

tertiary level of education and were smokers are 38.3% (41/107) compared to 61.7% (66/107) who are non-smokers. This difference was not statistically significant ($P = 0.38$).

Table 4, shows the association between alcohol consumption and socio-demographic variables. Respondents who are alcoholic drinkers and belonged to the 48-57 age brackets were 60.0% (18/30) compared with 40.0% (12/30) who are non-alcoholic drinkers. This difference was not statistically significant. ($P = 0.14$). While respondents who had secondary level of education and are alcoholic drinkers were 12.1% (13/107) compared with 87.9% (94/107) who are non-alcoholic drinkers. This observed difference was not statistically significant ($P = 0.30$).

Respondents who are obese and belonged to the 38-47 age bracket were 18.9% (10/53) compared to 81.1% (43/53) who are not obese. This difference was not statistically significant ($P = 0.38$). Respondents who had secondary level of education and are obese are 16.8% (18/107) compared to 83.2% (89/107) who are not obese. This observed difference was not statistically significant ($P = 0.30$) [Table 5].

Discussion

Two hundred and seventy two respondents participated in the study and the mean age was 36.7 ± 14.0 years. Majority of the respondents 39.3% had secondary level of education. It was not surprising that most of the inhabitants in Oghara community had secondary level of education as their highest educational attainment. This is probably because Oghara is a rural community and majority of the individuals who have higher educational qualification are likely to re-locate to urban centers and cities in search of white collar jobs.

The prevalence of hypertension in the study is 21.0%; this is lower than that seen in an urban area, Port Harcourt, Nigeria where the prevalence was found to be 40.8%.^[1] The morbidity and mortality caused by hypertension and CVDs alone have such a big impact on the country's economy and health care system. Decreasing this has become absolutely necessary and this can be achieved if it is diagnosis is made early and prompt management instituted.

The prevalence of cigarette smoking in the study was 15.8%. This is similar to that found in a rural community in Edo State, where the prevalence was 16.8%,^[40] as well as that found among U.S adult citizens in 2011, where the prevalence was recorded as 19.0%.^[41] It is not surprising that the prevalence of smoking from studies in Nigeria are close to that of the United States. This can be attributed to modernization and westernization of our culture, where the western culture and style of living are copied and emulated regardless of its negative effect on health.

Several studies have acknowledged smoking especially cigarette smoking as one of the major causes of non-communicable and chronic disease,^[42,43]. WHO reports that an estimated

Table 3: Smoking and socio demographic variable

Variable	Smoking n (%)		
	Smokers	Non-smokers	Total
Age (years)			
18-27	4 (4.8)	79 (95.2)	83 (100.0)
28-37	10 (12.8)	68 (87.2)	78 (100.0)
38-47	10 (19.2)	42 (80.8)	52 (100.0)
48-57	9 (30.0)	21 (70.0)	30 (100.0)
≥ 58	10 (34.5)	19 (65.5)	29 (100.0)
$P < 0.001$			
Level of education			
None	22 (51.2)	21 (48.8)	43 (100.0)
Primary	23 (50.0)	23 (50.0)	46 (100.0)
Secondary	32 (42.1)	44 (57.9)	76 (100.0)
Tertiary	41 (38.3)	66 (61.7)	107 (100.0)
$P = 0.38$			

Table 4: Alcohol consumption and socio-demographic variables

Variables	Alcohol consumption n (%)		
	Drinkers	None drinkers	Total
Age (years)			
18-27	30 (36.1)	53 (63.9)	83 (100.0)
28-37	32 (41.0)	46 (59.0)	78 (100.0)
38-47	22 (42.3)	30 (57.7)	52 (100.0)
48-57	18 (60.0)	12 (40.0)	30 (100.0)
≥ 58	16 (55.2)	13 (44.8)	29 (100.0)
$P = 0.14$			
Level of education			
None	8 (18.6)	35 (81.4)	43 (100.0)
Primary	11 (23.9)	35 (81.4)	46 (100.0)
Secondary	13 (12.1)	94 (87.9)	107 (100.0)
Tertiary	11 (14.5)	65 (85.5)	76 (100.0)
$P = 0.30$			

