SAM are specifically trained on the need to identify and refer children with bilateral pitting edema to the NRCs as these children are at a much high risk of death. These frontline workers make special effort in convincing the family of children with bilateral pitting edema for admission and treatment in NRCs.

The paper mentions that of the total program exits, 1.2% children died. The focus of this paper was on the outcomes of children with SAM while in the program. The outcome of children who defaulted is beyond the scope of the paper. The paper also acknowledges and highlights the high default rates and has recommended further investigation for corrective action.

NRCs are meant for the stabilization, transition and the initial part of the rehabilitation phase of management of children with SAM with medical complications; the major part of the rehabilitation (4-6 weeks) needs to be undertaken in the community using therapeutic foods. A child with SAM needs to be treated with therapeutic food for 6-8 weeks for full recovery; low recovery rates seen at NRC cannot be taken as a failure or inadequacy of NRCs.

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Artemesinin-based Combination Therapy in Malaria Non-endemic Areas

The National Vector-Borne Disease Control Programme (NVBDCP), the National Antimalarial Programme (NAMP) and the WHO Guidelines 2010 recommend the use of artemesinin combination therapy (ACT) for the treatment of uncomplicated and complicated malaria due to *P. falciparum*, and in chloroquine-resistant malaria due to *P. vivax* [1,2]. Having stated this, the pertinent question arises as to why the WHO Guidelines recommend the use of ACT even in malaria non-endemic zones like Pondicherry where drug resistance has not been documented, and especially when there is good response to other antimalarials like chloroquine, quinine, sulfadoxine-pyrimethamine and primaquine. Recent studies indicate the evidence of resistance even to artemesinin combination therapy [3]. Is there not a need to take necessary steps before the ACT drug resistance becomes a common phenomenon? Is it not logical to reassess the use of ACT, and use it only in cases of chloroquine resistance malaria, in severe complicated malaria, in cases of heavy parasitemia, malaria in endemic areas, and in cases where there is poor response to non- ACT antimalarials, rather than in all cases? Should ACT not be the preserved drug used in selective cases, especially with increasing incidence of drug resistant malaria? Should not the policy of treatment of malaria be different in the areas of stable and unstable malaria transmission zones, rather than having a blanket rule and uniform guidelines of usage of ACT throughout the country? It is also important to address the issue of increasing incidence of *P. falciparum* in unstable transmission zones and also the situation in the states where *P. falciparum* has not been rampant. There needs to be a reassessment as far as the use of ACT is concerned. As pediatricians, we have a much larger and responsible role to play for malaria to be controlled in our community. The WHO guidelines and the IAP Consensus Statement needs to review the issue of ACT in falciparum malaria in children according to the areas of stable and unstable malaria transmission zones. At the same time, there is also a need to introduce the ACT in Integrated Management of Neonatal and Childhood Ilness (IMNCI) guidelines for the effective implementation of ACT at the primary health centres in malaria-endemic zones [4].

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