Caregivers' and Healthcare Workers' Experiences of Referral Pathways for Community-Based Management of Acute Malnutrition in Gombe State, Nigeria: A Qualitative Study

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ABSTRACT

Background: Referral is central to Community-Based Management of Acute Malnutrition (CMAM), but the decision to seek care and the capacity of facilities to deliver it are shaped by household and service conditions. We explored how caregivers and frontline healthcare workers experienced referral pathways in Gombe State, Nigeria.

Methods: We conducted a qualitative descriptive study in Gombe, Dukku and Nafada local government areas. Twenty-one purposively recruited caregivers participated in three focus group discussions (Gombe, n=7; Dukku, n=8; Nafada, n=6), and three heads of outpatient therapeutic programme centres participated in individual key informant interviews (one per area). Interview guides covered recognition of malnutrition, referral decisions, household and transport constraints, facility experiences and suggested improvements. With consent, discussions and interviews were audio-recorded, supplemented by field notes, translated and transcribed. Manual thematic analysis combined concepts from Andersen's behavioural model and the Health Belief Model with inductive attention to participants' accounts.

Results: Five interconnected themes characterised referral experiences: (1) recognising malnutrition and understanding referral; (2) the financial and geographical burden of reaching care; (3) household authority and anticipated stigma; (4) confidence in service reliability, especially availability of ready-to-use therapeutic food; and (5) participant-suggested improvements. Caregiver and outpatient therapeutic programme managers described both household-level delays and service-related barriers.

Conclusion: Referral was experienced as a negotiated process rather than a single clinical instruction. Strengthening CMAM referral pathways may require accessible, respectful services alongside community communication, family engagement, dependable therapeutic supplies and referral feedback. These proposed strategies warrant prospective evaluation.

Keywords: Acute Malnutrition, Caregivers, Community-Based Management Of Acute Malnutrition.

INTRODUCTION

Childhood wasting remains an important public health concern, especially where food insecurity, infectious disease and limited access to treatment intersect. The World Health Organisation (WHO) recommends integrated identification and management of wasting and nutritional oedema, including community-based and facility-based services appropriate to clinical severity (World Health Organisation, 2023). Referral links these services, allowing children identified in communities or outpatient care to reach the next level of assessment and management when needed (World Health Organisation & United Nations Children's Fund, 2026).

Community-based management of acute malnutrition (CMAM) depends not only on recognising an affected child but also on whether caregivers can act on referral advice and whether the receiving facility offers reliable care. Studies from India and Ethiopia have highlighted the roles of local understandings of malnutrition, household decisions and expectations surrounding ready-to-use therapeutic food (RUTF) (Burtscher & Burza, 2015; Tadesse et al., 2015). A study of CMAM implementation in Ghana likewise identified service delivery and user experience as important dimensions of programme quality (Akuu & Amagnya, 2023).

Referral is therefore a pathway shaped by social relationships, household resources and health-system functioning. Quantitative indicators of attendance, defaulting or programme coverage are valuable, but provide limited insight into why a caregiver accepts, delays or abandons referral. Exploring both caregiver and provider accounts may identify actionable gaps between referral recommendations and their practical completion. We examined these experiences in three Local Government Areas (LGAs) of Gombe State, Nigeria.

METHODS

Design and conceptual orientation

We used a qualitative descriptive design to examine how caregivers and frontline healthcare workers experienced referral in Community-Based Management of Acute Malnutrition (CMAM). Andersen's behavioural model of health service use informed attention to predisposing, enabling and perceived-need factors, while the Health Belief Model directed attention to perceived severity, benefits and barriers (Lederle et al., 2021; Rosenstock, 1974). These perspectives served as sensitising concepts rather than prespecified thematic categories; the analysis also allowed themes to develop from the accounts. We used the Consolidated Criteria for Reporting Qualitative Research (COREQ) as a reporting guide (Tong et al., 2007.

Setting and participants

The study was conducted in Gombe, Dukku and Nafada LGAs, Gombe State, Nigeria. CMAM referral pathways linked community identification of children with acute malnutrition to Outpatient Therapeutic Programme (OTP) services and, when clinically indicated, higher-level inpatient management. Caregivers were eligible if they had first-hand experience of caring for a child with acute malnutrition who had been linked to CMAM services. The healthcare-worker participants were heads of OTP centres with direct knowledge of referral operations. The three LGAs and two participant groups offered perspectives from caregivers who encountered referral advice and providers responsible for receiving or coordinating referred children.

Sampling and data collection

Purposive sampling was used to select participants with direct experience of the referral process. Facility personnel assisted in identifying eligible caregivers, after which the research team invited them to participate. Of the 39 caregivers invited, 21 participated in three Focus Group Discussions (FGDs): seven in Gombe LGA, eight in Dukku LGA and six in Nafada LGA. Three OTP centre heads, one from each LGA, took part in individual Key Informant Interviews (KIIs). Thus, the reported dataset comprised three caregiver group discussions and three provider interviews.

