

**ALCOHOL CONSUMPTION AMONG GHANAIAN WOMEN OF CHILD BEARING
AGE – WHAT ARE THE CORRELATES?**

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***Abstract:** This paper examines the demographic and socio-economic correlates of alcohol consumption and drinking frequency among Ghanaian women aged 15-49 years. The study utilizes the 2008 Ghana Demographic and Health Survey data, which remains the most recent DHS for studying the phenomenon in*

Ghana. Using logistic regression, our findings indicate that alcohol consumption among Ghanaian women is influenced by age, education, and wealth status. In addition, while health insurance ownership significantly affects alcohol consumption among urban women, employment status is reported to be a significant determinant among rural women. Results from the ordered logistic regression show that age, wealth status, pregnancy status, and place of residence are significant predictors of alcohol drinking frequency among Ghanaian women. Moreover, while secondary educational attainment is significant among urban women, primary educational attainment is significant among rural women. The study concludes that the predictors of alcohol consumption and drinking frequency among women of childbearing age in Ghana vary by place of residence (i.e., rural vs urban).

Keywords: *alcohol consumption, alcohol drinking frequency, women of reproductive age, logit regression, ordered logit regression, rural/urban Ghana.*

1. Introduction

The health burden associated with the consumption of alcohol both in terms of morbidity and mortality is obvious (Cheah and Rasiah, 2017). Frequent consumption of alcohol to intoxication level may lead to increased probability of fatalities through accidents. People who frequently drink to intoxication levels may also absent themselves from work and this may affect productivity at both the micro and macro levels. In addition, excessive in-take of alcohol may incite people to engage in violent and crime-related activities culminating in various degrees of injuries and in some cases deaths.

Yet, alcohol consumption is pervasive in many countries. The world's highest consumption rates occur mostly in the developed countries, particularly Eastern and Western Europe. In Africa, the highest consumption rates are recorded in the southern part with South Africa and Namibia having the highest consumption levels. Likewise, the increasing participation of the youth and women in alcohol consumption is a matter of concern for health policy makers (Kim & Kim, 2008). Martinez et al. (2011) underscored the increasing prevalence of alcohol use by women in African countries such as Botswana (30%) and Namibia (47%) (see also McDermott et al., 2009). It is estimated that 18% of women of childbearing age (15–49 years) in Ghana drink alcoholic beverages (GSS, 2009). Due to the increasing prevalence of alcohol consumption, all the 193 WHO Member States endorsed a global strategy to reduce the harmful use of alcohol in 2010 (WHO, 2011).

In Ghana, alcohol consumption is increasingly becoming a major public health concern. Although the existing consumption level of 1.54 litres yearly seems relatively low, it poses one of

the highest risk factors for deaths and disability in the country (GSS, 2009). This is because the reported level of consumption obviously does not include those consumed surreptitiously due to the prevalence of traditional alcoholic beverages in Ghana; and this possibly represent a larger share of alcohol consumption. However, there is lack of consistent data on alcohol consumption pattern in terms of type consumed, the quantity consumed and frequency of consumption to inform rigorous studies. This necessitated the need to collect consistent information on alcohol consumption in the 2008 Ghana Demographic and Health Survey (GDHS). While available statistics on alcohol consumption in Ghana may seem relatively low compared to other countries in Africa, there is a disturbing trend of increasing consumption of especially the locally brewed alcoholic beverages among females. The type of alcohol usually consumed ranges from beer, spirits, wine, and other locally brewed alcoholic beverages. In Ghana, while *pito* (a fermented alcoholic beverage made from millet) is most commonly consumed in the northern part of the country, in the southern part, it is *palm wine* and/or *akpeteshie* (mostly distilled from palm wine). In addition, there is an upward trend for adolescent participation even though the minimum age for drinking alcohol in Ghana is eighteen (18) years. Nonetheless, there is no age limit for on and off purchasing of alcohol in Ghana coupled with the fact that there is no enforcement of the age limit for alcohol consumption.

Despite all the health and social problems associated with the abuse of alcohol, there is scant literature on consumption patterns and its socio-economic and demographic correlates. Given the relatively more adverse effects of excessive drinking on females compared to males due to their biological composition and coupled with the fact that female participation with respect to alcohol consumption in Ghana is increasing, this paper attempts to ascertain the key correlates of alcohol consumption and its frequency among urban and rural Ghanaian women (aged between 15 and 49 years). The paper focuses on women because of the role women play typically in Ghanaian households in terms of raising young-ones and so they are more likely to influence these young ones with any risky health behaviours they associate themselves with.

2. Related Literature

Grossman (1972) emphasizes the role of education in an individual's demand for health-related goods. Higher education is expected to result in less alcohol consumption (see also Perkins, 2002; Rintaugu et al. 2012; Kacapyr and Choudhury, 2006). Other studies have espoused the role of religious beliefs and other socio-economic attributes in alcohol consumption behavior

(Brown et al. 2001; Barros et al 2009; Martinez et al. 2011; Adeyiga et al, 2014). For instance, Brown et.al (2001) revealed that boys from very religious groups consumed less alcohol than their counterparts who are not very religious in the USA. Also, Dumbili (2013); Luginaah and Dakubo (2003); Martinez et al. (2011) have shown higher prevalence of alcohol use among women within lower income groups in Africa. Furthermore, working women, especially those who work outside the home, are found to be more likely to consume alcohol than their non-working counterparts. Dawson et al. (2005); Seaman and Ikeguowu (2010) further reported that women adopt the drinking patterns of men because they want to bridge the gender gap as well as reduce stress.

Newbury-Birch et al. (2009) found that while good family relations act as protective factor to decrease the probability of an individual drinking, poor relations may increase this probability. Also, a study by O'Malley and Wagenaar (1991) revealed that setting a higher minimum drinking age leads to lower consumption rates among high school seniors in the USA. Mbatia et al. (2009) reported that hazardous alcohol use is prevalent among never-married women. Additionally, Adusi-Poku et al. (2013) found that alcohol use is more prevalent among pregnant married women in Bosomtwe District (Ghana) than their unmarried counterparts.

A more recent study on Ghana explored the factors associated with alcohol consumption among a cross-section of women of child bearing age (Adeyiga et al. 2014). The study was however limited to women attending clinics of the Department of Obstetrics and Gynecology outpatient at the Korle Bu Teaching Hospital in Accra. Also, Anyawie (2013) investigated the determinants of alcohol consumption among women in three communities in Ghana using logit regression. While this was an informative study, the model omitted important covariates such as education and income/wealth, which in the absence of price are considered significant predictors of alcohol consumption. Besides, the study was limited to only three communities and thus results cannot be generalized to the Ghanaian population. The current study rather uses a nationally representative survey, the findings of which could be generalized to the population. Although this study is similar to Tampah-Naah and Amoah (2015), the contribution of this paper lies in the analysis of the results from a rural-urban perspective and the focus on women in the reproductive age bracket.

3. Methodology

3.1. Method of Analysis

This study employs two models to identify the factors influencing alcohol consumption and its frequency among Ghanaian women of reproductive age. In the first model, alcohol consumption is modelled as a binary variable; whether or not a woman consumes alcohol over the past 7 days preceding the survey. Here, the dependent variable takes the value of 1 if the respondent consumed alcohol and 0 otherwise. Since the dependent variable is dichotomous, the logit or probit models can be used by employing maximum likelihood procedure to estimate the parameters. In this study, the probability that a woman consumes alcohol can be written as $\Pr(Y_i = 1)$ if she consumes alcohol. It is assumed that the woman will weigh the utility to be derived from consumption of alcohol relative to the utility without such consumption. The woman takes a decision to consume provided the utility associated with its consumption is higher than the utility without consumption.

In the second model, the correlates of alcohol consumption frequency, the dependent variable is the number of times alcohol was consumed within a week. It is a categorical variable given as a range (0, 1, 2-3 times, 4 times or more). Thus, the dependent variable is polychotomous, there is a natural ordering; 0 = none, 1 = once, 2 = 2-3 times, and 3 = 4 times or more, hence multinomial logit is used to estimate the model.

The socio-economic characteristics considered in the model are educational level, wealth index, employment status, place of residence, health insurance ownership, and relationship to head, pregnancy status, and age. The choice of these variables is influenced by both theoretical and empirical literature. For instance, the place of residence (rural or urban) was included in order to determine whether or not living in the rural area (where most households are economically deprived) may influence the consumption of alcohol. However, based on the bivariate analysis, the variables which are statistically insignificant ($p > 0.05$) were excluded from either the logit regression and or ordered logit regression.

3.2. Source of Data and its Limitations

Out of the six rounds of the Demographic and Health Surveys, only the 2008 GDHS collected some relatively detailed information on the consumption of alcohol in Ghana. Hence, the study relies on the 2008 GDHS. The 2008 GDHS is a national household-based survey covering all the ten regions in Ghana. It is the fifth of its kind with other surveys conducted in 1988, 1993, 1998, 2003, and 2014. The 2008 GDHS was primarily carried out by the Ghana Statistical Service and the Ghana Health Service. The survey used two-stage sample which is based on the 2,000

Population and Housing Census to produce separate estimates for each region in Ghana (GDHS Report, 2008). In all, a total of 11,778 households were interviewed; 4,916 women between 15 and 49 years and 4,568 men, aged 15–59 years were interviewed. This study is however based on the women’s questionnaire.

The survey therefore contains detailed information on variables including *inter alia* fertility preferences, family planning (awareness, knowledge and use of methods), maternal health (antenatal care, delivery care, postnatal care, etc.), child health (nutrition, mortality, etc.), HIV/AIDS (awareness and behaviour) and other sexually transmitted infections. The ICF MACRO assisted the implementation of the survey financially and technically through the MEASURE DHS Programme funded by USAID. This programme is designed to help developing countries with regard to collecting data on fertility, family planning and maternal and child health. The data was collected between September and November 2008. While the 2008 GDHS happens to be one of the best data for such a study, it does not contain certain information on some variables like price of the alcoholic drink, type of drink consumed and income of the respondent which may be very important for such a study. However, with regard to income, the data uses wealth index (measured in quintiles) as a proxy. Table 1 presents description and measurement of the variables employed for the analysis.

Table 1: Description and Measurements of Variables used in the Estimations

Variable	Description	Measurement
Outcome Variable		
Drinks	alcohol drinking status	1 = drinks, 0 = otherwise
Drinking frequency	Times consumed alcohol in last 7 days	0 = none, 1 = once, 2 = few (2-3 times), 3 = more (4 times or more)
Explanatory Variables		
Age	Age of respondent	Measured in years
Age square	Square of respondent’s age	Square of age
Health insured	Health insurance status	1 = insured, 0 = uninsured
Relationship to head	Relationship to household head	1 = head, 0 = otherwise
Employed	Employment status	1 = employed, otherwise = 0
Urban	Type of place of residence	1 = urban, 0 = rural
Pregnant	Pregnancy status	1 = currently pregnant, 0 = otherwise
Poorest	Wealth quintile	1 = poorest, otherwise = 0
Poorer	Wealth quintile	1 = poorer, otherwise = 0
Middle	Wealth quintile	1 = average, otherwise = 0
Richer	Wealth quintile	1 = richer, otherwise = 0
Richest	Wealth quintile (omitted)	1 = richest, otherwise = 0
No education	Educational attainment (omitted)	1 = no education, otherwise = 0
Primary education	Educational attainment	1 = primary, otherwise = 0
Secondary education	Educational attainment	1 = secondary, otherwise = 0
Tertiary education	Educational attainment	1 = tertiary, otherwise = 0

4. Results

4.1 Descriptive Statistics

According to the 2008 GDHS report, alcohol consumption varies by background characteristics (gender, age, place of residence, education, etc). The descriptive statistics of the variables are reported in Table 2. It is reported that 19.49% of the women sampled for the analysis, consumed alcohol. However, more of the women in the rural subsample (21.78%), relative to the urban subsample (16.59), consumed alcohol. Moreover, the consumption of alcohol in the last seven days reduces from 37.1% for those who consumed it once to 8.77% for those who consumed it more than four times.

Table 2: Descriptive Statistics of Variables of Concern

Explanatory Variable	Full Sample (n=4,854)	Urban Subsample (n=2,140)	Rural Subsample (n=2,714)
<i>Alcohol Consumption</i>			
Yes	19.49	16.59	21.78
No	80.51	83.41	78.22
<i>Alcohol Consumption Frequency</i>			
None	28.33	43.94	18.95
Once	37.1	36.62	37.39
2-3 times	25.79	14.93	32.32
4 times or more	8.77	4.51	11.34
<i>Age of respondent</i>			
Age	29.00	28.64	29.29
Age square	935.03	909.39	955.24
<i>Health insurance policy holder</i>			
Yes	41.8	45.89	38.58
No	58.2	54.11	61.42
<i>Relationship to Household Head</i>			
Head	21.32	25.42	18.09
Other	78.68	74.58	81.91
<i>Currently Working</i>			
Yes	75.22	70.7	78.78
No	24.78	29.3	21.22
<i>Place of residence</i>			
Urban	44.09		
Rural	55.91		
<i>Currently Pregnant</i>			
Yes	7.48	6.50	8.25
No	92.52	93.5	91.75
<i>Wealth Quintile</i>			
poorest	21.98	1.17	38.39
Poorer	18.79	5.14	29.55
Middle	18.34	18.46	18.24
Richer	20.87	34.39	10.21
Richest	20.02	40.84	3.61
<i>Educational attainment</i>			
No education	25.18	12.34	35.30
Primary education	20.46	15.98	23.99
Secondary education	50.68	64.95	39.43
Tertiary education	3.69	6.73	1.29

Notes: All, but *age*, are in proportions

Similar trends were revealed considering the rural and urban subsamples. More women (11.34%) in the rural subsample consumed alcohol beyond three times in the past week than women

in the urban subsample (4.51%). The average age of the women sampled is approximately 29 years. Less than 50% of the women sampled owned health insurance policies while less than 10% were pregnant. Most households were headed by someone else (78.68%) other than the women themselves (21.32) but majority of the women sampled (75.22%) were employed. More women (55.91%) resided in the rural areas than in the urban areas (44.09%). With regard to wealth, a little over one-third of the women were in the poorest category with very few of them (3.61%) being classified in the richest wealth quintile considering the rural subsample, the reverse is true for the urban subsample. Although more of the women interviewed (74.82%) had some form of formal education, the percentage of educated women with respect to the urban subsample (87.66%) outweighs that of the rural subsample (64.70%).

Since the pregnancy status variable is insignificantly related to alcohol consumption (see Table 3), it is the only variable which is excluded from the logit regression estimation of the determinants of alcohol consumption. Similarly, health insurance ownership and relationship to household head variables were excluded from the ordered logit regression estimation of the frequency of alcohol consumption given that they are insignificant at the conventional 5 percent level of significance.

Table 3: Bivariate Analysis of variables of concern (Full Sample)

Explanatory Variable	Alcohol Consumption			Frequency of Consumption				P-value
	no	yes	P-value	none	once	few	more	
<i>Health insurance</i>			0.009					0.758
No	46.13	12.07		17.86	22.41	15.86	5.81	
Yes	34.38	7.42		10.47	14.69	9.94	2.96	
<i>Relationship to Household Head</i>			0.000					0.086
Other	64.19	14.48		19.98	29.28	18.82	6.24	
Head	16.32	5.01		8.35	7.82	6.98	2.54	
<i>Currently Working</i>			0.000					0.010
No		2.82		5.07	6.13	2.75	0.53	
21.96								
Yes	58.55	16.67		23.26	30.97	23.04	8.25	
<i>Place of residence</i>			0.000					0.000
Rural		12.18		11.84	23.36	20.19	7.08	
43.74								
Urban	36.77	7.31		16.49	13.74	5.60	1.69	
<i>Currently Pregnant</i>			0.353					0.046
No		18.17		25.58	34.78	24.21	8.67	
74.35								
Yes	6.16	1.32		2.75	2.33	1.59	0.11	
<i>Wealth Quintile</i>			0.000					0.000
Poorest	15.53	6.45		4.44	14.16	11.21	3.28	
Poorer	15.51	3.28		2.75	5.29	5.81	2.96	
Middle	15.82	2.51		5.29	3.91	2.64	1.06	
Richer	17.82	3.05		6.03	5.92	2.85	0.85	
richest	15.82	4.20		9.83	7.82	3.28	0.63	
<i>Educational attainment</i>			0.000					0.000
No education	18.46	6.72		5.07	13.85	11.84	3.70	
Primary education	16.42	4.04		4.76	7.19	5.60	3.17	
Secondary education	42.75	7.93		16.81	14.59	7.61	1.69	
tertiary_education	2.88	0.80		1.69	1.48	0.74	0.21	

4.2 Logit and Ordered Logit Regression Models

Table 4 presents the results from the logit and ordered logit regression models for the correlates of alcohol consumption and drinking frequency respectively among Ghanaian women (aged between 15 and 49 years). In addition to the full sample, separate estimations were performed for the rural and urban sub-samples. From both regression models, logit and ordered logit, age, wealth status and educational attainment are reported to be significant correlates of alcohol consumption and its frequency among Ghanaian women. Additionally, though employment status, health insurance status, and relationship to head were found to be important predictors of alcohol consumption, pregnancy status and place of residence are reported to be other significant variables affecting the frequency of consuming alcohol.

Table 4: Coefficient Estimates of Logit and Ordered Logit Regression Models

Explanatory Variables	Logit Model			Ordered Logit		
	Full	Urban	Rural	Full	Urban	Rural
<i>Educational status (no education)</i>						
Primary education	0.0674 (0.1436)	0.8001*** (0.2832)	-0.1659 (0.1731)	0.2653 (0.2256)	-0.5369 (0.4111)	0.5702** (0.2763)
Secondary education	-0.0073 (0.1237)	0.7604*** (0.2471)	-0.3549** (0.1598)	-0.3203 (0.2146)	-0.7748** (0.3573)	-0.2848 (0.2774)
Tertiary education	-0.2006 (0.2799)	0.3642 (0.3790)	0.1869 (0.5368)	-0.0177 (0.4380)	-0.7584 (0.6105)	0.7963 (0.5996)
<i>Wealth Status (Richest)</i>						
Poorest	-0.1548 (0.2057)	-0.9701 (0.8486)	-0.2887 (0.3026)	0.5580 (0.3382)	0.0714 (0.3960)	0.6807 (0.5759)
Poorer	-0.6202*** (0.1855)	-0.4874 (0.3207)	-0.6751** (0.3008)	1.0201*** (0.3328)	1.0824 (0.8166)	1.1184*** (0.5645)
Middle	-0.7565*** (0.1654)	-0.6182*** (0.2055)	-0.8425*** (0.3061)	-0.0993 (0.2828)	-0.1416 (0.3607)	0.0499 (0.5785)
Richer	-0.5507*** (0.1286)	-0.4888*** (0.1379)	-0.6781** (0.3408)	0.1143 (0.2225)	0.1961 (0.2477)	-0.0404 (0.5755)
Employed	0.2200 (0.1363)	0.1297 (0.1863)	0.4281** (0.2095)	-0.0848 (0.2072)	-0.2740 (0.2941)	0.1483 (0.3001)
Age	0.1772*** (0.0320)	0.1721*** (0.0472)	0.1734*** (0.0448)	0.1508** (0.0623)	0.1768 (0.1073)	0.1341* (0.0718)
Age square	-0.0022*** (0.0005)	-0.0021*** (0.0007)	-0.0022*** (0.0007)	-0.0019** (0.0009)	-0.0022 (0.0016)	-0.0017 (0.0011)
Health insured	-0.2986*** (0.0967)	-0.6308*** (0.1398)	0.0215 (0.1265)			
Relationship to head	0.1905* (0.0994)	0.2210 (0.1376)	0.1410 (0.1509)			
Pregnant				-0.4864** (0.2327)	-0.6831* (0.3681)	-0.3786 (0.3153)
Urban	-0.1461 (0.1577)			-0.4530* (0.2417)		
Constant cut1				1.8042* (1.0481)	2.1415 (1.7559)	1.8038 (1.2817)
Constant cut2				3.5610*** (1.0503)	3.9160** (1.7651)	3.5789*** (1.2718)
Constant cut3				5.3625*** (1.0311)	5.5837*** (1.6722)	5.4533*** (1.2851)
Constant	-4.3578*** (0.5038)	-4.9790*** (0.7100)	-4.2748*** (0.7269)			
Observations	4,854	2,140	2,714	946	355	591
F-statistic	12.08*** (0.000)	7.89*** (0.000)	7.77*** (0.000)	7.19*** (0.000)	3.55*** (0.000)	3.05*** (0.001)

Notes: Linearized standard errors are in parenthesis and *, *** represent significance levels at 10% and 1% respectively. The F-statistics have p-values reported in parentheses.

5. Discussion

5.1. Correlates of Alcohol Consumption

Generally, the results suggest that the probability of consuming alcohol is influenced by some background characteristics. Firstly, the results show that women with primary and secondary education only in urban areas of Ghana have higher propensity to consume alcohol compared to their counterparts with no formal education (reference group). The plausible explanation for this finding is that lower levels of education (primary and secondary education) in urban areas are associated with low wage employments. Thus, while those with no formal education will be content with low paying jobs, frustration might influence those with relatively high formal education who end up in low-paying jobs to consume alcohol. Conversely, women resident in rural areas with secondary education are less likely to consume alcohol compared with those with no formal education. In this regard, the importance of female education in the probability to consume alcohol may be attributed to the fact that educated women are more likely to appreciate the negative

consequences associated with alcohol consumption. While it is possible that the frustration effect of not being highly educated outweighs the negative implications effect in urban Ghana, the latter is likely to outweigh the former in rural Ghana also because not much education is required by rural women to get them employed in nonfarm wage employments. The finding for women resident in rural areas of Ghana is in line with Grossman (1972) that education improves the stock of knowledge of people and they are able to make decisions that have positive influence on their health. This is in contrast with Tampah-Naah and Amoah (2015) who found education as an insignificant variable influencing alcohol consumption among Ghanaian women.

The current study however reveals that some education categories in urban and rural Ghana significantly influence alcohol consumption decisions.

But for the poorest category, all the categories of wealth used in the study emerged significant in determining the probability of a woman's consumption of alcohol. Using the richest category as reference, the results from the full sample suggest that women in the 2nd to 4th quintiles are less likely to consume alcohol. Though the 2nd to 4th quintiles of wealth in the rural subsample are reported to be significant, the 2nd wealth quintile is insignificant in the urban subsample. This suggests that the effect of wealth on alcohol consumption among women in rural Ghana is more intense. However, while the higher quintiles (3rd and 4th) are highly significant at 1 percent level for the urban subsample, the 3rd quintile is the most highly significant category for the rural subsample, also significant at 1 percentage level. This suggests that though higher wealth in urban areas is associated with alcohol consumption, lower wealth is much more associated with alcohol consumption in rural areas. The findings further suggest that the factors that motivate Ghanaian women to consume alcohol vary from urban to rural areas. A probable reason for this finding is that affordability may play a role in a woman's decision to consume alcohol or not. Also, plausibly linked to affordability, though insignificant, rural women who are employed are reported to be more likely to consume alcohol. The positive relationship between alcohol consumption and being employed is supported by Dawson et al (2005) and Chung et al. (2007).

