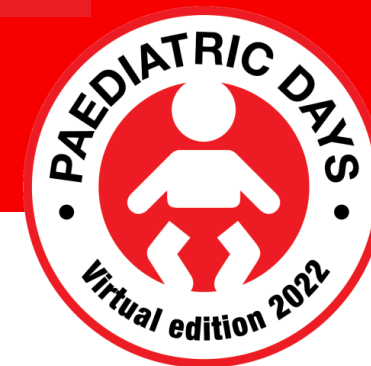





# MSF PAEDIATRIC DAYS

## KEY MESSAGES

29<sup>th</sup> of November -1st of December 2022



More information at [paediatrics.msf.org](https://paediatrics.msf.org)  
#PaediatricDays2022

TOPIC	KEY MESSAGES	WHY IS IT IMPORTANT?	CURRENT CHALLENGES	RECOMMENDATIONS
<p><b>Family-centred care and zero separation</b></p> 	<p><b>Parents and/or caregivers are essential to their newborn. They should be supported to be active partners in care for their newborn, even when sick and/or preterm.</b></p>	<p>Family-centred care has been shown to decrease the length of stay in hospital for preterm newborns, enhance bonding between them and their parents, and improve their well-being.</p> <p>Parental stress and frustration, when excluded from the care of their sick newborn, can be reduced if parents are given the place and opportunity to be involved in the care provided.</p> <p>A good relationship between families and care providers is key to achieving a positive experience in newborn care.</p> <p>The principles of family-centred care are suitable for all levels of care of sick newborns.</p>	<ul style="list-style-type: none"> <li>- Need for a radical culture shift from a healthcare-oriented approach to a family-centred one, where families are involved in the decision-making process as key care providers.</li> <li>- Restrictive visiting policies that hinder the presence of mothers and other primary carers in neonatal units in most MSF-supported projects.</li> <li>- Inadequate support for families to give them confidence in caring for their sick, vulnerable, newborn, such that families feel ill-equipped to care for their newborn whilst admitted, as well as after discharge.</li> <li>- Unfounded fears from health staff that mothers and families increase risk of neonatal infections if allowed unlimited access to the neonatal unit.</li> <li>- Lack of engagement with mothers and families to understand their needs and how staff can facilitate their presence and participation in the care of their newborn.</li> </ul>	<p><b>Project-level:</b></p> <ul style="list-style-type: none"> <li>- Allow unlimited access to parents or primary carers in neonatal units and involve them in everyday care of their newborn.</li> <li>- Ensure clear communication with parents and/or primary carers and give them a voice in the decision-making process.</li> <li>- Provide families with resources to confidently take care of their newborn through participation in workshops, cot-side coaching and peer-to-peer support groups, among others. Include families in the parent's support strategy design.</li> <li>- Involve families in the discussion on how to implement family-centred care in their specific context.</li> <li>- Train all neonatal unit staff about the concepts and relevance of family-centred care and zero-separation to overcome resistance to change.</li> </ul> <p><b>Operations:</b></p> <ul style="list-style-type: none"> <li>- Review hospital policies to allow family presence 24hrs/day in the neonatal unit.</li> <li>- Coordinate with different departments (e.g. logistics) to adapt neonatal units to be family-friendly.</li> <li>- Lead the culture change and integrate a family-centred approach into operations, ensuring continuous refinement of implementation procedures through learning from feedback of parents and staff.</li> </ul> <p><b>HQ/working groups:</b></p> <ul style="list-style-type: none"> <li>- Support teams with development of context-adapted parent training curriculums and materials.</li> </ul>
	<p><b>Allowing mothers and babies to stay together right from birth with a zero separation approach saves lives.</b></p>	<p>New evidence shows that Kangaroo Mother Care (KMC) for preterm or low-birth-weight infants should be started <b>as soon as possible after birth</b> to reduce morbidity and mortality (<b>Immediate KMC</b>).</p>	<ul style="list-style-type: none"> <li>- Siloed care which systematically separates mothers from their newborns is the norm when medical treatment is needed for either of them.</li> </ul>	<p><b>Project-level:</b></p> <ul style="list-style-type: none"> <li>- Remove any barriers that hamper proximity at facility level and identify opportunities to allow mothers and babies to stay together.</li> <li>- Avoid removing healthy babies from the maternity ward for evaluation when they are not unwell e.g. when reviewing an asymptomatic newborn with risk factors for sepsis.</li> </ul>


