CULTURAL BELIEF AND IMMUNIZATION IN BIRNIN KEBBI LOCAL GOVERNMENT AREA,

KEBBI STATE, NIGERIA.

BY

RABIU UMAR

1011203027

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CERTIFICATION

This project entitled “cultural belief and immunization in Birnin Kebbi local government area of Kebbi State” written by RABIU UMAR Admin No.: 1011203027 has been read and approved as meeting the requirement of the Department of Sociology, Faculty of Social Sciences, Usmanu Danfodiyo University Sokoto, for the award of B.Sc in Sociology.

_____ _____

Dr. Mrs Ngozi C. Okolo Date

(Project Supervisor)

_____ _____

Dr. Ahmad U Karofi Date

(H.O.D Sociology)

_____ _____

External Examiner Date

DEDICATION

All praise and adoration be to Allah who has bestowed me with the ability to meet up throughout my years of study. In view of this, I dedicate this work to my lovely late father Mal. Umar Muhammad Dangoje Ambursa, who could have witness this if he is still alive but couldn't seen it, as always mankind propose but God dispose, I pray may his perfect soul rest in peace (ameen).

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ABSTRACT

The hostility of community member towards immunization has been a concern to the health workers and this has been attributed to their cultural belief. The objective of this study is therefore to examine cultural beliefs and immunization of children. 120 questionnaire were administered were designed for three categories of respondents who are parent, health personnel's and traditional and religious leaders. Each group mentioned was administered with 40 questionnaires each as they were randomly sampled from each group. Simple percentage and chi- square was used to present the result of the questionnaire and the hypothesis. The result showed that cultural beliefs affect people's response to the immunization programme in Birnin Kebbi local government areas, that the attitudes of people toward immunization of children have affected the effectiveness of the immunization programme in Birnin Kebbi local government area and lastly, the immunization program has help eradicate some diseases within Birnin Kebbi local government areas. Conclusively, the cultural beliefs of those in the community have affected the effectiveness of the programme therefore it was recommended that there is need for more awareness and reorientation on immunization

Keywords: *Immunization, culture, face to face, sickness*

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CHAPTER ONE

INTRODUCTION

1.0 Background to the Study

Generally speaking, immunization is not newly introduced in this world. This is because it was shown in history that our forefathers have their own traditional ways of immunizing themselves and their families, through the use of leaves of trees, minerals vegetable and armlet. But nowadays due to the existence and establishment of new modern health care facilities that immunization becomes modernized.

The concept of immunization or how to artificially induce the body to resist infection, received a big boost in 1796 when Edward Jenner the first world's vaccinator, inoculated a young boy in England and successfully prevented him from getting smallpox, he also used a lancet to scratch some infected material from a woman with cowpox (similar to smallpox) under the boy's skin. Journal list>proc (bayl univ med cent) (2005, 18(1):21-25).

Nigeria's expanded programmed on immunization [EPI] was first initiated in 1979 and the federal government of Nigeria, through the federal ministry of health continues to place high priority on immunization. During that period the strategies used in the programmed were divided in two;

1. Fixed post; that is by visiting general hospitals, rural health centers, dispensaries and clinics.
2. Mobile team; that is by moving from one settlement to another. The aim and objectives of this programmed is to reduce diseases like; tuberculosis, measles, whooping, cough, pertisus, neonatal tetanus, diphtheria and child mortality rate. It was sponsored by donor agencies such as WHO, UNICEF, and World bank.

In 1995 WHO, UNICEF, AND WORLD BANK withdrew their active support for immunization and therefore departments were created at federal, state and local governments. The programmed was also renamed as; National Programmed on Immunization (NPI). Public health reports (2013; 112(1): 10-20).

In 1996 the campaign for eradication of polio started all over the country with northern part of the country being the main focus area, but taboo, cultural beliefs and attitude hindered the successful achievement of the program in most parts of the country of which Kebbi State is one. In Birnin kebbi Local Government areas such taboos and beliefs are actually affect the realization of the goals of the program. Such these taboos and beliefs are: illiteracy, religious beliefs, traditional beliefs, seeing it as a way of reducing fecundity and poor component of health personnel. But reducing the rate of family and religious beliefs are the most serious problems that affected the immunization programmed in that area.

In developed, developing and under developed nations of the world including Africa, Asia, Brazil, India, China, Japan, and Latin America, the implementation of large-scale application of immunization programmed has been remarkably successful in eliminating the prevalence of infectious diseases. For example in U.S childhood immunization is now a vital component of health [Mark and Darden 1999].

Since 1996 the concept of immunization as a method of diseases prevention has gained broad acceptance in Africa and Asia. Despite these advances, however, the diseases that are preventable through immunization still remain a major public health problem in Nigeria.

In 1995, a single disease among them (measles) claimed the lives of an estimated 1.2 million children and infected more than 45 million people. At the end of the twentieth century researches discovered that in the developing nations more than 3 million children still die annually from measles, neonatal tetanus and other diseases, while more than a quarter of a million children are crippled by poliomyelitis (WHO, 1995B).

However today in Nigeria there is improvement in medical facilities and health services and the rate of child and maternal mortality is reducing in our societies. The children considered adequately immunized against measles after receiving one dose of vaccine, (UNICEF, 2010).

It is against this background that, the research seeks to examine the impact of cultural beliefs on successful achievement of immunization programmed in Birnin Kebbi local government area of Kebbi State.

1.1 Statement of the Problem

Immunization has been a great area of controversies, complain and debate over the efficacy safety and mortality of compulsory immunization stem from other side, cultural beliefs influenced people to seeing immunization programs as hampering the demographic and social progress.

However, despite the existence of many campaigns aimed at enhancing the people's attitudes to relevance of immunization program in rural areas, the following appear to be the problems faced by the immunization campaign;

1. The spread rumors that, an immunization program is a way of reducing the rate of family members.

2. Lack of skilled and well trained health personnel with broad prospective and knowledge on how to address the matter on the relevance of immunization program.

3. Illiteracy and conservative attitudes of people toward immunization program.

4. Lack of orientation to our Muslim scholars toward immunization program.

5. Incompetent health person-nel in the area is also among the problem that affects the immunization program in Birnin Kebbi local government area, [Warraich, H.J 2009].

But the level of illiteracy remain a major problem, mothers attitude and beliefs, lack of orientation by our Muslim scholars, ignorance, conservative attitude and lack of health facilities, incompetent health personnel in the area are also other problem that affects the immunization programmed in Birnin Kebbi local government area, (CDC 2014).

Mallam Muhammad Mustapha (interviewee) who spoke on the reason why they reject the vaccine for their children had this to say: “the government has never done anything free pertaining to our health in Birnin Kebbi’’ and with one interviewee house hold in Ambursa developing area during the immunization exercise was reported to have said: “we are waiting the government to provide drugs for malaria, diarrhea for us, give us good drinking water and alleviate poverty, Olajide 2014.

Reacting to these complains of people, the health educator of Birnin Kebbi local government areas, Alh. Musa Na Allah said “the problem is more than what people saying”. He described the resistance to immunization as a problem of illiteracy; however, we are resolving the issue of non compliance through educating them house to house.

1.2 Research Question

1. How have cultural beliefs affected immunization in Birnin Kebbi local government areas?

1. What are the attitudes of people toward immunization?
2. To what extent has immunization program helped in eradicating diseases?

1.3 Research Objectives

The general objectives of this research, is to examine the cultural beliefs and immunization of children. The specific objectives include the following;

1. To examine how cultural beliefs affect immunization in Birnin Kebbi local government areas,
2. To examine the attitudes of people toward immunization of children,
3. To explain the extent to which immunization program helped in eradicating diseases,

1.4 Significance of the Study

This research is significant, in the sense that various people developed various attitudes and beliefs toward immunization program, because they are seeing it as something which is related to family planning. The research therefore is significant in examining, analyzing and explaining the beliefs and attitudes of people toward immunization program.

The research is also significant to encourage parents to allow their children in to the immunization programmed. It is also useful to the policy makers, health organization in formulating the policies related to the immune of children or preventive measures. The

result of this study will be useful to the researchers who want to know more about the benefits and effects of immunization program.

1.5 Scope/Limitation of the Study

This research covered Birnin Kebbi Local government area of Kebbi State. The research focuses measurably on the cultural belief, customs, values, norms, and attitudes of people toward immunization program.

1.6 Definitions of the Terms

CULTURE;

According to sir Edward B. Taylor (1871) culture is a complex whole, which include, knowledge, beliefs, norms, value, laws, arts, morals, customs and any other capabilities and habits acquired by a man as a member of society. According to Giddens (1989) culture consists of the values, the members of a given group hold and the material goods they created.

So therefore, culture is the characteristics of a particular group of people, which includes language, religion, cuisine, social habits, music and arts, etc.

BELIEFS:

Generally speaking belief is a mental representation of a sensation or feeling (By free Encyclopedia).

According to Parkinson G. and Arislane, R. (1996) belief may either be faucal truths or merely assumption about what is true. According to encyclopedia of sociology (vol 1: 146), belief are concepts of realities of how things are.

According to Oxford English dictionary (p. 87) beliefs as, the mental action, condition, or habit of trusting to, or confiding in a person or things, trust, reliance, confidence and faith, it is also as mental acceptance of a proposition statement or fact as true, on the ground of the mind to a statement, or the truth of fact beyond observation on the testimony of another.

ATTITUDES:

The term attitude has been variously defined from different scholars as; According to Allport (1935) attitudes are more or less permanently enduring state of readiness of mental organization which predisposes an individual to react in a characteristics way to any object or situation with which is related. He also said that attitude is tendency to act towards or against something in the environment which become thereby a positive or negative value.

