SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

PERSPECTIVES OF MOTHERS ON QUALITY OF COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION SERVICES IN THE WA MUNICIPALITY

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OCTOBER, 2018
DECLARATION

I, Mary Saratu Adamah, certify that this thesis is my own work towards the award of Master of Philosophy degree in Nursing at the University of Ghana, Legon.

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(SUPERVISOR) SIGNATURE DATE
DEDICATION

Praise, honour and adoration onto the Almighty God for this work and to my lovely and wonderful family for the words of encouragement and support.
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# LIST OF Abbreviations / AcronYms

<table>
<thead>
<tr>
<th>CHPS</th>
<th>Community-based Health Planning and Services</th>
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<tr>
<td>CMAM</td>
<td>Community-based Management of Acute Malnutrition</td>
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<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
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<td>IPC</td>
<td>In-Patient Care</td>
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<td>MAM</td>
<td>Moderate Acute Malnutrition</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MUAC</td>
<td>Mid Upper Arm Circumference</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NRC</td>
<td>Nutrition Rehabilitation Centre</td>
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<td>OTP</td>
<td>Out-Patient Care</td>
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<td>RUTF</td>
<td>Ready-To-Use Therapeutic Food</td>
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<td>SAM</td>
<td>Severe Acute Malnutrition</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WFH</td>
<td>Weight for Height</td>
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<td>WFP</td>
<td>World Food Programme</td>
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ABSTRACT

Severe acute malnutrition is still the main risk factor for children five years and below if not appropriately managed. The Community-Based Management of Acute Malnutrition (CMAM) has improved over the years as an effective approach in solving the problems of severe acute malnutrition in children below five years. This means that quality health care delivery is required in order for the CMAM approach to achieve the desired outcome.

The study explored the perspectives of mothers on the quality of community-based management of severe acute malnutrition services in children under five years in the Wa Municipality. The Donabedian model on quality of care was used to guide the study.

A descriptive exploratory qualitative research design was used. One-on-one interviews were conducted using a semi-structured interview guide for data collection. Twelve mothers with malnourished children aged 6-59 months were used for the study. Thematic content analysis was used to analyze the data. The key findings of the study revealed that, the mothers were satisfied with the quality of CMAM services rendered since the condition of their children improved. However, the mothers failed to perceive the condition of their children as nutritional but attributed their condition to spiritual forces. Policy makers should strengthen the health systems to make the quality of CMAM services more effective in order to motivate patronage. Health education in the Municipality should be intensified to help the populace to make informed choices.
CHAPTER ONE

1.1 Background of the study

Nutrition is taking in food to meet the body’s dietary requirement and good nutrition forms the foundation of good health. When the body fails to meet the dietary requirement, malnutrition results (World Health Organization, 2017). Malnutrition generally refers to both under nutrition and over nutrition (World Health Organization, 2017). For this study, we will only consider undernutrition. There are two types of undernutrition which are acute and chronic malnutrition. Acute malnutrition occurs when there is inadequate intake of food resulting in sudden weight loss. Acute malnutrition can be identified as Moderate Acute Malnutrition (MAM) or Severe Acute Malnutrition (SAM) which is determined by the degree of muscle wasting. Severe Acute Malnutrition (SAM) is defined as the presence of bilateral oedema. It can also be a weight to height ratio of at least three standard deviations below the median according to World Health Organization (WHO) growth standards. A child is said to be Malnourished when the mid-upper arm circumference is less than 115 mm. This condition occurs when there is a reduction in the amount of food intake due to food insecurity, poverty, poor feeding practices or conflict. The situation become serious when there are infections which make the condition even worse. This situation leads to a high risk of deaths if not treated appropriately (WHO, 2013). Severe acute malnutrition is the main cause of deaths in children below five years (World Health Organization, World Food Programme, United Nations System Standing Committee on Nutrition, United Nations Children’s Fund, & WHO, 2007).

Worldwide, two billion people suffer from malnutrition; it is also the underlying cause of death of about 2.5 million children each year and one third of death globally. Malnutrition accounts for 11 percent of the global burden of disease and considered the number one risk to health worldwide (Global Alliance for Improved Nutrition - Report,
Children who suffer from malnutrition are susceptible to death and disease and also at higher risk of developmental delays (United Nations Children’s Fund, 2013). Almost 10 to 13 percent of children below the age of five years suffer from acute malnutrition globally. This condition is not only a problem in emergency situations, but it is also common in areas where there is chronic food insecurity, or where health care service is difficult to access. In 2014, less than half of all children below five years lived in lower middle-income countries, and accounted for two thirds of global stunted children. Low-income countries accounted for 15 percent of the global under five population in the same year but one quarter of all stunted children lived in these countries. Within the same period, one quarter of all children below five years lived in upper middle-income countries, yet these countries only accounted for eight percent of all stunted children globally (WHO, 2015). The United Nations Food and Agriculture Organization most recent estimates revealed that in sub-Saharan Africa, 233 million people were hungry and malnourished in 2014-2016. From all the statistics stated above, there has been the least progress toward reducing hunger in sub-Saharan Africa, where more than one in four children remain undernourished, the highest prevalence of any region in the world.

Available statistics from the Ghana Health Service (GHS) indicate that 12,000 children in Ghana die every year of underweight related ailments due to malnutrition. The information also indicates that malnutrition accounts for about half of all child deaths during infancy. About one out of every thirteen children in Ghana die before age five mostly due to malnutrition (GHS Annual Reports, 2012). Many children suffer from health related issues stemming from malnutrition in Ghana which is an underlying cause of one third of all child death and one in five children in Ghana are stunted due to chronic malnutrition. The situation is worse in the Northern Regions where 37 percent of children are stunted due to childhood malnourishment (UNICEF, 2013).
According to World Food Programme Comprehensive Food Security and Vulnerability Assessment (2012), 24.2 percent of people living in Ghana are below the poverty line. Out of the total, 70 percent hail from the Northern, Upper West and Upper East Regions. The three regions in the North has high food insecurity rates which ranges from 10 to 28 percent. Out of every ten households six farms on a small piece of land with low productivity to meet the demand of the family.

In order to address the problem of acute malnutrition, essential treatment is required (Collins et al., 2006). Treatment of acute malnutrition had been limited to facility-based approaches. This limited the coverage and the impact of treatment until recently where children with severe acute malnutrition can be treated in large numbers in their communities without being admitted to a health facility or a Therapeutic Feeding Centre (WHO, 2007).

Community-Based Management of Acute Malnutrition (CMAM) has improved over the years as an effective approach to addressing severe acute malnutrition in children below five years. CMAM classifies Severe Acute Malnutrition (SAM) in children as complicated or uncomplicated. Complicated cases of SAM represent approximately 10–20 percent of children who has no appetite or medical complications such as high fever, severe dehydration, and lower respiratory tract infection. Children with these conditions are admitted and stabilized for 24-hour at the in-patient care (IPC) facilities before being referred to continue with treatment at the decentralized out-patient care (OPC) facilities. Uncomplicated cases of SAM are children without medical complications and have appetite. These children are managed at home with weekly or bi-weekly visits at a nearby health facility (Ayokunle & Odusoga, 2014). The CMAM approach is intended for management of severe malnutrition and to facilitate community capacity development in identifying and managing malnutrition in children. As part of the management of malnutrition all children enrolled receive essential medical care. Community mobilization, follow-up, screening,
counselling, and education of the community members constitute the cornerstone of CMAM. This allows for early detection of children with malnutrition, continuous monitoring the care, and linkages with other services (United Nations Children’s Fund, 2013). In this study, the Donabedian model of quality health care, encompassing the constructs structure, process and outcome was used as a guide to inform the study.

1.2 Problem Statement

Globally, about 52 million children below five years were wasted and 17 million of them, which accounts for about 30%, were severely wasted. The prevalence rates of children with wasting and severe wasting was 7.7% and 2.5% respectively (UNICEF, 2017). About two thirds of these children live in Asia and one third in Africa (UNICEF, 2017). Children in Sub-Saharan Africa were 14 times more likely to die before age five. About 5% of children under five years in Ghana were wasted as indicated by the Ghana Demographic Health Survey (Ghana Statistical Service, 2014). More than one in five children in Ghana are stunted (suffering from chronic malnutrition). The situation was worse in the Northern Regions of Ghana where 37% of children were stunted due to childhood malnutrition (UNICEF, 2011). The Upper West Region has not made significant improvement in the malnutrition situation among children less than five years. Studies done in the Upper West Region indicated that, the prevalence rate of malnutrition in children under five in the Wa Municipality was 15.9% of stunted and 6.8% of severely stunted; 16.7% wasted and 11.9% severely wasted with 11.4% underweight and 6.8% severely underweight (District Baseline Estimates, 2016).

Since poor feeding in the first 1,000 days of a child’s life can cause irreversible stunted growth, with impaired cognitive abilities and reduced performance in school and work, the community-based management of acute malnutrition (CMAM) programme was introduced as the key to a desired outcome in children under five years (UNICEF, WHO,
2012). The community-based management of acute malnutrition is the effective treatment for malnourished children with no medical complications in the community with the introduction of the ready-to-use therapeutic food (WHO, 2006). The effectiveness and success of CMAM as the treatment of severe acute malnutrition in children under five years is well known in both emergency and non-emergency situations (Collins, et al., 2006).

However, statistics from the baseline estimates above that there are malnourished children in the Wa municipality but the treatment coverage for CMAM is as low as 26.4% (MHD Database, 2017). There appears to be an unanswered question and this is; what accounts for the observed low coverage of CMAM services in the municipality? Since the quality and appropriateness of CMAM services is essential for the proper management of severe acute malnutrition, the study sought to explore the quality of services from the mothers’ perspectives. Some studies have been done on CMAM in the Northern and Upper East Regions in Ghana by Saaka, Larbi, Hoeschle-zeledoni and Appiah (2015) and Akparibo (2014) respectively but as far as the researcher is aware, no studies have been done in the Upper West region on CMAM, especially work on the perspectives of mothers on the quality of CMAM, hence this study set out to explore the perspectives of mothers on the quality of community-based management of acute malnutrition to provide knowledge that will help fill the gap.

1.3 Purpose of the study

The purpose of the study was to explore the perceptions of mothers on the quality of community-based management of acute malnutrition services in children under five years in the Wa municipality.
1.4 Objectives

- To determine mothers’ perception about the CMAM programme
- To identify the structural factors that influence the utilization of CMAM services
- To ascertain the processes involved in the CMAM services
- To assess mothers perception concerning the outcome of quality of CMAM services

1.5 Research Questions

In order to achieve the objectives of this study, these questions were formulated

- What are mothers’ perception about the CMAM programme?
- What are the structural factors influencing the utilization of CMAM services?
- What are the processes involved in the CMAM Services?
- What are mothers’ perception concerning the outcome of quality of CMAM services?

1.6 Significance of the study

The findings from this study will inform local implementers of the programme and stakeholders on measures to employ in planning interventions to improve on the quality care of acute malnourished children. Findings will also serve as a source of information for designing and implementing of nutritional programmes targeted at children below five years in specific communities. The research findings will enhance the understanding of health professionals on the perceptions of mothers on the quality of care which will help determine the type of health educational messages required. The study findings will inform the Ghana Health Service and other Non-Governmental Organizations on how to package educational messages on nutrition to mothers during pregnancy and after delivery. The information obtained from the study will also serve as an impetus for further research on CMAM in order to improve child health in the municipal and the country at large.
1.7 Operational definitions

**Perspectives:** A point of view or opinion of a person; it could be a particular attitude towards something.

**Mothers:** Any woman involved directly in the care of the malnourished child

**Quality:** A level or degree of something as measured against expected standard.

**Malnutrition:** Refers to under nourishment and not getting enough of essential nutrients to stay healthy.

**Severe Acute Malnutrition:** The presentation of bilateral pitting oedema or severe wasting due to inadequate food intake.

**Community-based management of acute malnutrition:** A community-based intervention for managing severe acute malnutrition.

**Mid-upper arm circumference:** It is used as an indicator to diagnose acute malnutrition in children 6-59 months.

**Outpatient care:** An outpatient centre where acute malnourished children 6-59 month are managed.

**Ready-to-use therapeutic food:** It is a food supplement, high in protein, minerals and vitamins used for the management of malnutrition.
CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

The chapter discusses the theoretical framework and relevant literature reviewed on the research topic.

2.1 Theoretical Framework of the study

The theoretical framework proposed by Avedis Donabedian (1988) on quality of care was used to guide this study on perspectives of mothers on quality of Community-Based Management of Acute Malnutrition Services. The model illustrates the intuitive relationship among three concepts. Quality of care encompasses three concepts: structure, process and outcome, which are the constructs of the model. Structure is defined as the setting in which health care takes place including the equipment, material and human resources. It refers to the environment, adequacy of the facility, staffing, equipment, safety devices and the overall organization.

Process refers to the set of activities that takes place within and between health care providers and their clients. The activities include diagnosis, treatment, rehabilitation and prevention with an interpersonal component that deals with health education, counselling and decision making. Outcome is the consequences to the health and welfare of individuals. It is the changes in a patient receiving health care. In this model, health outcomes result from the care delivered and patients’ characteristics. It seeks to capture whether the goals of care were achieved and patients’ satisfaction with the care.

The purpose of the framework is to justify whether the assumption that, what is known to be “good” medical care has been applied. This judgement is based on considerations such as the appropriateness and completeness of the care provided and information obtained through correct clinical history, physical examination and diagnostic
investigation. The technical competence of health providers in the performance of
diagnostic and therapeutic procedures, preventive management in health and illness is of
importance. Complications and incidents that may occur during treatment and coordination
between the various stages of the care delivery are considered and acceptability of care by
the patient is what is used to measure whether quality of care has been given. The framework
indicates that, care processes as well as structure influence patients’ outcome as indicated
in the figure below.

![Donabedian Framework on quality of care (1988)](image)

**Figure 1.1: The Donabedian Framework on quality of care (1988)**

### 2.2 Application of theoretical framework to CMAM services

This study considered the structure as competent nurses, attitudes of nurses,
conducive environment, distance, waiting time and working hours. Process encompasses
registration, anthropometric measurement / physical assessment, health education and
counselling, and provision of food supplement (RUTF). The outcome covers client
satisfaction and good or beneficial services.

#### 2.2.1 Structure

The structure relates to the resources of the provider and organizational settings in
which care is provided (Donabedian, 2005). These include competent staff, Attitudes of
nurses, conducive environment, distance, waiting time and working hours. The Donabedian
model has it that, structure affects process and process also affects outcome. Some studies
however show that the structural indicators are not adequate to ensure quality care (}
Bonaccorsi, Collins, Castagnoli, 2015) whiles other studies maintain that, the structural indicators can compromise quality of care (Ebben Vloet, Verhofstad, Meijer, Mintjes-de Groot & Van, 2013, Puett, Coates, Alderman & Sadler, 2013). Positive staff attitudes ensures patient’s compliance with treatment and improved outcomes. This plays a central role in ensuring quality care as it has been seen to influence both the care processes and the outcome of care (Al-Azri, 2008).

2.2.2 Process

The process of quality of care examines the standards of scientific medicine, ethics and values of people (Donabedian, 2005). The process indicates whether what is recognized as quality health practice has been applied (Mariko, 2003). The process is as follows; Registration / Documentation, Physical assessment/Anthropometric measurement, Health education/ Counselling and Provision of food supplement. This is how providers interact with their clients (Donabedian, 2005). Some studies indicate that, processes can significantly influence outcomes (Collins et al., 2006; Ebben et al., 2013). The relationship between health care providers and their clients has been seen as key in ensuring quality of care (Bannerman, Tweneboa, Baah-Odoo & Acquah, 2005). According to Hulton, Matthews and Stones (2007) positive interaction between providers and their clients to a large extent enable the clients patronize the services as well as complying with treatment. Health education and counselling to mothers with children suffering from malnutrition is fundamental to quality health care. This allows the clients to understand what is needed to help bring improvement to the health status of the children among other things. It also allows for clients to make informed decisions about the health of their children (Husson, Mols, & Van de Poll-Franse, 2011).
2.2.3 Outcome

This is where modification in patient’s present and future health status occur. Outcome is considered the most effective indicator of quality care even though some do not consider it as such (Puett et al., 2013). The framework of Donabedian quality of care indicates that the outcome is determined by the process and the structural aspects of care (Bonaccorsi et al., 2015).

Client satisfaction is important in quality health care since it can affect their health status and outcome (Guerrero, Myatt & Collins, 2010). According to Aldana, Piechulek and Al-Sabir (2001) clients’ assessment of care is based on their satisfaction with services that they have received. Studies showed that, satisfied clients usually comply with treatment and follow ups that ensure continuity of health care (Tayelgn, Zegeye, & Kebede, 2011; Ruel & Alderman, 2013). Improving the health outcome of clients is the main concern for quality health care provision. It is expected that the majority of children enrolled in the programme should have their conditions improved as quickly as possible. According to Guerrero et al. (2010) the beneficiary’s satisfaction with the programme is the main component of quality health care, where compliance and prompt participation of the client is key.

2.2.4 Justification of the model

There were several models that the researcher considered during the search for a theoretical framework to guide this study. These included the conceptual framework on child malnutrition by UNICEF (1990), the UNICEF framework on causes of malnutrition (1990), conceptual framework for the management of severe acute malnutrition in children – USAID, conceptual framework on factors influencing malnutrition – UNICEF (1998) among others. The Donabedian model on quality of care was deemed useful and the most appropriate for this study because the model best fitted the study. Given the nature of the
research problem and the contributory factors, the objectives of the study and the study design, the model was found to be the best one that will allow the researcher to identify or tease out all the factors that influence quality of care. It helped to foster a better understanding of the determinants of the quality of CMAM Services.

