CONSTRAINTS TO EFFECTIVE PARTICIPATION OF RURAL WOMEN IN UNICEF-NUTRITION AND HEALTH PROGRAMME IN SOUTH-EAST, NIGERIA

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Abstract

This study examined the constraints to effective participation of rural women in UNICEF nutrition and health programme activities in the South-East of Nigeria. A multi-stage random sampling was used to source for 288 rural women participants. The collected Data through structured questionnaire and scheduled interview sessions were analyzed using descriptive statistics such as percentages, means, and ordinary Least squares regression. Results revealed that the major programme activities the women participated in were Breastfeeding (97.9%), Long lasting Insecticide treated bed nets usage (97%), Delivery by skilled attendants (96%), HIV Counselling and Testing (91%), post-natal care (89.2%), Home gardening (88.9%), Iron and foliate supplementation (86.8%) and others. Results also show that;lack of awareness to the programme and its activities ($\bar{x}$ =3.38), inadequate information on the programme activities ($\bar{x}$ =4.36), inadequate health and nutrition personnel ($\bar{x}$ = 3.22) lack of adequate training of the Community health workers ($\bar{x}$ =3.51) were constraints, lack of proper training of the rural support group (RSG) members ($\bar{x}$ =3.11), Poor service delivery ($\bar{x}$ =3.31), lack of supervision ($\bar{x}$ =3.60), Political interference ($\bar{x}$ = 3.99), long time spent before receiving attention ($\bar{x}$ =3.76) were the major constraints that hindered the women from participating in the programme activities effectively. The regression results show the constraints did affect the effective participation of rural women in the programme activities positively with the F-ratio of 41.64 and significant at 1% alpha level. The study concluded and recommended an extensive advocacy and sensitization of the programme activities, and inclusion of time management skills in training activities for the community health workers, beckoning on the management of the programme to penalize individual state governments that defaults from paying her yearly counterpart funds as it should, to enable the women access and participate in the programme activities to improve their nutrition and health status.

***Keywords**:* constraints, effective participation, nutrition, health, rural women

Introduction

Nutrition is the science of food, the nutrients and the substances contained, their action, interaction and balance in relation to health and disease and the process by which the organism ingests, digests, absorbs, transports, utilizes and excretes food substances according to American Medical Association [AMA] (2002). Nutrition is a critical part of health and development. Better nutrition is related to improved infant, child and maternal health, stronger immune systems, safer pregnancy and childbirth, lower risk of non-communicable diseases (such as diabetes and cardiovascular disease), and longevity (WHO, 2026). More so, people with adequate nutrition tend to be more productive and can create opportunities to gradually break the cycles of poverty and hunger (WHO, 2026).

For a people to experience non-availability of adequate food at the right time and combination for a healthy living and growth, it is described as hunger. Inability of the food

material to supply the needed nutrients required by the body to ensure good body maintenance and metabolic function is known as malnutrition. Hunger and Malnutrition are factors of concern inimical to segments of the society. Household food insecurity is the major cause of hunger and malnutrition Ijarotimi and Odeyemi (2012). They stated that food insecurity is a state of limited or uncertain physical and economic access to secure adequate quantities of nutritionally and sufficient safe food or active and healthy living.

Globally, hunger and malnutrition are serious issues. The Global Hunger Index (GHI) Report (2023) reveals that the global food crises has left 281.6 million people in 59 countries to face high levels of acute food insecurity. The report shows that the compounding impacts of climate change, conflicts, economic shocks, global pandemic, and the Russian-Ukraine war have exacerbated social and economic inequalities and slowed or reversed previous progress in reducing hunger in many countries where large groups such as women and youth are suffering the burden of the crises. The report maintained that Nigeria is among the eight African countries where hunger has increased since 2015 efforts. Nearly 35 million Nigerians are facing food insecurity due to conflict, climate shocks, displacement and the systemic collapse of local systems World Food Programme (2026).

The burden of hunger is more felt among the poor. The women and children are the most affected Adepoju and Adejare (2013). Alaimo et al. (2002) agreed that gender inequality is the major cause of hunger and poverty, and they estimated that 60% of the chronically hungry people are women and girls, having 20% of children under five years of age. UNICEF (2006) agreed that Children and women are the most affected by hunger and malnutrition.

