

Global Scientific and Academic Research Journal of Multidisciplinary Studies
ISSN: 2583-4088 (Online)
Frequency: Monthly
Published By GSAR Publishers
Journal Homepage Link- https://gsarpublishers.com/journals-gsarjms-home/

An Assessment of Geographic Disparities in Child Welfare and Nutritional Wellbeing in Kogi State, Nigeria: A Qualitative Inquiry

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LOKPHDSW22001

Article History

Received: 15/10/2026
Accepted: 24/10/2026
Published: 27/10/2026

Vol – 5 Issue –10

PP: - 35-45

Abstract

Child undernutrition remains a persistent public health challenge in Nigeria, with geographic disparities in access to health and nutrition services identified as a key structural driver of poor outcomes among children under five. This study assessed how geographic disparities influence children's welfare and nutritional wellbeing in Kogi State, Nigeria, identified the barriers preventing vulnerable households from accessing available services, and proffered social work intervention strategies responsive to those barriers. Bronfenbrenner's Ecological Systems Theory provided the theoretical foundation for the study. An exploratory qualitative research design was adopted, with seven key informants selected through purposive sampling from among state and Local Government level officers holding direct professional oversight of child health, nutrition, and welfare services in Kogi State. Data were collected using a semi-structured interview guide and analysed thematically, with verbatim responses attributed to assigned codes to protect confidentiality. Findings revealed that geographic disadvantage operates through divergent mechanisms rather than as a uniform rural deficit, with rural households constrained principally by physical access to services through distance, flooded roads, and transport cost, while the urban poor were constrained principally by affordability despite the proximity of the same services. Four barriers to access recurred across the accounts, namely transport cost, absence of documentation such as birth registration, stigma, and unawareness of existing programmes, while cultural belief was consistently declined as an explanation. The study concludes that child welfare deficits in Kogi State reflect the failure of linkage between households and the institutions meant to serve them, and recommends differentiated rural and urban service delivery, reform of social protection targeting, and a strengthened social work role in identifying and linking vulnerable families to available support.

Introduction

Every year, millions of children across sub-Saharan Africa grow up without the nutrition they need to survive and develop fully. In 2024, an estimated 150.2 million children under five years of age were stunted and 42.8 million were wasted, only about a quarter of countries are on track to halve stunting by 2030, and Africa remains the only region where the absolute number of stunted children continues to rise (UNICEF, WHO, & World Bank Group, 2025). Bain et al. (2013) attribute the persistence of this burden in the region to the combined operation of household poverty, food insecurity, and constrained access to health services. What this tells us is that the problem goes beyond food availability alone and is rooted in deeper conditions that shape how children are fed and cared for within their homes, and in whether the services meant to support them are within reach.

Scholars have long argued that child nutrition cannot be understood in isolation from the social environment surrounding a child. Black et al. (2013) describe nutritional outcomes as a product of the interaction between a child's biological needs and the social conditions in which that child is raised, while Victora et al. (2021), reviewing progress across 50 low- and middle-income countries, report that social inequalities are evident for many forms of undernutrition, indicating a key role for poverty and low education. Bronfenbrenner (1979) supplies the architecture for this reading, situating the child within nested environmental systems in which the household, its linkages to surrounding institutions, and the wider economic order each exert influence. These perspectives shift the conversation from individual feeding behaviour to the structural conditions that make optimal nutrition possible or difficult for families.

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Nigeria presents one of the most serious cases of child undernutrition in the world. The Federal Ministry of Health and Social Welfare of Nigeria, National Population Commission, and ICF (2024) report under-five mortality at 110 deaths per 1,000 live births and full vaccination coverage of only 39% among children aged twelve to twenty-three months. Survey evidence consistently shows wide gaps between income groups and between rural and urban households, with Akombi et al. (2019) identifying maternal education at the no-education level, household wealth at the poorest category, and rural residence as key contributors to childhood undernutrition. The challenge, however, is that most available research captures these dynamics at the national level, leaving the conditions operating within individual states largely unexamined.

The geographic dimension of this disparity warrants attention in its own right, and not simply as a rural deficit. Ahinkorah et al. (2021), in a multilevel analysis across sub-Saharan Africa, identify distance to facility and transport cost as barriers operating independently of whether services exist, so that a household may be near a facility it cannot afford to use, or able to afford care it cannot physically reach. Compounding this, Bywaters et al. (2015) observe that services systematically fail those who most need them, a paradox they term the inverse intervention law, while Ezenwaka et al. (2021) found that conditional cash transfers improved uptake of maternal and child health services in Nigeria when they reached households, locating the decisive question in reach rather than in instrument.

Kogi State sits at the intersection of these challenges in ways that make it a compelling setting for this kind of study. The state combines rural farming communities with small urban centres across twenty-one Local Government Areas, and access to healthcare, nutrition education, and basic social services remains uneven. The National Bureau of Statistics (2022) reports that 63% of Nigerians are multidimensionally poor, with deprivation markedly higher in rural areas at 72% than in urban areas at 42%, and that two-thirds of children aged zero to seventeen are multidimensionally poor. This study therefore examines how geographic disparities influence children's welfare and nutritional wellbeing in Kogi State, identifies the barriers preventing vulnerable households from accessing available services, and proffers social work intervention strategies responsive to those barriers.

