"CARING FOR SEVERE MALNUTRITION (SM) OF INFANTS AND YOUNG CHILDREN AS A CORE COMPETENCY FOR PAEDIATRIC HEALTH PROFESSIONALS"

INTERNATIONAL MALNUTRITION TASK FORCE (IMTF):
(IPA/IUNS in collaboration with WHO/UNICEF/IAEA)
Report on activities for the 26TH INTERNATIONAL CONGRESS OF PAEDIATRICS, AUGUST 4-9, 2010 IN JOHANNESBURG, SOUTH AFRICA

Introduction

The achievement of the Millennium Development Goals will require concerted action across a wide range of actors working to common purpose in divergent situations and with variable resource at their disposal. There is the need to ensure that these actions are purposive, coherent and mutually supportive. Poor nutrition before birth and during the first years of life is directly associated with poor growth and development, increased mortality and morbidity in the short and longer terms. Severe malnutrition is a major cause of under five mortality and therefore directly related to the achievement of MDG4. Paediatricians carry a major responsibility to ensure that the needs of infants and children are met and where shortfalls exist to advocate for their correction. The international community have developed guidelines for the management and care of severely malnourished children which if practiced at scale would substantially reduce the incidence, prevalence and mortality from severe malnutrition.

The International Paediatrics Association held its 26th International Congress of Paediatrics at the Sandton Convention Centre in Johannesburg, South Africa from 4-9 August 2010 under the theme "Simunye", a Zulu word meaning 'We are one'. It was the first to be held in Africa and was attended by over 3500 participants from more than 130 countries. The International Malnutrition Task Force (IMTF) held a series of activities during the congress as part of its overall objective to promote the prevention and treatment of malnutrition in infants and children and to raise the profile of malnutrition as a key focus for child survival.

In anticipation of the Congress the IMTF sought the opinion of all national paediatric groups around the world. A short questionnaire was developed on: the awareness of

the recommended care of severe malnutrition, and the extent to which it might be taught to health professionals. The questionnaire was sent to 134 national groups around the world. Although the response was limited, the was a reply from centres in all continents indicating that some groups are already active. However, there was a stated desire for more help and greater effort to ensure that paediatric health professionals be better trained to be more effective in this regard.

At the 26th IPA Congress, the first activity of the IMTF was a pre-congress symposium on the August 4, with the theme "Caring for infants and children with severe malnutrition (SM) as a core competency for paediatric health professionals". The IMTF also had a stand within the IPA booth in the Exhibition Centre to publicise activities of the IMTF, and promote the IMTF website; gave oral presentations and poster presentations within the Congress itself.

Pre Congress Symposium to the 26th IPA Congress of Pediatrics Johannesburg August 4th

Theme: "Caring for severe malnutrition (SM) of infants and young children as a core competency for pediatric health professionals"

In the preparation and delivery of the pre-congress workshop the IMTF were actively supported by IPA/IUNS in collaboration with WHO, UNICEF, IAEA and RCPCH. The objective of the workshop was to discuss among other things making the care for children and infants with severe malnutrition a core competency for paediatricians. Therefore the preferred outcome was for paediatricians to agree and resolve that caring for infants and children with severe malnutrition be a core competency for every paediatric health professional. A summary of the programme presented on the day is shown below.

Summary of the Program:

Morning Session 8.30-12.40 Chair: Adenike Grange

8.30-8.45 Welcome from WHO/UNICEF/IAEA/RCPCH
8.45-9.00 Malnutrition: extent of the problem and need for action (Ricardo Uauy)
9.00-9.15 Prevention of malnutrition: overview of effective interventions (Zulfiqar Bhutta)
9.15-9.30 Principles of treating severe malnutrition: 10 steps of clinical management (A. Jackson)
9.30-9.50 Reaching populations at scale: essentials of community management (Paluku Bahwere)
9.50-10.10 Reducing malnutrition deaths by improving case-management (Tahmeed Ahmed)
10.10-10.30 Discussion

