Conclusion As older people in Haiti were often the sole carers of under-5s, there is a need to recognise their importance in this role and support them within it, allowing them access to the nutritional services the children in their care so vitally need. More generally, in any emergency setting, organisations need take into account all stakeholders in child nutrition when planning and implementing programmes.

G268(P) ARE ESSENTIAL MEDICINES AVAILABLE, RELIABLE AND AFFORDABLE IN LOW-MIDDLE INCOME COUNTRIES?

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Background There is increasing anxiety worldwide that the World Health Organisation recommended Essential Medicines may not be universally available, accessible, affordable and of good quality.

Aims/methods We wished to seek the perceptions of 10 lead paediatricians treating children with cancer in 9 low-middle income countries. We used a 17 point semi-structured questionnaire to gather the information. This study involved doctors in Cameroon, Ghana, Malawi, Tanzania, Zambia, Bangladesh, Myanmar, The Philippines, and Colombia. Collectively the centres were seeing over 2000 new patients annually of whom a median of 65% (range 5%–90%) received 'curative intent' therapy.

Results Only Bangladesh produced any but not all the required cytotoxics. All countries were required to import some or all the medicines. In only 3 countries did the Ministry of Health directly oversee procurement/importation of drugs. In 5 delegated pharmacies or a single hospital was responsible. In Bangladesh there was a free market approach for procurement and importation. Inconsistent supplies were cited by all respondents especially of critical drugs including antibiotics, morphine, 6-mercaptopurine, methotrexate, cytosine, asparaginase, and vincristine. Reasons cited for no-importation were non/or late renewal of licences to import, reluctance to procure low profit or low volume drugs and anxieties regarding importation of opiates. Medicines were imported from a range of countries most commonly from India (7/9) and China (often via India), Argentina, Brazil, South Korea, Cyprus and Malaysia. All respondents expressed anxiety about drug quality imported with no International Quality Certification. High rates of treatment refusal/abandonment (20% median range <5%–50%) were most often attributed to non-affordability by parents unless some subsidies were available.

Conclusions From these perceptions there are major obstacles to be overcome to ensure that all children can receive the medicines they need for any chance of cure certainly those living in low-middle income countries. There are challenges at each stage from production to the bedside and only a truly global effort by all interested parties including the WHO and the Pharmaceutical Industry can resolve these issues.

G269(P) INCREASING BURDEN OF THE IMPACT OF CLIMATE CHANGE ON PAEDIATRIC INFECTIOUS DISEASES

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Introduction Climate change refers to long-term shifts in weather conditions and patterns of extreme weather events, with recent earthquakes, natural disasters, there is epidemic and increase in many paediatric infectious diseases (PID) worldwide, including some newly-circulating ones, such as Zika virus and arbo-viruses in North America and the Caribbean, Ebola and Cholera outbreak in Africa, SIRS in middle east etc. This reflects the combined impacts of rapid demographic, environmental, social, technological and other changes in our ways of living.

Aims We reviewed the available scientific evidences of the impact of recent climate change on PID and also examines the observed and predicted impacts of changes in major climate variables on pathogen, host, and transmission of PID in order to estimate the future burden of infectious diseases on children.

Methods We reviewed published and unpublished literature on climate change and PID. The data were mainly descriptive and we used predictive analytical modelling to assess the future burden.

Findings We observed evidence of associations between climatic conditions and PID in children with different modality of transmission. The responsible agents identified were viruses, bacteria, protozoa and parasites, with various adaptations in the host. Increasing temperature was the most important contributing factor when compared with other natural disasters.

There is a global resurgence of hitherto controlled diseases and the emergence of new ones with redistribution of existing infectious diseases due to an unstable climate. Many of the most common infectious diseases, and particularly those transmitted by vectors, are highly sensitive to climate variation. New and resurgent vector-borne communicable diseases, including arbo-viruses, such as dengue, Zika and Ebola, and malaria are evident widely. Other infectious diseases, such as cholera have shown increased outbreaks due to elevated temperature and flooding with the resultant displacement of affected people.

Conclusions Changes in infectious disease transmission patterns are a likely major consequence of climate change. There is need for a better understanding of the causal relationships, in order to predict the future impacts of this on children's health. In addition, paediatrician are likely to see an increasing number of cases due to adverse effects of climate change. An international collaborative effort with an integrated model of care is therefore required.

G270(P) POST-OPERATIVE OUTCOMES OF GAMBIAN CHILDREN AND ADOLESCENTS POST VALVULAR SURGERY FOR RHEUMATIC HEART DISEASE

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Aims Rheumatic heart disease (RHD) is a potentially debilitating and fatal condition with a high prevalence in low resource countries. The Gambia has many individuals with severe, symptomatic RHD but limited cardiology and no cardiothoracic surgical services. Charitable organisations fund surgery overseas for a minority. We aimed to review post-operative outcomes in this group.

