many others take it once a week while a few have taken it just once. The frequency of use differ among the males and females, as most of the males take 'Pelebe' everyday while most of the females take 'Pelebe' once a week. This finding is in agreement with the report of Ukwayi, Ambekeh, Uwanede & Undelikwo (2013) who reported that 48.3% of respondents consumed alcohol daily, 34.2% consumed alcohol 1 – 3 times a week, while 8.3% and 9.2% consumed alcohol weekly and occasionally. A similar report was made by Onongha (2012) that 42% of the study respondents consumes alcohol on a daily basis and this was linked to addiction as the respondents could not function normally without taking alcohol in a day. The result of this current study reveals that majority of those who take 'Pelebe' daily are adolescents working and the apprentice while those who take 'Pelebe' once a week are mostly in-school adolescents. Remarkably, this study identifies a significant inverse relationship between knowledge of participants on effects of alcohol and frequency of use. It was made known that the more knowledgeable the participants on alcohol effects, the less frequent they take 'Pelebe'. This calls for the attention of relevant stakeholders to the need to raise awareness of alcohol consequences among adolescents especially those who are out of school.

One other salient finding of this study is the influence of peers in initiating and continuity of use of 'Pelebe', seconded by poor modeling of parents. Only a few participants got introduced to 'Pelebe' by siblings, neighbours or boss at work, majority got into drinking through the first call to alcohol by friends, parents and themselves. Many previous studies have identified this link and have statistically confirmed this assertion. As cited in Durodola (2009), Odejide et al., (2008) acquiesced that parents and friends play key roles in young peoples' first taste and experimentation with alcohol use. According to Mamman et al. (2010), peer group pressure plays a major role in influencing many youth's into drug usage. This is because peer pressure is a fact of teenage and youth's life. In Nigeria, and other parts of the world, one may not enjoy the company of others unless he conforms to their norms. This assertion is also supported by Amiegheme (2013) in her study conducted among adolescents in Edo state. Alcohol is an important substance for young people wishing to position themselves within a social network (Ikweguonu & Seaman, 2010).

As reviewed in literature by Adenugba & Ijagbone (2012), findings asserted that peer drinking levels were strongly related to young adults' drinking. They cited the findings of Schoor et al., 2008 which affirmed that agreeableness interacted with the effects of peer drinking on young adults' drinking in such a way that agreeable individuals adapted their actual alcohol consumption more easily than others when socializing in a high- or a low-drinking peer group. They therefore concluded that drinking in a peer context, irrespective of personality, played a major role in forming young adults' drinking. Supported by the qualitative aspects of this study and the discoveries of Durodola (2009), the pressure to conform to the general view, the fear of being left out of the scene and being ridiculed, branded as or immature by peers accounts for the irresistible drive that make adolescents succumb to the enticement into drinking which starts with a taste and continues in contest.

Moreover, the amount of time spent with friends in school, at home and social settings afford the opportunity for these interactions to yield greater result of initiating these young adolescents to drinking. Eventually, being accepted into the norms and values of peers consequentially gets to contribute to the confidence of the young person which is perceived to be derived from the alcohol. In this study, most of the respondents who drink, drink with their friends; this is followed by those who drink alone and then, those who drink with their parents. The proportion of the respondents who drink alone and with their parents explains the reason why many adolescents drink at home, since their parents support drinking.

Hoque & Ghuman (2012) discussed that parental disapproval of risky behaviours and substance use, and successful parent-child communication, is related to lower levels of adolescent risk behaviours. Parents adjust the manner in which they communicate about risky behaviour according to the gender of the adolescent. In a study it was reported that mothers rather than fathers play a pivotal role in communicating with their children and girls seem to receive more information than boys regarding risk behaviours. This explains why in this study, fathers are the most reported parent to be drinking, posing as the poor parental model for the adolescents. This is established by Ukwaiyi et al. (2013) affirming alcohol use to be a common phenomenon among males.

Many other authors concluded that parental behaviours such as negative socialisation skills and practices (like being drunk in the presence of their children) are significant precursors of

disruptive behaviour, vulnerability and succumbing to peer pressure and substance use by their adolescent children (Adeyemo, 2007; Durodola, 2009; Hoque & Ghuman, 2012; Onongha, 2012; Dumbili, 2013). In many families in Nigeria recently, parents send their young children to buy alcoholic beverages which they then consume in their presence and even give the children to drink (Oshodi, 1995; Dumbili, 2013). Qualitative results of this study presented the accounts of these young respondents who relayed how their parents sent them to buy the spirit and offered them a drink (which is the first time they were tasting alcohol), after which they began to take the alcohol together. About 65% of respondents whose parents drink are being sent by their parents to buy alcohol. Wood et al (2004), as cited by Dumbili (2013), reported that parental disapproval of adolescents' drinking correlates with reduced peer influence.

