

Health Status, Lifestyle Behaviours and Occupational Correlates among Commercial Drivers in Akure, Nigeria

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Abstract: Commercial drivers are central to Nigeria's transport economy but face prolonged sitting, long hours, irregular meals and limited access to care. Evidence on the health status of drivers in Ondo State, and on how it differs between intracity and intercity drivers, is limited. To determine the health status and lifestyle behaviours of intracity and intercity commercial drivers in Akure, Ondo State, Nigeria, and to examine the association between health status and their socio-demographic and occupational characteristics. A cross-sectional survey was conducted among 429 commercial drivers (260 intercity, 169 intracity) recruited from four motor parks and the taxi drivers' union in Akure. A validated structured questionnaire assessed self-rated health, functional status, lifestyle behaviours and self-reported medical conditions. Data were analysed using descriptive statistics and chi-square tests. Respondents were predominantly male (98.6%), with a mean age of 45.86 ± 11.23 years. Although 52.4% rated themselves very healthy and 61.5% had high functional independence, 30.8% reported at least one medical condition. Back pain (31.0%), body pain (30.1%), hypertension (22.6%) and arthritis (21.0%) were most common. Alcohol use (73.7%), energy drink use (80.0%), smoking (38.9%), meal skipping (31.4%) and unhealthy snacking (46.6%) were frequent. Health status was significantly associated with age, route type, vehicle type, driving experience and continuous driving time, but not with income or education. Positive self-rated health masks a substantial burden of musculoskeletal and cardiometabolic conditions and risky lifestyle behaviours. Occupational rather than socio-economic factors were linked to health status, supporting motor park-based screening and occupational health programmes.

Keywords: commercial drivers, health status, occupational health, lifestyle behaviours, musculoskeletal pain, Nigeria

INTRODUCTION

Commercial road transport is the predominant mode of transport for both passenger and goods transport in Nigeria and commercial road transport operators are one of the largest informal sector groups in Nigeria. It is hard work both physically and mentally. Drivers sit in vehicles for long periods of time and are exposed to vibration, heat and traffic congestion, often start early in the morning and end late at night, eat irregularly at motor parks and on the highway, and have daily incomes that are dependent on the number of trips they make. These conditions put drivers at risk for a variety of occupational health issues, and their health is not only important to them, but to others as well, because impaired drivers pose a threat to others on the road.

International evidence is consistent that professional drivers are burdened with ill health. In a systematic review of long-haul truck and bus drivers, high prevalence of obesity, hypertension, sleep disorders and musculoskeletal problems were identified, as well as poor diet, physical inactivity and smoking (Crizzle et al., 2017), and in a national survey of long-haul truck drivers in the United States, obesity and smoking were both found to be about twice as prevalent as in the general working population (Sieber et al., 2014; Olofin-Samuel et al., 2025). Musculoskeletal pain is especially prevalent; a systematic review of 56 studies of 18,882 professional drivers across 23 countries found a pooled 12-month prevalence of low back pain of 53% (Joseph et al., 2020). Such morbidities have been termed worksite induced and are the result of a combination of prolonged sitting, whole-body vibration, stress and limited chances for healthy behaviours (Apostolopoulos et al., 2010; Ologunde- Oladipo et al., 2026).

The same trend is evident in Nigerian studies. 89.3% of the occupational drivers in Ibadan reported musculoskeletal pain in the past year, with the low back being the most affected site, and most of the drivers used self-prescribed drugs and herbal remedies to treat their pain (Akinpelu et al., 2011). Akinbo et al., (2008) found that 64.5% of commercial drivers in Lagos reported back pain. There is also a high risk of cardiovascular and metabolic conditions: intracity drivers in Ibadan had measured hypertension 36.2% and alcohol use 51.3% and more than half were physically inactive (Rotimi-Oyedepo et al., 2026; Showande & Odukoya, 2020); long-distance bus drivers in Lagos had measured hypertension 39.7%, diabetes 13.9% and alcohol use 71.0% (Amadi et al., 2018). These findings are in contrast with the prevalence of hypertension in Nigeria which is approximately 28.9% among adults (Adeloye et al., 2015). Energy drinks are also popular among drivers to help fight fatigue; the prevalence of energy drink consumption among commercial bus drivers in neighbouring Ghana was 75% (Saku et al., 2020; Aderibigbe et al., 2024).

