Call for authors – systematic reviews on prevention and treatment of wasting

Deadline of submission: 31 May 2021

Appendix: detailed questions

1. A) In infants <6 months, what are the criteria that best inform the decision to initiate treatment in an outpatient/community setting for growth failure/faltering?

   **Population:** infants <6 months

   **Index prognostic factors:** possible criteria or likely combination(s) that best inform the decision to initiate treatment for growth failure/faltering in an outpatient/community setting including:

   Poor anthropometry (alone or in combination with below additional criteria)

   - Oedema (+, ++, or +++)
   - Low WLZ
   - Low WAZ
   - Low MUAC
   - Weight loss or slow weight gain

   **Additional criteria**

   - Low birthweight or small for gestational age (WHO or INTERGROWTH-21)
   - Age at presentation
   - Breastfeeding/lactation difficulties
   - Not exclusively breastfeeding
   - Maternal health, well-being, and social factors including:
     - Maternal illness
     - Difficulties caring for the infant
     - Adolescent mother
     - Maternal HIV
     - Low maternal BMI or MUAC
     - Mother has died

   **Reference prognostic factors:** absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

   **Outcomes (to be scored) may include:**
1. B) In infants <6 months, what are the criteria that best inform the decision for referral to treatment in an inpatient setting for growth failure/faltering?

**Population:** infants <6 months

**Index prognostic factors:** possible criteria or likely combination(s) that best inform the decision for referral to treatment for growth failure/faltering in an inpatient setting including:

Poor anthropometry (alone or in combination with below additional criteria)

- Oedema (+, ++, or +++)
- Low WLZ
- Low WAZ
- Low MUAC
- Weight loss or slow weight gain

Additional criteria

- Co-morbidities
- IMCI danger signs
- Low birthweight or small for gestational age (WHO or INTERGROWTH-21)
- Age at presentation
- Breastfeeding/lactation difficulties
- Not exclusively breastfeeding
- Maternal health, well-being, and social factors including:
  - Maternal illness
  - Difficulties caring for the infant
  - Adolescent mother
  - Maternal HIV
  - Low maternal BMI or MUAC
  - Mother has died

**Reference prognostic factors:** absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

**Outcomes (to be scored) may include:**

- Mortality
- Clinical deterioration defined by development of any life-threatening danger signs (obstructed breathing, respiratory distress, cyanosis, shock, severe anemia, convulsion, severe dehydration, profuse watery diarrhea, vomiting, and/or impaired consciousness)
- Weight increase or improvement in anthropometry
- Morbidity or recovery from co-morbidity

1. C) In infants <6 months admitted for inpatient treatment of growth failure/faltering, what are the criteria that best inform the decision for transfer to outpatient/community treatment?
**Population:** infants <6 months admitted for inpatient treatment for growth failure/faltering

**Index prognostic factors:** possible criteria or likely combination(s) that best inform the decision for transfer from inpatient to outpatient/community treatment including:

- Clinical stabilization
- Loss or absence of oedema
- Weight increase or improvement in anthropometry
- No breastfeeding/lactation difficulties
- Recovery from co-morbidity
- Absence of danger signs

**Reference prognostic factors:** absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

**Outcomes (to be scored) may include:**

- Mortality
- Weight increase or improvement in anthropometry
- Relapse (e.g. low anthropometry within six months after discharge)
- Readmission (e.g. requiring treatment for growth failure/faltering in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)

1. **D)** In infants <6 months receiving outpatient/community treatment for growth failure/faltering, what are the criteria that best inform the decision for discharge from outpatient/community treatment?

**Population:** infants <6 months receiving outpatient/community treatment for growth failure/faltering

**Index prognostic factors:** possible criteria or likely combination(s) that best inform the decision for discharge from outpatient/community treatment including:

- Absence of oedema
- Weight increase or improvement in anthropometry
- No breastfeeding/lactation difficulties
- Recovery from co-morbidity

**Reference prognostic factors:** absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

**Outcomes (to be scored) may include:**

- Mortality
- Weight increase or improvement in anthropometry
- Relapse (e.g. low anthropometry within six months after discharge)
- Readmission (e.g. requiring treatment for growth failure/faltering in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Sustained recovery (e.g. nutritional recovery sustained for at least six months)
2. A) In infants and children >6 months, what are the criteria that best inform the decision to initiate treatment in an outpatient/community setting for wasting and/or oedema?