There has been several programmes and projects by successive governments in Nigeria focused on achieving food security. Some of which Awoyemi et al. (2012) cited to include; National Special Programme on Food Security (NSPFS), Food Security Thematic Group (FSTG), National Food Crises Response Programme (NFCRP) and many others.

Apart from the government's efforts, there are other global and partner initiatives aimed at increasing food availability and stability in the rural communities of most developing countries. Women's participation in such programmes will be germane to promote and maintain the best attainable level of wellbeing. Considering the fact that adequate knowledge and skills necessary for critical thinking regarding diet and health will guide an individual to make healthy food choices from an increasingly complex food supply and to combine available food quantities in scarcity to give the needed nutrients to the body, it thus becomes pertinent that the women maximize and utilize such useful opportunity when it comes. Such opportunity assists the individual to identify resources for continuing access to sound nutrition and health information (Washington State Department of Social and Health Services WSDSHS, 2024).

UNICEF is one of such organizations whoplay crucial role by providing interventions to improve the resources of those deprived rural households and the promotion of their nutrition state especially the women. UNICEF nutrition and health programme is one of such programs that focuses on women of child bearing age (18-49 years) and their children especially those under the age of five. The programme activities are expected to contribute positively to the health and nutritional conditions of women and children especially those disadvantaged, vulnerable and poor ones in the rural communities. The expected programme intervention outcomes for example include change in behavior regarding these program packages; Intake of Iron and folic acid supplementation in pregnancy, Vitamin A supplementation in children

6-24 months and Breastfeeding behaviours, adoption of Exclusive breastfeeding, breastfeeding of children between 6-23 months along with appropriate food groups, usage of iodized salt in cooking for their families, having small garden at the backyard, boiling or treatment of family drinking water, feeding their families with protein giving food and vegetables, making dietary plans for the family, Immunization against killer diseases in children 0-9 months, De-worming of children six monthly, Screening for malnutrition and treatment in children 0-59 months, HIV counselling and testing, Screening of mother to child transfer of HIV at birth, Antenatal care (ANC), Personal hygiene and environmental cleanliness, Post-natal care (PNC), education of the girl child and washing of hands before preparation of meals especially for the children, Sleeping under insecticide treated bed nets every day, visiting healthcare givers when there's change in the body as a pregnant woman, usage of anti-malaria drugs when they have malaria, birth registrations of their new born babies, Treatment of diarrhoea in children in the family with zinc and oral rehydration solution (ORS) (UNICEF, 2011).

Following an earlier study carried out in Abia state in 2012 when the country had a slight decrease in its maternal mortality rate from 1100 deaths per 100 000 live births to 630 deaths per 100 000 live births and suffers also from food insecurity, many rural women were still constrained by some factors in utilizing the opportunity effectively to improve and solve their serious health and nutrition challenges which hugely impedes their contribution sufficiently to family food security as food producers, providers and processors,and as nutritional balance givers, keepers of traditional knowledge and preservers of biodiversity (UNICEF, 2008).These constraints affected these women's effective participation in the programme activities. Thismotivated the scale upof the study to the geo-political zone level.The non-effective participation of rural women in the UNICEF Nutrition and Health programme denied them directly the shared information, andindirectly affected their nutritional intake and consequently their health status. Participation effectively in the programme and its information shared, if adhered to, should lead to improved nutritional intake and health status. The objective of this study was to examine the constraints to effective participation of rural women in UNICEF Nutrition and Health programme in the South-East region of Nigeria.

Methodology

The study was conducted in South-East geo-political zone of Nigeria. The zone has five states namely; Abia, Anambra, Ebonyi, Enugu and Imo states. The south-east zone is located within longitude 5^0 25'E and 8^0 51'E and latitude 4^0 20'N and 7^0 25'N. It is bounded in the West by the River Niger, in the South by the Atlantic Ocean and in the North by Kogi and Benue states. The region is boarded in the east by Cross-River and Akwa-Ibom states. The zone occupies a land mass area of about 109.524 square kilometers (km^2) representing 11.86% of the total land mass of Nigeria (Ekong, 2010). The south-east states are situated in the rainforest region of Nigeria.