The research team used discussion and interview guides addressing recognition and explanations of malnutrition; awareness of CMAM services; receipt and interpretation of referral advice; decisions made within households; transport and financial obstacles; experience of receiving services; and possible improvements. Caregivers

discussed these subjects in groups, while OTP centre heads were interviewed individually about referral operations and service constraints. Participants consented to audio recording; field notes supplemented the recordings. Notes were translated into English and transcribed for analysis, with names omitted from the transcripts and quotations.

Data analysis and trustworthiness

The research team undertook manual thematic analysis of the translated transcripts, informed by Braun and Clarke (2006). First, the accounts were read to become familiar with how participants described referral decisions and service experiences. Second, passages relevant to recognition of malnutrition, referral advice, household decisions, practical access barriers, facility experiences and proposed solutions were assigned initial codes. Third, related codes were compared across the three caregiver FGDs and the three provider KIIs and organised into themes. Fourth, the themes were reviewed against the underlying accounts, including similarities and differences between caregiver and provider perspectives. Finally, related categories were refined into five interpretive themes, illustrated by verbatim quotations. Andersen's model and the Health Belief Model sensitised the interpretation.

Ethics

Ethical approval was secured from the Health Research Ethics Committee of the Gombe State Ministry of Health (MOH/ADM/621/VOL.1/231). Participants gave informed consent, including permission for audio recording. Participation was voluntary, and identifying names were omitted from transcripts and quotations.

Results

Twenty-one caregivers and three OTP centre heads contributed accounts from Gombe, Dukku and Nafada LGAs (Table 1). Their locations and referral-related roles are summarised in Table 1. The five themes trace recognition of need, mobilisation of resources, household and social negotiations, encounters with services, and participant-suggested improvements.

Local Government Area	Caregiver FGD participants	OTP head KIIs	Participant basis
Gombe	7	1	Caregiver: direct CMAM-related care experience; provider: OTP centre head
Dukku	8	1	Caregiver: direct CMAM-related care experience; provider: OTP centre head
Nafada	6	1	Caregiver: direct CMAM-related care experience; provider: OTP centre head
Total	21	3	Three FGDs and three individual KIIs

Table 1. Distribution and documented roles of qualitative study participants. FGD, Focus Group Discussion; KII, Key Informant Interview; OTP, Outpatient Therapeutic Programme.

Theme 1. Recognising malnutrition and understanding referral

Caregivers did not always interpret weight loss as a condition requiring assessment, particularly when thinness appeared familiar or was attributed to another illness. Knowledge of a formal pathway for malnutrition services was uneven. One caregiver connected weight loss to an earlier episode of illness:

"A few months ago, my child had fever and cough, which I think was measles. Since then, he refused to suck breast and started losing weight. I believe that is the cause of this problem." (FGD caregiver)

Another described limited knowledge of services for children with weight loss:

"I do not know anything about services for children who lose weight. We did not receive Western education. I only remember that some health workers once visited our communities and advised pregnant women with

problems to go to the hospital, but I was not aware of this for children with malnutrition." (FGD caregiver)

Providers also described uneven awareness across localities. A healthcare worker observed:

"Except for people in Gombe metropolis, I think many people in this local government are not aware of our activities." (KII healthcare worker)

The accounts suggest that a referral instruction may have limited meaning unless the caregiver recognises the condition and understands what the referral service offers.

Theme 2. The unaffordable journey from advice to attendance

A referral could be accepted in principle but remain beyond a household's financial reach. Participants described transport expenses and the possibility of further costs at receiving facilities. For one caregiver, wanting treatment was not enough:

"When they said I should take my child to the big hospital, I wanted to go so that he could be treated. But the truth is that transport money is a problem. I also heard that there are drugs they will write for me to buy there. How will I buy them?" (FGD caregiver)

A provider recounted similar experiences:

"On many occasions, mothers are willing to go for referral or seek care, but they cannot even afford the cost of transporting themselves to the next facility. The next thing we hear is that they have gone for traditional intervention." (KII healthcare worker)

Distance and expense therefore operated as practical constraints on referral completion.

Theme 3. Household authority and the social visibility of malnutrition

Some caregivers described waiting for a husband's permission before taking a child to a facility. Providers emphasised that household heads could shape both initial attendance and subsequent follow-up. One caregiver explained:

"The first time they came to my house and told me that my child was not having good weight for his age and that I should take him immediately to the health centre, I had to wait for my husband to come back and give me permission before I could take him another day." (FGD caregiver)

Stigma added a further obstacle: taking an undernourished child into public view could expose the caregiver to anticipated judgement.