Statement of the Problem

Every child under five ought to live within reach of the services that safeguard their health and nutrition, yet in Nigeria under-five mortality stands at 110 deaths per 1,000 live births and only 39% of children aged twelve to twenty-three months are fully vaccinated (Federal Ministry of Health and Social Welfare of Nigeria, National Population Commission, & ICF, 2024), with rural residence and poorest household wealth among the key contributors to childhood undernutrition (Akombi et al., 2019). The difficulty is compounded by a failure of reach, since welfare services systematically fail those who most need them (Bywaters et al., 2015), and distance and transport cost operate as barriers independently of whether services exist at all (Ahinkorah et al., 2021). National surveys have established that rural residence is associated with poorer child outcomes, but association is not mechanism: they do not establish whether rural disadvantage and urban poverty constitute degrees of a single constraint or distinct processes requiring distinct responses, nor do they document the administrative and social barriers through which eligible households come to be excluded. This gap is acute in Kogi State, where national aggregates conceal pronounced state-level variation (Adekanmbi et al., 2013) and research on child welfare remains virtually absent from the social work literature (Isangha et al., 2024). The consequence is practical, since a response assuming a uniform rural deficit will invest in outreach where affordability is the binding constraint, or in price support where distance is, and will succeed in neither setting. It is against this background that this study examines how geographic disparities influence children's welfare and nutritional wellbeing in Kogi State, identifies the barriers preventing vulnerable households from accessing available services, and proffers social work intervention strategies responsive to those barriers.

Research Questions

The following research questions guided the study:

1. How do geographic disparities influence children's welfare and nutritional wellbeing in Kogi State, Nigeria?
2. What barriers prevent vulnerable households from accessing available child health, nutrition, and social protection services in the study area?
3. What social work intervention strategies can improve child welfare and nutritional wellbeing in the study area?

Aim and Objectives of the Study

The aim of this study is to assess geographic disparities in child welfare and nutritional wellbeing in Kogi State, Nigeria, and to identify strategies for improving outcomes among children under five. Specifically, the study seeks to:

1. Examine how geographic disparities influence children's welfare and nutritional wellbeing in the study area.
2. Identify the barriers preventing vulnerable households from accessing available child health, nutrition, and social protection services.
3. Proffer social work intervention strategies for improving child welfare and nutritional wellbeing in the study area.

Literature Review

Geographic Disparities in Child Health and Nutrition

Geographic disparities refer to systematic differences in health and nutritional outcomes between populations distinguished by where they live, arising from unequal spatial distribution of services, infrastructure, and economic opportunity rather than from the characteristics of individuals

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alone. Adekanmbi et al. (2013), analysing childhood stunting across Nigeria, demonstrated pronounced state and regional variation that national aggregates conceal, establishing place of residence as an analytic category in its own right. Akombi et al. (2019) similarly identified rural residence as a key contributor to childhood undernutrition in Nigeria, alongside maternal education and household wealth, while Uthman (2009) found rural or urban residency to be among the important contributors to inequality in childhood malnutrition when the concentration index was decomposed.

The relationship between place and child nutrition is not, however, a simple rural disadvantage. Amare et al. (2021) show that urbanisation carries differentiated consequences for child nutritional outcomes rather than a uniform advantage, since proximity to services does not guarantee the means to use them. Adedokun and Yaya (2020), examining 31 sub-Saharan African countries, found adverse nutritional status concentrated among households of lower socioeconomic standing irrespective of setting, indicating that geography and economic position interact rather than operate independently. The analytic question is therefore not which setting fares worse but through what mechanism constraint operates in each, a distinction the aggregate literature has generally left unexamined.

Access to Child Health and Nutrition Services

Access to services denotes the actual capacity of a household to obtain care, which is distinct from the availability of that care within a given locality. Ahinkorah et al. (2021), in a multilevel analysis of barriers to healthcare access for childhood illnesses across sub-Saharan Africa, identify distance to facility, transport cost, and the requirement to obtain permission as constraints operating independently of whether services exist. Adedokun et al. (2022) similarly establish that contextual factors shape healthcare utilisation for acute childhood illnesses in Nigeria beyond the characteristics of the household itself. A facility may therefore be present and remain effectively unreachable, whether because the journey cannot be made or because the cost of making it cannot be borne.

This distinction carries direct consequences for child nutrition. Bain et al. (2013) attribute malnutrition in sub-Saharan Africa to the combined operation of household poverty, food insecurity, and constrained access to health services rather than to any single cause, while Ekholuenetale et al. (2021), analysing the 2018 Nigeria Demographic and Health Survey, identify a comparable configuration of risk factors for childhood malnutrition in Nigeria. Where growth monitoring, immunisation, and nutrition counselling are not reached, the household loses not only the service but the contact through which nutritional risk would ordinarily be detected.