The population of the study comprised all the women residing in rural communities in South–East geo-political zone of Nigeria, who participated in the programme activities in 2019. The programme activities of UNICEF–assisted nutrition and health are spread in the region.

A multi-stage random sampling was used for the study. In the first stage, 3 states (Abia, Ebonyi and Enugu), out of the 5 states were purposively selected based on the fact that they all had the programme activities carried out in them. In the second stage of selections, two senatorial zones each were randomly selected, from Abia (Abia Central and Abia North), Ebonyi (Ebonyi South and Ebonyi Central), and Enugu (Enugu East and Enugu West). In the

third stage, two Local Government Areas were purposively selected from each senatorial zones of Abia Central (Umuahia North and Ikwuano), Abia North (Bende and Isiukwuato), while in Ebonyi South (Afikpo North and Afikpo South) were selected, in Ebonyi Central (Ezza North and Ezza South) were selected. Enugu East (Nkanu East and Nkanu West) were selected while Enugu West has (Awgu and Ani-nri) selected. In the fourth stage, two communities each were randomly selected and from each Local Government Area, and this gives twenty-four communities. In the fifth stage, a village each was randomly selected form the twenty-four communities. In each village, 12 participants were randomly selected bringing the total sample size to 288. Interviews and well-structured questionnaire were used to generate data in the study area. The instrument was subjected to test-retest reliability test with 20 non-participants, whose score were correlated to determine the correlation coefficient of reliability (r) of 0.75 which confirmed the instrument being good enough to realize the study objectives. Data collected were analyzed using descriptive and inferential statistics. Specific objectives of this study were to:

1. examine the programme activities the rural women participated in.
2. examine the constraints to effective participation of rural women in those programme activities and,
3. determine the constraints that affected the women's effective participation in the programme activities in the South-East region of Nigeria.

To ascertain the programme activities the rural women did participate in, percentage was used. To ascertain the constraints that affected the women effective participation in the programme activities, a 5point likert rating scale was used having; Very Strongly Agree (VSA) =5, Strongly Agree (SA) =4, Agree (A) =3, Disagree (D) =2, and Strongly Disagree (SD) =1. A midpoint of 3.0 was obtained. Thus, mean score greater than or equal to the upper limit of 3.05 (3.0 + 0.05) benchmark implies a constraint and below 3.05 was regarded as not a constraint.

Hypothesis Testing

H_O: The constraints to effective participation of rural women in the programme do not significantly affect their participation. The ordinary least squares regression model was used to test that. The model is as specified below;

Double Log Function

$LnY=L_n\beta_0+\beta_1L_nX_1+\beta_2L_nX_2+\beta_3L_nX_3+\beta_4L_nX_4+\beta_5L_nX_5+\beta_6L_nX_6+\beta_7L_nX_7+.....\beta_{12}L_{12}X_{12}+ ei$

$Y= f (X_1, X_2, X_3, X_4, X_5, X_6, X_7, X_8, X_{12})$,

where

Y = Participation level of participants (measured on 5point likert rating scale of very strongly agree = 5, strongly agree = 4, agree = 3, disagree = 2 and strongly disagree = 1)

X_1 = Lack of awareness of the programme and its activities (mean scores).

X_2 = Usage of non-personal communication channels in advocacy and awareness creation (mean scores).

X_3 = Inadequate information on the programme activities (mean scores).

X_4 = Programme activities and services are not cost-effective (mean scores).

X_5 = Problem of having programme activities during farming season (mean scores).

X_6 = Inadequate Health facilities (mean score)

X_7 = Inadequate health and nutrition personnel (mean scores).

X_8 = Lack of proper training of the community health workers (mean scores).

X_9 = Lack of proper training of the rural support group (RSGs) members (mean scores).

X_{10} = Poor service delivery (mean scores).
X_{11} =Lack of proper supervision (mean scores).
X_{12} = Political interference (mean scores).
X_{13} = Poor rural roads infrastructures (mean scores).
X_{14} = Poor transport system (mean score)
X_{15} = Long time spent before receiving attention (mean scores).
e = Error term.

