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ALCOHOL CONSUMPTION BY USERS IN THE FAMILY HEALTH STRATEGY

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ABSTRACT

Objective: to analyze alcohol consumption among users of a family health strategy.
Method: descriptive, exploratory, cross-sectional study, with a quantitative approach. Data collection was conducted from a sociodemographic questionnaire and the AUDIT, with 199 registered users at the health family strategy. Data were analyzed with the aid of the STATA/SE 12.0. Chi-Square and Fisher's exact tests were used to verify the association of variables. The study was approved by the Ethics in Research Committee of the Federal University of Pernambuco.
Results: the study found that 75.4% of users were in low-risk use, 24.6% were in problematic use. Of these, 14.1% presented at-risk use, 5.5% alcohol abuse and 5.0% had possible addiction. It was also observed that the variables gender and religion have association with problematic use.
Conclusion: it was evidenced significant problematic alcohol consumption by users of the health family strategy.

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INTRODUCTION

According to the World Health Organization (WHO), about two billion people drink alcoholic beverages around the world each year. Alcohol, although licit, causes health damage to the individual and is the third cause of mortality and morbidity in the world (Brazil, 2013). In 2014, the WHO released a global report on alcohol and health, highlighting the causes of death and illnesses attributed to alcohol abuse. Among the diseases with the highest prevalence, alcohol use disorders and fetal alcohol syndrome should be highlighted. There are other diseases that presented lower prevalence, but they were relevant to collective health, such as cirrhosis, pancreatitis, tuberculosis, epilepsy, some cancers, heart diseases and vascular accidents (WHO, 2014). Still, according to data from the above mentioned report, there are other causes of death related to alcohol consumption, such as violence and accidents. About 22% of accidents are related to self-mutilation and interpersonal violence (WHO, 2014). Another problem observed regarding the alcohol consumption is addiction.

In Brazil, the last survey on the home use of psychotropic drugs revealed that 12.3% of the people interviewed had dependence (CEBRID, 2006). These data confirm the need for interventions aimed at coping with alcohol abuse by the population. In this sense, primary health care (PHC) plays an important role in preventing alcohol abuse and minimizing the negative impacts it causes. PHC is, preferably, the health service with the purpose of treating conditions and complications most common to health status (Giovanella and Mendonça, 2009), including those related to alcohol. This level of care is characterized by providing a set of individual and collective actions in the health area with the objective of promoting health through comprehensive care, which impacts on individuals' health conditions, autonomy and on health determinants and conditionings in a collective environment (Brazil, 2013). In order to minimize the consequences of alcohol abuse, the AUDIT and planned interventions, based on their results, can be applied to primary health care efficiently because it is a level of care that is attended by the majority of the population. The Alcohol Use Disorder Identification Test

(AUDIT) was developed in the 1980s by the WHO. Such an instrument can be applied in different cultures, is easy-to-apply and was created to help in the identification of aggravations from patterns of alcohol use and in the application of prevention strategies against social and health problems related to alcohol use (Babor, Higgens-Biddle, Saunders and Monteiro, 2014). The AUDIT was translated, adapted to the Brazilian reality and validated. This study showed that the AUDIT can be applied widely in clinical and primary health care in Brazil (Mendez, 1999). Studies have been carried out with the AUDIT in primary health care in different states of the country (Taufick, Evangelista, Silva and Oliveira, 2014; Jomar, Abreu and Griep, 2014; Vargas, Bittencourt and Barroso, 2014). Among them, a study was carried out in the city of Uberlândia, state of Minas Gerais, which identified that 17.5% of the individuals interviewed were considered at risk for alcohol consumption (Taufick, Evangelista, Silva and Oliveira, 2014). In 2010, in the city of Rio de Janeiro, another study observed that 17.6% of the participants had at-risk alcohol consumption (Jomar, Abreu and Griep, 2014). In the city of Bebedouro, state of São Paulo, another study revealed that 78% of the users were abstinent or presented low-risk consumption and 22% presented problematic alcohol consumption (Vargas, Bittencourt and Barroso, 2014). The results of these studies highlight the importance of using such an instrument. However, there is a need to develop other studies in this area, especially in medium-sized municipalities. From the above, the objective of this study is to analyze alcohol consumption by users registered in a family health strategy.