10.30-10.50 Coffee break

10.50-12.20 Experiences from the front-line in improving case-management: opportunities & challenges
10.50-11.05 Zambia (Beatrice Amadi)
11.05-11.20 Kenya (Ruth Nduati)
11.20-11.35 Ethiopia (Tsinuel Girma Nigatu)
11.35-11.50 Nigeria (Adenike Grange)
11.50-12.05 Sudan (Alamin Osman)
12.20-12.40 Discussion

12.40 -13.30 Lunch

Afternoon session 13.30-16.30 Chair: Ricardo Uauy

13.30-13.45 Improving case management in weak health systems (David Sanders)
13.45-14.00 Role of paediatricians: critical issues for paediatric competence (Alan Jackson)
14.00-15.00 Breakout sessions

- Enlisting paediatricians as advocates at national level for 'core competency'- ideas and logistics;
- Paediatric associations and engaging members for action
- Strategies to impart knowledge and skills for 'core competency' – what approaches are needed?
- Changing medical/nursing curricula to cover 'core competency': likely barriers and how to overcome them
- Achieving effective in-service training: negotiating who to train, by whom, and using what kinds of materials.

15.00-16.00 reporting back and Discussion
16:00-16:30 Presentation of Resolution and General Discussion

Speakers addressed their specific topics, providing up to date information of global impact of severe malnutrition on death and disability of children and progress towards achieving the MDG. In addition, evidence based preventive and treatment strategies were presented and discussed. The specific therapeutic approaches and WHO/UNICEF guidelines integrating community and institutional based management were considered focusing on strengths and limitations, need to update the existing guidance based on the accumulated experience and gaps requiring additional research were highlighted. The evidence presented was largely based on the data generated and summarized as 5 papers published by Lancet as the 2008 series on Malnutrition (Z. Bhutta and R. Uauy were authors of papers in this series). The attendance and active participation in the meeting exceeded expectations; 300-350 for the morning session and 150-200 in the afternoon session.

The information from earlier presenters revealed that the nutrition related MDGs would largely not be met. MDG 1 dealing with poverty and hunger will certainly not be met considering the recent food price crisis which has increased the number of hungry and food insecure people in the developing world. MDG 4 seeks to reduce by two thirds under-five mortality. Malnutrition is a key determinant of death and DALYs in children < 5yrs of age. The existing evidence from controlled clinical studies indicate that there are demonstrated effective interventions, which if implemented to scale would reduce by 30-50 % the burden of death and disability within a 3-5 year period for most countries. As an example if exclusive breast feeding from birth to six months was achieved for all children (promoted, protected and supported) the expected impact would include a reduction of severe/moderate malnutrition by 30-50 % leading to a reduction of 11 % in mortality of < 5 years. The treatment of SM following standard guidelines has proven effective and if implemented at scale could be 95 % successful. Context specific causes for failure were identified and discussed and which it was suggested might reduce success to 65-80 %. Important causes associated with failure of treatment were considered to be limited practical competency of health professionals and restrictions in the supply and materials needed for effective treatment. An important limiting factor that has not yet been adequately resolved is the need to address the treatment of children who present with SM but have underlying severe infections such as malaria, TB and HIV/AIDS. Presently 1 out of 3 death and 20 % of the DALYs lost in this age group are related to malnutrition in all its forms. The final cost in terms of death and loss of healthy life years is dwarfed by the impact on lifelong lost productivity due to death and impaired cognitive function. The impact on economic development has been quantified recently as 7-8 % of GDP in severely affected countries down to 3-4 % in less affected countries. Progress in Latin America and Asia has been made, however the situation in sub Saharan Africa has gotten worse.

