

Training Course on the Management of Severe Malnutrition in Hospitals Kabul, Afghanistan 8 - 19 June 2002

1. INTRODUCTION

Situation analysis and background:

After 23 years of conflict and political instability, Afghanistan's health system is seemingly among the poorest in the world. Obtaining the most basic necessities such as safe and adequate food and access to basic health care is constant struggle. Already poor nutritional status is burdened with acute respiratory illnesses, diarrhoeal diseases, and other infections which are killing and disabling thousands of children of Afghanistan.

A series of surveys conducted by non-governmental organizations (NGOs) in Afghanistan, at different point of times in different regions during the past couple of months, have found that 40-60 % of children suffer from chronic malnutrition or stunting (low height-for-age); around 6-16% are acutely malnourished or wasted (low weight-for-height). Although severe malnutrition rate is not reflected in nutrition surveys, an alarming number of hospitalised children across the country are found to be severely malnourished.

An analysis of data from records of 3 hospitals in Kabul (Indira Gandhi Children's Hospital, Ataturk, and Maiwand)¹ collected over a period of 3 years showed that 30-40% of admitted children are severely malnourished. These data show that during the period 1999- 2001 a total of 4062 severely malnourished children (age between 0-59 months) with other complications were admitted in the malnutrition ward. Of these 753 (18%) recovered and discharged, 1783 (43.8%) were transferred for other complications, 1229 (30.2%) defaulted or left against medical advice, and 297 (7.3 %) died during hospitalisation.

Outcome of the 3012 (74.1%) defaulted and the transferred children are not known. Of the 1050 children treated in the ward, a cumulative mortality of 28.2% was observed which is seemingly very high. Average length of hospital stay ranged from 18-32 days for those who recovered. Almost all children were complicated with one or more infections such as respiratory infection (30%), bloody diarrhoea (10%), watery diarrhoea with dehydration (28 %) and without dehydration (10.6%); approximately 6 % was diagnosed having clinical septicaemia and about 15% had other non-specified infections.

¹ ACF (Action Contre la Faim) and WHO Analysis Report: 2002

The findings mentioned above indicate that severe and acute malnutrition constitutes a large number of all paediatric admissions in hospitals in Kabul and possibly in other hospitals elsewhere in Afghanistan. Mortality is high among these children, recovery is slow and particularly the high rate of defaulters was of great concern. This unacceptably high mortality is largely preventable with appropriate treatment.

Indira Gandhi Children's Hospital - Venue for the workshop:

The training workshop was organised in Indira Gandhi Children's Hospital (IGCH), Kabul to meet the request of the Ministry of Health, Government of Afghanistan to reorient doctors and senior nurses in the management of severe malnutrition in hospital settings. IGCH is a 300- bed national, paediatric referral and teaching hospital. Patients are referred from all parts of Afghanistan and about 500 children attend the out-patient department everyday; 200 beds are available for general paediatric patients, of which 45 beds are allocated for severely children in 3 wards; 100 beds are allocated for paediatric surgical cases.

The aim of the training was to improve knowledge and skill of doctors and senior nurses in order to reduce mortality and enhance recovery in hospitalised malnourished children.

The training workshop had two components: an initial training for national facilitators for 4 days, followed by participants' training for 6 days. Course structure is given in the box on page 3; participants' list is given in annex 1 and the programme and clinical sessions in annex 2a and 2b.

Course structure

Training Course in the Management of Severe Malnutrition

Location of course:

Indira Gandhi Children's Hospital, Kabul, Afghanistan

Facilitator Training (conducted in English):

Dates of Facilitator training: *8 June 2002 - 11 June 2002*
Number of full days: *Four*
Total number of hours worked in course: *Twenty-seven hours*
(excluding lunch)
Number of participants: *Eight*
(plus training for one clinical instructor who attended most of the facilitator's course)

Course for participants (conducted in Daari):

Dates of course: *13 June; 15 June - 19 June*
Number of full days: *Six*
Total number of hours worked in course: *Thirty- nine (excluding lunch hour)*
Number of participants: *Eighteen*

Clinical Sessions:

Number of clinical sessions conducted: *Five (including one tour of wards /group)*
Number of hours/group devoted to clinical sessions: *Four plus half an hour touring wards*

