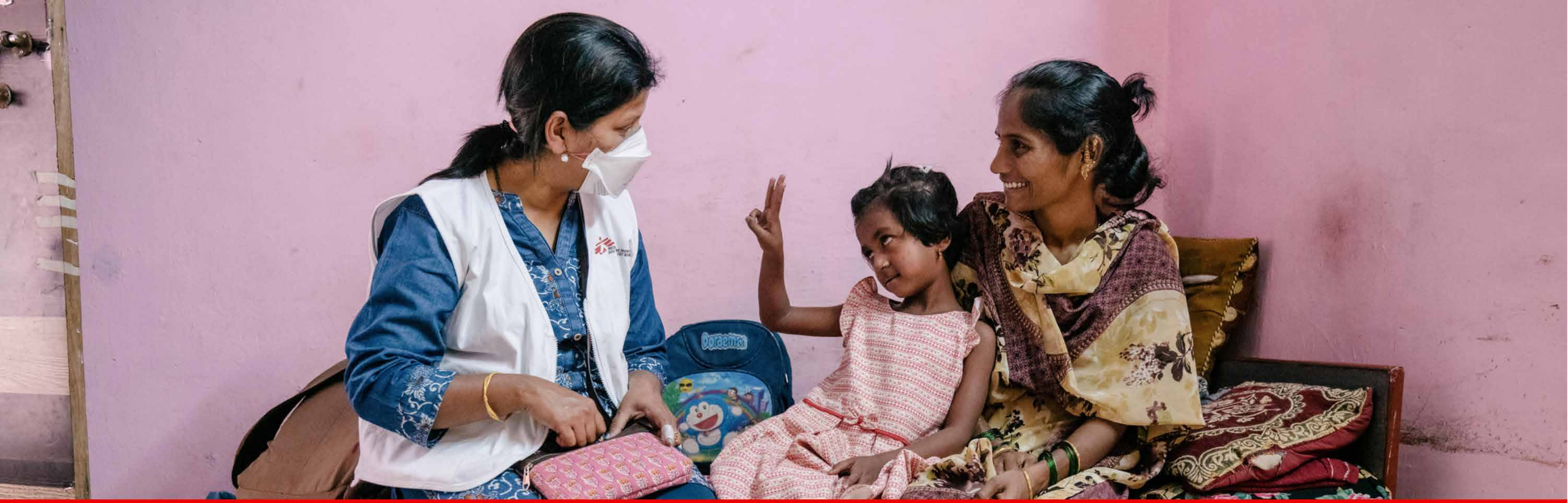
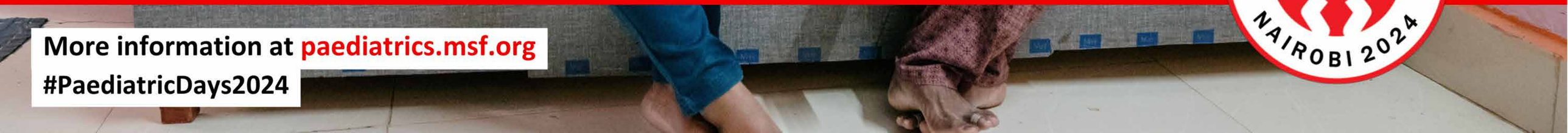