Results and Discussion

The result in the Table 1 shows the UNICEF Nutrition and Health programme activities that the rural women in South-East region participated in. The major programme activities the women participated in were Breastfeeding (97.9%), Long lasting Insecticide treated bed nets usage (97%), Delivery by skilled attendants (96%), HIV Counselling and Testing (91%),Post-natal care (89.2%), Home gardening (88.9%), Iron and foliate supplementation (86.8%), Birth registration (86.5%), Personal hygiene (75%), Vitamin A supplementation (71.2%), others include; Environmental sanitation (70.1%), Immunization against killer diseases (68.4%), Antenatal care (61%), Breastfeeding in children more than 6 months (58%), Deworming of children (54.2%), Anti malaria drug (51.4%) and many more, while Family planning (16%). This agrees with UNICEF, (2011) that the usage of good communication channel during sensitization enhances participation of the intended beneficiaries of such programmes.

Table 1: ***The UNICEF Nutrition and Health Programme Activities***

Nutrition Activities	***Frequency**	**Percentage***
Vitamin A supplementation	205	71.2
Iron and foliate supplementation	250	86.8
Breastfeeding	282	97.9
Exclusive breastfeeding in children 0-6 months	109	37.8
Breastfeeding in children more than 6 months.	167	58
Complementary feeding (after six months of exclusive breastfeeding)	89	31
Home gardening.	256	88.9
Attendance to nutrition health talks and training sessions	50	17.4
Health Activities		
Immunization against killer diseases	197	68.4
Long lasting insecticide treated bed nets usage	279	97
De-worming of children	156	54.2
Screening for malnutrition and treatment	56	19.4
Birth registration	249	86.5
HIV counselling and testing (HCT)	262	91
Antenatal care (ANC)	175	61
Focused antenatal care (FANC).	59	20.5
Post-natal care (PNC)	257	89.2
Treatment of diarrhoea with ORS and zinc	109	38
Personal hygiene (hand washing activities, bathing daily at least twice and washing of clothes once used)	215	75
Environmental sanitation (weeding the environment, proper disposal of faeces, etc)	202	70.1
Delivery by skilled birth attendants	276	96
Family Planning	45	16
Anti-malaria drugs	148	51.4

Note. From Field Survey

The result on Table 2 shows the constraints associated with effective participation of the women in UNICEF nutrition and health Programme activities. The study revealed that lack of

awareness of the programme and its activities ($\bar{x}$=3.38), Usage of non-personal communication channels in advocacy and awareness creation ($\bar{x}$= 3.94), Inadequate information on the programme activities ($\bar{x}$=4.36), the activities are not cost effective ($\bar{x}$ =3.09), Inadequate health and nutrition personnel ($\bar{x}$= 3.22), Lack of proper training of the rural support group (RSG) members ($\bar{x}$=3.11), and Lack of adequate training of the community health workers ($\bar{x}$=3.51) which could be the reason and explains why inadequate information was a constraint along spending long time before receiving attention. The women complained that Poor service delivery ($\bar{x}$=3.31), lack of supervision ($\bar{x}$=3.60), Political interference ($\bar{x}$= 3.99), long time spent before receiving attention ($\bar{x}$=3.76) were also constraints that affected their participation effectively in the programme activities.

Table 2: ***Constraints to Effective Participation of Rural Women in the UNICEF Nutrition and Health Programme Activities in the Study Area***

