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The Socio-Cultural Factors Affecting Client Participation in Health Education Programs in Umarusandandayako General Hospital Bida

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Abstract

This study was set to examine the socio-cultural factors affecting client participating in health education programs in UmaruSandandayako general hospital Bida. The objectives of this research were to ascertain the level of participation of client in health education, to find out socio-culture factors affecting client participation in health education programs and to find out ways to improve client participating in health education in umarusandandayako general hospital Bida. The design of the research was descriptive and a sample of 50 health workers was used for the study. Simple random method was adopted in the distribution of the questionnaires which were filled and retrieved. The data collected were analyzed and preserved in simple frequency tables. Finding from the analyzed data revealed that most of the respondents were aware and knowledgeable about health education (80% strongly agreed and 20% agreed, non-disagreed or strongly disagreed) and the need for participation in health education activities. The respondents also strongly agreed (28%) and agreed (40%) that they don't participate because they don't understand the concepts, others said they don't attend because illness comes from god and man made efforts are futile (36% strongly agreed and 44% agreed; only 14% disagreed and 6% disagreed). They also strongly agreed (60%) and agreed (24%) that considering their religious beliefs and giving health packets (70% strongly agreed and 16% agreed) or using interesting methods (50% strongly agreed and 30% agreed) can encourage their participation in health education. This research study can help clients participate in health education in order to better the life of the people by health prevention rather than by health curing.

Introduction

This chapter discusses the background of the study, statement ofthe problem, objectives of the problem, objectives of the study, research significance, research questions, scope and delimitation of the study, limitation of the study and operational definition of items.

Background of the study

The culture of a group of community or society is an indispensable requisite in the acceptance of certain health practices by that community. In fact the culture of people makes the concept of health highly subjective term and how people conceptualize health may be rooted in their culture's perception of health. Culture is that whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of the society (John, 2011) it is culture that makes an individual eat certain food, wear certain cloth observe certain festivals and engage in practices that may either be detrimental or beneficial and exists in a specific human behavior such as language behavior such as language, social practices such as kinship, gender, and marriage expressive forms such as art, music, dance, rituals religion and technologies such as cooking, shelter, clothing. Are said to be cultural universals found in human society (Michael, 2010)

The concept materials culture covers the physical expressions of culture such as technologies, architecture such and arts whereas the immaterial aspect of culture such as the principles of social organizations (including practices), my theology, philosophy, literature (both written and oral) and science made up of intangible culture heritage of a society. In humanities, one's sense of culture is an attribute of the individual has been the degree to

which they have cultivated a particular level of sophistication in arts, science, education, manners or health. The level of cultural sophistication has also sometimes been seen to distinguish civilization from less complex societies (John. 2011)

Culture is internally affected by both forces encouraging charge or resisting change. This force are related to both social structures and natural events and are involved in the perpetuation of culture ideas and practices within current structures which themselves are subject to change. In the same vein, culture can enhance or bring to mud certain health practices which are of benefits to a group of people including education on about themselves, attitude and belief toward health. (Emmanuel 2011)

Health education is the process of passing relevant health information efficiently and effectively by which the receiver is moved to make use of the information for the promotion, protection, maintenance or restoration of an individual, family or community's health. Health education is given to widen people's knowledge about and unknown health needs, hazards, responsibilities and international actions to make in improving the standard of health of the family and the community. Health education assists citizens to get knowledge and skills about health issues, take decision about their health needs, get people's support for programs, for information on improvement about technology and discoveries (Hubley, 2010)

Community participation in health education is very important as it makes health education programs very effective and successful and triggers the particular required behavioral change. Health educations programs are not worth holding if members of the education program are organized for are not ready to participate (Ayele and kaba 2010)

The social culture activities people believe and engage in can make people resist or easily accept change that is brought about by education. Health education of course may promote certain cultural activities discourage some or eliminate some completely the behavioral changes that may accompany this education maybe resisted or accepted by some either consciously or unconsciously and may be due to the socio- culture perception of an individual, group or community about that health phenomenon (Dharma Lingam 2011)

Statement of the problem

The modern health perception has been changed from curative to preventive, but developing countries Nigeria inclusive are still battling with ignorance that is not merely related to absence of awareness campaign, enlightenment programs or health education but the resistance and lack of interest and participation in such programs by individuals, groups or communities. This lack of participation maybe related to religious and socio-cultural practices embedded in a particular race or community (Hubley, 2010)

This prompted the researcher to seek and find out socio-cultural factors affecting client participation in health education programs in umarusandandayako general hospital Bida.

Research objectives

i. To ascertain the level of participation of clients in health education in umarusandandayako general hospital Bida.
ii. To find out socio- cultural factors affecting client participation in health education programs in umarusandandayako general hospital Bida.
iii. To find out ways to improve client participation in education in umarusandandayako general hospital Bida.

Significance of the study

- This study will look into and provide adequate information about health education in the area of study.
- It may help discourage cultural beliefs that make the effort of health educationists futile.
- This study may reveal the level of client participation in health education.
- It may uncover the problems hindering client participation in health education.

- It may help educationist to device means to improve health teaching.
- It may help the researcher acquire more knowledge about health education.