This study, through the in-depth interview was able to discover the existence of drinking contests among adolescents. As reported by the respondents, they are sometimes done by betting; they are planned by group of friends who contribute money to buy the drinks and then place prizes on winners who are able to finish the designated quantity. Another respondent explained that the drinking could be done among group of friends in certain events or occasions where a curse is placed on whoever does not partake of the drinking; the people present are hence compelled to drink. As noted by Dumbili (2013), recently, there are alcohol contests among young people where the winner is judged based on two standards - *the ability to drink large a quantity without showing a sign of intoxication and the ability to drink faster than the opponent*. These are usually organized and sponsored by the competitors or alcohol marketers (especially spirit) to introduce new products to the market or promote existing ones. This practice encourages binge drinking and among these competitors, alcohol consumption is no longer for *pleasure* as it used to be, but for a *prize* (Dumbili, 2013).

This study was able to probe into the reasons why participants take 'Pelebe'. The reason that had the highest frequency implied perceived health benefits of spirits, followed by recreation. In agreement with the submission of previous researches, no single factor could be defined as solely responsible for the abuse of drugs (Mamman et al., 2014). It is however worrisome to discover that many of the participants use 'Pelebe' because they think it cures or treats body ailments like cold, fever, sleeplessness etc. In one of the in-depth interviews, a respondent made a statement like, '*My dad just gave it to me to take it though I spilled it out initially, but*

he told me to take it so I won't feel cold again. So since then, I started taking it, I even took it yesterday.' Oshodi (1984) as cited by Dumbili (2013) had earlier noted that parents who give alcohol to their young children when they are sick contribute to early alcohol initiation. According to Durodola (2009), some medical researchers/columnists have contributed towards the positive image of alcohol by advocating that alcohol use in small quantities could contribute towards the promotion of the health of the heart.

Also, many participants take for recreation, i.e. relaxation, fun and refreshment. According to Mamman et al. (2014), the evidence of drug use within youth culture suggests that the experience of substances is often pleasurable rather than negative and damaging. This probably explains that the main reason why young people take drugs is for them to enjoy themselves.

Another reason why the participants use 'Pelebe' is for improved performance. Nearly all the participants in the in-depth interview claim that 'Pelebe' boosts strength of young people, including strength for sexual intercourse.

Risky Sexual Behaviour

Though more than a quarter of the participants are sexually active, majority of the sexually active adolescents in this study are the apprentice and working population. About 66% of the working participants are sexually active, while most of them are in their late adolescence. Also, about 41% of working adolescents have multiple sexual partners while a fewer percentage of the sexually active in-school participants do. This is divergent finding from Morhason-Bello et al. (2008) who concluded that in-school adolescents practiced unsafe sexual activity and they are therefore predisposed to STI/HIV and other reproductive health risks.

This study also revealed that 75% of those who used alcohol before sex did not use condom, an indication of one of the disinhibitory effects of alcohol. This finding affirms the researches that have established links between alcohol and risky sexual behaviours (RCP, 2011). Cooper (2002) established that that drinking prior to intercourse is associated with risky partner choice as well as with decreased risk discussion on that occasion.

Alcohol use is one of the contributing factors to the continuous rise in the incidence of HIV/AIDS among youths in Nigeria, particularly new infection cases (Dumbili, 2012). The

findings of this study reveals that majority of the sexually active respondents who take alcohol don't use condom, an indication of unprotected sex. RCP (2011) asserts also that 16–24-year-olds are among the highest consumers of alcohol, in terms of both prevalence and unit consumption, and have the highest rate of sexually transmitted infections.

Implication for Health Education and Social Policies

Health education is the part of health care that is concerned with promoting healthy behavior. Health education is therefore any planned combination of learning experiences designed to predispose, enable and reinforce voluntary behavior conducive to health in individuals, groups or communities (Durodola, 2009). Health education involves the collaboration with families, communities, regional and national authorities and stakeholders so that necessary resources and support are available to enable individual live a healthy life. The implications of the results of this study are therefore discussed in light of the definition, strategies and goals of health education.

Results of this study suggest that the participants' level of knowledge of the effects of alcohol on adolescents was low. Therefore, there is need to raise adolescents' knowledge of alcohol, which will eventually correct the misconceptions relating to the consequences of alcohol use, the cultural uses of alcohol and perceived psycho-social benefits of alcohol use.

There is also need to train teachers, parents and guardians on the effect of alcoholic drinks on adolescents, laws regulating alcohol sales and use, access of the under-aged to alcoholic drinks and consequences of alcohol use. Many parents don't even know their children/wards take alcohol, hence the need to sensitize them on the current pattern of adolescent alcohol use. These training programmes need to actively involve the students, teachers, parents and relevant authorities for those in school settings and the adolescents, parents/guardians, liquor sellers among others for those in the community setting.

Peer education will also be very useful as a tool for improving the awarenss and promoting health among the adolescents, as it has been used in addressing adolescents sexual and reproductive health issues in previous intervention programmes. Moreover, many of the respondents in this study associated alcohol use with improved sexual performance, and this ideology is shared among the adolescents.

Conclusion

Based on the results of the findings of this study, it can be deduced that majority of the participants are involved in under-age drinking according to the Nigerian alcohol-related laws which prohibits drinking under the age of 18 years, as majority of the participants are below the age of 18 years. Furthermore, majority of the adolescents in the community are enrolled in schools and live with parents/guardians.