2.2.5 Studies that used the Donabedian’s model

A number of studies used the Donabedian’s model as a guide (Pomevor, 2013; Liu, Singer, Sun and Camargo 2013; and Adda, 2016). Pomevor, (2013) used the model to guide his study on assessment of the quality of neonatal care in health facilities. He combined two models since according to him, quality care is perceived differently by different people. The opinion of quality care for the health care providers were different from those of the mothers who described quality as how their needs were met.

Liu et al. (2013) also used Donabedian’s model in their study which assessed the quality of care received by patients in an emergency department. The authors found that when one construct is omitted, the model fails to give insight into the deficiencies or strengths to which the outcome might be attributed. A measure of quality of care that includes all the constructs under consideration is reportedly more valid than one that excludes one of these dimensions. The authors identified some disadvantages of the Donabedian’s model which included difficulty in establishing the relationship among structure, process and outcome. They further indicated that, it was difficult to determine whether some factors are strictly part of structure and / or process or outcome as these concepts overlap. The authors modified the model by incorporating another quality domain, the Institute of Medicine (IOM) quality measure.

Adda, (2016) combined the Donabedian’s framework of quality of care with the perspective model in her study on assessment of quality of care on community-based
management of acute malnutrition services. According to the author, the Donabedian model contributed to the understanding of the comprehensive view of quality CMAM care and the perspective model explained how the perspective of quality differs for different stakeholders in the health system. She further explained that, clients perceived quality of services based on their experience with the care they received and how their expectations were met. This has implications for health providers as it will be important for them to monitor these perspectives of quality to sustain the high levels of client satisfaction. Ideas obtained from the Donabedian’s model and other models considered in these studies guided the search for literature.

2.3 Literature Review

Literature review focused on establishing what has been done in the area under study. Databases used to obtain information for the review included, “Science Direct”, “PubMed”, “Sage” and “Google Scholar”. Key words used for the search included a combination of words such as, “Perspectives of mothers”, “Malnutrition”, “Community-based management of acute malnutrition”, Acute severe malnutrition and Management of malnutrition.

The literature review was organized around the following themes most of which were consistent with the constructs of the model; severe acute malnutrition, Community-based Management of Acute Malnutrition (CMAM), quality of care, mothers’ perception of the CMAM programme, feeding practices of mothers of their children, factors influencing utilization of services, perception of mothers on quality of CMAM services and satisfaction with care. The themes are presented in the sections that follows.

2.4 Severe acute malnutrition (SAM)

Severe acute malnutrition is defined using anthropometric cutoffs and clinical signs. The current accepted definitions by the World Health Organization (WHO) are: WHZ< -3
or MUAC < 115 millimeters, or the presence of bilateral pitting edema, or both. This can be classified as Marasmus (severe wasting), Kwashiorkor (bilateral pitting oedema) and Marasmic kwashiorkor (mixed form of bilateral pitting oedema and severe wasting). These indicators qualify a child to be enrolled into the CMAM programme (UNICEF, WHO, 2012). In Ghana however, it is only MUAC that is used to assess wasting and when it measures <115mm in a child who is 6-59 months, it indicates SAM (Bahwere, Akor, Neequaye, & Sagoe-moses, 2011). Children are screened, referred and admitted using MUAC, weight for height and presence of bilateral pitting oedema. Admission can be directly to the Outpatient Therapeutic Programme (OTP), where there are no medical complications and the child is able to eat the RUTF (Kerac, Trehan, Weisz & Agapova, 2012). Before admission of the child, medical conditions are assessed by the health workers to rule out medical complications; appetite, oedema, temperature, respiration rate, vomiting, anaemia, hydration and alertness (Kerac et al., 2012). According to Kerac et al. (2012) after the child has gone through at least eight weeks of care, the child is assessed and discharged after the following requirements are met; weight for height > 85%, no oedema for two consecutive assessments, 15% weight gain for cases admitted based on MUAC or clinically well.

2.5 Community-based Management of Acute Malnutrition

CMAM is a strategy designed for the management of acute malnourished children where triaging is used for case-finding. The CMAM approach is used for malnourished children to receive treatment that best suits their nutritional and medical needs. Most of these malnourished children can be managed at home with a few of them needing in-patient care (Nutrition and Health Department ACF- International, 2005). The approach involves malnourished children who have no medical complications to be managed at home. This category forms the majority to be managed at the outpatient care through the use of
community mobilization and involvement of families of affected children (Collins et al., 2006; WHO, 2007). Community health workers identify and initiate treatment for severe acute malnourished children before the condition becomes serious. Mothers manage majority of these children at home using Ready-to-Use-Therapeutic Foods (RUTF) and routine medication. Children who are severely malnourished with medical complications are referred to the in-patient facilities for intensive treatment and stabilization (WHO, 2007). The majority of severely malnourished children without medical complications could be easily managed at the community level with simple energy dense foods. This could help reduce the risk of cross infections, which could worsen the condition and lead to mortality from severe acute malnutrition due to the overcrowding at the hospital setting (Collins et al., 2006).

The first pilot programme on Community-based Management was in the year 2000 in Ethiopia. In 2002, the programme extended to cover Malawi and a further scale up in Ethiopia in 2003-2004, Malawi and Niger in 2005-2006 all in Africa under emergency situations. In 2005, the United Nations Agencies endorsed the approach of CMAM when there was evidence that 25,000 malnourished children were successfully treated with RUTF. The programme was expanded and scale-up to involve other countries by various agencies, NGOs and Governments (World Health Organization, 2007). Several agencies and governments are now involved in the CMAM programme after the pilots, in both emergency and non-emergency situations. Examples of some of the countries involved in Africa are; Ethiopia, Malawi, Niger, Sudan, Democratic Republic of Congo, Kenya, Somalia, Sri Lanka and others.

The World Health Organization’s (WHO) first protocols for the management of severe acute malnutrition was in the mid-1990s, with the introduction of specialized milks (initially F100 and later F75). With the combination of the specialized milks, the use of
antibiotics and better management of fluids reduced the rate of mortality drastically (Federal Ministry of Health, Ethiopia, 2007). These methods were meant for in-patient care and were predominantly centre-based. The second revolution in the management occurred at the beginning of the year 2000 with the introduction of a decentralized community-based model involving Ready-to-Use-Therapeutic Foods (RUTF). This approach involves management of severe acute malnutrition with the involvement of the community, following an initial period of community sensitization and mobilization (Fmoh, 2007). The main aim of decentralization of the management of malnutrition (not only available in hospital wards) is to improve the treatment coverage above the levels the centre-based management achieved.

With the current evolution, the aim of management targets non-emergency communities with more involvement from governments with management of acute malnutrition that has become a public health concern (Nutrition and Health Department ACF- International, 2005). The CMAM services are provided in various facilities within the MOH/GHS service. The outpatient care are provided in hospitals, polyclinics, health centres, community-based health planning services (CHPS) zones and community outreach points, while inpatient care services are within the hospitals (Bahwere et al., 2011).

2.5.1. Community-Based Management of Acute Malnutrition (CMAM) in Ghana

CMAM was introduced in Ghana in June, 2007 in collaboration with the Ministry of Health (MOH), Ghana Health Service (GHS), World Health Organization (WHO), UNICEF, and U.S. Agency for International Development (USAID). Before then, GHS addressed the needs of malnourished children in Nutrition Rehabilitation Centres (NRCs) that serve children with cooked food using locally available food and also provide counselling. The NRCs did not follow the WHO treatment protocol for the management of SAM or provide specialized therapeutic foods for these children. This made the GHS to adopt and initiate the CMAM approach as a national policy.
After the meeting, CMAM centres were introduced in the Central and Greater Accra regions in 2008 (Bahwere et al., 2011). There was a two-phase national CMAM scale-up in 2009. Priority for inclusion of regions and districts for scale-up considered the prevalence of Severe Acute Malnutrition (SAM) in the area. The availability of financial resources to support CMAM supplies and to rollout activities was also considered (Bahwere et al., 2011). The first phase of the scale-up included Greater Accra, Central, Northern, Upper West and Upper East regions in 2010. In 2012, the second phase of the scale-up was done in the Volta, Ashanti, Eastern, Brong-Ahafo and Western regions. In all, 65 districts as of December 2012 had benefited from the CMAM programme with 756 health facilities, and 8,750 communities gaining access to CMAM services. In order to sustain the integration of CMAM into the health system, various activities were implemented at the national level to support the quality of CMAM service (Bahwere et al., 2011).

2.6 Quality of Care

Many authors have defined quality of care in various ways but the Institute of Medicine’s (IOM) definition as; the degree to which health care provided to an individual or group of people likely to increase the desired health outcomes and treatment should be consistent with current standards (Institute of Medicine, 2001). The aims of a high quality medical care system are;

- Safe – avoiding risk, harm and injuries to patients during the care.
- Effective – providing health care that is based on scientific knowledge to all who are in need to help in improving health outcome.
- Patient-centred – providing health care to a patient taking into consideration the needs and letting the patient’s values guide all clinical decisions.
- Timely – providing prompt and reducing delays when delivering care.
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- Efficient – making best use of resources, avoiding waste when providing health care.
- Equitable – providing quality health care to all no matter the gender, ethnicity, geographic location, and socioeconomic status.

2.7 Perception of mothers about the CMAM programme

This section looked at the views of mothers on the CMAM programme. What their thought are concerning the programme. A qualitative study in Ethiopia by Tadesse, Berhane, Hjern, Olsson, and Ekstro (2015) stated that mothers did not know about the CMAM programme and referred to the programme as food aid programme. The mothers expected that the food supplement (RUTF) should be provided to the children for a long-term. They believed sharing the RUTF with other family members was justified and not sharing was perceived as discriminatory. This made the programme not able to meet the intended objective. In a qualitative study, the CMAM programme was reviewed in the Republic of Sudan. The review revealed that, there was a separation of nutrition services from other health programmes. The nutrition staff focused on measurement of the children with inadequate communication with mothers. The staff were also confused with admission and discharge criteria. This behaviour resulted in a high defaulter rate (Grobler-Tanner & Walsh, 2013). In a study on coverage of community-management of acute malnutrition programme indicated low coverage due to lack of knowledge and lack of awareness about the CMAM programme. The authors found that the impact was lower as coverage and effectiveness are the main component of the programme impact (Rogers, Myatt, Woodhead, Guerrero, & Alvarez, 2015). According to Khunga, Okop and Puoane (2014) in their study on perception of mothers and caregivers regarding the detection and treatment of severely malnourished children in Zambia, the mothers did not know about the causes of malnutrition. They perceived a thin child as being infected by the HIV virus. This prevented them from sending their children for health care because of stigma associated with HIV infection.
2.8 Feeding practices of mothers

This section looks at how mothers feed their children at home, what they give to the children and how often this is done. This includes exclusive breastfeeding, complementary feeding and any other food given to the child. A qualitative study using mothers with children 24 months old by Sunil, Thapar, and Gupta (2017) revealed that, mothers had knowledge on breastfeeding but the will power to practise was a challenge. About 83.7% showed good knowledge on breastfeeding and its related activities and 76.25% had good attitudes towards breastfeeding. The practices of the mothers in relation to breastfeeding showed that 68.75% initiated early breastfeeding and 85% practised exclusive breastfeeding for children under 6 months. The major challenge however, was mothers who did exclusive breastfeeding for 6 months covered as low as 36.25% and about 63.75% of these mothers breastfed their children after one year of age. The reasons for the low coverage of exclusive breastfeeding were not given. This omission could be attributed to the research approach which was quantitative. The use of a qualitative approach would have unraveled the reasons.

A study in Nigeria on mothers knowledge on child feeding showed a significant relationship between maternal nutrition knowledge and feeding practices (Jemide, Enenobong, Edet, & Udoh, 2016). Maternal nutritional knowledge, minimum frequency of feeding and minimum acceptable diet were associated with underweight. These therefore indicated that, poor maternal knowledge on nutrition, child health and sub-optimal child feeding practices predispose to malnutrition in children (Jemide et al., 2016). According to the study, there is an important gap in knowledge about desirable feeding practices of children and where knowledge exists, there ass a gap between the ideal and practice with regards to infant feeding practices (Jemide et al., 2016). In a case control study at the Princess Marie Louise Children Hospital in Ghana on feeding practices and malnutrition reported that, not practicing exclusive breastfeeding for long, poor feeding practices, early
weaning, mixed feeding and intake of fruits predispose children under five years to malnutrition (Tette, Sifah, Tete-donkor, Nuro-ameyaw, & Nartey, 2016). According to the authors, although the use of mashed kenkey (local corn-based meal) was minimal, about one-third of the mothers weaned their malnourished children with plain unfortified fermented maize gruel “known as koko” which both predispose to malnutrition in children. These findings meant that feeding the child appropriately with the right nutrients will reduce the incidence of malnutrition (Tette et al., 2016). The authors found out that, refusal of a child to breastfeed was the reason most mothers mentioned for stopping breastfeeding their children malnourished.

Nonetheless, according to Chuprofski, Tsupal, Furtado and Falleiros de Mello (2012), there was an understanding that, the children’s nutritional status was related to lack of knowledge on the types of food varieties, influence of grandmothers’, complementary food and bad hygiene that led to malnutrition. Getting to know where the children live, the family situation and their values and beliefs will enable the health professional promote healthy eating practices as well as help to reduce malnutrition. The literature reviewed above, gives a comprehensive picture of poor feeding practices of mothers. Does it suggest that the knowledge received by mothers’ breastfeeding and complementary feeding is not adequate to be translated into practice? It is therefore important to educate and encourage mothers to practice proper feeding practices which will help reduce malnutrition.

2.9 Factors influencing utilization of services

These are factors that may influence mothers to either patronize or fail to use the services that are intended for children with severe acute malnutrition. Several factors are noted to have an impact on the utilization of CMAM services. These may include but not exhaustive factors such as, distance, high opportunity cost, long waiting time, competence of nurses, attitudes of nurses, conducive environment and many more. The competence of
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Health care providers is one of the main factors that can influence the utilization of the CMAM services. When mothers have confidence in the health care providers, it motivates them to patronize their services. In a study by Puett, Alderman, Coastes and Sadler (2013) on quality of care for severe acute malnutrition in Bangladesh, the findings revealed that, caretakers perceived community health workers’ services as acceptable and valuable. They reported that, the integration of the treatment of severe acute malnutrition into the community-based health and nutrition programmes appeared to be effective. A study by Pomevor (2013) on quality of neonatal care, found that some mothers expressed their confidence in health care providers. According to the study, the mothers mentioned that the nurses possessed the requisite knowledge and skills needed to assist their babies. Contrary to the observation that health care providers, especially nurses are rude and unfriendly, this study indicated that nurses were kind, respectful, friendly and approachable.

The attitudes of nurses and staff who provide care is a key determinant of mothers accessing services at the health care facilities. Attitudes of health workers was assessed in a study in Nigeria on assessment on CMAM services. The findings revealed that, mothers acknowledged the fact that health workers were polite and patient when providing care. They were also reportedly respectful and do not behave rudely towards them. The perception on health workers’ attitude was good as they were polite to their clients and educated them on good feeding practices and hygiene (Hockenhull, Abdulsalam, Odewale & Aliyu, 2016). A study was conducted in South Africa on Professional Nurses in paediatric wards involved in caring for malnourished children. The study comprised pre and post interventions. Before the training, the attitude of nurses towards malnourished children and their mothers was poor. There was no triaging done and the nurses delayed in admitting children to the ward because most of them felt that malnourished children were not ill like other patients (Puoane, Sanders, Ashworth & Ngumbela, 2006). Knowledge of the nurses were inadequate,
treatment practices were poor and they were not following International guidelines. Severely acute malnourished children needed feeding but the nurses did not consider malnutrition as a condition that warranted treatment and therefore refused to give antibiotics that were prescribed for the children (Puoane et al., 2006). According to, Puoane et al. (2006), the negative attitudes of many nurses towards the mothers and their malnourished children ceased as the nurses adopted positive attitudes after the training.

In a systematic review study by Mannava, Durrant, Fisher, Chersich, and Luchters (2015) on attitude and behaviour towards maternal care, there were documented evidence of negative attitudes of behaviour affecting patient health care seeking, well-being and satisfaction. The review reported that interacting with patients negatively far outweighed positive ones. The factors which influenced health worker attitudes and behaviour suggested that, there were health systems. Workforce development, including communication and counselling skills, which were important were lacking. Greater attention was required for the attitudes and behaviour of health care providers to improve maternal health, for the sake of both mothers and children. A related study in Ethiopia on knowledge attitude and practice concerning malnutrition among health care workers, concluded that health workers had inadequate knowledge on assessment and management of malnutrition in children. The health care workers also used nutritional assessment criteria poorly in clinical setting and overlooked assessment of the nutritional status of children hence their conditions could not be detected and managed as early as possible (Tafesa & Shele, 2015).

The experiences of nurses while working with parents of malnourished children showed that nurses worked with parents of malnourished children in many different ways. The nurses were to guide parents to change their way of thinking and to help parents understand their children's health. Through knowledge, participation and caring
relationship, the parents were given resources by the nurses to take control over their children's health situation (Olsson & Nilsson, 2012).

The health care environment is another factor that can influence health care seeking. To address safety issues, some fundamental changes of the physical environment are necessary. This will enable health care providers and the resources that support them set up for an enabling safe care (Stone, Hughes & Dailey, 2006). The health care environment may have some influence on patient and family perceptions of the quality of care and satisfaction with care received. A study by Mosadeghard (2014) on factors influencing healthcare service quality found that availability of resources affects the quality of service. The study considered quality of healthcare is a production of co-operation between the client and the healthcare provider in a conducive environment. Quality of healthcare depends on personal factors of the healthcare service provider, healthcare organization and the environment. Different factors such as availability of resources, collaboration and co-operation among providers and their clients affect the quality of care and patient outcomes.