Scope and limitation of the study

This study is limited to ‘‘socio-cultural factors affecting client participation in health education programs in umarusandandayako general hospital Bida’’. It was conducted among the patients who were on admission and those who attend clinic.

Literature review

Introduction

This chapter discusses relevant literatures from authors and researchers related to the study as well as conceptual frame work.

The concept of health education

Before discussing about health education: it is imperative to briefly conceptualize what health itself means. Health is a highly subjective concept. Good health means different things to different people and its meaning varies according to individual and community expectation culture and context. Many people consider themselves health if they are free of disease or disability may also see themselves as been in good health if they are also to manage their condition so that it does not impact greatly in them of life. However world health organization (WHO, 2010) defined health as a state of complete physical, mental, and social wellbeing and not mere absence of diseases or infirmity.

Physical health- refers to anatomical integrity and physiological functioning of the body. A person is physically health if:

- All parts of the body should be there
- All of themare in their natural place and position.
- None of them has pathology.
- All of them are doing their physiological function properly.
- And they work with each other harmoniously (WHO, 2010)

Mental health- refers to ability to learn and think clearly. A person with good mental health is able to handle day to day events and obstacles, work towards important goals and function effectively in society (WHO, 2010).

Social health- is the ability make and maintains acceptable interaction with other people. E.g. to feel sad when somebody close to you passes away (WHO, 2010)

The disease, illness and sickness, which usually means the something through social scientists give them different meaning to each.

Historical development of health education

While the History of health education as on emerging profession is only a little over hundred years old, the dawn of humans. It does not stretch the imagination too far to begin to see how health education first took place during pre-historic era. Someone may have eaten a particular plant or herb and became ill. That person will then warn (education) others against eating the same substance. Conversely, someone may have ingested a plant or herb that produced a desired effect. That person would then encourage (educate) others to use this substance (Newman, 2012).

At the time of Alma at al declaration of primary healthcare in 1978, health education was pal as one of the components of primary health care and it was organized as a fundamental tool to the attainment of health for all. Adopting this declaration, World health organization utilizes and recommends health education as a primary means of prevention of diseases and promotion of health.

Health education has been defined in many ways by different authors and experts Lawrence (2009) defined it as combination of learning experiences designed to facilitate

voluntary actions conductive to health. The term combinations designed facilitate, and voluntary actions have significant implication in this definition. Combination emphasizes the importance of matching the multiple determinants of behaviors with multiple learning experiences or education from incidental learning experiences as systematically planned activity facilitate means create favorable condition for action – voluntary action means behavioral measures that are undertaken by an individual groups community to achieve an intended health effect without the use of force i.e. with full understanding and acceptance of purposes.

Aims and principles of health education

The Aim of Health Education is to motivate people to adopt health-promoting behaviors by providing appropriate knowledge and helping to develop positive attitude. It is aimed at helping people to make decision about health and acquire the necessary confidence and skills to put their decision to practice (Lawrence 2009)

Basic principles of health education

The following are basic principle of health education as outlined by (WHO, 2010)

- All health education should be need oriented, therefore involving any individual, group or community in health education with a purpose or for program also specific and relevant to the problems and available solutions.
- Health education aims at change of behavior therefore multidisciplinary approach is necessary for understanding of human behavior as well as effective teaching process.
- It is necessary to have a free flow of communication. The two way communication is particularly of importance in health education to help in getting proper feedback and get doubt cleared.
- The health education has to adjust his talk and action to suit the group for whom the health education his talk and action to suit the group for whom the health educator has to give health education e.g. when the health educator has to deal with illiterates and poor people, he has to get down to their level of conversation and human relationships so as to reduce any social change.
- Health education should provide an opportunity for the clients to go through the stages of identification of problems, planning, implementation and evaluation. This is of special importance in the health education of the community where the identification of problems and planning, implementing and evaluating are to be done with full involvement of the community to make it the community's own program.
- Health education is based on scientific findings and current knowledge. Therefore a health educator should have recent scientific knowledge to provide health education. They should realize that they are enablers and not teachers. They have to win the confidence of client.
- Health educators should not only have correct information with them on all matters that they have to discuss, but also should practice what they profess otherwise, they will not enjoy credibility.
- It must be remembered that people are not absolutely without any information or ideas. Health education should not be merely passing information but opportunity should be given to the client to analyze fresh ideas with the old ideas, compare with past experience and take decision that are found favorable and beneficial.
- To avoid the grave danger of damaging the learning process information should be presented bit by bit not bulk of information in or exposure or the enthusiasm of the client might maybe dampened.
- Highly scientific jargon should be avoided, the health educator should use terms that will immediately be understood.
- Health education should start from known to unknown the existing indigenous knowledge and efforts should be considered. People will learn step by step and not

everything together. For every change of behaviors, a personal trail in required and therefore the health education should promote opportunities for trying out changed practices.

Approaches to health education

Mustapha (2009) outlined two approaches to health education;

- The persuasion approach; deliberate attempt to influence the other persons to do what we want to do also call directive approach.
- The informed decision making approach; giving people information, problems solving and decision making skills to make decision but leaving the actual choice to the people e.g. family planning methods.