		<p>Allowing the mother to be with her baby from birth allows the implementation of life saving interventions such as Immediate KMC and breastfeeding, reducing newborn mortality and morbidity and reducing maternal stress.</p>	<ul style="list-style-type: none"> <li>- The current health system paradigm underestimates the value and importance of the mother-baby dyad. Babies who need special care are often separated from their mothers.</li> <li>- Lack of an appropriate space and infrastructure for mothers (or other family members) to stay in neonatal units is a barrier that critically contributes to the physical separation of mothers and babies.</li> <li>- Mothers and families are not included during the design and planning process of neonatal units.</li> </ul>	<ul style="list-style-type: none"> <li>- Ensure adequate space in neonatal areas to include maternal beds together with the neonatal cots, to allow the mother to comfortably stay with her sick or preterm baby from birth, if desired.</li> <li>- Consider the feasibility of creating maternal–newborn intensive care units (M-NICUs), where both mother and baby are resident 24/7, allowing the provision of care to small and sick newborns <b>as well as</b> routine postnatal care for mothers.</li> <li>- Include and engage mothers, families and staff in the design of neonatal units.</li> </ul> <p><b>Operations:</b></p> <ul style="list-style-type: none"> <li>- Engage with local partners and the MoH to facilitate a paradigm shift that is reflected in local and national policies.</li> <li>- Ensure understanding of the concept of zero separation of mothers and babies and consider ways to promote this across operations.</li> <li>- Support and facilitate infrastructure changes at project level to allow zero separation +/- M-NICUs to take place.</li> </ul> <p><b>HQ/working groups:</b></p> <ul style="list-style-type: none"> <li>- Provide guidance and training on the concept of zero separation and its importance in maternal and newborn care.</li> <li>- Develop context-adapted solutions to allow zero separation to take place in different MSF settings.</li> </ul>
<p><b>Providing mothers and their babies with integrated care during their health journey (mother-newborn couplet care) improves outcomes for both and transforms maternal and newborn care.</b></p>		<p>Maternal and newborn health are inextricably linked: the health of one impacts the health of the other.</p> <p>Person-centred care is a priority in MSF operations. Responding simultaneously to mothers’ and babies’ needs throughout the continuum of care is an opportunity to carry out person-centered care for mothers and their babies.</p>	<ul style="list-style-type: none"> <li>- Individual, uncoordinated medical care is currently standard practice for mothers and newborns in most healthcare services at all levels of care.</li> <li>- Poor collaboration between maternal and neonatal care services at all levels.</li> <li>- Current health systems and facilities are not designed for collaborative care and policies do not include the concept of zero separation.</li> <li>- Lack of knowledge and understanding of the benefits of mother-newborn couplet care among healthcare staff.</li> </ul>	<p><b>Project level:</b></p> <ul style="list-style-type: none"> <li>- Identify opportunities to respond to both mother and baby’s needs at the same time (e.g. at any consultation for either mother or baby, enquire about the other).</li> <li>- Include newborn health and raise awareness on the concept of zero separation during antenatal visits to mothers, fathers and families.</li> <li>- Establish a structured interprofessional collaboration between maternity and neonatal services and ensure good communication and coordination between them.</li> <li>- Facilitate integration of care by supporting midwives’ competencies to provide newborn essential care.</li> <li>- Organise care around the couplet, making local adaptations according to staff capacity and national standards.</li> </ul> <p><b>Coordination/operations:</b></p> <ul style="list-style-type: none"> <li>- When planning maternal health activities include newborn health at any level of care, and vice versa.</li> </ul>

- Limited space and resources for reorganisation of care to allow mother-newborn couplet care to take place


- Become familiarised with the concept of mother-newborn couplet care and consider how to integrate this into operations during annual planning.
- If creation of maternal-newborn intensive care units (M-NICUs) is considered feasible, ensure that they have all the infrastructure, equipment, supplies and staff that traditional NICUs have to adequately care for small and/or sick babies, as well as those required to provide routine postnatal care to mothers.

**HQ/research/ working group:**

- Provide guidance and training on the concepts of mother-newborn couplet care, zero separation and M-NICUs and their potential to improve neonatal and maternal outcomes.
- Work in a multidisciplinary team to develop context-adapted solutions to allow couplet care to take place in various MSF settings.
- Analyse routine data from projects implementing integrated maternal and newborn care to estimate the impact of couplet care in MSF projects.
- Advocate to always keep maternal and newborn health services together when planning new operations.