A study conducted in Ghana among nurses on quality of nursing care reported that, a conducive environment influences quality of care. The study findings indicated that, the hospital set-up helped the nurses to move freely from one unit to the other to ensure patients received the needed care they deserve (Bour, 2014). According to Aiken, Clarke, Sloane, Lake and Cheney (2008) a carefully designed health care environment helped to achieve high quality of care. A study using mixed methods and carried out in Northern Nigeria mothers reported that the health facilities were clean and had handwashing facilities in place (Hockenhull., et al, 2016).

Distance to health facilities is another factor that affects health care seeking behaviour. It discourages women from making a decision to seek care and also constitutes an obstacle to accessing care after an individual has decided to seek health care. A
comparative qualitative study in Pakistan and Ethiopia revealed that distance was a common factor cited by most women, complicated by cultural factor, poor road network, lack of transportation and weather conditions particularly during rainy season or extreme temperatures (Puett & Guerrero, 2014). It was also mentioned that, distance from the village to the health facility and time taken to travel posed a challenge to most women. The distance varied from 10 minutes to over two hours by car and if one decides to walk because of the cost of transportation, it will take several hours (Hockenhull, et al., 2016). A study on health seeking behaviour and perception of childhood malnutrition and community-based management of acute malnutrition revealed that, mothers living far from the CMAM sites indicated difficulties in getting to the treatment centres during rainy seasons coupled with transportation problems and flooding. Sometimes, visits took the entire day since travelling entails four hours round trip, in addition to waiting for about three hours at the treatment centre, thereby discouraging mothers from visiting the facility (Burtscher, 2015). Al-Ghanim (2004), studied factors influencing the utilization of public and private primary health care services in India. He mentioned that the location of the facility had a negative influence on utilization since distance between the home and health facility is a factor. In a related study on coverage levels and barriers to coverage, it was discovered that, distance was a limitation to access even though the management of malnutrition has been decentralized to primary health care facilities (Rogers, Myatt, Woodhead, Guerrero & Alvarez, 2015).

In a case study to measure patient satisfaction on quality of care at the public health facilities in India, it was reported that the majority of the clients go to the health facility on foot which took them less than 15 minutes to get to the facility. The proximity was what motivated them to patronize the facility (Sodani, Kumar, Srivastava, & Sharma, 2010).
Another factor that can influence utilization is high opportunity cost. Caregivers forego seeking treatment for other important competing demands. Other pressing responsibilities included caring for other family members, harvesting, walking long distance for water among others (Puett & Guerrero, 2014). This becomes a barrier to seeking health care therefore hindering utilization. This barrier for receiving care has been reduced from inpatient care to outpatient care and decentralization of care away from therapeutic feeding centres, but these barriers continue to limit access to utilization of the CMAM programme (Rogers et al., 2015).

Waiting time can also be a factor that can challenge to utilization of health service. Long waiting time at the health facility can affect utilization. This leads to poor perception of the programme and can increase the rate in defaulting (Hockenhull et al., 2016). With regards to utilization of CMAM services in Biraul community in India, some factors identified to influence utilization were categorized into social and cultural factors, availability of transport and proximity to health care facility. Other important factors were cost of transportation, and being able to afford for health care (Burtscher, 2015). In a study by Al-Ghanim (2004) it was indicated that about 70% of participants reported the length of waiting time in the facility was important to influence patients’ choice.

Sensitization on CMAM is another factor that can influence utilization. Studies indicate that, sensitization on the programme where both health workers and community volunteers educated the community on the importance of CMAM and nutrition in general influenced utilization. A high awareness of health and nutrition among community members increased treatment seeking behaviour which enhanced utilization (Hockenhull et al., 2016). However, Roger et al., (2014) in a descriptive study of coverage levels and barriers to coverage suggested lack of awareness on the programme on malnutrition as a challenge to coverage and utilization. The persistence of lack of awareness suggest that, effective
engagement with beneficiaries was lacking. This therefore suggested that, strengthening community sensitization activities remained key to increased utilization.

From the above, it is obvious that, distance from, and poor accessibility to facilities adversely affect the utilization of services. The stereotyped traditional roles of women in most low-income economies coupled with long waiting hours which affect other important economic activities as well as inadequate publicity have impact on the utilization of CMAM services.

2.10 Perception of mothers on quality of CMAM services

These are the views of mothers on activities of CMAM at the clinic where services are rendered to their malnourished children. A study in Nigeria on quality of CMAM reported that, most of the mothers were of the view that, the CMAM programme was good and less expensive for one to send the child for services. However, a few of the mothers did not recognize malnutrition as a problem and blamed the mothers for the condition of their children. The study found that mothers acknowledged the fact that, the CMAM programme was free and effective in curing child malnutrition. They also mentioned the consistent supply of the Ready-to-Use Therapeutic Food (RUTF) though there could be occasional stock out with other routine drugs (Hockenhull et al., 2016).

However, a qualitative study by Muraya, Jones, Berkley and Molyneux (2016) on the perception of childhood undernutrition among rural households on the Kenyan Coast revealed that, perception of childhood illness and gender roles with household activities have an important influence on recognition and management of undernutrition. The study findings from Muraya et al. (2016) found that moderate malnutrition was not recognized as a health problem that aroused concern and require action. According to them, mothers were likely to bear the blame for their children’s poor health. Gender was key in the discussion of causes of childhood illness associated with malnutrition and management. Mothers were
perceived to have primary responsibility for ensuring that their children were of good health. The mothers identified providing nutritious food for their children, guaranteeing sufficient and appropriate breastfeeding and maintaining adequate child spacing could prevent malnutrition. They did not think there was the need to seek medical assistance when children were malnourished. Assessment of the quality of community-based management of acute malnutrition in Ghana using the mixed method revealed that, mothers perceived quality of services delivered as satisfactory. The study recorded 62% recovery rate which was below the acceptable Sphere Standard by the World Health Organization 75% and above (Adda, 2016).

The above studies clearly reveal that, quality of healthcare is necessary for optimum recovery and from the literature reviewed, there seem to be multiple perceptions of clients about quality.

2.11 Satisfaction with services

Satisfaction with services provided has been indicated to be a sensitive tool used for measuring quality of service within and outside the health system.

Clients’ satisfaction with health care is an integral component of quality monitoring in health care systems (Campbell, Olufunlayo & Onyenwenyi, 2010). Quality of health care can be defined to include characteristics such as efficiency, effectiveness, equity, accessibility, comprehensiveness, acceptability, timeliness, appropriateness, continuity, privacy and confidentiality. Abodunrin, Adeomi and Adeoye (2014), who researched on clients’ satisfaction with quality of health care using mothers attending infant welfare clinic in Nigeria stated that the majority of mothers were generally satisfied with the services rendered by the health care providers. These included treatment of their children, health education and registration processes. They were however, not satisfied with the non-availability of some amenities and the level of sanitation in the facilities.
A study by Al-Balushi and Al-Abri (2014) on satisfaction survey as a tool toward quality improvement provided explanation on some factors that determine patient satisfaction. The authors compared the degree of the effects of various independent healthcare dimensions on overall patient satisfaction. The study found that the mothers were satisfied with interpersonal skills in terms of courtesy and respect by health care providers. The mothers also mentioned that the way health care providers communicate with and explain information clearly to them was more important than other skills and clinical competence with equipment in the hospital. In a related study on measuring patient satisfaction to improve quality of care at public health facilities in India, it was found that, the patients were more satisfied with the basic amenities at the higher health facilities compared to lower level facilities. It was also observed that the patients were more satisfied with the behaviour of doctors and staff at the lower level health facilities compared to the higher level facilities.

2.12 Summary of the literature review

Extensive review of literature revealed that, much work has been done on community-based management of acute malnutrition. From the literature reviewed, CMAM has been adopted globally to serve as the panacea for malnutrition and related problems. This suggests that, most malnourished children can be rehabilitated at home with only a small number of mothers with malnourished children needing to travel for in-patient care. The majority of severely malnourished children without medical complications could easily be managed at the community level with simple energy dense foods. Almost all the studies reviewed on perception of mothers on quality care were quantitative studies and were conducted outside Ghana. The few studies conducted in Ghana employed either quantitative or mixed methods. Although many studies have been carried out on quality of care in relation to community-based management of malnutrition, most of them were on health
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worker/providers and little was done to explore the perspectives of mothers. There is an obvious gap hence this study sought to explore the perspectives of mothers on quality of community-based management of acute malnutrition to help improve the quality of health care delivery and add to the existing body of knowledge through qualitative research.
CHAPTER THREE

METHODS

3.0 Introduction

This chapter describes the methods that were used in this study to elicit from mothers their perspectives on quality of community-based management of acute malnutrition (CMAM) services in the Wa municipality. The various sections discussed under the methods included; the research design, the research setting, target population, sample size, sampling technique, data collection, data analysis and ethical considerations.

3.1 Research Design

Research design is the strategies used by researchers to enable them answer research questions (Polit & Beck, 2010). It is the plan or blueprint used to get valid and reliable answers to research questions. The design could also be the protocol or programme for a research study. The study employed a descriptive and exploratory qualitative research design. This helped to elicit the views of participants on the phenomenon being studied. Qualitative methods help to understand issues happening in the social world (Curry, Bonaccorsi, Castagnoli, Collini, Nembhard & Bradley, 2009). The qualitative approach is most appropriate in this study as it is more concerned with personal subjective meanings and takes place in a natural environment. It is also largely descriptive and will provide more in depth insight into the problem. The exploratory design helps to present the world view of the phenomenon from participants’ point of view (Brink & Wood, 2001). The design is also descriptive because, it involves accurate and objective representation of characteristics under study (Polit & Beck, 2010).
3.2 Research Setting

Research setting refers to the physical location and conditions in which the data collection takes place (Polit & Beck, 2010). The study was conducted in the Wa Municipalidad which is one of the three Municipalidades in the Upper West Region. Wa Municipalidad is one of the 11 Districts that make up the Upper West Region (UWR) of Ghana. The municipal administratively shares boundaries with the following Districts; to the north, Nadowli-Kaleo, the east, Wa East and to the West and South by Wa- West respectively. The Regional capital of the Upper West Region is Wa which happens to be the capital of the Wa, Municipalidad. It has a projected population of 120,032 with 24% being WIFA and 16.5% of the population being children aged 6-59 months. Approximately, the municipal has a land area of about 579.86 square kilometres and governed by the Local Governance Act of 2016, ACT 936 as the highest political and administrative body. The Municipalidad has 123 communities, six sub districts with a total of 26 government health facilities including Community-Based Health Planning and Services (CHPS) Compounds and four private facilities. The Municipalidad also has three Hospitals, six Health Centres, 22 Functional CHPS Zones, four Clinics, 15 Completed CHPS Compounds, one Adolescent Health centre and four Private Health Facilities. The Municipalidad has 264 Community Based Agents who help the sub district staff to carry out community based activities.

The Population and Housing Census conducted in 2010 showed that 80.4 percent of the population in the Municipalidad comprise of the Waalas being the indigenous people, the Dagaabas and Sissalas. These people inter-marry and this has removed language barriers among them causing them to peacefully co-exist. However, the differences between the groups is the adoption of the various religious groups where Islam is professed by the Waalas and some Sissalas and Christianity by the Dagaabas.

Agriculture sector has dominated the economic activities where most people mainly
farm to earn their living in the Municipality. Most of them are peasant farmers and the main crops they grow include maize, millet, sorghum, rice, cowpea and groundnut on subsistence basis. However, soya beans, groundnuts, and bambara beans are produced as cash crops. Sheanut, Dawadawa, Mango, Baobab, and Teak among others are economic trees within the municipality. Though the Ghana Statistical Service indicates that more people are employed, the majority of the people in the municipality are unemployed. This reflects the high level of poverty in the area and their inability to provide adequate food for the family and also pay for the health care services offered.

3.3 Target population

The target population for the study consisted of all mothers with children aged 6-59 months. These children should be malnourished and should have been residing in the Wa municipality for not less than six months prior to the study.

3.3.1 Inclusion criteria

- Mothers with malnourished children 6-59 months old who are accessing CMAM services at the clinics within the Municipality.
- Participants should be resident in the Wa municipality not less than 6 months prior to data collection and who have accessed the services for not less than four times. The study sought to explore the perspectives of mothers on CMAM services hence participants must have had some experience to be able to provide enough information.
- Participants should be able to speak English, “Waali” and “Dagare” (local languages) because the researcher is fluent in these languages.
- Participants should be directly involved in the care of the child and be willing to participate in the study.
3.3.2 Exclusion criteria

- Women with malnourished children 6-59 months who were not accessing CMAM services and had not lived in Wa Municipal for at least six (6) month.
- All non-consenting mothers were excluded.

3.4 Sample size

Unlike the quantitative approach, there is no specific formula for calculating sample size in qualitative research. The important aspect is that the sample should be large enough to be able to obtain feedback from most or all perceptions. Participants were interviewed until no new information was obtained. Data saturation was reached after interviewing the twelfth participant. The researcher observed that there were no new concepts emerging from the interview and stopped the interview after the twelfth participant.

3.5 Sampling method / technique

Sampling is the process of selecting a portion of the population to represent the entire population (Polit & Beck, 2010). This study employed purposive sampling technique to recruit mothers. Purposive sampling was used because participants had the characteristics needed to give the researcher the most and best information. They were people from whom one could learn greatly about the phenomenon being studied (Mayan, 2009). After obtaining ethical clearance from the Noguchi Memorial Institute for Medical Research and the Ghana Health Service Ethics Review Board, an introductory letter from the School of Nursing and Midwifery was sent to the Regional Health Director for permission to conduct the study. A letter was obtained from the Regional Health Directorate to the Municipal Director for assistance. The researcher was introduced to the Municipal Health Officer in charge of CMAM services by the Municipal Health Director. The officer in charge of CMAM assisted the researcher to access facilities providing CMAM services in the municipality. Four of
these facilities were recommended by the officer which he mentioned had substantial number of mothers with malnourished children. The facilities were visited by the researcher to familiarize herself with the staff and the purpose of the research was explained to them for their cooperation. With the help of the staff the researcher obtained the telephone numbers of the mothers who were then contacted on telephone. The mothers were informed that, the researcher was a student and conducting a study on CMAM services and would need their assistance. The mothers agreed to take part in the study therefore the researcher scheduled to visit them either at home or at the clinic depending on the mother’s choice. The mothers were briefed on the purpose and importance of the study by the researcher. They were also made to understand that, they were only required to offer their views on the phenomenon being studied. Mothers were informed that, participation was voluntary and one was at liberty to opt out of the study when necessary. They were assured that failure to participate in the study will not have any negative consequences on them when they go to seek health care at the facility. Participants were also informed about the topic for discussion, which was the perspectives of mothers on quality of CMAM services. Participants were informed on how data will be collected; this was through one-on-one interviews and was recorded using an audio recorder in order not to miss out on any information provided. They were assured that the information provided will not be used for any other purpose besides academic work and it was not going to be made available to anyone besides the researcher and the supervisors. The mothers were informed that confidentiality and anonymity would be ensured by assigning codes instead of names to transcripts. The study was conducted in a safe and serene environment, so there was minimal risk or potential harm. Participants were made aware there were no direct benefits but the findings of the study will help policy making which will help improve service delivery. A convenient date, time and venue which were conducive for the participants were agreed
upon for the interview.

3.6 Data Collection

An introductory letter was obtained from the School of Nursing and Midwifery, University of Ghana, to the Municipal Health Directorate to seek for permission to use the facility for the study. One-on-one interview technique was employed for data collection for this study. A semi-structured interview guide was used to elicit responses from mothers who met the eligibility criteria. Prior to the day of interview, the researcher ensured the recorder was functioning properly to be able to record what was discussed. Mothers were contacted to remind them of the day, time and venue of the interview. Interviews were conducted at a place of choice of the participants. Before the interaction, the purpose and nature of the study was explained to the mothers and they were encouraged to express their opinions on the issues without hesitation. The mothers were informed of the duration of the interview and the audio recorder was showed to them prior to the interview and their permission was sought for the discussion to be audio recorded to enable the researcher capture all that was discussed. They were given the chance to ask questions for clarification. Upon explaining the purpose of the study to their level of understanding they consented to participate in the study and were given consent forms to thumb print or sign based on their ability to do so. The interviews were conducted in English, “Dagare” and “Waalii”. The two languages besides the English language are local languages of the participants and the researcher is fluent in them. However, she employed the services of a teacher in the local language who carried out a back translation to ensure the transcription was valid. Each of the interviews lasted between 45-60 minutes. The researcher listened with interest and wrote down important points but probed further for clarification when there was the need. Participants were assured of confidentiality and anonymity and they were all relaxed during the interview due to the initial establishment of rapport.
3.7 Pre-test of interview guide

A pre-test was conducted with two participants who fell within the inclusion criteria at the Dobile health centre. The essence of the pre-test was to enable the researcher to test the voice recorder to be used for the main interviews as well as to assess whether the interview guide would actually measure what it was expected to measure. The findings from the pre-test guided the researcher to amend the interview guide to enable her collect credible data for the actual study. This was done because, during the pre-test a few questions were not clear and had to be reframed.

3.8 Data Management

To ensure confidentiality, all transcribed data, field notes and documented information given by the participants were stored in a cabinet under lock and key in the researcher’s office and this will be kept for at least five years and made available only to the researcher’s supervisors. The transcribed data were labelled and saved in files on the researcher’s personal computer which can be accessed only by the researcher. Storage for this duration implies that these documents can easily be retrieved for legal purposes and until such time, they cannot be deliberately destroyed.

