Report of visit by Elizabeth Poskitt to Lusaka, Zambia as Course Director for Facilitators' Training on the Management of Severe Childhood Malnutrition in Hospital

August 3rd - August 8th 2003

The Training took place in the University Teaching Hospital (UTH) at Lusaka. I only attended the Facilitator Training and the opening morning of the Course itself so I rely on Dr Beatrice Amadi to tell you how the main course went.

Dates of facilitator training: Monday August 4th
to Thursday August 7th (am only)

Number of full days : = 3.5 days

Number of facilitators trained: 12

The facilitator number quoted includes Chantal Gegout (WHO Nutritionist) and John Musuku (Course Clinical Director) who had already been trained in Malawi, and excludes Beatrice Amadi who was my excellent and indefatigable co-Course Director.

Five of the trainees were paediatricians (two, John Musuku and Stephen Hughes -research fellow from ICH in London - still in training); 3 were Medical Officers; 3 were Clinical Officers (equivalent to Medical Assistants) and one was WHO nutritionist.

Five of the trainees (ie all the paediatricians) were based at UTH; two were from Ndola, two from Livingstone and two were from (?) Mongu Hospital. The WHO nutritionist was on a short term appointment and was very much involved in organising the course as well as acting as facilitator but she seemed to manage both duties. There were no nurses amongst the facilitators.

The facilitation included one clinical session with guidance on making up *Resomal,* F75 and F100 as well as a tour of the wards and equipment, on the third day.

The timetable for the Facilitators' Training more or less followed that in the Course Director Manual (pp 69 - 71):

Facilitator Training:

Day One:	Introduction to the course. Introduction of facilitation members. Explanation of the role of facilitators. Explanation of the Facilitator Guide.	
	Module:	*Introduction* *Principles of Care* *Initial Management* - just begun
Day Two:	Module	*Initial Management* *Feeding*
Day Three	Module:	*Daily Care* *Monitoring and Problem Solving* Clinical Session
Day Four: (AM only)	Module:	Role play: *Monitoring and Problem Solving* module *Involving Mothers in Care* Separation into Groups of facilitators (3+4+4) General discussion over practicalities of course. Preparation by faciitators for course

General Comments.

This course was one of several planned by Beatrice and Chantal. They plan further courses in up country hospitals using the trainees from this course as facilitators. At the same time as running courses up country they hope to be able to evaluate the impact of this initial training and to advise and help implementation of the training. (All this is rather dependent on funding and perhaps also whether Chantal has her contract extended beyond October). There is encouragement from the Ministry for extension of the training.

I was very impressed by the clinical set up for the management of severe malnutrition in the paediatric wards at UTH Lusaka. Dr Beatrice Amadi, who attended the facilitation in Blantyre is no longer in charge of the malnutrition wards although she continues to offer advice there. John Musuku has also moved on in his clinical training. The paediatrician in charge of the malnutrition ward was one of the course facilitators and nurses and sisters from the malnutrition ward were attending the main training course.

The ward is clean. (Polishing floors and keeping places clean is seen as very important in Zambia). There is an admission area on the ward with desk, chairs

for mothers and children, and forms and equipment for measuring length and weighing, as well as Dextrostix and haemoglobin testing materials.

The ward itself is large but divided into bays. Children are moved from one bay to another according to the stage of recovery (stabilisation, transition, recovery phases). Children are fed three hourly at all times as this is felt to be simplest. Mothers are provided with food and the children in the recovery phase may get some additional food as well as the F100.

Charts seem fairly thoroughly completed. Weights are recorded. There is some attempt to record how much feed is left.

The children have cots. Mothers have relatively comfortable chairs to sit on beside the cots. There are a lot of heaters in the ward placed on the walls for safety and there is a notice on the entrance to the ward (two sets of doors to encourage keeping the ward warm) about keeping the door shut and how hypothermia can be a killer in malnutrition. Although it was 'winter' and cool when I was in Zambia, the ward was noticeably warm.

There are problems with staffing partly due to trained staff wanting to go abroad (or stay abroad if trained elsewhere) and partly due to hospital policy of moving staff, independent of how useful staff may be to a particular unit.