However, there are some gaps in this evidence. Most studies in Nigeria have been limited to examining a single condition or risk factor, few have captured health status in its self-rated, functional, behavioural and clinical aspects, and few have compared drivers working in an urban area with those who drive long distances between cities, whose working patterns and exposures are very different. Such study has not been reported from the capital of Ondo State, Akure, where four major motor parks are linking the State with much of the South-Western,

South-Southern and Northern Nigeria. In order to develop an occupational health, screening and health promotion service specifically for drivers, it is important to understand the health status of this workforce, and the characteristics associated with it. This study therefore set out to ascertain the health status and lifestyle behaviours of intracity and intercity commercial motor drivers in Akure, Ondo State and to investigate the relationship between health status of commercial motor drivers and their socio-demographic and occupational characteristics.

METHODS

Study Design and Setting

This paper reports the quantitative, cross-sectional survey component of a larger convergent mixed-methods study of self-efficacy, health status and healthcare access among commercial drivers; the other components are reported separately. The study was conducted in Akure, the capital of Ondo State in south-western Nigeria, which hosts four major intercity motor parks: Ilesha Garage (serving routes to Ilesha, Osogbo, Ilorin and Ibadan), Ondo Garage (serving Ondo, Ore, Okitipupa and Lagos), Benin Garage (serving Benin, Warri, Lokoja and Abuja) and Ado Garage (serving Ikere, Ado-Ekiti and nearby towns). Intracity commercial transport is organised mainly through the taxi drivers' union. Together these sites serve most of the state's 18 local government areas and neighbouring states. Reporting followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines (von Elm et al., 2007).

Population, Sample Size and Sampling

The study population comprised approximately 800 intercity drivers operating from the four motor parks and 300 intracity drivers registered with the taxi drivers' union. Sample size was calculated separately for each stratum using Cochran's formula with finite population correction, assuming a proportion of 0.5, a 95% confidence level and a 5% margin of error, giving 260 intercity and 169 intracity drivers, a total of 429. A stratified multistage approach was used. Drivers were first stratified by type of operation (intercity or intracity); the four intercity motor parks and the intracity taxi drivers' union were then purposively selected as the primary sampling units because they contained the largest concentrations of drivers; and individual drivers who were available and willing to participate were recruited at each site. Drivers who were actively engaged in commercial driving and gave informed consent were eligible.

Instrument

Data were collected using a structured questionnaire developed from the literature. The section on socio-demographic and occupational characteristics recorded age, sex, religion, education, marital status and family characteristics, route type, vehicle type, years of commercial driving, daily driving hours, time of departure and return, duration of continuous driving and rest, and average daily take-home income. The section on health status assessed four dimensions. Self-rated health was measured with a single five-category item ranging from "very healthy, no illness" to "attends clinic regularly". Functional status was assessed across six basic activities of daily living, adapted from the Katz index (Katz et al., 1963), and seven instrumental activities of daily living, adapted from the Lawton scale (Lawton & Brody, 1969), each rated as full performance, some assistance or a lot of assistance, and summed to classify overall

independence as low, moderate or high. Health-related behaviours covered frequency of clinic attendance, water intake, meal frequency, meal skipping and its reasons, meal composition, snacking, alcohol use, smoking and energy drink use. Finally, respondents indicated whether they currently had any of eight common medical conditions.

Content validity was established by a panel of five experts, comprising two community health nurse researchers, one biostatistician and two doctoral supervisors, who rated each item for relevance, clarity and comprehensiveness; items with an item-level content validity index below 0.78 were revised or removed, and a scale-level index of at least 0.90 was required (Polit et al., 2007). Reliability was assessed in a pilot study of 20 intracity and intercity drivers in Owo, Ondo State, using Cronbach's alpha for internal consistency and a two-week test-retest procedure with the intraclass correlation coefficient, with thresholds of 0.70 for both.

Data Collection and Analysis

The questionnaire was administered at the motor parks and the taxi union offices by the researcher and trained research assistants, with the support of union leaders who helped mobilise drivers. Data were analysed with descriptive statistics (frequencies, percentages, means and standard deviations). For hypothesis testing, health status was categorised into three levels and its association with each socio-demographic and occupational characteristic was examined using Pearson's chi-square test of independence. Statistical significance was set at $p < .05$.