**Population:** infants and children >6 months

**Index prognostic factors:** possible criteria or likely combination(s) that best inform the decision to initiate treatment for wasting and/or oedema in an outpatient/community setting including:

Poor anthropometry (alone or in combination with below criteria)

- Oedema (+, ++, or +++)
- Low WLZ or WHZ
- Low WAZ
- Low MUAC
- Concurrent wasting (low WLZ or WHZ and/or low MUAC) and stunting (low LAZ or HAZ)

Additional criteria

- Age at presentation
- Passed or failed appetite test
- Maternal health, well-being, and social factors including:
  - Maternal illness
  - Difficulties caring for the infant
  - Adolescent mother
  - Maternal HIV
  - Low maternal BMI or MUAC
  - Mother has died

**Reference prognostic factors:** absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

**Outcomes (to be scored) may include:**

- Mortality
- Weight increase or improvement in anthropometry
- Morbidity

2. B) In infants and children >6 months with wasting and/or oedema, what are the criteria that best inform the decision for referral to treatment in an inpatient setting for wasting and/or oedema?

**Population:** infants and children >6 months

**Index prognostic factors:** possible criteria or likely combination(s) that best inform the decision for referral to treatment for wasting and/or oedema in an inpatient setting including:

Poor anthropometry (alone or in combination with below criteria)

- Oedema (+, ++, or +++)
- Low WLZ or WHZ
- Low WAZ
- Low MUAC
- Concurrent wasting (low WLZ or WHZ and/or low MUAC) and stunting (low LAZ or HAZ)
Additional criteria

- Co-morbidities
- IMCI danger signs
- Age at presentation
- Failed appetite test
- Failure to respond to nutritional interventions
- Maternal health, well-being, and social factors including:
  - Maternal illness
  - Difficulties caring for the infant
  - Adolescent mother
  - Maternal HIV
  - Low maternal BMI or MUAC
  - Mother has died

Reference prognostic factors: absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

Outcomes (to be scored) may include:

- Mortality
- Clinical deterioration defined by development of any danger signs (obstructed breathing, respiratory distress, cyanosis, shock, severe anemia, convulsion, severe dehydration, profuse watery diarrhea, vomiting, and/or impaired consciousness)
- Weight increase or improvement in anthropometry
- Morbidity or recovery from co-morbidity

2. C) In infants and children >6 months admitted for inpatient treatment of wasting and/or oedema, what are the criteria that best inform the decision for transfer to outpatient/community treatment?

Population: infants and children >6 months admitted for inpatient treatment of wasting and/or oedema

Index prognostic factors: possible criteria or likely combination(s) that best inform the decision for transfer from inpatient to outpatient/community treatment including:

- Weight increase or improvement in anthropometry
- Clinical stabilization
- Loss or absence of oedema
- Recovery from co-morbidity
- Absence of danger signs
- Appetite

Reference prognostic factors: absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

Outcomes (to be scored) may include:

- Mortality
- Weight increase or improvement in anthropometry
- Relapse (e.g. presenting with moderate or severe wasting or oedema within six months after discharge)
2. D) In infants and children >6 months receiving outpatient/community treatment for wasting and/or oedema, what are the criteria that best inform the decision for discharge from outpatient/community treatment?