Experiences from the front-line (Zambia, Kenya, Ethiopia, Nigeria and Sudan) in treatment and management of SM were presented. The critical steps in case-management were analyzed and opportunities & challenges to enhance efficacy, cost-effectiveness and efficaciousness of treatment modalities were discussed. All present agreed that Pediatric Health Professionals were crucial in advancing the effective treatment of the severe malnutrition and also were key facilitators in advancing the real

solution to this problem which is effective prevention through the promotion, respect and protection of the right to food as a basic human entitlement.

Paediatricians as effective advocates for children are uniquely placed to meet the challenge of eradicating severe malnutrition as a significant cause of death and disability of children, in order to do this effectively they must be not only knowledgeable but competent in the practice of treating severely malnourished children. Thus in the afternoon session, participants discussed in small groups (10 per table) what the IPA might do to improve the competency of Pediatric Health Professionals in addressing severe malnutrition. The summary statements from each of the groups are presented in Appendix 1.

Each group was asked to address one of the following five areas; in addition all groups were requested to consider possible barriers to implementation and how they might be overcome.

- Enlisting paediatricians as advocates at national level for 'core competency'- ideas and logistics;
- Paediatric associations and engaging members for action
- Strategies to impart knowledge and skills for 'core competency' – what approaches are needed?
- Changing medical/nursing curricula to cover 'core competency': likely barriers and how to overcome them
- Achieving effective in-service training: negotiating who to train, by whom, and using what kinds of materials.

Findings of group deliberations

The first group discussed the topic "paediatricians as advocates in achieving core competency for care of children with severe malnutrition". They determined that:

- National pediatrics Association and other National Health Associations should harmonize their advocacy to Government in Policy making and implementation
- Pediatricians should conduct a situational analysis on Severe Malnutrition in the area they work in and what they can do by prioritizing and monitoring
- Communication strategies by pediatricians and other lay professions specifically on Malnutrition should be developed

Group 2 discussed the topic “achieving core competency in caring for infants and children with severe malnutrition: Role of National Paediatric Associations”.
Group 2a determined that paediatric societies:

- should begin to advocate for increased attention to be paid to the importance of prevention and treatment of malnutrition.
- should join forces with other influential bodies and to engage other professional organizations whose role in malnutrition care and prevention are vital, such as nurses and dietitians.
- should coordinate, advocate, and communicate with appropriate government ministries and international agencies to create the political will to provide the focus and resources to act on this problem.

Group 2b determined that paediatric societies need to:

- Dialogue with politicians and administrators: Advocacy for the problem
- Support pediatricians to teach/support pediatricians that are willing to provide voluntary temporary service
- Contact/support from paediatric associations from countries that do not have high prevalence of paediatric malnutrition. Brain Drain code of conduct for recruitment by centers of industrialized countries

They considered that barriers for achieving these would be:

- Physician ignorance and apathy toward malnutrition
- Lack of resources, organization and dedicated people
- Disagreements in the proper training techniques and knowledge to impart to trainees.
- Failure to coordinate approach to malnutrition with other sectors, such as agriculture.

Groups 3 deliberated on the topic “strategies to impart knowledge and skills for ‘core competency’ – what approaches are needed”. Group 3a determined that there should be prevention and treatment approaches at both facility and community based strategies to impart knowledge and skills for achieving core competency for paediatricians.
Group 3b determined that the strategies to impart knowledge and skills for core competency on caring for infants and children with severe malnutrition should include:

- The management of SAM in formal curricula for all health workers: Doctors, Paediatricians, Nurses, Nutritionist, Dieticians, Community Health Workers and involve also social workers
- To continue with training, stressing re-training
- Invest in other dissemination strategies such as the media (all media: TV, radio, mob- phones), health education in schools (consider the teenagers point of view to be effective and listened).

Groups 4 considered the likely barriers to changing medical/nursing curricula to cover 'core competency' and how to overcome them.

