

## COURSE DIRECTOR SUMMARY

### Training Course on the Management of Severe Malnutrition

Location of course: Queen Elizabeth Hospital, Blantyre, Malawi

Facilitator Training:

Dates: April 24th - 27th (midday)

Duration of Facilitator Training: Three and a half days

Number of Facilitators trained: Five\*

\* Professor Ann Hill is not included as she is already an experienced facilitator. Further one additional trainee from Mozambique has not been included in the count as she was so handicapped by poor English that she could not be considered 'trained' and did not participate actively as facilitator in the main training.

Course:

Dates of course: April 28th - May 3rd (midday)

Number of full days: Five and a half days

Total number of hours worked in course: Estimated 39h excluding lunch breaks

Number of participants: 23

Clinical sessions:

Number of clinical sessions conducted: Five

Number of hours devoted/group to clinical sessions  
Seven hours approximately

Modules completed: All modules were completed by all participants

Manual: All participants received a copy of the course modules and manual to take home

Number of facilitators serving at course: Seven\*

\* as already explained, one attendee who came to the facilitator's training was so weak in English that she could not participate as facilitator in the main training. Another Mozambiquan was likewise poor in English and was felt unsuitable as an unsupported facilitator. This meant that the Course Director co facilitated with this trainee facilitator and another facilitator. One group therefore had two facilitators, one group had two facilitators plus the Mozambiquan whose English limited her role, and one group had two facilitators plus the non-English speaking failed 'facilitator' as attendant/supporter but taking no active role in facilitation.

Ratio of facilitators to participants: one to 3/4  
(23 participants in main course)

Course Director's comments:

As Course Director I must commend the hospital and all the staff who helped with the management of the course for their unfailing friendliness, willingness to help and readiness to resolve problems. They were tireless in the help they offered and their flexibility over arrangements for the course. The accommodation provided for the training was very spacious and suitable. The proximity of the ward and the atmosphere of welcome offered by the hospital and the government made administration of the course easy. Excellent meals and refreshments within the training area meant no time was wasted. Good hotel accommodation and transport was much appreciated. My thanks to all those involved locally.

It was unfortunate that the Course Director had to participate fully as a facilitator in the main training since this prohibited her 'observing' teaching sessions other than very briefly during intervals in her own facilitation. However Dr Sultana Khanum was able to observe some sessions and gain an overall impression of the main training.

*Facilitators' training.*

This seemed to go well. There was a problem with the two 'facilitators' sent from Mozambique whose English was inadequate and who were paediatricians apparently still 'in training' and thus might have had difficulty carrying sufficient 'authority' to cope with the role of facilitator, had their English been better. There was also a problem over the Malawian choice of facilitators. The two Malawians chosen withdrew at a very late stage, creating a vacancy which had to be filled urgently. The person sent to fill the slot was a young clinical officer (not fully medically trained). She coped very well but again might have had difficulty providing the experience and authority had she not been paired with a very experienced facilitator. **All this stresses the critical importance of facilitator selection for the success of a course.**

The facilitator training was useful for later planning of the main course since it brought forward an area of concern which was to be raised from time to time in discussions during the main training course: **the prevalence of HIV/AIDS in the region and the implications -or perceived implications of this - for outcome from severe malnutrition.**

Facilitation also raised the other main area of topical difficulty with the course: **the differences between management practices demanded by some NGOs supporting hospitals/governments in the management of malnutrition, and the WHO guidelines**. A Malawi workshop running parallel with the facilitators' training was working to resolve issues relating to these differences.

The issue of the significance of HIV/AIDS was one which concerned both facilitators and trainees. Experience and evidence suggest that good management leads to positive response for most HIV/AIDS cases with severe malnutrition, but that response to appropriate management is often slower than with uninfected children. The development of good management practice is thus important for amassing good data relating to the real impact of HIV/AIDS on outcome in severe childhood malnutrition.

In the facilitators' course and in the main training it was pointed out that the training course was providing guidelines and that trainees were expected to implement as much as possible of the WHO recommended practice but may have to adapt recommendations to meet the facilities of their own hospital. The scientific basis of the WHO guidelines was stressed. Further it was pointed out that the differences between WHO and NGO recommendations were only minor issues compared with the, sadly too widespread, wrong or ineffective practices which beleaguer many units with high mortality rates and slow recovery rates.

#### *Main course.*

I have already listed the concern about the impact of HIV/AIDS on the outcome of severe malnutrition. This led to a few trainees appearing rather sceptical of the benefits of the good practice taught through the modules. At times this created a rather negative attitude to the course in one group in particular. Whilst the concept that poor responses to management in severe malnutrition is explained by HIV/AIDS prevalence may be more perceived than real, this area needs further consideration so that doubts over the value of the course can be quickly resolved and are not allowed to impact on the whole course.