Oscamp (1977), attitude is a relatively lasting cluster of feeling belief and behavioral tendencies directed towards specific person, groups, idea or objects. In summary attitude has to do with “posture of mind” which carries with it the idea of readiness for responses a predisposition.

IMMUNIZATION:

According to WHO immunization is the process whereby a person is made immune or resistant to an infectious disease typically by the administration of vaccines. Immunization according to Awosika (2004) is the production of body immunity by artificial mean. This is the use of treated antigens to stimulate the body to produces its own anti body through the procedure called Vaccination. Therefore immunization refers to the artificial creation of immunity by deliberately infecting someone so that the body learns to protect itself.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter seeks to review the contribution of some scholars with regard or related to cultural beliefs and immunization of children respectively, that is to say the chapter will critically analyze the scholars' opinions about this research topic. It also looks at the conceptual definitions of the research that are used in the previous chapter. This includes cultural aspect and beliefs religious perspectives and immune objectives and finally theoretical framework as well as criticism against the theory, and research hypothesis.

2.1.0 Conceptual Definitions

2.1.1 Cultural Aspect

Cultural aspect is an important feature and characteristic that distinguishes members of one community or society to another. Cultural aspect described a people's religion, spirituality, economic, family and community life, government, sports, foods, arts, building and other parts of their culture. This means that it focus is on people and what they do in a given place or time.

By Edward B. Taylor (1871) culture is a complex whole which comprises or include, knowledge, beliefs, customs, values, arts, morals and other capabilities and habits acquire by men as a member of society. According to Anthony Giddens (opcit,

1989), culture consists of the value the members of a given groups holds and the materials goods, they created. Geezt (1973) defined culture as a set of control mechanisms, i.e. plans, rules, constructions, what computer engineers call programs for the governing of behavior. Linton (1940) view culture as the sum total of knowledge, attitudes and habitual behavior patterns shared and transmitted by the members of a particular society.

To Miller (1979) culture is variously as a worldwide striving toward "civilization" through the accumulation and beliefs, acquire patterns of beliefs that shapes personalities in each society; a local system of ideas and practices, that are functionally integrated, an unconscious structures that generates ideas and behavior; a systems of shared symbols that come into play in social interactions, and a system by which people adopt to their environment. According to Oxford Advance Learners Dictionary (opcit) cultural aspect is anything connected with culture of a particular society or groups, its customs beliefs etc.

Therefore, societal values norms and beliefs are varies from one society to another. So, these cultural aspect or beliefs contribute to the failure of immunization in Nigeria in general especially northern Nigeria and here in Birnin Kebbi local government area in particular. This means that the people of that area prefer to relay on their cultural practices, that is to say people regarded traditional methods of curing diseases then the modern, more especially people that are living in a rural areas. In this regard, it is very

important to look at the concepts of attitude, because, it is an attitudes that determine the beliefs of an individual in a particular group or community.

Attitudes: according to Allport (1935) attitudes can be seen as a more or less permanently enduring state of readiness of mental organization which predisposes an individual to react in a characteristics way to any objects or situation with which is related. According to Back (opcit, 1979) attitude is a predisposition toward any person, idea or objects that contains cognitive effectives and behavioral components. To Hartisan (opcit 1976) attitudes mean a learned emotional and behavioral response to a person, things and events. Attitude is a predisposition or a tendency to respond positively or negatively towards a certain idea, object, person, or situation. Therefore the combination of feeling thought and action toward an individual mind predisposes the mothers not to take their children to immunization. Because some places in the study area are far away from local government headquarters like Janzomo, Gayawa, and Randali, those areas suffering from lack of social amenities such as good drinking water, electricity and good roads. Therefore their behavior or attitude toward immunization is negative.

2.2 Concepts of Beliefs

The concept of beliefs has been variously defined by scholars in different ways depending on how they perceived it. Belief simply means trust, faith or confidence in

someone or something. According to Parkinson, G. and Arislane R. (opcit, 1996: 52-53), beliefs may either be factual truth or merely assumption about what is true.

According to Oxford English Dictionary (P.87) beliefs as the mental action condition , or habits, of trusting to, or confiding in a person or things, trust dependence and faith, it is also mental acceptance and faith. Beliefs, is a feeling of being certain that something exits, like beliefs in God.

According to Brown and Cooney (1982) defined beliefs as dispositions to action and major determinants of behavior. Pajaces (1992) proposed definitions of belief and cited Abelson (1979), who defined beliefs in terms of people manipulating knowledge for a particular purpose or under a necessary circumstance. Sigel (1985)) defined beliefs as "mental constructions of experience, often condensed and integrated in to concepts that are held to be true and that guide behavior". Scholars in social science fields have more or less agreed upon a commonly acknowledge definition of beliefs; "beliefs are thought of as psychologically held understanding premises, or propositions about the world that are felt to be true (Richardson 1996 P. 103)

Generally speaking, a beliefs is a mental presentation of a sentient beings attitude toward the like hood or truth of something (free-encyclopedia). Therefore beliefs systems are the stories we tell ourselves to define our personal sense of "reality". So every human being has their own beliefs system which is varies from one society to

another. But some societies their beliefs system depend largely on their religion and traditional beliefs, more especially in Nigeria in general and Birnin kebbi local government area in particular. With regard to immunization such beliefs are more serious that affect the programmers, because they beliefs that no body or no things can protect them accept their God.

2.3 Immunization

The concept of immunization or how to artificially induce the body to resist infection, received a big boost in (1796) by Edward Jenner. The term immunization has been variously defined by different scholars based on their understanding. According to Awosika (opcit 2004:3) immunization is the production of body immunity by artificial means. Passive immunity which is temporary may be conferred by injection by antiserum but the productive active immunity call for the use of treated antigens to stimulate the body to produces its on antibody the procedures called “vaccination”.

According to (WHO) immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccine stimulates the body’s own immune system to protect the person against subsequent infectious or diseases. Therefore immunization is a form of preventive medicine, which its aim is to protect individuals and communities from infectious diseases. It also prepares the body to fight against infectious.

2.4 Forms/Types of Immunization

There are two types of immunization which is as follows;

- Active immunization
- passive immunization

1. **ACTIVE IMMUNIZATION; this** is the induction of immunity after exposure to an antigen. Antibodies are treated by the recipient and may be stored permanently.

   Active immunization is the microbe of an injection into the person before they are able to take it in naturally. That is artificial active immunization is the microbe injection treated, so that it will not harm the infected person.

2. **PASSIVE IMMUNIZATION;** is the transfer of active humored immunity into the form of ready-made antibodies, from one individual to another. Passive immunization is used when there is a high risk of infection and insufficient for the body to develop its own immune response, or to reduce the symptoms' of ongoing.

But to Awosika D. (2004 opcit 4:4-17) said generally the effective way of controlling the spread of infection is to strengthened the host defensive through immunization which is categorized into two;

- Active immunization
- Vaccination

ACTIVE IMMUNIZATION:- to him has been define as the administration of living modified agents (live activated vaccines e.g. yellow fever) an activated train (as in tetanus) and suspension of killed organism (as an pertisus) in order to evoke an immune responses and induce protections against diseases.

VACCINATION: - which is the mere administration of the vaccines irrespective of the immunological response of the person.

The national programmed on immunization (NPI) in Nigeria is aim to reduce the high rate of mortality and morbidity related to the targeting diseases such diseases are; polio, measles, whooping cough, neonatal tetanus, tuberculosis, diphtheria and so on. But here Nigeria we are more concern with polio disease.

POLIO: according to National programmed on immunization (NPI) is the effects of poliomyelitis virus on the spinal cord that lead to the classic manifestation facial paralysis. There are three basic pattern of polio infection, are as follows;

1. Sub-clinical infections
2. Non-clinical and
3. Paralytic types

2.5 CHILDREN: - in some places or states immunization is take at any age in order to provide the longest lasting and protection against disease. But in Birnin kebbi local

government area, childhood immunization is considered. Which does not provide lifelong immunity against some diseases such as tetanus (lockjaw) and diphtheria?

Children: - are young human beings that below the age of puberty or below the legal age of majority. But here we are referring to children that are below five (5) years. Because in this area of study, the immunization is give to the children which are below five years old.

So the immunization in Birnin kebbi local government area is taking from the infancy stage to toddlerhood respectively.

2.6 Empirical Review

CULTURAL BELIEFS ON IMMUNIZATION OF CHILDREN

Various opinions and view were expressed with regard to immunization exercise in Birnin kebbi local government area. According to medical anthropology quarterly (2000, 14:159-179), emphasizes that public opinions about immunization exercise include varies and deep seated of beliefs, as a result of the tension between divergent cultural view points and value system. That is to say some people regarded their culture more than what you are expected, especially the people of Birnin kebbi local government area, they seeing that if they go contrary to their culture they disvalued their norms and values of their society.

Several key of cultural perspectives on immunization stem from; individual rights and public health stance toward immunization. Various religious stand points and vaccines objections and suspicion and mistrust of vaccines among different Nigerian and global cultures and communities. The good public health policies balance both individual rights and community needs. Therefore public health officials most recognized and respect diverse social and cultural perspectives toward immunization policies to help support and their success and acceptance. Divergent cultural perspectives and opinions toward immunization including libertarian and religions objectives as well as vaccines suspicions

According to Statistical table of Birnin kebbi local government area in 2010 to 2014 more than 49% - 60% increases in the immunization routine coverage- because such beliefs and attitudes are now being decreases due to the influence of people that aware the members of that area about advantage of that vaccination. And they use to motivate the mother through giving their children ice cream, sweets, and biscuits etc, in order to allow their children to take vaccination.

