Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Abramovitz & Birch, 2000) USA Questionnaire and interview survey Evidence level: 3	197 girls aged 5 years and their parents. Girls lived with both biological parents and did not have severe food allergies or chronic medical problems affecting food intake. The mean age of mothers was 35.36 ± 4.77 years and fathers was 37.42 ± 5.39 years. 63% of mothers and 97% of fathers were currently employed.	Study Question: To explore 5-year-olds girls' ideas, concepts and beliefs about dieting. Statistical Analysis: Sample spilt into two groups "ideas" and "no ideas". Dichotomous and logistic regression analysis, to examine predictors of girls' ideas about dieting.	Child measures: • Dieting ideas questionnaire • Dieting messages and behaviour questionnaire • Weight concerns scale • Weight and height measured Parent measures • Personal health history • Dieting behaviours • Weight concerns scale • Eating Inventory • Weight and height measured	Depending on the question, from 34% to 65% of girls aged 5 years had ideas about dieting. Compared to girls whose mothers did not diet, girls whose mothers reported current or recent dieting were more than twice as likely to have ideas about dieting, suggesting that mothers' dieting behaviour is a source of young girls' ideas, concepts and beliefs about dieting. Among mothers, more than 90% reported recent dieting, and most reported use of both health promoting and health-compromising dieting behaviour.	May be applicable in the UK setting but generalisability doubtful	

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(Alder et al. 2004) Edinburgh, UK Questionnaire survey and interviews Evidence level: 3	Primiparous women 99% white ethnic group 66% married Mean school leaving age: 18 years Majority of women lived in areas with deprivation scores of 3-4 n=338 women	Study Question: What influences the timing of the introduction of solid foods to infants? Statistical Analysis: Bivariate and multiple regression analysis	Women interviewed at 12 weeks postpartum about patterns of infant feeding and time of introduction of solid foods Postal questionnaire at 20 weeks postpartum	Early introduction of solid foods associated with: Opinions of infant's maternal grandmother Living in a deprived area Personal disagreement with the advice to wait till baby was 4 month old Lack of encouragement from friends to wait till baby was 4 months old Being in receipt of free samples of manufactured food Results of open-ended questionnaires: Early introduction of solids influenced by mother's perceptions of the baby's needs.	Likely to be applicable in the UK setting but limited generalisability	Non-comparative study based on subjective outcome data Issues of reliability and generalisability

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Anderson et al. 2001) UK Focus group Evidence level: 3	29 women (22 primiparous; 7 multiparous) Mean age: 27 years Infants mean age: 13 months Social characteristics: one-third had completed education at age 15 or 16 years of age 7 completed education by age 20 9 on paid maternity leave 14 no current employment 7/29 women smokers while pregnant 10 already introduced solids to infants at mean age of 11.6 weeks 29 women in 5 focus groups	Study Question: What are mothers' attitudes and beliefs influencing the timing of introduction to solid food? Statistical Analysis: Qualitative: exploratory	Focus groups	Current feeding habits Range: Breastfeeding to combined milk and solids Choice of infant foods Rarely nutritional Food consistency Varied diet Organic option Views on decisions about when to introduce solids Waiting for babies to show 'signs': Pre-defined weight or subjective size Starting teething Increased saliva production Development of constipation Other 'signs': 'Hungry cry' 'Motherly instinct' 'Looking for more milk' 'Chewing hands' Taking food 'fast and furiously' 'Responding to smell of food' Feeling when infants had first solid foods 'Proud' 'A big achievement' 'Baby more settled and content' 'Being satisfied'	May be applicable in the UK setting but generalisability doubtful	Non-comparative study based on subjective outcome data Issues of reliability and generalisability

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				'Amazing to see baby eating with a spoon' 'Baby rattled plate' Knowledge and attitudes to current weaning guidelines: All aware of current guidelines 'Bowel develops differently if solids given early' Digestive systems not mature' Inappropriateness of rigid guideline: 'babies are individual guidelines have to be flexible'		

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Andrew. 2004) Huddersfield, UK Observational study Evidence level: 3	Asian populations in Huddersfield. The target populations were al families with children under 5 years old Asian populations in Huddersfield	Study Question: What are the clients' views on a health visitor oral health campaign 'Beakers for bottles' ? Statistical Analysis: Descriptive analysis	a UK public health campaign (Beakers for bottles), based on the Bradford 'Bottle Amnesty' of 1994, to improve child feeding practices and oral health among the Asian populations in Huddersfield. A collaborative venture between health visitors, Calderdale and Kirklees Health Authority and the Huddersfield Oral Health Promotion Department The objectives were to address and reduce the practice of giving babies any drinks other than milk or water in a feeding bottle; to encourage parents to swap bottles for beakers when the children reached 6 months old; to raise awareness of the damage sugar can do to children's teeth and to encourage proactive and regular contact with the dental service. The event was a collaborative effort, utilising peer health educators to assist with translation of posters and leaflets into Urdu and Punjabi. A rota was designed to ensure that an interpreter, health visitor and oral healthy workers were available every day. The event was advertised with flyers inserted in a free paper delivered to every home in the	Attendance 40% of the attendees were from the South Asian community. Client's views and feedback on the event Over 80% scored the event highly 30% requested contact regarding future public health events. Many people discarded their old bottles and were given feeding cups. No negative comments were recorded. Problems identified included: Communication difficulties between health professionals (not specified) Cups were reported to be more suitable for older children in addition to the lidded beakers for younger infants No translator available for Bosnian families who did not speak English The continued use of a bottles over a year may encourage over consumption of cow's milk, leading to iron deficiency anaemia should be addressed in future campaigns.	Likely to be applicable in the UK setting and target populations but no long term outcomes were assessed	No before-and-after evaluation No control group Likelihood of confounding biases It is not clear if the discarding of feeding bottles and giving of feeding cups had any effect on the increased use of feeding cups

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			area. Posters in English, Urdu and Punjabi with a bright coloured logo 'Beakers for bottles' were put up in local shop and community centres. The offer of free beakers and toothbrush and paste was advertised as an incentive for people to attend the event.	No long-term outcomes such as increased use of beakers or dental caries were assessed and no follow-up evaluation of the campaign was identified.		

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(Birch et al. 1998) US Observational case series study Evidence level: 3	Infants aged 4-7 months (21 girls, 18 boys; 23 breastfed, 16 formula-fed) Mothers' mean age: 31years 39 infants	Study Question: What are the effects of repeated exposure to the target food on enhancing acceptance of similar foods among infants? Statistical Analysis: Before-and-after analysis	Introduction of new foods All foods used in this study are commercially available baby food Pre-exposure: infants fed target, same (same as target food but from another manufacturer), similar and different foods for 4 days Exposure: 10 days, infants fed target foods only Post exposure: infants fed target, same (same as target food but from another manufacturer), similar, different foods and additional 'home-prepared' foods (of the target food) for 5 days.	Post-exposure intake of target foods: After exposure to the target food - A sig increase (from 35 to 72 g) Post-exposure intake of same foods: After exposure to the target food - A non-sig increase Post-exposure intake of similar foods: After exposure to the target food - A sig increase Post-exposure intake of different foods: After exposure to the target food - No sig increase	Likely to be applicable to UK settings and population	

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Birmingham et al. 2004) US Pretest post-test design and an intervention protocol based on preliminary focus group data. Evidence level: 2-	Eligible participants were non-pregnant and had a child enrolled in WIC living in their household. Mothers of high risk children were excluded. pretest (n=225), post-test (n=167) mothers having a child or children enrolled in the WIC	Study Question: (1) To identify WIC mothers' perceived barriers and behaviors related to fruits and vegetables (2) To estimate the impact of the Market Basket Booklet on mothers' perceived barriers and behaviors related to fruits and vegetables when the booklet is used as part of WIC Five-A-Day education	Evaluation of a five-a-day recipe booklet for enhancing the use of fruits and vegetables in low-income households	After receiving the booklet many WIC mothers reported feeling more confident about choosing good quality fresh produce (70%) and storing fruits and vegetables properly (68%), and also felt that it was easier to include fruits and vegetables in their family's meals (74%) Many mothers reportedly served more fruits and vegetables to their families after receiving the booklet. The greatest increase was seen with vegetables at dinner (56%) Mothers also evaluated the format and content of the booklet. Mother's barriers related to fruits and vegetables did not change. Mothers estimated intake of fruits and vegetables decreased slightly over the intervention period. Pretest (4.5 ± 2.8 average servings) to post-test (4.0 ± 2.7 average servings) for all post test responders.	May be applicable to the UK population with modification	The education on promotion of fruits and vegetables needs to be more specific as to how much more increase should be there, portion sizes etc. No follow-up WIC education was provided.