Group 4a identified the following barriers:

- Lack of competency for lecturers and trainers in medical schools
- Lack of awareness on the prevalence, causes and consequences of malnutrition at all levels, hence lack of appreciation of the problem
- Lack of equipment and logistics at training facilities
- Current training curriculum is loaded

They suggested that to overcome these barriers there need to be:

- Retraining or updating of trainers
- Advocacy and sensitisation at all levels
- Re-allocation of resources by policy makers, adapting guidelines to suit countries
- Integrate malnutrition into existing programmes

Group 4b identified these barriers to effecting change:

- Most schools of nursing and hospitals lack nutrition units
- Most pediatricians and trained nutritionists practice in tertiary hospitals, while malnutrition is higher in district hospitals
- Curricula in nutrition in some countries are handled by both the ministry of education and health and this reduces emphasis on nutrition.

To overcome these barriers the group agreed that:

- Making the study of nutrition and management of malnutrition compulsory and a priority in our schools.
- Involving the deans of college of nursing and medicine to emphasise the importance of nutrition education and changing of curricula for same.
- Encouraging community health practitioners to make rotation of students

Group 5 discussed the topic “achieving effective in-service training: negotiating who to train, by whom, and using what kinds of materials”.

Group 5a determined that for Members to achieve effective in-service training for every paediatrician, there is the need for:

- Proper diagnosis and triage with proper tools and good cut-off points leading to consistency of message delivery
- The 10 steps to management is good but need sub-steps for co-morbidities hence local adaptation necessary
- Context; use available materials and resources. Everybody involved in care of children can be trained. Identify within each sector a leader to take charge.
- Severe acute malnutrition is a misnomer; been there much longer and acute malnutrition is a bias of the provider
- Sustainability of training; start with medical students to turn into pre-service from in-service. This enables intergenerational continuity of the strategies

Group 5b determined that to achieve effective in-service training for every paediatrician there should be:

- In-house training: Training offered to people already with a formal training
- This training should be specific to malnutrition
- There should also be effective in service training aimed at achieving better outcomes based on performer indicators at each level

How can this be done?

- Situation analysis to identify the problem in each area/level
- Develop training protocols for each level and standardize them
- Integrate monitoring and evaluation in training.

Following the group discussions and presentation of group findings a resolution was arrived at to be presented to the IPA.

The Resolution presented to the IPA

The Pediatricians meeting at the 26th IPA Congress of Pediatrics called on the IPA to resolve:

- Paediatricians and related health professionals take responsibility for leadership in addressing the problem of severe malnutrition in all its forms as a major cause of death and disability of children that requires urgent action by all relevant social actors.
- IPA member societies should assure that all Paediatricians and related health professionals have the identification and treatment of severe malnutrition as a core competency and are certified accordingly.
- National Societies should examine the curriculum, training activities and evaluation processes to ensure the inclusion of the identification and treatment of severe malnutrition as a core competency.

Appendix 1

Findings of group discussions towards a resolution to make the care for infants and children a core competency for all paediatricians

IMTF pre-congress workshop at the 26th IPA Congress of Paediatrics
Johannesburg, 4th August, 2010

Introduction

Paediatricians are uniquely positioned to contribute towards eradicating severe malnutrition in infants and children since they are entrusted with care of children. At the workshop the participants discussed in small groups (10 per table) what should the IPA do to improve the competency of Pediatric Health Professionals in addressing severe malnutrition. The group deliberations were on the following 5 topics:

- Enlisting paediatricians as advocates at national level for 'core competency'- ideas and logistics;
- Paediatric associations and engaging members for action
- Strategies to impart knowledge and skills for 'core competency' – what approaches are needed?
- Changing medical/nursing curricula to cover 'core competency'
- Achieving effective in-service training: negotiating who to train, by whom, and using what kinds of materials

All groups were invited to consider likely barriers and how to overcome them.