Social Protection and the Reach of Entitlement

Social protection comprises the transfers, feeding programmes, and safety nets established to buffer vulnerable households against economic shock. Ezenwaka et al. (2021) found that conditional cash transfers improved the uptake of maternal and child health services in Nigeria by lowering the financial barrier to access, while Tiwari et al. (2016), in a cross-country analysis, established that generous, regular, and predictable transfers improved food security whereas small and irregular ones did not. Alderman and Yemtsov (2014) argue further that safety nets contribute to economic growth rather than merely redistributing, so that the case for provision rests on productive as well as protective grounds.

The decisive question, however, concerns reach rather than instrument. Bywaters et al. (2015) name the inverse intervention law, whereby services systematically fail those who most need them, a pattern they attribute to the same structural disadvantage that generates the need. Isangha et al. (2024) document the Nigerian expression of this problem, observing that child protection social work contends with chronic resource scarcity, heavy caseloads, and the non-domestication of the Child Rights Act across many states, leaving families entitled to support without the professional intermediary through which they might reach it. Menon et al. (2018) note in the Indian context that multisectoral action succeeds only where convergence is assured on the same geographies and households, which locates targeting rather than programme design as the operative constraint.

Child Welfare as a Multidimensional Construct

Child welfare extends beyond nutritional status to encompass immunisation, healthcare access, protection from harm, adequate supervision, and emotional security. Bronfenbrenner (1979) situates these dimensions within nested environmental systems, so that the child's wellbeing is determined simultaneously by the immediate care environment and by the wider household, service, and structural conditions surrounding it. The National Bureau of Statistics (2022) gives this multidimensionality empirical form in the Nigerian Child Multidimensional Poverty Index, which incorporates eight indicators of child survival and development including severe undernutrition, immunisation, breastfeeding, childcare, and birth attendance, reporting that two-thirds of Nigerian children aged zero to seventeen are multidimensionally poor.

Treating welfare as multidimensional has analytic consequences. Bywaters et al. (2015) argue that adverse child outcomes are patterned, produced, and remediable rather than randomly distributed, and are therefore properly described as inequalities rather than differences. Christian et al. (2023) demonstrate that household headship structure mediates the relationship between women's empowerment and children's nutritional status, indicating that welfare outcomes depend on intra-household arrangements as well as on aggregate household resources. The implication for the present study is that an account of child welfare confined to what a child eats will miss the supervision, protection, and service contact that equally determine wellbeing.

Review of Empirical Studies

Empirical studies on the factors influencing child nutrition and strategies for improvement have been conducted across various contexts, offering valuable insights into the social, maternal, and community level dynamics that shape nutritional outcomes among young children. While much of

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this evidence comes from settings outside Nigeria, the findings provide a useful foundation for understanding the problem and identifying what kinds of interventions have worked and under what conditions. The studies reviewed below are selected for their direct relevance to the objectives of this study.

Ketema, Bosha, and Feleke (2022) conducted a community based comparative cross sectional study assessing the effect of maternal employment on nutritional status among children aged 6 to 23 months in Bale Robe, Ethiopia, using a sample of 597 mother and child pairs. The study found that stunting, underweight, and wasting were significantly higher among children of employed mothers at 39.9 percent compared to children of unemployed mothers at 31.3 percent, suggesting that maternal time availability for childcare and feeding is a critical factor in child nutritional status. Binary and multivariable logistic regression analyses further revealed that being a girl significantly protected against stunting in both groups, pointing to the intersection of gender and maternal employment in shaping nutrition outcomes. The study concluded that reducing child undernutrition requires deliberate efforts to support employed mothers through flexible work arrangements and targeted nutrition programmes.

Nankinga, Kwagala, and Walakira (2016) investigated the relationship between maternal employment and child nutritional status in Uganda using data from the 2016 Uganda Demographic and Health Survey, drawing a weighted sample of 3,531 children under five born to working women aged 15 to 49 years. Findings revealed that children whose mothers were engaged in agricultural and manual labour had significantly higher odds of stunting compared to children whose mothers were employed in professional occupations, while children whose mothers worked for non-family members had higher odds of wasting and underweight. The study further established that maternal education at the secondary level significantly reduced the odds of stunting and underweight, reinforcing the interconnected roles of employment quality and education in child nutrition. The researchers recommended workplace flexibility, breastfeeding support, and targeted nutrition programmes for low socio-economic groups as critical strategies for improving child nutritional outcomes.

Sen and Sengupta (1983) examined malnutrition among rural children in West Bengal, India, with a specific focus on identifying gender based disparities in child nutritional status across two rural villages. Using anthropometric measurements and a statistical index related to the Wilcoxon rank test, the study found a consistent and statistically significant sex bias against female children, with girls recording higher levels of undernourishment than boys across all surveyed samples. Notably, the village with the better overall nutritional record showed sharper gender discrimination against girls, suggesting that economic improvements do not automatically translate into equitable nutrition outcomes within households. The study concluded that gender discrimination is a critical driver of childhood malnutrition and called for policy interventions addressing intra-household gender inequalities in nutrition and child care.