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Black et al. 1995) USA RCT Evidence level: 1+	Children with failure to thrive n = 130. Intervenors: lay home visitors Sample consisted of two groups: (1) Intervention - home visits and clinics (n = 64) and (2) control - clinics only (n = 66) Intervention and control groups stratified by age of child at recruitment: younger group = 1–12 months; older group = 12.1–24.9 months Attrition: n remaining at 18 months: 116/ 130 (89%)	The efficacy of a family-focused and home-based intervention on the growth and development of children with non-organic failure to thrive. Statistical Analysis: comparative analysis between the intervention and the control groups	The intervention consisted of home visits and clinics compared to clinics only. Intervention consisted of maternal support, promotion of parenting, child development, use of formal and informal resources and parent advocacy. Weekly home visits for one year. Mean (SD) number of visits = 19.2 (11.5) with a mean duration of just less than 1 hour.	Mean (SD) scores – weight for age (Z scores) Int younger -1.3 (1.1) Con younger -1.1 (1.0 Int older -1.8 (0.6) Con older -1.7 (0.7) Mean (SD) scores – weight for height (Z scores) Int younger -1.0 (1.4) Con younger -0.8 (1.1) Int older 1.5 (0.5) Con older -1.3 (0.6) All non significant Mean (SD) score Bayley Scales of Mental Development Int younger 89.3 (17.4) Con younger 86.1 (18.7) – not significant Int older 81.9 (12.5) Con older 80.8 (15.2) – not significant Bayley Scales of Motor Development Mean (SD) scores Int younger 92.0 (14.6) Con younger 91.5 (15.2) – not significant	Likely to be applicable in the UK settings and target populations	

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
				Int older 92.0 (18.7) Con older 91.6 (14.2) – not significant Int older 92.0 (18.7) Con older 91.6 (14.2) – not significant		

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Bournemouth University et al. 2004) Bournemouth, UK Descriptive Evidence level: 3	One community in West Hove, involving families, parents and toddlers One community in West Hove	Study Question: What is the impact of the Healthy Eating Project on the community? Statistical Analysis: Descriptive	The St Philips Healthy Eating Project The St Philips Healthy Eating Project is one of the 524 individual schemes (Sure Start) which bring together early education, childcare, health and family support. The project aims to help families develop healthy eating habits and strengthening families and communities. Multi-choice or single-choice meals were provided once a month, at the end of the Toddler Group sessions. Food was prepared fresh by volunteers and provided parents/carers and their children with a nutritious and healthy meal. Overall aims: Promote eating together as a family Promote healthier food Specific objectives: Increase frequency of meals at end of toddlers' sessions Parents and volunteers preparing meals together Increase variety of foods in 'multi-choice' meal sessions Talk about healthy eating and food Getting parents to think about what meals would be prepared Providing opportunity for	Participants feedback 1) Some achievement in promotion healthier ways of eating at local level - parents and carers to plan and cook nutritious meals 2) provide nutritious meals and opportunity to try something different 3) Promote eating together as a family, sharing a meal 4) opportunity for parents to talk about their children's development 5) opportunity to be creative in helping to choose meal and food preparation 6) meeting Sure Start objectives: improving health and strengthening families and communities 7) develop a locally-based initiative	Likely to be applicable in the UK settings and target populations	subjective data

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			parents to socialise Collection of ideas for a recipe book Children to eat together with other children			

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(Bruening et al. 1999) US Non-RCT Evidence level: 2+	Children aged 3-5 years from 2 nonprofit child care centres predominantly black children Similar characteristics in both groups except that higher no of children receiving federal food assistance in CACFP group 40 children aged 3-5 years	Study Question: What are the effects of CACEP program on children's health outcomes? Statistical Analysis: comparative analysis between the intervention and the control groups	CACFP program (n=20) vs no CACFP (brought meals and snacks from home) (n=20) The Child and Adult Care Food Program (CACFP) is a federal food program which reimburses child care institutions that serve nutritious food to children	Dietary intake No sig diff between the 2 groups in intakes of energy, CHO and fat Sig higher intake of protein, vitamins A, thiamin, riboflavin, pyridoxine, folate, calcium, iron, magnesium and zinc in CACFP group (than control (p=0.05) CACFP group consume sig more milk and vegetables , fewer servings of sweet/fats than control (p=0.05) Weight/height, dental caries No sig diff between the 2 groups no of days of illness CACFP group: 6.5 Control: 10.5 (p=0.05)	May be applicable to the UK setting and population with program modified	small sample reliability and accuracy of 24 hour dietary recall

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Bush et al. 1997) UK and Ireland Evidence level: 3	The review included studies relating to minority ethnic groups (South Asians, Afro-Caribbeans and the Irish) 107 qualitative, cross-sectional and quantitative studies published between 1980 to 1997	Study Question: What are the opportunities for and barriers to good nutritional health in minority ethnic groups? Statistical Analysis: Narrative summary	Opportunities for and barriers to good nutritional health in minority ethnic groups in the UK (South Asians, Afro-Caribbeans and the Irish)	Practical suggestions on South Asian infant health and infant feeding practices: Encourage breastfeeding soon after birth, recognising cultural differences and possible tensions Discourage pasteurised whole cows' milk till after the first 12 months Encourage introduction of solids by 6 months Discourage sweet commercial foods and promote use of South Asian foods for weaning Investigate feasibility of commercial halal baby food Investigate feasibility of labelling commercial weaning foods as halal for vegetarians in English and Asian scripts, together with appropriate symbol for those unable to read	Likely to be applicable to the UK setting and target populations	Thorough review, relevant to the target populations (up to 1997)

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(Byrne et al. 2002) US Evidence level: 1-	86 children aged 3 -5 years from a university preschool laboratory 86 children	Study Question: What are the effects of exposure to children's books on attitudes and behaviours in accepting unfamiliar vegetable? Statistical Analysis: Pre- and post-test comparison and analysis between the intervention and control group	Reading a storybook which had a positive message about Kohlrabi (n=29) vs Reading a storybook which had a negative message about Kohlrabi (n=29) vs Reading a storybook which did not mention food (control)(n= 28)	Children's knowledge (can name kohlrabi): Positive message group Pre-test: 0% Post-test: 62% ($p<0.01$) Negative message group Pre-test: 0% Post-test:34% ($p<0.01$) Control Pre-test: 0% Post-test: 14% ($p<0.01$) Children's willingness to ask kohlrabi (Post-test): Positive message group: 90% Negative message group: 69% Control: 61% ($p<0.05$)	Laboratory experiment-may not be applicable to the UK settings	RCT and before-and-after design and analysis Willingness to taste kohlrabi in positive message group already high at baseline Small sample Knowledge and willingness to taste not equate food consumption

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(Carroll et al. 1996) US Before and after study Evidence level: 2-	High-risk, low-income population receiving services from Maine's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) 697 WIC clients (women)	Study Question: Evaluation of an interactive, multimedia nutrition education computer application. Statistical Analysis: Theme analysis for interviews and focus groups. A chi-square test for dependent samples was calculated for each question on each survey.	Evaluation of an interactive, multimedia nutrition education computer application Components:	Responses to 44 of 66 (67%) survey questions improved from pre- to post-survey. Positive changes included: 1) Changing women's intentions to nurse their new infants 2) Using of lists at the grocery store, avoiding going to the store hungry 3) Not permitting children to eat in front of the television 4) Asking people who give children "junk" food to stop 5) Reducing fat in cooked foods 6) Avoiding using food as a reward 7) Not putting an overweight child on diet 8) Understanding the impropriety of selling, giving away, or returning WIC foods to the store or accepting and using rainchecks 9) The proper use of WIC foods Increasing the desire to quit smoking and learning that the craving for a cigarette will pass, and recognizing the risks of	May be applicable in the UK setting and target population with adaptation and modification of the intervention	No random selection of participants Focus groups methods-limited generalisability Issues of reliability or validity Some lack of changes may be attributable to high levels of baseline knowledge

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				household smoke to children. Negative comments from 7% of the clients who were dissatisfied by the "nonhuman" nature of the intervention Many nutritionists and aides reported that using this technology has a positive impact; some lack of staff acceptance appeared to limit its use		

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(Childs et al. 1997) Birmingham, UK Evidence level: 1-	1000 children from aged 6 weeks recruited (455 completed study) Ethnicity White: 11% Asian:78% Afro-Caribbean: 7% Others: 4% Mother's education None or primary school: 35% Father's occupation Social class I /II: 11% IV/V: 61% 1000 children from aged 6 weeks recruited (455 completed study)	Study Question: What is the effectiveness of a dietary education programme in improving iron deficiency anaemia in children in the inner city? Statistical Analysis: Comparative analysis between the intervention and control group	Specific health education information from health visitor to parents (n=198) Vs. Standard nutritional health education from health visitor to parents (n=257) Specific health education information involved: Promotion correct use of breast-milk or fortified infant feeds during the 1st baby's 1st year, to encourage good weaning diets containing appropriate intake of iron rich foods and vit C Strategy: Face-to-face Use of audiotapes Relevant language Discussion encouraged Culturally appropriate leaflets 20 families visited during study period to ensure education materials have been received and understood	Feeding practice Breastfeeding at 3 month: Intervention:15% Control: 23% Breastfeeding at 6 month: Intervention:6% Control:12% Breastfeeding at 9 month: Intervention:3% Control: 2% Introduction of pasteurised cow's milk: At 3 months Intervention:4% Control: 8% At 6 months: Intervention:57% Control: 39% Dietary data (24 hour recall) food score >4 Intervention:38% Control: 34% (NS) Dietary data (7 day recall) food score >4 Intervention:81% Control: 81% (NS) Growth data No sig dif in mean weight, height, or	Applicable to similar population in the UK setting	Drop-out rate: 455/1000 completed study (55.5% drop-out) Reliability of 'recall' data

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
				middle arm circumference between the 2 groups Biochemical data: anaemia (Hgb <110g/l): At 18 months Intervention group: 28% Control group: 27% (NS)		

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(Condon et al. 2003) Bristol, UK Focus groups Evidence level: 3	Postpartum women who had breastfed a baby within the previous year Ethnic origin: Somali Pakistani Bangladeshi Punjabi Afro-Caribbean Mixed race 26 women	Study Question: What are the cultural influences on breastfeeding and weaning? Statistical Analysis: Thematic analysis: Mono-culture focus groups Telephone survey	Explore attitudes towards breastfeeding and weaning	Positive attitude towards breastfeeding Women from ethnic minority groups more likely than white group to breastfeed to 8 months Bangladeshi women were adopting poor British weaning habits: introducing foods such as egg custard and tinned baby food at 4 months in accordance with what they perceived as 'British' custom	Maybe applicable to the UK setting but very limited generalisability	Study based on subjective outcome data Issues of reliability and generalisability