The overall level of knowledge of the effects of alcohol of the participants was good. However, many still demonstrated some gaps in knowledge especially in recognizing that any alcohol is a drug and consequences of alcohol use. The study revealed that the participants in school demonstrated a higher knowledge of alcohol than those out of school. This is an indication of the need to raise awareness of alcohol in the communities targeting not only adolescents, but also adults who influence and act as poor models to the adolescents.

According to the findings of this study, use of sachet liquor is a common phenomenon among adolescents, cutting across sexes, age groups, religions, school/work status and style of parent/guardian. The trend observed points to the fact that prevalence of 'Pelebe' increases towards the male sex, older adolescents, out-of-school and independent adolescents which are not different from what has been observed in previous researches. The participants generally showed preference for specific brands of 'Pelebe' which is accrued to efficacy of the brand.

The participants' first alcohol drink was majorly encouraged by friends and parents, emphasizing the role of peer and parental influence in alcohol initiation and continued use. Majority of the participants also drink with friends and at home which corroborates the point made ealier; and the frequency of use of alcohol differ significantly among in-school and out-of-school adolescents. This implies the extention of the target audience for health education from in-school and out-of-school adolescents to parents or adults in the community for effective interventions. Majority of the participants take sachet liquor for the perceived health benefits of the drink and also for fun and recreation which indicates a poor perception of 'Pelebe' and alcohol in general.

Majority of the participants buy alcohol with their money, either pocket money or money made from sales for those who work and those who school and work. The results also indicated that alcohol is sold around school premises. This is an indication of prospective

alarming prevalence of alcohol use among students in schools due to availability and accessibility to sachet liquor which could be easily smuggled into bags and pockets of students.

It has been revealed that many of the participants hold a positive perception towards the use of sachet liquor which is very close to the proportion of the participants who had poor knowledge of the effects of alcohol. It can be deduced therefore from this study that the higher the knowledge of an adolescent, the more the adolescent tends towards holding a negative view of alcohol and the tendency to avoid alcohol.

Some of the in-depth interview respondents who explained how adolescents use alcohol in boosting energy for improved sexual performance corroborated on the findings of the quantitative aspect of this study which highlighted the link between alcohol use and risky sexual behavior, especially unprotected sex. Majority of the participants who used sachet liquor before sex had unprotected sex, an indicator of poor adolescent sexual and reproductive health.

Recommendations

The recommendations made according to the findings of this study are as follows:

1. In view of the gaps in knowledge of alcohol effects and misconceptions about sachet liquor found among the participants in this study, both in-school and out-of-school, comprehensive health education strategies should be planned and implemented, involving all relevant stakeholders in adolescent health. Trainings are needed for adolescents on life building skills, incorporating skills such as critical thinking, decision making, assertiveness, self-esteem, and effective communications, among others.
2. In cognizance of the role of parental influence on the initiation and continued use of alcohol as implied by this study and previous studies, it is expedient that health education programmes targeted at adults in the community are carried out to sensitize parents/guardians on the prevalence of adolescent alcohol use, effects of adolescent alcohol use on health, academics, social and morals of adolescents on the growth and development of the family, community and nation at large. Parents need to be aware

of their roles as models in shaping the attitude and perception and eventually practice of alcohol use of adolescents.

3. There is need for alcohol sellers/servers to be educated and trained on the dangers associated with adolescent alcohol use and abuse, the Nigerian Alcohol-related laws emphasizing prohibition of under-age drinking so as to promote the restriction of alcohol sales to adults only in preventing adolescent alcohol use and abuse.
4. It is necessary to advocate the implementation and enforcement of available laws and policies on alcohol advertisement, sales and use in schools and the communities, involving the mass media, non-governmental organizations, and corporate organizations through corporate social responsibilities in rising up to the task of promoting adolescent health. This should also be implemented through campaigns.

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APPENDIX I

INFORMED CONSENT FORM

My name is Oluwaseunfunmi Akinsorotan from the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan.

I am carrying out a study on the use of small sachet liquor among adolescents in Ibadan South-East L.G.A. The information obtained from students in this study will be useful in understanding this practice and in proffering effective solutions through different intervention programmes for adolescents in the future.

It is not compulsory for you to take part in this study; you can decide not to be involved. If you wish, you can also withdraw at any time.

If you decide to participate, we will like to inform you that whatever you tell us will be kept secret and confidential, it will not be revealed to your teachers, parents, bosses, friends or the school authorities.

Thank you.

I understand all that has been explained above and I am willing to participate in this study.

_____ OR _____

Sign Thumb print

SECTION A: SOCIO-DEMOGRAPHIC INFORMATION

(Please tick (√) the most suitable answer to you).

1. **Gender** 1.Male **[ ]** 2. Female **[ ]**
2. **Age** (***as at last birthday***)……(*In years*)
3. **Educational status:** In-school **[ ]** Apprentice **[ ]** Working **[ ]**
   Others…….
4. **Highest Educational Qualification:** Primary School **[ ]** Junior secondary school **[ ]** Senior secondary school **[ ]**
5. **Religion:** Christianity **[ ]** Islam **[ ]** Traditional **[ ]**
   Others…….