RELIGIOUS PERSPECTIVES AND VACCINE OBJECTIVES

Today religious perspectives become the major problems in our societies in the sense that both Muslims and Christian use this opportunity or medium to appear the media or preaching ground to win peoples sympathy, religion become a serious problem in the immunization exercise, some people take it for guaranteed that whether they are

immunized or not still they remain alive and can survive and should be healed by God or natural means. The tension exists because public health regulations aim to protect as many people as possible but them sometimes privilege group needs over individual preferences. In the case of vaccination, mandates secretive individual autonomy to protect communities from diseases. Unvaccinated individuals pose ricks to children or people with medical contraindications who cannot be vaccinated as well as vaccinated individuals (vaccines are not 100% effective).

According to Warraich H.J. (2009) certain religions and beliefs system promote alternatives toward vaccination. Religious objectives to vaccines are based generally on:

- ✓ The ethical dilemmas association with using human tissue cells to creates vaccines.
- ✓ Beliefs the body is sacred, should not receive certain chemicals or blood or tissues, from animals and should be healed by God or natural means.

For example the Catholic Church recognized the value of vaccines and importance of protecting individual and community health. It asserts, however, that its membership should seek alternatives, when available to vaccine that are made using cell lines derived from aborted fetuses. Christian scientists do not have a formal policy against vaccines, but rely generally on prayer for healing. They believe that medical interventions, which could include vaccines, are unnecessary. The same with Muslims they believe that

medical interventions including vaccines are not necessary, they are generally rely on prayer for healing.

Internationally, in parts of Asia and Africa, mistrust of vaccines is often tied to “western plot” theories, which suggest that vaccines are ploys to sterilize or infect of non-western communities. Suspicion has existed for different infections and vaccines over the past 20 years. For examples in Cameroon in 1990, rumors and fears those public health officials were administering a range of children vaccines to limit the male and female from procreation. Similarly in Tanzania in the mid of (1990’s a missionary raised concern about tetanus immunization. And in 2005, measles vaccines suspicious led to decreased vaccination rates and increases infection in Nigeria. One of the most striking instances of vaccine suspicious in Africa has concerned with polio vaccine.

In 1999, British Journalist Edward Hooper wrote the River: a journey to the source of HIV/AIDS. He speculated that the virus that causes HIV/AIDS transitioned from monkeys to human via a polio vaccine. He argued that the polio vaccine was made from the cells of chimpanzees infected with the primate form of HIV(simian immunodeficiency virus, or SIV) which adopted in humans and caused disease, and that there were coincidence in the sites where the polio vaccines was first administered and where the first case of HIV originated. Although scientist and medical scholars have provided plentiful evidence to discover Hoofer’s ideas, media attention has sparked conspiracy theories and concern globally.

The Muslim fundamentalists have driven suspicious about the polio vaccine in three different countries in which polio is still alien, such countries are; Pakistan, Afghanistan and Nigeria.

In 2003 polio vaccination campaign, religious leaders in three different Nigerian states claimed that the vaccines were contaminated with the virus that causes AIDS, sterilization and cancer-causing agents, despites tests conforming the vaccine is safety. The standoff was eventually resolved through dialogue among religious and political leaders (WHO and UNICEF, 2010).

2.7 THEORETICAL FRAMEWORK

This research adopts the Health belief model and behavior theory as the theoretical basis for the work.

HEALTH BELIEF MODEL

The health belief model (HBM) provides the most appropriate theoretical framework in which to examine how parents of Birnin kebbi local government area thinking about the immunization to their children. The health belief model (HBM) is a social cognitive model developed in the year (1950) by the U.S public health services [Mullen et'al (1987), which is often used to explained and predict health related to behavior of different people with different culture.

Stretcher and Rosenstock (1990), when applied to parent's immunization behavior the health belief models (HBM) suggest that simply having knowledge and awareness about effective disease will not necessarily result in increased visits to a hospital for vaccination. Instead, the model specified four (4) related elements that must to be presents for the knowledge about disease to be translated into preventive action.

FOUR (4) ELEMENTS OF HEALTH BELIEF MODEL (HBM)

1. **Perceive susceptibility:** an individual must perceive that he/she is susceptible, that is likely to be affected to an infectious diseases in regard to he/she may take action by visiting hospitals and clinic for checking if he is in good health condition.
2. **Perceive severity:-** that an individual must also perceive that, that disease is a serious condition therefore he/she may take action
3. **Perceive benefit in taking action: -** an individual must belief that there is benefit for taking preventive action.
4. **Barriers to taking action: -** an individual must to be also perceive that may potentials barriers to take preventive action are outweighed (valued) by potential benefit.

These elements of health belief model (HBM) more especially on perceive susceptibility, perceived severity and perceive benefits are likely to be positively related to

immunization behavior. While fourth one, that is barriers to taking action are likely to be negative related to immunization. The variables that completed the original health belief model are the presence of an internal and external stimulus, or cue to actions "that triggers the individual health behavior. Here, the internal cure may includes the symptoms of illness, whereas the external cue includes media campaign about health promotion or interpersonal interaction, such as learning that a friend has been affected by a health problem or by some disease.

CRITICISM OF HEALTH BELIEF MODEL

The health belief model is all about the health behavior in order to protect you from getting in to the illness. The critics also pointed out the variety of limitations of this model. According to Champaign (1984) was of the view that, the model has the lack of uniformity in testing, especially in the way variables are operational. Tools that are used to measure health belief model component have not been standardized or refined.

According to Rosentock (1990), in addition the model does not apply numerical coefficient to the concepts of susceptibility, serenity. Benefit and barriers nor does it delineate (to sketch out) the specific nature of the relationship among the variables in all studies. Like identifying and measuring the concepts of cure to action that has been problematic. Also the model has been criticized on not focusing on other factors related to individual such as demographic variables, personality factors, social support, or

previous health experiences may play a role in influencing behavior, which are nor an explicit part of this model. In addition concepts that reflective the larger social structures, such as public policy, poverty and social isolation that may affect access to health care, are not included in this model.

Finally, because this model is a psychological in nature, it account as only for the variance in health behavior as can be explain by beliefs and attitudes that are obviously to and consciously evaluated by individual Janz (1984).

BEHAVIOR THEORY

According to Dobbs et'al (1974) sees attitude within the framework of behavior theory and emphasis on attitude as learned responses to definable stimuli; for example attitude of peoples toward immunization programmed is a learned response to the belief people have. This theory recognized that individuals act rationally and emphasizes the power of individual's intention to induce behavior govern by three principles:

- **ATTITUDES:** the individual position or negative feelings about engaging in a given behavior.
- **SUBJECTIVE NORMS:** standards or influences established by the individuals' larger context for instance, familial beliefs, media conceptions, and society models.

- **PERCEIVE BEHAVIORAL CONTROL:** the degree to which the individual could perform a behavior

CRITICISM AGAINST THE THEORY

The theory is limited to discrete sample population and does not incorporate profiles of previous behaviors nor does it address when positive intentions are not enough to enact behaviors (e.g. cues of action). In addition the medical sociologists and anthropologists which were mainly concern with the role of social and cultural factors in the individual perception towards disease and health treatment, criticized that, this 'theory is concern only on people life, how they lives their beliefs and values system based on their level of technological development not tell the people what are support to do.

2.8 Research Hypothesis

- There is no relationship between cultural beliefs and peoples response to the immunization program.
- There is no significant relationship between the attitudes of people toward immunization of children and the effectiveness of the immunization programme,
- There is no significant relationship between immunization program and eradication of diseases within the community.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the research methodology that is, the instrument used for data collection and method of data analysis and contains some sections as, research design, study area, study population, sample, and sampling procedure, data collection and data analysis respectively.

3.1 Research Design

The research is also going to be based on Descriptive design, and then this research design will allow a clear explanation and understanding of cultural beliefs of parents of that area toward immunization. Descriptive research is used to describe the characteristics of a population or phenomenon being studied.

3.2 Study Area

Birnin kebbi local government area is among the twenty one (21) local government areas of kebbi state, and one of the biggest local government areas in the state. According to Abubakar and William (2001) kebbi state is located between latitude 4^0N and 7^0N and longitudes 5^0E and 5^0E kebbi has 36,800 square kilometers area and has about 3,238,628 (2006 Estimates).

Birnin kebbi, town and capital of kebbi state is located in northwestern Nigeria. And it is the headquarter of Gwandu (Gando) after the Jihal movement of Abdullahi bin Fodio (the brother of Usmanu Danfodio) in a year 1805. Formerly it was the capital of kebbi emirate, which relocated to Argungu after the conquest by Gwandu in 1831. Birnin kebbi local government area is located on the Sokoto River and is connected by road to Argungu (45km northeast), Jega (35km southeast) and Bunza (45km sourthwest). And it is located on the center of the state, World Gazetteer (2007).

The estimated population of Birnin kebbi local government area is about 125,594 in a year (2007). The area is dominated by Hausa Fulani tribes and some minority tribes i.e. Igbo, Yoruba and Tiv who find their selves in the area as traders or civil servants. Birnin kebbi town is like any other traditional towns in the state, has got their own beliefs system, norms and values, cultural heritage etc, before they accepted Islam. But later on with the coming of Islam, they accepted Islam as a religion and a way of life, which their 'beliefs and value are very much Islamic.

