

# Self-Reported Lifestyle and Health Status of Community Members in Ede, Osun State, Nigeria

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## ABSTRACT

As non-communicable diseases appear to be replacing communicable diseases in the 21st century, it is important to assess health status of communities even in rural settings in relation to their health related lifestyles. This survey seeks to determine the health status of respondents present at the outreach program by identifying the prevalent disease conditions among rural community members in Ede town, Osun state; understand the existing relationship between certain demographic characteristics of community members and their health related lifestyle/habits. Data was obtained through an interviewer administered questionnaire. Respondents (who were present at the outreach program) narrated their past and present medical condition. A total of 232 respondents were interviewed comprising of 80.20% females and 19.8% males. Mean age was 49.11±19.56 years and mean BMI of 24.34±4.88. Respondents had mean systolic and diastolic blood pressure of 139.87mmHg and 80.97mmHg respectively. Prevalent health conditions among respondents included: back problem, joint or muscle disorder, Seizures, Malaria, stress headaches and Depression. No statistically significant relationship exist between demographic characteristics (age, sex) of community members and their health-related lifestyle/habits. In conclusion, some chronic illnesses, as well as malaria, remain of concern even among rural populations. These disease conditions need to be of priority in planning and implementing community health programs in the developing countries.

**Keywords:** rural community, self-reported health status, non-communicable diseases, lifestyle, blood pressure, Body Mass Index

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### Aims Research Journal Reference Format:

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## 1. BACKGROUND OF THE STUDY

Lifestyle includes the behaviour and activities that make up daily life. This includes: the work one does, leisure activities, food/diet, interaction with family and friends, neighbours, co-workers and strangers. An Iran Research has shown that lifestyle changes in diet and levels of physical activity improve the health of entire communities (WHO, 2009). Increasingly, lifestyle in relation to health status is being looked at; however lifestyle of rural communities has been poorly researched. One of the major methods of effecting lifestyle change has been through mobilizations and outreach programs.

It has been established that outreach programs are most successful avenues for improving access to the target program/project such as screenings, services, support and empowerment (Guide to successful Outreach Education Programs, 2014). Outreaches are known to motivate individuals (and communities) to take action or make changes to improve their health beyond raising awareness and educating participants.

### 1.1 Statement of the Problem

Lifestyle undoubtedly impacts and plays important role in health. There is very strong evidence that our lifestyles are a major factor in our chances of living a long and healthy life (Karen, et al, 2013); however, lifestyle in relation to rural communities' health status has been poorly researched.

### 1.2 Study Objectives

The objectives of the study is determine self reported health status of selected individuals in the Ede town and by extension, determine if any relationship exist between demographic characteristics (age, sex) of community members and their health-related lifestyle/habits

## 2. METHODOLOGY

### 2.1 Study Design Setting and Population

This was a cross sectional study. Both quantitative and qualitative methods of inquiry were used to obtain data from community members at Ede Local government area in Osun state, Nigeria. Ede is a rural community located in Osun state Nigeria with a population of about 76,035 (National Census, 2006). A total of 232 respondents were interviewed using an interviewer administered questionnaire during an outreach program sponsored by the Springtime Development Foundation (SDF). General observation and current self reported ill health were noted. All the participants at the outreach program participated in the interview.

### 2.1 Data collection

**Instrument:** Data for this study was obtained through a 48-item structured, interviewer-administered questionnaire with 5 sections namely: personal information, health information/history (previous and present), health-related lifestyle/habits, physical assessment/observation and special complaints.

### 2.3 Measuring total health-related life style scores:

Several questions asked in the questionnaire about individual lifestyle and habit were scaled and scored and later dichotomised as close as possible to the mean health-related lifestyle/habit into good health-related lifestyle/habits (17 - 30 points) and poor health related lifestyles/habits 0 – 16 points).

The total health-related lifestyle/habit score was cumulated from 15 different questions. These include questions regarding breakfast, food frequency, intake of vegetables and fruits, multivitamin use, regular intake of water, sleeping pattern, frequency of check up/medical examination, alcohol intake, cigarette and coffee intake, exercise, significant other and religious belief. A likert scale of 3 was used to compile responses on each question (Never = 0 point, sometimes = 1 point; and often = 2 points) such that highest attainable score is 30

### 2.4 Data collection procedure

Data for this work was obtained during a one-day advertised outreach program which is a cluster of community members present at the outreach program. Interviewers obtained individual consent prior to obtaining responses for the individual questionnaire.