6. **Family type** Monogamy **[ ]** Polygamy **[ ]**
7. **What is your birth order in your family:** 1st born **[ ]** Middle born i.e. 2nd , 3rd, 4th but not last born **[ ]** Last born **[ ]** Only child **[ ]**
8. **Who do you live with?** Parents **[ ]** Grandparents **[ ]** Father alone **[ ]** Mother alone **[ ]** Relatives **[ ]** Friends **[ ]** Nobody, I stay alone **[ ]** Others (Pls. Specify)……..

SECTION B. KNOWLEDGE ABOUT EFFECTS OF ALCOHOL DRINKS

Instruction- *Please answer the following questions to the best of your knowledge, however it is not a test or exam. Tick either* ***true or false*** *for the following statement.*

SN	Statements	True	False
9	Any alcohol is a drug		
10	Alcohol drink is dangerous to health		
11	It is not possible for alcohol use to lead to the damage of one's liver		
12	It is not possible for alcohol use to worsen any health condition		
13	Alcohol use can cause diabetis or even cancer		
14	Alcohol use makes one get so used to drinking that one cannot function normally without taking it		
15	Alcohol use overtime can make people not to remember things easily		
16	Alcohol use cannot affect students' performance at school in any way		
17	Alcohol use can make someone aggressive and violent		
18	Alcohol can make someone lose control of oneself		

SECTION C: PATTERN OF ALCOHOL USE

Instruction: *- Please answer the following questions as sincerely as possible; remember nobody will judge you with these questions; they are just for research purpose.* ***Please tick (√) the most suitable answer to you***

19. Have you ever taken any alcoholic drink? Yes **[ ]** No **[ ]** ***(if no, go to question* 43)**

20. If yes, how old were you when you first took an alcoholic drink?..... *(in years)*

21. Do you take alcoholic drinks now? Yes **[ ]** No **[ ]**

22. Have you ever taken **'Pelebe'** (small sachet liquor)? Yes **[ ]** No **[ ]**

23. What brand of **'Pelebe'** do you take most? State here:……..

24. Why do you take this brand more than other brands? State here:
……
……
……
……

25. Did you take **'Pelebe'** during the last one month? Yes **[ ]** No **[ ]**

26. How often do you drink? Rarely **[ ]** Once a week **[ ]** Twice a week **[ ]** Once a day **[ ]** Twice a day **[ ]** Three times a day **[ ]** More than three times a day **[ ]**

27. How many sachets did you take the last you took **'Pelebe'** ? ……

28. Have you ever been drunk from taking **'Pelebe'**? Yes **[ ]** No **[ ]**

29. The first time you took 'Pelebe', who encouraged you to drink it? Parent **[ ]** Friends **[ ]** Brother/Sister **[ ]** Neighbour **[ ]** Boss **[ ]** Senior in School/work **[ ]** Others (please specify) ……

30. Does any of your parents drink any type of alcohol? Yes **[ ]** No **[ ]*(if no, go to question 31)*** If yes, which of them……

31. Do they send you to buy alcohol? Yes **[ ]** No **[ ]**

32. Do you smoke? Yes **[ ]** No **[ ]** If yes, what do you smoke? ……

33. On the average, how many sachets of 'Pelebe' do you take in a day? …….

34. What time of the day do you usually drink 'Pelebe'? Morning **[ ]** Afternoon **[ ]** Evening **[ ]** Anytime of the day **[ ]**

35. Who do you drink with? Parent **[ ]** Friends **[ ]** Brother/sister **[ ]** Senior in School/work **[ ]** Boss **[ ]** Neighbours **[ ]** Alone **[ ]**

36. Where do you drink? ***(You can tick (√) more than one option)*** At home **[ ]** In school/work **[ ]** At the bar **[ ]** At parties **[ ]** In friends' house **[ ]** On the street **[ ]** At corners/hidden places **[ ]** Anywhere **[ ]**

37. Why do you take 'Pelebe'?.....
.

……
……
……

SECTION D: ACCESSIBILITY TO 'PELEBE'

Instruction: *- Please answer the following questions as sincerely as possible; remember nobody will judge you with these questions; they are just for research purpose.* ***Please tick (√) the most suitable answer to you***

38. How do you get ''Pelebe''? I buy **[ ]** I get from friends **[ ]** I get it from home **[ ]** Others, specify……

39. If you buy, where did you buy the last one? Garage/Bus stop **[ ]** Beer parlour/Joint **[ ]** Shops **[ ]** Hawkers *(Oniparaga)* **[ ]** Others, specify…….

40. Where did you get money to buy it?

.....

41. Has anybody tried to stop you from taking 'Pelebe'? Yes **[ ]** No **[ ]** ***(if no, go to question 42)*** If yes, who? …….