The main occupations of people in the area are mainly famers, business men, fishing and rearing of animals. The dominants tribes are; Kabawa, Zabarmawa, Fulani Arawa, Barebari, e.t.c which are speaking moistly Hausa tribe and majority of them living in an extended family system. It now serve as a collection point of tobacco, groundnuts and rice and as a major local market centre in millet, sorghum, rice, fish, goats, cattle's, skins and cotton etc.

3.3 Study Population

The population of the study area in the year 2006 census is about 268,420 people. Also the study population consists of parents both male and female, and other stakeholders such as traditional rulers, religious leaders and health personnel of Birnin Kebbi local government area.

3.4 Sample Size and Sampling Procedure

The researches selected its sample size from the residents of Birnin kebbi local government area. The sample size of this research tends to select one hundred and twenty (120) respondents out of the total population of 268,420 (2006 census). These respondents are selected from seven (7) districts, these districts are; Birnin Kebbi, Gwadangaji, Makera, Ambursa, Zauro, Glumbe and Kardi.

The purposive sampling technique will be administered to the questionnaires; forty (40) questionnaires administered to the parents for each 7 districts, forty (40) questionnaires to traditional and religious leaders in each 7 districts, while remaining forty (40) questionnaires distributed to health personnel respectively.

3.5 Method of Data Collection

The instrument of data collection in receiving data for this study collected both from primary and secondary sources.

Primary sources here include; the use of structured questionnaire which contain questions on the issues, such as: demographic characteristics of respondents, their beliefs and attitudes toward immunization, religions and traditional affiliations on immunization and problems that are associated with immunization.

Secondary sources of data include; consulting text books, journals and magazine, articles, newspapers and other printed materials.

3.6 Method of Data Analysis

The research employed the use of descriptive statistical method and inferential tools, in explaining the information collected from respondents.

Descriptive statistical tools includes; frequency and percentage. While inferential tool include; chi-square.

3.7 Ethical Consideration

The consent of the respondent sought as no coerce was made for participant in the research without his/her willingness to participate. Also the confident of respondents has been safe guarded as no names were required. And assurance has been given to all respondents that the research is neither law enforcement agencies nor governmental officials but the information given is solely use for academic purpose.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter shows the data presentation and analysis. 120 questionnaires were administered and they were divided into three categories 40 each for parent, health personnel's and traditional/ religious leaders and returned and they have been analyzed in this chapter using simple percentage and chi-square.

4.2 Data Presentation and Discussion

Section 1: Socio-Demographic Characteristics of Respondents

TABLE 4.1: Distribution of Respondents by Age

Respondents	Parent		Health Personnel		Traditional and Religious Leader	
Age	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
21-30	26	65.0	16	40.0	0	0.0
31-40	4	10.0	24	60.0	16	40.0
41-50	10	25.0	0	0.0	24	60.0
Total	**40**	**100.0**	**40**	**100.0**	**40**	**100.0**

Source: Field survey, 2015

Table 4.1 above shows that 65.0% of the parents are between 21-30years, 40.0% of the health personnel's also10% of the parent are between 31- 40, 60% of the health personnel's are between 31-40 while 40% of the traditional/religious leader are between 31-40. Also, 25% of the parents are between 41-50, while 60% of the traditional/religious leaders are between 41-50. This implies that most of the Respondents are within the age of 31- 40.

Table 4.2: Distribution of Respondents based on Sex

Respondents	**Parent**		**Health Personnel**		**Traditional and Religious Leader**	
Sex	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Male	20	50.0	15	37.5	40	100.0
Female	20	50.0	25	62.5	0	0.0
Total	**40**	**100.0**	**40**	**100.0**	**40**	**100**

Source: Field survey, 2015

Table 4.2 above shows that 50% of the parents are male while 50.0% are females, 37.5% of the health personnel's are male while 62.5% are females, and 100% of the traditional/religious leaders are male. This implies that the males are really concerned

about immunization issues in the community and that most of the traditional/religious leaders in the community are males.

TABLE 4.3: **Distribution of Respondents by marital status**

Respondents	**Parent**		**Health Personnel**		**Traditional and Religious Leader**	
Marital Status	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Divorced	0	0.0	16	40.0	0	0.0
Married	24	60.0	24	60.0	40	100.0
Widowed	16	40.0	0	0.00	0	0.00
Total	**40**	**100.0**	**40**	**100.0**	**40**	**10.0**

Source: Field survey, 2015

Tables 4.3 above shows 40.0% of the health personnel's are divorced, 60% of the parent are married, 60% of the health personnel's are married, 100.0% of the traditional/religious leader are also married while, 40% of the parents are widowed. This implies that most of the respondents are married and are most likely to be concerned with immunization issues before/ now/ or in the further.

TABLE 4.4: Distribution of Respondents Based On Education Attainment

Respondents	Parent		Traditional and Religious Leader		Health Personnel		
Education	**Frequency**	**Percent**	**Frequency**	**Percent**	**Education**	**Frequency**	**Percent**
Informal Education	8	20.0	14	35.0	Nurse	16	40.0
Primary Education	6	15.0	0	0.0	Doctor	16	40.0
Secondary Education	7	17.5	0	0.0	Communit	8	20.0
Tertiary Education	19	47.5	26	65.0	y health		
Total	**40**	**100.0**	**40**	**100.0**	**Total**	**40**	**100.0**

Source: Field survey, 2015

Table 4.4 above shows 20.0% of the parents and 25.0% of the traditional/religious leader had informal education, 40% of the health personnel's had formal nursing related trainings. 15.0% of the parent had primary education while 40% of the health personnel have had formal training as a doctor.17.5% of the parents had secondary school education while 20% of the health personnel have had formal training on community health. 47.5% of the parents and 65% of the traditional/religious leader had tertiary education. This implies that most of the Respondents have tertiary education and as such they would have a vivid knowledge of the concept of immunization.

TABLE 4.5: Distribution of Respondents based on Religion

Respondents	Parent		Health Personnel		Traditional and Religious Leader	
Religion	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Islam	23	57.5	16	40.0	40	100.0
Christianity	15	37.5	24	60.0	0	0.0
Traditional	2	5.0	0	0.0	0	0.0
Total	40	100.0	40	100.0	**40**	**100.0**

Source: Field survey, 2015

Table 4.5 above shows that 57.5% of the parents, 40% of health personnel's and 100.0% of the traditional and religious leaders take Islam as their religion, 37.5% of the parents and 60% of health personnel's take Christianity as their religion while 5.0% of the parents are into traditional worshiping. This implies that majority of the respondents are Muslims and practice Islam as a religion.

. **Table 4.6: Distribution of Respondents based on Monthly income**

Respondents	**Parent**		**Traditional and Religious Leader**	
Income	**Frequency**	**Percent**	**Frequency**	**Percent**
1,000-20,000	9	22.5	7	17.5
21,000-30,000	20	50.0	7	17.5
31,000 - 40,000	4	10.0	8	20.0
41,000-50,000	7	17.5	0	0.0
50,000 and above	18	45.0	18	45.0
Total	**40**	**100.0**	**40**	**100**

Source: Field survey, 2015

Table 4.6 above shows that 22.5% of the parents and 17.5% of the traditional and religious leader earn between 1,000 – 20,000 naira monthly, 50.0% of the parents and 17.5% of the traditional and religious leaders earn from between 21,000-30,000 naira monthly, 10.0% of the parents and 20.0% of the traditional and religious leaders earn from between 31,000-40,000 naira monthly, also, 17.5% of the parents earn from 41,000 – 50,000, while 45% of the parents and 45% of the traditional and religious earn from 50,000 and above. This implies that most of the respondents earn more than 50,000 naira

which means that even if immunization is would cost a fortune, the can afford it so therefore, finance is not a reason why they should react negatively towards immunization.

TABLE 4.7: Distribution of respondents based on Ethnic groups

Respondents	**Parent**		**Health Personnel**		**Traditional and Religious Leader**	
Ethnic group	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Hausa	25	62.5	32	80.0	40	100.0
Fulani	2	5.0	0	0.0	0	0.0
Yoruba	1	2.5	8	20.0	0	0.0
Igbo	1	2.5	0	0.0	0	0.0
Others	11	27.5	**0**	**0.0**	**0**	**0.0**
Total	40	**100.0**	**40**	**100.0**	**40**	**100.0**

Source: Field survey, 2015

Table 4.7above shows that 62.5% of the parents, 80.0% of the health personnel and 100.0% of the traditional and religious leader are Hausa's, 5.0% of the parents are Fulani, 2.5% of the parents and 20.0% of the health personnel's are Yoruba's, 2.5% of the

parents are Igbo's while 27.5% of the parents are from other ethnic groups like the TIVs. This implies that the study area is dominated by the Hausa's.

TABLE 4.8: Respondents based on Residence

Respondents	Parent		Health Personnel		Traditional and Religious Leader	
Residence	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Hamlet	7	17.5	0	0.0	0	0.0
Village	17	42.5	15	37.5	14	35.0
Town	10	25.0	16	40.0	26	65.0
Others	6	15.0	9	22.5	0	0.0
Total	**40**	**100.0**	**40**	**100.0**	**40**	**100.0**

Source: Field survey, 2015

Table 4.8 above shows that 17.5% of the lives resides in Hamlet, 42.5% of the parents, 37.5% of the health personnel's and 35% of the traditional and religious leader live in the village, 25.0% of the parents, 40% of the health personnel's and 65.0% of traditional and religious leader lives the town while 15.0% of the parents and 22.5% of the health workers lives in other places which they did not specify. This implies that most of the respondents live in the town.