Constraints to effective participation	Abia (n =96)		Ebonyi (n =96)		Enugu (n =96)		S/E
	$\sum f(x)$	$\bar{x}$	$\sum f(x)$	$\bar{x}$	$\sum f(x)$	$\bar{x}$	Pooled $\bar{x}$
Lack of awareness of the programme and its activities	338	3.52	338	3.06	342	3.56	3.38
Usage of non-personal communication channels in advocacy and awareness creation	391	4.07	345	3.59	398	4.15	3.94
Inadequate information on the programme activities	428	4.46	405	4.22	423	4.41	4.36
Programme activities and services are not cost effective	234	2.44	418	4.35	237	2.47	3.09
Problem of having programme activities during the farming season	255	2.66	239	2.49	250	2.60	2.58
Inadequate health facilities	245	2.57	244	2.54	244	2.54	2.55
Inadequate health and nutrition personnel	345	3.60	241	2.51	341	3.55	3.22
Lack of proper training of the community health workers	341	3.55	336	3.50	334	3.48	3.51
Lack of proper training of the rural support group (RSGs) members	282	2.94	327	3.41	287	2.99	3.11
Poor service delivery	326	3.40	291	3.03	335	3.49	3.31
Lack of proper supervision	346	3.60	343	3.57	348	3.62	3.60
Political interference	418	4.32	348	3.63	385	4.01	3.99
Poor rural roads infrastructure	218	2.27	355	3.70	217	2.26	2.74
Poor transport system	331	3.45	215	2.24	322	3.35	3.01
Long time spent before receiving attention	349	3.64	349	3.24	423	4.41	3.76
Grand mean		3.34		3.27		3.39	

Note. Field Survey**.** *(Benchmark=3.05)*

Data on Table 3 shows the Ordinary Least Squares Regression estimates of relationship between constraints to effective participation of the rural women participants of UNICEF nutrition and health programme and their participation effectively in the programme in the study area. The Double log functional formwas chosen based on the magnitude of R^2 value, number of significant variables and F-ratio. The R^2 (coefficient of multiple determination) value was 0.782, which implies that 78.2% of the total observed variation in the dependent variable (Y) was accounted for, while 21.8% of the variations was due to error. F statistic was significant at 1% indicating the fitness for the analysis.

The result revealed that the coefficient of poor rural roads was statistically significant at 10% alpha level and negatively related, the coefficient of lack of awareness of the programme and its activities was significant at 5% alpha level and negatively related to their participation, the coefficient of usage of non-personal communication channels in advocacy and awareness creation was statistically significant at 5% alpha level and negatively related, the coefficient of lack of proper training of the community health workers was statistically significant at 5%

alpha level and negatively related. More so, the coefficient of inadequate information on the programme activities was statistically significant at 1% alpha level and positively related, the coefficient of political interference was statistically significant at 1% alpha level and negatively related, the coefficient of long time spent before receiving attention was statistically significant at 1% alpha level and negatively related. This implies that any increase in these coefficients will lead to a corresponding decrease in the participation level of women in the programme.

The F-ratio of 41.64 confirmed the result statistically significant at 1% alpha level and positively related. The study therefore rejected the null hypothesis which stated that the constraints to effective participation of the women in the programme do not significantly affect their participation and concluded otherwise.

Discussion of Findings

The key findings here are that (1) Inadequate information on the programme activities, (2) Political interferenceand (3) Long time spent before receiving attention are the major constraints to women participation effectively in UNICEF–Nutrition and health programme activities. The coefficient of inadequate information on the programme activities being significant at 1% alpha level and negatively related implied that any increase it had, hampered the quality and meaning of the information at the disposal of the women thereby denying them the opportunity of tapping into the beneficial components of the programme. The coefficient of political interference being significant at 1% alpha level and negatively related implied it did affect the women's effective participation in the programme. Here, some state governments' non-commitment to their responsibilities as it has to do with counterpart funding for the programme and its activities contributed to the women's non-effective participation in the programme. Which means that when a state did not pay its counterpart, the women will not have access to participate in the program. Finally, the coefficient of long time spent before receiving attention being significant at 1% alpha level implied that as women spent time waiting for turns to be attended to at primary healthcare facilities, it affected their participation negatively because it was at the expense of other things.

Table 3: ***The ordinary least squares regression model showing the constraints to effective participation of rural women in the programme that significantly affected their participation***