Paudel, Gurung, Khatri, Poudyal, Acharya, Upadhyaya, Singh, Paudel, Sah, Lee, Adhikari, Sapkota, and Paudel (2025) carried out a quasi-experimental time series study assessing the impact of a community based nutritional intervention among 75 children aged 6 to 59 months with undernutrition in rural Nepal. The intervention package included super flour, milk, growth monitoring, nutrition education, and counselling delivered over six months, with results showing consistent monthly improvements in weight for age z scores by 0.49 units, weight for height z scores by 0.41 units, and height for age z scores by 0.31 units. The study demonstrated that community based nutrition interventions using locally available resources can produce measurable reductions in undernutrition within a relatively short period of implementation. The researchers concluded that similar interventions can be effectively promoted in other low resource settings where access to formal nutrition services is limited.

Ghodsi, Omidvar, Nikooyeh, Roustaee, Shakibazadeh, and Al-Jawaldeh (2021) conducted a systematic review and meta-analysis examining the effectiveness of community based nutrition specific interventions on the nutritional status of children under five in the Eastern Mediterranean Region, drawing from eight studies selected from over 1,000 identified across multiple databases. Nutrition education, counselling, and cash based interventions were the most commonly applied strategies, with pooled results showing a significant improvement in weight for height z scores among children who received the interventions. The review highlighted that capacity building at the community level and the integration of multiple nutrition specific strategies are essential for producing meaningful reductions in child malnutrition across different country contexts. The study recommended further investigation into new implementation approaches, particularly in high burden settings where child malnutrition rates remain persistently elevated.

Fadare, Amare, Mavrotas, Akerele, and Ogunniyi (2019) investigated the association between maternal nutrition related knowledge and child nutrition outcomes in rural Nigeria using Demographic and Health Survey data, applying ordinary least squares regression to examine relationships between maternal knowledge and children's height for age and weight for height z scores. Results showed that maternal nutrition knowledge was independently and positively associated with better child nutrition outcomes, with higher levels of maternal education above primary school level producing significant improvements in both height for age and weight for height scores. The study further found that nutrition knowledge could serve as a substitute for formal education in improving child nutrition outcomes among populations with limited access to schooling, pointing to the potential of informal education channels in addressing malnutrition. The researchers recommended the promotion of adult literacy and out of school nutrition education programmes as practical

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strategies for improving child nutrition in rural Nigerian communities.

Gap in Literature

While the reviewed studies provide valuable insights into the factors influencing child nutrition and effective intervention strategies, most of them are situated outside Kogi State, drawing from contexts in Ethiopia, Uganda, Nepal, and the Eastern Mediterranean Region that may not fully reflect the socio-economic and cultural realities of communities in Kogi State (Ketema, Bosha, & Feleke, 2022; Paudel et al., 2025). The Nigeria-based study by Fadare, Amare, Mavrotas, Akerele, and Ogunniyi (2019) addresses rural Nigeria broadly without capturing the specific community dynamics, cultural practices, and structural barriers that shape child nutrition in Kogi State. Furthermore, existing studies largely examine factors and strategies in isolation rather than exploring how they interact within a single qualitative framework grounded in the lived experiences of caregivers. This study fills that gap by examining the factors influencing child nutrition and identifying context-specific improvement strategies through the perspectives of caregivers and health professionals in Kogi State, Nigeria.

Theoretical Framework

This study is grounded on the assumptions of the Ecological Systems Theory. The theory, propounded by Bronfenbrenner (1979), holds that human development does not occur in isolation but is shaped by a layered set of environmental systems, each nested within the next and each exercising a distinct degree of influence over the individual. The theory is anchored on five such systems: the microsystem, comprising the immediate settings in which the person directly participates, such as the household and the caregiver relationship; the mesosystem, comprising the linkages between those settings, such as the connection between a household and a primary healthcare facility or a social welfare office; the exosystem, comprising settings in which the person does not participate but which affect them nonetheless, such as parental employment, household income, and the design and administration of social protection programmes; the macrosystem, comprising the cultural values, belief systems, and socioeconomic structures that pattern how the inner systems operate; and the chronosystem, which introduces the dimension of time and the accumulation of advantage or disadvantage across the life course. In its mature formulation, Bronfenbrenner and Morris (2006) placed proximal processes, the enduring reciprocal interactions between the developing person and their immediate environment, at the centre of the framework, describing them as the engines of development.

In relation to this study, the theory is most directly engaged at the mesosystem and exosystem levels, since what distinguishes rural from urban disadvantage is not the condition of the household alone but the quality of its linkage to the institutions meant to serve it. Where a household is separated from a health facility by distance, flooded roads, or the cost of transport, the mesosystem has failed regardless of how well the caregiver performs within the microsystem; where a facility is proximate but unaffordable, the failure is located instead at the exosystem, in the income and employment conditions that govern what the household can command. The theory likewise frames the reach of social protection, since cash transfers, feeding programmes, and welfare entitlements are exosystem instruments whose design, targeting, and documentation requirements determine whether support arrives at the household at all, and whose failure to arrive is invisible from within the microsystem. The theory therefore supplies the explanatory logic for the study's central proposition, namely that geographically comparable outcomes in child welfare may be produced by entirely different mechanisms, and that an intervention addressed to one system level will not remedy a failure located at another.