Ethical Considerations

Ethical approval was obtained from the relevant institutional review board, and permission was obtained from the leadership of each motor park and the taxi drivers' union. Participants received information about the purpose and procedures of the study, and written informed consent was obtained before data collection. Participation was voluntary, participants could withdraw at any time without penalty, and no personal identifiers were recorded. Electronic data were password-protected and paper records were stored securely with access restricted to the research team.

RESULTS

Characteristics of Respondents

All 429 drivers completed the questionnaire, 260 (60.6%) intercity and 169 (39.4%) intracity (Table 1). Almost all were male (98.6%), and the mean age was 45.86 ± 11.23 years, with 33.8% aged 40 to 49 years and 20.7% aged 60 years or older. Most were Christian (76.9%) and married (81.4%), and 16.8% were in polygamous marriages. Nearly half (49.0%) had completed senior secondary school as their highest level of education, and 21.0% had primary or junior secondary education only. Cars (62.2%) and buses (36.8%) were the main vehicles driven. Driving experience was substantial, with 47.5% having driven commercially for more than 10 years. Most drivers worked 5 to 8 hours a day (65.5%), set out at 6 or 7 a.m. (71.1%) and returned home at 6 or 7 p.m. (70.6%), and 31.9% drove for more than four hours at a stretch.

Table 1*Socio-demographic and occupational characteristics of respondents (N = 429)*

Characteristic	Category	n	%
Age (years) ^a	20–29	32	7.5
	30–39	85	19.8
	40–49	145	33.8
	50–59	78	18.2
	≥60	89	20.7
Sex	Male	423	98.6
	Female	6	1.4
Religion	Christianity	330	76.9
	Islam	91	21.2
	Traditional	8	1.9
Highest education	Primary	56	13.1
	Junior secondary	34	7.9
	Senior secondary	210	49.0
	OND/NCE or equivalent	109	25.4
	University degree or higher	19	4.4
	Other	1	0.2
Marital status	Married	349	81.4
	Single	41	9.6
	Separated, divorced or widowed	39	9.1
Route type	Intercity	260	60.6
	Intracity	169	39.4
Vehicle type	Car	267	62.2
	Bus	158	36.8
	Truck or other	4	0.9
Commercial driving experience (years)	1–5	121	28.2
	6–10	104	24.2
	11–20	127	29.6
	>20	77	17.9
Daily driving hours	1–4	83	19.3
	5–8	281	65.5
	9–12	43	10.0
	≥13	22	5.1
Continuous driving time	≤60 min	56	13.1

Characteristic	Category	n	%
	61–120 min	113	26.3
	121–240 min	123	28.7
	>240 min	137	31.9

Note. *Mean age = 45.86 ± 11.23 years. OND = Ordinary National Diploma; NCE = Nigeria Certificate in Education.

Self-Rated and Functional Health

Slightly over half of the drivers rated themselves as very healthy with no illness (52.4%), and a further 22.1% as healthy with occasional illness. However, 9.6% reported monthly illness, 7.2% were managing a chronic illness and 8.6% attended a clinic regularly (Table 2). In terms of basic activities of daily living, between 62.7% and 67.6% reported full independence in mobility, feeding, dressing, bathing, continence and toilet use, although between 11.4% and 16.8% reported needing a lot of assistance with individual activities. Independence in instrumental activities was similar for transportation planning (65.0%), financial management (66.0%), shopping (62.7%) and communication (61.1%), but markedly lower for meal preparation (42.9%) and house cleaning (41.0%). Overall, 61.5% of drivers had high functional independence, 34.5% moderate and 4.0% low.

Table 2

Self-rated health and functional status of respondents (N = 429)

Measure	Category or activity	n (%)
Self-rated health	Very healthy, no illness	225 (52.4)
	Healthy, occasional illness	95 (22.1)
	Fairly healthy, monthly illness	41 (9.6)
	Managing a chronic illness	31 (7.2)
	Attends clinic regularly	37 (8.6)
Full independence in basic activities	Mobility	290 (67.6)
	Feeding	273 (63.6)
	Dressing	282 (65.7)
	Bathing and grooming	269 (62.7)
	Bladder and bowel control	286 (66.7)
	Toilet use	277 (64.6)
Full independence in instrumental activities	Transportation planning	279 (65.0)
	Financial management	283 (66.0)
	Shopping	269 (62.7)
	Meal preparation	184 (42.9)
	House cleaning	176 (41.0)

Measure	Category or activity	n (%)
Overall functional independence	Communication	262 (61.1)
	Medication management	251 (58.5)
	High	264 (61.5)
	Moderate	148 (34.5)
	Low	17 (4.0)

Note. Functional items were rated as full performance, some assistance or a lot of assistance; only full performance is shown for individual activities.