### 2.5 Method of data analysis

Analysis of data collected was done using the IBM SPSS for windows version 21.0 to determine statistically significant association, P-values, computation of means and standard deviations. Descriptive statistics were used to summarize the socio-demographic information of participants. As a standard for hypothesis testing, p-value was set at 0.05.

## 2.6 Study limitation

This study was a one-day advertised outreach program which was carried out at Ede town and it is probable that individuals interviewed had health problems, or are interested in their health and therefore had adopted healthy lifestyles. Those interviewed are mostly elderly individuals in the community. In addition, this study was based on reported health status of respondents and has not been followed up to determine their true health status. Also, the health related lifestyle and health status of respondents have not been compared with the types of occupation the rural populace who participated in the study engage in. These respondents may also not be a true representative of the community in itself.

## 3. RESULTS

### 3.1 Socio-demographic characteristics of respondents

Total respondents for the community based outreach program were 232 which comprised of 80.20% of females and 19.8% males. Majority (83.6% ; 194) who were present at the outreach program had never participated in previous health screening conducted by the organizers. Respondents' mean age was  $49.11 \pm 19.56$  years with minimum age of 13 years and maximum age of 100 years; Median age = 50 years. Minimum total health related lifestyle and habit score obtained was 9.0 and a maximum of 25.0 with mean score of  $17.90 \pm 3.07$ .

**Table 1: Independent T-test table showing difference in means of Health related lifestyle/habit score of male and female respondents**

t-test	Gender	N	Mean	Std. Deviation	P values (equal variances assumed)
<b>Health related Lifestyle and Habit score total</b>	Male	45	17.4444	3.18059	p > 0.05
	Female	184	18.0054	3.03980	

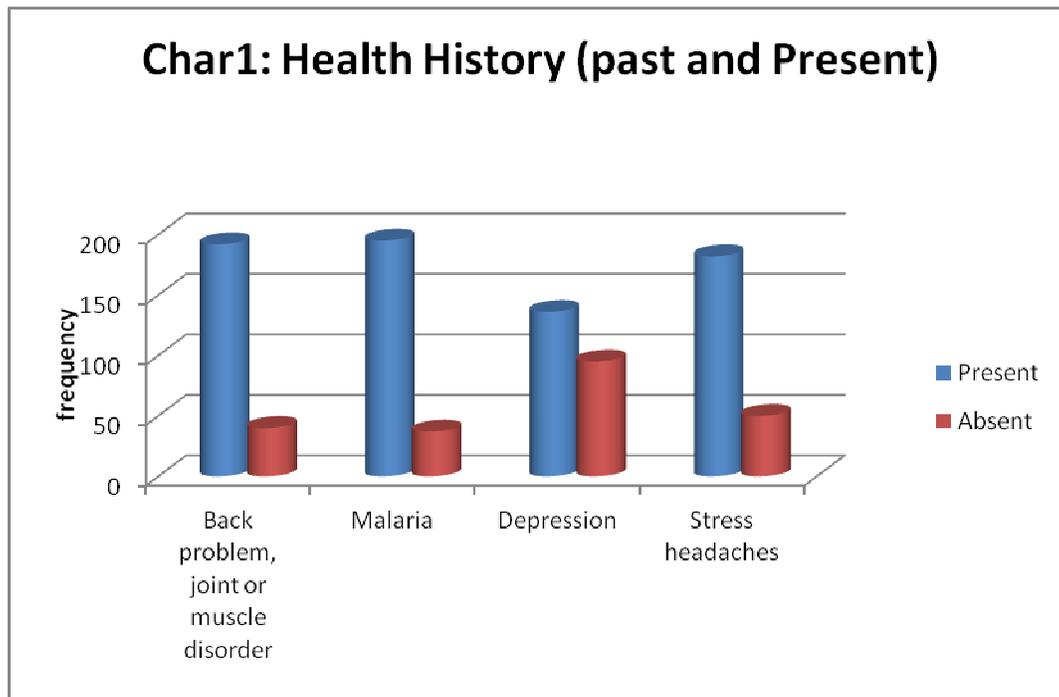
Table 1 shows that Females appeared to have higher mean health related lifestyle score than males, however, this is not statistically significantly different ( $p > 0.05$ ).