42. When you need 'Pelebe' and you don't have money to buy it, what do you do?

……
……

43. On the average, how much do you spend on 'Pelebe' in a week? …… ***(in naira)***

44. Do you get to buy 'Pelebe' around your school premises? Yes **[ ]** No **[ ]**

SECTION E: PERCEPTIONS OF 'PELEBE'

Instruction- The table below contains a set of views and opinions about 'Pelebe', ***Please tick (√) whether you agree, disagree or you are undecided.***

SN	INDICATORS	**Agree**	**Undecided**	**Disagree**
45	'Pelebe' is fun, it makes people feel good or happy			
46	'Pelebe' makes people bold enough to do certain things they would not have been able to do			
47	'Pelebe' helps one to have some confidence to do or say certain things in the public			
48	'Pelebe' is good for celebrating success			
49	'Pelebe' is necessary after a day's hard work			
50	'Pelebe' strengthens a young person			

51	Any adolescent who does not drink 'Pelebe' will not become a strong man			
52	'Pelebe' clears one's eyes			
53	'Pelebe' makes sex fun			

SECTION F: ALCOHOL AND SEXUAL BEHAVIOUR

Instruction- The table below contains a set of questions that seek to understand adolescents' sexual experiences, be free to answer the questions as sincerely as possible, ***remember your responses would be kept very confidential.***

54. Do you have boy/girlfriend(s)? Yes **[ ]** No **[ ]**
55. Have you ever had sex before? Yes No (***If no, please submit your questionnaire)***
56. How many times have you had sex in the last 3 months ……
57. How many people have you had sex with in the last 3 months …….
58. Did you take alcohol before/during sex with your partner? Yes **[ ]** No **[ ]**
59. Did you give your sexual partner alcohol before having sex with him/her? Yes **[ ]** No **[ ]**
60. Did you use condom in your last sexual episode with your sexual partner? Yes **[ ]** No **[ ]**
61. If yes, why did you use condom?.....

APPENDIX II

IN-DEPTH INTERVIEW DISCUSSION GUIDE

	Main Questions	Hint/Follow-up Probe
1	a) How common is the taking of 'Pelebe' in Ibadan? b) How common is the use of 'Pelebe' among adolescents like you? c) How will you describe the number of young people like you who drink compared to those who do not? d) Where do adolescents like you buy and drink 'Pelebe'?	What type do young people like you prefer to drink – squadron, Schnapps, Whisky, Dry gin, or Brandy? What about these alcoholic herbal bitters in small sachets? Why do adolescents like you like the preferred brand? Which brand did you start with? Do you consider the alcoholic content of a brand before choosing the brand? Are boys and girls involved in buying and drinking 'Pelebe'? Why do you think girls drink 'Pelebe'?
2	a) What are the effects of drinking 'Pelebe' on adolescents like you? b) Does 'Pelebe' have any effect on adolescents'	• Good effects • Bad effects • What are those bad things boys/girls want to do that make them take 'Pelebe'?

	sexual activity?	• Does alcohol make you feel like having sex or is it when you feel like having sex you take 'Pelebe' to have an exciting sexual experience? • Is there any difference between your sexual experiences with alcohol and those without alcohol? • Do you remember to consider risks of STIs, HIV and unwanted pregnancy after you have taken alcohol for sex? • What measures do you take to prevent these infections and unwanted pregnancies?
3	Were you influenced to take 'Pelebe' by any advertisement?	Is the hawking of 'Pelebe' by 'Oniparagas' any form of advertisement? Does the advertisement of beer and other alcohol have any effect on the use of 'Pelebe'? Are there promo incentives for buying 'Pelebe'?
4	Are you aware of any 'Pelebe' drinking contest among	Have you witnessed any?

	your co-drinking friends or in your neighbourhood?	Have you participated in any? Who organized the drinking contest? What are the prizes for winners of such contest?
5	What makes adolescents like you drink alcohol or 'Pelebe'?	• Parents, peer pressure, frustrations from home, school or social relationships, advertisements, or what more? • Which one influences you most and least among these factors? • Where motivating factors cease to exist, would you continue to take 'Pelebe'?
6	What are your opinions about the use of 'Pelebe'?	• Does it have any negative effect, can you share your experiences (positive and negative) with the use of 'Pelebe'? • Does it put you at any risk? • Are you concerned about the negative effects? • Have you ever tried stopping the use of 'Pelebe'? • What are the values 'Pelebe' adds to you? • Does the use of 'Pelebe' affect your

		academic/work performance? How?

YORUBA TRANSLATION OF THE INSTRUMENTS

Iwe Mogba Lati Kopa

Oruko mi ni Oluwaseunfunmi Akinsorotan, mo je akeko ni Department of Health Promotion and Education ni Faculty of Public Health, ni Univasiti ti Ibadan.

Mon se iwadi lori Lilo Oti Inu Ora ‘Pelebe’ ni arin odo langba ni ekun Ibadan South-East. Iroyin ti a ba gba lowo awon odo langba ninu iwadi yi yio wulo fun afikun oye ise yi ati lati wa ojutu ise yi nipase orisirisi eto idasi fun odo langba ni ojo iwaju.

Ko pon dandan ki e kopa ninu iwadi yi, e le pinnu lati ma kopa. Ti o ba si wu yin, e le kuro ninu eko yi nigba kugba.

Ti e ba pinnu lati kopa, a o fe lati so fun yin pe, a o pa ohunkohun ti e ba so fun wa mo ni asiri, e ko nilo lati so oruko yin, a ko si ni so fun enikeni, yala awon obi, ore, oga yin lenu ise, alabagbe yin tabi awon agbofinro ni awon idahun si ibeere ti a ba bi yin. Die ninu awon ibeere yi le je ohun to je mo eyin funrayin ni pato to si je asiri, sugbon mo fe ki e mo pe ko si nkankan ninu awon idahun yin ti a o lo ni ilodi si yin ninu ati lehin ti a ba pari eko yi.