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(Daly et al. 1996) Birmingham, UK Evidence level: 1+	100 infants aged 6 month, from a deprived inner city area Infants already on pasteurised cows' milk, recruited at mean age of 7.8 months 47 boys and 53 girls (74% white, 24% Afro-Caribbean, 2% Asian) Preterm infants excluded Similar iron status at enrolment Anaemia (hgb below 110g/l): 16% in cows' milk group, 13% in follow-on formula group 100 infants Pasteurised cows' milk (n=43) Follow-on formula (n=41)	Study Question: What are the haematological and dietary effects of a follow-on formula with pasteurised cows' milk in a group of inner city toddlers who were already receiving pasteurised cows' milk by 6 months of age? Statistical Analysis: Comparative analysis between the control and intervention groups	Follow-on formula (1.2 mg iron/l)(n=41) vs Pasteurised cows' milk (0.05 mg iron/l) (n=43) At 18 months, the follow-on formula group returned to cows' milk and both groups were followed up till 24 months Mothers asked to weigh and record in food diary food intake for 3 days at enrolment, and at 12, 18 and 24 months of age. Mothers were provided with electronic balance scales and visited to check accuracy of use of diary and measures.	Anaemia (hgb below 110g/l): At 12 months Follow-on formula: 3% Pasteurised cows' milk: 31% (p<0.007) (At 18 months of age, the follow-on formula group returned to cows' milk and both groups were followed up till 24 months) At 18 months Follow-on formula: 2% Pasteurised cows' milk: 33% (p<0.0001) At 24 months Follow-on formula: 0% Pasteurised cows' milk: 26% (p<0.002) Dietary iron intake (mg/day) from milk and solids was low in both groups at recruitment, and decreased significantly in the cows' milk group than the follow-on formula group at 12 months (76 ± 33 vs 158 ± 54, p<0.001) and at 18 months (82 ± 33 vs 133 ± 41, p<0.001) but not at 24 months. No diff in growth between the 2 groups in weight and height throughout the study	Likely to be applicable in the UK setting	Method of randomisation not clear Likely confounders: Content of solids fed Accuracy of food measurement and diary Volume of milk consumed

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Daly et al. 1998) Birmingham, UK Questionnaire survey Evidence level: 3	Parents (mean age 25 years) of infants who already elected to introduce cow's milk before the recommended age of 12 month Parents lived in deprived inner city area 79% left school at 16 74% Caucasian 24% Afro-Caribbean 2% Asian 100 parents of infants (mean age 8 months)	Study Question: What are the parental views on infant feeding and practices? Statistical Analysis:	Questionnaire survey top elicit views on infants feeding practices	Weaning practices handed down from family and friends, especially form grandmothers Mistakes in feed preparation were common Low motivation to seek professional advice Advice from friends and family readily available and adopted	May be applicable to the UK setting. Limited generalisability	Non-comparative study based on subjective outcome data Issues of reliability and generalisability

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Domellof et al. 2001) (Dewey et al. 2002) Sweden Evidence level: 1+	Healthy infants from aged 4 months, exclusively breastfed and whose mothers intended to breastfeed till at least 9 months No sig diff in maternal characteristics, infant anthropometric or iron status between intervention and placebo group at baseline Prevalence of iron deficiency anaemia: <3% in this population A study reporting 2 RCTs (1 conducted in Honduras and 1 in Sweden, only data from the latter presented) 121 breastfed infants (96 completed study) Additional results reported in	Study Question: What are the effects of iron supplements on growth or morbidity of breastfed infants? Statistical Analysis: Comparative analysis between the intervention and the placebo group	Iron supp (1 mg /kg/d)from 4-9 months (Fe 4-9)(Group 1)(n=30) vs Placebo 4-6 months and iron from 6-9 months (Fe 6-9)(Group 2)(n=30) vs Placebo 6-9 months (Placebo)(Group 3)(n=36) Iron supp: Liquid ferrous sulfate 1mg elemental iron, adjusted monthly according to infant's weight Given by mothers daily before or after breastfeeding Complementary feeding: Between 4 to 6 months, mothers asked to continue exclusive breastfeeding but were permitted to give 'taste portions' of food with little/no iron; adherence confirmed at monthly visit Between 6 to 9 months, mothers continue breastfeeding and gave complementary food at their own discretion with no influence from investigators on choice of food or extent of breastfeeding	Hgb (g/L)(reported in (Domellof et al. 2001)) Group 1 vs Group 3 (+4.5, p=0.002) Group 2 vs Group 3 (NS Infant weight gain No sig diff between the 3 groups Length gain Combined groups 1 and 2 sig lower than group 3 (0.04) Morbidity data (reported in (Domellof et al. 2001)): Diarrhoea (%) Group 1: 30 Group 2: 27 Group 3: 14 (p=0.046)	May be applicable to UK setting and populations	Methods of randomisation and allocation concealment unclear Infants completed study: 121at enrolment, 101 at 6 months, 96 at 9 months Accuracy of records Compliance of iron drops

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	another papers (Domellof et al. 2001)			Compliance with iron or placebo drops: At 4-6 months: 95% At 6-9 months:96%		

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Dundas et al. 2004) US Before and after study Evidence level: 2-	Children (71 were white and 18 were Latino) were -family had not participated in a WIC program for the previous 2 years -child was at least 24 months old at the initial certification -child had a second certification within 7 months of the initial one -dietary histories were declared a typical intake by the parent or guardian -child received the regular WIC child food package 91 children from WIC program	Study Question: What is the impact of the WIC program on the eating behaviours of preschool children in participating WIC clinics? Statistical Analysis: Comparative analysis before-and-after the intervention	WIC program preschoolers (n=91) Data collection by 24-hour dietary recall	The mean HEI score increased 3.3 points (from 73.3 at baseline to 76.6)	Maybe applicable in the UK setting and target population with modification of the intervention	Limited generalisability Dietary data obtained from skilled WIC personnel not verified by other dietary intake measures. Not possible to follow up children to determine if positive changes in food consumption continued over time.

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Fisher et al. 1999) US Before-and-after study Evidence level: 2-	Children aged 3-5 years old attending daycare programs at an university Childe Development Laboratory 31 children aged 3-5 years old	Study Question: What are the effects of restricting children's physical access to a palatable food? Statistical Analysis: Before-and-after analysis	4 sessions of unrestricted snack (target food) and wheat crackers (control food) ad lib	Children's behaviours: Within the restricted setting Restricted food elicited more positive comments about it, more request for it, and more attempts to obtain it than before Outside the restricted setting: No sig diff between pre- and post-restriction in % of children selecting the target snack food	Children in laboratory setting, may not be applicable to the UK setting	Children in Laboratory setting Level 2- evidence Confounders

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Gerrish et al. 2001) US Evidence level: 1-	Non-smoking mothers whose babies (mean age under 5 months) were formula-fed, who began feeding cereals to their infants during the past month and planned on introducing solid foods during the next few weeks Ethnic mix: African American (49%) White (40%) Hispanic (2%) Others (13%) Infants: 8 girls and 8 boys in each group 48 mothers and infants	Study Question: What are the effects of flavour variety in enhancing food acceptance in formula-fed infants? Statistical Analysis: comparative analysis before and after intervention between the experimental and control groups	Carrot only group (n=16) vs Potato only group (n=16) vs Variety group (Pea, potato, Squash)(n=16) Duration of intervention: 12 days, infants were given chicken on day 12 All foods were commercially available infant foods Mothers given mask to wear and cover the nose and mouth area while feeding to eliminate any potential influence of their facial or verbal responses on the infants' behaviours and to minimise effects of maternal responses to the food odours. Mothers to keep daily record of infants' food intake	Total food intake Carrot and variety groups ate significantly more carrots after the 9-day exposure than before No significant increase in carrot in potato group Duration of feeding time No significant differences between the 3 groups Rate of feeding Carrot and variety groups ate carrots at a faster rate after the exposure than before Mothers' perception of infants' enjoyment of food Mothers of variety group reported that their infants enjoyed carrots more after the exposure Infants' acceptance of a novel food (chicken) at end of exposure period Variety group ate significantly more chicken than did the carrot group No sig group	May be applicable to the UK settings and population	

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
				differences in the duration and rate of feeding, or mothers' rating of their infants' enjoyment of this food		

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Gill et al. 1997) UK RCT Evidence level: 1-	Healthy term infants aged 6 months, receiving formula or cow's milk at entry Recruited at 21 centres in the UK and Republic of Ireland Exclusion: Totally or partially breastfed Receiving iron supplements Suffering from chronic diseases Diagnosed with iron-deficiency anaemia 406 infants	Study Question: What are the effects of an iron-fortified follow-on formula on the iron and haemoglobin status of infants aged 6 to 15 months? Statistical Analysis: Comparative analysis between the intervention and control group	Infants randomised and allocated on a ratio of 3:1 to receive either of the two follow-on milks Iron-fortified follow-on formula (12.3 mg iron/l)(Group A)(n=264) vs Non-fortified follow-on formula (1.4 mg iron/l)(Group B)(n=85) vs Unmodified cow's milk (Group C)(n=57)(A convenience sample as control)	Weight (kg) No sig diff at baseline or during the study At 15 months Group A: 11.1 (95% CI 10.0 to 11.3) Group B; 11.1 (95% CI 10.7 to 11.5) group C: 11.3 (95% CI 10.9 to 11.7)(NS) Length (cm) No sig diff at baseline or during the study Hgb levels (g/l) At 15 months Group A: 121.5 (95% CI 120.2 to 122.8) Group B; 117.7 (95% CI 115.2 to 120.2) group C: 111.4 (95% CI 107.0 to 115.8)(p=0.006) % of anaemia (hgb <110g/l) At 15 months Group A: 11% Group B; 13% group C: 33%	Likely to be applicable to the UK setting and target population	Control group C is a convenience sample