Many of the trainees were intelligent, experienced, clinicians with excellent reading skills and ability to complete the individual exercises quickly and easily. Many of them continued work on the modules in the evenings. This made it difficult when some of the members of a group were much slower than others and kept the rest of their group waiting. A few trainees admitted to being bored waiting for others. There seems a need to develop materials to keep the interest and to widen the knowledge gained by the course for those who work through the modules quickly. Possible suggestions for such supplementary materials are:

- optional materials which could include published papers, recommendations, exercises which deal particularly with HIV/AIDS and severe malnutrition.
- a package of scientific papers filling in the background and history to the development of the WHO recommended practice. Several trainees asked for the scientific evidence for the WHO recommendations. Those who are quick readers and are used to reading scientific papers might be more satisfied if they had opportunity to work with such background materials.

Although some replies to the questionnaire given to trainees at the end of the course suggested the course should be shortened, I question the value of shortening the course. This is the first course I have been involved in where the groups have all appeared to reach the end of the last module without skipping or rushing other modules excessively. The timing for the groups as a whole would therefore seem 'about right' particularly when it is remembered that some of the clinical teaching was limited (see below) and thus may have involved less time than on some other courses.

#### *Clinical sessions*

Although in many ways QEH Blantyre provided excellent facilities and clinical material in terms of patients with evidence of severe malnutrition, some aspects of clinical teaching were limited by lack of appropriate ward procedures which could be used as demonstration and example. Thus the 'feeding' clinical session planned in the trainee course was impossible and had to be modified into a session looking at practical problems in management - itself hampered by incomplete documentation of children's progress. Also the 'nutrition teaching' session developed for the course was useful but a bit 'staged'. There were no routine ward sessions for stimulating play which could be used as teaching for the course. It is helpful if hospitals where training courses are held practise procedures which can be used as clinical examples for trainees.

Ideally the course should be held somewhere which is currently following excellent practice with rapid recovery rates and low mortality. However this may not be possible in some countries. Equipment can be introduced for weighing etc, but lack of other facilities can be more problematic. If supervision and record keeping are limited and education sessions for the mothers poor, there is no good example to counteract trainee scepticism and conviction that these aspects of the WHO recommendations are unimplementable. Trainees need to see practices which **they** could implement and sustain without great change in staffing or facilities. It is difficult to suggest an answer to this dilemma. In a situation where time, cost and people are not limited, the answer might be to take a team to a hospital unit and allow them the opportunity to support staff in implementing the relevant changes. However this is unrealistic - effective long term changes would require time and extreme sensitivity and delicacy dealing with local cultural issues.

**Some process of follow up and evaluation monitoring the effect of these courses on trainees and their workplaces is needed.**

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## Evaluation of WHO Training Course; Blantyre April 28<sup>th</sup>-May 3<sup>rd</sup> 2003

Summary of responses to questionnaire after training course,  
Compiled by Professor Ann Hill.

a) **Course content** : There were 22 responses

**Modules:** Over 95% of those who gave an answer judged the modules to be useful or very useful. Most judged them to be very useful.

The ranking according to usefulness was:

- Initial management
- Feeding
- Principles of care
- Monitoring and problem solving
- Daily care
- Involving mothers in care

**Videos:** Of those who gave an answer, 80% or more considered the videos to be useful or very useful.

The ranking according to usefulness was:

- Mental development
- Emergency treatment
- Teaching about feeding
- Transformations

**Photograph exercises and clinical sessions:** Most respondents (64%) found the photograph exercises very useful. The clinical sessions were very useful to 59%.of respondents but only somewhat useful to 23%.

### b) Ranking of 'difficulty' of the modules

There were 17 responses of which 4 reported having no difficulties, 1 considered the modules too easy given the education of the participants, and 12 indicated the module they found most difficult as follows:

Initial management was considered the most difficult by 6 respondents, the reasons given being the large number of exercises to be completed in a short time, and the fact that there was much new information to assimilate.

Monitoring and problem solving was considered the most difficult by 5 respondents, the reasons being i) too much information ii) challenging as it required synthesis and application of all elements of the course iii) not easy to find root cause.

Daily care. One respondent was unclear about signing on the CCP when a task was done.

### c) Course schedule

Most found the time adequate for the various components, but 5/22 (23%) considered the course too long (especially for doctors/senior health staff n=3). One found the course not sufficiently challenging and one found the logistics around the ward visits tedious. One suggested more could have been done to draw on participants' own experiences. Two offered suggestions for shortening the course,

- i) Read ahead and then 1 day theory, 1 day ward/demonstrations, 1 day discussions on any adaptations needed for implementation and training needed for junior auxiliary staff
- ii) Omit things already known (like how to chart temperatures). 1½ days theory, 1 day practical sessions, ½ day discussions and action plans.

Two participants would have liked some background on the evidence-base for the guidelines or a shorter more scientific course.