Section B: Immunization Awareness

TABLE 4.9: Distribution of Respondents based on Parent's and Traditional/ Religious leaders Awareness of Immunization

Respondents	Parent		Traditional and Religious Leader	
Awareness on immunization	**Frequency**	**Percent**	**Frequency**	**Percent**
Yes	36	90.0	40	100.0
No	4	10.0	0	0.0
Total	**40**	**100.0**	**40**	**100.0**

Source: Field survey, 2015

Table 4.9 above shows that 90.0% of the parents and 100.0% of the traditional and religious leaders said that they are aware of immunization while 10.0% of the parents said that they are not aware. This implies that most of the respondents are aware of immunization.

TABLE 4.10: Distribution of Respondents based on immunization related discussion

Respondents	Parent		Traditional and Religious Leader	
Response	**Frequency**	**Percent**	**Frequency**	**Percent**
Yes	21	52.5	18	45.0
No	19	47.5	22	55.0
Total	**40**	**100.0**	**40**	**100.0**

Source: Field survey, 2015

Table 4.10 above shows that 53% of the parents and 45.0% of the traditional and religious leader said that yes they discuss immunization at some of their meetings while 47.5% of the parents and 5.5% of the traditional and religious leader said no, they don't discuss immunization at some of their meetings.

TABLE 4.11: Distribution of Respondents based on Parent's Position on immunization

Position on immunization	Frequency	Percent
Approved	33	82.5
Disapproved	2	5.0
Undecided	5	12.5
Total	**40**	**100.0**

Source: Field survey, 2015

The table **4.11** above shows that 82.5% of the respondents approve of it, 5.0 % disapprove of it while 12.5 are undecided. This implies that immunization is a welcome idea in that community.

TABLE 4.12: Distribution of Respondents based on Major Source of information for parents

Media source	Frequency	Percent
Radio	15	37.5
Television	20	50.0
community/ traditional leaders	5	12.5
Total	**40**	**100.0**

Source: Field survey, 2015

Table **4.12 above** shows that 37.5% of the respondents said that the major source of information dissemination on immunization is radio. 50.0% said it is through television, 12.5% said it is through community/traditional leaders. This implies that television is a common source of information dissemination in that community.

TABLE 4.13: Distribution of Respondent's (parents) based on the usefulness immunization to children

Useful	Frequency	Percent
Yes	30	75.0
No	10	23.0
Total	**40**	**100.0**

Source: Field survey, 2015

Table **4.13** above shows that 75.0% of the respondents said yes they believe that it is useful while 23.0% said that it is not useful to immunize a child. This implies that the community believes that immunization is of benefit to their children

TABLE 4.14: Distribution of respondent (Parent's) based effect of immunization on a child

Effect	Frequency	Percent
It paralysis	15	37.5
reduce number of children you bear	24	60.0
Others Specify	1	2.5
Total	**40**	**100.0**

Source: Field Survey, 2015

Table 4.14 above, shows that 37.5% of the respondents said that if a child is not immunized it can lead to paralysis, 60.0% of the respondents said it can lead to reduced number of child bearing while 2.5% said that it cause other illness which were not specified.

TABLE 4.15: Distribution of Respondents (Health Personnel's) based on the efficacy of immunization

Efficacy	Frequency	Percent
Reduces sickness	23	57.5
Reduce death rate	7	17.5
Improved health	10	25.0
Total	40	100.0

Source: Field survey, 2015

Table 4.15 above, shows that 57.5% of the respondents said it has reduced sickness, 17.5% said that it has reduced death while 25.0% said that it has improved their health.

TABLE 4.16: Distribution of Respondents (Health personnel's) based on Disease that are immunized against

Disease immunized against	Frequency	Percent
Measles	24	60.0
Polio	16	40.0
Total	40	100.0

Source: Field survey, 2015

Table 4.16 above shows that 60.0% of the respondents said children are immunized against measles, while 40% said they are immunized against polio. This also implies that immunization is majorly for measles.

TABLE 4.17: Distribution of Respondents (Health personnel's) based on problems facing immunization

Problems	Frequency	Percent
Poverty	7	17.5
Illiteracy	25	62.5
Lack of awareness	8	20.0
Total	40	100.0

Source: Field Survey, 2015

Table **4.17** above shows that the 17.5% of the respondents said that poverty is the major problem facing immunization, 62.5% said Illiteracy, while 20.0% said lack of awareness. This implies that there are still some persons in that community that are ignorant and do not know what immunization is all about.

TABLE 4.18: Distribution of Respondents (health personnel's) based on immunization strategy

Strategy	Frequency	Percent
Visits hospitals or dispensaries	8	20.0
House to House	32	80.0
Total	**40**	**100.0**

Source: Field Survey, 2015

Table **4.18** above shows that the 20.0% of the respondents said that the major strategy they adopt is to invite the beneficiary to visit the hospital or dispensary while 80.0% said it is a house to house strategy that is adopted.

Section C: Cultural Beliefs and Attitudes of People

TABLE 4.19: Distribution of Respondents based on influence of cultural believe on57immunization

Respondents	Parent		Health Personnel		Traditional and Religious Leader	
Cultural believe	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Yes	29	72.5	23	57.5	23	57.5
No	11	27.5	17	42.5	17	42.5
Total	40	100.0	40	100.0	40	100.0

Source: Field Survey, 2015

Table **4.19** above shows that 72.5% of the parents, 57.5% of the health personnel's and 57.5% of the traditional and religious leaders agree that yes, cultural believes influence immunization while 27.5% of the parents, 42.5% of the health personnel's and 42.5% of the traditional and religious leaders said no, cultural believes does not influence immunization.

TABLE 4.20: Respondents view based on Religious influence on immunization

Respondents	Parent		Health Personnel		Traditional and Religious Leader	
Religious influence	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Yes	38	95.0	32	80.0	25	62.0
No	2	5.0	8	20.0	15	37.5
Total	40	100.0	40	100.0	40	100.0

Source: Field Survey, 2015

Table **4.20** above shows that 95.0% of the parents, 80.0% of the health personnel's and 62.0% of the traditional and religious leaders agree that yes, religious believes influence immunization while 5.0% of the parents, 20.0% of the health personnel's and 37.5% of the traditional and religious leaders said no, religious believes does not influence immunization.

TABLE 4.21: Distribution of Respondents (parents) based on the roles of Traditional and religious leaders.

Responses	Frequency	Percent
Yes	29	72.5
No	11	27.5
Total	40	100.0

Source: Field Survey, 2015

Table **4.21** above shows that 72.5% of the Respondents are of the opinion that yes traditional and religious leaders have a role to play about polio immunization. While 27.5% said no they do not have any role to play.

TABLE 4.22 Distribution of Respondents based on attitudes towards Immunization.

Respondents	Health Personnel		Traditional and Religious Leader	
Response	**Frequency**	**Percent**	**Frequency**	**Percent**
I don't care attitude	17	42.5	31	77.5
Conservation	7	17.5	9	22.5
Ignorance	8	20.0	0	0.0
Others Specify	8	20.0	0	0.0
Total	40	100.0	40	100.0

Source: Field Survey, 2015

Table **4.22** above shows that 42.5% of Health personnel's and77.5% of traditional and religious leaders said the attitude of people towards it is an I don't care attitude, 17.5% Health personnel's and 22.5% of traditional and religious said that people are very conservative about it, 20% said that the attitude of people on it is based on ignorant while 20.0% did not specify but generically mention some other reasons.

4.3 HYPOTHESIS

HO_1: There is no relationship between cultural beliefs and response of people to the immunization programmed.

Chi- Square Table

Item	Observed N	Expected N	Df	x-cal	Xcri	Sig	Decision
Yes	32	20.0	1	14.400[a]	3.841	0.05	Reject Ho
No	8	20.0					

Source: Field Survey, 2015 P<0.05

The table above shows that the calculated value (14.400[a]) is more than the table value (3.841).Since the X^2 is greater than the X^2t therefore we reject the Null hypothesis and accept the alternative hypothesis. The implication of this result is that there is a relationship between cultural beliefs and response of people to the immunization programme.

HO_2: There is no significant relationship between the attitudes of people toward immunization of children and the effectiveness of the immunization program.

Chi- Square Table

Item	Observed N	Expected N	Df	x-cal	Xcri	Sig	Decision
I don't care attitude	17	10.0	2	6.600[b]	5.991	0.05	Reject Ho
Conservation	7	10.0					
Ignorance	8	10.0					
Others Specify	8	10.0					

Source: Field Survey, 2015 $P<0.05$

The table above shows that the calculated value (6.600^b) is more than the table value (5.991).Since the X^2 is greater than the X^2 therefore we reject the Null hypothesis and accept the alternative hypothesis. The implication of this result is that there is significant relationship between the attitudes of people toward immunization of children and the effectiveness of the immunization program in the community.

Ho_3: There is no significant relationship between immunization program and eradication of diseases within the community.

Chi- Square Table

Item	Observed N	Expected N	Df	x-cal	Xcri	Sig	Decision
Yes	30	13.3	2	33.650[a]	5.991	0.05	Reject Ho
No	10	13.3					

Source: Field Survey, 2015 P<0.05

The table above shows that the calculated value (33.650^a) is more than the table value (5.991).Since the X^2 is greater than the X^2t therefore we reject the Null hypothesis and accept the alternative hypothesis. The implication of this result is that there is significant relationship between immunization program and eradication of diseases within the community.