Lifestyle Behaviours

Unhealthy behaviours were common (Table 3). Although 40.6% ate three meals a day, 38.2% ate only twice and 8.4% once, and 31.4% skipped at least one meal daily, most often lunch (31.7%). Time pressure was the most frequent reason for missing meals (31.7%), followed by economic reasons and lack of access to food (18.6% each). Heavy carbohydrate-based "swallow" meals dominated dinner (51.3%), and nearly half of the drivers (46.6%) snacked on fried or processed foods. Half consumed about 1.5 to 2 litres of water daily (50.1%), while 17.0% consumed one litre or less.

Almost three-quarters of the drivers (73.7%) drank alcohol, 12.1% always and 26.8% often, and half (49.9%) reported consuming one to two bottles, sachets or litres daily; beer (27.7%) was the most common drink, followed by wine and sachet spirits. Smoking was reported by 38.9%, and 24.0% smoked four or more sticks a day. Energy drinks were consumed by 80.0% of drivers, 18.6% always and 24.9% often, with locally marketed brands predominating.

Table 3

Selected health-related behaviours of respondents (N = 429)

Behaviour	Category	n (%)
Meals per day	Once	36 (8.4)
	Twice	164 (38.2)
	Three times	174 (40.6)
	Four times	55 (12.8)
Skipped at least one meal daily	Yes	135 (31.4)
Main reason for missing meals	Time constraints	136 (31.7)
	Economic	80 (18.6)
	Food not accessible	80 (18.6)
Dinner composition	Heavy carbohydrate ("swallow")	220 (51.3)
Snack type	Unhealthy, fried or processed	200 (46.6)
	Healthy or natural	97 (22.6)
	No snack	132 (30.8)
Daily water intake	≤1 litre	73 (17.0)
	1.5–2 litres	215 (50.1)

Behaviour	Category	n (%)
Alcohol use	>2 litres	141 (32.9)
	Always	52 (12.1)
	Often	115 (26.8)
	Occasionally	149 (34.7)
	Never	113 (26.3)
Smoking	Always	33 (7.7)
	Often	61 (14.2)
	Occasionally	73 (17.0)
	Never	262 (61.1)
Energy drink use	Always	80 (18.6)
	Often	107 (24.9)
	Occasionally	156 (36.4)
	Never	86 (20.0)

Note. Water intake was reported in sachets (approximately 0.5 litre each).

Self-Reported Medical Conditions

Overall, 132 drivers (30.8%) reported having at least one medical condition. Musculoskeletal complaints were the most frequent, with back pain reported by 31.0% and generalised body pain by 30.1%, followed by hypertension (22.6%), arthritis (21.0%) and eye problems (19.6%). Diabetes (18.4%), asthma (18.2%) and depression (18.2%) were each reported by nearly one in five drivers (Table 4).

Table 4

Self-reported medical conditions among respondents (N = 429)

Condition	Present, n (%)	Absent, n (%)
Back pain	133 (31.0)	296 (69.0)
Generalised body pain	129 (30.1)	300 (69.9)
Hypertension	97 (22.6)	332 (77.4)
Arthritis	90 (21.0)	339 (79.0)
Eye problems	84 (19.6)	345 (80.4)
Diabetes	79 (18.4)	350 (81.6)
Asthma	78 (18.2)	351 (81.8)
Depression	78 (18.2)	351 (81.8)
Any medical condition	132 (30.8)	297 (69.2)

Note. Conditions were self-reported and not clinically verified.

Association between Health Status and Driver Characteristics

Health status was significantly associated with five characteristics (Table 5): age ($\chi^2 = 21.090$, $df = 8$, $p = .007$), route type ($\chi^2 = 40.262$, $df = 2$, $p = .001$), type of vehicle driven ($\chi^2 = 15.802$, $df = 6$, $p = .015$), years of commercial driving experience ($\chi^2 = 18.940$, $df = 6$, $p = .004$) and

duration of continuous driving ($\chi^2 = 41.645$, $df = 6$, $p = .001$). No significant association was found with sex, religion, education, marital status, family characteristics, daily driving hours, time of departure, rest duration, time of return or average daily take-home income (all $p > .05$). The null hypothesis was therefore rejected for age and the four occupational characteristics and retained for all other variables.