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(Griffiths et al. 1995) UK Controlled trial Evidence level: 2+	All children aged between 6 and 12 months registered with two adjacent general practitioners (n = 34) and a control group (n = ?) from the other side of town (Bolton). Geographical setting – two inner city areas of Bolton characterized by high social deprivation. Infants from mainly Asian families of low socioeconomic status. Groups were similar in terms of social class, ethnicity and age range	Study Question: study focus on diet and anaemia prevention. Dietary advice focuses on improving intakes of iron rich foods and vitamin C. Statistical Analysis: Comparative analysis between the intervention and control group	Baseline assessment: haemoglobin (Hgb) and serum ferritin measurements taken and a 24-hour food frequency list for previous 24 hours. Intervention: Parents of children were shown a health promotion display illustrating iron rich foods and given one-to-one advice on suitable foods and recipes by the community health and food adviser. Bolton health authority weaning leaflets were provided in appropriate language with advice and recipes. These were explained by a health visitor with a translator if required. Children were visited bi-monthly so the dietary health messages could be reinforced. Health visitors used a standardized approach to ensure all issues were covered. Control group: received standard care Duration: visits covered a 12-month period Length of follow up: 12 months	A 24-hour food frequency list was completed at each bi-monthly visit and assessed according to a scoring system. At 12 months a blood sample was taken for an estimate of Hgb and serum ferritin levels and a further food frequency list was completed. Mean Hgb Before Intervention 11.2 Control 11.0 After Intervention 11.6 Control 10.9 % anaemic Before Intervention 28 Control 37 After Intervention 24 Control 50 New anaemics Intervention 5 Control 4	Likely to be applicable to the UK setting and target population	Small and limited study so reasons for differences in the results cannot be attributed to any one factor. Intensive study

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				Corrected anaemias Intervention 7 Control 3 Diet scores Before Intervention 5.9 Control 5.4 After Intervention 5.22 Control 4.9 Attrition rate: 9 children lost to follow-up in interventions group (26.5%) and 5 from the control. No comparison of characteristics given.		

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(Hammond et al. 1998) Canada Evidence level: 1-	Kindergarten children (mean age 5 years), >70% of Canadian/British/ English origin 123 kindergarten children and their parents 13 kindergarten teachers	Study Question: What are the effects of an early childhood nutrition education program on children's knowledge and behavioural intention to eat a variety of foods? Statistical Analysis: Before-and-after analysis	Program K (n=67) vs Control (n=56) Objectives of K programme: Identification of and experiences of food, complementing the developmental stage of most kindergarten-aged children Components of program K: 1. Food introduction - explored with their hands 2. Cooking- hands-on multi-sensory exploration of the food introduced 3. Journals - describe their experience 4. Stickers and 'I Tried it!' Class Club activities- to encourage dialogue between themselves and their parents At least 8 foods to be introduced Pre-test interviews with children to determine familiarity and willingness to eat them Parental questionnaires to determine their perception of and to rate the child's willingness to eat them Teachers K program (n=7) Control (n=6)	Children's familiarity with introduced and non introduced foods K program: familiar with sig greater no. of introduced foods only from pre-test to post-test ($p<0.0001$) Control: familiar with sig greater no. of introduced and non-introduced foods ($p<0.01$, $p<0.05$) from pre-test to post-test Children's stated willingness to eat the introduced and non introduced foods: No sig changes between pre- and post-test in either children's or parents' assessments of willingness to eat either category of foods (introduced or non-introduced) in either the K program group or the control group Parents' perceptions: Sig more parents in the K program group reported that their children had mentioned exposure of a food at school when requesting food at	Maybe applicable to the UK setting and populations with modification of the intervention	RCT and pre- and post test design and analysis Foods introduced mostly ''Western' Stated willingness to eat not equate food consumption

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
				home. No sig group differences in the proportion of parents who reported noticing changes on their child's food habits over the school year Teacher's views (reported in (Hammond et al. 1994): K program viewed positively by teachers The 'Cooking' component was rated as the most important and enjoyable		

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(Hastings et al. 2003) Studies mainly from the US Evidence level: 1+	Children under the age of 19 years 31 studies (22 RCTs and 9 cross-sectional studies)	Study Question: What are the effects of food promotion on children's food knowledge and behaviours? Statistical Analysis: Narrative summary	Food promotion (television, public announce systems etc)	Based on 11 RCTs which included children aged up to 11 years old: Children (aged 2-6 years) who viewed the commercials were more likely to select the advertised food. There were no significant differences between boys and girls in the rate at which they selected advertised vs non-advertised food items and no significant difference in the proportion of responses for advertised items in relation to amount of media technology in the home. [EL=1+] Children (aged 3-9 years) who were exposed to serious 'Public Service Announcements' (PSA) plus a toy advert were significantly more likely to make fewer sweet dessert choices than children exposed to PSA plus the sweet dessert advert and children exposed to humorous PSA plus the toy dessert advert.	Maybe applicable to the UK setting and target populations	Studies all based in the US where TV advertising regulations may vary from that of the UK Target groups of studies included children older than 5 years

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				Serious PSA appeared to have more impact on children's fruit choices than the humorous version when it was not followed by a sweet dessert.[EL=1+] The preference for a fruit drink was not significantly influenced by programme type, advertising exposure, or whether or not food was offered during the viewing situation, among children (mean age 53 months). [EL=1+] Children (aged 3.5 to 6.75 years) who were exposed to the adverts for no added sugar foods plus dietary PSAs viewed with adult comments were significantly more likely to request fewer sugared snacks than children exposed to adverts for added sugar foods viewed without adult comments; adverts for added sugar foods viewed with adult comments; and adverts for no added sugar foods plus		

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				dietary PSAs, viewed without adult comments. Children in the control condition (no adverts) requested significantly more sugared snacks than children in three of the above experimental conditions.[EL=1+] Among children (aged 3-11 years), there is a significant positive relationship between overall television reinforcement value and number of Purchase Influence Attempts (PIAs) made. The number of PIAs made correlated positively and significantly with total number of hours of commercial television watched per week. [EL=1–] Children (aged 5-6 years) exposed to sugared food adverts selected significantly greater number of sugared foods than children exposed to wholesome PSA, and the control group who are exposed no adverts. Children exposed to the 9		

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				minutes of adverts selected more non-advertised sugared foods than children exposed to the 4.5 minutes of advert and than children in the control group.[EL=1+] Children (aged 5-6 years) exposed to a pro-nutritional television programme selected significantly fewer sugar snacks than children who were exposed to no pro-nutritional television programme. [EL=1+] Children (aged 5-8 years) exposed to sweets advert selected significantly less fruits than children exposed to fruit advert or dietary PSAs or no advert.[EL=1+] Among children (aged 4-8 years), the impact of free gifts on food choice behaviours was minimal, although there was an effect on child's preference.[EI=1+] There was no significant difference in food consumption		

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				behaviour or attitudes in children (aged 4-5 years) exposed to low-nutrition adverts, pro-nutrition adverts or no adverts. Pre- post changes within each group were suggestive of a possible influence from low-nutrition adverts on children's food consumption.[EI=1+] Children (aged 3-5 years) exposed to food adverts engaged in significantly more Purchase Influence Attempts (PIAs) than children not exposed to food adverts. Mothers of children exposed to the adverts used power assertion responses significantly more frequently than mothers of children not exposed to food adverts. There was no significant difference between the two groups in number of hours of television reportedly viewed per week, [EL=1+]		

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(Heinig et al. 2006) US Evidence level: 1+	Healthy breastfed infants recruited during the first 3 months after delivery Mothers planned to breastfeed for > 10 months, not to introduce solids before 4 months Mothers mostly white and relatively affluent Similar demographic characteristics between the two groups 85 infants	Study Question: What are the effects of zinc supplementation in breastfed infants? Statistical Analysis: Comparative analysis between the intervention and the placebo group	Zinc supplementation (5 mg/day)(n=41) vs Placebo (n=44) Mothers instructed to give zinc by dropper each morning 1 hour before feeding complementary foods Data available for final analysis: Zinc (n=33) Placebo (n=37)	At aged 4-10 months Anthropometry Mean wt gain (g) zinc: 348 ± 75 placebo: 359 ± 89 (NS) Mean ht gain (cm): zinc: 1.48 ± 0.15 placebo: 1.48 ± 0.19 (NS) Serum zinc levels Sig higher in zinc group than placebo group Infants' dietary intake: No sig diff between the 2 groups Common foods offered: fruit, cereals and vegetables Morbidity No sig diff between the 2 groups in prevalence of diarrhoea, otitis media, respiratory illness, fever Motor development No sig diff between the 2 groups in AIMS (Alberta Infant Motor Scale): all above 25th percentile and no infants were classified as at risk	Likely to be applicable to the UK setting and target populations	Double blind RCT: investigator and mothers Allocation by Moses-Oakford algorithm (random permutations) Intention-to-treat claim (85 infants randomised, data of 70 infants available for analysis)

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(Hindin et al. 2004) New York, USA Before-and-after study Evidence level: 2-	Parents of children aged 3 - 6 years (Latino, African, Central American, South American, West Indian, Spanish Caribbean, Indian, Haitian) 35 parents from the Head Start programs	Study Question: What are the effects of a media literacy nutrition education curriculum on TV advertising in influencing parents' behaviours? Statistical Analysis: Pre- and post-intervention analysis	Media literacy nutrition education curriculum (n=35) vs Food safety curriculum (control)(n=35) (Parents acted as own controls) Aims of the Media literacy nutrition education curriculum: 1) comprehend the effects of TV on young children 2) appreciate the benefits of talking about and analysing TV food adverts with their young children 3) develop skills to evaluate TV food adverts by reading food labels 4) demonstrate ability to analyse and talk about food commercials with their children Components of 4-week curriculum: 1) Session one: learning about TV food commercials 2) Session two: Analysing food products advertised on TV 3) Session three: Truth in advertising 4) Session four: Talking to your child about TV food commercials Delivered by instructors (?? dietitian)	Sig increase after intervention in understanding of TV advertising attitudes about TV adverts outcomes expectations values self-efficacy TV mediation behaviours understanding of and ability to read food labels	Maybe be applicable to the UK setting and target populations when curriculum is adapted or modified	Parents act as own control Duration of intervention not clear Prior knowledge (contamination)