Modules completed:

Introduction: *All completed*
Principles of Care: *All completed*
Initial Management: *All completed*
Feeding: *All completed*
Daily Care: *All completed*
Monitoring and Problem Solving: *All completed*
Involving Mothers in Care: *All completed*

Manual:

Each participant received a copy of the manual (in English) "*Management of Severe Malnutrition: a manual for physicians and other senior health workers*" and course modules, *but these modules were translated in the local language Daari. There were some problems with the translation.*

Inauguration:

In the inaugural address, His Excellency Dr Feroz, the Deputy Minister for Public Health stated that war, violence, infra-structural destruction and mass movement of population are all contributing to widespread malnutrition among women and children in Afghanistan. Severe malnutrition with complication poses a serious threat to the health and survival of infants and young children. He appreciates that the rapid development in the management of severely malnourished children have taken place over the past years that has brought down mortality in severely malnourished in the rest of the developing countries. Due to the disturbances in Afghanis life and living, their doctors, nurses and other health professionals have not been able to access to this knowledge and information. Therefore, the Ministry of Public Health was happy to receive this state-of-the art training from the World Health Organization (WHO) to doctors and senior nurses in management of severely malnourished children in hospitals in Afghanistan. He emphasized the need for similar training in other cities this year and hoped that WHO would carry out this important task and continue to provide necessary technical and material support to these courses with fully assured cooperation of the Ministry of Public Health. Dr Musa, the Acting WHO Representative in his address underscored the need for continuing WHO's technical support to the Ministry of Public Health and working with partners to ensure reduction and prevention in malnutrition related mortality in children in Afghanistan.



2. COMMENTS AND OBSERVATIONS

Facilities:

Considering the recent history of the country, facilities in Kabul were better than expected. However, there was a shortage of basic equipment such as measuring vessels for preparing the feeds, accurate and precise food weighing scales. Some needs were met by WHO's provision of low reading thermometers, Dextrostix and vitamin-mineral mix. We had perhaps failed to recognise the likely deficiency of even more basic kitchen equipment.

Facilitator training or training facilitators in management of malnutrition?

Many of the doctors who trained as facilitators were quite senior paediatricians. However, lack of appropriate facilities had probably limited the clinical tools at their disposal. Lack of access to modern journals may also have restricted their up-to-date scientific knowledge in certain areas, although there was no question of the value of their clinical skills. Although almost all the national facilitators received some sort of training in management of malnutrition from non-governmental organizations and others before this workshop, the facilitators' course aimed at training in facilitating skills became, at times, training in the management of malnutrition. This sort of modification of the aims of the course is, in all probability, inevitable if the training is to reach areas which really need help in the management of malnutrition. The problem may need formal recognition.

Time and language problems:

Most of the facilitators had substantial difficulties understanding spoken English and reading English at speed. This necessitated considerable revision of plans for presentation of the facilitators' course and meant that the facilitators had to skim through the later training modules because facilitator training in English proceeded so slowly. This may account for some of the problems which arose when the facilitators came to teach the Feeding and Daily Care modules which were covered only very briefly in the facilitator training course.

The facilitators' course does demand (as planned in the Course Director's manual) some overnight reading. In situations such as exist in Afghanistan (and are common in many other countries) doctors have to go from hospital work to private practice in order to survive financially. Thus it is impossible to expect overnight reading - with the result that the facilitator training becomes very rushed and sketchy.

Clinical Instruction:

Dr Sher M. Faqiri, the clinical instructor, received training with the facilitators and was able to undertake his responsibility diligently. He did a commendable job in organizing and taking the clinical sessions with some assistance and supervision from the international facilitators.



Use of the Critical Care Pathway (CCP):

We found the very complex Action Contre la Faim (ACF) forms used on the malnutrition wards were not properly understood by many of the staff whose role it was to complete them. The CCP of the WHO training module (and any similar record such as the ACF chart) is a sensitive item in the management of severe malnutrition. It has enormous potential usefulness but may be demanding degrees of observation and documentation of patients by ward staff, not currently practised. It may be almost impossible, given the staffing conditions of some hospitals, to achieve the required degree of observation and monitoring. Yet this is essential for the successful management of these children. More time perhaps needs to be allotted to understanding the day to day use of the CCP, so as to convince trainees (and facilitators) of the benefits of the CCP so that detailed monitoring is accepted into clinical practice and used to determine clinical management.