Parameters	Linear	Exponential	Semi-log	Double log +
Constant	4.578	8.150	51.804	1.324
	(4.238)**	(6.913)***	(4.334)***	-(5.545)***
Lack of awareness of the programme and its	-447.06	-0.511	-891.993	-0.743
activities	(-1.310)	(-0.44)	(-1.900)*	(-2.551)**
Usage of non-personal communication	-4.123	-0.009	-648.511	-0.370
channels in advocacy and awareness creation	(-4.090)***	(-2.907)***	(-2. 348)**	(-1.972)**
Inadequate information on the programme	-8.923	-0.004	-0.629	-0.071
Activities	(7.950)***	(2.132)**	(5.050)***	(3.830)***
Programme activities and services are not cost	-82.300	-0.077	-35.354	-0.117
effective	(-0.596)	(-0.907)	(-0.101)	(-0.685)
Problem of having programme activities	-9.592	-0.002	-0.526	-0.003
during the farming season	(3.690)***	(3.570)***	(1.962)**	(0.033)
Inadequate health facilities	-33.500	-0.014	320.904	0.045
	(-0.743)	(-0.390)	(0.613)	(0.255)
Inadequate health and nutrition personnel	0.001	2.301E-7	52.349	0.107
	(0.860)	(6.988)***	(7.330)***	(3.716)***
Lack of proper training of the community	-170.124	-0.008	-69.215	-0.006

health workers	(0.587)	(0.044)	(3.131)***	(2.505)**
Lack of proper training of the rural support	418.022	.006	21777.121	.371
group (RSGs) members	(0.806)	(0.845)	(0.644)	(1.048)
Poor service delivery	-4445.507	-0.052	-33766.830	-.172
	(-0.359)	(0.529)	(-1.203)	(-0.586)
Lack of proper supervision	945.149	.025	-22358.072	0.195
	(0.252)	-(0.048)	(-1.090)	(-0.907)
Political interference	-246.548	-0.011	-1613.220	-0.188
	(10.152)***	(5.537)***	(7.055)***	(6.611)***
Poor rural roads infrastructure	-2945.011	-.023	-38490.305	-.298
	(1.841)*	(1.714)*	(2.284)**	(1.876)*
Poor transport system	18136.906	.037	31148.830	.150
	(0.768)	(0.121)	(0.998)	(0.198)
Long time spent before receiving attention	-0.017	-2.34507	-14938.368	-0.028
	(2.487)**	(2.775)***	(2.005)**	(11.232)***
R^2	0.575	0.617	0.690	0.782
R Adjusted	0.541	0.538	0.656	0.738
F – Ratio	44.803***	27.107***	38.926***	41.638***

Note. FromField Survey.

Note. * Significant at 10%, ** Significant at 5%, *** Significant at 1% ***, + = Lead Equation and the values in parenthesis are the t-value; H_o was rejected at 5% alpha level.

Limitations of the Study

Several challenges were encountered in the course of this research work. Among such include: (1) Lack of time control (2) Participants' unwillingness to respond, and (3) Paucity of funds. Regarding lack of time most of the women participants could not be reached individually in their homes; instead, they were met in groups especially on immunization days, and on maternal and neo-born child health week (MNCHW) activities schedules which records high women turn-out and attendance. As immunization holds twice a month, the MNCHW programme is a biannual health programme that offers the women access to healthcare free of charge, even deliveries made during this period are free. Most often the States' primary healthcare development agency (SPHCDA) dates for these programmes clashes with others, thereby making it impossible for such ample opportunity to be utilized. Another problem encountered was the fact that many women participants were unwilling and reluctant to respond to the questions raised in the questionnaire. This however, necessitated the development of a strategy aimed at arousing and sustaining the women's interest to offer the needed assistance. To achieve this, the researchers having noticed that there was a moimoi vendor that receives the highest patronage asked her to serve all the women present, while at another location egg was served all of them present.Also,at another location buns were given to them. It was only in one of the locations that some five women ate jollof rice on the researchers. Finally, paucity of funds was a major challenge central to this study. Lack of funds reduced the pace at which this work was carried out. It also made it difficult forthe researchers to meet with these women in groups on their appointment days at health facilities, or otherwise would have to wait till there's fund to embark on the trip.

Conclusion

The findings revealed that inadequate information on the programme's activities, political interference, and long time spent before receiving attention at the health facilities affected the rural women's participation effectively in the programme. Practically, advocacy and sensitization of future programmes should be done extensively, as time management skills should be included in the training and retraining packages of Community health workers. From the policy perspective, the individual state governments shouldbe penalized under the

management policies if they fail to pay their yearly counterpart funds to enable the rural women have access and participate in the programme activities to improve their BMI.

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