"It is not easy when they tell you to take your child to a distant hospital. I feel people will laugh at me because my child is so slim and weak, and health workers will be blaming you as if it is your fault." (FGD caregiver)

These narratives show how referral decisions were mediated by family authority and concerns about blame, rather than being individual choices alone.

Theme 4. Facility reliability and confidence in referral

Experiences at facilities informed whether further visits seemed worthwhile. RUTF stock-outs were particularly consequential because caregivers had travelled and incurred costs expecting help. One participant reported:

"I once went to the health centre and the milk they gave to our children was not available. Honestly, I felt very disappointed and was not willing to come the next time, because you spend money on transportation to go to the hospital." (FGD caregiver)

An OTP centre head described how absent supplies could affect subsequent attendance:

"People always like things that are free, and once this RUTF is out of stock, many of them refuse referral. Sometimes you can find a child with multiple registrations just for them to get RUTF." (KII healthcare worker)

Caregivers also reported lengthy waiting times and perceived staffing shortages. These accounts suggest that referral counselling cannot be separated from expectations about the receiving facility's ability to provide timely, dependable care.

Theme 5. Participant-identified opportunities for improvement

Across participant groups, proposed improvements included clearer community education on malnutrition and CMAM services, earlier involvement of husbands and household heads, communication that reduces blame, more reliable RUTF supplies, adequate staffing and better links between referring and receiving services. Healthcare workers pointed to the potential of families whose children had improved to encourage others to seek care.

DISCUSSION

The findings show referral as a sequence of decisions and encounters, any of which may interrupt care. Recognition of malnutrition, capacity to travel, household approval and trust in the receiving service operated together. This interpretation is consistent with Andersen's model: perceptions and knowledge shaped readiness to seek care, whereas transport, money and service availability shaped the ability to act (Lederle et al., 2021). The Health Belief Model further helps explain how anticipated stigma and costs may compete with perceived benefits of referral (Rosenstock, 1974).

The local meanings attached to thinness and childhood illness mattered because caregivers did not necessarily interpret visible weight loss as requiring formal assessment. Qualitative work in rural Bihar similarly found that understandings of undernutrition and family influence shaped engagement with CMAM services (Burtscher & Burza, 2015). In the present study, awareness did not simply mean having heard of malnutrition; it included understanding when referral was necessary, where the child should be taken and what support was realistically available.

Financial barriers were equally important. Caregivers who accepted clinical advice could still postpone or abandon referral when transport and potential treatment costs exceeded what a household could afford. This distinction challenges explanations of non-completion that focus only on knowledge or motivation. The finding also implies that a referral mechanism should consider the feasibility of completing the journey, not merely issuing instructions.

Household authority and stigma added relational dimensions to care-seeking. The accounts do not establish that all husbands obstructed care; rather, they show that some caregivers needed approval or practical support before acting. Communication involving caregivers and relevant household decision-makers may therefore help, provided it does not delay urgent care or undermine the caregiver's ability to seek treatment. Anticipated blame from communities or health workers could also discourage attendance, pointing to the importance of respectful, non-stigmatising counselling.

Perhaps most importantly, caregivers assessed referral through their experience of service reliability. A trip made at considerable cost could become a reason not to return if RUTF was unavailable or waiting times were long. Research from Ghana has similarly identified implementation quality and service-user experience as important aspects of CMAM delivery (Akuu & Amagnya, 2023). Work in Ethiopia has also examined community responses to RUTF provision, underscoring its wider social significance (Tadesse et al., 2015). Strengthening demand without improving the capacity to respond may have limited value.

These findings support a practical approach to referral improvement: communicate the purpose and urgency of referral, consider household and transport constraints, involve trusted local actors, and ensure that referral facilities can receive and manage children appropriately. Closed-loop referral documentation and feedback

between community actors, OTP centres and inpatient services are plausible programme responses, but their acceptability, cost and effect on referral completion require evaluation. The newer WHO and UNICEF implementation guidance provides a relevant operational reference for future programme adaptation (World Health Organisation & United Nations Children's Fund, 2026).

Strength: The study provides valuable insights into CMAM referral challenges by exploring the experiences of both caregivers and healthcare workers.

Limitation: The small sample size and purposive sampling across three LGAs may limit the transferability of the findings to other settings.

CONCLUSION

Caregivers' experiences of CMAM referral in Gombe State were shaped by recognition of malnutrition, household finances, stigma, and confidence in receiving care. Providers described corresponding obstacles, especially unreliable RUTF supply and referral coordination. Improving referral is likely to require an integrated response that addresses communication, access and service reliability rather than awareness alone. Prospective research should assess whether these locally proposed changes improve completed referrals and continuity of care.

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