4.4 Discussion of the findings

The discussion of these findings is based on the objectives of the research, the hypothesis and the results. The age group of the respondents 31-40 years and the marital status which is married supports this research since it was actually meant for experience persons who are exposed on the subject matter. In this community, it appears that the males have more interest in immunization related matters than the females. In addition to the aforementioned, the research also discovered the rate of tertiary education in that community is high, thus it would be wrong to say that the people within the community are not informed and that they are not exposed. The role that both the traditional, religion and culture plays in influencing immunization is high.

Although some people do trace the I don't care attitude of people towards immunization to poverty, but this research reveled that it is not true, most of the respondents are into other occupation such as business, artisan etc from which they earn more than 50,000 naira. In addition from the above mentioned monthly income, this is what has enabled most of them who are Hausa's to reside in town. Although most of them see immunization as a welcome idea base on their level of awareness which has been enhanced through the television, and based on its benefit on their children who are immunized against measles. This immunization against measles supports UNICEF, (2000) where it was said that children should be considered adequately immunized

against measles after receiving one dose of vaccine, as this immunization is very crucial to their survival.

Conclusively, the fact that there is a relationship between cultural beliefs and response of people to the immunization programme really means that whatever the values that the culture of a man has instilled inside of him is what he will carry on for life and this is what would be transferred to the next generation and the ideology continues. The medical anthropology quarterly (2000, 14:159-179), backs up this result that involvement in immunization exercise varies and depends on deep seated beliefs, based on the tension between divergent cultural view points and value system. Furthermore, this research was able to show that immunization program has help reduce and eradicate some diseases within the community. Also it shows that the attitudes of people toward immunization of children is relatively poor and has affected the effectiveness of the immunization program in the community.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter presents the summary, conclusion, recommendations and it also makes suggestions for further research study.

5.2 Summary

Chapter one presented the introduction and the background for the study, statement of research problems in which issues such as several campaigns aimed at enhancing the people's attitudes to relevance of immunization program in rural areas without positive response against the false news that an immunization program is a way of reducing the rate of family members etc are some of that called for concern. The research questions coupled with research objective which is to examine the cultural beliefs and immunization of children which expanded the subject matter and gave it a wider view. In addition the significance of the study, and the scope it cover and the limitations that were encountered were discussed.

The chapter two contained the literature review. The chapter two started discussed the subject matter in relations to scholarly view. It begins by first presenting the conceptualization of words such attitudes, believe, culture, immunization etc. After which it furthered discussion on the empirical review where cultural believes on immunization

was critically accessed. Health believes theory was the theory on which this research work was built and explained this theory was developed by U.S public health services in the year (1950). In addition behavioral theory was also applied to this work while that chapter was concluded with hypothesis.

The chapter three discussed the methodology. The introduction to method was first given after which the descriptive research was used, the history of the study are which is brining kebbi one of the 21 LGA was discussed. In all, 120 questionnaire were administered were redesigned for three categories of respondents who are parent, health personnel's and traditional and religious leaders. Each group mentioned was administered with 40 questionnaires each as they were randomly sampled from each group. Simple percentage and chi- square was used to present the result of the questionnaire and the hypothesis.

The chapter four presentational the result where the result showed that there is a relationship between cultural beliefs and response of people to the immunization program, the attitudes of people toward immunization of children have affected the effectiveness of the immunization program in Birnin Kebbi local government areas and there is significant relationship between immunization program and eradication of diseases within the community.

Chapter five is the last chapter and it presents the summary of entire work. The chapter contains summary, findings, conclusion, and recommendations which are discussed under their respective subheadings below.

5.3 Summary of the Findings

The findings of this research are based on the three major objectives of the research. They include;

1. The cultural beliefs affect people's response to the immunization program in Birnin Kebbi local government areas
2. The attitudes of people toward immunization of children have affected the effectiveness of the immunization program in Birnin Kebbi local government areas.
3. The immunization program has help eradicate some diseases within Birnin Kebbi local government areas.

5.4 Conclusion

The research concludes that although the community is aware of immunization, and the strategy for carrying out the immunization is a face to face method but the cultural beliefs of those in the community has affected the effectiveness of the program.

5.5 Recommendation

The recommendations are base on the findings and the conclusion drawn from the study, and from the critical assessment of the result in the chapter four. These include:

1. There is need for more awareness and reorientation on immunization.
2. The traditional and religious leaders should learn to create few minutes out of their meeting time to disco immunization with their members and encourage them.
3. People should shift their notion that illiteracy and not poverty is the reason why people shy away from immunization.
4. The traditional and religious leaders should try and create forum where the culture of the community can be discussed so that the people within the community can know how to align their culture with immunization programmes.

5.6 Suggestion for Further Research

It is suggested that the following under listed area can be considered for further research:

- An empirical study of the role of cultural and religious believe on the acceptance of immunization programme

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Appendix 1

DEPARTMENT OF SOCIOLOGY

FACULTY OF SOCIAL SCIENCES

USMANU DANFODIYO UNIVERSITY, SOKOTO.

QUESTIONAIRE

DEAR RESPONDENTS

My name is Rabiu Umar, a student of above institution, undergoing a research on cultural beliefs and immunization of children in Birnin Kebbi local government area of Kebbi State, in partial fulfilment of the requirement for the award of B.Sc sociology.

The information gathered using this questionnaire would not be traceable to any of you, as no name is needed. The information gathered will be used solely for research and academic purpose only and confidentiality is highly guaranteed.

Thanks for your cooperation.

SECTION (A)

QUESTIONAIRE FOR PARENTS

DEMOGRAPHICAL CHARACTERISTICS OF THE RESPONDENTS

INSTRUCTION: tick the option you consider most appropriate to the question below;

1. Age

(a) 10-20 ( ) (b) 21-30 ( )

(c) 31-40 ( ) (d) 41-50 ( )

(e) 51 and above ( )

2. Sex

(a) Male ( ) (b) Female ( )

3. Marital status

1. Single ( ) 2. Married ( )

3. Divorced ( ) 4. Widowed ( )

4. Education

1. Informal education ( )

2. Primary education ( )

3. Secondary education ( )

4. Tertiary education ( )

5. Religion

1. Islam ( )

2. Christianity ( )

3. Traditional ( )

4. Others ----------

6. Occupation

1. Politics ( ) 2. Farming ( )

3. Trading ( )

4. Civil servants ( ) 5. Others----------

7. Monthly Income

1. 1000-20,000 ( ) 2. 21,000-30,000 ( )

3. 31,000-40,000 ( ) 4. 41,000-50,000 ( )

5. 50,000 and Above ( )

8. Ethnicity

1. Hausa ( ) 2. Fulani ( )

3. Yoruba ( ) 4. Igbo ( )

5. Others ( )

9. Residence

1. Hamlet ( ) 2. Village ( )

3. Town ( ) 4. Others (specified ----------

SECTION (B)

IMMUNIZATION (AWARENESS)

10. Are you aware of immunization program in your locality?

1. Yes ( )

2. No ( )

11. Have you attended any meeting where immunization issues were discussed?

1. Yes ( )

2. No ( )

12. What is your position on immunization?

1. Approved ( )

2. Disapproved ( )

3. Undecided ( )

13. What is your major source of information about immunization?

1. Radio ( ) 2. Television ( )

3. Newspaper ( ) 4. Traditional leaders ( )

5. L.G. Officials ( ) 6. Others (specify) ----------

14. Do you believe that immunization is useful to your children?

1. Yes ( ) 2. No ( )

15. If no to what extent does it affect your children?

1. It paralyzed ( )

2. Reduce the number of children you bear ( )

3. Others (specify) ----------

SECTION (C): CULTURAL BELIEFS AND ATTITUDES OF PEOPLE

16. Does religion have any influence toward immunization program?

1. Yes ( ) 2. No ( )

17. Does a cultural belief have any influences about immunization?

1. Yes ( ) 2. No ( )

18. Do the traditional and religious leaders have any role to play about immunization in your locality?

1. Yes ( ) 2. No ( )

Thank you

DEPARTMENT OF SOCIOLOGY

FACULTY OF SOCIAL SCIENCES

USMANU DANFODIYO UNIVERSITY, SOKOTO.

QUESTIONAIRE

My name is Rabiu Umar, a student of above institution, undergoing a research on cultural beliefs and immunization in Birnin Kebbi local government area of Kebbi State, in partial fulfilment of the requirement for the award of B.Sc sociology.

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Thanks for your cooperation.