Many health educators fell that instead of using persuasion. It is better to work with communities to develop their problem solving skills and provide information to help them make informed choices. However, in situations where there is serious threat such as epidemic, and the actions needed are clear cut. It might be considered justified to persuade people to adopt specific behaviors changes.

Targets of health education

Targets of health education outlined by Mustapha (2007) are;

- Individuals such as clients that come for services, patient, healthy individuals.
- Groups e.g. group of student, youth club, market woman etc.,
- Community e.g. people living in a village.
- Individual with special condition such as HIV/AIDs or hepatitis B.

Health education settings

Health education takes place in locations such as

- Communities.
- Health care facilities
- Work Sites
- Industries
- Schools
- Prisons
- Refugee camps
- Occupational group e.g. drivers, mechanics, welders etc., (Mustapha 2009) etc.,

Method of health education

Different methods are used to health educate client according to their level of understanding and in order to achieve the aim of education WHO (2010) classified health education methods as follows.

- Individual health education method; is a person to person contact in which one person is educated by another and to find solution to problems. This service can be given to patients at the health center, to pupils in school, to families during home visit casual visit to community (e.g. water well)

Home visit is important in this because people feel happier in their homes and maybe more willing to talk than when in clinic. It also gives opportunities to see how the environment and the family situation might affect a person's health, this making observations and any necessary suggestions for change right there health workers should visit homes in their community regularly group health education methods: a group is defined as a gathering of two or more people with a common interest. E.g. of groups includes family, health committee, people working in a factory, business or agency, a class of school children or a farmers' cooperative, youth club, in a bus or patient in a clinic group health education is carried out using:

- Group discussion: discussion in a group is informal and allows people to say what is in their minds. They can talk about their problems, share ideas, support and encourageeach other to solve problems and change their behavior.
- Meeting: is more formal and organized and allows for sharing ideas, making decisions and plans to solve problems. It is led by a leader and may use some visual aid to clarity things. Consensus based decision may also be reached.
- Clubs: people belong to different organizations, involving children, women and men. They provide an opportunity for a systematic way of teaching over an extended period of time.
- Demonstration: involves theoretical teaching and practical work. It is used to show people how to do something. The main purpose is helping people in learning new skills. It is particularly useful when combined with a home visit. This allows people to work with familiar materials available in the locality.
- Village criers: they spread information in the past eras but maybe find today in remote areas where modern mass media are scarce. They are ordered by village leaders, and may use bell or drum to attract attention. Drum beats and other sound can be special code or signal that people understand. The significance about these people is that villagers know who is the real village crier and may only respect information coming from him or her. Warning about dirty water maybe give during cholera outbreak, sanitation campaign, or a reminder to mothers about immunization.
- Songs: people sing to express ideas and feelings, such as love and sadness, to tell story of a famous person, commemorate religious days etc., in addition to expression of feelings, songs can be used to give ideas about health and topics can be synthesized for dissemination. Songs like the village without safe water, the malnourished child who got well when given proper food and how to prevent house flies and mosquitoes.
- Stories: story telling is highly effective. It can be developed in any situation or culture and requires no money or equipment. Stories can be used to encourage people about their health.
- Role playing: role playing is acting out a real life situation and problems. It can be used to describe the possible consequence of an action. It can discover how attitudes and values encourage cooperation during a health program and how attitude and values create problems during a health program.
- Health talks: in groups health talk is very important and can be done individually or in a family. Health talk remains the most common way to share health knowledge and facts. Health talk can be made more effective by combining them with visual aids such as posters, slides. Demonstrations and video shows. It is important to have up to date information and have a single topic of discussion, visual object and health education can be effective if visual aids are combined with interaction sessions. They provide a clear mental picture of a message and can stimulate active thinking. Leaf lets, posters, photographs, projected aids and newspapers also important tools that can be utilized to make health talk or health teaching effective.

Role of health educators

Mustapha (2009), discussed that health education is the duty of every one engage in health and community development activities. Doctors, nurses, pharmacists and community health extension workers who are primarily responsible in working with the families and community at the grass root level to promote health and prevent disease through practicing health education in their daily work, they are not doing their job correctly. When treating someone with skin infection or malaria, a health worker should also educate the patient about the cause of the illness and teach preventive skills.

Drug alone will not solve the problems. Without health education the patient may fall sick again from the same disease. Health workers must also realize that their own personal examples serve to educate others. Some of the roles of the health educator include:

- Talking to people and listening to their problems.
- Thinking of the behavior or action that could cause, cure and prevent these problems.
- Finding reasons for people's behaviors.
- Helping people see the reason for their actions and health problems or benefits.
- Asking people to give their own ideas for solving the problems.
- Helping people to look as their ideas so that they could wee which is most useful and simplest to pal to practice.
- Encouraging people to choose the idea best suited to their circumstances.