Ese pupo.

Ohun gbogbo ti won salaye fun mi ye mi, o si wunmi lati kopa ninu iwadi yi.

---------- ----------

Ifiowo si iwe/Iteka Ojo oni

ABALA KINNI: IROYIN NIPA OLUKALUKU

(Jowo fa ila yi* (√) *si eyi ti oba je idahun).

1. **Eya** 1.Okunrin **[ ]** 2. Obirin **[ ]**
2. **Ojo ori** (***gege bi ojo ibi re tokehin***)……(*ni odun*)
3. **Oro Iwe/Ise:** Akeko **[ ]** Ikose **[ ]** Mi o si ni ilewe/Ikose **[ ]** Omiran…….
4. **Eri iwe ti o ga ju wo ni o ni:** Iwe mefa **[ ]** Iwe mesan **[ ]** WAEC **[ ]**
5. **Esin:** Igbagbo **[ ]** Musulumi **[ ]** Esin Abalaye **[ ]** Omiran…….
6. **Iru Idile:** Oniyawo kan **[ ]** Oniyawo pupo **[ ]** Obi to ndagbe **[ ]**
7. **Ipo wo ni o wa ninu omo ni idile:** Akobi **[ ]** Aarin, bi iketa tabi ikerin sugbon ki nse abigbeyin **[ ]** Abigbeyin **[ ]** Emi nikan ni omo lowo obi **[ ]**
8. **Odo tani o n gbe?** Obi **[ ]** Iya/Baba Agba **[ ]** Baba nikan **[ ]** Iya nikan **[ ]** Ibatan **[ ]** Awon ore **[ ]** Kosi enikankan, mo n da gbe **[ ]** Omiran (Jowo so pato)……..

ABALA KEJI: IMO NIPA ATUNBOTAN OTI OLOGOGORO

Itoni- *Jowo dahun awon ibeere wonyi gege bi oye re, sugbon kii se ayewo tabi idanwo. Fi maaki yi* (√) *si idi beeni tabi beeko si awon gbolohun wonyi.*

SN	Gbolohun	Beeni	Beeko
9	Se gbogbo ogogoro ni ogun		
10	Oti ogogoro lewu fun ilera		
11	Ko seese ki lilo ogogoro fa bibaje edo foro		
12	Ko seese ki lilo ogogoro dakun ailera ara		
13	Lilo ogogoro le fa nini ito sugar tabi pelu aisan jejere		
14	Ogogoro lilo ma mu ki eniyan kudun mimu to be ti eniyan le ma se wonran wonran ti eniyan ko ba mu		
15	Aloju ogogoro le mu ki eniyan ma ranti nikan taara		
16	Ogogoro lilo ko le nipa abukun lori kiko eko yala ni ilewe tabi enu ikose		

17	Ogogoro lilo le mu ki eniyan ma se jagidija tabi wuwa ipa nle		
18	Ogogoro lilo le mu ki eniyan ma le ko ara re ni ijanu		

ABALA KETA: OGOGORO LILO

ITONI: *- Jowo dahun awon ibeere wonyi pelu aiseke, ranti pe ko si eniti yio se idajo re pelu awon idahun re, won kan wa fun iwadi lasan ni.* ***Jowo fa ila yi (√) si eyi ti oba je idahun***

19. Nje o ti mu ohun mimu ti o ni ogogoro ri? Beeni **[ ]** Beeko **[ ]** ***(ti o ba je beeko, lo si ibeere 44)***
20. Ti o ba je beeni, o to omo odun melo nigba ti o koko mu?..... *(ni odun)*
21. Nje o si n mu ohun mimu ti oni ogogoro ninu baji? Beeni **[ ]** Beeko **[ ]**
22. Nje o ti mu 'Pelebe' ri (Oti ti o wa ninu ora 'Pelebe')? Beeni **[ ]** Beeko **[ ]**
23. Iru 'Pelebe' won i o ma n saba mu ju? So nibi:……..
24. Kilode ti o fi ma n mu iru eyi ju awon iru miran lo?
    ……
    ……
25. Nje o mu 'Pelebe' larin osu kan seyin? Beeni **[ ]** Beeko **[ ]**
26. Bawo ni o se ma nmu si? Ekankan **[ ]** Ekan lose kan **[ ]** Ekan lojumo **[ ]** Emeji lojumo **[ ]** Emeta lojumo **[ ]** O ju emeta lojumo **[ ]**
27. Ora melo lomu nigba ti omu 'Pelebe' gbeyin ? ……
28. Nje o ti mu 'Pelebe' ni amu para ri? Beeni **[ ]** Beeko **[ ]**
29. Nigba akoko ti o mu 'Pelebe', ta ni o gba o niyanju lati mu? Obi **[ ]** Awon ore **[ ]** Egbon/Aburo **[ ]** Ibatan **[ ]** Alajogbe **[ ]** Oga **[ ]** Awon ti o wa ni kilasi ti oju mi lo ni ile iwe tabi enu ise **[ ]** Omiran (So ni pato) ……
30. Nje ikankan ninu awon obi re nmu oti ogogoro kankan? Beeni **[ ]** Beeko **[ ]** ***(Ti o ba je beeko, lo si ibeere 31)*** Ti o ba je beeni, tani ninu won……
31. Nje won ma nran e lati lo ra ati ogogoro wa? Beeni **[ ]** Beeko **[ ]**
32. Nje o nfa siga? Beeni **[ ]** Beeko **[ ]** ti o je beeni, iru kini o nfa? ……..
33. Ni akopo, ora 'Pelebe' melo ni o nmu ni ojumo? …….
34. Ni akoko wo ni o ma nmu 'Pelebe' lojumo? ***(O le fala (√) si idahun to ju eyokan lo)*** Aro **[ ]** Osan **[ ]** Ale **[ ]**
35. Tani e jo ma nmu 'Pelebe'? Obi **[ ]** Awon ore **[ ]** Egbon/Aburo **[ ]** Ibatan **[ ]** Awon ti o wa ni ipele ti o ga ni ilewe/enu ise **[ ]** Oga **[ ]** Alajogbe **[ ]** Omiran, so ni pato …….