3.9 Data Analysis

The purpose of data analysis is to organize, provide structure to and elicit meaning from data (Polit & Beck, 2010). Thematic content analysis was used to analyse the data. Content analysis is the process of organizing and integrating narrative qualitative information according to emerging themes and concepts. It involves data reductions, data display, conclusion drawing and verification (Miles & Huberman, 1994). The data analysis was conducted concurrently with data collection through interviews. The recorded interviews were played and replayed and transcribed verbatim with the researcher listening...
carefully to the responses. The interviews conducted in the local languages were transcribed in English by the researcher. Following this, a professional teacher in the local language conducted a back translation to ascertain credibility and to ensure it depicted what the participants meant. The researcher read through the data repeatedly after transcription to be familiar with and to understand the data gathered. The data was then coded manually. Coding is the process of organizing, sorting and the basis for developing data analysis (Saldana, 2012). The transcribed data was coded in the order in which the interviews were conducted. The transcribed interviews and field notes were printed with margins. The researcher and supervisors discussed and analysed the first two transcribed interviews before the subsequent ones. Data was examined for similar ideas, words and phrases which were used to generate codes. Words, phrases and concepts of importance were noted in the margin. Similar codes were summarized into themes and subthemes. A thematic framework was developed where the subthemes were listed and meanings given to each with abbreviations to identify each subtheme. Using the thematic framework, the entire data set was coded and findings that fit the description of each subtheme were copied and pasted in a separate file in the computer. The findings were then described in detail using the themes and sub-themes to make meaning.

3.10 Ensuring Rigour

Qualitative researchers aim to design and incorporate methodological strategies to ensure trustworthiness of findings (Polit & Beck, 2010). Lincoln and Guba (1985) proposed trustworthiness with its attributes as; Credibility, dependability, transferability and confirmability. In order to achieve credibility, the researcher purposively selected participants who met the eligibility criteria and could best provide in-depth information on the issue under study. A good rapport was created in order to build a trusting relationship with participants to ensure they give credible information. There was also prolonged
engagement with participants, spending considerable amount of time in the setting to collect accurate data. A very good recorder was used to collect the data and a field diary was also used. A pre-test of the interview guide was done to ensure it measured what it was intended to measure. The data transcribed from the local languages into English was back-translated into the local languages by a teacher in those local languages for purposes of credible.

Dependability was assured when all procedures and processes used to conduct the study were accurately documented. The researcher ensured that decisions and choices made during the study were clear and transparent to enable others to be able to replicate, where necessary.

Confirmability were ensured by the researcher through audit trail. An audit trail comprises a variety of research decisions that must be consistently and consciously recorded and skillfully organized throughout the research process (Mayan, 2009). Immediate recording of spontaneous notes, ideas generated during planned analysis and note-generation sessions were ensured. During analysis of data, collected data were synchronized with other study data and literature was reviewed to obtain hunches and different perspectives about the data. The interview recordings, transcribed data and field notes which served as an audit trail for an objective assessment and confirmation of documented information were made available.

To ensure transferability all that transpired during the study including interviews, the design, setting and data collection among others were clearly documented. This was done to enable other researchers apply in their setting where necessary. A rigorous presentation of the findings together with appropriate quotations were documented to enhance transferability.
3.11 Ethical Considerations

Ethical issues are basic principles that should be considered when conducting research. These include ethical clearance, privacy and confidentiality, consent, benefit or harm. As a researcher, the following principles must be observed to ensure proper ethical consideration. Ethical clearance was obtained prior to data collection from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research (NMIMR), University of Ghana and the Ethics Review Committee of the Ghana Health Service for approval to enable the researcher conduct the study in the facilities. Permission was sought from the Regional Health Directorate and Municipal Health Directorate to enable the researcher to conduct the study within the municipality. Participants for this study were recruited purposively and were informed about the purpose and nature of the study. They were informed that participation was voluntary and that they were free to withdraw from the study at any time.

Privacy and confidentiality were ensured by interviewing each participant alone and holding all information provided confidential, not making it accessible to others. Confidentiality and anonymity of participants was ensured by assigning codes instead of names. Participants were informed that some of their comments would be mentioned in the report of the study or any presentation related to the study but their names would not be used. They were assured that the information provided would not be used for any other purpose besides academic work and would not also be made available to anyone besides the researcher and the supervisors. The study was conducted in a safe environment, therefore risk or potential harm was minimal. Participants were informed there would not be direct benefits to them but the findings of the study will help with policy making that would improve on the quality of service delivery to them and other users of the facilities. Those who agreed to participate in the study were given the information sheet to read and further
clarification given by explaining to them what was stated on the form. However, those who could not read had a witness read and explain the contents of the form to them with clarification from the researcher. The mothers who were willing to take part in the study were asked to sign or thumb print the consent form showing their approval.
CHAPTER FOUR

FINDINGS OF THE STUDY

4.0 Introduction

This chapter describes the findings of the study conducted in the Wa municipality on perspectives of mothers on quality of Community-based Management of Acute Malnutrition (CMAM) services. Data was generated by interviewing participant on CMAM services and thematic content analysis used to analyze the data. Five major themes emerged from the data analysis with their corresponding subthemes. Three of the major themes were consistent with the constructs of the model on quality of care. Data analysis yielded other information outside the model used to guide the study which are; mothers’ beliefs on causes and management of acute malnutrition and mothers’ reasons for patronizing CMAM services and sources of referral. The information yielded outside the model would be presented first followed by the information from the model.

4.1 Demographic characteristics

Twelve mothers took part in the study with 11 being the biological mothers of the children and one a foster mother. All the mothers had children who were malnourished and aged between 6 – 59 months. The ages of the mothers ranged from 19 to 36 years. The mothers had different educational background with only one not having any formal education. Four of the mothers had only basic education, six had senior high education and one had tertiary education. The majority of mothers were married and living with their husbands and two of the mothers were not married. Out of the 12 mothers, three were hairdressers, two seamstresses, one teacher, one conductor with the metro mass transport and five engaged in petty trading. The number of children of mothers ranged from one to three with those in the polygamous marriages having other children from the other wives.
Eight of the mothers professed the Islam religion with four professing Christianity. From the data analysis, five major themes emerged with their corresponding sub-themes.

Table 4.1: Major Themes and Sub-Themes

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Sub – Themes</th>
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<td>Mothers’ beliefs on causes and management of acute malnutrition.</td>
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<td></td>
<td>• The spiritual understanding of mothers concerning the child’s problem.</td>
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<td>Mothers’ reasons for patronizing CMAM services and sources of referral.</td>
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4.2 Mothers’ beliefs on causes and management of acute malnutrition

This major theme explored the various beliefs that mothers and caregivers of children with acute malnutrition had on the causes and management of the condition. It was clear from the interaction that, there were diverse understanding of mothers concerning the causes and management of acute malnutrition. This led them to go to so many places in search for solutions to the child’s problem. They had various health seeking behaviours that necessitated them to go to various places in an attempt to get solution for the condition. Some of the mothers thought it was just an ordinary sickness and hence took the children to
the hospital and health centres. A few of the mothers also believe the condition of the child was as a result of spiritual attacks which led them to seek divine interventions. Some of the mothers also relied on traditional preparations and remedies to solve their children’s problem. From the data analysis, three sub-themes emerged from this major theme as follows: health seeking behaviour of mothers with malnourished children, mothers’ perception of spiritual dimension of malnutrition and the use of traditional medicine to manage child’s condition.

4.2.1 Health seeking behaviour of mothers with malnourished children

Participants of this study had genuine problems with their children’s condition but did not know where to go for assistance. In the search for solutions for their children’s condition, almost all the participants initially sent their children to the hospital and health centre for treatment, but there was no improvement in the children’s condition. One of the participants had little knowledge as to where to send the child so she decided to keep the child home without seeking any medical attention until she was advised by some nurses who went on home visit within her area to send the child to the clinic. This was how she expressed and shared her experience:

“The way my child was, I did not know what to do so I saw some nurses going round giving children medicine, so I brought my child out to show to them for some assistance and they said, the way the child was, I will have to bring him to the clinic”.

M 6

Another mother recounted how she had to go to so many places in the quest to getting a solution to her child’s sickness. After sending the child to the hospital for treatment without any improvement, she decided to seek help from a herbalist which also did not solve the problem. She had this to say:
“*We took him to the hospital for treatment several times and when there was no improvement, we went to an herbalist for some local medicine but finally we were referred to the clinic*”.

M 8

The herbal preparation could not solve the child’s condition so they were referred to the CMAM clinic for management. The difficulty on the part of some of the mothers in seeking proper management and cure for their children was reportedly due to the fact that they lacked knowledge and the appropriate information on the child’s condition and how to manage the condition effectively. A mother lamented that:

“I really do not know the cause because I was not told. The child was sick and admitted at the hospital and later discharged and that started the whole thing. The child will not eat and the weight started dropping that made me to seek for treatment at the clinic”.

M 10

Lack of knowledge on the part of mothers on the causes and management of acute malnutrition made them attribute the condition to other factors.

4.2.2 The spiritual understanding of mothers concerning the child’s problem

The mothers had different views regarding the child’s condition. About half of the mothers who took part in the study demonstrated their lack of knowledge regarding the causes of the condition but rather believed that, their child’s condition was as a result of spiritual influence. This made them to wait upon God to expose whoever was behind the act and to heal the child. Some of them had to rely on some form of divine intervention for the healing of the child. Some of the mothers had to consult with the spiritualist or herbalist for a spiritual intervention and still a few of them relied on both God and the herbalist for the solution of their child’s condition. Below is what a mother had to say:
“I thought someone was doing me so I kept praying to my God to expose the person and to heal the child. I also prayed that, I should not be thinking negatively about myself and the child but I should rather think positive for God to intervene”.

M 2

Mothers had to seek God’s intervention by praying and positively thinking about the child’s illness. A mother indicated that, after sending her child to many places to seek help for her child’s condition with no improvement, she eventually left everything in the hands of God and tried in her own way to do what she could to help restore her child’s health. This was how she described her experience:

“After going through all these, you will have to leave everything in the hands of God and also do your part by treating him with all seriousness so that at the right time, God will heal him”.

M 8

Few of the mothers had superstitious beliefs about the cause of their children’s illness. A mother mentioned that, the grandmother of the child went to explain how the child was to a herbalist who gave them some herbs to give to the child. The mother narrated how the child got the sickness and how he looked like. According to the mother, the child cried a lot and refused to breastfeed or eat. It was said that this condition is acquired when the child is in the uterus of the mother. It is believed that when a woman sees a child with this condition while pregnant, she will also deliver a child with it or when a child with this condition is bathed and the water is poured outside and a pregnant woman steps in the water, that woman will also give birth to a child with that condition.

“The child gets the sickness while he is still not born. When a woman is pregnant and sees a child with this sickness or you cross the water used in bathing the sick child, you will give
birth to a child with the same sickness who cries a lot refuses eat and looking very same and tiny”.

M 4

A participant also belief that, her child’s condition was as a result of been possessed by a spirit from a monkey. She attributed it to some hunters who have been passing in front of her shop with monkeys and believed that the child might have been possessed by the monkey. This is how she narrated her suspicion:

“I was told that where I sit to sew, was not a good place to sit. Hunters normally pass through that road when going for hunting and that they had monkeys and other things that they carry along when passing so it was one of the monkeys that entered into the child. This boy used to behave like a monkey by coiling himself and will not straighten up so they said it was the monkey that was in him. This time, we had to go for a different medicine to bath him for seven days and after the seventh day, he changed”.

M 3

These beliefs made the mother go from one herbalist to another in search for a solution to the problem. Some significant others of the participants also had their own beliefs concerning the children’s condition. In the setting where the study was conducted, most of the people believe in the external family system and mothers in-law have much influence regarding the health seeking behaviour of their sons’ wives and grandchildren. Another mother narrated how she was advised by others in the family to abandon and kill her child because they believed the child was a snake and not a human being because of the way the child was.

“Some people even said my child is not a human being but a snake so I should send him to the spiritualist to kill him for me so that I can give birth again but I refused and told them I will keep him till anytime God wants to take his life. It was him who gave me so if he is taking him, then that is all”.

M 8
4.2.3 The use of traditional medicine

Almost all the mothers interviewed first sent their children to the hospital or health centre at the beginning of their condition. However, some of the mothers claimed they did not see any changes in their children’s condition while on admission in the hospital so they sought a second opinion with traditional medicine to support the orthodox treatment. A few of the mothers in their frustrations, resorted to using traditional medicine themselves with the perception that the traditional medicine will be able to help them produce enough breastmilk which they can use to manage the child’s condition. This was expressed in various forms by mothers. Here is an account from a mother:

“I normally ask for permission from the nurses in the ward to bath the child with the local medicine outside but I promised them I will not give him some to drink”.

M 3

Some mothers also resorted to the use of traditional medicine themselves with the hope of getting the right amount of breastmilk for the child which would help solve the child’s problem. They mentioned that, after using the traditional preparations, it was helpful because the breast milk started flowing for the child to breastfeed.

“It was some herbs the man pounded and I do not know whether he recited some words or what, after which they put in water and gave me some to drink and also some to wash the breast so that whatever is in the breast preventing the milk from flowing will disappear for the milk to come for the child to suck”.

M 7

Few of the mothers indicated that they used some traditional medicine in the form of herbal preparations. They believed that the herbal medicine was helpful in the improvement of their children’s condition. However interacting further with the mothers, they indicated that using the traditional medicine on the breast affected breastfeeding
because it made the nipple bitter. Even though the traditional medicine was intended for a good purpose, it affected the child’s ability to breastfeed.

“The medicine man brought some medicine for both myself and the child. With mine, I was asked to use and wash my breast because breast milk was not flowing but with that of the child, I was to bath him with it. When we boiled the medicine, we were asked to use it for seven days and thereafter, there were actually changes. The changes started from the fifth day and by the seventh day, those things that made him look different from human were no more”.

M 3

4.3 Mothers’ reasons for patronizing CMAM services and sources of referral

There were various reasons why mothers sent their malnourished children to the clinic for the community-based management of acute malnutrition (CMAM) services. Some of the reasons that were mentioned for sending these children to the clinic were for treatment because the children were seen to be sick and needed some medical care. Some of the children refused to eat or breastfeed and a few of the mothers said their children were not growing as expected because the weights of the children were not increasing and sometimes reduced. Two sub-themes emerged from data analysis and these were; needing help with child feeding and poor child growth / “small baby”.

4.3.1 Needing help with child feeding

From the data, participants had inexplicable problems with child feeding. The mothers did not know what to do and had to contact the nurses on how to feed their children. A vast majority of mothers did not know the variety of complementary food to give to their children. A few of the mothers did not have breastmilk to feed the children while others did not have enough. This made them introduce artificial feeding and a few of the mothers practiced mixed feeding. These mothers could not sustain the artificial feeds because they
were expensive and mothers could not afford to buy. These were some accounts of mothers regarding the difficulties they went through. This is what a mother said:

“I needed help as to how to make my child eat. Well the nurses saw the child and realized that the child needed help and I also want the child to be healthy and so when they asked that I follow them to the office, I knew they were going to help me, so I agreed to go with them”.

M 4

It was also observed that inexperience on the part of some mothers on child feeding was the challenge. A mother lamented on how she had problems feeding her child. She said, she was not having enough breastmilk and could not afford to buy the artificial feed. According to her, she had complained to the nurses at the child welfare clinic where the nurses constantly told her the weight of her child was not increasing. As this mother was narrating the difficulties she was going through with feeding the child, she shed tears showing her frustration.

“I had to struggle with him to eat even the food I collected from the clinic, I struggled with one sachet but he was not able to finish with it and when I tried forcing him, they said I should not but take my time to feed. He will just not eat and I really do not know what to do”.

M 7

Few of the mothers were so desperate for their children to eat so they went to many places in search for solutions to their child’s feeding problem. A mother went to a licensed chemical seller to buy medicine that will enable the child to eat and grow well as is expected of any normal child. This was how she narrated her story:

“Whenever I complain my child is not eating, the nurses will say I should try and force him to eat. The nurses have never advised that I buy medicine, so I had to go
to the drug store to buy some because I am the one who is with the child and know how it feels like to have a child who does not eat and looking very tinny”.

During the interaction with mothers, it was realized that there used to be some traditional beliefs to prevent children from taking some protein foods such as eggs and meat. Most people now know the importance of these and no more practise the tradition. However, a few mothers still practise it by preventing the children from eating these protein food that will help with proper growth and development. This was what a mother had to say:

“I was told not to give the child eggs because as a twin, there were certain things he could do naturally to help others in the community and eating eggs, will destroy this ability”.

4.3.2 Poor child growth / small baby

Generally, mothers had problems with feeding their children and this impacted negatively on the growth of the children. The retarded growth of the children had psychological effects on the mothers because a child when born is supposed to be growing normally but on the part of these mothers, their children had problems and were not growing as expected. Their children’s weights were stagnant and sometimes reduced. The small size of such babies prevented mothers from associating with other mothers. They hide their children to avoid gossip. These are some experiences from mothers:

“When I send him to the clinic for weighing, they will tell me his weight was not increasing and even at a point the weight was reducing. He was 10 months by then but weighed 5.5kg and very small as compared to the age meaning is not good enough”.

In our society, it is believed that when your child is big, it means that your baby is healthy and normal making family members and friends associate with you. On the other hand if you have a child who looks small, you are despised and a lot of things are attributed
to the reason why your child looks that way. This made a few of the mothers hide their
children in their rooms and also prevented them from associating with others. These were
comments made by some mothers:

“I wanted her to eat well and look well like other children. When there is an
occasion, and you send your child who looks different from other children around,
the women start to talk about you. That is why I want the child to eat and also grow
fat”.

M 1

Another mother said:

“The house in which we stay, I delivered for about two months before some women
delivered but one’s child is sitting and the other one is crawling. When I see some of
these things, I become worried and thinking of why my child was not growing well.
Because my child is very small, I don’t even sit outside with my child, am always
inside my room I don’t bring him out”.

M 3

Most of these mothers said the condition of their children were identified at the child
welfare clinic and referred to the CMAM site. A few however, went to the CMAM site as a
result of recommendations from friends.

“It was at the weighing centre that one of the nurses used a coloured tape and
measured the arm of the child and told me, my child was malnourished. She told me
to come back at a later date to attend a clinic where they give some food to children
who are malnourished”.