Sensitivities of demonstrating good practice when an NGO's supports already initiated a regimen for the management of malnutrition on the wards:

The practical course in hospital in Kabul presented a difficult ethical problem since the staff and food provision for the treatment of malnutrition in Afghanistan are largely supported by ACF (French NGO). Most of the management protocols supported by ACF are equivalent to those promoted by WHO but in a few areas (e.g. feeding infants under six months who are malnourished; introduction of weaning foods in children over six months) practices do differ quite significantly. This makes it difficult to teach or to answer questions which support policies not in agreement with those promoted by the supporting organisation (ACF) since the trainees are probably dependent on following ACF guidelines for their continued support. However, if the guidelines common to both WHO and ACF are implemented effectively, it is likely that treatment will be more effective than at present, irrespective of any differences in management that exist between the organisations' recommendations.

Training of participants:

A total of 18 participants, including 8 females, took the training. There were three groups of six participants each, one group comprised of only nurses. There was a good countrywide representation with participants coming from Herat, Mazar-e-Sharif, Jalalabad, Kandahar, and Kabul.



Number of facilitators serving at course:

All facilitators served on parts of the course. One was absent for one day. Another, as Director of the hospital where the course was taking place, had other commitments but nevertheless managed to participate in many of the teaching sessions during the course.

Ratio of facilitators to participants:

1 to 3 (The three international facilitators had no direct facilitating role in the course proper due to the language barrier). Three groups of trainees each with at least two

facilitators (one with the Hospital Director as well when he was free to facilitate) and in one 'nurses only' group there were regularly three facilitators.

Translated version of the modules:

Having the modules translated into *Daari* language was an excellent method of improving the training course. All participants could read and understand, to a large extent, the modules. There were, however, plenty of translation errors that were a cause of concern. Most of the modules were delivered just before the respective sessions, allowing little time for the facilitators and participants to read them in advance. This probably happened because of the little time available for translation. The Facilitator's Guide in *Daari* was not available.

Understanding the modules:

The errors (Annex 3) in translation initially resulted in confusion among the participants. The national facilitators had to clarify points of contention first with the international facilitators and then explain it to the participants. In case of any disparity between the *Daari* and the original English version, the English version took precedence. In general, the participants faced more problems in understanding the Feeding and Daily Care modules. Calculation of rate of weight gain was difficult for most of the nurses as well as for some of the doctors. The use and utility of the CCP was poorly understood by the participants. This was probably because the concept of CCP was not clear to even many of the national facilitators. When this became evident from the performance of Group C (nurses), attempts were made to clarify the concept. All participants were asked to fill in the CCP during the clinical session on initial management.

Novelty of the facilitation procedure:

The interest, dedication and effort of the facilitators were impressive, as was the readiness of the trainees to work. Nevertheless, we may have underestimated the extent to which the techniques of facilitation were unfamiliar to the facilitators. There was a slight tendency of some facilitators to teach didactically. Some did appear from time to time to be teaching their own view on the management of malnutrition rather than following the modules but this may have been due to problems with the translation. There was reluctance in all training groups to use individual feedback. This may have been the influence of the accommodation since two of the rooms gave little opportunity for semi private discussion. It could be that individual feedback was culturally strange.

Summary for future action and evaluation:

The Kabul course was very much an initial process since there is a huge need for effective change. All of us felt that the course could not be effective without future support in the form of national courses run by trainees and facilitators and further training nation-wide. Such courses would need, initially at least, some back up from a WHO official designated for nutritional activities in Afghanistan or someone with

appropriate aptitude and expertise. It would seem vitally important for the future of nutrition in Afghanistan that there is collaboration between the various agencies working in the nutrition field so there is neither conflict nor overlap but a unifying consensus on which to build progress.

Participants' impression of the training workshop is given in Annex 4.

Conclusions:

Despite several problems, which are expected in a country facing dire circumstances, the training course went well. This was the first ever-comprehensive course of its kind to take place in Afghanistan. National facilitators were trained in the course; several of them have been identified to be capable of continuing the training in different parts of the country. Following discussions with the participants who came from various regions of the country, it was apparent that the course was an 'eye opener' for them and will be very useful. They have, to say the least, learnt the basic elements required for the survival of a severely malnourished child presenting to a health care facility with an acute illness.