36. Nibo ni o ti n mu oti ‘Pelebe’? ***(O le fala (√) si idahun to ju eyokan lo)*** Ile **[ ]**
Ile iwe/Ibise **[ ]** Ile oti **[ ]** Inu igbo **[ ]** Ibi ariya **[ ]** Ile awon ore **[ ]**

37. Kini idi ti o fi n mu ‘Pelebe’?.....
……
…….

ABALA KERIN: BI ‘PELEBE’ SE WA NI AROWOTO

Itoni: *- Jowo dahun awon ibeere yi pelu aiseke, ranti wipe ko si eni ti yio se idajo re pelu awon ibeere wonju, won wa fun ise iwadi lasan ni.* ***Jowo fala (√) si idahun ti o to ni oju re.***

38. Bawo ni o se ma nri ‘‘Pelebe’’? mo ma nra **[ ]** Mon gba lowo awon ore **[ ]**
Mo nri ni ile **[ ]** Others, specify……

39. Ti o ba nra, ibo ni oti ra eyi ti o mu kehin?***(O le fala (√) si idahun to ju eyokan lo)*** Garaji oko/Ibi oko ti nja ero **[ ]** Ile oti **[ ]** Ile itaja **[ ]** *Oniparaga* **[ ]**
Omiran, so ni pato…….

40. Nibo ni o ti ri owo ti o fi ra? .....

41. Nje enikankan di e lowo lati mu ‘Pelebe’ ri? Beeni **[ ]** Beeko **[ ]*(Ti o ba je beeko, lo si ibeere 42)*** Ti o ba je beeni, tani …….

42. Ti o ba nilo ‘Pelebe’ sugbon ti o ko lowo lati fi ra, kini o ma nse?
……
……

43. Ni akotan, elo ni o ma nna lori ‘Pelebe’ ni ose kan? …… ***(ni naira)***

44. Nje o ma nri ‘Pelebe’ ran i agbegbe ilewe/ibise re? Beeni **[ ]** Beeko **[ ]**

ABALA KARUN: IWOYE NIPA ‘PELEBE’

Itoni- Tabili isale yi kun fun ero ati oye nipa ‘Pelebe’, ***jowo fala (√) boya o fara mo, o ko faramo tabi o le se ipinnu***

SN	ASAFIHAN	**Mofaramo**	**Nko le pinnu**	**Nko faramo**
45	‘Pelebe’ je ohun faaji, o ma nmu inu eniyan dun			
46	‘Pelebe’ ma nmu ki eniyan ni igboya lati se awon ohun kan ti eniyan ko le se tele			
47	‘Pelebe’ nran eniyan lowo lati koju ero ati lati ni awon idaniloju/igboya ni gbangba			

48	‘Pelebe’ dara lati fi se ajoyo aseyori			
49	‘Pelebe’ ye ni mimu lehin ise oojo alagbara			
50	‘Pelebe’ nfi okun ati agbara fun odo			
51	Odo langba ti ko ba mu ‘Pelebe’ ko ni le di alagbara okunrin/obirin			
52	‘Pelebe’ ma nmu ki oju eniyan mole kedere			
53	‘Pelebe’ nmu ki ibalopo dun			

ABALA KEFA: OTI OGOGORO ATI IWA IBALOPO

Itoni- Tabili ti o wa ni isale yi ni oni awon ibeere lati wadi oye nipa iriri odo langba nipa ibalopo, aye gba e lati dahun awon ibeere wonyi pelu inu kan, ranti wipe a o pa idahun re mo.