The concept of culture

Culture is the complex whole of knowledge, attitude norms, beliefs, values, habits traditions and any other capabilities and skills acquired by man as a member of the society. It involves tradition (behaviors that have been carried out for a long time and handed over from parents to children), customs (it represents the group behavior, a pattern of action shared by some or all members of a society) life style (collection to behavior that make up a person's way of life including diet, clothing, family life, housing and work. Culture also consists of belief, attitude and values (Michael 2010)

- Beliefs are a conviction that a phenomenon or object is true or real. Beliefs deal with people understands of themselves and their environment. People usually do not know whether what they believe is true or false. They are usually derived from our parents, grandparents and other people we respect. Beliefs may be helpful, harmful or neutral if it is not certain that a belief is harmful, it is better to leave it alone. For example a certain society may have the following beliefs.
- Diarrhea may cause or end up with death (helpful)
- Measles cannot be prevented by immunization (harmful)
- Attitude: relatively constant feelings, predisposition or set of belief directed towards an object, person or situation they are evaluative feelings and reflect our likes and dislikes they often come from our experience or from those of people close to us. They attract us to do things or not to them. For instance a patient has fever and visited the nearby health center. The staff on duty that day was busy and shouted at him/her. ''do you want us to waste our time for a mild fever? Comeback when we are less busy''. He/she did not like being shouted at, this had attitude could discourage her from attending the health center next time he/she is sick.
- Values: are broad ideas and widely held assumptions regarding what are desirable, correct and good that most members of the society share. Values are so general and abstract that they do not explicitly specify which behaviors are acceptable and which are not, instead, values provide us with criteria and conceptions by which we evaluate people, object and wants as their relative worth merit beauty or morality e.g. being married and having many children is highly valued in African communities.

Norms are social rules that specify appropriate and inappropriate behaviors in given situations. They tell us what we should and must do as well as what we should not and must not do. For example people often regard greeting as a social norm to be confronted among members who know each other people therefore should greet each other. Murder, theft and rape often bring strong disapproval, therefore one must not kill.

Characteristics of culture

The following are some characteristics of culture as discussed by (Williams 2008)
Culture is symbolic: it is an abstract way of referring to and understanding ideas, objects feeling or behavior. It has the ability to communicate with symbols using language to convey new idea people may invent single words to represent different ideas, feelings or values.

- Culture is shared: people in the same society share common behavior patterns and ways of thinking through culture. For example people living in as society share the same

language dress in similar style. Eat much of the same food, observe the same festivals and celebrate many of the same holidays.

- Culture is learned: a person must learn culture from other people in a society. For instance, people must learn to speak and understand a language and abide by the rules of the society.
- Culture is adaptive: people use culture to adjust flexibly and quickly to change in the worlds around them. For instance a person can adjust his diet when he changes an area of residence.

Socio-cultural factors in health education

Mustapha (2009) discussed some socio cultural factors in health education.

- Family: in a society, many difference in the ways in which families are organized. Families vary in their composition and in their descent, residence and authority patterns. An understanding of the family structure, the status of various members of the family and who is involve in the decision making process within the family on all major decisions as well as those related to health is valuable to work with community. Without this knowledge you may direct your educational activities towards the wrong member of the family.
- The political structure of a community: the basis of leadership and power within the community should be explored. The cooperation or disapproval of leaders can either enhance or discourage health education.
- General activities: know about businesses, industries agricultural conditions, unemployment family debts and how land is distributed this information will increase your knowledge of what is important to the people and what resources are available to them.
- Religion: religion may have great influence on the life style of the community including the health practice and belief of individuals. A mother may believe that her child is sick because it is God's desire. It is important therefore to know.
- The major religions group in the community their leaders and roles of the religion in community life.
- Whether there are any conflicts between them.
- The attitude of government and the community towards religious affiliated programs.
- Health beliefs and practice: observe and record the practices in the community whether or not to encourage or discourage them observe for the following health practices and beliefs:
- How people define good health and disease.
- Some may harbor the belief that prevention of illness is impossible or every difficult.
- What methods are used to maintain their health?
- What are people's attitudes towards such services as vaccination, family planning, insecticide sprays etc.,
- Local attitudes and practices regarding personal hygiene.
- Existence of special beliefs concerning food generally or when child is ill or when a woman is pregnant.
- Breast feeding and weaning practices for infants.
- Where woman given birth and who assist in delivery, method of cutting umbilical cord.
- Source of water, excreta disposal and level of awareness about face or oral route.
- Preference of traditional/herbal over orthodox.

The concept of community participation

The health of the community will improve only if the people themselves come involved in planning and implementing and having a say about their own health and health care. Nevertheless involvement will not just happen without enlightenment or education. It has only been emphasized that development issues including health education and health

promotion can become a success through community participation. In health education, one should be concerned about how people actually feel not how one think they should feel. Interest should be developed in how people look at their own problems not only in the problems seen by the educator, community participation encompasses the process which individuals and families assume responsibility for their own health and families assume responsibility for their own health and welfare communities should be active not passive recipients of health education (Mitike 2011)