Table 5

Association between health status and socio-demographic and occupational characteristics
($N = 429$)

Characteristic	χ^2	Df	p
Age	21.090	8	.007*
Sex	1.272	2	.529
Religion	3.227	4	.521
Highest educational level	10.799	16	.822
Marital status	12.817	8	.118
Type of marriage	5.716	8	.679
Number of wives	8.493	6	.204
Wives' occupation	7.442	8	.490
Number of children	9.445	8	.306
Sex of children	0.704	4	.951
Route type (intracity or intercity)	40.262	2	.001*
Type of vehicle	15.802	6	.015*
Years of commercial driving	18.940	6	.004*
Average daily driving hours	8.467	6	.206
Time of departure	3.798	4	.434
Continuous driving time	41.645	6	.001*
Rest time	7.468	6	.280
Time of return home	7.308	4	.120
Average daily take-home income	12.298	8	.138

Note. Pearson's chi-square test of independence. * $p < .05$.

DISCUSSION

This study aimed to describe the health status of intracity and intercity commercial drivers in Akure in the self-rated, functional, behavioural and clinical dimensions. Three key results were identified. Most of the drivers rated their health positively and were functionally independent, but a large proportion of drivers indicated musculoskeletal and cardiometabolic conditions. Secondly, there was a high prevalence of unhealthy behaviours, such as alcohol and energy drink consumption, smoking, skipping meals and poor nutrition. Third, health was related to age, and to occupational factors, such as route type and the length of the continuous driving period, but not to education or income.

Over half of the drivers said that they were very healthy with no illness; however, back or body pain was reported by nearly one-third, while hypertension, arthritis, diabetes, asthma or depression was reported by about one-fifth. SRH is a useful global measure for predicting mortality and it is not a measure of the presence of disease, but how people interpret their bodies in relation to their expectations and social context (Jylhä, 2009). Being able to drive may be a part of being healthy for drivers whose livelihood is tied to their ability to work every day, and chronic pain and silent conditions like hypertension are normalised or ignored. The disconnect between the perceived health and actual morbidity has implications for practice as drivers who think they are healthy are less likely to seek screening or treatment.

Back pain and body pain were the most prevalent conditions, which is in line with the extensive research that has been conducted on musculoskeletal disorders and their association with professional driving (Joseph et al., 2020). The percentage of back pain in this study (31.0%) is less than the 64.5% reported among Lagos drivers (Akinbo et al., 2008) and 89.3% prevalence of any musculoskeletal pain in Ibadan (Akinpelu et al., 2011). This discrepancy is likely due to the method of measurement, with those studies relying on 12-month recall of symptoms (including in the Standardized Nordic Questionnaire), while the current study inquired about symptoms in the past month, which would likely capture more persistent or severe problems. Despite this, the fact that almost one-third of drivers saw back pain as an existing medical condition suggests a significant occupational burden.

The self-reported hypertension prevalence of 22.6% was lower than the intracity drivers in Ibadan (Showande & Odukoya, 2020) and long-distance bus drivers in Lagos (Amadi et al., 2018) who reported 36.2% and 39.7% prevalence respectively, and lower than the national prevalence among adults of about 28.9% (Adeloye et al., 2015). However, only a small proportion of the hypertensive drivers in Nigeria had been diagnosed with hypertension (Showande & Odukoya, 2020) and therefore, self-report is likely to underestimate the actual prevalence of hypertension in drivers in Akure. This was different from the prevalence of diabetes as reported by intracity drivers in Ibadan (Showande & Odukoya, 2020) (5.9%) but comparable to the prevalence of diabetes as reported by older long-distance drivers in Lagos (Amadi et al., 2018) (13.9%). It may be a true burden in this relatively old sample or it may be an error in the respondents' answers or both; it could be verified by blood glucose testing. Also the high prevalence of depression among drivers, which is related to the stress, long hours and financial insecurity of the job, should not be overlooked.