M 10

4.4 Structural factors influencing utilization of CMAM services

This main theme describes factors that should be available for quality CMAM
services. It was observed from the analysed data that, participants were influenced by the
nature in which the staff at the clinic performed their duties. According to the mothers, the
nurses were knowledgeable, hardworking and took their work seriously. The cordial
relationship that was created by the nurses and the conducive and convenient environment that existed for them to receive care and services made them comfortable. These subthemes emerged from the major theme. These were: competent nurses, attitudes of nurses, conducive environment and distance / waiting time / working hours.

4.4.1 Competent nurses

This subtheme describes the various opinions participants shared concerning the care provided by nurses during their interaction. According to the mothers, the nurses knew exactly what to do to help solve their problems. They described the nurses as being hardworking, skillful and serious with their duties. They were satisfied with the services provided by the nurses and even felt been pampered. These are some expressions from mothers:

“The nurses are hardworking, skillful and take their work serious. They know what to do when you go with your problem”.

M 2

This was how another mother expressed her view on the competence of the nurses:

“They are hardworking and do their work well by encouraging the mothers. The nurses respect mothers and are always ready to listen to what the mothers have to say. They are also hardworking and serious when working”.

M 3

Few of the mothers also described the nurses as being able to encourage them to go for treatment and gave them attention by listening to their problems. The following quotations describes the views of some of the participants:

“The nurses know their work, they know how to pamper you to come for treatment. They also have concern for the children and will use their credit to call you if they do not see you in the clinic”.

M 10
Another mother’s expressed that:

“The nurses are able to solve the problems of the children. They are also serious with their work. When you approach the nurses at any time, they receive you and help you with your problem. They are also serious regarding their work”

M 1

The mothers said the nurses knew their work and they acknowledged that, the care provided was as a result of the training they received. This made mothers to have confidence and trust in the nurses and were ready to put the lives of their children under their care. The mothers therefore perceived, competence of the nurses played an important role in improving their children’s condition.

4.4.2 Attitudes of nurses

This subtheme describes the participants’ views on how the attitudes of the nurses at the clinic influenced their utilization of the services. The participants experienced various attitudes from the nurses ranging from good to worse. They described the nurses as being good to them, they welcome and establish rapport with them any time they visited the clinic. Some nurses were described as been polite and respectful by the participants. According to the mothers, the nurses called on their mobile phones and sometimes visit them at home. One of the participants had this to say about the attitude of the nurses:

“When you get to the clinic, the staff will welcome you, engage you with conversation and jokes. You are welcomed and offered seats which are always arranged in the yard, and the treatment they give to your child is also good”.

M 1

This was another expression from a mother on how nurses related with them:

“The staff however are good, I really do not see any problem with them. When you get to the clinic, you are warmly welcomed, and they start to ask how you and the
The mothers described how polite and encouraging some nurses were and also expressed how approachable the nurses were to them. These positive attitudes were described as follows:

“We relate well but I don’t know their names. They are very good, polite and respectful. They will laugh and chat with you and will want to know more about you and your child. They are not rude and treat everybody equally”.

According to a few of the mothers, the nurses encouraged them not to give up on their children but to have hope and be serious with their care. Here is a statement from one of the mothers:

“They also continue to give me hope on my child’s condition. They told me that, with time my child will be okay. They said his own has delayed even though some recover faster, but I should not give up but continue to take good care of him”.

There were some follow up mechanisms put in place by nurses to enable them reach the mothers for continuity of care. The mothers said the nurses collected their telephone numbers and called them occasionally and sometimes visit them at home. Here is a statement from a mother:

“Mostly they call to find out how the child is doing, like, is the child well, is he eating well, and I will tell them what is happening and they will advise me on what to do. Sometimes, the men among them come around the house to see us”.

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Despite all the good things said about the nurses, there were some bad attitudes on the part of some nurses. Some of the mothers had bad experiences with nurses when they went to the clinic for services. Some of the clients alleged some of the nurses were very rude and this attitude of the nurses prevented them from assessing the service. This is an account from a mother:

“I went to the clinic to weigh my child and a nurse talked to me in a manner that I didn’t like so I stopped going for the weighing. Because the child was not eating, he was like something that I don’t know how to describe, so when I sent him for the weighing a nurse insulted me, which made me felt very bad.”

M 2

The attitudes of care providers towards the clients played a very significant role and this influenced their utilization of the CMAM services.

4.4.3 Conducive environment

This subtheme described how the environment at the clinic influenced their utilization of the services. The participants expressed their views about the environment and how it met their expectations. One of them had this to say:

“The place is always clean with long benches well arranged. They have dust bins in place with running water from a pipe. The place is spacious and airy and is able to accommodate many people. There is a place to free yourself when there is the need to do that. There are some facilities in the clinic other clinics do not have like a laboratory”.

M 8

The cleanliness of the environment was also a factor that was of concern to the participants. This was an impression of one of the participants:

“The surrounding is clean with a dustbin for mothers to put rubbish in and not to throw them anyhow. The place is not also grown with weeds. When it come to the
siting arrangement, it is first come first serve and the benches are arranged in a way that when you get there, you sit accordingly”.

M 1

A participant however was not satisfied with the space at the clinic and felt there was congestion at the clinic due to inadequate space. This was how she described her observation:

“The clinic is not big and the space is small making us not comfortable when we are many. The clinic is clean, there are few benches for us to sit but the yard is small with no shade. We normally have to sit inside where the room is small with some few seats making the place congested”.

M 5

The environment in which services are provided plays a role and influence mothers utilization of the services.

4.4.4 Distance / Waiting time / Working hours

Distance, waiting time and working hours have an influence on mothers accessing the CMAM services. Distance is how far the mothers live from and the interval or time spent by the mothers to get to the clinic. According to the participants, the distance from their homes to the clinic was not far therefore did not have problem accessing the services. The journey for most mothers was a walking distance and took them between 10 – 30 minutes to get to the clinic. A mother commented that:

“My house is not that far from the clinic. It will take me less than 10 minutes when I am using a motor bike and may be 20 – 30 minutes when am walking”.

M 8

This was what another mother said:

“I normally use about five minutes to get there. It is a walking distance. I can even say less than that if I do not stop to greet or chat with people I meet on the way”.

M 5
Waiting time was how long it took the mothers to receive care. With regards to waiting time, the mothers said when they get to the clinic early, the nurses took care of them first before attending to those who come after them. The mothers said when the nurses are not busy and you get there, they see to it that the mothers do not waste time at the clinic except when it is child welfare days where so many mothers come to the clinic for services:

“When you go there, it is first come first service. If you get there and they are not busy, they will attend to you early but if you meet people coming for weighing, then you will have to wait for them to be seen before and that will make you stay a bit longer, if not within 20-30 minutes you should leave the clinic”.

M 7

One of the participants had this to say:

“I leave the house early to the clinic. So I normally meet few people. I mostly sit and others come to meet me, I have never gone to meet a lot of people that will make me stay there for long”.

M 3

The mothers were comfortable with the working hours of the nurses at the CMAM clinic. They knew the time services start and when it is supposed to end. Here is what some mothers had to say:

“The place is opened by 8am and close after 5pm but when they have patients, they will attend to them before closing”.

M 1

“They start work at 8am so I try leaving the house early whenever am going to the clinic so I can go back home in time. So any time or day, I could go to the clinic provided it is within working hours”.

M 8

Despite the fact that majority knew the working hours, this mother said she did not know the hours the nurses work but makes sure she gets to the clinic early for the services:
“For me, I don’t know their working hours, any time I go there they are always there so I cannot tell but to me the time I go to the clinic is okay for me and once I go to meet them and get what I want, then it is okay for me”.

M 9

4.5 Processes involved in CMAM services

This major theme describes the activities that are carried out at the CMAM clinics. It was observed after analyzing the data collected from the mothers that, the following services were provided to mothers whenever they visited the clinic. According to the mothers, the growth of their children were monitored by the nurses and they were counselled on how to care for their children to enhance quick recovery. The mothers said they were given food supplement and educated on how to feed their children. Four sub-themes emerged from this theme. These were; registration / documentation, Physical assessment / anthropometric measurement, health education / counselling and provision of food supplement.

4.5.1 Registration / Documentation

These describe the information taken and documented on the mother and child and the state of child’s condition. These are vital information required for continuity of care and in order to be able to do follow up to monitor child’s progress. The mothers mentioned the first time they visited the clinic some information was obtained on both the child and mother and recorded on the child record book and the register. This was done any time they visited the clinic, the nurses recorded whatever they did to the child. These are statements from mothers:

“I was asked some questions about myself and the child. The nurses wanted to know where we stay, the number of children I have, the work I do. I told them all that they wanted to know and they wrote them in a book”.

M 1
Another mother said;

“*I went and they took his weight and other things and registered us and gave us the food*”

M 2

4.5.2 Physical Assessment / Anthropometric Measurements

This subtheme discusses the assessment carried out on the children when they visited the clinic. Assessment is done to ascertain and diagnose the condition of the children. This is done by asking mothers some questions, physical examination, observation and measuring the Mid Upper Arm Circumference (MUAC) of the child. According to the mothers, when they go to the clinic, the nurses will first weigh the children and measure the arm circumference. The mothers said the nurses sometimes assess the feet of the children for oedema. This was what a mother had to say as to how her child was diagnosed of malnutrition:

> *It was there that one of the nurses used a coloured tape and measured the arm and told me my child was malnourished. She called some of her colleagues to have a look at the measurement. One of them then told me they will enroll me at the village and that they have some food they give to children who are malnourished*.  

M 7

Another mother’s account on how her child was assessed is as follows:

> *The nurse will check her, weigh the child, measure the arm and will sometimes press the legs to see whether it is swollen*”.

M 1

This is the statement of another mother:

> *They will ask me to undress the child and weigh him, they will also measure his arm and other things. After that, they will inform me that my child’s weight have increased and I will be happy*.  

M 6
A few mothers also indicated that besides the weighing, examination and measurement, the nurses sometimes take their temperature, refer them to the laboratory for some investigations when their children were not feeling well and give some medications. This was what a mother said:

“When we finished weighing, they came and measured the arm and recorded it. On our second visit, I told them he was vomiting so they took his temperature and made us to go to their dispensary for some medicine. They also requested that we do some lab test for them to know what was wrong with him”.

M 8

According to another mother, the first time she visited the clinic, after all the necessary interactions including the assessment that was carried out on her child, she was given a sachet of the food supplement to feed the child to see whether the child will eat. This was done to test the child’s appetite for food.

“I was asked to undress him which I did and they weighed him. They gave me a sachet of the “plumpy nut” (food supplement) to give to the child and see whether he will eat. When I gave to him, he ate”.

M 10

4.5.3 Health Education / Counselling

This describes how the nurses educate mothers on all aspects of their children’s condition. A few of the mothers were educated on the condition of their children and the types of malnutrition. They were also educated on what indicators to watch out for when the condition of the child is improving. This was evident in the narrative of some mothers:

“I was told that the child was suffering from kwashiorkor that is why the body and the hair is like that. They also said the sickness have types and showed me pictures of people with the sickness and ended by pointing on a particular one and said that was what my child was suffering from”.

M 9
“When we went for weighing, I was told my child had kwashiorkor and I had to go through the malnutrition process. They told me that, when the indicator points at the red or so, then the child will have to go through the malnutrition process but when it is on the green, then the child is improving and becoming normal”.

M 2

The mothers were educated on the need to feed their children with nutritious food. They were asked to give food from the various food groups to enable the children to have a balanced diet to help improve their condition. One of the mothers had this to say:

“They say we should give the child good food because he is malnourished and when he eats well, he will be normal again. They also asked that I give him fruits and the like, I should give beans, and use dawadawa with “keta school boys” some type of fish with green leafs soup for him to eat”.

M 8

Another mother commented:

“That we should eat “T.Z” with green leafs soup with either fish or meat and take fruits and vegetables, beans and tom brown. I was taught how to prepare the local tom brown to use to prepare porridge for him and that will also helped”.

M 9

The mothers were educated on the care of their children. The mothers mentioned that the nurse told them to take good care of the children by observing their personal hygiene, practicing proper hand washing, using protective clothing and proper handling of the feeding utensils. This was what a mother had to say:

“They talk to us on how to take care of our children. They say we should keep our children clean by bathing the child twice a day, change the dress and diaper when it is wet. The nurses also said we should wash our hands properly before handling the child’s food. We should wash the hands of the child before she eats to prevent dirt that will give the children sickness. The nurses also said we should wear the children clothing to prevent cold”.

M 1
Perspectives of Mothers on the Quality of CMAM

One of the mothers mentioned that she was worried about her child’s growth because she delivered before two women in their house but their children were doing well whilst hers was not. According to her, she was encouraged by the nurses not to be comparing her child with other children. This was how she narrated it:

“I was told that, I should not compare my child with others so that it will disturb me. They said if I think so much, my breastmilk will stop and I will not have enough to feed the child”.

M 11

Another mother expressed her satisfaction with the education provided her. This demystified the belief she had concerning her child’s condition. According to her, she thought her child’s condition was as a result of spiritual attack. The woman expressed:

“I did not know what was wrong, I thought someone was doing me so I kept praying to my God to expose the person till I was told at the clinic that my child had kwashiorkor”.

M 2

All the mothers attending the CMAM services received health education. According to them, it helped them to care for their children. Mothers therefore expressed their satisfaction for the information they received.

4.5.4 Provision of food supplement

The food supplement known as Ready to Use Therapeutic Food (RUTF) or “plumpy nut” is an already made food in a pack mainly used for the management of malnourished children. It is one of the main components of the community-based management of acute malnutrition. Mothers attested to the fact that they were given this food supplement to feed their children whenever they visited the clinic. They were reportedly educated on how to feed their children with the food and also encouraged to give water when feeding to prevent dehydration. Mothers’ were of the view that the food supplement was always available for them to collect any time they went to the clinic for services. It did not cost them any money since it is given to them free of charge. They
believed that the food supplement was medicine because it made their children’s condition improve and they had hope that it would be effective for the treatment of their children’s condition. The quotes that follow are the accounts of some mothers:

“After everything is done, if there is the need to collect medicine, you are given and then they will give you the food”.

M 1

Another mother indicated:

“The nurse normally gives me some food in a pack to feed the child with. They said the food will help improve the child’s condition if he is able to eat.

M 10

The mothers were encouraged to make sure the children drink enough water as they eat to prevent dehydration. According to the mothers, they were advised to give the children portable water since contaminated water could cause further problems:

“They made me understand that, if I want to feed him with the food, I should wash my hands properly with soap and water before handling the food. I was told to give him water to drink as I feed and not just any water. They advised I give Voltaic (mineral water) or any bottle water for him to be drinking”.

M 3

According to a mother, she was educated on how to feed the child with the food supplement so that it will not be contaminated. The mother had this to say:

“They said before I feed the child with the food, I should shake it and make it soft then I tear the sachet a bit and squeeze it out into his mouth slowly for him to eat”.

M 6

Despite the fact that mothers were happy when given the food supplement, they did not know the ingredients used to prepare it. Interacting with them, almost all the mothers
did not know what it was made up of. They mentioned what they thought could be the ingredients. These were comments from two mothers:

“I think they used groundnuts with salt, sugar with maize that is combined to give us the paste. I actually do not know but that is what I think”.

M 10

“Hmmm, what I see is like groundnuts paste, soya beans, malt or what, I can’t tell but it is some type of ingredients put together to make paste”.

M 2

According to the mothers, the food supplement was regular, they always received it any time they went to the clinic for services. It was always available for them to collect when one goes to the clinic. These are some statements from the mothers:

“The supply to me is regular. I went to the market clinic twice and I was given some. When I relocated to Nandom, any time I go to the hospital, they give us and now bro Joe normally bring it to my school for me. When I finish using it, I call him to tell him our plumpy nuts is finished and he will supply us”.

M 12

Another mother had this to say;

“We have never gone to the clinic without getting the food. The only time we did not get was during the Christmas holidays. According to the nurses, they went to the office and did not meet anyone so I should come back after the holidays for the food. So after the holidays, the nurses called me and I went for the food”.

M 6

It was also realized that the quantity of the food supplement given to mothers was not the same anytime they went to the clinic. Mothers said the quantity varied according to how much the child consumed.
Perspectives of Mothers on the Quality of CMAM

“The quantity is not the same always. Sometimes he gives us 18 sachets or less but 18 sachets is the highest they ever gave us and this is to last for a week. He says if I can give him 2 sachets every day till it all finishes he will supply us with more”.

M 2

Another mother said:

“It is not the same every week, depending on how much the child eats, if he is able to finish what was given the previous week then they will increase the quantity, if not they either reduce or give the same quantity as before”.

M 5

The mothers reported occasional shortages of the food supplement at some clinics. According to them, they were asked to come back later for the food supplement when the nurses receive their supply. Here is an account of a mother:

“It is not every time you get the food. Sometimes you go to the clinic and after going through everything, you are told there is no food so you come later for it. I made mention that, I was asked to go and wait for the food to come because the food was finished in the clinic”.

M 1

Most of the mothers reported that, the food supplement was giving to them free of charge. This food supplement had some economic benefits to mothers as they expressed their views on how economical it was to them. According to them, food is provided to them free to feed their children with enabling them save the money they would have used to buy food for the children. This was what a mother said:

“The food is free, they do not collect money. This makes me save the money I would have used to buy Lactogen. The father even suggested we buy some cereals for him but I told him we have start with some food we collect from the clinic which he eats”.

M 7

One of the mothers testified that the food supplement is given to them at no cost. She mentioned it is offered free of charge with no money collected from them.
“Since I started going to the clinic for the food, they have never collected any money from me. I have never paid a penny for services rendered”.

**M 10**

A few of the mothers mentioned that they used the NHIS card to collect medications from the clinic when their children were ill. According to them, a prescription was given for you to buy if the medicine was not available in the clinic. This is a mother’s comment:

“They don’t collect money from us. It was when I reported that the child was sick that they asked us to go to the lab and with that, we had to use the health insurance for both the lab and also to see the doctor for medicine”.