3. RECOMMENDATIONS FOR FUTURE

- The treatment facilities from where the doctors and nurses came for the training course should be evaluated. If there is no nutrition ward or unit, then it should be established. If a new establishment is not feasible, at least a few beds in the general wards should be allocated for severe malnutrition. Nutrition wards or units already in existence should be strengthened. What is required immediately is the provision of ingredients for therapeutic milk (F75 and F100 or other available milk), antibiotics, combined mineral vitamin mix (CMV), weighing scales and length boards, kitchen utensils (measuring cups, jugs). (See Annex 5, Pre-training questionnaire)
- Culturally appropriate and inexpensive diets for catch-up growth should be identified and promoted in the management of severely malnourished children. The module and the video emphasize on a particular diet used as an example in Bangladesh (*khichuri*), can be tried or a more culturally acceptable diet identified (rice / wheat with fresh or dried beans and oil?) and advocated. Such a diet may lessen the dependence on expensive packaged diet, such as F100 in catch-up phase.
- An evaluation of the nutrition units / wards should be undertaken after a certain period of time following the training and establishing / strengthening of the nutrition units / wards, i.e., after 6 months or one year. Case-fatality rates, average duration of stay, rates of weight gain, defaulter rates should be analyzed and, if possible, compared with previous data or the data already available from the three hospitals in Kabul.

- The *Daari* translation of the seven training modules should be thoroughly revised with appropriate corrections. The facilitator's guide, course director's manual, as well as the WHO manual for management of severe malnutrition should also be translated.
- Fresh training courses should be organized in Kabul and in the provinces. Those who were identified to have a good performance in the recently concluded training course may be selected as facilitators and clinical instructors. However, care must be taken to maintain the quality of the courses. An option may be to have an international facilitator oversee the initial 2-3 courses.
- Some of the professionals who will be identified as future facilitators, based on performance in the just concluded course, may be sent to institutions abroad for short-term *hands-on* training on the management of severe malnutrition. Such an exposure will further improve their skills and make them more committed to the care of severely malnourished children.
- The WHO should take the initiative in having the curriculum of medical and nursing schools reformed so that childhood malnutrition gets due emphasis.
- Activities based on the recommendations mentioned above could be effectively executed by a WHO official designated for nutrition activities in Afghanistan. In the absence of such a designated official, it is imperative that a person having the appropriate aptitude and expertise be appointed at WHO Afghanistan. This will not only streamline nutrition-related activities in the country, but also help in establishing a close collaborating network with other national and international agencies and NGOs.
- There should be a meeting between those involved in the WHO course and the ACF Management to resolve the differences in the case management policy.

Acknowledgements:

Contributors of this report - Dr Tahmeed Ahmed (External Facilitator), Dr Elizabeth Poskitt (Course Technical Director), and Dr Sultana Khanum (Course Coordinator), gratefully acknowledge the excellent collaboration, support and cooperation of Dr Sayed Ali Shah, President (Course Administrative Director), Indira Gandhi Children's Hospital, Dr Zobaida Siddiqui, Vice President (Facilitator) and the staff of Indira Gandhi Children's Hospital. In particular, we all appreciated the enormous efforts that Dr Mohammed Mansour, WHO Short-term Consultant in Nutrition, Afghanistan had made to organise the course locally despite immense difficulties, and his untiring ability to work and to act flexibly during the course. We thank Dr Musa, Acting WHO Representative and WHO office staff in Kabul, and Dr Kunal Bagchi, Regional Adviser, Nutrition, Food Security and Food Safety (NFS), WHO Regional Office for the Eastern Mediterranean (EMRO), for their assistance and collaboration.