Alcohol use prevalence was 73.7% similar to that of Amadi et al., 2018 who found 71.0% among long-distance drivers in Lagos and higher than the 51.3% found among intracity drivers in Ibadan (Showande & Odukoya, 2020), while half of the drivers consumed 1-2 or more units of alcohol daily. Alcohol consumption has been reported to be high among Nigerian road transport workers previously (Abiona et al., 2006) and the use of alcohol by drivers who drive for long periods is a clear concern for road safety and also for hypertension and liver disease. Energy drink use was even more prevalent (80.0%) and comparable to the 75% reported by commercial bus drivers in Ghana where most drivers reported using energy drinks for staying awake and reducing fatigue (Saku et al., 2020). Consuming caffeinated, high-sugar beverages to help keep you awake and productive all day can actually be a symptom of fatigue, and

increase the cardiometabolic risk already there. The dietary findings, such as meal skipping due to time pressure, high evening meal carbohydrate intake and high consumption of fried snacks, represent a pattern of working that leaves little time for regular, balanced meals and in combination with smoking constitute a cluster of modifiable risk factors that are common to professional drivers across the world (Crizzle et al., 2017).

The majority of drivers were able to drive, which is to be expected in an active working population. But two results call for careful interpretation. A much reduced independence in meal preparation and house cleaning is not likely to be a sign of disability but rather of gendered roles in the household where these activities are done by wives (and the sample was almost entirely male, and mostly married). In contrast, it is harder to see how a large proportion of drivers (11% to 17%) needing a lot of help with basic activities like feeding or using the toilet can be compatible with active commercial driving, and it may be that some drivers who responded to these items were interpreting them as being about help that they receive routinely, rather than about functional incapacity. Functional measures that are commonly used with older or clinical populations may thus require adaptation for use with working adults.

This correlation between health status and route type, vehicle type, driving experience and length of continuous driving and not with education or income, indicates that it is the nature of the work itself that is more closely associated with drivers' health than their socio-economic status. This is in line with the belief that many of the driver's morbidities are workplace-induced, and are caused by the chronic exposure to prolonged sitting, vibration, and irregular rest and stress (Apostolopoulos et al., 2010). This is interesting because of its strong correlation with continuous driving time, with over 30% of drivers driving for more than four hours at a time, and it is an easily modifiable target for intervention by means of a scheduled rest break. This correlation with age and experience is in line with the accumulated exposure during a working life. These relationships may overlap, however, in a bivariate analysis, e.g., intercity drivers may have longer durations without rest and older drivers may also have longer durations of driving experience.

Implications for Practice and Policy

The findings suggest a number of actions. Drivers who feel well are not likely to seek care, so screening should be brought to them: regular screening of blood pressure, blood glucose and vision should be held at motor parks, organised in partnership with transport unions, which would identify undiagnosed conditions and link drivers to treatment. Roadside and depot-based services have been demonstrated to be able to reach this mobile workforce in programmes for truck drivers in sub-Saharan Africa (Lalla-Edward et al., 2016). At motor parks, brief education on posture, stretching and rest breaks, safe alcohol consumption, and energy drink risks as well as practical healthy eating could be delivered by occupational health nurses and/or community health workers. Rest facilities and healthy food, which are affordable to drivers, should be considered at parks, as well as limits on continuous driving time, and drivers should be included in health insurance schemes, which would remove the cost barrier to follow-up care.

Strengths and Limitations

The study has strong points such as the relatively large sample size from all the major intercity parks and intracity union in Akure, the use of intracity and intercity drivers and the multidimensionality of the assessment of health status. There are a number of caveats to be considered. Health conditions and behaviours were self-reported and not clinically measured, which may lead to under-reporting of conditions like hypertension and to misclassification of other conditions. Responses for treatment for each condition were not consistent within the item - the number responding to treatment exceeded the number responding to the condition for some conditions, so treatment status is not reported. Convenience sampling was used to recruit drivers within sites, the sample was nearly all male, and the cross-sectional design does not allow for causal inferences. Lastly, the associations were analysed only with bivariate tests, and the three level health status variable applied in these tests, was a combination of several dimensions of health. Multivariable analysis and objective measurements should be used in future studies.

CONCLUSION

Although the commercial drivers in Akure generally view themselves as healthy and functional, there is a significant level of musculoskeletal pain, self-reported hypertension, diabetes and depression, as well as high prevalence of alcohol and energy drink consumption, smoking and poor dietary habits. There was an association between health status and age, and with occupational characteristics, such as route type, vehicle type, experience and continuous driving time, but not with education or income. To ensure the health of drivers and the safety of the travelling public through them, motor park-based screening, occupational health education, regulation of continuous driving time and improved rest and food facilities, in collaboration with transport unions, are necessary.

Declarations

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