**M 9**

The food supplement provided at the clinic is for the malnourished children and is not supposed to be shared with other children. According to the mothers, they were advised by the nurses not to share the food supplement with others. A few of the mothers said it was difficult but they had to ensure that they did not share with other children. This was the account from two mothers:

“When my child is eating the food from the clinic, children around cry and want to also eat some. Mostly I just tell them that is all so she will not be able to share. Whenever I go for this food, I keep it in the room and only bring out one for my child to eat because other children will beg for some, I first give her some inside to eat and put the rest in a cup and cover. Once they don’t see her eat it, there will not be any trouble”.

**M 1**

“Before I was given the food, the nurses said, what they will give is not for me to eat but for the child. I should try to force the child to eat and not to share it with others”.

**M 3**

According to some of the mothers, they went to the hospital many times seeking for cure for their children’s condition but they could not get the solution until they were referred
to the CMAM clinic. In their view, the food supplement they were given have been helpful to their children since they have seen improvement in their children’s condition. The mothers saw the food supplement as efficacious and medicine for their children’s condition. Here is a mother’s comment:

“We went to the hospital severally but still we did not see any improvement till these nurses decided to start giving me this medicine as food to use. This food has been helpful and now see him running around looking well”.

M 4

Another mother perceived the food supplement as good and helpful medicine, without which she would not have known what would have happened to her child. This was what she said:

“I will say the food from the clinic is really medicine to my child. I do not know what would have happened if I had not sent her to the clinic for this food”.

M 5

A mother also testified to the fact that the food supplement was medicine;

“The medicine is helpful so not getting it to give your child for months is something to be worried about”.

M 1

Some mothers mentioned that, some nurses also referred to the food supplement as medicine and advised that the mothers should constantly give it to the children to eat to help improve their condition.

“The other nurse whom I was asked to see then took my phone number and told me to go and come later because the medicine had finished, he was expecting some and will call me when he receives the medicine”.

M 10
There were mothers who perceived the food supplement as hope for remedy for their children’s condition. They also mentioned it was not available in the market for them to buy in times where the clinic was out of stock. A few mothers’ expressions are shown below:

“My child was not eating any other food besides breast milk but when I introduced the food I collected from the clinic, she started to eat. This gave me the hope that the child will be well when I give her the food.”

M 1

Another mother shared this:

“Though the child still does not eat much, there is some improvement. Nowadays, we go to the clinic every week to weigh and measure the arm and anytime we weigh, at least, there is always a little increment in the weight. When we started going for the food, his weight was around 4kg but now he is 6kg and above so there is hope”.

M 7

There were some mothers who complained that the food supplement even though good and helpful, it is not sold outside the health facility to enable them buy for their children to eat in case they do not get the supply at the clinic. One of the mothers stated:

“The food is not also popular because you cannot get it in the market or drug store to buy, that made me to know that, it is only the health people that supply it and if not at the health facilities, you will not be able to get this type of food anywhere”.

M 3

Another mother stated:

“They will have to try to supply the food regularly so that it will not run out because when we know it is finish at the clinic but are sold outside, we will buy. This is because we know it is good and helpful to our children, but here is the case we cannot get some to buy if not at the clinic”.

M 9
4.6 Mothers’ perception concerning outcome of CMAM services

These were opinions of mothers regarding the CMAM services. This was to determine whether the services were effective and whether the needs of mothers were met. The mothers had confidence in the CMAM services provided as they mentioned during the interaction. This theme had two sub-themes which were; satisfaction and good / beneficial.

4.6.1 Satisfaction

This describes the views of participants concerning how adequate their expectations or needs were met. The mothers were appreciative of the care rendered them and the various changes they saw in their children. Some of the comments made by the mothers were as shown:

“Seeing this child, my heart is always at peace and am saying this your work is very good. The child you see today, others thought he was going to die and that he was not a human being. He is now ten months old so you can imagine if the nurses had not taken interest in his care what would have happened. There is a lot of improvement in the child and I am so happy that this treatment is successful”.

M 6

One of the mothers, talked of the fact that the services were good because her child now looked well and one will not believe the child was malnourished. This was her comment:

“The services are good because of that, I have decided to continue to weigh my child here and will not change or go anywhere else. If anyone sees this child now, will you believe that he was malnourished? But before I brought him to the clinic, you could count all his bones because there was no flesh on the body”.

M 1
Another mother stated that, if it had not been the support the nurses gave her, she believes the child would have been dead. Now he has grown and increased in weight. This was what she had to say:

“Now when am carrying him, I also know am carrying a child because he is looking plumpy and heavy. I even sent him for weighing today and was told that the weight has increased. I will thank the nurses for their support, if not for them, I believe my child would have been dead by now. I thank them for their advice and the interest they have for my child. God will bless them for that”.

M 4

4.6.2 Good / Beneficial

The mothers approved that the services were effective and beneficial to their children. A mother mentioned that when she brought her child to the clinic and started with the treatment, she has seen that the treatment is good and also helpful. This was what she said:

“At first, he could not do things by himself because he was weak. He could not eat, he will not do anything on his own but just sit down like that like “okyena be wu” {laugh} like someone who will die tomorrow but now he is very active”.

M 2

One of the mothers explained that the child used not to eat and had grown very lean but now, she has seen some improvement, meaning the services is beneficial. Here is her statement:

“Practicing what I was told has been beneficial to me. Because now the child is growing well and the body now has some flesh, her weight has increased and the hair too has changed and now she also eats. Before now, she used not to eat”.

M 9

A mother also said even though her child has not improved as she expected, she thinks the service is beneficial. This was what she said:
"I have also seen that my child’s health is improving compared to how he was from the beginning. Even though not much but I will say, the food is really beneficial".

M 3

From the statement of mothers, one will deduce that there are some benefits that mothers derived from the CMAM services. This was evident in the increase in the weights of their children and they being able to eat well.

4.7 Summary

This chapter represented the findings from the analysis of the data collected. The analysis generated five major themes with twenty sub-themes. The findings showed that majority of the mothers did not know the causes and management of their children’s condition and went from place to place searching for help. The mothers did not know where to go for the appropriate care until they were identified at the child welfare clinic or friends and referred to the CMAM site. According to the mothers, they were satisfied with the services provided by the nurses at the clinic. They mentioned the services were beneficial to their children as they saw the condition of their children improved.
CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

This chapter discusses the findings from this study in relation to relevant literature review. The essence of this is to build on ideas or to refute from other literature. The study sought to explore the perspectives of mothers on the quality of community-based management of acute malnutrition (CMAM) services in the Wa Municipality. The objectives of the study were to:

- Determine mothers’ perception about the CMAM programme
- Identify the structural factors that influence the utilization of CMAM services
- Ascertain the processes involved in CMAM services
- Assess mothers’ perception concerning the outcome of the quality of CMAM services

The findings were discussed under five headings in relation to the themes that emerged. In this study, the Donabedian model on quality of health care was used which has the structure, process and outcome as constructs. Data analysis yielded other findings which were not consistent with the model. These included; mothers’ beliefs on causes and management of acute malnutrition and mothers’ reasons for patronizing the CMAM services. Being a qualitative study, these are valuable information that should not be ignored hence, these would be discussed first followed by discussions of information yielded from the model.
5.1 Demographic characteristics

Twelve mothers were involved in the study. Majority of them (11) being the biological mothers of the children and one (an Aunty) a foster mother. All the mothers in the study had children who were malnourished and aged between 6 – 59 months which is the high risk age for acute malnutrition according to World Health Organization (WHO, 2013). The ages of the mothers ranged from 19 to 36 years. The mothers had different educational background with only one not having any formal education. Four of them had only basic education, six had senior high education and one had tertiary education. This mainly explain the lack of knowledge on the causes of malnutrition and attributed the condition to many factors which led them shopping for help for the right treatment for their children’s illness. A study findings in Uganda revealed that, mothers educational level determines the health outcome of their children (Shariff & Ahn, 2014). Majority of the mothers were married and living with their husbands. According to the participants, some husbands were supportive and helped them find solution to their children’s illness. Two of the mothers were not married and lived with their parents. Out of the 12 mothers, three were hairdressers, two seamstresses, one teacher, one bus conductor and five engaged in petty trading. The findings revealed that, these mothers were not economically empowered to cater for their families due to the type of economic ventures they were engaged in. This finding corroborates other findings that showed that women with lower economic empowerment had less decision making autonomy regarding the health outcome of their children (Burgess, Propper & Rigg, 2004; Ibrahim, Tripathi & Kumar, 2015). The number of children of mothers ranged from one to three with those in the polygamous marriages having other children from the other wives. Eight of the mothers professed the Islam religion with four professing Christianity.
5.2 Mothers’ beliefs on causes and management of acute malnutrition

The study findings revealed that most of the mothers lacked knowledge on the causes and management of acute malnutrition. Some of the mothers mentioned sickness as the cause of their children’s condition while a few of the mothers believed the cause was as a result of spiritual attacks. Some of the participants alluded to the fact that, the poor feeding of their children as a result of the sickness brought about their present condition. These findings are similar to findings of Abubakar, Holding, Mwangome and Maitland (2013) where they reported that some mothers identified sickness as a factor that caused malnutrition. A few of the mothers in this study emphasized that the condition of their children had spiritual dimensions and attributed the cause of the children’s illness to spiritual attack. Findings from Abubakar et al. (2013) showed that mothers had some cultural beliefs associated with acute malnutrition which included witchcraft and the “evil eye” from bad people. These traditional and cultural beliefs prevented some mothers from seeking appropriate health care rather consulting traditional healers. Health education targeting the causes and management of acute malnutrition would go a long way in addressing these harmful cultural beliefs.

In a related study which assessed the perception of mothers and caregivers on the community-based management of acute malnutrition programme, it was realized that some mothers lacked knowledge on malnutrition and the CMAM programme. This led to a low coverage of the services among mothers (Rogers et al., 2015). Their study’s findings are congruent with this study where some mothers did not know the condition of their children. In order to prevent malnutrition with its related complications, there should be increased knowledge and practice as recommended by World Health Organization (WHO, 2007). Most mothers in this study had lower educational background indicating that, their low educational background affected the health of their families. According to a great scholar, if you educate a man you educate an individual but if you educate a woman you educate a
whole nation (Aggrey, 1924). This means an educated women is better likely to keep her family healthier by providing the appropriate food nutrients that will prevent the children from malnutrition. Her knowledge would go a long way to impact positively on the community in productive ventures and health educational messages. Girl child education should be especially encouraged. This is because her knowledge would lead her into economic activities which will earn her income for the upkeep of her family in future. She would also be beneficial to the society because she is well informed to educate the community and use skills acquired to engage in economic venture that could be of benefits to the entire community.

The theme discussed has the following sub-themes: health seeking behaviour of mothers with malnourished children, mothers’ perception of spiritual dimensions of malnutrition and the use of traditional medicine.

5.2.1 Health seeking behaviour of mothers with malnourished children

The health seeking behaviour of mothers, encompassing the actions taken to get solutions to their children’s condition was influenced by the beliefs they had. The mothers’ health seeking behaviour varied from sending the children to the hospital and health centres, consulting spiritual and traditional healers, the use of traditional medicine and purchasing over the counter drugs to help improve the condition of their malnourished children. In this study, most of the mother’s first reaction when they observed the condition of their children was to seek health care by sending the children to the hospital. The findings of the study revealed that, some mothers did not know where to seek help so did nothing but kept the children at home without seeking health care until some nurses met them during home visits. These mothers were fortunate to have met these nurses who offered to help. The children’s condition would have been worse if they had not met these nurses. This finding is in line with what was reported by Mbagaya (2005) where mothers did nothing as their first response
to the symptoms of the illness as experienced by their children. Education of mothers on how to identify and seek appropriate care for their children when they are ill is key to prevent complications. Health seeking behaviour largely depends on awareness or knowledge individuals have on causes and management of acute malnutrition. This will motivate mothers to seek early health care when their children are sick. Some of the mothers in this study had to go to many places to find solutions to their children’s condition until they found correct or effective treatment. This was because of knowledge deficit or lack of awareness as mothers did not know the appropriate place to seek health care. These findings are similar to those of Mweemba, 2017; Chandwani & Pandor, 2015 who found that, health seeking behaviour largely display the felt needs and the awareness generated in the individual or the knowledge acquired.

Participants in this study found the appropriate treatment when the condition of their children got worse. The nurses at the child welfare clinic could not identify these malnourished children early hence making the condition worse. The findings corroborate findings from Somalia (Qayad, 2005) and Ethiopia (Tafesa & Shele, 2015) which showed some deficiencies on the part of nurses in detecting malnutrition in children. This means nurses at the clinics should undertake periodic in-service training on early detection of acute malnutrition and the CMAM programme. This would enable them educate mothers on identifying the condition and seeking early health care to prevent complications.

In order to reduce child mortality, United Nations Children Fund (UNICEF) and the World Health Organization (WHO) have acknowledged the fact that, seeking early health care is paramount hence the development of the strategy known as “integrated management of childhood illness” (IMCI) which is crucial for improvement of the health status of children. This was made known by Bryce, Boschi-pinto, Shibuya and black (2005) in WHO estimates of the causes of death in children. In this study, even though all mothers had a
positive health seeking behaviour this might not be the appropriate treatment. The treatment sought was largely based on their knowledge or perception of the cause of the illness. The CMAM programme should therefore be part of the educational messages at the child welfare clinics (CWC) in order for mothers to know where to seek for proper care with their malnourished children.

5.2.2 The spiritual understanding of mothers concerning the child’s problem

Findings from this study revealed that, the mothers had different views regarding the causes of malnutrition. About half of the participants had the belief that their children’s illness were as a result of spiritual forces. This made mothers seek divine intervention from God by praying for their children to be healed. Some mothers also consulted the spiritualists or traditional healers to help cure the children from their illness. These findings corroborate study findings in Kenya by Abubakar, et al. (2013) which showed that mothers had cultural beliefs associated with severe acute malnutrition which included witchcraft and the “evil eye” from others. It is essential that at the child welfare clinics, the nurses intensify the education they give mothers. The education should cover child care including where to seek health care and how early. It is also important to educate significant others like grandmothers and mothers in-law on the need to seek early health care instead of seeking help from spiritualist and traditional healers. This is because, the in-laws have much influence regarding health care seeking of their grandchildren and wives of their sons.

5.2.3 The use of traditional medicine for the management of children’s condition

Although participants in this study initially sent their children to the hospital when they became sick, there were however some mothers who were not satisfied with the treatment given at the hospital and so they resolved to traditional medicine. Herbal preparations were to be used in bathing, drinking and for mothers to use in washing their breasts to enable breastmilk to flow in cases where the mother’s breastmilk was not
sufficient for the child. A mother attributed her child’s condition to hunters who pass by carrying monkeys which reportedly possessed her child. She went to the traditional healer for medicine to cure the child by getting rid of the monkey. This supports findings from Zambia by Khunga, Okop and Puoane (2014) who reported of mothers seeking care from traditional healers to cure their children from attacks from bad spirit.

A few of the mothers preferred the traditional medicine to the orthodox medicine. According to these mothers, they thought the traditional medicine was more effective until they were referred to the CMAM centre where their children were receiving treatment. These findings were consistent with findings of a study in South Africa which reported high case fatality rates on admission due to factors including preference for traditional medicine over the orthodox medicine (Muzigaba, 2018). In some studies, the mothers reported buying medicine from local chemist and traditional medicine to treat their children which was similar to the finding of this study (Mweemba, 2017; Amuyunzu-nyamongo & Nyamongo, 2006).

In contrast with findings from a study in Kenya by Mbagaya et al. (2005) which indicated mothers consulting traditional healers and using traditional medicine because, proximity to the health facility was a problem. In this study, mothers were closer to the health facility and could walk to the clinic for services but still used traditional medicine because that was their preference. Community sensitization could help address the beliefs and misconceptions regarding the use of traditional medicine in the management of acute malnutrition. The community members should be educated on the harmful effects of the use of traditional medicine on children.
5.3 Mothers’ reasons for patronizing CMAM services

The mothers with malnourished children in this study had various reasons for sending their children for CMAM services. According to these mothers, they went to the clinic for treatment because their children were sick and needed medical attention. Some mothers said they were referred to the services by nurses from the child welfare clinic because their children’s growth was stagnant. Others said their children had refused to eat any solid or semi-solid food. A few of the mothers mentioned they did not have enough breastmilk to feed their children and these children had refused to eat any other food given. As a result, the children were stagnant in growth and mothers had to send them to the clinic for the CMAM services. The following subthemes were discussed under the main theme; needing help with child feeding and poor child growth.

5.3.1 Needing help with child feeding

Feeding practices play a pivotal role in determining the optimal physical growth, development and health of infants and young children (WHO, 2015). Findings from this study revealed that mothers had problems with feeding of their children which led to growth retardation. All the mothers reported they practiced exclusive breastfeeding until they introduced complementary feeding. According to them, the children refused to eat the newly introduced foods but depended solely on the breast milk which was not enough to meet their nutritional needs. Some participants introduced artificial foods earlier because the breast milk was not enough to satisfy their children. All the mothers interviewed mentioned that they started giving the children porridge and other foods prepared for the entire family but the children ate these new foods for some time and refused to eat later. This indicated that, mothers did not have adequate knowledge on the variety of weaning foods to give to their children and constantly gave porridge to their children who refused to eat. This finding agrees with findings of Udoh and Amodu (2016) in Nigeria who found that mothers started
complementary feeding because their breast milk was not enough so mothers resorted to starchy foods because they did not know the various types of food to give to their children. Similarity in these findings could be because both study settings are in the same sub-region (rural setting) with similar characteristics. Health education on the varieties of locally available complementary foods should be intensified at the clinics to enable mothers feed their children with them. Few of the mothers in this study reported they could not initiate immediate breastfeeding because their babies were admitted at the neonatal intensive care unit (NICU). This they said affected breastfeeding and the flow of breast milk where mothers had to introduce complementary foods early. Porridge, a locally prepared food in Ghana which is usually made from corn dough is the commonest weaning food. Findings was consistent with findings from Piechulek, Aldana and Hasan (2015) in their study on feeding practices and malnutrition in children in rural Bangladesh. They reported that, mothers with inadequate breast milk had to introduce complementary food early because the children cried of hunger. Similarly, Nankumbi and Muliira (2015) in their study on barriers to infant and child feeding practices in Uganda stated mothers had to give porridge made of cassava flour and maize to satisfy their children because the mothers’ breast milk was inadequate. The similarities in findings showed that, economic and educational characteristics of the participants were the same though the geographical locations were different. The need to intensify health education on infant and child feeding is necessary to empower mothers to feeding their children effectively.