ANNEX 1: LIST OF PARTICIPANTS

Course Instructors:

Name of participant	Title	Contact address	Ward for severe malnutrition
Dr Tahmeed Ahmed	International Facilitator	Dhaka, Bangladesh	N/A
Dr B. Soegianto	International Facilitator	Surabaya, Indonesia	N/A
Dr Elizabeth Poskitt	Course Technical Director	London School of Hygiene and Tropical Medicine, UK	N/A
Dr Sultana Khanum	Course Coordinator	WHO, Geneva	N/A
Dr Sayed Ali Shah	President (Course Administrative Director)	Indira Gandhi Children's Hospital	Yes
Dr Zobaida Siddiqui	Vice President (National Facilitator)	Indira Gandhi Children's Hospital, Kabul	Yes
Dr M. Arid Hassanzai	Paediatrician (National Facilitator)	Indira Gandhi Children's Hospital, Kabul	Yes
Dr M. Ishaq Maasher	Chief, Paediatric Ward (National Facilitator)	Marwand Hospital, Kabul	Yes
Dr Asif Ghaisy	Supervisor of three malnutrition wards in Kabul City (National Facilitator)	Action Contre la Faim Kabul	works in hospitals in Kabul with ACF
Dr Zemary Hussain	Director (National Facilitator)	Ataturk Hospital, Kabul	Yes
Dr Salah Rahman Rahmani	Chief, General Paediatric Ward (National Facilitator)	Indira Gandhi Children's Hospital, Kabul	Yes
Dr Mir M. Essa Jalal	Medical Doctor (National Facilitator)	Indira Gandhi Children's Hospital, Kabul	Yes
Dr Sher M. Faqiri	IGCH Malnutrition Ward (Clinical Instructor)	Indira Gandhi Children's Hospital, Kabul	Yes
Dr Ghulam Sakhi Rawan	Lecturer of Medical Faculty (National Facilitator)	Marwand Hospital, Kabul	Yes

N/A = Not applicable

Participants:

Name	Title	Contact address	Ward for severe malnutrition
Dr Basir-Ahmad	Paediatrician	Ataturk Hospital Kabul	Yes
Mr Mohamed Saleem	Senior Nurse	Ataturk Hospital, Kabul	Yes
Mrs Kamela	Head Nurse	Indira Gandhi Children's Hospital, Kabul	Yes
Dr Amir Mohamed Jalali	Medical Doctor	Indira Gandhi Children's Hospital	Yes
Dr Quodsia Miry	Paediatrician	Indira Gandhi Children's Hospital	Yes
Dr Sharifa Azizi	Medical Doctor	Indira Gandhi Children's Hospital	Yes
Dr Fareeda Momand	Paediatrician	Maiwand Hospital Kabul	Yes
Mrs Maroofa	Head Nurse	Maiwand Hospital, Kabul	Yes
Dr Mohtarama Ishaq	Paediatrician	Maiwand Hospital Kabul	Yes
Dr Shafiqullah Shafaq	Provincial Supervisor of Malnutrition	Chaghasari Hospital, Konar Province	No. Therapeutic feeding centre proposed
Mr Abdul Majid	Nurse	Regional Hospital, Herat	Yes
Dr Meraj Hamid	Paediatrician	Regional Hospital, Herat	Yes
Dr Asmatullah Habit	Paediatrician	Pediatric Ward, Ningarhar University Hospital Jalalabad	Few beds in paediatric ward
Dr Muhammadulla Nasrat	Assistant Health Coordinator for Malnutrition Programme	Paediatric Ward Public Health Hospital Jalalabad	Separate Nutrition Room
Mr Sardar Mohamad	Nurse	Mirawaiss Hospital, Kandahar	Yes
Dr Dost Shams	Medical Doctor	Pediatric Ward Minwis Hospital Kandahar	No separate ward
Dr Wida Jalal	Paediatrician and Focal Point in Nutrition	Paediatrics Ward, Mulki Hospital Mazar-e-Sharif	No separate ward; cases treated in private clinics
Mrs Ziagul	Nurse	Mazar-e-Sherif Children's Hospital	Yes