TOPIC	KEY MESSAGES	WHY IS IT IMPORTANT?	CURRENT CHALLENGES	RECOMMENDATIONS
<p data-bbox="107 209 311 261"><b>Malaria: prevention is better than cure</b></p> 	<p data-bbox="338 209 607 408"><b>Prevention is better than cure: A well-developed, tailored malaria prevention plan is a key component of any medical strategy in malaria endemic settings.</b></p>	<p data-bbox="636 225 987 660">Malaria remains a leading cause of morbidity and mortality among children in Sub-Saharan Africa. While tools for prompt diagnosis and treatment of malaria have been widely and successfully implemented, not all cases of severe malaria can be avoided using this strategy alone. Prevention, when done well, has a significant impact on reducing the number of malaria cases, and thus the proportion of those who develop severe and potentially fatal malaria complications.</p> <p data-bbox="636 683 909 735">Each setting is different and requires a unique plan.</p>	<ul data-bbox="1016 217 1424 699" style="list-style-type: none"> <li>- Major funding gap for malaria activities and priority given to curative rather than preventive services.</li> <li>- Lack of knowledge and understanding about which malaria prevention interventions are possible and effective.</li> <li>- Use of prevention tools has declined since 2010 especially in sub-Saharan Africa e.g. access to and use of insecticide treated bed nets (ITNs) (it is estimated that only 50% of children in sub-Saharan Africa sleep under an ITN); populations protected by indoor-residual spraying (IRS).</li> </ul>	<p data-bbox="1451 217 1585 237"><b>Project-level:</b></p> <ul data-bbox="1451 256 2175 448" style="list-style-type: none"> <li>- Advocate for malaria prevention activities locally.</li> <li>- Educate yourself and your team on the different malaria prevention activities and their advantages.</li> <li>- Ensure familiarity with the MSF toolkit of prevention activities.</li> <li>- Review currently existing malaria prevention activities in the project and by other actors and consider how they could be strengthened.</li> </ul> <p data-bbox="1451 467 1570 488"><b>Operations:</b></p> <ul data-bbox="1451 507 2175 647" style="list-style-type: none"> <li>- Ensure a malaria prevention plan is included in malaria strategies as standard.</li> <li>- Support projects in monitoring and evaluating malaria prevention activities as intensively as keeping track of malaria cases tested for and treated.</li> </ul> <p data-bbox="1451 667 1653 687"><b>HQ/working groups:</b></p> <ul data-bbox="1451 707 2175 759" style="list-style-type: none"> <li>- Ensure malaria prevention activities are included in guidance documents with the same importance as treatment.</li> </ul>
	<p data-bbox="338 839 607 1243"><b>The success of different malaria prevention activities is dependent upon: adequate epidemiological and contextual analysis; robust implementation plans that include active community participation; opportunistic and strategic combinations of prevention activities; and working within a multidisciplinary team.</b></p>	<p data-bbox="636 855 981 963">Understanding local epidemiology and contextual constraints allows a realistic prevention strategy to be created.</p> <p data-bbox="636 986 987 1187">Engaging communities is key to success: each community is unique and has specific cultural, practical, organisational and hierarchical structures that must be taken into account in order to define the most appropriate strategies.</p> <p data-bbox="636 1209 987 1410">No single malaria prevention tool is sufficient to tackle malaria – impact is much greater when used in tandem to complement each other e.g combining malaria vaccination with SMC is more effective than either strategy alone.</p>	<ul data-bbox="1016 847 1424 1374" style="list-style-type: none"> <li>- Poor analysis of local context and epidemiology.</li> <li>- Limited resources allocated to implementation of malaria preventive activities.</li> <li>- Lack of effective community engagement on designing, implementing and sustaining malaria prevention strategies.</li> <li>- Few staff with experience in other preventive strategies that allow replication or adaptation to other settings.</li> <li>- Poor implementation or optimisation of prevention opportunities in regular programmes (ANC, EPI, at discharge and in the community).</li> </ul>	<p data-bbox="1451 847 1585 868"><b>Project-level:</b></p> <ul data-bbox="1451 887 2175 1294" style="list-style-type: none"> <li>- Evaluate the seasonal pattern and local epidemiology of malaria to design an appropriate malaria prevention strategy.</li> <li>- Engage with the community to develop methods to improve existing, and devise new, implementation strategies for malaria prevention activities.</li> <li>- Integrate malaria prevention activities into existing prevention programmes where possible, such as EPI, ANC.</li> <li>- Take advantage of every patient contact to promote and facilitate malaria prevention e.g. ensure provision of bed-nets on discharge from hospital etc.</li> <li>- Engage and co-ordinate the multidisciplinary team to ensure good collaboration and effective implementation of prevention activities and consider combining strategies where possible.</li> </ul> <p data-bbox="1451 1313 1570 1334"><b>Operations:</b></p> <ul data-bbox="1451 1353 2175 1453" style="list-style-type: none"> <li>- In emergency interventions in areas with known high malaria burden include malaria prevention more actively in the initial package of intervention (e.g., Mass drug administration (MDA) for temporary reduction of burden, mass net distribution or larvicides).</li> </ul>