Methodology

The exploratory qualitative research design was adopted for this study to obtain the views of child health, nutrition, and welfare experts in Kogi State, Nigeria, on the research problem. The design was considered appropriate because the study sought to establish not merely whether disparity exists but through what mechanism it operates in particular settings, a question of process that requires accounts of professional experience rather than aggregate measurement (Creswell & Creswell, 2018). The population of the study consisted of child health, nutrition, and welfare professionals with direct oversight of services across the twenty-one Local Government Areas of the state, a state located in the North Central region of Nigeria in which agriculture is the mainstay of the economy and access to healthcare, potable water, and nutrition information remains uneven, particularly in rural communities. A semi-structured interview guide comprising thirteen open-ended questions was used as the instrument for data collection.

Purposive sampling was employed to ensure that informants selected possessed the professional vantage the study required. Seven key informants were selected on the basis of their designation, expertise, and direct working experience with mothers and caregivers of under-five children, comprising the State Nutrition Officer, the Primary Healthcare Coordinator, the Community Health Extension Worker, the Social Welfare Officer, the Maternal and Child Health Programme Officer, the Public Health Officer, and the Environmental Health Officer. They were drawn from the Ministry of Health, the Kogi State Primary Health Care Development Agency, the Ministry of Women Affairs and Social Development, and Local Government health departments in Lokoja, Dekina, and Ankpa, and their combined professional experience exceeds ninety years. This number was considered sufficient because the aim of qualitative inquiry is depth of insight rather than statistical representativeness, and because a small number of interviews can achieve thematic saturation where participants are homogeneous in expertise (Guest et al., 2006). All seven planned interviews were successfully conducted face to face at the informants' offices or other convenient locations and, with their consent, were audio recorded to ensure accuracy in transcription. The credibility of the instrument was established through review by lecturers in the Department of Social Work

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and experts in public health and nutrition research, and the observations arising were duly effected.

The method of analysis was thematic. Recordings were transcribed verbatim, read repeatedly for familiarisation, and coded, with codes grouped into categories and then into themes aligned with the objectives of the study. Verbatim quotations are attributed to assigned identifiers rather than to names in order to protect confidentiality, and are presented under the research question to which each speaks, so that it is clear which informant responded to which issue. Trustworthiness was pursued through the purposive selection of informants occupying different positions within the service system, which permitted convergence across professional vantage points to be assessed, and through the retention of verbatim material so that interpretations remain traceable to the accounts from which they derive. Ethical approval was obtained prior to fieldwork, informed consent was secured from each participant, and participation was voluntary throughout.

Results

This section presents the findings from the key informant interviews conducted with seven experts in child health, nutrition, and welfare services in Kogi State. The interviews were analysed thematically, and the findings are presented in accordance with the research questions of the study. To protect confidentiality, the informants are identified throughout by assigned codes rather than by name, and their verbatim responses are attributed to these codes and presented under the research question to which each speaks.

Profile of Participants

The seven key informants were purposively selected as state and Local Government level officers with direct professional oversight of child health, nutrition, and welfare services in Kogi State. Together they represent the nutrition, primary healthcare, community health, social welfare, maternal and child health, public health, and environmental health dimensions of the service system, and their combined experience exceeds ninety years of practice. This range of designations allowed the study to capture the several interconnected determinants of child welfare rather than a single professional viewpoint. Table 1 presents the profile of the participants.

Table 1: *Profile of Key Informants*

Code	Designation	Institution	Location	Experience
KI-1	State Nutrition Officer	Ministry of Health	Lokoja	14 years
KI-2	Primary Healthcare Coordinator	KSPHCDA	Lokoja	17 years
KI-3	Community Health Extension Worker	LGA Health Department	Dekina LGA	11 years
KI-4	Social Welfare Officer	Ministry of Women Affairs and Social Development	Lokoja	16 years
KI-5	Maternal and Child Health Programme Officer	Ministry of Health	Lokoja	13 years
KI-6	Public Health Officer	LGA Health Department	Ankpa LGA	15 years
KI-7	Environmental Health Officer	LGA Health Department	Lokoja LGA	12 years

Note. KSPHCDA = Kogi State Primary Health Care Development Agency; LGA = Local Government Area. Informants are identified by assigned codes to protect confidentiality.

Research Question One: How do geographic disparities influence children's welfare and nutritional wellbeing in Kogi State?

The informants were unanimous that household income is the single most powerful determinant of child welfare and nutrition, ahead of education, culture, and every other factor, and they consistently subordinated cultural explanation to economic and structural explanation.

