PEER REVIEW HISTORY

BMJ Paediatrics Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

TITLE (PROVISIONAL)	New WHO Guideline on the prevention and management of acute malnutrition in infants and young children: remaining challenges
AUTHORS	Rohloff, Peter Gupta, Subodh López Canu , Waleska Rodríguez Gómez , Wendy Sridhar, Shela Venzor, Anahi

VERSION 1 – REVIEW

REVIEWER	Prof. Subhashchandra Daga Pacific Medical College and Hospital, Pediatrics
REVIEW RETURNED	11-Feb-2024

GENERAL COMMENTS	1. The successful outcome of acute malnutrition in infants depends on the individual case management, which may be supervised care in the community or facility-based care in some. This needs to be clearly spelt out. The measures recommended are targeted largely towards prevention. 2. Drawing attention towards the vulnerable infants less than six months is praiseworthy. 3. RUTF is a contentious issue. The option of locally available fortified supplement should find mention. Milk-based nutrition supplements have major storage issues and are liable to get spoilt. This brings bad name to thee programme.

REVIEWER	Dr. Raul Gerardo Mercer Social Sciences and Health
REVIEW RETURNED	02-Apr-2024

GENERAL COMMENTS	Regarding the title Management of acute malnutrition in young infants and young children: New guidelines from the World Health Organization and remaining challenges I recommend: New WHO Guideline on the prevention and management of acute malnutrition in infants and young children: remaining challenges General comments: The manuscript is well written and is the result of reviewing of the WHO Guidelines. It needs an introduction explaining its aim and how the challenges were identified.

	It is highlighted that the authors incorporate a perspective of community-based and social paediatrics, also considering dimensions related to compliance with the rights of the child in health setting, despite the fact that this last point is not made explicit in the text (i.e the right to health, to have a family, to eradicate discrimination, to play, among others). Where it says: The evidence provided in these guidelines provides Ministries of Health with the evidence they need to allocate resources to social programs upstream rather than focusing exclusively on the acute phase of malnutrition. Comment: These guidelines are not restricted exclusively to Ministries of Health. As the authors comment later in the article, it should include other stakeholders. (governments, policy and advocacy organizations, and clinicians)

REVIEWER	Dr. Vandana Prasad Public Health Resource Society, New Delhir
REVIEW RETURNED	05-Apr-2024

GENERAL COMMENTS	This is an important viewpoint on an important subject. I make a few points as a general communication to fellow-travellers which they may or may not choose to accommodate in this or future work. 1. I think growth-faltering as a trigger for action continues not to find its space, and this has been a very specific recommendation I have been making to unicef and the government. the definition must be based on trajectory on growth charts or z score deterioration, and not being in the category of mam or sam. It is time to make the distinction between a baby following its own growth curve and one falling off it regardless of starting point. failure to gain weight is not good enough. weight can remain static or weight gain may not be adequate. 2. The issue of the community health worker is very important. one of the key bottlenecks for us in India is also her status as a non-worker. 3. The in-patient experience issue is very important. One factor is economic opportunity cost; some parents make the hard choice to risk a child rather than a milch animal...this might be specifically mentioned 4. On rutf - as you might know I have written extensively. the issue is not just one of caution on grounds of hfss, but that there are effective alternatives that offer as much of a short-term outcome with better outcomes on sustaining improvements long term. 5. Finally, there is a role for childcare arrangements/supervised feeding using local foods at community level for greater impact in certain contexts of extreme vulnerability. All of these will need government intervention to implement - not just in terms of capacity building, but also remunerating chws, compensating families for economic costs of in patient care, organising childcare as vehicles for community based management etc

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Prof. Subhashchandra Daga, Pacific Medical College and Hospital

Comments to the Author
1. The successful outcome of acute malnutrition in infants depends on the individual case management, which may be supervised care in the community or facility-based care in some. This needs to be clearly spelt out. The measures recommended are targeted largely towards prevention.

This is an excellent point and we have emphasized it by adding it as the very last line of the entire commentary:

> *It is also essential that these general guidelines not cause clinicians to lose sight of the necessity to individualize care to each child and family, which is essential for the management and prevention of acute malnutrition, and which includes a need to act quickly on risk factors and early onset of growth faltering long prior to the diagnosis of MAM and SAM.*

2. Drawing attention towards the vulnerable infants less than six months is praiseworthy.

We've emphasized this point even more by adding a modified sentence to our paragraph on Good Practice Recommendations A1:

> *Although the novel focus on prevention for infants younger than 6 months as praiseworthy, we should recognize that there are many operational challenges to achieving this recommendation including:*

3. RUTF is a contentious issue. The option of locally available fortified supplement should find mention. Milk-based nutrition supplements have major storage issues and are liable to get spoilt. This brings bad name to thee programme.