MSF PAEDIATRIC DAYS

KEY MESSAGES

3-4 May 2024



More information at paediatrics.msf.org

#PaediatricDays2024

Vaccination

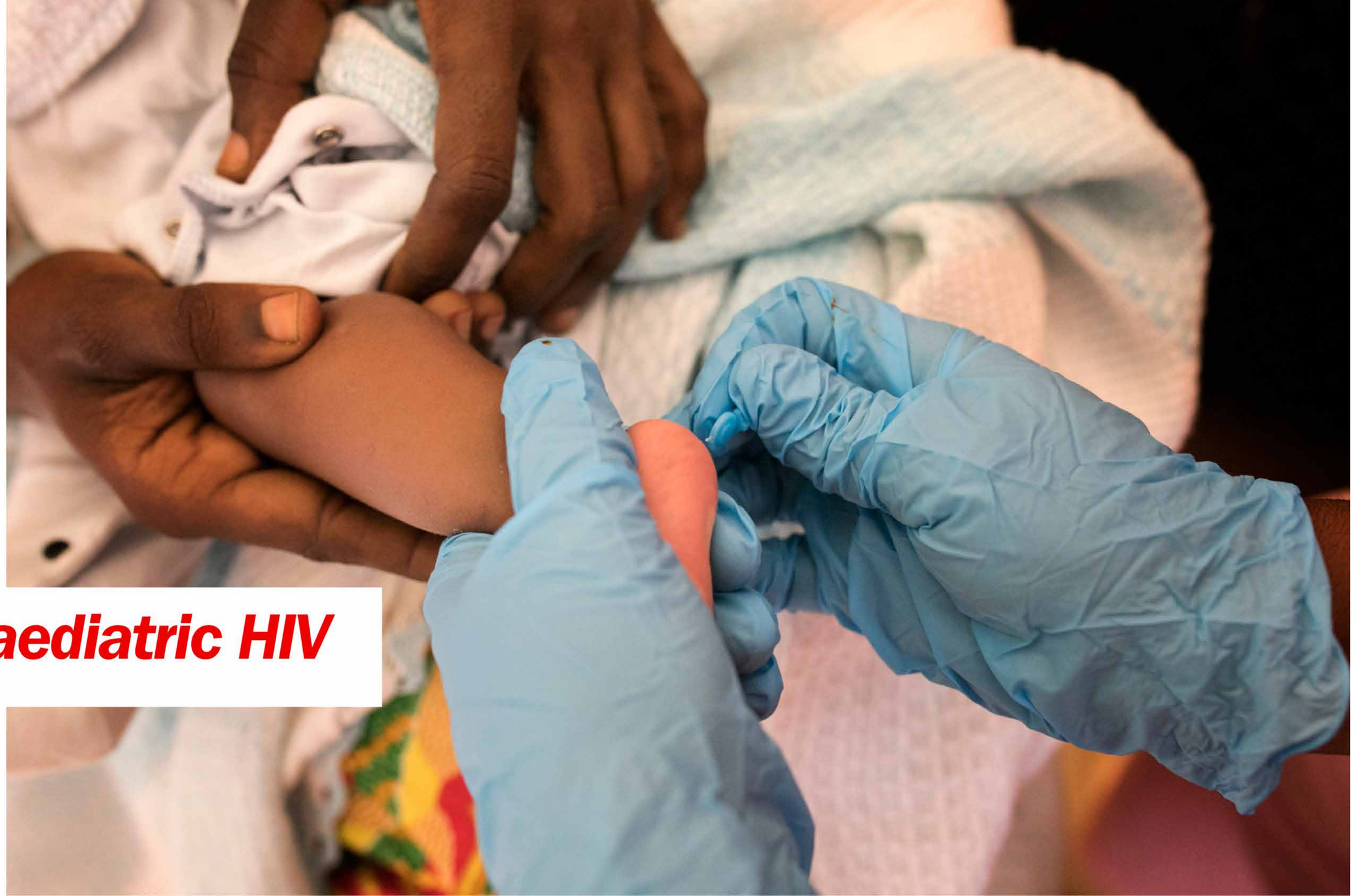
“ Everyone can do more to identify and reach unvaccinated children ”

KEY MESSAGE	→ WHY IS IT IMPORTANT?	→ RECOMMENDATIONS
VACCINATE AT EVERY OPPORTUNITY AND COMMIT TO REACHING EVERY CHILD	Every time we have contact with a child in a medical facility is an opportunity to vaccinate against potentially fatal vaccine-preventable diseases, whether that is in the in-patient department, the out-patient department, the emergency room, the nutritional programme, the postnatal clinic or in any other service. It is everyone’s responsibility to check vaccination status and to ensure that we don’t miss any opportunities to vaccinate children in our care. Everyone can do more to identify and reach unvaccinated children and ensure that they are offered the vaccinations they need.	**Operational recommendations:** • Ensure that all health staff are equipped and sensitised to check eligibility for vaccination in all services where children may be seen, including, but not limited to, in-patient departments, out-patient departments, emergency rooms and postnatal clinics. • Ensure that efficient vaccination services are available in all health facilities and that referral pathways are known by all staff. • Set up systems (patient circuits) to ensure that unvaccinated children do not leave health structures without a plan for vaccination. **Policy and advocacy recommendations:** • Continue to publish research showing missed opportunities for vaccination and how to mitigate these.
IMPROVE COLLABORATION BETWEEN IMMUNISATION PARTNERS	Vaccination activities require teamwork, collaboration and coordination at all levels for maximum efficacy and coverage. Transparent collaboration between key vaccination partners such as WHO, UNICEF, MSF, Gavi (1) and the national Ministries of Health (MoHs) optimises the resources available and maximises coverage.	**Operational recommendations:** • Map out organisations carrying out vaccination activities in all projects. • Improve relationships with national MoHs and local NGOs (2) carrying out vaccination activities. • Collect and read national policies for vaccination and other important documents (vaccination reports, etc.) • Regularly participate in meetings about routine immunisation and response to epidemics e.g. EPI (3) managers meetings, NITAGs (4), Regional WGs (5), etc. **Policy and advocacy recommendations:** • Advocate for MSF to have access to catch-up doses from the MoH.

