Course Director's Report on Facilitator Training in the Management of Severely Malnourished Children in Hospitals: Lahore Pakistan March 7-10 2005

Course Director: Elizabeth Poskitt

Location of Course: Fatima Jinnah Medical College, Lahore, Pakistan

Facilitator Training: 7 03 05 – 10 03 05

Number of full days: Three and one half days on facilitator training and then one half day discussing action by trainees on return from the training.

Number of facilitators trained: 19

Course: There was no training course to follow this facilitator training.

Clinical sessions: One clinical session was conducted during the facilitator training. This lasted about two hours and included time for mineral solution, ReSoMal and formula preparations in the kitchen area.

Modules completed: All the modules were covered in the facilitator training. However due to pressure of time, delays due to power cuts and the facilitator trainees reading little overnight, the modules were covered rather sketchily – especially the last two modules. Further, because there were so many facilitators in training, it was impossible to offer the usual experience in role play, demonstrations, leading group discussions etc. that facilitator trainees should acquire during the course of the training. (see comments at end).

Manual: Did each participant receive a copy of the course and manual to take home? Yes

Number of facilitators serving on the course: not relevant

Ratio of facilitators to participants: not relevant

Course Director's comments:

Numbers: This course was far too big for a facilitator training course which requires active involvement of the trainees in practising facilitation skills. This is not possible if there is about three times the usual number of facilitators to be trained. Dividing the group was not practical in terms of available room space and only the Course Director and her co-Director had been trained as facilitators.
The large number of facilitator trainees made it difficult to keep the group's attention all the time. It was certainly difficult to ensure everyone was following the course effectively. One facilitator's poor contact with the teaching only became apparent towards the end of the course.

Space:
The room was not large enough for the number of facilitator trainees. If all the facilitator trainees originally listed had arrived the situation would have been impossible.
Students should have table space which, *as an absolute minimum requirement*, provides 2 x A3 in depth and 2 x A3 in width since trainees often need three books open plus their note pad and

plasticized sheets on the table in front of them at any one time. It was not really possible even to have two books fully open at one time in the space provided on this occasion.

Sitting trainees too close not only makes it difficult for them to cope with the modules and guides of the course but also lessens concentration on the reading and work of the course. It is difficult to remain silent and concentrate when elbow to elbow with your neighbour. Whilst is makes it easier for those who are having difficulty to seek advice from their neighbour, it is also easier for a trainee to 'cover up' when having difficulty with the course. I feel lack of space contributed to the poor focus and poor concentration of some trainees.

Practical spaces:
The area used as a 'kitchen' was excellent apart from some rather troublesome background traffic noise. The demonstration of making up feeds was very well done and it was a bonus that the demonstration included what could be done when CMV was not available. The problems in the demonstrations were those which develop when demonstrating to about 20 people crowding round a table. This illustrated the ongoing difficulties of this course. (Some trainees had to be absent at this point so the kitchen demonstration took place on two occasions but the first occasion had about 15 trainees plus various 'hangers –on' (eg the course directors).

The ward was reasonably spacious and would have been very adequate with a more normal number of facilitator trainees. It is always a matter of some luck whether the cases of malnutrition have good clinical signs or not. The ambience of the ward was excellent and the anthropometric equipment very suitable.

Other facilities:
Power cuts were unfortunate and resulted in rearranging the use of videos and some of the feedback exercises which use overheads. It is important that if power supplies cannot be assured that the room used for a course has good natural lighting.

Although a flip chart was requested it did not appear. This was a pity, particularly for listing the commitments made by trainees at the end (copy enclosed with this report).
Black or whiteboards should be available for these courses, as in this case, but they must be quite large and *easily* cleaned.

Arrangements for refreshments and meals were excellent in that they were on the premises so time was not wasted going to and from lunch etc. The social programme was also excellent.

The purpose of the course.
The Director was requested by WHO *to facilitate training for facilitators of the WHO training course on the management of severe malnutrition*. She did not have other remit. She tried her best to facilitate the course in circumstances which (as indicated above) were not ideal.