		<p>Combining malaria prevention activities with other preventive strategies mutualises resources and optimises coverage. More importantly, it can increase the impact of malaria prevention activities e.g. combining SMC with nutritional supplementation was shown to reduce the incidence of simple malaria compared to SMC alone.</p> <p>Malaria, as a vector-borne disease, requires a multidisciplinary approach to prevention, including not only the medical team and technical advisors but also logistics, watsan, entomology, health promotion (HP) and community engagement (CE).</p>	<ul style="list-style-type: none"> <li>- Weak coordination between human resources, HP, CE and logistics during malaria prevention activity planning, leading to poor population coverage and reduced impact, limiting the overall success of the intervention.</li> </ul>	<ul style="list-style-type: none"> <li>- Engage the multidisciplinary team in the design of malaria prevention plans to ensure all components are included.</li> </ul> <p><b>HQ/research/working groups:</b></p> <ul style="list-style-type: none"> <li>- Develop effective tools to help project teams combine malaria prevention interventions based on their geography and epidemiology.</li> <li>- Support projects with innovative strategies and operational research around malaria prevention including vaccination rollouts, new combinations of interventions, community-based packages etc.</li> <li>- Explore synergies between prevention interventions to increase efficacy.</li> </ul>
	<p><b>The greatest impact that we can have on malaria morbidity and mortality in children is by coupling malaria prevention strategies with robust early testing and treatment strategies at community level.</b></p>	<p>Early testing and treatment of malaria at community level continues to be an effective strategy to prevent severe complicated malaria – it should not be neglected in order to implement prevention activities.</p>	<ul style="list-style-type: none"> <li>- Limited budgets usually require choices to be made between strategies.</li> <li>- Misunderstanding that one strategy can replace the other.</li> </ul>	<p><b>Project-level:</b></p> <ul style="list-style-type: none"> <li>- When planning any preventive strategy, ensure that the 'basics' are in place and done well i.e. community test and treat activities in place, adequate availability of malaria RDTs and ACTs.</li> </ul> <p><b>Operations:</b></p> <ul style="list-style-type: none"> <li>- Ensure malaria plans include both prevention and testing/treatment activities.</li> <li>- Continue to emphasise the importance of early testing and treatment of malaria to save lives.</li> </ul> <p><b>HQ/working groups:</b></p> <ul style="list-style-type: none"> <li>- Continue to advocate for early testing and treatment of malaria at community level.</li> <li>- Educate on the benefits of both prevention and early test and treat activities.</li> </ul>