(1) Gavi = the vaccine alliance (2) NGO= Non-governmental organisation (3) EPI= Expanded Program on Immunisation (4) NITAG = National Immunisation Technical Advisory Groups (5) WG = Working Group

“ *Children under 5 years old are at the greatest risk of dying from vaccine-preventable diseases* ”

KEY MESSAGE	→ WHY IS IT IMPORTANT?	→ RECOMMENDATIONS
UPDATE POLICIES FOR CATCH-UP VACCINATION	Catch-up vaccination policies are designed to vaccinate children who missed the crucial childhood vaccinations recommended in the EPI schedule. In many countries catch-up vaccination policies are restricted to children under 2 years old, meaning that children older than this who are not fully vaccinated do not meet the criteria for inclusion in catch-up vaccination strategies. Children under 5 years old are at the greatest risk of dying from vaccine-preventable diseases therefore policies should be changed to ensure inclusion of these children in the target population for catch-up vaccination.	**Operational recommendations:** • Know the national vaccination schedule and the MoH strategic plans for catch-up vaccination. • Analyse and look for opportunities to optimise catch-up vaccination locally in the best interest of the children in the project. **Policy and advocacy recommendations:** • Lobby for policy change at country level and with Gavi to ensure that children at least up to the age of 5 years old have access to catch-up vaccination.
MAKE PREVENTIVE VACCINATION A PRIORITY	Prevention is always better than cure but is often neglected due to budget restrictions, with funding diverted to acute emergencies whenever there is need. Carrying out opportunistic multiantigen campaigns as part of outbreak response maximizes the impact of the emergency response without the need to invest significant additional resources.	**Operational recommendations:** • Make multiantigen preventive vaccination a priority in humanitarian emergencies. • Promote opportunistic multiantigen campaigns as part of outbreak response. **Policy and advocacy recommendations:** • Advocate internally to operations to incorporate preventive vaccination by default in humanitarian emergencies.



Paediatric HIV

“ *Only 30% of newborns are adequately followed up to the point of final diagnosis and treatment* ”

KEY MESSAGE	→ WHY IS IT IMPORTANT?	→ RECOMMENDATIONS
IMPROVE COVERAGE AND ACCESS TO PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) AND EARLY INFANT DIAGNOSIS (EID)	Despite attention and focus on PMTCT programmes, follow up of infants born to women living with HIV is poor. While effective maternal antiretroviral (ARV) treatment in pregnancy and initiation of prophylactic ARVs at birth for newborns have seen great advances, only 30% of newborns are adequately followed up to the point of final diagnosis and treatment. The rest are lost to follow-up and are either diagnosed later in life when they become sick, or die without ever having been diagnosed and started on treatment.	**Operational recommendations:** • Make ARVs for neonates born to women living with HIV available in all facilities. • Map and appropriately link infants born to women living with HIV to existing diagnostic pathways, depending on local testing availability. • Make early infant diagnosis an operational priority through investment in training of staff, and creation of robust systems for follow-up of infants born to women living with HIV until final diagnosis (which may be at 18 months of age or older). • Increase availability of DNA PCR/NAT (5) testing (including point-of-care options), especially in maternity and neonatal services. • Engage with HIV partners working locally to ensure that there are no gaps in PMTCT and EID. **Policy and advocacy recommendations:** • Advocate for DNA PCR/NAT testing (including point-of-care options) to be widely available and accessible to confirm diagnosis in young infants.
INCREASE DETECTION OF CHILDREN WITH HIV THROUGH INTEGRATION OF CARE	Diagnosis of children is often missed because we are not systematically looking for it. We should be thinking of HIV and actively looking for children with clinical features or history suggestive of HIV in health facilities or in community-based health programmes, regardless of which service they are in, and testing them on site or referring them for testing. This is especially important if the mother or any siblings are sick or are known to be living with HIV.	**Operational recommendations:** • Systematically test all children with malnutrition and tuberculosis (TB) for HIV and actively consider HIV in any child who is not improving on standard treatment. • Look and ask about children or siblings during consultations of women and children with known HIV. • Devise ways to integrate HIV testing and treatment routinely into other services e.g. EPI services, nutrition screening. • Put in place adolescent-friendly approaches where HIV testing and treatment is integrated into services. **Policy and advocacy recommendations:** • Engage with communities to improve detection of children and adolescents living with HIV.