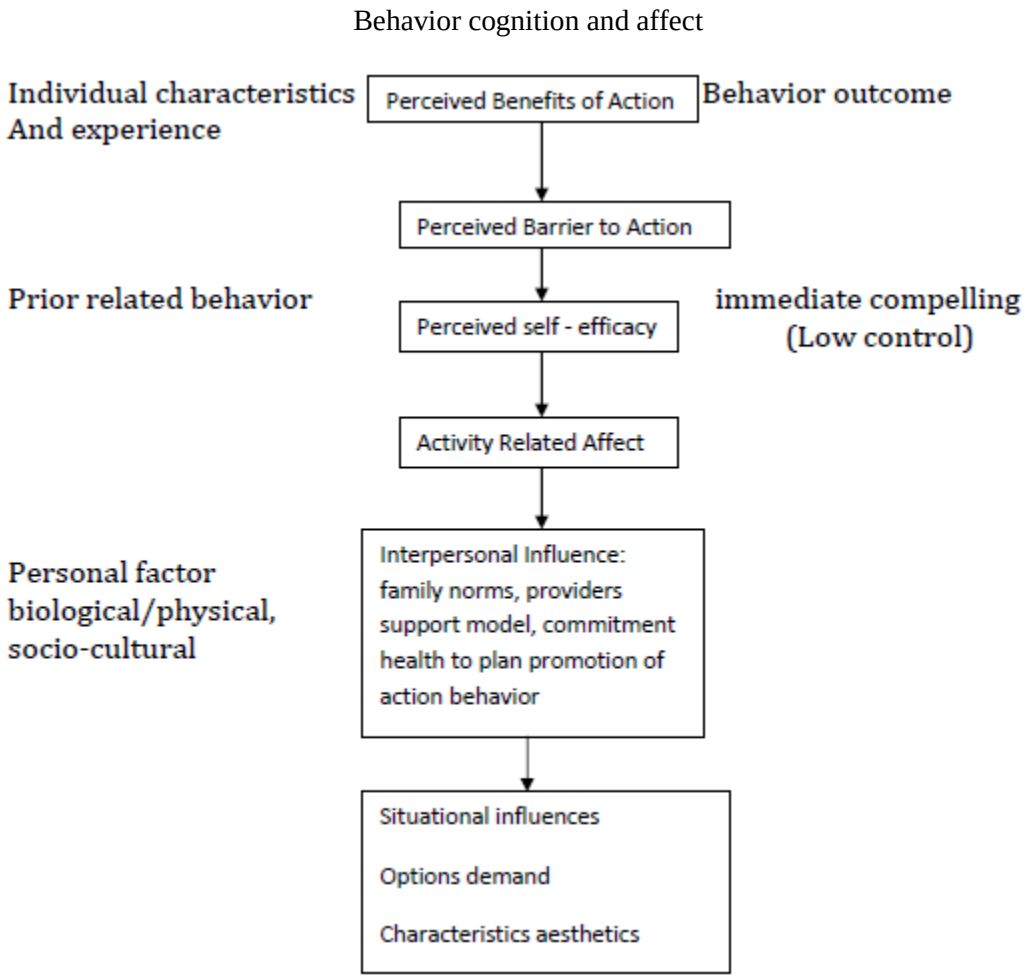
Benefits of community participation

- It can lead to success in health educating developmental programs.
- Shifts the emphasis of health education off from individual to community
- Since communities have detailed knowledge about their surroundings through participation in health education. It makes health program relevant to local situation.
- Improve trust and partnership between community and health work.

Conceptual/theoretical framework

Nora J. Pender developed the health promotion model of health promoting behavior for use in research and practice. She is a professor Emeritus in the school of nursing at the University of Michigan and an advocate of health promotion. I committed myself to the practice stance of health promotion and disease prevent with the conviction that it is much better to experience exuberant wellbeing and prevent disease than let disease happen when it is avoidable and then try to cope with. Health promotion and disease prevention should be the primary focus in health care and when health promotion and prevention fail to prevent more problems and the care in illness becomes the next priority.

Nola's Health Promotion Theory



Source. Nursing Online (2012)

Figure 2.8 conceptual/theoretical frameworks (Nola's Health Theory)

She described this theory in two forms which forms includes health promotion theory and health protection or illness prevention theory.

- She defied health promotion as behavior motivated by the desire to increase wellbeing and actualized human health potential. It is an approach to wellbeing.
- Health protection or illness prevention is described as behavior motivated desire to actively avoid illness, detect it early or maintain functioning within the constraints of illness

This model is moving towards understanding multifaceted nature of persons correlating with their interpersonal and physical environment as they trail towards health. Because of this model nurse have already advanced their health approaches addressing not only the curative side but as well as prevention of disease and promotion of wellbeing.

Application of the nola model

Nora's model is centered on health promotion and health protection/illness prevention. Her perception is that individual can improve their health and wellbeing only if they show great interest. This interest will make them seek health behavior that makes them lead a healthy life. Health education is an aspect of health promotion and prevention. Because when people are educated they

I. They are taught the importance of eating good, nutritive diet and how to combine different food to make up adequate DIET

II. Accept immunization practice which could affect their health
III. Taught on how to maintain personal and environmental hygiene
IV. To avoid cultural taboo which could affect health
V. Encouraged on family planning in order to adequately space their children.
VI. Encourage women to attend ante-natal visit to prepare them towards their birth and rule out any complications.

Research methodology

Research design

The researcher adopted a descriptive design to examine the socio-cultural factors affecting client participation in health education programs in UmaruSandaNdayako General Hospital Bida

Target population

The study population consist of men and women seeking health services in UmaruSanda General Hospital, Bida. The researcher stayed at the outpatient Department for easy access of Respondents

Sample size and sampling technique

The researcher employed simple random sampling technique. It is a research technique in which every member of the target population has a chance of been selected. A total number of 50 respondents were used as the sample size.