ANNEX 2 A: COURSE SCHEDULE

Day	Group A (Doctors)	Group B (Doctors)	Group C (Nurses)
Day 1 Thursday 13 June	10:30-11 am: Introduction 11-12 noon: Principles of care 1-2:30 pm: Principles of care 2:30-3 pm: Video Transformation <u>3-3:30 pm: Tour of wards</u>	10:30-11 am: Introduction 11-12 noon: Principles of care 1-2 pm: Principles of care <u>2-2:30 pm: Tour of wards</u> <u>2:30-3:30 pm: Principles of care including Video Transformation at 2:30 pm</u>	10:30-11 am: Introduction 11-12 noon: Principles of care <u>1-1:30 pm: Tour of wards</u> 1:30-3:30 pm: Principles of care including Video Transformation at 2:30 pm
Day 2 Saturday 15 June	8-9 am: Principles of care 9-10 am: Clinical Session (wt, length, glucostix) 10-12 noon: Initial management 1-3:30 pm: Initial management	8-9 am: Principles of care 9-12 noon: Initial management 1-2 pm: Clinical Session (wt, length, glucostix) 2-3:30 pm: Initial management	<u>8-9 am: Clinical Session (wt, length, glucostix)</u> 9-10 am: Principles of care 10-12 noon: Initial management 1-3:30 pm: Initial management
Day 3 Sunday 16 June	8-11:30 am: Initial management 11:30 am: Video on Initial management 1-2 pm: Clinical session (preparation of ReSoMal) 2-3:30 pm: Feeding	8-10:30 am: Initial management <u>10:30-11:30 am: Clinical session (preparation of ReSoMal)</u> 11:30 am: Video on Initial management 1-2 pm: Initial management 2-3:30 pm: Feeding	8-9 am: <u>Clinical session (preparation of ReSoMal)</u> 9-11:30 am: Initial management 11:30 am: Video on Initial management 1-2 pm: Initial management 2-3:30 pm: Feeding
Day 4 Monday 17 June	8-9 am: Clinical session (Preparation of F75, F100) 9-12 noon: Feeding 1-3:30 pm: Feeding	8-11 am: Feeding 11-12 noon: Clinical session (Preparation of F75, F100) 1-3:30 pm: Feeding	8-12 noon: Feeding 1-2 pm: Clinical session (Preparation of F75, F100) 2-3:30 pm: Feeding
Day 5 Tuesday 18 June	8-11 am: Daily care 11-12 noon: Monitoring and problem solving 1-3:30 pm: Monitoring and problem solving	8-11 am: Daily care 11-12 noon: Monitoring and problem solving 1-3:30 pm: Monitoring and problem solving	8-11 am: Daily care 11-12 noon: Monitoring and problem solving 1-3:30 pm: Monitoring and problem solving
Day 6 Wednesday 19 June	<u>8-10 am: Clinical session (initial management)</u> 10-12 noon: Involving mothers in care 1-1:30 pm: Video on mental development 1:30-3 pm: Involving mothers in care 3-3:30 pm: Closing	8-10 am: Involving mothers in care 10-12 noon: <u>Clinical session (initial management)</u> 1-1:30 pm: Video on mental development 1:30-3 pm: Involving mothers in care 3-3:30 pm: Closing	8-10 am: Involving mothers in care 1-1:30 pm: Video on mental development 1:30-3 pm: <u>Clinical session (initial management)</u> 3-3:30 pm: Closing

ANNEX 2 B: CLINICAL SESSIONS SCHEDULE

Day	Group A (Doctors)	Group B (Doctors)	Group C (Nurses)
Day 1 Thursday 13 June	3-3:30 pm Tour of wards	2-2:30 pm Tour of wards	1-1:30 pm Tour of wards
Day 2 Saturday 15 June	9-10 am Clinical session (weight, length, glucostix)	1-2 pm Clinical session (weight, length, glucostix)	8-9 am Clinical session (weight, length, glucostix)
Day 3 Sunday 16 June	1-2 pm Clinical session (Preparation of ReSoMal)	10:30-11:30 pm Clinical session (Preparation of ReSoMal)	8-9 am Clinical session (Preparation of ReSoMal)
Day 4 Monday 17 June	8-9 am Clinical session (Preparation of F75, F100)	11-12 noon Clinical session (Preparation of F75, F100)	1-2 pm Clinical session (Preparation of F75, F100)
Day 5 Tuesday 18 June	No clinical session		
Day 6 Wednesday 19 June	8-10 am Clinical session (Initial management)	10-12 noon Clinical session (Initial management)	1:30 –3 pm Clinical session (Initial management)

ANNEX 3: TRANSLATED VERSIONS OF THE MODULES – FEEDBACK FROM NATIONAL FACILITATORS

Written feedback on the *Daari* translations of each of the 7 modules was solicited from the national facilitators as follows. The feedback was conveyed to Dr. Friba Hamayun of WHO Afghanistan Office.