**Self-reported health Status of selected individuals in the community (past and present)**

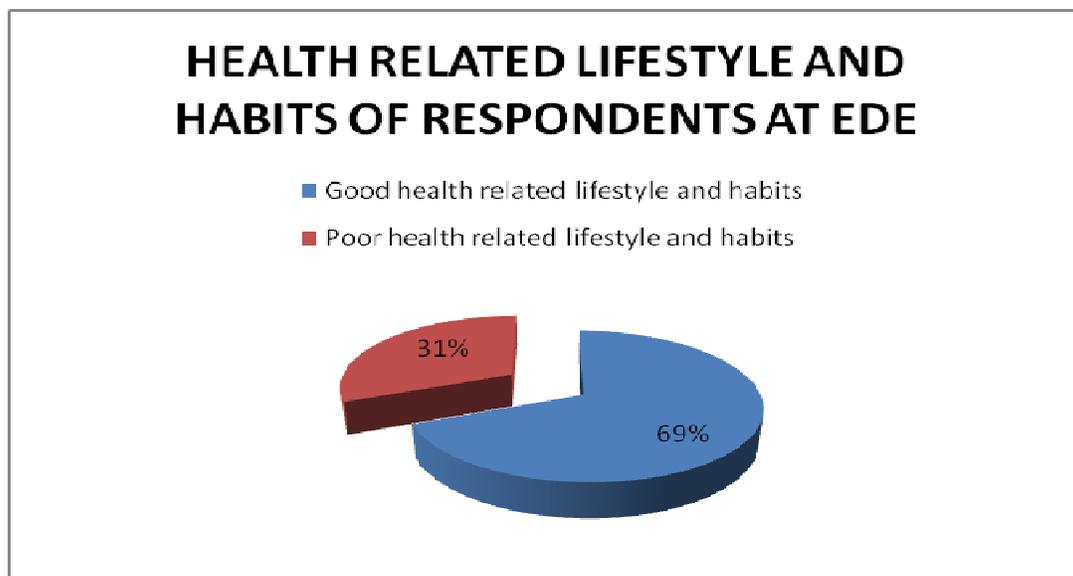
**Table 2: Responses to the question: Do you presently have or previously had the following health conditions?**

s/n	Health history (N= 231) (past and present)	Yes Freq	%	No Freq	%
1	Heart problem, recurring chest pain, heart murmur or stroke	88	37.9	143	61.6
2	Diagnosis of HTN or take medicine for some	46	19.8	185	79.7
3	Diabetes Mellitus	13	5.6	218	94.0
4	Asthma, breathing or lung problem	24	10.3	207	89.2
5	Cancer	6	2.6	225	97.0
6	Seizures, neurological problem	94	40.5	137	59.1
7	Gallbladder disease or intestinal issues	54	23.3	176	75.9
8	Back problem, joint or muscle disorder	192	92.8	40	17.2
9	Recent surgery (last 12 months)	15	6.5	216	93.1
10	Hernia or any condition that may be aggravated by lifting weights	33	14.2	198	85.3
11	Malaria	195	84.1	37	15.9
12	Enteric fever	77	33.2	154	66.4
13	Tuberculosis	15	6.5	214	92.6
14	Guinea worm	2	0.9	229	98.7
15	Elephantiasis	14	6.0	216	93.1
16	Round worm	35	15.1	196	84.5
17	Sickle cell disease	10	4.3	221	95.3
18	Depression	136	58.6	95	40.9
19	Stress headaches	182	78.4	50	21.6
20	Malnutrition	101	43.5	130	56.0

Prevalent health conditions among respondents as shown in the table 2 include back problem, joint or muscle disorder (92.8%), Malaria (84.1%), Depression (58.6%) and stress headache (78.4%). Self reported malnutrition accounted for 43.5%. Others included heart problem, recurring chest pain, heart murmur or stroke (37.9%), hypertension (19.8%), asthma, breathing or lung problem (10.3%), seizures, neurological problem (40.5%), gallbladder disease or intestinal issues (23.3%) and enteric fever (33.2%). In addition, significant difference was found in the following diseases reported among male and female respondents – seizures and neurological problems, enteric fever and stress headaches at  $p < 0.05$  (Chi square test).