Instrument for data collection

Structured questionnaire was used to obtain data from respondents. The questionnaires were in from the respondents. The questionnaires were in concord with the research objectives sand questions.

Method of data collection

Questionnaire was administered by the researcher which was later retrieved with 100% return.

Method of data presentation and analysis

The data was analyzed and presented using descriptive statistic of frequency distribution table and percentages.

Introduction

This chapter deals with data presentation and analysis

Table 4.1. Personal data of the respondents

Age Range (yrs)	**Frequency**	**Percentage %**
15-20	3	6
21-25	7	4
26-30	25	50
31-35	15	30
Total	**50**	**100**

Marital Status	**Frequency**	**Percentage %**
Married	30	60
Single	15	30
Divorced	3	6
Widowed	2	4
Total	**50**	**100**

Sex	Frequency	Percentage %
Male	26	52
Female	24	46
Total	**50**	**100**

Tribe	Frequency	Percentage %
Nupe	24	48
Gbagyi	6	12
Igbo	6	12
Yoruba	6	12
others	8	16
Total	**50**	**100**

Occupation	Frequency	Percentage %
Students	5	10
Civil servant	14	26
Farmers	16	32
Business	15	30
Total	**50**	**100**

From table 4.1, the age range 15-20 was represented by 6 followed by age group of 21-25 (14%) then 26-30 (50%) and lastly 31-35 (30%), most of the respondents were married (60%) followed by single (30%) the remaining. Few were either divorced (6%) or widow (4%)

The table also revealed that 52% of the respondents were males while the remaining 48% were females for the tribe Nupe. Was represented by 48% others 10% the remaining tribe (Gbagi, Igbo or Yoruba) had a tie of 12%.

From the table the data relating to occupation revealed that majority of the respondents were farmers (32%) closely following by Business (30%) and civil servant (25%). The least group represented were students with (10%)

Table 4.2. Level of participation of client in health education

6th statement: health education means teaching people about their health and how to live healthy lives		
Option	**Frequency**	**Percentage %**
Strongly agreed	40	80
Agreed	10s	20
Disagreed	0	0
Strongly disagreed	0	0
Total	**50**	**100**
7th statement: I attend health education programs in this hospital whenever one is Organized		
Options	**Frequency**	**Percentage %**
Strongly agreed	15	30
Agreed	18	36
Disagreed	7	14
Strongly disagreed	10	20
Total	**50**	**100**
8th statement: there is no need to attend health education programs so even if am informed, I won't attend		

Options	**Frequency**	**Percentage %**
Strongly agreed	1	2
Agreed	2	4
Disagreed	23	46
Strongly disagreed	24	48
Total	**50**	**100**
9th statement: I only see hospital as a place for the sick not for education, another setting will be more appropriate		
Options	**Frequency**	**Percentage %**
Strongly agreed	20	40
Agreed	10	20
Disagreed	10	20
Strongly disagreed	10	20
Total	**50**	**100**
10th statement: I would like to be part of health education if given the opportunity like sharing of pastors or passing information		
Options	**Frequency**	**Percentage %**
Strongly agreed	25	50
Agreed	15	30
Disagreed	5	10
Strongly disagreed	5	10
Total	**50**	**100**

From table 4.2, majority of the respondents strongly agreed (80%) and agreed (20%) that health education meant teaching people about their health and how to live healthy lives. None strongly disagreed or disagreed. Also 30% and 36% of the respondents. Strongly agreed and agreed that they attend health education programs when whenever one is organized while 14% disagreed and 20% strongly disagreed.

In response to the 8th statement, 48% strongly disagreed 46% disagreed that there is no need to attend health education programs, so will not attend even if informed, only 2% and 4% strongly agreed and agreed with the statement. The table also revealed that 4% and 2% strongly agreed and agreed with the 9th statement that hospital is only for the sick not for education, but will prefer another setting, while a tie of 20% disagreed and strongly disagreed respectively.

Most of the respondents strongly agreed (50%) and (30%) that they would like to be part of health education programmed if given the opportunity while a tie of 10% disagreed and strongly disagreed respectively.

Table 4.3. Factors affecting client participation in health education

11th statement: whenever I attend health education programs, the teaching does not consider my beliefs		
Options	**Frequency**	**Percentage %**
Strongly agreed	10	20
Agreed	12	24
Disagreed	12	24
Strongly disagreed	16	32
Total	**50**	**100**
12th statement: I don't participate because I don't understand the concept and the teachings are beyond community actualization		
Option	**Frequency**	**Percentage %**
Strongly agreed	14	28
Agreed	20	40

Disagreed	10	20
Strongly disagreed	6	12
Total	**50**	**100**
13th statement: I don't participate because my religious leaders are not informed or because I was not informed by my religious leaders		
Option	**Frequency**	**Percentage %**
Strongly agreed	15	30
Agreed	15	30
Disagreed	10	20
Strongly disagreed	10	20
Total	**50**	**100**
14th statement: my belief is that illness comes from God, so any man effort (such as health education) is futile		
Option	**Frequency**	**Percentage %**
Strongly agreed	18	36
Agreed	22	44
Disagreed	7	14
Strongly disagreed	3	6
Total	**50**	**100**
15th statement: proper channel is not formed in passing information e.g posters, radio, leaders (both religious and titled man) to encourage attendance		
Option	**Frequency**	**Percentage %**
Strongly agreed	20	40
Agreed	15	30
Disagreed	10	20
Strongly disagreed	5	10
Total	**50**	**100**