MATERIALS AND METHODS

This is a descriptive, exploratory, cross-sectional study with a quantitative approach carried out at a basic health unit (BHU) in a medium-sized municipality in the state of Pernambuco (Brazil). The study population consisted of users enrolled in the BHU. In order to compose the sample, individuals were selected according to the following criteria: individuals over 18 years of age, of both genders. On the other hand, individuals who were illiterate or who had some type of difficulty that made them unable to answer to the data collection instrument were excluded. For the sample calculation, the formula for finite population was used with the following parameters: users enrolled in unit 1462, 95%confidence level, 5% error, 18.3% of prevalence of the phenomenon (Magnabosco, Formigoni and Ronzani, 2007). Therefore, the sample consisted of 199 participants. In order to select the participants, we used the probabilistic sampling process, by simple random lottery, in which the households of the families registered in the basic health unit were drawn, and in each household, a participant was drawn for the study. If the individual had not been found at home on the first visit, two further attempts were made. If he/she had not been located after the attempts, it was automatically disconnected from the study and a new participant was selected from the next household. The research used two instruments to collect the data, namely the sociodemographic questionnaire and the AUDIT. The sociodemographic questionnaire contains information such as age, gender, religion, occupation, monthly income, schooling, marital status and person with whom one lives. The AUDIT refers to recent alcohol use, dependence, symptoms and conditions in the past 12 months. The questionnaire analyzes quantity and frequency, symptoms related to dependence and harmful use of alcohol. In view of the acquired score, the participant's alcohol consumption pattern is categorized into risk levels: low risk or risk zone I (0 to 7 points); at-risk consumption or risk zone II (8 to 15 points); harmful consumption or risk zone III (16 to 19 points); possible dependence or IV risk zone (20 to 40 points). Problematic alcohol use was also considered when the final AUDIT score is equal to or greater than 8 (Babor, Higgens-Biddle, Saunders and Monteiro, 2014). For the data collection, the randomized participant was invited to participate in the study. After agreeing, he/she signed the informed consent form and answered the questionnaires. The participant's questionnaire completion time was, on average, ten minutes. The data were inserted in Excel spreadsheet and analyzed with the help of STATA/SE 12.0 Software. In order to verify the existence of association between the variables, the Chi-square test and the Fisher's exact test were used and 95% confidence was adopted. The results were presented in tables and/or charts with their respective absolute and relative frequencies. This study is a cut of the project entitled "Alcohol consumption pattern in users served in family health units", which was approved by the Research Ethics Committee of the Federal University of Pernambuco (Protocol No.: 21018913.0.0000.5208).

RESULTS

A total of 199 individuals enrolled in the family health strategy participated in the study. Table 1 presents the main sociodemographic data of the participants. Table 1 shows prevalence of women, under the age of 30, married, Catholic and with some type of occupation.

Table 1. Sociodemographic characteristics of participants. Vitória de san to Antão, Pernambuco, 2015

Variable	n	%
Gender		
Male	78	39.2
Female	121	60.8
Age		
< 30	72	36.2
30 |- 40	53	26.6
40 |- 50	34	17.1
≥ 50	40	20.1
Religion		
Catholic	124	62.3
Evangelical	50	25.1
Without religion	24	12.1
Others	1	0.5
Occupation		
With occupation *	155	77.9
Without occupation **	44	22.1
Monthly income		
No income	68	34.2
Below a minimum wage	47	23.6
One minimum wage	74	37.2
Two or more minimum wages	10	5.0
Schooling		
1 to 9 years of study	136	68.4
10 to 12 years of studies	52	26.1
Over 12 years of studies	11	5.5
Marital status		
Single	64	32.2
Married	128	64.3
Widowed	6	3.0
Divorce	1	0.5
Lives with		
Parents	25	12.6
Partner	130	65.3
Alone	13	6.5
Other relatives	31	15.6

*employee, student, housewife, freelance. ** unemployed, pensioner, retired.
Source: research data.

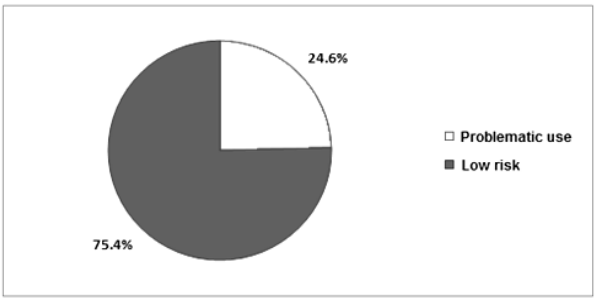
Table 2 shows the distribution of study participants, according to the alcohol consumption pattern.

Table 2. Alcohol consumption pattern of participants according to the risk zone. Vitória de Santo Antão, Pernambuco, 2015

Zone	N	%
Zone I or low risk	150	75.4%
Zone II or at-risk use	28	14.1%
Zone III or harmful use	11	5.5%
Zone IV or possible dependence	10	5.0%

Source: research data.