The atmosphere of the ward was pleasant and the mothers of children who were getting better seemed content and quite cheerful. Difficulties over getting mothers to accept naso-gastric tubes when necessary seem to be less than they were when we met Beatrice in Blantyre.

Mortality rates are still quite high. I do not think there were very complete mortality data prior to changes in practice following the Blantyre workshop. Rates are now said to be around 11% mortality with rates in HIV/AIDS children in the region of 19% and non HIV/AIDS cases around 8%. (HIV/AIDS is a problem for a high proportion of children in the hospital).

The CCP is not used on the malnutrition ward at present, but Beatrice was trying it out on her research ward. She was delighted that one rather difficult diarrhoea and malnutrition case had been put on to a CCP by the sister and the nurses had expressed their delight on using the form since it 'told them what to do next'. Beatrice had been very pleased with their management so it seemed they were very able to follow procedures using the form.

Feeds are currently made using packet F75 and F100 although these packet feeds are being phased out. But they do also used cooked F75. The kitchen was short of good weighing and measuring equipment especially that suitable for weighing the small amounts of ingredients needed to make up 1-2litres of feed. Suitable reliable scales for weighing ingredients are a problem. We were shown

several sets of scales which were either rather erratic or did not measure sufficiently small amounts.

Currently there is little nutrition training on the ward for mothers and no cooking demonstrations. There is a play area and there are plans to introduce more stimulated play and also more health and nutrition advice for the mothers.

Overall the ward set up seemed good compared with many other malnutrition wards I have visited. There are reasonable attempts to follow the WHO guidelines and to implement management, though this is taking place gradually. It is hoped that the current paediatrician in charge will be a force for change (along with the trainee paediatrician doing research on malnutrition who is over from ICH London for two years).

The trainee facilitators were for the most part hard working and capable. There was one trainee who seemed less committed to the course (? Not much homework done. His wife and family had come to Lusake with him). He was originally from the Congo and may have had some slight language difficulties). His overall knowledge of paediatrics seemed quite limiting. There were the usual problems of Beatrice requesting trainee facilitators who were involved in managing malnutrition - and people arriving whose experience or whose current clinical responsibilities were not totally suitable to the position of trainee facilitator. But this one medical officer was the only trainee whose ability to act as facilitator caused much concern. There were plenty of facilitators so it was possible to put the weaker members of the course with several others. I hope they benefited from this support during the course proper.

One of the trainees had done the Unicef course commented on how much better he felt the WHO training was in that he had to work by himself with realistic clinical problems.

There were slight difficulties running the facilitators' course due to shortage of equipment such as overhead projector and flip chart and video projector although all these were eventually mobilised. However I think the rooms chosen for the three groups during the main course did not all have these facilities. This may have caused some problems in the main course as audiovisual equipment seems in short supply in the teaching hospital.

I attach a list with a few errors pointed out as we worked our way through the modules. Some of these are already known.

Elizabeth Poskitt

Errors noticed in Manuals and Modules during the Zambia course.

Facilitators' Guide: page 16. Grey Box 'for nurses' : 3rd paragraph:

Where it reads: *so they see that 8.5kg is -1SD, 7.8kg is -2SD …* should read *so they see that 8.5kg is the median and 7.8kg is -1SD…*

Further down in that grey box in the last paragraph, instead of *In the example of the boy who is 73 cm*…should read *In the example of the boy who is 75cm…*

Facilitators' Guide: page 27. Last sentence of italicised comments about Dikki: *Dikki is first fed 75mls of F75 at 9.30 am* should probably read *Dikki is first fed 19mls of F75 at 9.30 am followed by similar feed half hourly for a total of two hours*, since Dikki has been treated for hypoglycaemia.

Modules: Initial Management. Data are still missing on Marwan in *Initial Management.* These data are vital for doing this exercise and should perhaps be added to the Volume as a Correction stuck in the front of the Module.

Course Director Guide p45. Under Assignments for the next day the first sentence should read *'page 49'* NOT *page 37 of the Facilitator Guide.*