SECTION (A)

QUESTIONAIRE FOR HEALTH PERSONNEL

DEMOGRAPHICAL CHARACTERISTICS OF THE RESPONDENTS

INSTRUCTION: tick the option you consider most appropriate to the question below;

1. Age

(a) 10-20 ( ) (b) 21-30 ( )

(c) 31-40 ( ) (d) 41-50 ( )

(e) 51 and above ( )

2. Sex

(a) Male ( ) (b) Female ( )

3. Marital status

1. Single ( ) 2. Married ( )

3. Divorced ( ) 4. Widowed ( )

4. Education

1. Informal education ( )

2. Primary education ( )

3. Secondary education ( )

4. Tertiary education ( )

5. Religion

1. Islam ( ) 2. Christianity ( )

3. Traditional ( ) 4. Others ----------

6. Occupation

1. Politics ( ) 2. Farming ( )

3. Trading ( ) 4. Civil servants ( )

5. Others (specify) ----------

7. Monthly Income

1. 1000-20,000 ( )

2. 21,000-30,000 ( )

3. 31,000-40,000 ( )

4. 41,000-50,000 ( )

5. 50,000 and Above ( )

8. Ethnicity

1. Hausa ( ) 2. Fulani ( )

3. Yoruba ( ) 4. Igbo ( )

5. Others (specify) ----------

9. Residence

1. Hamlet ( ) 2. Village ( )

3. Town ( ) 4. Others (specified) ----------

SECTION (B)

IMMUNIZATION (AWARENESS)

10. Are you aware of immunization program in your locality?

1. Yes ( ) 2. No ( )

11. Have you attended any meeting where immunization issues were discussed?

1. Yes ( ) 2. No ( )

12. What is your position on immunization?

1. Approved ( )

2. Disapproved ( )

3. Undecided ( )

13. What is age bracket of children considered for immunization?

1. 3-5 months ( )

2. 1- 7 years ( )

3. Others (specify) ----------

14. What is the efficacy of immunization?

---

15. What form of disease is being immunized in your locality?

1. Measles ( )

2. Cholera ( )

3. Malaria ( )

4. Tuberculosis ( )

5. Polio ( )

6. Neo-natal tetanus ( )

7. Others (specify) ----------

16. What is the major problem facing immunization in your locality?

1. Poverty ( )

2. Illiteracy ( )

3. Lack of awareness ( )

17. What are the strategies used during immunization exercise?

1. Visits hospitals or dispensaries ( )

2. House to house ( )

3. Others (specify) ----------

SECTION (C)

CULTURAL BELIEFS AND ATTITUDES OF PEOPLE

18. Do cultural beliefs have any influences in your locality?

1. Yes ( ) 2. No ( )

19. Does religion has any influence toward immunization program?

1. Yes ( ) 2. No ( )

20. How you see the attitudes of the people toward immunization?

1. I don't care about attitude ( )

2. Conservative ( )

3. Ignorance ( )

4. Others (specify) ----------

Thank you

DEPARTMENT OF SOCIOLOGY

FACULTY OF SOCIAL SCIENCES

USMANU DANFODIYO UNIVERSITY, SOKOTO.

QUESTIONAIRE

My name is Rabiu Umar, a student of above institution, undergoing a research on cultural beliefs and immunization in Birnin Kebbi local government area of Kebbi State, in partial fulfillment of the requirement for the award of B.Sc sociology.

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Thanks for your cooperation.

SECTION (A)

QUESTIONAIRE FOR TRADITIONAL AND RELIGIOUS LEADERS

DEMOGRAPHICAL CHARACTERISTICS OF THE RESPONDENTS

INSTRUCTION: tick the option you consider most appropriate to the question below;

1. Age

(a) 10-20 ( ) (b) 21-30 ( )

(c) 31-40 ( ) (d) 41-50 ( )

(e) 51 and above ( )

2. Sex

(a) Male ( ) (b) Female ( )

3. Marital status

1. Single ( ) 2. Married ( )

3. Divorced ( ) 4. Widowed ( )

4. Education

1. Informal education ( )

2. Primary education ( )

3. Secondary education ( )

4. Tertiary education ( )

5. Religion

1. Islam ( ) 2. Christianity ( )

3. Traditional ( ) 4. Others ----------

6. Occupation

1. Politics ( ) 2. Farming ( )

3. Trading ( ) 4. Civil servants ( )

5. Others (specify) ----------

7. Monthly Income

1. 1000-20,000 ( ) 2. 21,000-30,000 ( )

3. 31,000-40,000 ( ) 4. 41,000-50,000 ( )

5. 50,000 and Above ( )

8. Ethnicity

1. Hausa ( ) 2. Fulani ( )

3. Yoruba ( ) 4. Igbo ( )

5. Others (specify) ----------

9. Residence

1. Hamlet ( ) 2. Village ( )

3. Town ( ) 4. Others (specified) ----------

SECTION (B)

IMMUNIZATION (AWARENESS)

10. Are you aware of immunization program in your locality?

1. Yes ( ) 2. No ( )

11. Have you attended any meeting where immunization issues were discussed?

1. Yes ( ) 2. No ( )

SECTION (C)

CULTURAL BELIEFS AND ATTITUDES OF PEOPLE

12. How parents perceived immunization in your locality?

1. Positively ( ) 2. Negative ( )

13. What is the success rate of immunization?

1. Very successful ( ) 2. Successful ( )

3. Average ( ) 4. Less successful ( )

14. How are able to achieve this level of success?

1. Through orientation ( ) 2. Through tasking order ( )

3. Order ( )

15. What are the attitudes of the people toward immunization in your locality?

1. I don't care about attitudes ( ) 2. Conservative ( )

3. Ignorance ( ) 4. Others (specify) ----------

16. What are the peoples' attitudes toward immunization in your locality?

1. Traditional ( ) 2. Religious ( )

3. Personal ( ) 4. Cultural ( )

5. Others ----------

17. Does religion has any influences toward immunization program?

1. Yes ( ) 2. No ( )

18. Does cultural belief have any influences about immunization/

1. Yes ( ) 2. No ( )

Thank you

Appendix 2

SPSS Result

```
DATASET ACTIVATE DataSet0.


SAVE OUTFILE='C:\Users\medupin\Documents\femi\back
up\Project\Project\usdus\umaru 2\Rabiu 2.sav'
  /COMPRESSED.

FREQUENCIES VARIABLES=AP1 AP2 AP3 AP4 AP5 AP6 AP7 AP8 AP9 BP10
BP11 BP12 BP13 BP14 BP15 CP16 CP17 CP18 AH1 AH2 AH3 AH4 AH5 AH6 AH7
BH8 BH9 BH10 BH11 CH12 CH13 CH14 AT1 AT2 AT3 AT4 AT5 AT6 AT7 AT8 BT9
BT10 CT11 CT12 CT13
  /ORDER=ANALYSIS.
```

Frequencies

Notes

Output Created		15-SEP-2015 17:05:35
Comments		
Input	Data	C:\Users\medupin\Documents\femi\back up\Project\Project\usdus\umaru 2\Rabiu 2.sav
	Active Dataset	DataSet0
	Filter	<none>
	Weight	<none>
	Split File	<none>
	N of Rows in Working Data File	40
Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics are based on all cases with valid data.

Syntax		FREQUENCIES VARIABLES=AP1 AP2 AP3 AP4 AP5 AP6 AP7 AP8 AP9 BP10 BP11 BP12 BP13 BP14 BP15 CP16 CP17 CP18 AH1 AH2 AH3 AH4 AH5 AH6 AH7 BH8 BH9 BH10 BH11 CH12 CH13 CH14 AT1 AT2 AT3 AT4 AT5 AT6 AT7 AT8 BT9 BT10 CT11 CT12 CT13 /ORDER=ANALYSIS.
Resources	Processor Time	00:00:00.17
	Elapsed Time	00:00:00.27

[DataSet0] C:\Users\medupin\Documents\femi\back up\Project\Project\usdus\umaru 2\Rabiu 2.sav

Statistics

		Age	Sex	Marital status	Education	Religion	Occupation
N	Valid	40	40	40	40	40	40
	Missing	0	0	0	0	0	0

Statistics

		Monthly Income	Ethnicity	Residence	Are you aware of immunization program in your locality?	Have you attended any meeting where immunization issues were discussed?
N	Valid	40	40	40	40	40
	Missing	0	0	0	0	0

Statistics

		What is your position on immunization?	What is your major source of information about immunization?	Do you believe that immunization is useful to your children?	If no to what extent does it affect your children?	Do the traditional and religious leaders have any role to play about immunization in your locality?
N	Valid	40	40	40	40	40
	Missing	0	0	0	0	0

Statistics

		Does a cultural belief have any influences about immunization?	Does religion have any influence toward immunization program?	Age	Sex	Marital status	Education
N	Valid	40	40	40	40	40	40
	Missing	0	0	0	0	0	0

Statistics

		Religion	Ethnicity	Residence	What is the efficacy of immunization	What form of disease is being immunized in your locality	What is the major problem facing immunization in your locality
N	Valid	40	40	40	40	40	40
	Missing	0	0	0	0	0	0

Statistics

		What are the strategies used during immunization exercise?	Do cultural beliefs have any influences in your locality	Does religion has any influence toward immunization program	How you see the attitudes of the people toward immunization	Age
N	Valid	40	40	40	40	40
	Missing	0	0	0	0	0

Statistics

		Sex	Marital status	Education	Religion	Monthly Income	Ethnicity
N	Valid	40	40	40	40	40	40
	Missing	0	0	0	0	0	0

Statistics

		Residence	Are you aware of immunization program in your locality?	Have you attended any meeting where immunization issues were discussed?	What are the attitudes of the people toward immunization in your locality?	Does religion has any influences toward immunization program?
N	Valid	40	40	40	40	40
	Missing	0	0	0	0	0

Statistics

		Does cultural belief have any influences about immunization/
N	Valid	40
	Missing	0

Frequency Table

Parent

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	21-30	26	65.0	65.0	65.0
	31-40	4	10.0	10.0	75.0
	41-50	10	25.0	25.0	100.0
	Total	40	100.0	100.0	

Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	20	50.0	50.0	50.0
	Female	20	50.0	50.0	100.0
	Total	40	100.0	100.0	

Marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	24	60.0	60.0	60.0
	Widow(er)	16	40.0	40.0	100.0
	Total	40	100.0	100.0	

Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Informal Education	8	20.0	20.0	20.0
	Primary Education	6	15.0	15.0	35.0
	Secondary Education	7	17.5	17.5	52.5
	Tertiary Education	19	47.5	47.5	100.0
	Total	40	100.0	100.0	

Religion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Islam	23	57.5	57.5	57.5
	Christianity	15	37.5	37.5	95.0
	Traditional	2	5.0	5.0	100.0
	Total	40	100.0	100.0	