5.3.2 Poor child growth

The findings of this study revealed that some mothers resolved to hide their children in the room because the children were looking very small and thin to prevent being stigmatized. The children’s growth were stagnant as a result of poor feeding resulting in mothers hiding them from the public. This finding is similar to findings of Khunga et al.
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(2014) who indicated that, mothers perceived a thin child as being infected by the HIV virus. This prevented the mothers from sending their children to the clinic because of stigma. A mother in her frustration had to force the child at a point to eat but the child would not eat. In this era, are children to be forced in order to eat? The underlying factor noticed in this study for children not eating was because, the mothers lacked knowledge on the variation of food to give to their children. It is therefore important to educate mothers on food varieties in the community and how to prepare them for their children to enhance proper growth and development.

5.4 Structure, process and outcome of CMAM services

This section describes the views of mothers concerning quality of services provided at the CMAM clinics. The discussions were done in relation with the constructs of the quality care model of structure, process and outcome by Donabedian (2005).

5.5 Structural factors influencing utilization of CMAM services

Quality of health care given to a client is associated with factors within the systems, organization and environment (Kramer & Schmalenbberg, 2007). These could be human, social and environmental factors. According to Donabedian (2005) structure is the setting where the care takes place and the resources needed to deliver the care. Quality and effective care can be provided if nurses have the requisite knowledge and skills, enough resources and a clean and safe environment to work in. When clients know all these are available to meet their health needs, they will be motivated to utilize the services. The study identified the following sub-themes and discussed under structure according to the model; competent nurses, attitudes of nurses, conducive environment of the facility and distance / waiting time / working hours.
5.5.1 Competent nurses

Most of the staff working at the CMAM clinics were nurses and community nutrition officers. However, the nurses were the vast majority. In this study, trained nurses are considered as the human resources indicated in the model and most of them were highly competent. For quality of services to be provided, there should be trained and competent nurses. These nurses should have the required knowledge and skills to be able to provide the quality of care required. The mothers believed the competence of the nurses was instrumental in improving their children’s condition. In their view, the nurses were knowledgeable and had the skills to manage the condition of their children. They also reported that the nurses were hardworking and took their work seriously. This findings was consistent with findings of a study done in Ghana by Pomevor (2013) on quality of neonatal care and Puett et al (2013) on quality of care of severe acute malnutrition in Bangladesh. Similarly, a study conducted by Adda (2016) where mothers saw health workers as knowledgeable and with appreciable skills for managing their children. Knowledge is an important tool in providing health care because knowledge would have to be translated into practice to provide the care. It is therefore necessary for all the nurses providing care at the CMAM clinics to attend frequent refresher trainings to update their knowledge and skills on current event that would enhance quality of care to the malnourished children at the CMAM sites.

5.5.2 Attitudes of nurses

Findings from this study revealed that, mothers were generally impressed with the relationship they had with nurses while seeking care for their malnourished children. The mothers indicated that the nurses were good to them and always welcomed them and rapport established when even they visited the clinics. The nurses were polite, respectful and friendly and according to the mothers, this motivated them to patronize the CMAM services.
The findings corroborate findings of a study done in Nigeria on perception of quality of maternal health services among women, where mothers expressed their satisfaction with the attitudes of health care providers towards them (Emelumadu, Onyeonoro, Ukegbu, Ezeama, Ifeadike & Okezie, 2014). Good and positive interpersonal relationship between nurses and their clients promotes effective and quality of care. The mothers reported they had a good relationship with the nurses. This supports findings of a study in Tanzania by Boller, Wyss, Mtasiwa & Tanner (2003) which reported that positive relationships between nurses and their clients yield positive outcomes. The findings also confirmed that of Hockenhull et al. (2016) who found in their study that mothers acknowledged the fact that health workers were polite and patients when attending to them.

According to the mothers, because of the positive attitudes of the nurses, they sometimes visit them in their homes and called them on their cell phones to check on them or to find out why they were not able to come to the clinic for services. These are follow up mechanisms put in place to facilitate the interaction between nurses and their clients outside the health care setting. This also fostered compliance to treatment and continuity of care which are all highly essential for patients’ wellbeing. A study conducted in Bangladesh on quality of care for severe acute malnutrition by community health workers, confirmed the findings which showed that follow up on clients promote quality of care (Puett et al., 2013). Adda (2016) study confirmed the findings where mothers expressed their joy when they were visited or called to check on them by health providers.

However, in this study, a few mothers were not satisfied with the attitude of some nurses. This they described as bad because the nurses spoke harshly to them and disrespected them. This findings supports the findings of Ofori Appiah (2015) in a study in Ghana on the community-based management of acute malnutrition programme. He found out that the attitude of some nurses was bad since they were harsh on their patients. The
attitudes of nurses is very important in providing quality health care. The study revealed how the mothers placed much value on the attitudes of nurses towards them. The relationship between nurses and their clients was very important where mothers perceived that nurses respected their dignity. The attitudes of nurses therefore have to change for the better to enable clients patronize health care services. From the study, it could be concluded that there was good interpersonal relationship between the nurses and their clients.

5.5.3 Conducive environment

Setting of health care belong to structure according to the model on quality care (Donabedian, 2005). According to Stone et al. (2006) maintaining a safe environment reflects a level of compassion and vigilance for patient welfare that is as important as any other aspect of competent health care. The mothers in this study mentioned that the clinics were clean and spacious with well-arranged benches for clients to sit. This finding is consistent with a study in India which reported that clients were satisfied with basic amenities such as the sitting arrangement for patients and cleanliness of the facility which made them comfortable (Sodani et al., 2010). According to the mothers in this study, they were also able to move around freely without obstruction because the clinics were spacious. The findings of this study support those of Aiken et al. (2008) on their study, effects on hospital care environment on patients’ mortality and nurse outcomes. In their study, it was indicated that a carefully designed health care environment helps to achieve high quality of care. The physical characteristics of the health care setting is important and most people take that into consideration before patronizing the services. Without a conducive environment, quality health care cannot be provided. This study’s findings are congruent with findings of a study done in Nigeria on assessment of CMAM services where mothers reported that, the health facilities were clean with handwashing facilities available (Hockenhull et al., 2016). A clean, neat and spacious health care environment attracts
clients and promote easy movement. This enabled clients move freely in order to receive health care with less interference. A study findings in Ghana confirmed that, nurses reported that the hospital set-up helped them move freely from one unit to the other to ensure patients received needed care (Bour, 2014). The mothers in this study were appreciative with the environment in which they received care. Nurses should always ensure that the environment in which health care is provided is always conducive enough to make their clients comfortable whilst they receive care. It should be acknowledged that a conducive environment plays an important role in quality health care.

5.5.4 Distance / Waiting time / Working hours

These three factors are important and can influence utilization of health services. Findings from the study revealed that, mothers did not have problem with the distance from their homes to the CMAM clinics. The journey to the clinic for most mothers were short and lasted between 10 – 30 minutes; some mothers were privileged to go to the clinic on motor bikes. This finding supports the findings from Sodani et al. (2010) who reported that, most clients go to the health facilities on foot which lasted about 15 minutes. The proximity to the clinic was not a problem to most of the mothers and motivated them to patronize the clinic without defaulting. This findings differs from other findings where mothers had to travel over 2 -7 hours to access CMAM services (Hockenhull et al., 2016; Ofori Appiah 2015). In siting a CMAM service centre, the distance should be considered. The proximity of the clinic to the clients will determine the utilization of the clinic. Health facilities should be sited in order to be convenient to clients as much as possible to enable them access the services.

Waiting time at the clinic according to the mothers was satisfactory. The mothers did not have challenges with the waiting time which reportedly lasted between 30minutes to one hour. The findings support study findings from Bangladesh which indicated that
averagely, the facilities attends to 40 patients daily with the waiting time in those facilities being 30 minutes (Aldana, piechulek & Al-sabir, 2001). However, findings from another study from Nigeria disagree and reported long waiting time at health facilities due to shortage of staff (Hockenhull et al., 2016). The waiting time for the mothers in this study was not long and mothers could go to the clinic for services and still go back home for other activities of importance. Waiting time for clients solely depends on the health care providers and the number of clients attending the health facility. To ensure that clients do not waste much time at the clinics, nurses should ensure that activities are coordinated in a way that the clients leaves early. To prevent clients from defaulting, unnecessary waste of time in the clinics should not be enhanced.

Furthermore, mothers reported being comfortable with the working hours at the CMAM clinic. According to them, the working hours were between 8am – 3pm and nurses were always available to attend to them. This does not support the findings by Aldana et al. (2001) which showed that although the official working hours were from 9: 00am to 17:00, the services were opened to the public at about 9:47 and about 25% of them opened after 10:20am. Working hours should be strictly adhered to by health care providers to ensure clients are provided with the needed services. The working hours could sometimes be scheduled to suit clients when the normal working hours is not conducive to enable mothers and their malnourished children benefit from the services.

5.6 Processes involved in the CMAM services

The process refers to the activities that goes on in the clinic in order to provide quality health care to the clients / patients (Donabedian, 2005). This gives the nurse the opportunity to perform the actual activity on and interact with their clients. According to the model of quality care, the process is the activities the nurses carry out at the CMAM clinics and how these impact on the health of the malnourished children. Findings from this study
revealed that, activities carried out at the clinics where CMAM services are provided, were; registration / documentation, Physical assessment / anthropometric measurement, health education / counselling and provision of food supplement.

5.6.1 Registration / Documentation

Documentation is giving accurate account of activities provided, where the event occurred and the person who provided it (Perry & Porter, 2010). The mothers acknowledged that the nurses at the clinic obtained information from them and recorded them any time they visited the clinic. They also recorded any activities they performed on the children. This confirms that of Adda (2016) findings on the study, assessment of quality care of community-based management of acute malnutrition services in Ghana who found that monitoring and documentation could help achieve quality case management of malnourished children. Documentation is keeping of records of the client in order to monitor the progress of treatment and recovery. It is important that nurses document all the care provided to their clients and ensure that it is accurate and complete for continuity of care and follow up.

5.6.2 Physical Assessment / Anthropometric Measurements

According to the protocol guidelines of CMAM, health care providers are to assess the malnourished children whenever they visit the clinic (WHO, 2009). Findings from this study revealed that some assessment were carried out on the children which included measurement of the Mid Upper Arm Circumference (MUAC), taking the weights, physical examination and assessing for oedema. The mothers mentioned that their children were also given treatment when they were sick. Assessment is done to ascertain and diagnose the condition of the children and necessary in detecting complications. This findings were consistent with the study findings of Simbar, Nahidi and Dolatian (2012) on assessment of quality of prenatal care. According to the authors, using the physical examination checklist
on the clients helped to detect risk factors and improve performance. This findings is also in accordance with study findings on quality nursing care which indicated that, nurses conducted regular assessment of patients to facilitate effective planning of patient care (Bour, 2014). Monitoring the progress of the malnourished children is important to determine how well the children are improving. Assessment is an important tool in quality health care and should not be neglected. Nurses should ensure that all patients under their care are constantly assessed to monitor their progress.

5.6.3 Health Education / Counselling

Husson, Mols and Van de Poll-Franse (2011) said providing information to clients which is consistent with their specific needs is a significant determinant of client’s satisfaction. The mothers mentioned that they were educated on the condition of their children. The nurses counselled mothers on nutrition, proper handwashing, child care and information necessary to assist in the recovery of their children. Counselling mothers with malnourished children prepare them to adhere to treatment and rehabilitation which facilitate prompt recovery. Health education enable the mothers to comply and contribute to the treatment of their children. Participants were reportedly satisfied with the counselling offered since they understood the condition of their children, how it is managed and what it takes for the child to recover. This confirms study findings by Puett et al. (2013) where mothers were satisfied with information given them while they were receiving CMAM services. The mothers identified the counselling on nutrition as important in ensuring the prompt recovery of their children. This findings were consistent with findings from Sword et al. (2012) on women’s and care providers’ perspectives of quality prenatal care. In their findings, the women considered counselling on nutrition as an essential component of quality prenatal care. Patients’ education according to nurses in a study in a Ghanaian
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hospital, helps to allay patients anxieties and to ensure co-operation and compliance during treatment (Bour, 2014).

Providing health education to mothers of malnourish children would promote positive attitude towards child care. Health education is important in improving the health status of these mothers and their families. Health education has been a powerful tool used to disseminate information. It is therefore necessary that nurses possess the skills and competence to enable them impact knowledge to their clients to help maintain healthy lives and reduce the risk of chronic malnutrition and other diseases.

5.6.4 Provision of food supplement

Ready to Use Therapeutic Food (RUTF) or “plumpy nut” is the food supplement used mainly to manage acute malnourished children. From this study, mothers testified and accepted the food supplement as the remedy to their children’s condition because it yielded a better outcome. The mothers said they were always provided with the food supplement and they were educated on how to use it to feed their children. Participants testified there was regular supply of the RUTF with occasional shortages in some clinics. The good thing that motivated mothers to patronize the services was that, it was free and mothers did not pay for anything including the RUTF. The medications given to the children were done via the NHIS card. This findings were consistent with study findings on assessment of CMAM services where mothers acknowledged the fact that the RUTF was free and effective in curing child malnutrition (Hockenhull et al., 2016). Although the mothers see the RUTF as improving the condition of their children, there were occasional stock out in some of the clinics making mothers unsatisfied. Findings were in line with study findings by Ofori Appiah (2015) where mothers reported shortage of RUTF from the outpatient care sites. The mothers were educated on how to feed their children with the RUTF and this enabled them feed their children properly leading to the improvement of their children’s condition. They
were also educated not to share the food supplements with others which was a challenges to most mothers at home because other children wanted to eat. The food supplement was seen by mothers as medicine since it was effective and improved the condition of their children. They also had their hope on the food supplement which they believed was the reason for the improvement of their children’s health. The health staff in the clinics should therefore ensure there is frequent supply of the food supplement to enable mothers have enough to feed their children who are malnourished.

5.7 Mothers’ perception concerning the outcome of quality of the CMAM services

In relation to the theoretical framework adopted for the study, outcome is the third construct in the quality care model according to Donabedian (1988). Outcome is considered the most effective indicator of quality care even though some do not consider it as such (Puett et al., 2013). Mothers based their views of quality care of CMAM on provision of services and how fast their children’s condition improved. The theme had two sub-themes which were: satisfaction and good / beneficial.

5.7.1 Satisfaction

Satisfaction with service provision has been reported to be a sensitive tool that has been used for measuring quality of service within and outside the health system. (Campbell et al., 2010). Clients’ satisfaction with health care is an integral component of quality monitoring in health care systems (Campbell et al., 2010). According to Aldana et al. (2001) clients assess care based on their satisfaction with services that they have received. Satisfactory care is where the expectations of mothers are met. Mothers in this study were appreciative and satisfied with the care rendered them and the various changes they saw in their children’s health. This was because they practiced what the nurses advised. Similar findings showed that satisfied clients usually comply with treatment and follow ups that ensure continuity of health care (Abodunrin et al., 2014; Ruel & Alderman, 2013). A related
study on perception of quality on maternal care showed a high level of satisfaction among mothers (Emelumadu et al., 2014).

5.7.2 Good / Beneficial

Mothers’ confirmed that the services were effective and beneficial to their children and mentioned that the treatment was good and also helpful. According to mothers’, practicing what they were told by the nurses was beneficial since the children were now growing well and their weights were increasing and their general appearance now look improved. Mothers’ explained that their children used not to eat and had grown very lean, they have now seen improvements which meant that, the services was beneficial. There were some benefits that mothers derived from the CMAM services. This was evident in the increase in the weights of their children and they being able to eat well.

5.8 Usefulness of the model

There were several models that the researcher considered during the search for a theoretical framework to guide this study. These included, conceptual framework on child malnutrition by UNICEF, (1990), The UNICEF framework on causes of malnutrition, (1990) among others. The Donabedian model on quality care was deemed useful and the most appropriate because the model best fitted the study. The model seeks to justify the assumption whether what is known to be good medical care has been applied. The model has three constructs which are structure, process and outcome. The model of Donabedian quality of care has contributed immensely to the understanding of the comprehensive views of the quality of CMAM services. The findings of the study were discussed in line with the constructs of the model, which explicitly showed that before quality health care can be provided, there should be an interplay of the three constructs of structure, process and outcome.
The structure of health care embodies the setting where care takes place, the equipment, resources and all that are necessary to provide quality care. In this study, elements within the structure, the improved health care environment and competent staff contributed to the mothers’ satisfaction with the quality of CMAM services.

Processes within the model refer to the gamut of activities carried out by nurses to help improve, restore or maintain the health status of patients. These processes are carried out within the structure to yield the outcome. The model clearly delineates these processes and all the nuances that lead to patients’ satisfaction which is good. In this study, the effective interaction between nurses and their clients as well as delivery of good CMAM services to the malnourished children led to satisfaction (outcome) of the vast majority of mothers.

The outcome is the end result. Thus, following the processes, if the patients’ needs are met or their problems are solved and their health status improves, satisfaction results. The Donabedian model clearly and exhaustively illuminated the study’s trajectory, bringing out what the study set out to do and the “path” along which it was carried out.