There were also 'consultants' attached to the course who had neither taken the course nor were taking the course on this occasion. Their presence as 'consultants' had not been indicated to the Course Director prior to the course nor was their role explained to the Course Director prior to the Course. Their purpose even during the course was unclear although it was made quite clear that they were *not* facilitator trainees and would *not* take part in the facilitator trainee interaction. Whilst the Course Director was prepared to try and involve these two people it became increasingly difficult to do so since they were out of the room much of the time and seemed unaware of the nature of the training and, at times, the material of the modules or the WHO protocol.

It is not necessary to have consultants as such on this training. The trainees are the ones whose experience should be used as the basis on which to build knowledge and understanding of the WHO protocol. The course allows reasonable time – particularly with smaller numbers- for discussion and pooling of experiences and encourages interaction between trainees.

If consultants or their equivalent are to be used in the future, it is only fair to make absolutely clear to the Course Director when he/she is 'appointed' who these people are and what their role is expected to be. Given only four days to run the facilitator training means there is no time for a parallel agenda.

The facilitator training is concentrated into a short space of time. Trainees need to work hard and work overnight. They need to be closely involved in the course. Whilst observers need not be excluded, *on reflection* I feel it is important that no observer occupies a space within the main circle of facilitator trainees – especially when there is inadequate space for the trainees to work. Focusing on the facilitator trainees diminishes if there are others sitting in the main circle who are not participating and do not take part in the exercises, demonstrations, role plays etc. Observers should be in positions from which they can 'observe'. Perhaps some thought should be given to whether they need copies of the modules in such positions.

Timing of the sessions and start of the course.
On the first day people are tired. Concentration may be difficult particularly on the first day. I wonder whether a course which begins with registration late morning, inauguration around midday followed perhaps by lunch might be helpful to the trainees? The training could then begin in the afternoon making the first day of work short – and thus less important perhaps if the trainee does not do much reading *that* night. However such a programme would leave either a three and one half day course finishing at the end of the fourth day with no time to plan and set up the training (if a training followed the facilitator training course), or the facilitator training moves into a further day if there is to be a 'where do we go from here?' session at the end. (The Course Director guide suggests a three and one half day training session for facilitators). If followed by a training course, the 'where do we go from here' should probably be at the end of that course rather than in between the two trainings).

Rough Timetable of Training of Facilitators

Day 1 (7 3 05)

Introductions and administrative tasks

Review of purpose and nature of course

Inauguration

Morning:

Introduction module; role of facilitator; using Facilitator Guide

Afternoon*:*

Principles of Care module: Introducing and summarizing modules
Leading a discussion: exercise A
Giving individual feedback
Oral drills

Allocation of tasks for next day (to those who had little traveling and more sleep!

Day 2 (8 3 05)

Morning & afternoon

Concluding *Principles of Care* module

Initial Management module: Introducing the CCP
Individual feedback experience
Conducting a demonstration
Working with a co facilitator
Introducing and summarizing modules

Video sections 1 and 2 (not possible previously because of power cuts)

Allocation of tasks for next day

Day 3 (9 3 05)

Morning

Feeding module: Oral drill
Individual feedback
Group discussion

Visit to 'kitchen' and ward:

Observe and help with making up electrolyte solutions, ReSoMal and F75 using basic materials: FCM powdered; basic chemicals for electrolyte solution; hand whisk (no electricity).

Ward: overall layout with space, toys, washing facilities etc.
Anthropometry: opportunity to weigh and measure children; opportunity to observe children for clinical signs of malnutrition

Afternoon:

Daily Care module

Demonstrations of sections of CCP and weight charts

Assignments for the next day. Stressed the importance of completing reading *Daily Care* module and working through *Monitoring and problem solving* module in preparation for the next day. Preparation for role play next day.

Day 4 (10 3 05)

Morning:

Monitoring and Problem Solving module Practice in leading Group Discussions
Role play: Mortality meeting

Involving mothers in care Module

Shortage of time meant that the Course Director more or less 'walked' the trainees through this module although there was important role play using the discharge card.

Final two sections of the video.

Afternoon.

Trainees were asked to work in national groups (Sudan and Djibouti combined) to develop plans of action focusing on the following points:

- How are you going to advocate encouraging your hospital administrator/MoH to implement these actions for rehabilitation?
- What do you need in terms of supplies/equipment/training to implement at hospital level/provincial level?
- What constraints will you face: What possible solutions can you have to overcome these obstacles?
- Outline a strategic plan for the next one year. Include your objectives and time period by which you think this can be achieved.