The outcome of these group discussions is presented below:

Group 1 Paediatricians as advocates in achieving core competency for care of children with severe malnutrition

Group 1A

We resolve that:

- National pediatrics Association and other National Health Associations should harmonize their advocacy to Government in Policy making and implementation

- Situational analysis by Pediatricians as to Severe Malnutrition in the area they work in, what they can do by prioritizing and monitoring
- Communication strategies by pediatricians and other lay professions specifically on Malnutrition

Group 2: Achieving core competency in caring for infants and children with severe malnutrition: Role of National Paediatric Associations

Group 2A: Findings

Currently within Africa these organizations do not play a significant role in raising the profile of childhood malnutrition. We believe that Pediatric Societies should begin to advocate for increased attention to be paid to the importance of prevention and treatment of malnutrition.

Pediatric societies should join forces with other influential bodies, such as the SA College of Pediatrics to engage other professional organizations whose role in malnutrition care and prevention are vital, such as nurses and dietitians.

Pediatric Societies should coordinate, advocate, and communicate with appropriate government ministries and international agencies to create the political will to provide the focus and resources to act on this problem.

Barriers to fulfillment

- Physician ignorance and apathy toward malnutrition
- Lack of resources, organization and dedicated people
- Disagreements in the proper training techniques and knowledge to impart to trainees.
- Failure to coordinate approach to malnutrition with other sectors, such as agriculture.

Group 2B findings

We believe that Paediatric Associations

- Dialogue with politicians and administrators: Advocacy for the problem
- Support pediatricians to teach / support pediatricians that are willing to provide voluntary temporary service

- ? Contact / support from paediatric associations from countries that do not have high prevalence of pediatric malnutrition. Brain Drain code of conduct for recruitment by centers of industrialized countries...

Group 3: Strategies to impart knowledge and skills for 'core competency' – what approaches are needed

Group 3A.

We believe that there should be prevention and treatment approaches to impart knowledge and skills for achieving core competency for paediatricians.

1. Prevention strategies
   - All levels involved, that is, health care workers, parents, teachers and everyone who comes in contact with a child.
   - Early detection of severe malnutrition in the community by identifying children at risk.
   - Continued education of health care workers, parents and continuous follow-up of children.
2. Treatment strategies

   COMMUNITY LEVEL
   - Identify district leaders in each community
   - Educate all citizens about malnutrition by "media assault" – pamphlets, ads on TV, and radios, in and out of hospitals.
   - Add malnutrition to education syllabus in schools
   - Government and private business buy-in
   - Identify problematic local practices which are promoting malnutrition

   FACILITY BASED –
   - Primary champion in each hospital.
   - Protocols on identifying and managing malnutrition visible in every area a child is seen.
   - Compulsory malnutrition CPD points/year for health care workers.
   - Clinics linked to hospitals for continuous education and feedback and Road to health card promotion
   - All HCW to be competent on all aspects of malnutrition.

3. BREASTFEEDING

- Enable/Encourage breastfeeding by all mums
- Promote the Baby Friendly Hospital Initiative
- At every EPI visit enquire about feeding practices and do weights
- Remove stigma of breastfeeding.

Group 3B.

We resolved that the strategies to impart knowledge and skills for core competency on caring for infants and children with severe malnutrition include the following:

1. Include the management of SAM in formal curricula for all health workers: Doctors, Paediatricians, Nurses, Nutritionist, Dieticians, Community Health Workers, and social workers

- Barriers: There will be many resistances to achieving this.
- Opportunities: involve scientific societies and Universities; GL already exist.

1. To continue with training, stressing re-training:

Characteristics of courses:

- On site
- Involve all (doctors, nurses, nutritionist, CHW, social workers)
- Built a team that really work together
- Core part for all, then diversify depending on tasks
- Keep it very practical: “what to do when…”
- Stress assessment of nutritional status for every child (+ mothers)
- Stress integration with other programs: IMCI, EPI, antenatal care
- Include strategies for retraining: simulation day every 3 months, rotation of personnel
- Give responsibilities for implementation, retraining, M&E
- M&E should be part of the training contents
- Produce and disseminate materials: use simple charts, use them for case simulation to be sure they are known, remember integration with other programs
- Disseminate to all provinces and RURAL areas