> Household income influences almost every aspect of child welfare… When income decreases, nutrition is usually the first area affected. Families begin reducing meal frequency, buying cheaper foods and postponing healthcare. (KI-2)

Upon this shared foundation, however, the informants drew a consistent and clearly articulated distinction between the form disadvantage takes in rural communities and the form it takes among the urban poor. Every informant addressed the contrast, and each did so by pairing a rural example with an urban one drawn from their own professional experience.

> In one rural community in Ibaji… mothers travelled long distances before reaching the nearest health facility. During the rainy season, transportation became almost impossible

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because roads were flooded… In contrast, in Lokoja, health facilities are much closer… However, urban poverty presents another challenge… nutritious foods [are] unaffordable despite their availability. (KI-1)

In a rural community in Bassa LGA… the family lived several kilometres from the nearest health facility… In Lokoja, I handled a case involving an unemployed single mother living in a crowded rented apartment. Health facilities were nearby, but she could not consistently afford food or transportation. (KI-4)

Across the seven informants a clear and consistent structure emerged, expressed independently in relation to Ibaji, Omala, Bassa, Ofu, and Dekina on the one hand, and Lokoja on the other: rural households are constrained principally by physical access to services, whereas the urban poor are constrained principally by affordability despite the proximity of services. The outcome in each case may be comparable, yet the mechanism producing it differs entirely. Where the rural household holds resources it cannot convert into care because the journey cannot be made, the urban household faces care it cannot enter because the means are lacking. This distinction constitutes the study's central finding on geographic disparity, and it corresponds directly to the mesosystem and exosystem levels of Bronfenbrenner's (1979) framework, since it concerns the linkages, or their failure, between the household and the institutions meant to serve it.

Notably, the informants declined to attribute poor child nutrition to cultural belief, describing younger mothers in particular as pragmatic and constrained by resources rather than governed by tradition. Several observed that caregivers frequently knew what their children required but could not obtain it, a reading that locates the constraint in material circumstance rather than in disposition or custom.

Research Question Two: What barriers prevent vulnerable households from accessing available child health, nutrition, and social protection services?

The informants were candid that the families most in need are frequently those least able to reach the services designed for them. Four barriers recurred across the accounts: the cost of reaching services, the absence of documentation, stigma attending the seeking of assistance, and simple unawareness of what exists.

Many mothers tell us they survive from one market day to another. Sometimes they have to decide whether to buy food or pay transport to the health centre. (KI-3)

Some vulnerable families also feel embarrassed to seek assistance because they fear discrimination or social stigma. Others simply do not know which government programmes exist or how to enrol. (KI-1)

Some lack birth registration documents required for certain programmes… Stigma also discourages some caregivers from seeking assistance because they fear being labelled as irresponsible parents. (KI-4)

The barriers described are therefore not confined to the physical or the financial. Documentation requirements exclude households that have never been registered with the state, while stigma operates as a social barrier that no adjustment to programme design alone will remove. That a caregiver must weigh the cost of transport against the cost of food, as KI-3 describes, indicates that the choice presented to such households is not between service and no service but between one necessity and another.

On the reach of social protection specifically, the informants were unanimous that coverage remains inadequate and that targeting frequently fails to identify those most in need.

Cash transfer programmes, nutrition support and other welfare initiatives have benefited some households, but many eligible families are not reached. Sometimes targeting mechanisms fail to identify the most vulnerable households. (KI-1)

This gap between entitlement and access is precisely the paradox that Bywaters et al. (2015) term the inverse intervention law, whereby services fail those who most need them. It is corroborated by the evidence of Ezenwaka et al. (2021), who found that conditional cash transfers improve the uptake of maternal and child health services when they reach households, so that the decisive question is one of reach rather than of instrument.

Research Question Three: What social work intervention strategies can improve child welfare and nutritional wellbeing in Kogi State?

On strategy, the informants consistently prioritised structural and economic measures, delivered through multidisciplinary collaboration, over the provision of information alone. Their accounts situated child welfare within a domain considerably broader than nutrition, encompassing immunisation, protection, supervision, and emotional security.

A child's wellbeing includes healthcare, education, emotional security, protection from abuse, adequate supervision, safe housing and opportunities for healthy development… Some children are left alone throughout the day while parents search for work. (KI-4)

The recurring image of children left in the care of older siblings while caregivers pursue income illustrates how exosystem-level economic pressure penetrates the microsystem of daily care, and indicates why a response confined to feeding advice would leave the greater part of the problem untouched. Asked what social work should contribute, the informants described a role centred on identification, assessment, and linkage rather than on instruction.

From the social work perspective, professionals should conduct family assessments, identify vulnerable children, provide counselling, organise parenting education, undertake home visits, advocate for children's rights and connect families with available support services. (KI-1)

The role proposed corresponds closely to the barriers documented under the preceding research question. Where

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households are excluded by unawareness, the remedy is outreach; where by documentation, advocacy; where by stigma, the sustained relationship that home visiting affords. It likewise corresponds to the constraints documented by Isangha et al. (2024), whose study of child protection social work in Nigeria establishes both the necessity of this role and the institutional fragility, including the non-domestication of the Child Rights Act, that presently limits its exercise.