**Fig. 2: Chart showing health history (Past and Present)**



**Fig. 2: Chart showing health related lifestyle and habits categories of respondents**

Chart one shows that many respondents (69%) reportedly had good health related lifestyle and habit while 31% had poor health related lifestyle and habit.

### Relationship between demographic characteristics (age, sex) of community members and their health related lifestyle/habits

Table 3 shows that there is no significant relationship between age category and gender of respondents and their health related lifestyle and habits.

**Table 3: Relationship between age, gender of respondents and their health related lifestyles**

Variable*Categories of Health related lifestyle and habits	Variable category	Good health related lifestyle and habits	Poor health related lifestyle and habits	Total
Age category (chi square = 6.192; P>0.05)	Teenagers/Adolescents (13 - 19years)	6	3	9
	20 - 30 years	25	12	37
	31 - 40 years	29	11	40
	41 - 50 years	28	16	44
	51 - 60 years	21	10	31
	60 - 70 years	21	7	28
	old age (70 - 100 years)	20	9	29
Gender (chi square = 2.404; P>0.05)	Male	27	18	45
	Female	130	54	184

Using Chi square test, no significant relationship was found between age categories and health related life style ( $p>0.05$ ). Similarly, no significant relationship was found in gender and the health related lifestyle categories.

## 4. DISCUSSION

### 4.1 Socio-demographic features of respondents for the outreach program

A total of 232 respondents were present at the advertised community based outreach program which was held at Ede town, Osun, Nigeria. Majority were females and many had never participated in previous health screening conducted by the organizers. Usually, females in rural settings respond more than males to similar outreach program (especially when health related). This often goes undocumented (Edet-Utan, Atolagbe, Aliu, Solademi, 2015).

Respondents' mean age was 49.1 years with minimum age of 13 years. Majority of respondents were older adults (31 – 100 years). This can be attributed to fact that the few persons present who were below 30 years accompanied some of the elderly that were present at the outreach. Youths are also not likely to take their health status assessment seriously and this may explain the low turnout of younger population for the outreach program.

#### **4.2 Self reported health Status history of selected individuals in the community**

The most prevalent health conditions among respondents in Ede town (a rural area) in south west Nigeria, were back problem, joint or muscle disorder, Malaria, stress headache and Depression respectively. In the locality where the outreach program was conducted, their major occupation is farming and trading. This may have contributed to high prevalence of back problem, joint or muscle disorder. A similar survey has reported higher incidence of obesity and depression among females who participated in the 6<sup>th</sup> Guernsey and Alderney healthy lifestyle survey (Hughes et al, 2013).

Malaria remains a top communicable disease in Nigeria despite all the national and international efforts towards its control and eradication. Others of concern included: malnutrition (43.5%), seizures, neurological problem (40.5%), heart problem, recurring chest pain heart murmur or stroke (37.9%), enteric fever (33.2%), gallbladder disease or intestinal issues (23.3%), hypertension (19.8%) and asthma breathing or lung problem (10.3%).

Community based studies in Nigeria have reported varying prevalence of hypertension in various parts of the country. The result obtained in this study showed that the prevalence of hypertension has increased beyond that of 1997 National survey on non communicable disease in rural areas with prevalence of 9.8%. In the Guernsey and Alderney Healthy Lifestyle Survey, 2013, the most commonly reported conditions were high blood pressure (26.5%), excess weight (24.2%), high cholesterol (22.1%) and depression (20.9%). This advertised free rural medical outreach greatly compromised the cluster of participants present.

#### **4.3 Reported Health Related lifestyle**

Even though this is a self-reported health status assessment, it probably reflects the true health status of the respondents. Considerably, many respondents (about two-thirds) reportedly had good health related lifestyle and habit. In the Guernsey and Alderney Healthy lifestyle survey, 2013, 80% of respondents reported their general health as good or very good. In this study, health related lifestyle score was a function of diet (quantity and quality), sleep pattern, fluid intake, regular/routine health checks, alcohol intake, cigarette/coffee intake, regular exercise and sharing of a problem with others/God.