Methods Paediatric RHD patients with documented pre- and post-operative management at our institution were included. Retrospective data from clinical records was collected on age, sex, HIV, HBV and sickle cell status, operation type, pre- and post-operative Ross scores and medication burden (table 1). For warfarinised patients, 'percentage days within therapeutic range' was calculated using the Rosendaal method.

Results 17 patients matched our inclusion criteria; 11 male, 6 female. Median age at surgery was 16 years. There was one death (cause: infective endocarditis). In total, 19 operations were performed involving 31 valve procedures; 7 metallic and 5 bioprosthetic valve replacements and 19 repairs.

Abstract G270(P) Table 1

	Pre-operative median (IQR)	Post-operative median (IQR)	P value
Ross Score	2 (2–3)	1 (1–1)	0.013
Number of Pills per day	3 (2–5)	1 (0–2)	0.004
Daily Furosemide dose (mg)	20 (10–40)	0 (0–20)	0.242
Daily Spironolactone dose (mg)	25 (0–25)	0 (0–0)	0.075
Daily captopril dose (mg)	37.5 (5–50)	0 (0–50)	0.279

For the six warfarinised patients, median percentage days within target therapeutic range (TTR) was 40.2% and percentage of tests within TTR was 34.1%.

Conclusion In this small cohort of Gambian children and adolescents, cardiac surgery had a positive impact with significant effects on exercise tolerance and pill burden. Normal exercise tolerance following fifteen (78.9%) operations had positive social, economic and medical implications. However, there is a long-term risk of haemorrhage and thromboembolism in warfarinised patients given the low proportion of time in therapeutic range. Our evaluation highlights the challenges of working with adolescents around medication adherence, lack of alternatives to warfarin for young women of child bearing age and the need for high quality pre- and post-operative assessment and follow-up in low resource environments.

G271(P) IMPROVING PRACTICE OF PAEDIATRIC ADMISSION VITAL SIGN MEASUREMENT: AN AUDIT OF VITAL SIGN DOCUMENTATION FOR PATIENTS ADMITTED TO A LARGE PAEDIATRIC MEDICAL WARD BEFORE AND AFTER DELIVERY OF A PAEDIATRIC ASSESSMENT EDUCATION PROGRAMME

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Aims This audit aimed to quantify the impact that delivering a Paediatric Assessment Skills and Leadership (PAS) course would have on the measurement and documentation of patients' vital signs on admission to an inpatient department.

Methods Data was collected from the paediatric medical ward over seven days. Notes for each admission in the past 24 hours were examined for the recording of vital sign parameters. The standard for data inclusion was from the local Critical Care Pathway which defines eight base line observations to be recorded on each admission to the department. Over the following two weeks a PAS course was delivered to 34 nurses. The course taught clinical examination skills and a Train the Trainer programme to empower the local team to deliver the course in the future. One month after the course a re-audit was taken on the same ward. To avoid bias neither audit timings were disclosed to the ward staff.

Results In the initial audit, notes for 97% of the 234 admissions (n=227) were examined. Of these only 1.76% (n=4) had a full set of documented vital signs. Blood pressure was the least recorded (2.4%), respiratory rate was recorded in less than half of all admissions (45.3%) and temperature was the highest documented vital sign (96.5%). After delivery of the PAS course the re-audit captured 100% (n=28) of admissions in a 24 hours period and found that a full set of vital signs were documented in 32% of all admissions (an increase of 30.24%), blood pressure measurement increased by 34% and respiratory rate was documented in 75% of all admissions.

Conclusion The PAS course had a positive impact on the frequency of documentation of admission vital signs. Further improvement is required to ensure all children receive a comprehensive documentation of vital signs. This may be achieved through on-going education. Future audits should be carried out to assess the development of the service and act as an incentive to maintain high standards. For sustainability the responsibility of the audit, feedback and education process should be given to the leaders within the local team.

G272(P) ABSTRACT WITHDRAWN

G273(P) SUCCESSES AND CHALLENGES OF INTRODUCING CLINICAL JOB AIDES IN DISTRICT HOSPITALS IN MYANMAR

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Aims Clinical job aides directly benefit clinical care and assist project evaluation. We describe early experience of their introduction as part of an Emergency Paediatric Care Programme (EPCP).

Methods An EPCP working group developed pilot job aides. These included admission, observation and drug charts that were piloted in 11 hospitals. Between May and October 2016 the job aides were reviewed and a survey of local healthcare workers undertaken.

Results In the majority of hospitals job aides were limited or inadequately completed. Vital sign charts typically only