Introduction:	Dr. GS Rawan
Principles of care:	Dr. M Ishaq Maasher
Initial management:	Dr. Asif Ghaisy
Feeding:	Dr. SR Rahmani
Daily care:	Dr. Syed Ali Shah Alawi
Monitoring and problem solving:	Dr. M Arif Hassanzai
Involving mothers in care:	Dr. Zemary Hussain

Some specific points and examples are:

- Thorough revision of the translated versions required.
- Confusion between *aosat* (mean) and *miongin* (median). *Miongin* seemed to be a new word for the participants. This probably reflects the use of different dialects in the translation.
- Grammatical mistakes not uncommon.
- Controversy over the use of the words *wahim* or *shadid* for the English word 'severe'.
- Translation errors, i.e., 0.6 kg in *Daari* version instead of 6 kg, 39 cm instead of 38 cm.
- Pages 2-5 missing from the *Daari* version of the Feeding module.
- Pages 3-6 and 11-12 missing from the *Daari* version of the monitoring and evaluation module.

ANNEX 4: COMMENTS FROM NATIONAL FACILITATORS

Almost all national facilitators attended several training courses before organised by NGOs and others in the country or attended training courses out side the country on management of severe malnutrition. A summary of their comments on the recently concluded WHO course is given below.

- WHO course showed new and better training methods;
- Principles of Care module is very useful for understanding reductive adaptation in malnourished children;
- WHO course is more practical & has no lectures, which is good. There should be more time for practical sessions;
- Good points about the WHO course are use of video films, emphasis on mental development;
- The period of transition. F75, F100 cards from WHO course are good. The Critical Care Pathway (CCP) is simple and effective;
- The WHO course is more informative, provides more details. There are plenty of exercises and practical sessions including preparation of ReSoMal, F75 and F100. Use of dextrostix is a new exercise, never shown before;
- Transition in the WHO course is slower, therefore more tolerable, by the patients;
- The WHO course is more practical, interactive, involves group discussions, and role play;
- The WHO course is very comprehensive. Self-reading is a good practice which allows participants to learn by themselves;
- It is suggested that the module summary should be done by the participants and not by the facilitator (as demonstrated in the national facilitator's course);
- It is recommended that nurses should have separate course using modules with more emphasis on daily care;
- More time needed for practical exercises.

ANNEX 5: PRE-TRAINING INVENTORY QUESTIONNAIRE

Consolidated report from 7 hospitals in Afghanistan

Responders: course participants from 7 hospitals

	No. of hospitals	No. of hospitals	Percent/no. where applicable
	Yes	No	
1. Special place for severely malnourished (MN) children:			
a) Separate malnutrition ward	5		-
b) Special room			-
c) Beds in paediatric department	2		-
d) Other (specify)			-
2. Referral of MN children to hospital (%):			
a) Referred from out patient/emergency clinic (%)	7		-
b) Referred from MCH clinic (%)	5		-
c) Referred from other public health facility (%)			-
d) Coming directly to hospital (%)			-
e) Other: specify (%)			-
3. Admission criteria:			
a) Weight-for-height	3	4 INA	
b) Weight-for-age	3	4 INA	
c) Presence of oedema	3	4 INA	
d) Other: (specify)			
4. Maximum MN children managed at the same time:	3 4		40-45 10-30
Constraints: shortage of beds	7	0	
5. Doctors available at MN ward:			
a) Day time	3 4		5 4
b) Night time	7		1
6. Nurses available at MN ward:			
c) Day time	3 4		5 4-6
d) Night time	7		2
7. Current mortality:			
a) Malnourished (% or number)	3	4 INA	18%
b) normal nourished (% or number)	3	4 INA	4-5%
8. Current duration of recovery (days):	3	4 INA	28-30 days
9. Discharge criteria:			
a) > 80% weight-for-height	0	7 INA	
b) Improvement in clinical conditions	0	7 INA	
10. Equipment facilities/supplies:			
a) Normal thermometer	7	0	
b) Low-reading thermometer (25 degree C)	0	7	