TOPIC	KEY MESSAGES	WHY IS IT IMPORTANT?	CURRENT CHALLENGES	RECOMMENDATIONS
<p data-bbox="107 217 293 268"><b>Neglected tropical diseases (NTDs)</b></p> 	<p data-bbox="338 217 607 443"><b>Neglected diseases affect neglected populations and children are particularly vulnerable: MSF is committed in the fight to overcome this neglect and work towards elimination of NTDs.</b></p> <p data-bbox="338 839 607 1011"><b>NTD epidemiology is particularly prone to the effects of climate change and a One Health approach to elimination is key.</b></p>	<p data-bbox="633 236 972 319">Every year, NTDs affect 1-2 billion people, half of whom are children living in resource-poor settings.</p> <p data-bbox="633 344 972 427">NTDs are neglected by definition and therefore effort is required to improve awareness.</p> <p data-bbox="633 453 972 625">In MSF projects, we regularly see and treat NTDs in children, but there is often difficulty in recognising them, including common NTDs such as schistosomiasis.</p> <p data-bbox="633 651 972 759">The WHO 2021-2030 roadmap to move towards elimination of NTDs requires support from all global health actors.</p> <p data-bbox="633 861 972 970">NTDs are highly prevalent in tropical areas where changes in climate and environment have the most impact.</p> <p data-bbox="633 995 972 1046">Most NTDs are vector-borne or zoonotic in origin.</p> <p data-bbox="633 1072 972 1219">A One Health approach allows us to better analyse human, animal and environmental interactions and their impact on health, and develop strategies to tackle the root causes.</p>	<ul data-bbox="1016 226 1420 695" style="list-style-type: none"> <li>- Previously NTDs were tackled in vertical projects, integration in relevant horizontal projects is lagging behind.</li> <li>- Unclear whether to focus resources and activities on prevention or treatment.</li> <li>- Lack of access to guidelines, diagnostic tools and implementation packages.</li> <li>- Poor buy-in from operations in implementing policies and commitments made at HQ level.</li> <li>- Limited awareness of NTD burden at project level.</li> </ul> <ul data-bbox="1016 849 1420 1027" style="list-style-type: none"> <li>- Lack of awareness or understanding of the One Health concept.</li> <li>- Poor documentation of changing NTD patterns and their potential link to the environment, climate and/or One Health.</li> </ul>	<p data-bbox="1449 226 1585 245"><b>Project-level:</b></p> <ul data-bbox="1449 264 2175 373" style="list-style-type: none"> <li>- Ensure good knowledge of local epidemiology within the team.</li> <li>- Add specific NTDs to the diagnostic list at project level to increase visibility and awareness.</li> <li>- Ensure availability of diagnostic tools for NTDs.</li> </ul> <p data-bbox="1449 383 1570 402"><b>Operations:</b></p> <ul data-bbox="1449 421 2175 529" style="list-style-type: none"> <li>- Ensure potential relevant NTDs are outlined during training of new staff.</li> <li>- Ensure existing guidelines, diagnostic tools and implementation packages available in all projects.</li> </ul> <p data-bbox="1449 539 1653 558"><b>HQ/working groups:</b></p> <ul data-bbox="1449 577 2175 686" style="list-style-type: none"> <li>- Improve data collection to ensure NTDs are accounted for and quantified.</li> <li>- Develop, provide, and promote guidelines, diagnostic packages, trainings.</li> </ul> <p data-bbox="1449 849 1585 868"><b>Project-level:</b></p> <ul data-bbox="1449 887 2175 970" style="list-style-type: none"> <li>- Document disease burden and changing seasonal patterns.</li> <li>- Engage with community and local partners to understand best approaches to NTD elimination.</li> </ul> <p data-bbox="1449 979 1570 999"><b>Operations:</b></p> <ul data-bbox="1449 1018 2175 1069" style="list-style-type: none"> <li>- Analyse changing disease patterns (seasonality, geography), including any potential human-animal-environmental links.</li> </ul> <p data-bbox="1449 1078 1749 1098"><b>HQ/research/working groups:</b></p> <ul data-bbox="1449 1117 2175 1251" style="list-style-type: none"> <li>- Work across sectors in a multidisciplinary team (watsan, vector control, planetary health) to understand and develop strategies to tackle NTDs.</li> <li>- Advocate for a One Health approach to NTD elimination both internally and externally.</li> </ul>