The suggestions arising from this work is on the following pages under country headings.

Following this the EMRO representative introduced a list of statements about the management of malnutrition to which the group gave agreement. (I do not have a copy of those statements).

Closing ceremony.

E M E Poskitt

SHORT NOTES ON FUTURE ACTION SUGGESTED BY NATIONAL GROUPINGS IN THE LAST SESSION OF THE FACILITATOR TRAINING.

PAKISTAN

1. Collect data from accident and emergency departments about admissions with malnutrition; death rates and management.

2. Advocate for improved management by educating both the Ministry of Health and hospital administrators on the WHO Manual.

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3. Develop training literature for all levels of staff working with malnutrition.

4. Obtain supplies of minerals and vitamins; obtain better scales and anthropometry equipment; train staff to use these.

5. Work to train paramedics in hospitals and in nutrition rehabilitation units to follow WHO practices.

6. Develop inter-institute collaborations over the management of severe malnutrition

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7. Main hindrances seemed to be overall pessimistic view of ability to create significant change and overbearing administration.

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8. Plan:
    a. collect data
    b. advocate for action
    c. seek partners
    d. train teams of 3-5 persons who will then train others
    e. train those working in tertiary care units about importance of appropriate management of severe malnutrition

9. Implement the WHO programme in the framework of implementing the MDG looking to decrease child mortality.

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YEMEN

1. Talk with ministers/ministries about WHO programme and training.

2. Encourage interest in the programme by using whatever data available on child nutrition and malnutrition and mortality.

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3. Implement in-patient management

4. Introduce the WHO management into the medical/nursing training curriculum.

5. Obtain supplies especially for mineral mixture and anthropometric equipment

6. Develop core of staff trained in the WHO practice.

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7. Hindrances include attitudes of doctors

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8. Work with the diarrhoeal diseases department to implement the WHO management

9. Collaborate with MoH, UNICEF etc. to implement management

10. Network to develop and spread management of severe malnutrition according to WHO protocol.

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SUDAN/DJIBOUTI

1. Meet with MoH and hospital administrators on return

2. Also meet with National Nutrition Department

3. Training must not be wasted

4. Implement WHO protocol in main hospitals

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5. Equip each hospital with needs to implement WHO protocol

6. Dedicate space in hospitals as nutrition ward or at least nutrition unit on ward

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7. Main hindrance is lack of standard management for malnutrition: everyone 'does their own thing'.

8. Also Staff: shortage of staff and short of trained staff

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9. Introduce WHO management to create consistent management

10. Get ready to train others

11. Plan: *First two months*: active advocacy
    Then three months: training of trainers
    Then seven months: training across the country

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AFGHANISTAN

1. There has been, in theory at least, implementation of the WHO protocol since 2002

2. There is confusion because of the varied versions of practice introduced by NGOs

3. Will work to advocate with Public Nutrition Department for one consistent management as per WHO protocol

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4. In theory there is already everything needed for implementation of the WHO protocol

5. Need to develop local sustainability in management using WHO protocol

6. More training of clinical staff is needed

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7. Main hindrances include:
    a. Geography and terrain of Afghanistan
    b. Poor infrastructure
    c. Public insecurity
    d. Default rate of those attending hospital

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8. Need to develop the management of severe malnutrition at the community level

9. Have plans for a national standard guideline to be published

10. Management of severe malnutrition as WHO protocol is part of community and hospital plans

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IRAQ

1. Will contact General Directors of hospitals to change management of malnutrition programmes to conform with WHO protocol

2. Nutrition Rehabilitation has been in action since 1995

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3. Arabic versions of modules are needed

4. Equipment such as scales and measuring boards needed

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5. Main hindrance to action is security – everywhere

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6. Will arrange further courses to improve knowledge of programme and to implement programme

7. Assess what is needed and where

8. Meet with paediatricians to get them to accept implementation of the WHO protocol

9. Develop college curricula to include WHO management

10. Involve the media in interest and action and spreading knowledge

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