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(Horodynski et al. 2004) US Controlled before-and-after study Evidence level: 2-	Carers of children aged 1- 3 years, from low-income, rural areas Attendance in Early head Start Program Similar demographics between the intervention and the control groups Exclusion: Cares' whose children younger than 12 months old Eating problems non-English speaking 38 carers of children aged 1- 3 years	Study Question: What are the effects of NEAT intervention? Statistical Analysis: before-and-after comparison and analysis A pilot study	Carers receiving NEAT intervention (n=19) vs No intervention (control) (n=19) NEAT aims to improve carer-toddler mealtime interaction by empowering carers to become responsive to the child's verbal and nonverbal behaviours, enabling the child to clearly communicate hunger, fullness and eating preferences, thus developing the child's ability to self-regulate his food intake, crucial to the development of healthy life-long eating habits. The NEAT lessons were designed to increase caregiver's awareness and knowledge of healthy eating and feeding practices in relation to their toddlers' development. The 90-minute NEAT lessons delivered by trained paraprofessional nutrition instructors. Classes taught to group of 4-5 participants, using discussion, video, hands-on learning activities, later joined by toddlers in food tasting, simple food preparation and family eating time. Data collection instruments: questionnaires on knowledge,	Carers' knowledge No sig diff between the 2 groups 3/4 of both groups had correct knowledge about feeding toddlers Attitude No sig diff between the 2 groups Positive attitudes in both groups Mother's dietary intake No sig diff: poor intake in both groups Children's dietary intake No sig diff: less than optimal in both groups Participants enjoyed food preparation, liked the information on food safety and learn about foods and how much to give toddlers, enjoyed meeting new people and having focused time with their kids Found most useful: appropriate serving sizes and tasting different foods Improve NEAT: offer more classes to allow time for cooking, information and	Unlikely to be applicable in the UK setting and populations unless program is adapted	A pilot study Small sample

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			attitude and dietary intake (24 hour dietary recall)	sharing		

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(Horodynski et al. 2005) US controlled before-and-after study Evidence level: 2+	Parents of toddlers aged 11-25 months Low income Mean age: 26 years Mothers: 92% Fathers: 5% Female carers: 3% Caucasians: 84% Similar socio-demographic characteristics 96 parents	Study Question: What are the effects of NEAT on parents' knowledge and parent/child mealtime behaviours? Statistical Analysis: Pre- and post-intervention comparisons	NEAT intervention (n=43) vs No NEAT (Control) (n=53) NEAT (Nutrition Education Aimed at Toddlers program: Aims to improve carer-toddler mealtime interaction by empowering carers to become responsive to the child's verbal and nonverbal behaviours, enabling the child to clearly communicate hunger, fullness and eating preferences, thus developing the child's ability to self-regulate his food intake, crucial to the development of healthy life-long eating habits Components: 1) 4 weekly group-based (4-5 participants) nutrition lessons (90 mins long) - discussion, videotapes, hands-on activities 2) 18 individually structured activities Children later joined parents in activities: food tasting, food preparation and family eating time Reinforcement provided by home visitors over 6 months. This included areas such as childe development, feeding, nutrition, parenting and prolonged toddler feeding, self-regulation and positive	Parents' knowledge Intervention group: Significant increase from baseline and when compared with control Toddler-parent mealtime behaviour (proportion of families with TV on during mealtimes): No sig diff between the 2 groups Frequency, timing and number of reinforcement activities may need to be improved Respondents' self-report maybe unreliable: social acceptable answers	May be applicable if intervention program modified for the target population in the UK	Non RCT

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			toddler-parent feeding interaction			

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(Ilett et al. 2004) Keighley, West Yorkshire, UK Before-and-after study Evidence level: 2+	Mothers of Pakistani Muslim origin, with babies found to have haemoglobin of 8.0 -10.9 g/dl at 13 months check-up Exclusion: Very disorganised households Child previously treated for anemia Children with thalassemia Mothers previously received enhanced input on infant feeding 33 mothers of children aged 13 months and over	Study Question: What are the effects of an individual intensive dietary education programme, delivered in the home by a native-speaking health worker, on mothers' nutritional knowledge and changes to their children's diets? Statistical Analysis: Pre- and post-intervention comparative analysis	Dietary education programme in 6 one-hour visits over 12 weeks Delivered at mothers' homes by a project worker who was an experienced interpreter (linkworker), supervised on a day-to-day basis by the health visitor, not less than at monthly interval Dietary education programme message (Weaning File): Weaning at 4 and 7 months Introduction of a cup at 6 months Food hygiene and storage use of family foods Food preparation such as pureeing Avoiding salt and sugar healthy eating iron-rich foods Encourage iron consumption and Vit C-rich foods Reduce excessive intake of cow's milk Encourage completion of the course of iron Use of follow-on milk not recommended Where relevant Encourage use of cup for drinking Improve maternal diet Improve mealtime behaviour and dental hygiene Cookery demonstration where appropriate	Mothers' gain in knowledge No of mothers who gave relevant definition of anaemia Before: 14 After:24 (p=0.005) Knowledge of iron-rich foods 5 vs 12 A bottle constantly available 4 vs 0 Most children allowed to feed themselves using their fingers or a spoon No child was always fed by an adult Most children sat on a sofa to feed Difficult feeding behaviour declined after the intervention (NS) Reduced cow's milk consumption 18 oz vs 12 oz Food frequency scores A trend towards improvement (NS) Mothers' comments on the home-based nature of intervention Valued because it was	Likely to be applicable in the UK setting and target population	No control group Risks of confounders No biochemical data, eg haemoglobin Accuracy of 24-hour recall Unclear if outcomes long-lasting Small study.

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				'under her own roof', especially in women with young children and who couldn't manage to get out Influence of grandmothers		

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(Koelen et al. 2000) The Netherlands Uncontrolled before and after Evidence level: 2-	Parents of children aged 0 to 4 years, with a specific focus on parents of children aged 9 to 18 months. Parents of children aged 0 to 4 years in a population of 15 millions	Study Question: What are the effects of a national oral health campaign on encouraging parents to switch from milk bottles to feeding cup in their children? Statistical Analysis: Before-and-after comparative analysis	Materials developed to transmit the message included fact files, posters, tear-off pads and support materials that could reinforce each other and which intermediaries could use in their communication with parents. The message was 'Bottle it up – take a cup! From 9 months onwards'. These materials, available in Arabic and Turkish, were pre-tested among various target groups to ensure optimal clarity, comprehensibility and eye-catching quality. Delivered by health intermediaries at primary, secondary and tertiary levels to stimulate , motivate and enable them to address the topic in their communication with the parents The campaign was introduced to the intermediaries 9 months before the campaign and at when the campaign was launched. There was a press release for health journals, magazines and newspapers, a press conference at the official start and a commercial for television.	Intermediaries: Changes in attitude Changes in structure of oral health consultation Parents: Awareness of nursing caries post campaign 60% pre vs 78%% (P<0.05) Received this information 'through health education' post campaign (47% vs 14% (p<0.000) Switch to feeding cups: Use of bottles after the campaign 64% vs 88% (p<0.001) Switch from bottle to feeding cup before 12 months after the campaign 88% vs 72% (p<0.10)	Likely to be applicable to the UK setting with organisational adjustment	No control group, high possibility of bias No comparative data on prevalence of nursing caries before and after the campaign

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(Kramer et al. 2006) Philipines, US, Peru, Chile, Sweden, Honduran, Bangladesh, Finland, Belarus, Australia, Italy, East India,, Segalese Evidence level: 2++	20 studies: 9 from developing countries (including 2 controlled trials) 11 from developed countries (observational studies) 20 studies:	Study Question: What are the effects of exclusive breastfeeding for 6 months vs exclusive breastfeeding (BF) for 3-4 months with mixed breastfeeding thereafter through 6 months on child health and development? Statistical Analysis: Systematic review and metaanalysis when appropriate	Exclusive breastfeeding for 6 months and exclusive breastfeeding for 3-4 months with mixed breastfeeding thereafter through 6 months	Growth (weight and length gain): No deficits in exclusive BF for 6 months when compared with exclusive BF for 3-4 months with mixed BF thereafter through 6 months Iron status (Evidence from developing countries) Exclusive BF for 6 months without iron supplementation may compromise hgb status Episodes of gastroenteritis (based on 1 RCT in Belarus) Reduced risk in infants on exclusive BF for 6 months Risks of atopic eczema, asthma No sig reduction	Likely to be applicable to the UK setting	A well-conducted systematic review