Opportunities: standard GLs already existing, role of Universities in training and M&E

2. Invest in other dissemination strategies. These include
    - Using the media (all media: TV, radio, mob- phones.)
    - Health education in schools (consider the teenagers point of view to be effective)

Group 4: Changing medical/nursing curricula to cover 'core competency': likely barriers and how to overcome them

Group 4A

We believe changing the medical/nursing curricula to cover core competency for the care of infants and children with severe malnutrition could be faced with severe barriers. These may include:

Barriers

- Lack of knowledge and training (lecturers and trainers)
- Lack of awareness on the prevalence, causes and consequences of malnutrition at all level, hence lack of appreciation of the problem
- Lack of equipment and logistics at training facilities
- Current training curriculum is loaded

We suggest that the following could help overcome these barriers

Solutions

- Update trainers
- Advocacy and sensitisation at all levels
- Re-allocation of resources by policy makers, adapting guidelines to suit countries
- Integrate malnutrition into existing programmes

Group 4B

We believe that the following barriers could stand in the way of achieving core competency for care of children with severe malnutrition for all paediatricians. These barriers may include:

Barriers

1) Most schools of nursing and hospitals lack nutrition units
2) Most pediatricians and trained nutritionists practice in tertiary hospitals, while malnutrition is higher in district hospitals
3) Curricula in nutrition in some countries are handled by both the ministry of education and health and this reduces emphasis on nutrition.

We believe the following suggestions could help overcome these challenges. These include

1) Making the study of nutrition and management of malnutrition compulsory and a priority in our schools.
2) Involving the deans of college of nursing and medicine to emphasise on the importance of nutrition education and changing of curricula for same.
3) Encouraging community health practitioners to make rotation of students in nutrition a priority

Group 5 Achieving effective in-service training: negotiating who to train, by whom, and using what kinds of materials

Group 5A

Members of this group agreed that to achieve effective in-service training for every paediatrician, there is the need for

1. Proper diagnosis and triage with proper tools and good cut-off points leading to consistency of message delivery
2. 10 steps good but need sub-steps for co-morbidity hence local adaptation necessary
3. Context; use available materials and resources. Everybody involved in care of children can be trained. Identify within each sector a leader to take charge.
4. Severe acute malnutrition is a misnomer; been there much longer and acute malnutrition is a bias of the provider
5. Sustainability of training; start with medical students to turn into pre-service from in-service. This enables intergenerational continuity of the strategies

Group 5b

We agree that to achieve effective in-service training for every paediatrician these are required.

There should be:

In-house training: Training offered to people already with a formal training

This training should be specific to malnutrition

There should also be effective in service training aimed at achieving better outcomes based on performer indicators at each level

How can this be done?

- Situation analysis to identify the problem in each area/level
- Develop training protocols for each level and standardize them
- Integrate monitoring and evaluation in training.

Who to train?

Community Health Workers

Medical school lecturers

Hospital level personnel working in malnutrition in one way or the other

Administrators/managers

Who should be trained?

- Multi-disciplinary team which has expertise in management of SAM
- Develop training manuals for trainer of trainers
  - Guidelines
  - Algorithms
  - Treatment/management protocols for each level

Materials needed for t raining

- Overview lectures
- Practical orientated training: Center where severely malnourished children are admitted
- Bedside demonstrations with actual cases
- Food preparation: phase specific
- Practical demonstrations for mothers
- Teaching guides

- Check list

Likely barriers against success

Lack of the following

- political will
- adequate knowledge
- Motivation
- Trained human resource
- There is a perpetual situation of inadequate/erratic supplies
- Inadequate supervision

Opportunities for affecting changes

- Availability of local foods
- Expertise
- Integrate in already existing systems like:
  - Malaria, HIV, TB
  - Immunization
  - Family program me
  - PMTCT
  - Medial and nursing basic training
- Support group development