**Population:** infants and children >6 months with wasting or oedema

**Index prognostic factors:** possible criteria or likely combination(s) that best inform the decision for discharge from outpatient/community treatment including:

- Absence of oedema
- Weight increase or improvement in anthropometry

**Reference prognostic factors:** absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

**Outcomes (to be scored) may include:**

- Mortality
- Weight increase or improvement in anthropometry
- Relapse (e.g. presenting with moderate or severe wasting or oedema within six months after discharge or other definition)
- Readmission (e.g. requiring treatment for moderate or severe wasting or oedema in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Default (e.g. absence at consecutive outpatient/community program visits)
- Sustained recovery (e.g. nutritional recovery sustained for at least six months)

3. In mothers/caregivers of infants <6 months with growth failure/faltering who are experiencing difficulties with breastmilk intake, which interventions to manage difficulties with breastfeeding/lactation can improve breastfeeding practices and increase breastmilk intake?

**Population:** mothers/caregivers of infants <6 months with growth failure/faltering who are experiencing difficulties with breastmilk intake (author-defined)

**Intervention:** management of difficulties with breastfeeding/lactation, supplementary suckling, or other interventions to increase breastmilk intake

**Comparison:** none of the above interventions and/or interventions compared to each other

**Outcomes (to be scored) may include:**

- Breastfeeding indicators and intake
- Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
- Mortality
- Morbidity or recovery from co-morbidity
4. A) In infants <6 months with growth failure/faltering, which criteria best determine if and when an infant should be given a supplemental milk formula (in addition to breastmilk if the infant is breastfed)?

**Population:** infants <6 months with growth failure/faltering (author-defined)

**Index prognostic factor:** possible criteria or approaches for giving commercial infant formula, F-75, or diluted F-100 or likely combination(s) including:
- Early versus late introduction of supplemental milk formula
- Giving supplemental milk formula versus no supplemental milk formula given
- Introduction of supplemental milk formula based on specific criteria (including when mothers experience difficulties with breastfeeding/lactation)

**Reference prognostic factor:** alternative approaches to introduction of supplemental milk formula and/or above approaches compared to each other

**Outcomes (to be scored) may include:**
- Mortality
- Clinical deterioration defined by development of any danger signs (obstructed breathing, respiratory distress, cyanosis, shock, severe anemia, convulsion, severe dehydration, profuse watery diarrhea, vomiting everything, and/or impaired consciousness)
- Duration of hospital stay or time to discharge
- Weight increase or improvement in anthropometry
- Relapse (e.g. low anthropometry within six months after discharge)
- Readmission (e.g. requiring treatment for growth failure/faltering in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Morbidity or recovery from co-morbidity

4. B) In infants <6 months with growth failure/faltering meeting the above criteria, what is the most effective supplemental milk formula (commercial infant formula, F-75, or diluted F-100) and for how long should these feeds be given?

**Population:** infants <6 months with growth failure/faltering (author-defined)

**Intervention:** commercial infant formula, F-75, or diluted F-100; different durations of commercial infant formula, F-75, diluted F-100

**Comparison:** commercial infant formula, F-75, or diluted F-100 compared to each other

**Outcomes (to be scored) may include:**
- Mortality
- Clinical deterioration defined by development of any danger signs (obstructed breathing, respiratory distress, cyanosis, shock, severe anemia, convulsion, severe dehydration, profuse watery diarrhea, vomiting, and/or impaired consciousness)
- Duration of hospital stay or time to discharge
- Relapse (e.g. low anthropometry within six months after discharge)
• Readmission (e.g. requiring treatment for growth failure/faltering in an inpatient or outpatient/community setting within six months after discharge)
• Non-response (e.g. not achieving recovery within four months of initiating treatment)
• Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
• Morbidity or recovery from co-morbidity

5. In infants <6 months with growth failure/faltering, should an antibiotic be routinely given (as per the 2013 guidelines for severe wasting and oedema)?