54. Nje o ni orekunrin/orebirin olulufe? Beeni **[ ]** Beeko **[ ]**
55. Nje o ti ni ibalopo ri? Beeni **[ ]** Beeko **[ ]** (ti o ba je beeko, da iwe yi pada fun oluwadi)
56. Bi emelo ni oni ibalopo ni aarin osu meta sehin? ……
57. Eniyan melo ni oti ni ibalopo ni aarin osu meta sehin? …….
58. Nje o mu oti ologogoro ki o to ni ibalopo tabi lasiko ti o ni ibalopo pelu eni keji re? Beeni **[ ]** Beeko **[ ]**
59. Nje o fun ore re ti o balopo ni oti ologogoro mu ki o to ni ibalopo pelu re? Beeni **[ ]** Beeko**[ ]**
60. Nje o lo roba idabobo Kankan nigba ti o ni ibalopo ti o ni kehin pelu orebirin/orekunrin re? Beeni **[ ]** Beeko **[ ]**
61. Kini idi ti o fi lo roba idabobo?
    ……

ITOSONA FUN IFOROWANILENUWO TI O JINLE

	AWON KOKO IBEERE	Olobo nipa bi a tin ro ni lati ri koko gbamu
1	e) Bawo ni mimu ‘Pelebe’ se wopo si ni ilu Ibadan? f) Bawo ni lilo pelee se wopo si larin awon odo langba bi tie? g) Bawo ni o se le se apejuwe iye odo bi tire ti o nmu pelu iye awon ti ko mu? h) Nibo ni awon odo bi tire ti nra ati mu ‘Pelebe’?	Iru ewo ni awon odo langba bi iwo feran lati mu – squadron, Schnapps, Whisky, Dry gin, bitters tabi Brandy? Awon egbogi ologogoro ti o wa ninu ora ‘Pelebe’ nko? Ki ni idi ti awon odo bi tie se feran eyi ti iwo yan laayo? Iru ewo ni iwo fi beere? Nje o kiyesi bi ogogoro se po si ninu iru kan ki o to yan laayo? Se todomokunrin ati odomobirin ni won rat i won sin mu ‘Pelebe’? Kini o ro wipe o fa ti odomobirin se nmu ‘Pelebe’?
2	c) Kini atunbotan mimu ‘Pelebe’ lori odo bi tire? d) Nje ‘Pelebe’ ni atunbotan lori ise ibalopo odo langba?	• Awon atunbotan to dara • Awon atunbotan ti ko dara • Kini awon ohun to ku die kaato ti odokunrin/odobirin ma nfe se to nmu won mu ‘Pelebe’? • Nje ogogoro mimu ma nje ki o fe ni ibalopo tabi ibalopo ti o fe se ni o ma nmu e mu ‘Pelebe’ lati gbadun ibalopo na? • Gege bi iriri re, nje

		iyato wa laarin ibalopo pelu oti ogogoro ati ibalopo lai mu oti ogogoro? • Ti o ba mu oti ogogoro fun ibalopo, nje o ma nranti lati se akiyesi ewu kiko arun ibalopo bi HIV ati oyun airotele? • Kini awon igbese ti o ngbe lati dena awon arun ibalopo ati oyun airotele?
3	Nje ipolowo oti Kankan se okunfa fun o lati mu 'Pelebe'?	Nje kikiri 'Pelebe' awon oniparaga je ona ipolowo bi? Nje ipolowo oti beer ati awon agogoro ni ipa Kankan ninu lilo 'Pelebe'? Nje awon ebun gba ma binu wa fun rira 'Pelebe'?
4	Nje o mo nipa ifigagbaga Kankan wa lori oti 'Pelebe' larin awon ore re ti e jo nmu oti tabi ni adugbo re?	Nje ikankan ninu re ti soju re? Nje o ti kopa ninu ikankan? Tani o se eto idije yi? Kini awon ebun ti o wa fun awon to ba pegede ninu idije yi?
5	Kini o nmu odo langba bi re mu oti ogogoro bi 'Pelebe'?	Lati odo awon obi, ipa ore, inilara lati ile, ilewe tabi ibi ikose, ibasepo pelu awon eniyan, ipolowo, tabi ki tun ni? Ewo ninu awon idi yi ni o je okunfa to ga ju ati okunfa to kere ju?

		Ti awon ohun iwunilori ko ba si mo, nje wa si maa mu ‘Pelebe’?
6	Kini ero tire nipa lilo ‘Pelebe’?	Nje o le se alaye iriri re lori lilo ‘Pelebe’, eyi to dara ati eyi to ku die kaato ‘Pelebe’? Nje o fi e sinu ewu Kankan? Nje o gbe atunbotan ibi oti ologogoro yewo ri? Nje o ti gbiyanju lati dawo lilo ‘Pelebe’ ri? Kini awon iyi ti ‘Pelebe’ fi kun e? Nje lilo ‘Pelebe’ ni ipa lori eko/ise re? Ni ona wo?

APPENDIX III

TELEGRAMS..... TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....
All communications should be addressed to the Honorable Commissioner quoting
Our Ref. No. AD 13/ 479/ 684

24th October, 2014

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
University of Ibadan,
Ibadan.

Attention: Akinsorotan Oluwaseunfunmi

Ethical Approval for the Implementation of your Research Proposal in Oyo State

In response of your letter requesting for Renewal of your Research Proposal tittled: "Use of Small Sachet Liquor among Adolescents in Ibadan South-East Local Government Area, Oyo State."

2. The committee has noted your compliance with all the ethical concerns raised in the initial review of the proposal. In the light of this, I am pleased to convey to you the approval of committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of the findings as this will help in policy making in the health sector.

4. Wishing you all the best.

Sola [illegible]
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee