
Factors Associated with Unhealthy Lifestyles among Residents of Eti-Osa East LCDA, Lagos State, Nigeria: Implications for Health Promotion

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ABSTRACT

This study assesses the factors associated with unhealthy lifestyles among residents of Eti-Osa East LCDA, Lagos State. A descriptive cross-sectional design was employed, utilizing a structured questionnaire administered to a stratified sample of 448 residents aged 18 years and above. Participants provided information on demographics, dietary habits, physical activity, smoking, sleep patterns, and other health behaviours. The mean age of respondents was 46.69 years. The majority were married and had a tertiary education. Notably, 48.9% had a normal body mass index, while blood pressure readings were normal for most participants. The study found that 55.8% of respondents reported unhealthy eating habits, 56.2% engaged in moderate physical activity, and 68.5% did not consume alcohol. Alarming, only 7.8% exhibited good, healthy living practices. Moreover, individuals aged 25-34 were 1.73 times more likely to have poor health practices compared to those over 49, with men displaying poorer health behaviours. Education level was significant, as respondents with secondary education had 2.74 times the odds of poor health compared to those with tertiary education. The study highlights the urgent need for targeted public health interventions to promote healthier lifestyle choices among residents of Eti-Osa East LCDA. By addressing dietary habits, physical activity levels, and sleep quality, health promotion strategies can mitigate the risk of NCDs and improve the overall well-being of the community.

Keywords: *Unhealthy lifestyles, dietary habits, physical activity, smoking, sleep patterns, and health behaviours.*

INTRODUCTION

Unhealthy lifestyle practices have become major contributors to the rising prevalence of non-communicable diseases (NCDs) among urban populations in Nigeria, with Eti-Osa East LCDA, Lagos, serving as a notable example of this trend. Adopting healthy lifestyles that promote good health has the potential to stop chronic diseases from developing and

progressing, as well as provide people more control over their health (Sadiq, 2023). A healthy lifestyle places an emphasis on actions that enhance one's quality of life, including regular exercise, eating wholesome meals, managing stress, avoiding risky behaviour, fostering fulfilling friendships, and setting and achieving goals (Sadiq 2023; Sharma, Marwale, Sidana & Gupta 2024).

According to WHO (2023), unhealthy lifestyle practices are major contributors to the burden of NCDs. Although communicable diseases continue to be the largest cause of death in Nigeria (WHO, 2023), according to Idris, Oguntade, Mensah & Kitamura (2020), it has become a global public health issue that non-communicable diseases (NCDs), such as diabetes mellitus, hypertension, and heart disease, are becoming more prevalent and more common among the general population (WHO, 2023). In most developing nations, non-communicable diseases (NCDs) are now the main cause of death among young people and members of the working class. Inactivity, dangerous alcohol use, bad diets, and tobacco use all increase the danger of an NCD causing death (WHO, 2023). Because it stresses the active role that individuals play in sustaining their own welfare, self-care is seen as an important and desirable notion. The idea and practice of self-care are currently receiving renewed attention as a vital part of health promotion to enhance people's health, wellness, and welfare, as well as a tactic to lower the high costs of medical services.

According to the World Health Organization (WHO, 2024), NCDs account for approximately 24% of all deaths in Nigeria, highlighting an urgent need for targeted interventions to address these health challenges (WHO, 2023). Sedentary behaviour, characterized by prolonged periods of sitting or physical inactivity, has become pervasive in Eti-Osa East LCDA. Many residents spend substantial amounts of time engaged in sedentary activities such as working at desks, watching television, or using electronic devices. The lifestyle of an individual, shaped by factors such as diet, physical activity, sleep patterns, and socioeconomic status, plays a crucial role in determining their overall health and well-being. Sekoni (nd), Shehu, Abdullahi & Adekeye (2010), Aderibigbe et al. (2017); Okafor, Aiyegbusi, Udachukwu & Oghumu (2020) indicated that unhealthy lifestyle practices, including sedentary behaviour, poor dietary habits, and lack of sleep, are prevalent in urban Nigerian populations, exacerbated by socioeconomic disparities and limited access to health resources.

According to Umuerrri (2019), there is a growing body of evidence indicating that lifestyle-related health problems are increasingly affecting younger demographics, thereby posing serious implications for the broader economy and healthcare systems. Understanding the specific risk factors that contribute to unhealthy lifestyles in Eti-Osa East LCDA is essential for developing effective community health programs and policies that promote healthier behaviours. This study seeks to assess the factors associated with unhealthy lifestyles among residents of Eti-Osa East LCDA, Lagos State, Nigeria.

METHOD

Study Design

This study employed a descriptive cross-sectional design to assess the factors associated with unhealthy lifestyles among residents of Eti-Osa East LCDA, Lagos.

Study Population and Sample

The target population for this study consisted of residents aged 18 years and above living in Eti-Osa East LCDA. A stratified sampling method was utilized to ensure representation across various demographic groups, including age, gender, and socioeconomic status. A sample size of 448 participants was determined using Cochran's formula for sample size calculation, taking into account the expected prevalence of unhealthy lifestyle practices and a 95% confidence level with a 5% margin of error.

Data Collection

Data were collected using a structured questionnaire, designed to capture relevant information on demographics, lifestyle practices, and health behaviours. Upon getting the necessary approvals to conduct the research. Two research assistants were recruited to help in collecting the data, and various strategic places (health facilities, playgrounds, and community hall etc) were mapped out so residents could be captured for the study.

An introduction to the study was made to all the participants for completing the instruments. They were assured that a strict measure of confidentiality would be ensured. Upon the completion of questionnaires by the participants, all the questionnaires were thoroughly checked to see if they were all completed. The well-filled or completed questionnaires were then subjected to data analysis.

Assessment of healthy living practices

Inquiry on tobacco smoking included smoking status (never, former, or current smoker); Do you currently smoke, have you ever smoked and If yes, when did you quit smoking. Questions about alcohol intake included are you a regular consumer of alcohol (more than one glass of wine or beer with the meals) and have you ever been a regular consumer of alcoholic drinks? Information on physical activity was obtained by asking participants about their usual type and duration of activities in each of the four domains (occupational, commuting, domestic, and leisure-time) in the past 1 months. We calculated the total physical activity level by multiplying the metabolic equivalent tasks (METs) value for each activity by hours spent on that activity per day and summing the MET-hours for all activities. The physical activities was categorized in (intense, moderate and poor). Habitual dietary intakes during the one week were assessed via a validated qualitative food frequency questionnaire, which covered 10 major food groups using a short qualitative food frequency questionnaire. Each food group was provided with five frequency categories to choose from (never/ rarely, monthly, 1–3 days/week, 4–6 days/week, or daily). The eating habit was categorized into healthy and unhealthy. Questions on sleeping

habits included Do you sleep well, how many hours per night, how often do you wake up at night, do you wake up feeling tired and do you take sleeping pills.

Physical Assessment of Participants

Trained research assistants measured weight, height, circumferences of waist and hip and blood pressure using calibrated instruments. We calculated BMI as weight in kilograms divided by height in metres squared. Waist-to-hip ratio (WHR) was the ratio of waist circumference to hip circumference.

Data Analysis

Following the completion of the data collection, the test scores were coded. Statistical Package for Social Sciences (SPSS) software programme 25 was used. Descriptive statistics were conducted for socio-demographic and lifestyle factors, Physical Activity, healthy eating, smoking habits, alcohol consumption and sleeping duration. Logistic regression was done to assess factors associated with unhealthy lifestyles among residents of Eti-Osa East LCDA, Lagos State, Nigeria. Healthy living practices were categorized as participants who do not smoke, do not consume alcohol, have adequate sleep, have good eating habit and have moderate physical activities.

Ethical Considerations

Ethical approval for the study was obtained from the Lagos State University Research Ethics Committee (REF. NO: LREC/06/10/2032). Participants were provided with an information sheet explaining the purpose of the study, and they were required to give written informed consent before enrollment. Confidentiality was maintained by assigning identification codes to participants and ensuring data security throughout the research process. Participants had the right to withdraw from the study at any point without any repercussions.

RESULT AND DISCUSSION

Table 1: Socio Demographic Characteristics of Respondents

Variables	Frequency	Percent (%)
Age	46.69± 18.308	
≤24	30	6.7
25-34	179	40
35-49	115	25.7
>49	124	27.7
Sex		
Male	217	48.4
Female	231	51.6
Marital Status		
Single	123	27.5

Married	178	39.7
Divorced	48	10.7
Separated	43	9.6
Widowed	56	12.5
Level of Education		
None	64	14.3
Primary	59	13.2
Secondary	130	29
Tertiary	195	43.5
Employment Status		
Unemployed	118	26.3
Self- employed	161	35.9
Fully employed	85	19
Student	28	6.3
Full House Wife	58	12.5

Table 1 below shows the socio demographic characteristics of the respondents. The mean age of the respondent was 46.69 standard deviation of ± 18.308 . Most of the respondents are married (39.7%) and had tertiary education (43.5%). Most of the respondents are self-employed (35.9%).

Table 2: Physical Assessment of Respondents

Variables	Frequency	Percent (%)
Body Mass Index (kg/m²)		
Normal(18.5-24.9)	219	48.9
Obese(≥ 30.0)	42	9.4
Overweight(25.0-29.9)	124	27.7
Underweight (<18.5)	63	14.1
Blood Pressure		
Hypertensive ($\geq 140/90$ mmHg)	78	17.4
Normal ($\leq 120/80$ mmHg)	329	73.4
Prehypertension (120-139/80-89mmHg)	41	9.2
Male WHR (217)		
High	66	30.4
Low	95	43.8
Normal (<0.90)	58	25.8
Female WHR (n=231)		
High	166	71.9
Low	18	7.8
Normal (<0.85)	47	20.3

Table 2 shows the physical assessment of the respondents 48.9 % of the respondents have normal body mass index. The majority of the respondents have normal blood pressure among the male respondents most of them have low waist circumference (43.8%) and among the female respondents most of them have high waist circumference (71.9%).

Table 3A: Lifestyle Practices

Lifestyle practices	Frequency	Percent (%)
Physical Activity		
Inactivity	188	42
Moderate	252	56.2
Intense	8	1.8
Eating Habit		
Healthy	189	44.2
Unhealthy	259	55.8
Smoking		
Never	250	55.8
Former	109	23.8
Current Smoker	89	20.4
Alcohol Consumption		
Yes	141	31.5
No	307	68.5
Sleeping Habits		
Not Adequate (< 5 hours)	115	25.7
Moderate (5 to 7 hours)	213	47.5
Adequate (> 7 hours)	120	26.8

Table 3A presents an overview of lifestyle practices among residents, focusing on physical activity levels, eating habits, smoking status, alcohol consumption, and sleeping habits. The majority of participants (252 individuals, or 56.2%) engage in moderate physical activity. The majority (259 individuals, or 55.8%) reported unhealthy eating practices. Additionally, the majority (250 individuals, or 55.8%) have never smoked. In terms of alcohol consumption, the majority (307 individuals, or 68.5%) indicated they do not consume alcohol. Lastly, the majority (213 individuals, or 47.5%) reported moderate sleep (5 to 7 hours).

Table 3B

Healthy Living Practices	Frequency	Percent (%)
Good	415	92.2
Poor	33	7.8

Table 3B show the level of healthy living practices among the respondents, good healthy living practices comprises of respondents that fall in the category of : do not smoke, do

not consume alcohol, have adequate sleep, have good eating habit and have moderate physical activities. Only 7.8% of the respondents have good healthy living practices.

Table 4: Factors Associated Unhealthy Living Practices

	UOR	95% CI	P Value	AOR	95% CI	P Value
Age						
<24	0.54	0.13,2.22	0.391	0.338	0.066,1.729	0.193
25-34	1.73	0.56,5.26	0.338	0.943	0.272,3.274	0.927
35-49	0.30	0.12,0.75	0.010	0.448	0.263,1.227	0.118
>49	1					
Sex						
Male	2.51	1.17,5.36	0.017	2.339	0.63,5.685	0.061
Female	1					
Marital Status						
Single	0.14	0.045,0.41	0.000	0.258	0.063,1.057	0.60
Currently Married	0.47	0.14,1.53	0.210	0.922	0.249,3.417	0.903
Previously Married	1					
Level of Education						
None	2.85	0.830,9.82	0.096	1.534	0.389,6.054	0.541
Primary	4.0	0.92,17.45	0.065	2.531	0.521,12.29	0.249
Secondary	2.90	1.15,7.31	0.024	2.742	1.015,7.413	0.047
Tertiary	1					
Employment Status						
Unemployed	4.6	1.1,19.13	0.036	4.695	0.963,22.89	0.056
Self Employed	0.758	0.29,1.98	0.571	0.745	0.239,2.332	0.612
Fully Employed	3.28	0.785,13.70	0.103	2.652	0.564,12.46	0.217
Student	3.24	0.371,28.32	0.288	8.998	0.825,98.10	0.071
Full Housewife	1					

Table 4 showed factors associated with unhealthy lifestyles. The findings showed that people aged 25-34 were 1.73 times more likely to practice poor healthy living compared to those aged > 49 years. Male were more inclined to poor healthy living practices compared to female (UOR= 2.512; 95% CI 1.17-5.36). The odds of poor healthy living practices was less among singles (UOR= 0.14; 95% CI 0.045-0.41) and currently married (UOR = 0.47; 95% 0.14-1.53). Level of education is significantly associated with healthy living practices. Those with secondary were 2.74 times more likely to have poor healthy living compared to those with Tertiary education (95% CI 1.02-7.41). Also, employment status was a significant predictor of healthy living practices.

A significant proportion of participants (55.8%) reported unhealthy eating practices, which is concerning given the rising burden of diet-related non-communicable diseases (NCDs). Poor dietary habits, characterized by high consumption of processed foods and low fruit and vegetable intake, have been reported globally (Clemente-Suárez et al. 2023). Christabel, Peters, Otovwe, Browne & Richard (2024) found that over 74.9% of respondents had poor dietary practices, indicating a similar trend. This finding aligns with the nutrition transition theory, which suggests that as countries develop, dietary patterns shift from traditional to Westernized diets high in fats and sugars (Popkin & Ng, 2022).

The study found that 56.2% of participants engage in moderate physical activity. This aligns with global trends, where moderate activity levels are commonly reported among populations. The World Health Organization (WHO, 2024) recommends at least 150 minutes of moderate-intensity physical activity per week. Oyeyemi AL, Oyeyemi AY, Jidda & Babagana (2013) conducted a study in Nigeria and found that about 54% of adults engaged in moderate physical activity¹⁵. However, studies in high-income countries, such as the United States, report lower levels of physical activity due to sedentary lifestyles associated with urbanization (Boakye et al 2023).

Also, this study showed that less than one quarter of the respondents were smokers. According to the Global Adult Tobacco Survey (GATS), smoking prevalence in Nigeria is relatively low compared to Western nations, with only about 10% of males and less than 1% of females being smokers (Adeniji, Bamgboye & Walbeek, 2016). However, the rise of alternative tobacco products, such as e-cigarettes, may influence future trends. As shown in several studies, adequate sleep is important for stable health and well-being. For adequate sleep, a minimum of 7 hours of sleep is recommended per day. However, in this study only a small proportion of the study participant sleeps more than 7 hours (adequate) daily. The finding is in line with Endeshaw et al. (2022) whose study in Ethiopia was that only 28.5% had good sleep quality.

The study found that individuals aged 25-34 years were 1.73 times more likely to engage in unhealthy lifestyle behaviours compared to those aged 49 years and above. This is consistent with Ho & Ng (2020) who indicate younger adults tend to adopt riskier health behaviours due to increased autonomy, peer influence, and urbanization. Males were significantly more likely to engage in unhealthy lifestyle practices than females. This finding is well-documented in literature, with Li et al. (2021); Al Ali & Khazaaleh (2023) who report that men are more likely to smoke, consume alcohol, engage in physical inactivity, and adopt poor dietary habits compared to women. Oladoyinbo et al. (2017) reported that men have a higher prevalence of risk behaviours such as tobacco use and excessive alcohol consumption, which aligns with global epidemiological trends (Adeloye et al. 2019).

The odds of engaging in unhealthy lifestyle practices were lower among singles and currently married individuals. This aligns with literature indicating that marriage is generally associated with healthier lifestyle behaviours, often due to spousal influence and greater social support (Lee et al., 2005); Ross, Hill & Mirowsky, 2016). Education level was significantly associated with healthy living, with those having secondary education being three times more

likely to engage in unhealthy practices compared to those with tertiary education. Individuals with higher education are more likely to have access to health information, better socioeconomic status, and improved awareness of health risks (Mirowsky, 2017).

Employment status emerged as a significant predictor of unhealthy lifestyle practices. This is consistent with Burgard & Lin (2013); Cooper, McCausland & Theodossiou (2015) who show that unemployed individuals or those in low-income jobs are at a higher risk of adopting unhealthy behaviours due to financial constraints, stress, and limited access to healthcare.

CONCLUSION

This study underscores the alarming prevalence of unhealthy lifestyle practices among residents of Eti-Osa East LCDA, Lagos State, Nigeria, with significant concerns arising from poor dietary habits, low levels of physical activity, and inadequate sleep. These factors greatly contribute to the increasing burden of non-communicable diseases (NCDs) in the community, reflecting global trends influenced by urbanization and socioeconomic challenges. To combat this health crisis, targeted interventions focused on public education, accessibility to healthy food, and the promotion of physical activity are essential. By implementing these strategies, we can foster healthier behaviours, reduce NCD risk factors, and ultimately enhance the overall health and quality of life for the residents of Eti-Osa East LCDA.

Acknowledgement: *The authors appreciate the study participants and all the authorities who granted permission to make the study possible.*

Competing Interest: *The authors declare no competing interest.*

REFERENCES

- Adeloye D., Olawole-Isaac A., Auta A., Dewan M. T., Omoyele C., Ezeigwe N., Jacobs W., Mpazanje R. G., Harhay M. O., Alemu W. & Adewole I. F. (2019). Epidemiology of harmful use of alcohol in Nigeria: A systematic review and meta-analysis. *The American Journal of Drug and Alcohol Abuse*, 45(5):438-50.
- Adeniji F., Bamgboye E. & Walbeek C. (2016). Smoking in Nigeria: Estimates from the global adult tobacco survey (GATS) 2012. *Journal of Scientific Research and Reports*, 11(5):1-0.
- Aderibigbe S. A., Sule G. O., Olatona F. A., Goodman O. O. & Sekoni O. O. (2017). Knowledge and practice of sedentary lifestyle among bankers in Abuja, North-Central Nigeria. *Research Journal of Health Sciences*, 5(3):167-74.
- Al Ali N. M & Khazaaleh F. K. (2023). Assessment of food consumption, smoking, alcohol use, and physical activity by sex and major of study among a sample of college students in Jordan. *Heliyon*, 9(6).
- Boakye K., Bovbjerg M., Schuna Jr J., Branscum A., Varma R. P., Ismail R., Barbarash O., Dominguez J., Altuntas Y., Anjana R. M. & Yusuf R.. (2023). Urbanization and physical

- activity in the global Prospective. *Urban and Rural Epidemiology study. Scientific reports*, 13(1):290.
- Burgard S. A. & Lin K. Y. (2013). Bad jobs, bad health? How work and working conditions contribute to health disparities. *American Behavioral Scientist*, 57(8):1105-27.
- Christabel O. N., Peters E., Otovwe A., Browne O. & Richard A. A. (2024). Dietary practice and nutritional status of low-income earners in a rural adult population in Delta State, Nigeria: a cross-sectional study. *The Pan African Medical Journal*, 48:138.
- Clemente-Suárez V. J., Beltrán-Velasco A. I., Redondo-Flórez L., Martín-Rodríguez A., Tornero-Aguilera J. F. (2023). Global impacts of western diet and its effects on metabolism and health: A narrative review. *Nutrients*, 15(12):2749.
- Cooper D., McCausland W. D. & Theodossiou I. (2015). Is unemployment and low income harmful to health? Evidence from Britain. *Review of Social Economy*, 73(1):34-60.
- Endeshaw D., Biresaw H., Asefa T., Yesuf N. N. & Yohannes S. (2022). Sleep quality and associated factors among adult cancer patients under treatment at oncology units in Amhara region, Ethiopia. *Nature and Science of Sleep*, 1049-62.
- Ho G. & Ng B. (2020). The importance of the environment in community integration for supporting and sustaining healthy aging: A self-determination Theory perspective. *Self-Determination Theory and Healthy Aging: Comparative Contexts on Physical and Mental Well-Being*, 229-45.
- Idris I. O., Oguntade A. S., Mensah E. A. & Kitamura N. (2020). Prevalence of non-communicable diseases and its risk factors among Ijegan-Isheri Osun residents in Lagos State, Nigeria: a community-based cross-sectional study. *BMC Public Health*, 20:1-0.
- Lee S, Cho E, Grodstein F, Kawachi I, Hu FB, Colditz GA. (2005). Effects of marital transitions on changes in dietary and other health behaviours in US women. *International Journal of Epidemiology*, 34(1):69-78.
- Li L., He J., Ouyang F., Qiu D., Li Y., Luo D., Yu Y. & Xiao S. (2021). Sociodemographic disparity in health-related behaviours and dietary habits among public workers in China: a cross-sectional study. *BMJ Open*, 11(8):e047462.
- Mirowsky J. (2017). *Education, Social Status and Health*. Routledge.
- Okafor U. A., Aiyegbusi A. I., Udachukwu A. D. & Oghumu S. N. (2020). Physical fitness knowledge, attitudes and exercise practices of commercial bank workers in Lagos, Nigeria. *African Journal for Physical Activity and Health Sciences*, 26(2):174-87.
- Oyeyemi A. L., Oyeyemi A. Y., Jidda Z. A. & Babagana F. (2013). Prevalence of physical activity among adults in a metropolitan Nigerian city: a cross-sectional study. *Journal of Epidemiology*, 23(3):169-77.
- Popkin B. M. & Ng S. W. (2022). The nutrition transition to a stage of high obesity and noncommunicable disease prevalence dominated by ultra-processed foods is not inevitable. *Obesity Reviews*, 23(1):e13366.
- Ross C. E., Hill T. D. & Mirowsky J. (2016). Reconceptualizing health lifestyles: The case of marriage. In *Special social groups, social factors and disparities in health and health care* 8 (pp. 243-260). Emerald Group Publishing Limited.

- Sadiq I. Z. (2023). Lifestyle medicine as a modality for prevention and management of chronic diseases. *Journal of Taibah University Medical Sciences*, 18(5):1115-7.
- Sekoni A. O. (nd). Knowledge, Attitude and Practice of Bankers in Lagos Island Local Government Area Regarding Healthy Lifestyle in the Prevention and Control of Non-Communicable Diseases.
- Sharma I., Marwale A. V., Sidana R. & Gupta I. D. (2024). Lifestyle modification for mental health and well-being. *Indian Journal of Psychiatry*, 66(3):219-34.
- Shehu R. A., Abdullahi A. A. & Adekeye D. S. (2010). Sedentary lifestyle and wellness in Kaduna State, Nigeria. *Studies on Ethno-Medicine*, 4(1):15-9.
- Umuerrri E. (2019). Heart disease: Lifestyle, knowledge, and perception among young Nigerian adults. *International Journal of the Cardiovascular Academy*, 5(4):134-
- World Health Organization (2024). Noncommunicable diseases [Internet]. Geneva: WHO. Accessed on December 23, 2025. Available at <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>
- World Health Organization (2023). Nigeria: Noncommunicable diseases country profile [Internet]. Brazzaville: WHO Regional Office for Africa. Available at <https://www.afro.who.int/sites/default/files/2023-08/Nigeria.pdf>
- World Health Organization (2024). Physical activity [Internet]. Geneva: WHO. Available at: <https://www.who.int/news-room/fact-sheets/detail/physical-activity>.