(5) NAT = nucleic acid testing

“ The sooner children start treatment for HIV the higher their chances of survival are ”

KEY MESSAGE	→ WHY IS IT IMPORTANT?	→ RECOMMENDATIONS
START PAEDIATRIC HIV TREATMENT AS EARLY AS POSSIBLE	The sooner children start treatment for HIV the higher their chances of survival are. Globally 50% of children living with HIV are not on antiretroviral therapy (ART), and without treatment half of them will die before their 2nd birthday. On top of this, those who start treatment face interruptions to treatment due to drug ruptures and poor coordination between HIV partners.	**Operational recommendations:** • Link children to treatment services, if not provided by MSF, as soon as they are diagnosed and follow up to ensure that treatment has started. • Make ARVs available in all MSF projects to ensure that children who require emergency treatment can start ART as soon as possible. • Establish and reinforce linkage with MoH and other partners working in paediatric HIV care to maintain continuity of care. **Policy and advocacy recommendations:** • Advocate for paediatric-specific treatment formulations e.g. DTG-based therapy (6) to be widely available.
USE A PATIENT-CENTRED APPROACH TO RETAIN CHILDREN IN HIV CARE	Paediatric HIV care can be burdensome on the child and on the family, and children are frequently lost to follow-up due to difficulties in attending follow-up appointments or lack of understanding of the need for lifelong treatment. Keeping the child at the centre of care and involving the family in their treatment and follow-up plan allows us to create individual plans for each child depending on their specific circumstances. This collaborative approach allows us to build relationships with the child and their family, including them in their own care, which is more likely to lead to retention.	**Operational recommendations:** • Strengthen community engagement messages around HIV care. • Create individual patient follow-up plans that take into account the family’s circumstances, school holidays etc. • Treat mothers and children as a dyad. • Implement strategies to ease the burden of ART on children and their families e.g. creation of community ART support groups (CAGs) that include treatment for infants and children. • Include psychosocial support in HIV care to build resilience and respond to challenges faced by children and adolescents living with HIV. • Implement and adapt adolescent-specific approaches to increase retention of this vulnerable age group e.g. adolescent friendly packages, teen clubs. **Policy and advocacy recommendations:** • Support and fund community-led organisations centred around children and adolescents living with HIV.

(6) DTG = dolutegravir

“ We need to normalise the conversation around HIV in society ”

KEY MESSAGE	→ WHY IS IT IMPORTANT?	→ RECOMMENDATIONS
NORMALISE THE CONVERSATION AROUND PAEDIATRIC AND ADOLESCENT HIV AND DEMYSTIFY HIV CARE	There should be no shame in being diagnosed with HIV as a child, yet many parents are afraid of disclosing their child's HIV status to the child themselves as well as the wider community for fear of judgement and stigma. We need to try to normalise the conversation around HIV in society in general and start talking about HIV openly as we do any other medical condition, to allow children to thrive and live freely with this lifelong condition.	**Operational recommendations:** • Encourage early disclosure of HIV status to children using family counselling that is tailored to the developmental level of the child. • Add paediatric HIV education and information to community health promotion messages. • Incorporate HIV awareness activities in local communities to normalise HIV e.g. World AIDS day activities, fundraisers, storytelling etc. • Explore community-led models of care. • Promote and facilitate the creation of local support groups for children and adolescents living with HIV and their families. **Policy and advocacy recommendations:** • Promote integration of HIV messaging into sexual education in schools. • Advocate for more public discussion on paediatric HIV.
WE CAN DO BETTER IN THE PAEDIATRIC HIV CONTINUUM OF CARE	The paediatric HIV continuum of care involves a continuation of care through the age groups from neonates to adolescents, as well as through the stages of care, from diagnosis to treatment initiation and retention in care across all levels of healthcare.	**Operational recommendations:** • Assess where gaps exist for finding and treating HIV exposed and positive children across age groups, and tailor interventions to fill those gaps. • Map and assess HIV services in each project, from screening and testing to treatment initiation and follow-up, and work with partners across all levels of healthcare from community and primary health services to tertiary hospitals, to ensure that there are no gaps across this continuum. **Policy and advocacy recommendations:** • Give testimony and participate in policy discussions for the areas where gaps are noted for HIV testing and treatment in children.