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(Linday et al. 2004) New York, US Evidence level: 1-	Latino children aged 6 months to 5 years from inner-city Mean age of supp group:2.03 years Mean age of control group:2.08 years No sig diff between the 2 groups at enrolment: most children had been breastfed, immunised, lived with another child and cared for by mothers. Most families denied smoking 94 children aged 6 months to 5 years from 2 paediatric group practices	Study Question: What are the effects of cod liver oil and multivitamin-mineral supp on upper respiratory tract paediatric visits? Statistical Analysis: Comparative analysis between the intervention and control group?	Daily cod liver oil and multivitamin-mineral (vit A,D,E,K,B2,B6,B12, calcium, iron, phosphorus, iodine, magnesium, zinc, selenium, copper, manganese, chromium, molybdenum, potassium)(Starting dose was halved for children 6 months to 1 year) (n=47) Control (n=47) Parents informed verbally and in writing about instructions of giving supplements (mixed with small amount of food such as yogurt or rice cereal) and keeping them out of reach of children Compliance determined by contact from investigators and parental report in calendar diary	Upper respiratory tract visits (decrease in mean no of visits over time) Supp group: r=0.893; r2=0.797; y=0.602+0.002x (p=0.042) Control group: r=0.0006; r2=0.000; y=0.259+_1.43x10-6x (p=0.999) Supp well tolerated and acceptable, no adverse effects reported	May not be applicable to the UK setting taking into consideration the difference in health service delivery system	70% of children completed the course of supp

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(McGarvey et al. 2004) US Non randomized controlled 1-year prospective study Evidence level: 2-	WIC parents with 2- to 4-year-old children were consecutively recruited from the WIC clinics by staff during a 2-month period. 336 WIC parents	Study Question: Whether it is feasible to implement a parent-focused child obesity prevention program in a WIC clinic. Hypothesis: Clients (i.e., parents) at the clinic offering the Virginia Fit WIC intervention program would be significantly more likely than clients at the comparison clinic to report 1 or more of the 6 targeted behavioural changes. Statistical Analysis: Multivariate analysis of variance for continuous variables and $\chi 2$ analysis for discrete variables. Changes in outcome variables were tested with the general linear model analysis of variance for repeated measures. Statistical analyses were conducted with SPSS version	Fit WIC intervention (n=185) vs Standard WIC (Control) (n=151) Fit WIC intervention: a parent-focused child obesity prevention program in a WIC clinic The Fit WIC intervention components: 1) increase physical activity 2) monitor mealtime behaviour 3) limit household television viewing 4) drink water instead of sweetened beverages 5) consume 5 fruits or vegetables daily, and 6) increase family activities to promote fitness. The WIC is a food and nutrition assistance program for low-income pregnant, breastfeeding and post-partum women, infants and children up to age 5 years. It provides nutrition education, vouchers for supplemental food packages and referrals to other health care and community resources. A standard WIC intervention will include attendance of nutrition education classes once every 2 months and an individual	Significant increased frequency of engaging in active play with the child (P=.009) and frequency of offering the child water (P=.005)	May be applicable to the UK population setting with program modification	Non-RCT design Reliability of parental self-report measures.

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		10.0.	session with a nutritionist once every 6 months.			

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(Moffatt et al. 1994) Canada Evidence level: 1-	Bottle-fed infants aged from birth to 2 months Similar in socioeconomic background: low income families Exclusion: prematurity, low birth weight, major anomalies and those who had received evaporated milk feedings 225 bottle-fed infants	Study Question: What are the effects of iron-fortified infant formula in preventing developmental delay and abnormal behaviour in bottle-fed infants from low income families? Statistical Analysis: Comparative analysis between the intervention and control group	Iron-fortified formula (12.8 mg iron/l)(n=113) vs Regular formula (1.1 mg iron/l)(n=112)	Hgb levels (g/l) At 9 months (n=204) Iron-fortified milk:116.4±5.6 Regular milk:111.6±5.6 (p=0.02) At 15 months (n=154) Iron-fortified milk:118.6±5.7 Regular milk:115.1±5.7 (p=0.02) % of anaemia (Hgb <110g/l) At 9 months (n=204) Iron-fortified milk:8.1% Regular milk:28% (p=<0.001) At 15 months (n=154) Iron-fortified milk:2.6% Regular milk:10.4%(p=0.005) Bayley Scales PDI: a decline of 6.4 points in the regular milk group from 6 months to 12 months At 15 months (n=154): Iron-fortified milk: 100.6±10.7 Regular milk:97.8±11.9(p=0.02) MDI: No sig diff between the two groups throughout the study	Likely to be applicable to the UK setting in target population	Randomisation: pre-assigned from a table of random numbers. Status in sealed opaque envelopes Double-blind (researcher, research nurse and assessor of Bayley tests) Withdrawal rates: data available 204 infants at 9 months 186 at 12 months 154 at 15 months

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				Weight (kg) No sig diff between the two groups at any point in time during the intervention At 15 months (n=154): Iron-fortified milk:11.7 Regular milk: 11.0 (NS) 16 withdrawals due to reported iron intolerance to the formula		

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(Morley et al. 1999) UK (Leicester, Norwich, Nottingham) Evidence level: 1-	Parents of 11,021 infants were sent letters, 2043 replied, 493 infants already on cow's milk randomised. Healthy infants aged 9 months being fed pasteurised cow's milk Pre-randomisation demographic characteristics and developmental scores and anthropometry of children who completed study were similar and well balanced Non-English speaking 'parents' were excluded as the Bailey scales have not been validated for use with foreign language speakers in the UK 10 children recruited from Asian families and were randomised	Study Question: What are the effects of iron fortified follow on milk on iron status of infants from 9 to 18 months? Statistical Analysis: Comparative analysis between the intervention and control groups	Unmodified cow's milk (0.05mg iron/l)(n=166) vs Unfortified formula (0.9mg iron/l)(n=165) vs Iron fortified formula (1.2mg iron/l)(n=162) Powdered milk supplied ad libitum to infants' homes, and parents given written and verbal information on how to make up the milk. Solid foods and other drinks were given as parents chose At 12 and 15 months, research nurse visited the homes to check on compliance, measure infants' length, weight, skin fold thickness and head circumference. Parents to complete a two day food diary before each visit.	Serum haemoglobin (g/l) At 18 months (at one centre only) Unmodified cow's milk (n=35) 119 ± 14 ** Unfortified formula 120 ± 11* Iron fortified formula 126 ± 11 ** P<0.01, * p< 0.05 (significantly lower than group fed iron fortified formula) Bailey mental and psychomotor development index (MDI And PDI) At 18 months No sig differences between groups or between boys and girls No adverse effects reported after 9 months of iron supplementation	Likely to be applicable to UK settings	Randomisation schedule prepared by independent statistician using permuted blocks of random length. Each centre had a separate schedule and subjects were randomised by research nurse from consecutively numbered opaque sealed envelopes. Codes for the formula milk and fortified milk not revealed till end of study No. of infants remained at assessment at 18 months Unmodified cow's milk (n=160) Unfortified formula (n=135) Iron fortified formula (n=133) Consented to blood test at 18 months Unmodified cow's milk (n=96) Unfortified formula (n=76) Iron fortified formula (n=90)

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
	separately to ensure balance between groups Parents of 1,021 493 infants approached to participate in study, 493 infants already on cow's milk randomised					

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(Pollard et al. 2001) Australia Observational study Evidence level: 3	Long day care centres (children younger than 12 years of age) in Western Australia 330 long day care centres (LDDC)	Study Question: What is the impact of the Start Right-Eat Right Award Scheme on day care centres Statistical Analysis: Descriptive	Introduction of the Start Right-Eat Right Award Scheme The Start Right–Eat Right Award scheme aims to improve nutrition and food service standards in child care centres. The components in achieving the award included aspects of nutrition training, food service planning, safe food handling and menu planning by centre coordinators and cooks.	Take-up rate At 9 months 76 centres registered , 25 received award Feedback from LDDCs Over 90% reported that training course were relevant to LDDC coordinators and cooks 90% reported making changes to menus, increasing milk, meat and variety of foods served and improving knowledge in nutrition and food service At 2 years, 40% of LDDCs have registered in the scheme	May be applicable if programme adapted to the UK settings	Process evaluation

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(Rask-Nissila et al. 2000) (Talvia et al. 2004) (Rask-Nissila et al. 2002) (Talvia et al. 2006) Refer to Lagstrom 1997 (York rapid review) Evidence level: 1–	Children aged from 6 months old	Study Question: What are the effects of Special Turku Coronary Risk Factor Intervention Project (STRIP) on fat and nutrient intake in children aged from 6 months onwards (nutritional counselling)?	STRIP nutritional counselling (n=540) v Control (n=522) Refer to Lagstrom 1997 (York rapid review) for details of intervention	Intake of saturated fatty acids was markedly reduced, age-related increase in serum cholesterol concentrations was diminished with normal neurological development, similar to that of the control group At 10 years STRIP (n=289) Control (n=268) The reduced intake of saturated fatty acids continued with out disadvantageous dietary effects, but the 2:1 goal for unsaturated –saturated fat ratio was not reached At 11 years follow-up male children in the nutritional counselling group consumed more vegetables than did the control ($p<0.001$). Mother's consumption correlated with the consumption with their daughters and sons, whereas father's consumption correlated only with the consumption of their sons	Maybe applicable to the UK setting and target populations with program modification	About 50% drop out at 10 years

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Raynor et al. 1999) Middlesex, UK Evidence level: 1+	Children aged 3-40 months with a high proportion of families unemployed and in local housing, receiving income support Ethnic mix: Predominantly white, 3 Of Asian descent Similar demographics between the 2 groups at baseline 83 children aged 3-40 months	Study Question: What are the effects of a specialist health visitor intervention for failure to thrive? Statistical Analysis: Comparative analysis between the intervention and the control group	Specialist health visitor (HV) intervention (n=42) Vs conventional care (control)(n=41) Intervention: Intensive home visiting from HV for a year HV trained in managing eating problems, assessment of parent-child interactions, counselling skills and nutrition, who could seek advice from a psychologist, dietician and paediatrician for any concerns relating to the families.	No sig diff between the 2 groups in growth, Cognitive and motor development, Behavioural problems and Maternal mental health Both groups had good weight gain and improvement in developmental score and energy intake Referral and use of services: Control groups had sig more referrals to dietitian, social service sad hospital admissions and were less compliant with hospital appointments	Likely to be applicable to the UK settings and target population	Assessor blind RCT Small sample size

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(Sangster et al. 1999) Australia Controlled before-and-after study Evidence level: 2+	Long day care centres licensed to care for 30-49 children daily 59 daycare centres	Study Question: What are the effects of the GFFC intervention? Statistical Analysis: Before-and after comparison and analysis	Good Food for Children (GFFC) intervention (n=40) vs Control (n=19) GFFC: a multi-strategic intervention aimed at improving the nutritional adequacy of food provided in child care centres Major strategies of GFFC: 1) Assessment of centre's menus with individual feedback to centres 2) Advice on development of policies 3) Workshops for child care staff to improve nutrition knowledge and skills Improvement of training and support for child care cooks 4) Provision of nutritional information for parents 5) Inter-sectoral collaboration with government departments responsible for child care to improve legislation and guidelines relating to food in child care	Mean menu score GFFC: Sig increase from pre- to post-test ($p<0.05$) Control: non-sig decrease from pre- to post-test Menu check list: GFFC Sig increase in meeting criteria ($p<0.05$) Control: no sig increase from pre- to post-test Mean number of times that red meat appeared per fortnight per fortnight: GFFC group Non-sig increase Control Non-sig decrease	May be applicable to the UK setting and populations with adaptation of intervention	

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(Siega-Riz et al. 2004) US Secondary data analysis of a nationally representative cross-sectional survey conducted by USDA in 1994 to 1996 and 1998. Evidence level: 2-	For this study, only child information on participation was used. Since one of the eligibility requirements for participation was having an income <185% of poverty, only children with a family income less than <185% (n = 2461) were included. This subpopulation was further stratified by income to reflect the different cut points used for participation in the food stamp and WIC programs (<130%, n = 1772, and 130% to 185% of poverty, n = 689). 2641 WIC children	Study Question: What are the effects of WIC on nutrient, food intake, and snacking behaviour of preschoolers? Statistical Analysis: Statistical analysis was performed correcting for sample design effects and weighting for children in two income groups (<130%, n = 1772 and 130% to 185% of poverty, n = 689).	WIC program Vs non WIC program	Among WIC participants, the prevalence of snacking was significantly lower (68%) compared with non-participants (72%) (P = 0.01)	Maybe applicable to UK population with modification of the intervention	A limitation of using the USDA data set to examine the effect of WIC participation is the lack of data on eligibility for the program aside from income. So they may be comparing individuals with some who may not be at medical risk but are income eligible and this would result in a bias towards the null. There is no information on how long the child participated in the program in order to examine if those with the longest duration of participation benefited the most. Only two 24-hour recalls were collected by proxy.

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(Smith et al. 1986) Los Angeles, USA Retrospective cohort study Evidence level 2+	50 anaemic children aged between 6 months and 4 years and their parents or guardians. 200 names were randomly selected to identify anaemic children (defined as haemoglobin (Hgb) ≤ 11g/ dl). 50 non-WIC participants were chosen and divided into the experimental (n = 25) and control group (n = 25). The children were matched for age, sex and ethnicity. Process of allocation not specified – assumed to be non-random. Attrition rate not stated.	To assess the effectiveness of counselling, education and food vouchers in improving the iron intake and status of anaemic children, aged 6 months to 4 years.	A pre-test, post-test design was used to assess the effectiveness of the programme. Baseline assessment: Hgb levels were taken from all participants at the initial stage of enrolment. The children's dietary intakes in the experimental group were estimated using a 24-hour dietary recall taken from their parents or guardians. A food consumption frequency was determined from this, as well as estimates of various nutrient intakes. Results of the dietary assessment formed the basis of individual counselling which the parents of participants in the experimental group received. The control group's dietary intake was not assessment nor did they participate in the intervention. Intervention: The parents of the experimental group received: • Individual counselling. This included meal planning, food shopping, storage and preparation. • Group Nutrition education. This consisted of 30-minute long audio-visual presentation which discussed the importance of breastfeeding, infant	Baseline: The 24-hour dietary recall of the experimental group showed that 44% of the children did not meet the RDA for vitamin A, 22% for vitamin C, 40% for calcium, 44% for iron, 32% for protein and 12% for folacin. Post intervention: showed improvement in Hbg levels and nutrient intakes. Mean and sd of Hgb (g/ dl) Baseline Exp 10.1±0.76 Control 10.0±0.7 6 months later Exp 11.8±0.88 Control 11.1±1.0 One-way ANOVA showed that the diff between the mean of the control and the experimental group was (t = 2.5) p = 0.05. The % of children with intakes below the RDA fell to 8% for vitamin A, 4% for iron and 4% for folacin. Intakes for vitamin C, calcium and protein were adequate.	Likely to be applicable to UK settings and population except for WIC voucher element of intervention. WIC is a US scheme. Need to assess value of WIC voucher compared to value of Healthy Start vouchers.	Retrospective study design limits interpretation as does low sample size. Lack of information regarding selection criteria.

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			nutrition, childhood nutrition, consumption of adequate amount of vitamins A and C, iron, protein, calcium and folic acid. Parent-child interaction and attitudes to feeding were also discussed. • WIC food vouchers with which to purchase food rich in the emphasised nutrients. Diet and Hbg levels were reassessed after six months but actual duration of the intervention has not been clearly specified.	Pre and post-test scores (test not specified) from the parents who participated in the educational classes showed an increase in scores on breastfeeding, infant nutrition, childhood nutrition, vitamins A and C, iron , protein and calcium.		

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(Smith et al. 2004) Luton, UK Observational study Evidence level: 3	30 families of Pakistani origin with infants aged up to 3 months 30 families with infants aged up to 3 months	Study Question: What are the effects of extending the role of link workers to deliver a weaning intervention to UK British Pakistani families? Statistical Analysis: Post-intervention observation	Intensive training and support Two link workers were trained by health visitors to be competent to visit clients in their own homes to offer appropriate weaning advice, using discussions, case-studies and role play to cover issues of safe working in the community, confidentiality, accountability, role boundaries, record keeping and communication skills relating to the delivery of the weaning intervention. Monthly meeting and discussion of issues relating to weaning, also debates and individual mentorship, particularly in debriefing following home visits Reflective learning on home visits encouraged in either English or Urdu Aide memoir at every visit Key weaning message: 1. Food texture - thicker and soft lumps 2. 2-3 meals a day. Breast or formula milk may be reduced 3. Using a cup, including formula milk 4. Use of high chair 5. Ready for finger food? 6. Social aspects of feeding	Infant feeding practice At 8-12 months (n= 26 families) Varied diet: 92% Drinking juice/water from cup: 100% Finger feeding: 100% Mothers' views on the offering of weaning advice and support from link workers Overall positive: 1. '..wouldn't have the time to go to GPs ' 2. More secure with regular visits 3.More confident with 4. two mothers preferred to receive advice from a professionally qualified person, either a health visitor or a doctor Health visitors' views: 1. Reservations about the use of 'unqualified' workers 2. May lead to 'losing touch with clients' Link workers' views 1. Independent working 2. Job satisfaction	Likely to be applicable in the UK setting and target population	Non-comparative study Risk of confounders Retention and maintenance of knowledge and practice in the long term

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			Consent sought from Asian families, involving translation into Urdu and explanation to husbands and family Intervention monthly, delivered at the women's homes until the baby was 12 months old Weaning leaflets in Urdu and English			

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(Stevens et al. 1995) Gloucester, UK Evidence level: 1-	Infants of normal birth weight not breastfed not ill no major congenital malformation No sig diff in demographics and completion rates between the 2 groups No sig diff in iron intake and age of weaning between the 2 groups at baseline 92 healthy infants aged 6 -18 months	Study Question: What are the effects of iron in formula milk after 6 months of age? Statistical Analysis: Comparative analysis between the intervention and control group	Iron fortified follow-on milk (1.2 mg iron /100ml) (n=43) vs Non-fortified follow-on milk (n=44) Mothers advised to continue with their normal diet and to avoid all other forms of milk. No other dietary advice was offered or given. Trial milk supplied free of charge and delivered to home every 3 months	At 6, 9, 12, 15 and 18 months Serum Hgb No sig diff between the 2 groups at any age No. of anaemic infants (Hob <110 g/l) At 6 months Fortified group: 15 Unfortified group: 11 (NS) At 12 months Fortified group: 7 Unfortified group: 6 (NS) At 18 months Fortified group: 0 Unfortified group: 4 (NS)	Likely to be applicable to the UK setting	Double-blind RCT (mothers and investigators blind) - method not stated Power size calculation carried out before trial Higher % of social class 4 and 5 among the study population Dietary intake of infants not known Drop out rate: at end of trial, 24 infants left in fortified group and 29 in unfortified group - small sample size

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Walravens et al. 1992) Paris, France Evidence level: 1-	57 breastfed infants, mostly from low-income, immigrant families (North Africa, Caribbean, SE Asia) Age: 4-9 months (range 3.8 - 8.2) No significant differences between zinc and placebo groups 72 nursing mothers with infants (15 did not complete study)	Study Question: What are the effects of zinc supplementation on growth velocity in breastfed infants? Statistical Analysis: Comparative analysis between the treatment and control group	Zinc supp 5 mg daily (n=25, 15 boys, 10 girls) vs Placebo (n=32, 15 boys, 17 girls) for 3 months All infants received occasional bottle of formula and solids, and ergo-calciferol supp were regularly provided	Length-for-age Z score Zinc: +21 Placebo: –0.13 (p=0.029) Linear growth (cm) (in boys only) Zinc: 6.0 Placebo: 4.6 (p=0.02) (Linear growth not sig diff between 2 groups in girls) Weight (kg) Zinc: 1.64 Placebo:1.28 (p=0.047)	Likely to be applicable in the UK setting and similar population groups	Assign by random numbers 20% drop out rate Not intention-to-treat analysis

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Wardle et al. 2005) London, UK Survey Evidence level: 3	Parents of children 2-6 years old, recruited from 22 London nursery schools Ethnicity: 68% white European 19% others (not specified) Children: 47% boys 50% girls 564 parents of children 2-6 years old	Study Question: What is the association between parental control and fruit and vegetable consumption in children? Statistical Analysis: multiple regression analysis	Relationships between 2 variables: parental control food neo-phobia	Intake of fruits and vegetables (daily) in parents:72% In children: 70-80% Parental control of feeding: More parental control associated with less frequency of children's' fruits and vegetables consumption Children's' fruits and vegetables consumption was positively correlated with parental consumption of fruits and vegetables and negatively correlated with neophobia There was no sig diff between boys and girls	Likely to be applicable but limited generalisability	Observational study Limited generalisability: due to confounders Large sample

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Watt et al. 2006) Camden, London UK Evidence level: 1+	Women of infants aged from 10 weeks to 18 months First baby: 62% Male baby: 52% minority ethnic groups: 50% Lone parent: 28% Mean age: 30 years Disadvantaged: 67% Exclusion: non-English speakers Intervention and control groups well matched in terms of baseline demographics, socioeconomic, infant feeding and nutritional/health variables Volunteers: Living with partners: 61% Income support: 50% Ethnic minority: 53% Council housing: 69% Left full time education at 16 years: 28% Mean age: 36.6	Study Question: what are the effects of a peer support intervention on infants feeding practices\/ Statistical Analysis: Comparative analysis between the intervention and control groups	Peer support (n=157) vs Standard professional care (n=155) Peer support components: 1). Local volunteers trained to provide non-judgmental support and practical assistance on infant feeding, esp weaning practices 2). Police and safety checks of volunteers 3). Home-based support offered over 9 months till infants 12 months old Volunteers providing peer support (n=27) Peer support structure: 1). Monthly home visits 2). Advice and support offered on: affordability and access to recommended foods, practical support, offering a listening ear 2) Ongoing training, designed to complement the advice provided by health professionals Peer support contents: 1). Encourage and support mothers in breastfeeding 2). Develop mothers' nutritional knowledge on foods and especially fruits (increasing variety of weaning foods etc)	At 6 months Fruits and vegetable consumption Feeding practices No sig diff in mean age (weeks) to introduce solids Peer support:18.1 Control: 17.8 Foods first offered: Baby rice No sig diff Peer support: 64% Control: 60% At 12 months (response rate 77%, n=239): Daily vitamin C intake (mg) Peer support: 92.5 Control: 91.1 (NS) No sig diff between the 2 groups in duration of exclusive or mixed breastfeeding, and in terms of introducing cow's milk and solid foods Child growth and health No sig diff in growth parameters between the 2 groups At 18 months (response rate 68%, n=212):	Likely to be applicable in similar UK setting and populations	Computer randomisation Women and researchers blinded before allocation Assessor dealing with data entry and analysis blinded to allocation

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
	years 312 women		3). Develop mothers' cooking skills 4). Develop mothers' budgeting skills 5). Provide appropriate information about better access to food 6), Advise on practical ways of introducing and encouraging the child to eat a varied diet 7). Encourage ways of accessing professional support and advice 8). Particular emphasis on selection of appropriate weaning foods, drinks for infants and best options for feeding methods 9). Use of existing leaflets and recipes 10). Monitoring forms to log activities after each visit Training of volunteers: 1). A volunteer coordinator to provide support and assistance, to match volunteers to mothers, accompanying volunteers at first home visits 2). Support volunteers on an ongoing basis 3). Regular group meetings for continued training and sharing of experiences 4). Administration of travel and child care expenses 5). Collating information from monitoring forms	Daily vitamin C intake (mg) Peer support: 103.4 Control: 109.5 (NS) Increased consumption of fruits and vegetables in the peer support group vs the control Peer support children less likely to be stll using bottles at follow-up No sig diff between the 2 groups in intakes of micro and macro-nutrients, in use of medicines and in growth parameters Mean no of visits received by mothers: 5.1 Mothers opinions of intervention: 1) Rated good/excellent: (> 50%) 2) More knowledgeable and confident in following recommendations on infant feeding such as when to discourage bottle feeding Volunteers' opinions of intervention:		

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				1) Active nature of training prepared them well for the intervention and was appreciated 2) Gained confidence 3) Needed more support in dealing with women from different cultures whose English is not 'great' 4) Too long a gap between receiving training and active volunteering 5) Challenge in maintaining and arranging appointments with mothers		

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(Williams et al. 1999) Refer to Daly 1996 Evidence level: 1+	Refer to Daly 1996 Griffiths scales similar in both groups at enrolment Follow-up study: refer to Daly 1996	Study Question: refer to Daly 1996 Statistical Analysis: refer to Daly 1996	Refer to Daly 1996	Developmental assessments using Griffiths scales - decrease in mean scores At 24 months Follow-on formula: 14.7 Pasteurised cows' milk: 9.3 (p<0.02, 95% CI 0.4 to 10.4) Sub quotient score Sig greater decrease in cow's milk group than the follow-on milk group (p=0.02)	Likely to be applicable in the UK setting and target population	Likely confounders: Content of solids fed Accuracy of food measurement and diary Volume of milk consumed

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(Williams et al. 2002) US Non-RCT Evidence level: 2+	Children from 9 Head Start Centers Age: 2-5 years old Low income Ethnic status: African-American (41%), Latino (33%) No sig diff between the 2 preschools in calories in menus from total and saturated fat at baseline 628 children	Study Question: What are the effects of a preschool nutrition education and food service intervention 'Healthy Start' on 2-5 years old children? Statistical Analysis: Before-and-after analysis	Healthy Start (food service modification + classroom education)(n=374) vs control (not amenable to food service modification (n=254) Healthy Start: Food service modification + nutritional education on CVD risk reduction in preschool children Aims: to increase children's health awareness and knowledge to provide children with ample opportunity to practice positive health behaviours through stories and poems, games, crafts and creative play, hands-on demonstrations, interactive discussions and investigative observations Food service modification: One-day training of cooks in menu planning, recipe development, food purchasing and preparation Gradual increased offering of fruits and vegetables, breads, grains and decreased total and saturated fat content in school meals due to alteration in food preparation techniques Data collection: Children's 24 hours dietary recall, parental report	School menu: Kcal from fat At 2 years Intervention schools: 12.5% to 8% from baseline Control schools: 12.1% to >11.6% ($p<0.001$) Dietary intake from school meals: energy intake from saturated fat At 1 year Intervention schools: decrease from 11% to 10.4% from baseline Control schools: increase by 10.2% to 13% from baseline ($p<0.001$) At 2 years Intervention schools: further decrease to 8% Control schools: 11.4% Growth	Maybe applicable to UK setting and populations with program modification	Confounders: accuracy of data collection instruments

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
			and observation			

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Wright et al. 1998) UK RCT Evidence level: 1+	Children identified as failing to thrive n = 229, aged 7 – 35 months Intervenors: health visitors Sample consisted of two groups: (1) Intervention - structured health visitor management (n = 120) and (2) control – routine care (n = 109) Primary care centres, each comprised 1-3 health visitors, were randomised to the intervention centres At follow-up beyond age 3 years, only 58% of families consented to home visits.	To examine the effects of a health visitor intervention on children (aged 7-35 months) diagnosed with failure to thrive Statistical Analysis: comparative analysis between the intervention and the control groups	Health visitor management consisted of identification of dietary problems with dietetic, paediatric and social work input as required.	Weight SDS (at last evaluation: Int = -1.16 Con = -1.49 Mean diff: 0.32 95% CI: 0.05 to 0.6, p = 0.019 Weight deficit (at last evaluation): Int = -0.82 Con = -1.17 Mean diff: 0.35 95% CI: 0.11 to 0.59, p = 0.005 Height SDS (at home visit): Int = -0.79 Con = -1.13 Mean diff: 0.34 95% CI: 0.03 to 0.66, p = 0.034 Height deficit (at home visit): Int = -0.28 Con = -0.58 Mean diff: 0.6 95% CI: -0.01 to 0.02, p = 0.061 Weight SDS (at home visit): Int = -0.93 Con = -1.29 Mean diff: 0.36 95% CI: 0.01 to 0.71, p = 0.044 Weight deficit (at home	Likely to be applicable in the UK settings and target populations	

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
				visit): Int = -0.54 Con = -0.90 Mean diff: 0.36 95% CI: 0.07 to 0.65, p = 0.016 Number (%) of hospital visits for organic conditions: Int = 18 (15) Con = 14 (13) Not significant Number (%) of hospital visits for failure to thrive: Int = 15 (13) Con = 24 (22) Not significant		

Authors Year Country Study Design Quality	Study Population	Research Question	Intervention	Main Results	Applicability to UK populations and settings	Confounders & Comments
(Wright et al. 2004) Scotland, UK Questionnaire survey Evidence level: 3	Parents recruited from the Millennium Baby Study 707 parents	Study Question: Why are babies weaned early? Statistical Analysis: Descriptive Logistic regression	To explore by questionnaires: Why introduce solids early Whether child had seen GP, suffered cold, diarrhoea, rash or chest infection or hospital admission Questionnaire at 6 weeks, and 4, 8 and 12 months	Strongest predictors of earlier age at weaning: Rapid weight gain to age 6 weeks Lower socioeconomic status Parent's perception that baby was hungry Feeding mode Babies weaned before 3 months, compared with after 4 months, and an increase risk of diarrhoea	Likely to be applicable to UK setting and similar population	Non-comparative study based on subjective outcome data Issues of reliability and generalisability

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