**Population:** infants <6 months with growth failure/faltering (author-defined)

**Intervention:** no routine antibiotics or different approaches (e.g. types of antibiotics, doses, etc.) than treatment protocols in the 2013 guidelines

**Comparison:** routine antibiotics following treatment protocols in the 2013 guidelines

**Outcomes (to be scored) may include:**

• Mortality
• Clinical deterioration defined by development of any danger signs (obstructed breathing, respiratory distress, cyanosis, shock, severe anemia, convulsion, severe dehydration, profuse watery diarrhea, vomiting, and/or impaired consciousness)
• Antimicrobial resistance
• Hospital acquired infections
• Duration of hospital stay or time to discharge
• Relapse (e.g. low anthropometry within six months after discharge)
• Readmission (e.g. requiring treatment for growth failure/faltering in an inpatient or outpatient/community setting within six months after discharge)
• Non-response (e.g. not achieving recovery within four months of initiating treatment)
• Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
• Morbidity or recovery from co-morbidity
• Markers of intestinal and systemic inflammation

6. In mothers/caregivers of infants <6 months with growth failure/faltering, do maternal nutritional supplementation and/or counselling and/or maternal-directed mental health interventions improve infant outcomes?

**Population:** mothers/caregivers of infants <6 months with growth failure/faltering (author-defined)

**Intervention:** maternal nutritional supplementation and/or counselling and/or maternal-directed mental health interventions including:

• Maternal nutritional supplementation (micronutrients, LNS, balanced energy and protein, etc.)
• Breastfeeding, complementary feeding, and other nutrition and health counselling/education
• Relaxation therapy while breastfeeding
• Women’s empowerment interventions
• Mental health, psychosocial, peer, or social support
• Cash transfers
• Kangaroo mother care
**Comparison:** none of the above maternal-directed interventions and/or compare interventions (or combinations) to each other

**Outcomes (to be scored) may include:**

- Mortality
- Nutritional recovery
- Relapse (e.g. low anthropometry within six months after discharge)
- Readmission (e.g. requiring treatment for growth failure/faltering in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
- Child development

7. In infants and children >6 months with moderate wasting across settings and contexts, which children require specially formulated foods; also what is the effectiveness of specially formulated foods (including RUSF, RUTF, CSB++, MDCF) vs non-specially formulated food interventions vs other approaches?

**Population:** infants and children >6 months with moderate wasting (outpatient/community), disaggregated by subgroups to determine effectiveness for different children

**Intervention:** specially formulated foods (including RUSF, RUTF, CSB++, MDCF) vs non-specially formulated food interventions vs other approaches (e.g. improved quality / augmented family foods, counselling, cash distribution)

**Outcomes (to be scored) may include:**

- Mortality
- Nutritional recovery
- Time to recovery
- Sustained recovery (e.g. nutritional recovery sustained for at least six months)
- Relapse (e.g. presenting with moderate wasting within six months after discharge)
- Readmission (e.g. requiring treatment for moderate wasting in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Deterioration to severe wasting
- Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
- Morbidity or recovery from co-morbidity
- Micronutrient status
- Child development
- Risk of noncommunicable disease
- Body composition

8. In infants and children >6 months with moderate wasting, what is the appropriate dietary treatment in terms of optimal type, quantity, and duration?

**Population:**

- infants and children >6 months with moderate wasting (receiving community/outpatient treatment)
• infants and children >6 months with moderate wasting (receiving inpatient treatment)

**Intervention:** dietary treatment in addition to standard clinical care

**Comparison:** no specific dietary treatment in addition to standard clinical care and/or compare different dietary treatment approaches to each other

**Outcomes (to be scored) may include:**

- Mortality
- Nutritional recovery
- Time to recovery
- Sustained recovery (e.g. nutritional recovery sustained for at least six months)
- Relapse (e.g. presenting with moderate wasting within six months after discharge)
- Readmission (e.g. requiring treatment for moderate wasting in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Deterioration to severe wasting
- Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
- Morbidity or recovery from co-morbidity
- Micronutrient status
- Child development
- Risk of noncommunicable disease
- Body composition

9. In infants and children >6 months with severe wasting or oedema, what is the optimal quantity and duration of RUTF?

**Population:** infants and children >6 months with severe wasting and/or oedema

**Intervention:** varying quantity or duration of RUTF

**Comparison:** current RUTF quantity and duration of treatment from the 2013 guidelines

**Outcomes (to be scored) may include:**

- Mortality
- Nutritional recovery
- Time to recovery
- Sustained recovery (e.g. nutritional recovery sustained for at least six months)
- Relapse (e.g. presenting with severe wasting or oedema within six months after discharge)
- Readmission (e.g. requiring treatment for severe wasting or oedema in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
- Morbidity or recovery from co-morbidity
- Micronutrient status
- Child development
- Risk of noncommunicable disease
- Body composition
10. In infants and children with growth failure/faltering or severe wasting or oedema who are not tolerating F-75 or F-100, what is the effectiveness of hydrolyzed formulas during inpatient care?