INA = Information not available

	No. of hospitals Yes	No. of hospitals No	Percent/no where applicable
c) Functional child weighing scale	7	0	
d) Board for measuring length	3	4	
e) Board (stadiometer) for measuring standard height:	4	3	
f) Hemoglobinometer	3	4	
g) Paediatric naso gastric tubes	7	0	
h) Supplies for IV (scalp vein, poles, tubing, etc.)	6	1	
i) Supplies for blood transfusion	4	3	
j) Syringes (50 ml for feeds)	6	1	
k) Syringes (2 ml for drugs)	7	0	
l) Syringes (5 ml for drawing blood)	7	0	
m) Syringes (10 ml)	7	0	
n) Sterile needles	7	0	
11. Cooking facilities:			
a) Cooking space (kitchen)	6	1	
b) Refrigerator	3	4	
c) Stove or any other cooking method	6	1	
d) Dietary scales with 5g precision	1	6	
e) Electric blender	0	7	
f) Manual whisks	0	7	
g) Large containers/spoons for mixing/cooking	3	4	
h) Feeding cups, saucers, spoons, etc	3	4	
i) Measuring cylinders for measuring ingredients	1	6	
j) Jugs (1 liter)	6	1	
12. Hygiene facilities:			
a) Source of running of potable water	7	0	
b) Toilet and hand washing facilities	7	0	
c) Wash basin for bathing children	6	1	
d) Place for washing bedding and clothing	6	1	
e) Any method for trash disposal	7	0	
f) Soap for hand washing	7	0	
13. Pharmaceutical equipment/supplies			
a) Pharmaceutical scales for measuring chemicals	0	7	
b) WHO ORS	7	0	
c) Commercial ReSoMal	4	3	
d) Mineral/Vitamin Mix without iron (CMV)	5	2	
e) Glucose or sucrose powder	5	2	
f) Vaccines (BCG, OPV, DPT, Measles)	4	3	
Do you have iron tables?	4	3	
h) Do you have iron syrup?" If yes, what sort?	3 0	4 7 INA	
i) Folic acid	7	0	
j) High potency Vitamin A (100,000/200,000 IU)	7	0	
k) Sterile water for diluting: If no, how do you sterilize water?	6	1	

	No. of hospitals Yes	No. of hospitals No	Percent/no where applicable
l) IV fluids			
i) Half-strength Darrow's sol with 5% gluc.	0	7	
ii) Ringer's lactate sol. With 5% gluc.	4	3	
iii) Half-normal (0,45%) saline with 5% gluc.	3	4	
m) Electrolytes and minerals			
i) Potassium chloride solution	5	2	
ii) Magnesium chloride power	2	5	
iii) Zinc acetate solution	0	7	
n) Supplies for blood transfusion			
i) Blood packs	2	5	
ii) Bottles	1	6	
iii) Syringes and needles	2	5	
14. Drugs available:			
a) Amoxicillin	7	0	
b) Ampicillin	7	0	
c) Benzylpenicillin	5	2	
d) Chloramphenicol	6	1	
e) Cotrimoxazole	6	1	
f) Gentamicin	7	0	
g) Metronidazole	7	0	
h) Nalidixic acid	6	1	
i) Mebendazole or albendazole	7	0	
j) Tetracycline or chloramphenicol eye drops	4	3	
k) Atropin eye drops	1	6	
l) Gentian violet for skin	7	0	
m) Potassium permanganate	1	6	
n) Nystatin ointment drops (for Candidiasis)	3	4	
o) Parafine gauze (tulle gras)	3	4	
15. Access to the following laboratory resources:			
a) TB tests (x-rays, culture of sputum, Mantoux)	4	3	
b) Urinalysis	7	0	
c) Stool culture	0	7	
d) Blood culture	0	7	
e) Cerebrospinal fluid culture	0	7	
16. Do you have all the necessary equipment/supplies /drugs etc. for case management of severe MN?:			
(Please describe):a) where there is no facilities for treatment of malnourished children , they are treated with others in general beds (Mazar Mulk and Mirwais hospitals)			
b) most do not have necessary supplies, Mazar Mulk hospital is the most deprived one from all necessary supplies including drugs to treat respiratory tract infections, diarrhoea, dysentery and no facilities for laboratory investigation			