**5.9 Conclusion**

Having discussed the findings of this study in relation to literature reviewed, existing knowledge on the subject has been authenticated. New knowledge has also been unraveled as the mothers failed to recognize the condition of their children as nutritional but attributed the condition to spiritual forces adding to the body of knowledge in Nursing.
CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary of the entire study, implication of the study findings to the nursing profession, conclusion and recommendations.

6.1 Summary

The study explored the perspectives of mothers on quality of community-based management of acute malnutrition using the Donabedian model of quality care as a guiding framework.

Before the commencement of the data collection, ethical clearance was obtained from the Institutional Review Board of Noguchi Memorial Institute of Medical Research and the Ethics Review Committee of the Ghana Health Services in Accra. Permission was also sought from the Regional and Municipal Health Directorates in the Upper West Region.

Findings from the research indicated that majority of the mothers lacked knowledge on the causes and management of malnutrition. Though a few of the mothers said it was due to sickness, others said it was as a result of spiritual attacks. This made them seek help from spiritualists and traditional healers until they went to the CMAM site either referred from the child welfare clinic or by friends.

Upon referral, mothers had tangible reasons why they had to send their children for the services. This included going for treatment because they felt the children were sick, the weights of children were stagnant, indicating growth failure and their children refused to
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Mothers did not know what to do and had to contact the nurses for assistance for their children.

Quality of health care given to a client is associated with factors within systems, organizations and environments (Kramer & Schmalenbberg, 2007). Some of the factors that motivated mothers to send their children for the services were the competence of the nurses to solve their children’s problems. They also attested to the fact that the nurses were hardworking and took their work seriously. Mothers also mentioned that the attitudes of the nurses were good, respectful and related cordially with their clients. However, a few of the nurses were rude and disrespectful towards the mothers. The clinic environment, according to the mothers was clean and conducive. The distance from the homes of mothers to clinics was usually walking which took them between 10 – 30 minutes to get to the health facility. However, a few were privileged to use motor bikes to the clinic. The mothers also said they usually did not stay at the clinic for long. The working hours were between 8 am – 3pm which mothers were comfortable with when accessing services.

The services utilized by mothers at the clinic were as follows: registration, where the nurses requested for some information from them for records. Their children were weighed and their MUAC measured with a general physical assessment conducted on them. The mothers were also educated on the condition of the children and nutritious food to give their children. They were encouraged to take good care of the children to enhance prompt recovery. The mothers were also given some food supplements to feed the children with. According to them, the food supplement was good because it helped to improve the condition of their children. The supply of the RUTF was not that regular because of occasional shortages. The food supplement was provided free of charge and also very effective for the treatment of the children.
6.2 Implications of findings on the nursing profession

The findings from the study on the perspectives of mothers on quality of community-based management of acute malnutrition services, have implications for nursing practice, nursing education, nursing research and policy formulation.

6.2.1 Nursing Practice

The CMAM programme was established by UNICEF, WHO and Ghana Health Service to address severe acute malnutrition in children under five years (Bahwere et al., 2011). The effectiveness and success of CMAM in the management of malnutrition is well known (Akparibo, 2014). It was realized from this study that, even though the mothers were attending child welfare clinic (CWC), the nurses could not identify the problem in order to direct them to the CMAM site. The nurses kept telling the mothers their children had stagnant weights and were not growing well. This means that the nurses have an important role to identify and refer children with malnutrition early to the CMAM site. It was also revealed that, the mothers did not know the condition of their children and where to seek for the appropriate treatment. Nurses are therefore expected to educate the mothers and give the necessary information that will enable them provide quality care to their children. The mothers reported occasional shortage of the RUTF at some clinics. In order to realize the aim of the CMAM programme, Ghana Health Services and in-charges of the facilities should ensure adequate supply of the food supplement to promote prompt recovery.

6.2.2 Nursing Education

This study portrayed that some nurses lacked knowledge on the CMAM programme. To ensure adequate knowledge for nurses as well as publicity about the programme, periodic in-service trainings should be organized on CMAM for nurses to bridge this knowledge gap. This will enable the nurses to effectively communicate information about the programme to
the general public. Periodic in-service training should be organized for nurses on CMAM to keep them updated with current events on the programme.

6.2.3 Nursing Research

The findings of this study showed more research is required on mothers’ knowledge level of the community-based management of acute malnutrition programme. This will elicit important information to help provide quality health care to children with acute malnutrition. Application of the model in exploring the perspectives of mothers on CMAM in the Wa municipality has contributed to the understanding of quality of care.

6.2.4 Policy Formulation

The findings revealed that, mothers did not know about the CMAM programme because community sensitization had been poor and case search was non-existent. The mothers also identified occasional shortages of the Ready-to-Use- Therapeutic Food (RUTF) which they use to feed their malnourished children. It is therefore imperative for the Ministry of Health, the policy maker, to formulate policies that will make it mandatory for effective health education from the staff of the Ghana Health Service and Non-Governmental Organizations to be organized about the CMAM programme. The Ghana Health Service should also ensure that, the food supplement (RUTF) is always available in all facilities that provide CMAM services.

6.3 Limitations of the study

The study was conducted only in the Wa Central of the Wa municipality hence the findings could be peculiar to the area. It is therefore important for further research to be conducted in other areas of the Region and the country at large in other to ascertain the situation in a larger extent.
6.4 Conclusion

In conclusion, mothers had confidence in the CMAM services provided. They were appreciative and satisfied with the care rendered and the remarkable changes they saw in their children. The mothers affirmed that the services were effective and beneficial to their children. They also mentioned that they were willing to educate their friends about the CMAM Programme to help reduce the incidence of malnutrition in the municipality.

Exploration of the perspectives of mothers on the quality of CMAM services has been an important experience for the researcher. The eagerness, willingness and passion expressed by the mothers while expressing their views on the issues depicted their interest and desire for CMAM services to be improved. This study has revealed various findings that must be giving the needed attention to ensure the CMAM services achieve its intended purpose. Although the CMAM services instituted by the Ghana Health Services to address acute malnutrition in children under five years is going on successfully, the programme still needs some support. Policy makers and service providers should invest in strengthening the health systems in making quality of CMAM services become more effective. Donor agencies and Government should support the CMAM services with sustained and continuous supply of the food supplement and medicines for the treatment of the malnourished children.

6.5 Recommendations

Based on the findings of the study, the following recommendations were made:

Ministry of Health (MOH)

The Ministry of Health should ensure:

- There is an integrated collaboration between MOH and some None Governmental Organizations to address the problem of severe acute malnutrition.
• They formulate policies that will ensure mandatory and effective health education in all health facilities on CMAM.

• That adequate and prompt supply of Ready–to-Use Therapeutic Food (RUTF) to all health facilities.

**Ghana Health Service (GHS)**

The Ghana Health Services should ensure that:

• Health education should be intensified by nurses at the Child Welfare Clinics on the causes, signs and management of malnutrition so that mothers can identify these signs early and seek treatment.

• Mothers should be encouraged to practise exclusive breastfeeding and to introduce complementary food at the right time. They should be educated on the varieties of appropriate weaning diet to prevent them from giving the children only starchy foods that can cause malnutrition.

• The public should be sensitized on how to identify and refer malnourished children to the CMAM site by both health staff and Non-Governmental Organizations.

• The CMAM programme should be well publicized for people, especially mothers, to know the purpose and benefits it has to the management of acute malnutrition which will help reduce child morbidity and mortality in the municipality.

• Ghana Health Service and staff in charge of facilities should ensure adequate supply of the food supplement to the facilities to prevent occasional shortages.

• Further research on CMAM should be conducted to unearth views that will help promote the success of the programme.
Ghana Education Service (GES)

- The Ghana Education Service should give priority to girl child education by supporting with scholarships to enable girls pursue higher education to enable them support their families and community in future.

Ministry of Gender, Children and Social Protection (MGCSP)

The ministry of Gender, Children and Social Protection should;

- Collaborate with Non-Governmental Organizations to provide support systems for the unemployed mothers to enable them feed their families with nutritious foods.
REFERENCES


Perspectives of Mothers on the Quality of CMAM


Perspectives of Mothers on the Quality of CMAM


Perspectives of Mothers on the Quality of CMAM


hunger and markets. Analysis. https://doi.org/10.4324/9781849771658


APPENDICES

Appendix A: Ethical Clearance NMIMR

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979
A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

Phone: +233-302-916438 (Direct)
+233-289-522574
Fax: +233-302-302182/513202
E-mail: nirb@noguchi.ug.edu.gh
Telex No: 2556 UGL GH

My Ref. No: DF.22
Your Ref. No:

13th November, 2017

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824
IRB 00001276
NMIMR-IRB CPN 042/17-18
IORG 0000908

On 13th November, 2017, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL: Perspectives of mothers on quality of community-based Management of acute malnutrition in Wa Municipality

PRINCIPAL INVESTIGATOR: Mary Saratu Adams MPhil Cand.

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 12th November, 2018. You are to submit annual reports for continuing review.

Signature of Chair: ................................
Mrs. Chris Dadzie
(NMIMR – IRB, Chair)
Perspectives of Mothers on the Quality of CMAM

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

MyRef: GHS/RDD/ERC/Admin/App [915]  
Your Ref. No.

Mary Saratu Adamah  
University of Ghana  
School of Nursing and Midwifery  
Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

<table>
<thead>
<tr>
<th>GHS-ERC Number</th>
<th>GHS-ERC: 013/12/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Title</td>
<td>Perspective of Mothers on Quality of Community-Based Management of Acute Malnutrition</td>
</tr>
<tr>
<td>Approval Date</td>
<td>28th February, 2018</td>
</tr>
<tr>
<td>Expiry Date</td>
<td>27th February, 2019</td>
</tr>
<tr>
<td>GHS-ERC Decision</td>
<td>Approved</td>
</tr>
</tbody>
</table>

This approval requires the following from the Principal Investigator:

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol.

SIGNED..........................  
DR. CYNTHIA BANNERMAN  
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra
Title of study: Perspectives of mothers on quality of community-based management of acute malnutrition services in the Wa Municipality.

INTERVIEW GUIDE
Section A
Socio-demographic data
Age
Educational background
Marital status/ Type of marriage: example, monogamy or polygamy
Occupation
Occupation of husband
Number of children
Religion

Section B
Information on quality of CMAM
1. Can you please tell me what you know about CMAM?
   Probe:
   - Establishment – how did it come about/ who brought it
   - Objectives – what is the reason/ purpose for it
   - Benefits
2. How did you get to know about the clinic?
   Probe:
   - Reasons for use
   - Who initiated the move to use the services
   - Why decide to use the service
3. What services do the nurses give to your child when you go to the facility?
   Probe:
   - Assessment (history taking, weighing, MUAC, physical examination e.g. checking temp, breathing, etc)
   - Medication (treatment of other conditions)
   - Food supplements (provision of RUTF etc.)
     - What is the food made up of
     - Where does it come from
     - Is it regular/ is it always available
     - What quantity is given
     - Is it free
4. What do the nurses tell you when you go to the health facility for services?
Probe:

- On malnutrition – causes, s/s, management, prevention and complications
- Nutrition /diet/food groups
- Care of the child
- Worm infestation
- Personal and environmental hygiene

5. What did you do with the information you received from the nurses?
Probe:

- Were you allowed to ask questions
- Did the information address your needs

6. Describe how your child is responding to the treatment?
Probe:

- Tell me the way you feel about the treatment given to your child
- What observations have you made bringing your child here

Section C

Mothers views about services

7. Tell me your general impression about the facility and services?
Probe:

- Cleanliness of the environment
- Working hours
- Waiting time
- Distance/ travel time
- Staff attitude / describe how the nurses treat you
- Competence of staff
- Cost of services / is it free
- Availability of drugs and RUTF

8. What is your belief about your child’s condition?
Probe:

- What did you do before going to the clinic

9. What is your relationship with the nurses after the clinic?
Probe:

- Visited at home
- What service did the nurse provide
- What did the nurses tell you to do

10. What is your overall impression about the service?
Probe:
Perspectives of Mothers on the Quality of CMAM

• How good or bad is it
11. What suggestions will you give to improve on service you receive?
12. Tell me all about how you feed your child at home?
Probe:
• Exclusive breastfeeding
• Weaning diet – timing
• Type of food
• Taboos on food
• Who determine when the child should be weaned
13. Is there anything else you want to tell me?
14. Will you recommend the service to a friend / Relative?
Give reasons
Do you have any other thing to tell me?
Do you have any thing you need me to explain further?
Thank you for your contribution and time. I am grateful.
CONSENT FORM

Title: Perspectives of Mothers on quality of Community- Based Management of Severe Acute Malnutrition in the Wa Municipality

Principal Investigator: Mary Saratu Adamah.
M Phil Nursing (Student).
Tel: 0244-593981,
E-Mail: mtoxla@yahoo.co.uk

Address: School of Nursing, College of Health Science, University of Ghana, Legon

General Information about Research
This study is to research into the services of the community-based management of acute malnutrition programme (CMAM), and its purpose is to explore the perspectives of mothers on quality of community-based management of acute malnutrition services in children under five years in the Wa municipality.
You will be asked to share your experiences and opinion in my interview with you lasting approximately forty-five to sixty minutes. I may ask you to take part in a second interview after the first one. The topic of the discussion will be related to how nurses provide services on the community-based management of acute malnutrition programme (CMAM). An appropriate time will be arranged for the interview based on your convenience. Our discussion will be recorded on an audio recorder and the information will later be typed out. At the end of the study, the typed out copies and the recorded data will be kept for at least five years under lock and key in researcher office. The researcher will store both the typed copies and the
Perspectives of Mothers on the Quality of CMAM

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON

INSTITUTIONAL REVIEW BOARD

Compensation
At the end of the interview, you will be given a pack of lunch or its equivalent of ten Ghana Cedi (10 GHS) to compensate you for your time in the study.

Voluntary Participation and Right to Leave the Research
Your decision to be part of this study should be on your own will. You may refuse to answer any questions that you do not wish to answer. Your decision to take part in the study or not will not affect any services you may need at the health facility. You have the right to remain in this study or to withdraw at any stage of the study and there will not be any penalty against you.

Contacts for Additional Information
In case you have any further questions on the research, you can contact me on my cell phone number 0244593981 or my supervisors Dr. Patience Aniete on her cell number 0244681352.

Your rights as a Participant
This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh

NMIMR-IRB Form A (Students Only)
Version Date: May, 2016

Valid Until: 12 Nov 2018

Approved Document

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# Perspectives of Mothers on the Quality of CMAM

## Thematic Framework

<table>
<thead>
<tr>
<th>Sub – Themes</th>
<th>Description</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health seeking behaviour of mothers with malnourished children.</td>
<td>Everything the mothers did including where they went to seek help for their child’s condition.</td>
<td>HSB</td>
</tr>
<tr>
<td>2. Mothers’ perception of spiritual dimension of malnutrition.</td>
<td>The spiritual understanding of mothers concerning the child’s problem.</td>
<td>SUM</td>
</tr>
<tr>
<td>3. The use of traditional medicine.</td>
<td>Any traditional medicine mothers used to solve child’s problem.</td>
<td>UTM</td>
</tr>
<tr>
<td>5. Poor child growth / “Small baby”.</td>
<td>Child’s weight being stagnant or weight loss making child look small for age.</td>
<td>PCG</td>
</tr>
<tr>
<td>6. Competence of nurses</td>
<td>Mothers’ view of capabilities of nurses to help improve child’s condition.</td>
<td>CON</td>
</tr>
<tr>
<td>7. Attitude of nurses</td>
<td>How nurses relate and behave towards mothers when they go to the clinic for service.</td>
<td>AON</td>
</tr>
<tr>
<td>8. Conducive environment</td>
<td>A place that encourage treatment or enable work to be done.</td>
<td>CE</td>
</tr>
<tr>
<td>9. Distance / waiting time / working hours.</td>
<td>How far the clinic is from mother’s home, how long mothers stay at the facility when they go for services and how conducive the working hours is to the mothers.</td>
<td>DWW</td>
</tr>
<tr>
<td>10. Registration / documentation.</td>
<td>Any recordings in a register or book concerning child and the condition.</td>
<td>RCC</td>
</tr>
<tr>
<td>11. Physical assessment / Anthropometric measurement.</td>
<td>All assessment and examinations physical/measurement conducted on the child as a form of monitoring child’s progress.</td>
<td>MCP</td>
</tr>
<tr>
<td>12. Health education / counselling.</td>
<td>Education and encouragement that nurses gave to mothers regarding the child’s condition.</td>
<td>HEC</td>
</tr>
<tr>
<td>13. Provision of food supplement.</td>
<td>Giving mothers food supplement to feed their malnourished children.</td>
<td>GMF</td>
</tr>
<tr>
<td>14. Regular supply.</td>
<td>Food supplement always available for mothers to collect.</td>
<td>RSF</td>
</tr>
<tr>
<td>15. Free services.</td>
<td>Mothers’ are not charged for the services they access at the clinic.</td>
<td>FS</td>
</tr>
<tr>
<td>16. No sharing of food supplement.</td>
<td>Food supplement given to the malnourished child is not to be shared with other children.</td>
<td>NS</td>
</tr>
<tr>
<td>17. Food supplement as efficacious and medicinal.</td>
<td>Mothers’ seeing the effectiveness of the food supplement</td>
<td>FAM</td>
</tr>
<tr>
<td>18. Hope in food supplement</td>
<td>Expectation of mothers on how the food supplement will work for the child</td>
<td>HFS</td>
</tr>
<tr>
<td>19. Satisfactory</td>
<td>Meeting the needs of mothers by improvement of child’s condition.</td>
<td>SAT</td>
</tr>
<tr>
<td>20. Good / beneficial</td>
<td>The approval of mothers that the service is effective.</td>
<td>BEN</td>
</tr>
</tbody>
</table>