**Population:**
- infants <6 months with growth failure/faltering who are not tolerating F-75 or F-100 (inpatient only)
- infants and children >6 months with severe wasting and/or oedema who are not tolerating F-75 during the stabilization phase or F-100 during the rehabilitation phase (inpatient only)

**Intervention:** hydrolyzed formulas (partially or fully hydrolyzed proteins and/or carbohydrates)

**Comparison:** standard therapeutic feeds including F-75 and F-100

**Outcomes (to be scored) may include:**
- Mortality
- Clinical deterioration defined by development of any danger signs (obstructed breathing, respiratory distress, cyanosis, shock, severe anemia, convulsion, severe dehydration, profuse watery diarrhea, vomiting, and/or impaired consciousness)
- Tolerance of feeds (vomiting, need for NGT, osmotic diarrhea, persistent abdominal distension, paralytic ileus)
- Duration and intensity of osmotic diarrhea
- Duration of NPO and IV maintenance fluids used
- Markers of intestinal and systemic inflammation
- Duration of hospital stay or time to discharge
- Weight change
- Morbidity or recovery from co-morbidity

11. A) In infants and children ≥6 months with moderate or severe wasting or oedema, how can dehydration be identified?

**Population:**
- infants and children ≥6 months with moderate wasting (inpatient only)
- infants and children ≥6 months with severe wasting and/or oedema (inpatient only)

**Index test:**
- History of diarrhea or vomiting
- Loose watery stools
- Lethargy
- Fever
- Reduced consciousness
- Prolonged capillary refill time
- Abnormal respiratory patterns
- Inability to drink
- Low urine output
- Low blood pressure
- Rapid pulse
- Hyponatremia
11. B) In infants and children >6 months with moderate or severe wasting or oedema and dehydration but who are not shocked, what is the effectiveness of standard WHO low-osmolarity ORS compared with ReSoMal during inpatient care?

**Population:**
- infants and children >6 months with moderate wasting and dehydration but who are not shocked (inpatient only, excluding children with cholera/profuse watery diarrhea)
- infants and children >6 months severe wasting and/or oedema and dehydration but who are not shocked (inpatient only, excluding children with cholera/profuse watery diarrhea)

**Intervention:** standard WHO low-osmolarity ORS

**Comparison:** current guidelines for fluid strategies with ReSoMal (from 2013 guidelines and ETAT guideline)

**Outcomes (to be scored) may include:**
- Mortality
- Clinical deterioration defined by development of any danger signs (obstructed breathing, respiratory distress, cyanosis, shock, severe anemia, convulsion, severe dehydration, profuse watery diarrhea, vomiting, and/or impaired consciousness)
- Adverse outcomes such as electrolyte imbalance, oedema
- Duration of diarrhea
- Time to full rehydration
- Duration of hospital stay or time to discharge
- Weight change
- Morbidity or recovery from co-morbidity

12. A) Which infants and children with growth failure/faltering, moderate or severe wasting, or oedema require post-discharge interventions?

**Population:** infants and children with growth failure/faltering, moderate or severe wasting, and/or oedema

**Index prognostic factors:** possible criteria or likely combination(s) including:
- Low WHZ
- Low MUAC
- Low WAZ
- Low HAZ
- Age at presentation
- Breastfeeding/lactation or feeding difficulties
- Maternal health, well-being, and social factors including:
  - Maternal illness
  - Difficulties caring for the infant
  - Adolescent mother
o Maternal HIV
o Low maternal BMI or MUAC
o Mother has died

Reference prognostic factors: absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

Outcomes (to be scored) may include:

- Mortality
- Relapse (e.g. low anthropometry or presenting with moderate or severe wasting or oedema within six months after discharge)
- Readmission (e.g. requiring treatment for growth failure/faltering or moderate or severe wasting or oedema in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Deterioration to severe wasting
- Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
- Morbidity or recovery from co-morbidity

12. B) In infants and children with growth failure/faltering, moderate or severe wasting, or oedema meeting the above criteria, which post-discharge interventions are effective?