The results from the study also revealed that age significantly affects alcohol consumption of women in both rural and urban areas. A year's increase in age, increases the propensity to consume alcohol by women in urban and rural areas. However, based on the negative sign on the age square variable (which is highly significant at 1 percentage level), as the woman further advances in age, she is less likely to consume alcohol in both urban and rural areas. This is probably

due to the fact that older women are aware of their reduced health stock and the dangers associated with consuming alcohol, and so their probability to consume alcohol may be lower than their younger women counterparts. This finding is at variance with O'Malley and Wagenaar (1990) and Kacapyr and Choudhury (2006) whose studies did not find support for the influence of age in alcohol consumption.

Similarly, it is likely that because women who purchase health insurance policies are comparatively more health conscious, they are less likely to consume alcohol. The study finds that women in urban Ghana who own health insurance policies are less likely to consume alcohol. Conversely, their counterparts in rural areas are more likely to consume alcohol. Although insignificant, this could result from the negative moral hazard effect of owning a health insurance policy.

Finally, women who were heads of their households are revealed to have a higher probability to consume alcohol than their counterparts who were not household heads, albeit this variable is statistically significant at 10 percentage level for the full sample only. This may not be very surprising given that being a household head may imply her ability to afford the drink and also being a household head could mean she is not accountable to anyone in the household and so will have a higher probability to consume alcohol compared to their counterparts who do not head their households.

5.2 Correlates of the Frequency of Alcohol Consumption

Of the educational attainment categories, while secondary education attainment negatively and significantly affected the drinking frequency of urban women, primary education attainment positively and significantly influenced the drinking frequency of rural women. Also, in terms of the wealth quintiles, the poorer category was found to be significant in explaining the frequency of alcohol consumption. Relative to the richest category, women in the poorer category were found to be more likely to increase the frequency or quantities of alcohol consumed. This is highly significant at 1 percentage level and 5 percentage level in the full sample and rural subsample respectively. This revelation that poorer women in rural areas are more likely to consume greater quantities of alcohol than their counterparts in the richest category raises serious development and public health concerns. The results show that if age increases by a year, women have a higher propensity to consume greater quantities of alcohol. Finally, pregnant women and women who

resided in urban areas were revealed to be less likely to increase the frequency of alcohol consumption relative to their counterparts who were not pregnant and those who resided in rural areas respectively.

6. Conclusion and Policy Recommendations

This paper sought to identify the correlates of alcohol consumption among Ghanaian women (between 15 and 49 years) in addition to the frequency of consumption relying on data provided by the 2008 GDHS.

The study reveals that alcohol consumption among women in urban and rural Ghana was influenced by age, education, and wealth status. Although health insurance ownership is reported to affect alcohol consumption decisions of urban women, employment status significantly affects the alcohol consumption decisions of rural women. Moreover, the frequency of alcohol consumption among women of child bearing age in Ghana is found to be influenced by age, place of residence, pregnancy status, wealth, and education. The significance of these variables varied by place of residence. The study revealed that women without health insurance policies in urban Ghana, those with primary and secondary education in urban Ghana, females with no formal education in rural Ghana, and those employed in rural Ghana have higher probabilities to consume alcohol. The implication is that an effective alcohol policy should probably focus more on uninsured urban residents, women with primary and secondary education in urban areas, those with no formal education, as well as employed women resident in rural areas. In other words, more awareness about the dangers associated with the abuse of alcohol should be embarked among these women.

On the correlates of alcohol drinking frequency, the results from the ordered logit regression indicates that whereas pregnancy status, and secondary education attainment correlate with alcohol drinking frequency among women resident in urban areas, the correlates of alcohol drinking frequency among rural Ghanaian women are respondent's age, attainment of primary education, and wealth status. As policy measure, this current paper reveals the need for policies designed to reduce alcohol consumption among poor women resident in rural areas since this is likely not to affect the women only, but their families as well. Despite the smallness of the sample used in exploring the correlates of alcohol consumption frequency among Ghanaian women, the study

modestly contributes to policy as well as existing literature. Further study should therefore be based on relatively larger samples.

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