	<p><b>Prevention and early treatment strategies used to tackle NTDs should be expanded to include young children and/or combined wherever possible to have greater impact.</b></p>	<p>NTDs in young children are under-diagnosed and often unrecognised. Inclusion in preventive and/or presumptive treatment strategies may be beneficial and should be explored.</p> <p>Many strategies work synergistically with each other and have greater impact when combined. Control of vectors is an important element of any strategy to tackle NTDs that is easily combined with other preventive measures.</p>	<ul style="list-style-type: none"> <li>- Young children are often left out of prevention activities due to lack of evidence, tools and child-friendly medications.</li> <li>- Lack of planning and foresight to effectively combine strategies.</li> <li>- Control of vectors is often forgotten or overlooked as it falls outside the scope of the medical team.</li> </ul>	<p><b>Project-level:</b></p> <ul style="list-style-type: none"> <li>- According to local epidemiology, consider all opportunities to combine preventive treatment strategies tackling different NTDs.</li> <li>- Consider ways to include young children in NTD programmes.</li> </ul> <p><b>Operations:</b></p> <ul style="list-style-type: none"> <li>- Be aware of partners and opportunities locally and in the international framework.</li> <li>- Design strategies to tackle NTDs using a multidisciplinary approach to ensure that not only 'medical' interventions are considered.</li> </ul> <p><b>HQ/research/working groups:</b></p> <ul style="list-style-type: none"> <li>- In collaboration with the Access Campaign and other relevant partners (e.g. DNDi) advocate for the availability of paediatric formulations of NTD drugs e.g. arpraziquantel for MDA in schistosomiasis.</li> </ul>
	<p><b>Not all fever is malaria! The key components to accurate and timely NTD diagnosis include: thorough history-taking, including actively searching for unique clues that may indicate a specific NTD; having a logical approach to persistent fever; seeking early support from experts; and knowing the epidemiology in your area.</b></p>	<p>Fever can be caused by a combination of diseases; a diagnosis of a common underlying cause (such as malaria) does not rule out a concomitant NTD, especially in the case of persistent fever.</p> <p>There are often specific clues to the diagnosis in the history.</p> <p>NTD presentation is very varied and can be complex to diagnose and treat. Early advice from experts can improve management and outcomes.</p>	<ul style="list-style-type: none"> <li>- If malaria RDT positive, other diagnoses are not sought even if the symptoms persist despite treatment.</li> <li>- Lack of time and importance attached to the value of taking a thorough history.</li> <li>- Poor knowledge of local epidemiology and potential NTDs.</li> </ul>	<p><b>Project-level:</b></p> <ul style="list-style-type: none"> <li>- Ensure good knowledge of local epidemiology within clinical team.</li> <li>- Provide regular skills training on history-taking and examination for clinical staff.</li> <li>- Support and encourage clinicians to submit complex cases to telemedicine for advice.</li> </ul> <p><b>Operations:</b></p> <ul style="list-style-type: none"> <li>- Ensure appropriate HR ratios to allow clinicians the time to carry out thorough clinical assessments.</li> </ul> <p><b>HQ/research/working groups:</b></p> <ul style="list-style-type: none"> <li>- Include NTDs in the paediatric training curricula.</li> <li>- Improve fever algorithms and the actions to follow in the case of persistent fever.</li> <li>- Provide epidemiological support to assist with mapping NTDs where MSF works.</li> <li>- In collaboration with the Access Campaign and other relevant partners (e.g. FIND) advocate for improved diagnostic tests that are adapted to context.</li> </ul>