Figure 1 shows the distribution of participants according to alcohol use.



Source: research data.

Figure 1. Distribution of participants according to alcohol use

Data in Table 3 show association between the study variables and the problematic use of alcohol. There is a statistically significant relation between problematic alcohol consumption and the variables gender and religion.

DISCUSSION

The results of the study revealed a high index of problematic alcohol consumption (24.6%), which corroborates other studies conducted in Uberlândia (17.5%), Rio de Janeiro (17.6%) and Bebedouro (22%) (Taufick, Evangelista, Silva and Oliveira, 2014; Jomar, Abreu and Griep, 2014; Vargas, Bittencourt and Barroso, 2014). A similar study, conducted in the same municipality but in a different family health unit, identified that 40.6% of the interviewed users presented at-risk alcohol use (Silva *et al*, 2014), which differs from the result presented here. This difference may be related to sociodemographic and cultural characteristics existing between the two health units. There is an association between the variables gender and religion with the problematic use of alcohol. As observed in other studies conducted in different Brazilian states, men presented significantly higher problematic alcohol consumption than women (Taufick, Evangelista, Silva and Oliveira, 2014; Jomar, Abreu and Griep, 2014; Vargas, Bittencourt and Barroso, 2014; Magnabosco, Formigoni and Ronzani, 2007; Silva *et al*, 2014).

Table 3. Relationship between problematic alcohol use and sociodemographic characteristics of participants. Vitória de Santo de Antão, Pernambuco, 2015

	AUDIT		
Variable	Problematic Use n (%)	Low risk n (%)	p-value
Gender			
Male	30 (38.5)	48 (61.5)	< 0.001 *
Female	19 (15.7)	102 (84.3)	
Age			
< 30	22 (30.6)	50 (69.4)	0.336 *
30 |- 40	13 (24.5)	40 (75.5)	
40 |- 50	8 (23.5)	26 (76.5)	
≥ 50	6 (15.0)	34 (85.0)	
Religion			
Catholic	33 (26.6)	91 (73.4)	0.014 **
Evangelical	6 (12.0)	44 (88.0)	
Without religion	9 (37.5)	15 (62.5)	
Others	1 (100.0)	0 (0.0)	
Ocupation			
With occupation *	41 (26.5)	114 (73.5)	0.261 *
Without occupation **	8 (18.2)	36 (81.8)	
Monthly income			
No income	12 (17.6)	56 (82.4)	0.137 *
Below a minimum wage	13 (27.7)	34 (72.3)	
One minimum wage	19 (25.7)	55 (74.3)	
Two or more minimum wages	5 (50.0)	5 (50.0)	
Schooling			
1 to 9 years of study	35 (71.5)	101 (67.3)	0.467 *
10 to 12 years of studies	13 (26.5)	39 (26.0)	
Over 12 years of studies	1 (2.0)	10 (6.7)	
Marital status			
Single	20 (31.3)	44 (68.8)	0.526 **
Married	28 (21.9)	100 (78.1)	
Widowed	1 (16.7)	5 (83.3)	
Divorce	0 (0.0)	1 (100.0)	
Lives with			
Parents	9 (36.0)	16 (64.0)	0.573 *
Partner	30 (23.1)	100 (76.9)	
Alone	3 (23.1)	10 (76.9)	
Other relatives	7 (22.6)	24 (77.4)	

(*)Chi-square test (**)Fisher's exact test. Source: research data.

Data obtained by the WHO showed that women have greater alcohol withdrawal than men. In addition, men drink more frequently and their consumption is also related to heavy drinking. These values are reflected in the number of deaths worldwide attributed to alcohol between men (7.6%) and women (4.0%), which indicates differences regarding consumption patterns between genders (WHO, 2014). The results of this study corroborate with the results of a national survey showing that 83.5% of men had made use of alcohol throughout life, while women obtained lower values, 68.3%, reaffirming the relation between alcohol consumption and gender (CEBRID, 2006). Concerning religiosity, this study showed that having a religion is not related to the problematic use of alcohol, as observed in other studies (Jomar, Abreu and Griep, 2014; Vargas, Bittencourt and Barroso, 2014; Magnabosco, Formigoni and Ronzani, 2007; Silva *et al*, 2014). Although the present study identified that the variables gender and religion are related to problematic use, another study revealed that other variables, such as marital status, age and occupation, may also be related to problematic use. In this case, individuals between the ages of 18 and 30, having an occupation and being single presented problematic use (Silva *et al*, 2014).