Appendix 2

Other Activities of the IMTF at the IPA congress

Exhibition

At the IMTF stand, banners and posters in different languages were displayed and the IMTF leaflet, which describes the Task Force's objectives, activities, governance, and examples of impact, was distributed in English, French and Spanish. Delegates visiting the stand were invited to suggest ways of widening individual participation in Task Force activities in their respective countries and regions. Contact details were obtained for delegates wishing to join the mailing list or requiring further information. About 150 participants attending the IPA and who visited the IMTF exhibition wanted to be engaged with the IMTF and left contact details for further information. Also displayed at the stand were resources on the website www.imtf.org, and posters, postcards and information on the current eLearning course.

Trial of ongoing eLearning course on caring for infants and children with acute malnutrition

IMTF also organized a trial of the ongoing eLearning course which was done by five paediatricians and paediatric registrars at the University of Witwatersrand Medical School in Johannesburg. The course is in 3 modules: Module 1 is Definition and classification of malnutrition; Module 2: how to identify children with malnutrition; and Module 3: how to care for children with acute malnutrition. The objective of the trial was use feedback from the user's perspective to improve the content, interactivity and overall design of the course. The trial involved the first module and took about 2 hours to complete and this was followed by a focused-group discussion on their experiences. Full report of the trial will be available after the data have been analysed.

Appendix 3: Johannesburg Resolution

"CARING FOR SEVERE MALNUTRITION (SM) OF INFANTS AND YOUNG CHILDREN AS A CORE COMPETENCY FOR PEDIATRIC HEALTH PROFESSIONALS"

INTERNATIONAL MALNUTRITION TASK FORCE IMTF
(IPA/IUNS in collaboration with WHO/UNICEF/IAEA)
Pre Congress Symposium to the 26th IPA Congress of Pediatrics Johannesburg August 4th

The group in their deliberations noted with great concern that malnutrition continues to be a major cause of death and disability for young children: 1 out of 3 deaths and 20 % of the lost healthy life years are attributable to malnutrition in all its forms. The final cost in terms of death and lost healthy life years is dwarfed by the impact on lifelong lost productivity with a major negative impact in social capital and economic development. The impact on economic development has been quantified recently as 7-8 % of GDP in severely affected countries. Some progress in Latin America and Asia is being made, however the situation in sub Saharan Africa has gotten worse. The impact of the recent food price crisis on hunger and poverty has led to an increase in the number of hungry and food insecure people globally. If we fail to take the necessary actions the nutrition related MDGs (1-hunger and poverty 4-infant mortality) will not be met. The existing evidence demonstrates that effective interventions are available, which if implemented to scale would reduce by 30-50 % the burden of death and disability within a 3-5 year period for most countries. As an example if exclusive breast feeding from birth to six months was achieved for all children the expected impact would include a reduction of severe/moderate malnutrition by 30-50 % leading to a reduction of 11 % in mortality of children < 5 yrs of age. The treatment of severe malnutrition following standard guidelines has proven efficacious and if implemented to scale would by itself reduce childhood mortality by 30 %. An important cause behind failure of treatment is the limited competency of health professionals. Paediatricians as effective advocates for children are uniquely placed to meet the challenge of eradicating this significant cause of death and disability of children. In order to do this effectively Pediatricians must not only be knowledgeable but competent in the practice of treating severely malnourished children.

Pediatricians meeting at the 26th IPA Congress of Pediatrics called on the IPA to resolve:

1. Paediatricians and related health professionals take responsibility for leadership in addressing the problem of severe malnutrition in all its forms as a major

cause of death and disability of children that requires urgent action by all relevant social actors.

2. IPA members societies should assure that all Paediatricians and related health professionals have the identification and treatment of severe malnutrition as a core competency and be certified accordingly.
3. National Societies should examine the curriculum, training activities and evaluation processes to ensure the inclusion of the identification and treatment of severe malnutrition as a core competency.