Summary of Findings

Taken together, the seven interviews converge on a coherent account. Poverty and insecure informal livelihoods are identified as the primary drivers of poor child welfare and nutrition, with cultural explanation consistently declined. Geographic disparity operates through divergent mechanisms rather than a uniform rural disadvantage: rural households are constrained chiefly by physical access to services while the urban poor are constrained chiefly by affordability despite proximity. Child welfare is understood by practitioners to extend well beyond nutrition, encompassing healthcare, protection, emotional security, and safe living conditions. Social protection programmes, though present, do not consistently reach the most vulnerable households, being obstructed by transport cost, missing documentation, stigma, and unawareness. Read through the ecological systems framework, these findings locate the determinants of child wellbeing across the nested levels of household, service system, and structural economy, and they point toward a response acting at several of these levels at once rather than relying upon behaviour change directed at mothers alone.

Discussion of Findings

Research Question One: How do geographic disparities influence children's welfare and nutritional wellbeing in Kogi State?

The answer to this research question is provided in the accounts presented under Theme One, in which all seven informants identified household income as the dominant determinant of child welfare and nutrition, yet described disadvantage as taking two distinct forms according to where a household is located. Rural households, exemplified in the accounts concerning Ibaji, Omala, Bassa, Ofu, and Dekina, were constrained principally by physical access to services, through distance, flooded roads, and the cost of transport; the urban poor in Lokoja were constrained principally by affordability despite the proximity of the same services. This suggests that comparable outcomes in child welfare may be produced by entirely different mechanisms. This further implies that a household may hold resources it cannot convert into care because the journey cannot be made, while another faces care it cannot enter for want of means. This follows the assumptions of the Ecological Systems Theory, which locates such failures at the mesosystem, where the linkages between a household and the institutions meant to serve it either hold or give way, and at the exosystem, where income and employment conditions govern what the household can command (Bronfenbrenner, 1979).

This finding is in tandem with those of Nankinga et al. (2019), who established in Uganda that children whose mothers were engaged in agricultural and manual labour recorded significantly higher odds of stunting than those whose mothers held professional occupations, and that children of mothers working for non-family members faced higher odds of wasting and underweight. The livelihood categories that carried elevated risk in their analysis are precisely those the present informants described as dominant in rural Kogi State, namely subsistence farming and informal trading, which suggests that the rural disadvantage documented here operates partly through the occupational structure of rural economies rather than through location alone. The finding is likewise consistent with Ketema et al. (2022), who found in Bale Robe, Ethiopia, that stunting stood at 39.9% among children of employed mothers compared with 31.3% among children of unemployed mothers, with underweight at 39.9% against 24.0% and wasting at 22.2% against 11.8%, and who attributed the differential to maternal time availability for childcare and feeding. The informants' recurring image of children left in the care of older siblings while caregivers pursue income describes the same mechanism in the Kogi context. The implication is that a uniform intervention will succeed in neither setting, since outreach addresses a constraint the urban poor do not face and price support addresses one that rural households do not principally face.

A further consideration concerns whether improvement distributes evenly once it occurs. Sen and Sengupta (1983), examining rural children in West Bengal, found that the village with the better overall nutritional record exhibited sharper discrimination against female children than the poorer village, demonstrating that aggregate gains do not automatically translate into equitable outcomes within households. Their finding bears directly upon the present study, since it cautions that closing the rural and urban gap in service access would not by itself guarantee that the benefit reaches every child within a household. The informants' emphasis on identifying vulnerable children specifically, rather than vulnerable communities alone, is consonant with this caution.

Equally notable is the informants' consistent refusal to attribute poor child nutrition to cultural belief, describing younger mothers in particular as pragmatic and constrained by resources rather than governed by tradition. This challenges the assumption, common in the nutrition literature, that traditional practice constitutes a major driver of suboptimal feeding. It accords in part with Fadare et al. (2019), who found maternal nutrition knowledge to be independently and positively associated with child nutrition outcomes in rural Nigeria, while also establishing that knowledge could substitute for formal schooling among populations with limited access to education. The informants' position refines this: knowledge matters, but where resources are absent it cannot be enacted, so that attention properly belongs with material and structural constraint.

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Research Question Two: What barriers prevent vulnerable households from accessing available child health, nutrition, and social protection services?

The accounts presented under Theme Two answered this research question, identifying four recurrent barriers: the cost of reaching services, the absence of documentation such as birth registration, stigma attending the seeking of assistance, and simple unawareness of the programmes that exist. That a caregiver must weigh the cost of transport against the cost of food, as one informant described, implies that the choice presented to such households is not between service and no service but between one necessity and another. This suggests that the barriers operating here are not confined to the physical or the financial, since documentation requirements exclude households never registered with the state, while stigma operates as a social barrier that no adjustment to programme design alone will remove. According to the Ecological Systems Theory, these are mesosystem failures, concerning not the adequacy of any single setting but the quality of the connections between the household and the institutions surrounding it (Bronfenbrenner, 1979).