From table 4.8, in response to the 111th statement. The respondent 20% strongly agreed and 24% agreed that whenever they attend health education programs, the teaching does not consider their belief while24% and 32% disagreed and strongly disagreed. To the 12th statement some of the respondents strongly agreed 28% and agreed 40% that they don't participate in health education programs because they don't understand the concepts and the teaching are beyond community actualization while 20% and 12% disagreed and strongly disagreed respectively.

In response to the 13th statement a tie 30% both strongly agreed and agreed that they don't participate because their religious leaders were not informed, while a tie of 20% disagreed and strongly disagreed respectively.

As to 14th statement that illness come from God and so any man and effort such as health education is futile, 36% strongly agreed and 44% agreed while 14% disagreed and 6% strongly disagreed. In regards to the 15th statement that proper channel is not followed in passing information about health education 40% strongly agreed and 30% agreed while 20% disagreed and 10% strongly disagreed respectively.

Table 4.4. Ways to improve client participation in health education

16th statement: considering my religious belief can encourage me to attend health education programs		
Option	**Frequency**	**Percentage %**
Strongly agreed	30	60
Agreed	12	24

Disagreed	5	10
Strongly disagreed	3	6
Total	**50**	**100**
17th statement: giving health packets (such as close up, medicated soap) can encourage me to attend health education programs		
Option	**Frequency**	**Percentage %**
Strongly agreed	35	70
Agreed	8	16
Disagreed	6	12
Strongly disagreed	2	4
Total	**50**	**100**
18th statement: proper passing of information van increase anticipation in health education		
Option	**Frequency**	**Percentage %**
Strongly agreed	20	40
Agreed	26	52
Disagreed	3	6
Strongly disagreed	1	2
Total	**50**	**100**
19th statement: using another venue such as school, mosques or churches can induce more participation		
Option	**Frequency**	**Percentage %**
Strongly agreed	18	36
Agreed	22	44
Disagreed	7	14
Strongly disagreed	3	6
Total	**50**	**100**
20th statement: using interesting methods such as drama and role plays can improve participation		
Option	**Frequency**	**Percentage %**
Strongly agreed	25	50
Agreed	15	30
Disagreed	10	20
Strongly disagreed	0	0
Total	**50**	**100**

From table 4.4, the respondents strongly agreed 60% and agreed 24% that considering their religious belief can encourage them to attend health education program while 10% disagreed and 6% strongly disagreed. Also 70% strongly agreed and 16% agreed that giving health packets (such as close up, medicated soap) can encourage them to attend health education programs while only 12% disagreed and 4% strongly disagreed.

The analyzed data also showed that 40% strongly agreed and 52% agreed that proper passing of information can increase participation in health education while the remaining 6% and 2% disagreed and strongly disagreed respectively. Also 36% strongly agreed and 44% agreed that using other venue such as school, mosques or churched can induce more participation while 14% and 6% disagreed and strongly disagreed respectively. And lastly 50% and 30% strongly agreed and agreed respectively that using interesting methods such as drama, role play can improve participation while 20% disagreed, none of the respondents strongly disagreed.

Discussion of research findings

Discussion of the research findings

This research work was conducted to find out the socio-cultural factors affecting client participation in health education in UmaruSandaNdayako General Hospital Bida. Findings in relation to the demographical data revealed that most of the respondents were aged 26-30 (50%), followed by age 31-35 (30%), only few were within the age of 21-25 (14%) and 15-20 (6%). Most of them were Nupe (48%) followed by other (16%) the remaining (Gbagyi, Igbo or Yoruba) had a tie of 10% each. In relation to the occupation followed by business (30%) and civil servants (28%) of the least from the results was student. (10%)

From the table majority of the respondents strongly agreed (80%) and agreed (20%) that health education meant teaching people about their health and how to live healthy lives. None strongly disagreed or disagreed. Also 30% and 36% of the respondents strongly agreed and agreed that they attend health education programs whenever ones organized while 14% disagreed that 20% strongly disagreed. The result showed that% strongly disagreed and 46% disagreed that there is no need to attend health education programs, so will not attend even if well informed, only 2% and 4% strongly agreed and agreed that hospital is only for the sick not for education, but will prefer another setting, while a tie of 20% disagreed and strongly disagreed respectively. Most of the respondents strongly agreed (50%) and agreed (30%) that they would like to be part of health education programs if given the opportunity while a tie of 10% disagreed and strongly disagreed respectively. Test findings are in line with that of Mitike (2011) who discovered that people willing to participate health education/antenatal care if will informed.