#### **4.4 Relationship between demographic characteristics (age, sex) of community members and their health related lifestyle/habits**

No significant relationship was found between age categories, gender of respondents and their health related lifestyle and habits.

### **5. CONTRIBUTIONS TO KNOWLEDGE**

This study is another pointer to the fact that Malaria remains an endemic disease in rural settings, despite all the multidimensional efforts and approaches which has been put into combating the disease. In addition, disease conditions such as Back problem, joint or muscle disorder and stress headaches, which were found prevalent, may be associated with the occupations of the rural community farmers which were mostly trading and farming.

This survey has been able to establish that chronic illnesses (such as high blood pressure, back problem, joint or muscle disorder, Malaria, stress headache and depression) are prevalent in Ede town (a rural community). In addition, public health programs need to deliberately target the female populace and youths in rural areas for the implementation of programs that will help combat these illnesses.

## 6. RECOMMENDATION FOR FUTURE RESEARCH WORK

Usually, the sick ones are those who present at many advertised and sponsored outreaches. Therefore, further studies related to health status should consider a different rural population setting.

We have presented the self-reported life style in relation to health status of rural community members in this study, it will be beneficial if other studies can follow up with a cohort over a period of time to objectively assess lifestyle and compare with a control population.

## 7. SUMMARY/CONCLUSION

Despite respondents reported good health-related lifestyle, it is **confounding** to observe in this study that illnesses such as back problem, joint or muscle disorder, malaria, depression and stress headaches are very much prevalent amongst rural communities in Ede, Nigeria. This is a reflection of many rural communities in Nigeria. Malaria happened to be the communicable disease which is very prevalent across the nation and rural communities are not an exception. Public health programs need to deliberately target the female populace and youths in rural areas for the implementation of programs that will help combat these illnesses. Conclusively, chronic illnesses (high blood pressure, back problem, joint or muscle disorder, malaria, stress headache and depression), remain of concern even among the rural populace. These disease conditions need to be of priority in planning and implementing community health programs.

## REFERENCES

1. Akinkugbe O.O. (Editor). Non Communicable Diseases in Nigeria: National Survey (final report) on hypertension, coronary heart disease, diabetes mellitus, G6PD deficiency and anaemia. National Expert Committee on Non communicable disease. Federal Ministry of Health and social services, Lagos, 1997.
2. Centres for Disease Control and prevention: Mean Body weight, Height and Body Mass Index
3. Edet-Utan Oluwakemi, Atolagbe James E., Aliu Micheal and Solademi Bayo. Health Status and Lifestyle of Community Members in Ede, Osun state Nigeria. Proceedings from iSTEAMS conference – International Science, Technology, Engineering, Arts, Management and Social Sciences, Wednesday 12<sup>th</sup> – Friday 14<sup>th</sup> August, 2015, Senate Chambers, University of Benin, Edo City, Nigeria.
4. How Lifestyle Impacts Your Health, Action on Smoking and Health, [www.ashg.org](http://www.ashg.org)
5. Jay Schwartz (2011) The Body mass Index in Males vs. Females. Livestrong.com tracker article. [www.livestrong.com/article/356517-the-body-mass-index-in-males-vs-females/#page=2](http://www.livestrong.com/article/356517-the-body-mass-index-in-males-vs-females/#page=2)
6. Public Health England, 2015, <http://www.gov.uk/government/organizations/public-health-england>
7. Steven Hall, (2015) The BMI gap, The Body mass index difference between men and women. Halls.md Moose & Doc.
8. The Guide to Successful Outreach and Education Programs and Impact Awards, 2014 – <http://geneticalliance.org/guide-successful-outreach-and-education-programs>
9. Wellens R.I, Roche A.F., Khamis H.J, Jackson A.S., Pollock M.L, Siervogel R.M. (1996) Relationship between Body Mass Index and body composition. *Obese Res*, Jan 1996: 4(1): 33-34#WHO, Veronica Reima, podcast, 2009, number 56 [www.who.int/multimedia/podcasts](http://www.who.int/multimedia/podcasts)