This finding aligns with Bywaters et al. (2015), who term precisely this pattern the inverse intervention law, whereby services systematically fail those who most need them, and who argue that the failure arises from the same structural disadvantage that generates the need. It is corroborated for Nigeria by Ezenwaka et al. (2021), who found that conditional cash transfers improved the uptake of maternal and child health services when they reached households, indicating that the decisive question concerns reach rather than instrument. Ghodsi et al. (2021), reviewing community nutrition-specific interventions across the Eastern Mediterranean Region, reached a convergent conclusion from the delivery side, finding that capacity building at community level produced better outcomes than expert-driven information dissemination alone. Read together, these accounts indicate that both the instrument and its channel must reach the household, and that a programme correctly designed but delivered through facilities the intended beneficiaries cannot enter will not register in outcomes. The implication is that expanding provision without reforming targeting and delivery will reproduce the existing pattern of exclusion.

Research Question Three: What social work intervention strategies can improve child welfare and nutritional wellbeing in Kogi State?

The accounts presented under Theme Three answered this research question, showing that informants consistently prioritised structural and economic measures delivered through multidisciplinary collaboration over the provision of information alone, and that they situated child welfare within a domain considerably broader than nutrition, encompassing immunisation, protection, supervision, and emotional security. The role they proposed for social work, comprising family assessment, identification of vulnerable households, counselling, home visiting, advocacy, and the linking of families to entitlements, corresponds directly to the barriers documented under the preceding research question: outreach answers unawareness, advocacy answers documentation, and the sustained relationship afforded by home visiting answers stigma. This implies that the professional intermediary is not an addition to the service system but the mechanism by which its existing provisions become reachable.

This outcome is supported by Ghodsi et al. (2021), whose meta-analysis found community-based nutrition-specific interventions to produce significant improvement in weight-for-height z-scores, with nutrition education, counselling, and cash-based interventions the most commonly applied strategies and community-level capacity building central to their effectiveness. It accords equally with the informants' call for mothers' support groups and community nutrition champions in place of top-down instruction. The outcome is further consistent with Isangha et al. (2024), whose study of child protection social work in Nigeria establishes both the necessity of this role and the institutional fragility, including the non-domestication of the Child Rights Act across many states, that presently limits its exercise. The implication for Kogi State is that improving child welfare requires not merely more programmes but a strengthened professional capacity to connect the most excluded families to those that already exist, since the instruments are largely in place and the deficiency lies in the linkage.

Conclusion

This study found that child welfare and nutritional wellbeing in Kogi State are shaped primarily by structural and economic conditions rather than by individual behaviour or cultural resistance. Geographic disparity was found to operate through divergent mechanisms rather than as a uniform rural disadvantage, with rural households constrained principally by physical access to services and the urban poor constrained principally by affordability despite proximity, a distinction carrying direct consequences for the design of any response. The barriers preventing vulnerable households from reaching available services were found to extend beyond cost and distance to encompass missing documentation, stigma, and unawareness, so that expanding provision without reforming targeting and delivery would reproduce the existing pattern of exclusion. Informants were unanimous that addressing these conditions requires multisectoral action combining economic support, service strengthening, and community-level engagement, together with a social work capacity directed at identification, assessment, and linkage. The study concludes that sustainable improvement in child welfare in Kogi State depends less upon instructing caregivers than upon connecting them to the entitlements and services from which they are presently excluded, and upon differentiating that response according to whether the binding constraint in a given setting is access or affordability.

Recommendations

The following recommendations are made on the basis of the findings:

1. Health authorities should differentiate service delivery between rural and urban settings, investing in mobile clinics, outreach, and transport or road infrastructure in

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rural communities while prioritising food affordability and cost-waived care among the urban poor, since findings revealed that the two populations are constrained by different mechanisms and would not be reached by a uniform intervention.

2. Government and its social welfare agencies should reform the targeting and enrolment mechanisms of existing social protection programmes, including provisions for households lacking birth registration and other documentation, since findings revealed that eligible families are frequently excluded by administrative requirements rather than by ineligibility.

3. Nutrition programming should be delivered through community-level channels such as mothers' support groups and community nutrition champions rather than through facility-based instruction alone, since findings revealed that the current approach reaches chiefly those caregivers who already attend clinics while missing those most in need of support.

4. Social workers and welfare officers should be deployed to undertake family assessment, identification of vulnerable households and vulnerable children within households, home visiting, and the active linking of families to their entitlements, since findings revealed that stigma and unawareness keep the households most in need away from services that already exist.

5. The Kogi State Government should domesticate and fully implement the Child Rights Act and accord adequate recognition and resourcing to the social work profession, since findings revealed that the professional capacity required to connect excluded families to available support is presently constrained by institutional fragility.

6. Future research should incorporate place of residence as a measured variable alongside qualitative inquiry, so that the magnitude of the rural and urban differential established here in mechanism may also be established in scale.

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