TOPIC	KEY MESSAGES	WHY IS IT IMPORTANT?	CURRENT CHALLENGES	RECOMMENDATIONS
<p data-bbox="107 212 309 268"><b>Climate change and global child health</b></p> 	<p data-bbox="338 212 607 587"><b>Infants and children are disproportionately affected by both the direct and indirect impact of climate change and the greatest burden is borne by children living in low- and middle-income countries (LMICs). We, as healthcare professionals working with children, must be their advocates and increase awareness.</b></p>	<p data-bbox="636 228 987 312">By 2050, 200 million people could require humanitarian assistance as a result of extreme weather events.</p> <p data-bbox="636 333 972 651">WHO estimates that up to 88% of the burden of disease due to climate change falls on children under 5 years of age. Direct and indirect effects of climate change on child health include increased diarrhoeal diseases, exposure to vector-borne diseases, respiratory allergies, asthma, heat-related illness, malnutrition, stunting and mental health disorders.</p> <p data-bbox="636 671 983 842">Effects of extreme heat on pregnant women has a direct impact on the health of the unborn baby, leading to prematurity, stillbirth, low-birth weight and increased rates of infection.</p> <p data-bbox="636 863 987 1166">LMICs are under-reporting climate-related disasters, even though they account for the bulk of the countries affected by climate change globally. The health effects of climate change in LMIC are compounded by weak health infrastructure and inability to increase capacity following disasters.</p>	<ul data-bbox="1016 220 1424 496" style="list-style-type: none"> <li>- Increasing food insecurity directly related to climate change and extreme weather events.</li> <li>- Lack of data in LMIC to quantify the impact of climate-related exposures on child health.</li> <li>- Lack of awareness by healthcare staff of the potential impact of climate change on child health.</li> </ul>	<p data-bbox="1451 212 1585 236"><b>Project-level:</b></p> <ul data-bbox="1451 244 2175 472" style="list-style-type: none"> <li>- Be aware of, and educate staff on, the potential impacts of climate change on child health.</li> <li>- Consider whether climate change may be implicated in the diagnosis of neonates, infants and children presenting to MSF structures e.g. secondary to flooding, extreme heat, drought, food insecurity etc., and document frequency and impact.</li> <li>- Integrate advice on avoidance of extreme heat in pregnancy in routine ANC visits.</li> </ul> <p data-bbox="1451 480 1570 504"><b>Operations:</b></p> <ul data-bbox="1451 512 2175 587" style="list-style-type: none"> <li>- Add climate-related health indicators to routinely collected data to improve evidence of potential climate change impact on child health in MSF operations in LMIC.</li> </ul> <p data-bbox="1451 595 1749 619"><b>HQ/research/working groups:</b></p> <ul data-bbox="1451 627 2175 855" style="list-style-type: none"> <li>- Develop trainings to educate staff on the effects of climate change on child health.</li> <li>- Contribute to the evidence-base to show associations of infant and child-health outcomes with climate change exposures, through innovations, operational research, and adaptations.</li> <li>- Temoinage – bear witness to how the climate crisis disproportionately impacts vulnerable groups and use this to inform humanitarian activity and advocacy goals.</li> </ul>
	<p data-bbox="338 1246 607 1422"><b>As humanitarian health actors, we can contribute to fighting climate change and environmental degradation by mitigating our environmental impact.</b></p>	<p data-bbox="636 1246 976 1331">Humanitarian action can be both a cause and consequence of climate change.</p>	<ul data-bbox="1016 1254 1413 1370" style="list-style-type: none"> <li>- Increasing frequency of weather/climate-related events or disasters increase the need for humanitarian action and movement.</li> </ul>	<p data-bbox="1451 1246 1585 1270"><b>Project-level:</b></p> <ul data-bbox="1451 1278 2175 1449" style="list-style-type: none"> <li>- Provide access to online resources and platforms for staff to allow them to participate in trainings, knowledge-sharing and exchange with peers.</li> <li>- Make a plan to reduce the environmental impact of activities at project level e.g. reduce unnecessary plastic waste; avoid single-use items wherever possible.</li> </ul>

Humanitarian action necessitates movement of HR, transportation of equipment and supplies, importation, and construction, all of which have the potential to have a high carbon footprint.

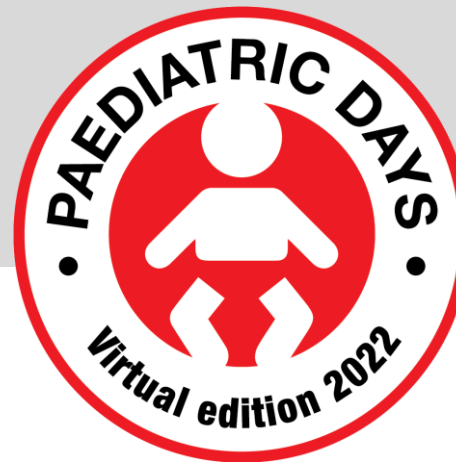
- Reliance on international supply chain for medications as difficult to procure quality-controlled medications locally.
- Lack of locally qualified staff necessitates movement of HR from capital/overseas.

**Operations:**

- Consider alternative ways to conduct face-to-face trainings to minimize staff displacement e.g. project-level trainings, centralized trainings (+/- with other organisations) at capital level.
- Prioritise remote training where possible through webinars, online courses etc.
- Consider ways to increase capacity of local staff.
- Prioritize local purchase of non-food items wherever possible.

**HQ/research:**

- Lobby to reduce unnecessary packaging in the supply chain e.g. medications, medical equipment, logistic items.
- Measure climate impact, carbon footprint and set targets.
- Evaluate and innovate low-cost efficient interventions that can mitigate the health effects of climate change on children in humanitarian settings.



🐦 MSFPaedsDays 📘 Médecins Sans Frontières

Useful resources on these topics are available on the MSF Paediatric Days website [paediatrics.msf.org](https://paediatrics.msf.org)