Population: infants and children with growth failure/faltering, moderate or severe wasting, and/or oedema

Intervention: post-discharge interventions (e.g. counselling, nutritional supplementation, conditional cash transfers, etc.) in addition to standard of care

Comparison: no additional post-discharge interventions in addition to standard of care

Outcomes (to be scored) may include:

- Mortality
- Nutritional recovery
- Time to recovery
- Sustained recovery (e.g. nutritional recovery sustained for at least six months)
- Relapse (e.g. low anthropometry or presenting with moderate or severe wasting or oedema within six months after discharge)
- Readmission (e.g. requiring treatment for growth failure/faltering or moderate or severe wasting or oedema in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Deterioration to severe wasting
- Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
- Morbidity or recovery from co-morbidity
- Child development
- Body composition

13. In infants and children with wasting without co-morbidities, what is the effectiveness of the identification and treatment of wasting by community health workers (in community settings)?

Population: children with wasting without co-morbidities
**Intervention:** identification and treatment of wasting by community health workers (in community settings) following the same criteria for identification of wasting and program admission and discharge, following the same treatment protocols

**Comparison:** identification and treatment of wasting by health care staff (at health facilities) following the same criteria for identification of wasting and program admission and discharge, following the same treatment protocols

**Outcomes (to be scored) may include:**

- Mortality
- Nutritional recovery
- Sustained recovery (e.g. nutritional recovery sustained for at least six months)
- Relapse (e.g. wasting within six months after discharge)
- Readmission (e.g. requiring treatment for wasting in an inpatient or outpatient/community setting within six months after discharge)
- Non-response (e.g. not achieving recovery within four months of initiating treatment)
- Default (e.g. absence at consecutive treatment program visits)
- Deterioration to severe wasting
- Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
- Morbidity

14. In communities with infants and children up to five years old at risk of wasting, what community characteristics increase or mitigate risk of wasting for individual children?

**Population:** infants and children up to five years old at risk of wasting

**Index prognostic factors:** community settings characteristics including:

- Seasonal dimensions
- Food insecurity
- Humanitarian or stable settings
- Geographical location
- Health system quality and coverage
- WASH indicators

**Reference prognostic factors:** absence of the criteria or combination of criteria (categorical factors) or the increase or decrease in a criteria or combination of criteria (continuous factors)

**Outcomes (to be scored) may include:**

- Wasting incidence and prevalence
- Mortality

15. In communities with infants and children up to five years at risk of wasting, what is the effectiveness of community prevention interventions for prevention of wasting?

**Population:** infants and children up to five years at risk of wasting

**Intervention:** community prevention interventions including:
• Nutritional supplementation
• Nutritional counselling
• Breastfeeding interventions
• Social protection programs
• Cash transfers

**Comparison:** prevention interventions compared to each other and/or no prevention interventions

**Outcomes (to be scored) may include:**

• Mortality
• Wasting incidence and prevalence
• Deterioration to severe wasting
• Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
• Morbidity

16. In communities with infants and children up to five years at risk of wasting, what is the effectiveness of population-based interventions compared to targeted interventions for primary and secondary prevention of wasting?

**Population:** infants and children up to five years at risk of wasting

**Intervention:** population-based interventions including:

• Blanket supplementary feeding programs
• Nutritional supplementation programs
• Cash transfers

**Comparison:** population-based interventions compared to each other

**Outcomes (to be scored) may include:**

• Mortality
• Wasting incidence and prevalence
• Deterioration to severe wasting
• Anthropometric outcomes (WLZ, WAZ, MUAC, change in anthropometry, weight gain)
• Morbidity