Occupation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Politics	7	17.5	17.5	17.5
	Farming	10	25.0	25.0	42.5
	Trading	6	15.0	15.0	57.5
	Civil Servant	8	20.0	20.0	77.5
	others	9	22.5	22.5	100.0
	Total	40	100.0	100.0	

Monthly Income

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1,000-20,000	9	22.5	22.5	22.5
	21,000-30,000	20	50.0	50.0	72.5
	31,000 - 40,000	4	10.0	10.0	82.5
	41,000-50,000	7	17.5	17.5	100.0
	Total	40	100.0	100.0	

Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hausa	25	62.5	62.5	62.5
	fulani	2	5.0	5.0	67.5
	Yoruba	1	2.5	2.5	70.0
	Igbo	1	2.5	2.5	72.5
	Others	11	27.5	27.5	100.0
	Total	40	100.0	100.0	

Residence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hamlet	7	17.5	17.5	17.5
	Village	17	42.5	42.5	60.0
	Town	10	25.0	25.0	85.0
	Others	6	15.0	15.0	100.0
	Total	40	100.0	100.0	

Are you aware of immunization program in your locality?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	36	90.0	90.0	90.0
	No	4	10.0	10.0	100.0
	Total	40	100.0	100.0	

Have you attended any meeting where immunization issues were discussed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	21	52.5	52.5	52.5
	No	19	47.5	47.5	100.0
	Total	40	100.0	100.0	

What is your position on immunization?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Approved	33	82.5	82.5	82.5
	Disapproved	2	5.0	5.0	87.5
	undecided	5	12.5	12.5	100.0
	Total	40	100.0	100.0	

What is your major source of information about immunization?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	radio	15	37.5	37.5	37.5
	Television	20	50.0	50.0	87.5
	Traditional leaders	5	12.5	12.5	100.0
	Total	40	100.0	100.0	

Do you believe that immunization is useful to your children?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	75.0	75.0	75.0
	No	10	23.0	23.0	100.0
	Total	40	100.0	100.0	

If no to what extent does it affect your children?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	It paralyse	15	37.5	37.5	37.5
	reduce number of children you bear	24	60.0	60.0	97.5
	Others Specify	1	2.5	2.5	100.0
	Total	40	100.0	100.0	

Do the traditional and religious leaders have any role to play about immunization in your locality?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	72.5	72.5	72.5
	No	11	27.5	27.5	100.0
	Total	40	100.0	100.0	

Does a cultural belief have any influences about immunization?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	72.5	72.5	72.5
	No	11	27.5	27.5	100.0
	Total	40	100.0	100.0	

Does religion have any influence toward immunization program?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	38	95.0	95.0	95.0
	No	2	5.0	5.0	100.0
	Total	40	100.0	100.0	

Health Personnel

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	21-30	16	40.0	40.0	40.0
	31-40	24	60.0	60.0	100.0
	Total	40	100.0	100.0	

Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	15	37.5	37.5	37.5
	Female	25	62.5	62.5	100.0
	Total	40	100.0	100.0	

Marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Divourced	16	40.0	40.0	40.0
	Married	24	60.0	60.0	100.0
	Total	40	100.0	100.0	

Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Nurse	16	40.0	40.0	40.0
	Doctor	16	40.0	40.0	80.0
	Community health	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Religion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Islam	16	40.0	40.0	40.0
	Christianity	24	60.0	60.0	100.0
	Total	40	100.0	100.0	

Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hausa	32	80.0	80.0	80.0
	Yoruba	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Residence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Village	15	37.5	37.5	37.5
	Town	16	40.0	40.0	77.5
	Others	9	22.5	22.5	100.0
	Total	40	100.0	100.0	

What is the efficacy of immunization

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Reduces sickness	23	57.5	57.5	57.5
	Reduce death rate	7	17.5	17.5	75.0
	Improved health	10	25.0	25.0	100.0
	Total	40	100.0	100.0	

What form of disease is being immunized in your locality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Measles	24	60.0	60.0	60.0
	Polio	16	40.0	40.0	100.0
	Total	40	100.0	100.0	

What is the major problem facing immunization in your locality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poverty	7	17.5	17.5	17.5
	Illiteracy	25	62.5	62.5	80.0
	Lack of awareness	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

What are the strategies used during immunization exercise?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Visits hospitals or dispensaries	8	20.0	20.0	20.0
	House to House	32	80.0	80.0	100.0
	Total	40	100.0	100.0	

Do cultural beliefs have any influences in your locality

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	80.0	80.0	80.0
	No	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Does religion has any influence toward immunization program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	80.0	80.0	80.0
	No	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

How you see the attitudes of the people toward immunization

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I don't care attitude	17	42.5	42.5	42.5
	Conservation	7	17.5	17.5	60.0
	Ignorance	8	20.0	20.0	80.0
	Others Specify	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Traditional/ Religious leaders

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	31-40	16	40.0	40.0	40.0
	41-50	24	60.0	60.0	100.0
	Total	40	100.0	100.0	

Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	40	100.0	100.0	100.0

Marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	40	100.0	100.0	100.0

Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Informal Education	14	35.0	35.0	35.0
	Tertiary Education	26	65.0	65.0	100.0
	Total	40	100.0	100.0	

Religion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Islam	40	100.0	100.0	100.0

Monthly Income

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1,000-20,000	7	17.5	17.5	17.5
	21,000-30,000	7	17.5	17.5	35.0
	31,000 - 40,000	8	20.0	20.0	55.0
	50,000 and above	18	45.0	45.0	100.0
	Total	40	100.0	100.0	

Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hausa	40	100.0	100.0	100.0

Residence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Village	14	35.0	35.0	35.0
	Town	26	65.0	65.0	100.0
	Total	40	100.0	100.0	

Are you aware of immunization program in your locality?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	40	100.0	100.0	100.0

Have you attended any meeting where immunization issues were discussed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	18	45.0	45.0	45.0
	No	22	55.0	55.0	100.0
	Total	40	100.0	100.0	

What are the attitudes of the people toward immunization in your locality?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I don't care attitude	31	77.5	77.5	77.5
	Conservation	9	22.5	22.5	100.0
	Total	40	100.0	100.0	

Does religion has any influences toward immunization program?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	25	62.0	620.0	62.0
	No	15	37.5	37.5	100.0
	Total	40	100.0	100.0	

Does cultural belief have any influences about immunization/

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	23	57.5	57.5	57.5
	No	17	42.5	42.5	100.0
	Total	40	100.0	100.0	

```
.NPAR TESTS
  /CHISQUARE=CP17 CH12 CT13
  /EXPECTED=EQUAL
  /MISSING ANALYSIS.
```

NPar Tests

Notes

Output Created		15-SEP-2015 17:33:26
Comments		
Input	Data	C:\Users\medupin\Documents\femi\back up\Project\Project\usdus\umaru 2\Rabiu 2.sav
	Active Dataset	DataSet0
	Filter	<none>
	Weight	<none>
	Split File	<none>
	N of Rows in Working Data File	40
Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics for each test are based on all cases with valid data for the variable(s) used in that test.
Syntax		NPAR TESTS /CHISQUARE=CP17 CH12 CT13 /EXPECTED=EQUAL /MISSING ANALYSIS.
Resources	Processor Time	00:00:00.05
	Elapsed Time	00:00:00.16
	Number of Cases Allowed[a]	131072

a. Based on availability of workspace memory.

[DataSet0] C:\Users\medupin\Documents\femi\back up\Project\Project\usdus\umaru 2\Rabiu 2.sav

Chi-Square Test

Frequencies

Do cultural beliefs have any influences in your locality

	Observed N	Expected N	Residual
Yes	32	20.0	12.0
No	8	20.0	-12.0
Total	40		

	Do cultural beliefs have any influences in your locality
Chi-Square	14.400[a]
df	1
Asymp. Sig.	.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 20.0.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 13.3.

NPAR TESTS

/CHISQUARE=BP14 CH14

/EXPECTED=EQUAL

/MISSING ANALYSIS.

NPar Tests

Notes

Output Created		03-OCT-2015 17:08:06
Comments		
Input	Data	C:\Users\medupin\Desktop\project\usdus\umaru 2\Rabiu 2.sav
	Active Dataset	DataSet1
	Filter	<none>
	Weight	<none>
	Split File	<none>
	N of Rows in Working Data File	40
Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics for each test are based on all cases with valid data for the variable(s) used in that test.
Syntax		NPAR TESTS /CHISQUARE=BP14 CH14 /EXPECTED=EQUAL /MISSING ANALYSIS.
Resources	Processor Time	00:00:00.02
	Elapsed Time	00:00:00.02
	Number of Cases Allowed[a]	157286

a. Based on availability of workspace memory.

[DataSet1] C:\Users\medupin\Desktop\project\usdus\umaru 2\Rabiu 2.sav

Chi-Square Test

Frequencies

Do you believe that immunization is useful to your children?

	Observed N	Expected N	Residual
Yes	30	13.3	16.7
No	10	13.3	-16.7
Total	40		

How you see the attitudes of the people toward immunization

	Observed N	Expected N	Residual
I don't care attitude	17	10.0	7.0
Conservation	7	10.0	-3.0
Ignorance	8	10.0	-2.0
Others Specify	8	10.0	-2.0
Total	40		

Test Statistics

	Do you believe that immunization is useful to your children?	How you see the attitudes of the people toward immunization
Chi-Square	33.650[a]	6.600[b]
df	2	2
Asymp. Sig.	.000	.086

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 13.3.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 10.0.