We agree and had already dedicated an entire paragraph at the end of the viewpoint to this issue. In addition to that paragraph we have removed the early mention of RUTF in the first paragraph to not create the impression of an endorsement. This sentence now reads:

> *"…including improving inpatient protocols for severely ill children and expanding opportunities for management beyond the inpatient setting to community-based programs for children with severe acute malnutrition"*

Reviewer: 2
Dr. Raul Mercer

Comments to the Author
Regarding the title

Management of acute malnutrition in young infants and young children: New guidelines from the World Health Organization and remaining challenges

I recommend:
New WHO Guideline on the prevention and management of acute malnutrition in infants and young children: remaining challenges

We have changed the title as recommended.

General comments:

The manuscript is well written and is the result of reviewing of the WHO Guidelines. It needs an introduction explaining its aim and how the challenges were identified.

We added an additional paragraph:

> *With the introduction of these new guidelines, a group of global health practitioners and child nutrition experts met to review the guidelines critically, with a particulary emphasis on emphasizing social pediatrics and child rights. Our primary goal was to offer insights into the challenges of implementing these directives, drawing from our varied experiences in lower resourced settings around the world. Each team member conducted a thorough review of the guidelines and contributed key talking points, which were subsequently synthesized.*

It is highlighted that the authors incorporate a perspective of community-based
and social paediatrics, also considering dimensions related to compliance with the rights of the child in health setting, despite the fact that this last point is not made explicit in the text (i.e the right to health, to have a family, to eradicate discrimination, to play, among others).

We have modified the relevant phrase to read:

> *"…from the perspective of social pediatrics and community-based and rights-based approaches."*

Where it says:
The evidence provided in these guidelines provides Ministries of Health with the evidence they need to allocate resources to social programs upstream rather than focusing exclusively on the acute phase of malnutrition.

Comment:
These guidelines are not restricted exclusively to Ministries of Health. As the authors comment later in the article, it should include other stakeholders. (governments, policy and advocacy organizations, and clinicians)

We modified the relevant sentence to read:

These guidelines provide Ministries of Health and other stakeholders, including clinician organizations, civil society, and advocacy organizations, with the evidence they need to allocate resources to social programs upstream rather than focusing exclusively on the acute phase of malnutrition.

Reviewer: 3
Dr. Vandana Prasad, Public Health Resource Society, New Delhir

Comments to the Author
This is an important viewpoint on an important subject. I make a few points as a general

communication to fellow-travellers which they may or may not choose to accommodate in this or future work.

1. I think growth-faltering as a trigger for action continues not to find its space, and this has been a very specific recommendation I have been making to unicef and the government. the definition must be based on trajectory on growth charts or z score deterioration, and not being in the category of mam or sam. It is time to make the distinction between a baby following its own growth curve and one falling off it regardless of starting point. failure to gain weight is not good enough. weight can remain static or weight gain may not be adequate.

This is an important point and one we can't fully engage in this short viewpoint, but we have added a final sentence to conclude the viewpoint as follows:

> *It is also essential that these general guidelines not cause clinicians to lose sight of the necessity to individualize care to each child and family, which is essential for the management and prevention of acute malnutrition, and which includes a need to act quickly on risk factors and early onset of growth faltering long prior to the diagnosis of MAM and SAM.*

2. The issue of the community health worker is very important. one of the key bottlenecks for us in India is also her status as a non-worker.

We have modified the relevant sentence to read:

> *"In many contexts, community-based services are provided by CHWs who are not always provided adequate training and mentorship or even formal employment status.*

3. The in-patient experience issue is very important. One factor is economic opportunity cost; some parents make the hard choice to risk a child rather than a milch animal...this might be specifically mentioned

We added the following additional lines to this paragraph:

> *We should also consider the weighty economic direct and indirect costs that inpatient pediatric care imposes on families, including lost wages, the need to arrange childcare for siblings, and transportation costs. These expenses are often overlooked and continue to deter families from accessing care.*

4. On rutf - as you might know I have written extensively. the issue is not just one of caution on grounds of hfss, but that there are effective alternatives that offer as much of a short-term outcome with better outcomes on sustaining improvements long term.

We have added a reference to one of Dr. Prasad's viewpoints, and have made this point more clearly as follows:

> *In some settings such as India, which contains a large proportion of the global burden of acute malnutrition, RUTFs are not commonly used because clinicians, policy makers, and advocacy organizations have convincingly argued about how they about how they may displace whole food interventions which can be deployed with equal efficacy and a higher degree of sustainability.(6) More advocacy is urgently needed to continue to improve local, sustainable food solutions globally.*

5. Finally, there is a role for childcare arrangements/supervised feeding using local foods at community level for greater impact in certain contexts of extreme vulnerability.
All of these will need government intervention to implement - not just in terms of capacity building, but also remunerating chws, compensating families for economic costs of in patient care, organising childcare as vehicles for community based management etc

We briefly address these issues now in the paragraph on inpatient care:

> *We should also consider the weighty economic direct and indirect costs that inpatient pediatric care imposes on families, including lost wages, the need to arrange childcare for siblings, and transportation costs. These expenses are often overlooked and continue to deter families from accessing care.*