Another study pointed out that this pattern of problematic alcohol consumption was identified in black and/or brown individuals, smokers and without chronic disease (Jomar, Abreu and Griep, 2014). One can also mention monthly income, in which individuals with incomes greater than six minimum wages presented problematic use (Vargas, Bittencourt and Barroso, 2014). When considering the results of this study according to risk zones, a similar result was observed in another study, in which 10% of the participants were found to be at risk, 2% presented harmful consumption, and 10% were likely to be dependent (Vargas, Bittencourt and Barroso, 2014). A study conducted in the cities of Juiz de Fora and Rio Pomba (Minas Gerais/Brazil) also corroborated these results, in which 77.9% of respondents presented low-risk consumption, 15.1% at-risk use, 3.3% harmful consumption and 3.8% were in the zone of possible dependence (Magnabosco, Formigoni and Ronzani, 2007). Thus, the results obtained in this study corroborate with findings in the literature.

Conclusion

Most of the individuals that participated in this study were female (60.8%), mean age between 18 and 30 years (36.2%), Catholic (62.3%), married (64.3%), had occupation (77.9%), nine years of education (68.4%) and monthly income of a minimum wage (37.2%). The present study identified a pattern of problematic alcohol consumption in 24.6% of the participants and showed that the variables gender and religion were associated with this consumption. These results are relevant to the primary health care practice, as it provides information for the family health team to plan and adopt prevention strategies for problematic use. It is important to emphasize that these strategies should not only focus on the individual who presents a problem regarding consumption, but on the family and the environment in which the user is inserted.

The conduction of the study in only one family health unit was a limitation. Thus, we suggest the development of studies in other health units, especially in small and medium-sized municipalities in different regions of the country. Therefore, professionals and the population must be aware about the alcohol consumption pattern in order to identify the characteristics of the individuals who present greater vulnerability to problematic alcohol consumption, and to provide subsidies to the healthcare team to family health in order to better deal with this problem.

REFERENCES

Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., and Monteiro, M.G. 2001. The alcohol use disorders identification test: guidelines for use in primary care. Genebra: World Health Organization.

Brazil. 2013. Ministério da Saúde. Secretaria Nacional sobre Drogas. Prevenção do uso de drogas: capacitação para conselheiros e lideranças comunitárias. Brasília: SENAD.

Brazil. 2013. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Caderno de Atenção Básica 34. Brasília: Ministério da Saúde.

Cebrid. 2006. II Levantamento domiciliar sobre o uso de drogas psicotrópicas no Brasil: estudo envolvendo as 108 maiores cidades do país: 2005 / E. A. Carlini (supervisão) [et. al.], -- São Paulo: CEBRID - Centro Brasileiro de Informação sobre Drogas Psicotrópicas: UNIFESP - Universidade Federal de São Paulo.

Giovanella, L., and Mendonça, M. H.M. 2009. Atenção Primaria à Saúde. Disponível em: www.escoladesaude.pr.gov.br/.../ATENCAO_PRIMARIA_A_SAUDE_E.

Jomar, R.T., Abreu, A. M. M., and Griep, R.H. 2014. Padrões de consumo de álcool e fatores associados entre adultos usuários de serviço de atenção básica do Rio de Janeiro, RJ, Brasil. Ciênc. saúde coletiva. 19: 27-38.

Magnabosco, M. B., Formigoni, M.L.O.S., and Ronzani, T.M. 2007. Avaliação dos padrões de uso de álcool em usuários de serviços de Atenção Primária à Saúde de Juiz de Fora e Rio Pomba (MG). Rev. bras. Epidemiol. 10: 637-647

Méndez, E.B. 1999. Uma Versão Brasileira do AUDIT (Alcohol Use Disorders Identification Test) Pelotas: Universidade Federal de Pelotas.

Silva, J.K.S., Guimarães, F.J., Perrelli, J.G.A., Santos, Z.C. and Pagliuca, L.M.F. 2014. Pattern of Alcohol Consumption in Registered Users of a Family Health Unit. Health. 6: 1172-1179. Doi: 10.4236/health.2014.611144.

Taufick, M.L.C., Evangelista, L.A., Silva, M.D.A., and Oliveira, L.C.M. 2014. Perfis de consumo alcoólico entre pacientes da atenção primária à saúde e seu reconhecimento pelos profissionais de saúde. Cad. Saúde Pública. 30: 427-432.

Vargas, D., Bittencourt, M.N., and Barroso, L.P. 2014. Padrões de consumo de álcool de usuários de serviços de atenção primária à saúde de um município brasileiro. Ciênc. saúde coletiva. 19: 17-25.

World Health Organization. 2014. Global status report on alcohol and health. Geneva, Switzerland: WHO.

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