Nutrition

“ *Treating mothers and their children as a dyad can improve nutritional outcomes for both the mother and her child* ”

KEY MESSAGE	→ WHY IS IT IMPORTANT?	→ RECOMMENDATIONS
TREAT MOTHERS AND CHILDREN TOGETHER TO IMPROVE OUTCOMES IN CHILD NUTRITION	Maternal, neonatal and child nutrition are interdependent, therefore to improve child nutrition we must also focus on maternal nutrition. Simple interventions during pregnancy, such as multiple micronutrient supplementation, can reduce preterm birth and low birthweight (LBW) with long-lasting effects on child health and nutrition, while treating mothers and their children as a dyad can improve nutritional outcomes for both the mother and her child.	**Operational recommendations:** • Evaluate maternal nutrition when young children are identified with wasting or stunting and ensure access to treatment for mothers requiring nutritional support. • Apply the principles of MAMI (7), which aims to treat young infants and mothers as a pair, in project activities. • Consider creation of mother-to-mother peer support groups after discharge of LBW babies, which have been shown to improve breastfeeding success and provide psychological support. **Policy and advocacy recommendations:** • Lobby for sufficient resources to enable children’s and women’s right to nutrition.
PROVIDE HOLISTIC CARE FOR CHILDREN WITH MALNUTRITION, ENSURING INTEGRATION OF NUTRITION AND HEALTH CARE	Children with malnutrition may have malnutrition due to food insecurity, an underlying health problem or both. Integration of health care and nutritional care ensures that we do not only treat the malnutrition but also its cause, leading to better long-term outcomes and reducing relapse. Holistic care involves treating the child as a whole person and not as a series of individual medical conditions. It includes the physical, but also the psychological, social and spiritual wellbeing of the child.	**Operational recommendations:** • Evaluate the health status of all children presenting with malnutrition, and the nutrition status of all sick children. • Integrate nutritional care into general health services and avoid treating children with malnutrition in a silo. • Implement psychosocial stimulation for children with malnutrition and their families. • Improve community management of malnutrition and build capacity of community health workers (CHWs) to facilitate nutritional treatment for children and their families. **Policy and advocacy recommendations:** • Align MSF guidance to the 2023 WHO recommendations and collaborate at national level in the countries where MSF works to support their integration into national nutrition policies and facilitate smooth implementation. • Advocate for integration of health and nutrition at government policy level.

(7) MAMI = Management of small and nutritionally at-risk infants under 6 months and their mothers

KEY MESSAGE → WHY IS IT IMPORTANT? → RECOMMENDATIONS

PREVENT MALNUTRITION BY IDENTIFYING AND TREATING INFANTS AND CHILDREN AT RISK

Infants and children at risk of malnutrition can be identified at an early stage to prevent progression to wasting. Food provision for families facing food insecurity, promotion of age-appropriate feeding practices, maternal and child food supplementation and management of children with moderate acute malnutrition (MAM), among others, are all strategies that contribute to the prevention of malnutrition. With early recognition and timely intervention, at-risk infants and children can avoid the need for prolonged intense nutritional treatment, and instead thrive and grow.

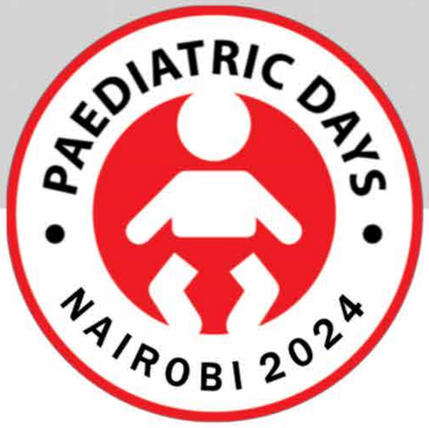
Operational recommendations:

- Increase focus on the nutritional management of small vulnerable newborns – preterm, small for gestational age (SGA) and LBW newborns – to improve long-term nutrition status.
- Identify infants under 6 months of age at risk of poor growth and development and treat them using the MAMI approach.
- Expand nutrition programmes to include the identification and management of children with MAM.
- Evaluate operational capacity and feasibility of carrying out nutritional prevention and early identification activities during emergencies e.g. nutrition screening, blanket supplementary food distribution.

Policy and advocacy recommendations:

- Improve educational resources and availability of information on exclusive breastfeeding and complementary feeding for families with infants and young children.
- Lobby governments to add resources and bring focus to preventative nutritional activities, including the provision of food for food insecure populations.

> *"With early recognition and timely intervention, at-risk infants and children can avoid the need for prolonged intense nutritional treatment"*



Putting 'Humanitarian Paediatrics' on the map: Striving for global and equitable child health

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