From the analysis, most of the respondents disagreed (24%) and strongly disagreed (32%) that health education dose note consider their belief while the rest 20% strongly agreed and 24% agreed. Also 28% agreed and 40% strongly agreed that they participate in health education is crippled by elephant concepts beyond their actualization while 20% and 12% disagreed and strongly disagreed respectively. This means that the notion that the belief of people is not considered during health education is false and may not be a hindering factor, rather it may be actualized. Lawrence (2009) stressed clearly that the belief of the people is usually considered and so might not be a problem. But a move encouraging factor that can ignite participation is using terms and breaking down large task into the communities' level of maximal achieved.

From the findings a tie of 30% agreed and strongly agreed that they don't participate because their religious leaders were not informed while a tie of 20% disagreed and strongly disagreed respectively. It also showed 36% strongly agree and 44% agreed that illness comes from God and so any man made effort such as health education is futile while 14% disagreed and 6% strongly disagreed. Majority also strongly agreed (40%) and agreed (30%) that proper channel is not following in passing information about health education, while 20% disagreed 10% strongly disagreed respectively. The religious belief of the people and reverence to their leaders according to Mitike (2011) as a socio cultural factor that either makes health education a success (if properly consider) or a failure (if not considered). The finding above support this statement as most of the respondents said they don't attend because their leader were informed, illness comes from God and that information is passed wrongly.

From the results, most agree (60%) and agrees (24%) that considering their religious belief can encourage them to attend health education programs while 10% disagreed and 6% strongly disagreed. Also most of the respondents. 70% strongly agreed and 16% agreed that giving health packets (such as close up, medicated soap) can encourage them to attend health education programs while only 12% agreed and 52% agreed that proper passing of information can increase participation in health education while the remaining 6% and 2% disagreed and strongly disagrees respectively. Also 36% strongly agreed and 4% disagreed that using either venue such as schools, mosques or churches can induce more participation while 14% and 6% disagreed and strongly disagreed respectively. And lastly 50% and 30%

strongly agreed and agreed respectively that using interesting method such as drama and role play can improve participation while 20% disagrees, none of the respondents strongly disagreed. This found out that considering religious beliefs, giving health packets, and using interesting methods can increase participation in health education.

Implication of the finding to nursing profession

The findings has significance to the nursing profession in the following ways:

I. Nurses as health professional should consider themselves integrally paramount in the dissemination of health information.
II. Nurse should accordance with the findings be abreast of the fact those who don't participate in health education only need more enlightenment and so should not be treated with hostility.
III. The findings revealed that nurses should consider people's belief religion and context while holding health education programs.
IV. Nurse need to conduct more studies in a bid to uncover factors that can promote participation in health education

Summary and conclusion

This study consists of five chapters: chapter one contained the introductory aspect of the study, the statement of problems. Significance, scope and delimitation, and objective of the study. It also contained research questions of the study. It also contained research questions and operational definition of terms.

Chapter two contains the literature review while chapter three discussed the research design, target population, sampling techniques, instrument used for data collection, method of data collection and analysis, validity and ethical consideration.

Chapter four dealt with the interpretation and analysis of data while chapter five discussed the findings of the research, implications to nursing, summary, conclusion and recommendations.

This study was conducted to assess the socio-cultural factors affecting client participation in heath education. The study showed that client are aware of health education and are willing to participation in health education if proper channel is followed.

Referrences

[1]. Ayele, F. & Kaba, M. (2010). Training Guide on Communication and Social Mobilization of Health Communicators. Ethiopia: Jimma Institution of Health Sciences, Department of Community Health.

[2]. Dharmalingam, R. (2011). Health Education, A New Approach. New Del Hi: Jaypee Brothers.

[3]. Emmuael, A (2011). The Concept of Health Education. Ibadan: Spectrum Books.

[4]. Garaba M. (2010) Health Education for Health Science Students. Addis Ababa the Price Publishers

[5]. Hubley, J. (2010). Communicating Health; An Action Guide to Health Education and Health Promotion. African Journal of Medicine, 5(4), 13-25.

[6]. John, H. (2011). The Principles and Practice of Health Education; A Preliminary Guide. Lagos: Star Books Limited

[7]. Lawrence, K. (2009). Breaking New Bounds in Health Prevention: Health Education in Focus: Nigeria Medical Journal, 6 (5), 34-56

[8]. Micheal, O. (2010). The Precept of Culture and Societal Interrelationship: Breaking Medical Journal, 6(4) 45-60

[9]. Mitike, Y. (2011), Involving African Communities in Community Mobilization and Participation: The Way Forward. Africa Journal of Medicine. 15(3) 45-80

[10]. Mustapha, K. (2009). Health Education in The Tropics: Ibadan: Spectrum Books,

[11]. Newman, J. (2012). The Promotion of Health Utilizing The WHO Guidelines for Health Education. Africa Medical Journal, 4(7) 45-70

[12]. Nursing Online, (2012). The Nursing Theories Retrieved, 13th September 2015 from http://ww.nursingonline.com/pdif/
[13]. Redolph. L. Education for Better Health: A Manual for Senior Health Educators Ethiopia: UNICEF/MOH Addis Ababa
[14]. Who, (2010). Education for Health. A Manual on Health Education in Primary Health Care. Geneva: WHO
[15]. Williams U (2008). Africa Customs. Accra: Kolite Printers and Publishers.
[16]. Yusuf L. Health Promotion Foundations for Practice. London: Clear Concept Publisher.