Table 5: Obesity and socio demographic variables

Variables	Obesity n (%)		
	Obese	None obese	Total
Age (years)			
18-27	11 (13.1)	73 (86.9)	84 (100.0)
28-37	20 (26.0)	57 (74.0)	77 (100.0)
38-47	10 (18.9)	43 (81.1)	53 (100.0)
48-57	6 (20.7)	23 (79.3)	29 (100.0)
≥ 58	4 (13.8)	25 (86.2)	29 (100.0)
$P = 0.38$			
Level of educational			
None	5 (11.6)	38 (88.4)	43 (100.0)
Primary	9 (19.6)	37 (80.4)	46 (100.0)
Secondary	18 (16.8)	89 (83.2)	107 (100.0)
Tertiary	19 (25.0)	57 (75.0)	76 (100.0)
$P = 0.30$			

5.4 million people die annually because of cigarette smoking. Smoking is the sixth cause of death in the world, and if the trends remain unchecked until 2030, the number of smoking

induced deaths will increase to eight to ten million. Smoking is a recognized cause of cancer, lung disease, coronary heart disease and stroke. It is considered to be the single most important avoidable cause of premature morbidity and mortality in the world,^[44] yet our people have coped this culture and style of living. There is therefore an urgent need to swing into action and reverse this ugly trend and unhealthy style of living in order to forestall these impending epidemics of NCDs. The prevalence of cigarette smoking increased with increasing age in the study and this has also been reported in other studies elsewhere.^[45-47] Similar to that found in other studies, the prevalence of smoking was inversely associated with educational status.^[48,49] This is probably because with increase in educational attainment, there is increase in the level of knowledge and the individual is likely to have access to diverse kind of health information, and as a result is able to make better choices concerning his health.

The prevalence of alcohol consumption in the study was 43.4%. It is not surprising that the prevalence of alcohol consumption in Oghara community was very high; this can be attributable to the fact that in the community just as in many parts of the state alcoholic beverages is a common feature of many social gatherings, also among the Urhobo tribe which is the predominant tribe in Oghara, it is believed that alcoholic drink should be consumed first thing in the morning in order to be agile and active all day long. Extensive reviews of several studies in different parts of the world have shown that moderate alcohol consumption is beneficial to the heart. It has also been shown that alcohol consumption is related to total mortality in a U-shaped manner, where moderate consumers have a reduced total mortality compared with non-consumers and heavy consumers,^[50,51] Hence moderate alcohol consumption is encouraged. Heavy alcohol consumption, on the other hand carries adverse health and social consequences due to its intoxicating and addictive properties. As a result of this addictive property light to moderate consumer can easily drift and become a heavy alcohol consumer. Heavy alcohol consumption has been established to be associated with many adverse health effects such as liver diseases, cancer, cardiomyopathy, etc.^[52] The draw back in encouraging moderate alcohol consumption is that there is a thin line separating moderate alcohol consumption from heavy alcohol consumption because of this addictive property. The prevalence of overweight in the study was 33.5%, while the prevalence of obesity was 16.9%. This is similar to that found in a nationwide survey in the United State In 2008, where the prevalence of overweight among adults aged 20 years and above was 35% and 11% for obesity. Previously overweight and obesity was thought to be a disorder of the developed countries,^[52] but recently evidence has shown that many low and middle income countries are now facing a “double burden” of disease. While they continue to deal with the problem of infectious diseases and under nutrition, they are now experiencing a rapid upsurge in NCD risk factors such as overweight and obesity. Overweight and obesity is characterized by raised

body mass index (BMI), and as BMI increases, so does the risk for coronary heart diseases, angina heart failure, hypertension, stroke, osteoarthritis, type II diabetes, cancers, to mention but a few. There is therefore need to make policies that will encourage regular physical activity and healthier dietary choices while making them available, affordable and accessible to all. The findings of the study have revealed high levels of modifiable risk factors of hypertension. These values are as high as those found in the developed countries, hence a likely increase in the burden of hypertension and other non-communicable diseases in the near future. There is therefore need to encourage changes in behavior and style of living in order to forestall this impending epidemic of non-communicable diseases among our population.

Conclusion

The prevalence of modifiable risk factors of hypertension in Oghara is comparable to the values seen in developed countries. It therefore means that if nothing is done to reverse this ugly trend and style of living; hypertension and other NCDs will soon become an epidemic in the country coupled with epidemics of communicable diseases still plaguing us.

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