The nexus between water sufficiency and water-borne diseases in cities in Africa: a scoping review protocol [version 1; peer review: 2 approved with reservations]

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\textbf{Abstract}

\textbf{Introduction:} Currently, an estimated two thirds of the world population is water insufficient. As of 2015, one out of every five people in developing countries do not have access to clean sufficient drinking water. In an attempt to share the limited resource, water has been distributed at irregular intervals in cities in developing countries. Residents in these cities seek alternative water sources to supplement the inadequate water supplied. Some of these alternative sources of water are unsafe for human consumption, leading to an increased risk in water-borne diseases. Africa contributes to 53\% of the diarrheal cases reported globally, with contaminated drinking water being the main source of transmission. Water-borne diseases like diarrhea, cholera, typhoid, amoebiasis, dysentery, gastroenteritis, cryptosporidium, cyclosporiasis, giardiasis, guinea worm and rotavirus are a major public health concern. The main objective of this scoping review is to map the available evidence to understand the sources of water among residents in cities in Africa and the relationship between clean water sufficiency and water-borne diseases in urban Africa.

\textbf{Methods and analysis:} The search strategy will identify studies published in scientific journals and reports that are directly relevant to African cities that have a population of more than half a million residents as of 2014 AND studies on the ten emerging water-borne diseases, which are diarrhea, cholera, typhoid, amoebiasis, dysentery, gastroenteritis, cryptosporidium, cyclosporiasis, giardiasis, guinea worm and rotavirus.

\textbf{Ethics and dissemination:} This scoping review did not require any formal ethical approval. The findings will be published in a peer-reviewed journal.
Keywords
Water-borne diseases, water insufficiency, scoping review, African cities, water supply

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Author roles: Mutono N: Conceptualization, Data Curation, Formal Analysis, Investigation, Writing – Original Draft Preparation, Writing – Review & Editing; Wright J: Methodology, Supervision, Visualization, Writing – Review & Editing; Mutembei H: Methodology, Supervision, Writing – Review & Editing; Muema J: Data Curation, Investigation, Methodology, Validation; Thomas M: Data Curation, Investigation, Validation; Mutunga M: Data Curation, Investigation, Methodology, Validation; Thumbi SM: Conceptualization, Methodology, Supervision, Validation, Visualization, Writing – Review & Editing

Competing interests: No competing interests were disclosed.

Grant information: NM has a graduate fellowship through the Washington State University Global Health Kenya. SMT is an affiliate of the African Academy of Sciences.

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Introduction

By 2050, the population in sub-Saharan Africa is projected to double, with cities experiencing an annual growth rate of more than 4%\(^1\). However, the fast rate of urbanization has not been reflected in the rate of infrastructure growth and this has affected the capacity of most cities to provide basic amenities, leading to challenges including water insecurity, poor housing and inadequate social amenities\(^3\). Water is an important natural resource which lies at the nexus of food security, poverty reduction, economic growth, energy production and human health\(^1\). Urbanization will accelerate demand for water\(^4\).

The 2030 United Nations Sustainable Development Goal 6 aims to attain sustainable management and availability of sufficient clean water and sanitation for all\(^5\). Currently, an estimated 40% of the global population is water insufficient\(^5\). The minimum water access requirement per person per day is 50 litres\(^7\). However, as of 2015, one out of every five people in developing countries do not have access to clean sufficient drinking water\(^5\). In an attempt to share the limited resource, water has been distributed in cities in developing countries at irregular intervals\(^8\). To cope with the irregular supply, residents in the cities have responded to these challenges by seeking alternative sources of water, some of which are unsafe for human consumption, leading to an increased risk of water-borne diseases\(^9,10\).

Africa contributes to almost half (53%) of the diarrheal cases reported globally, with contaminated drinking water being the main source of transmission\(^11,12\). Water-borne diseases like diarrhea, cholera, typhoid, amoebiasis, dysentery, gastroenteritis, cryptosporidium, cyclosporiasis, giardiasis, guinea worm and rotavirus are a major public health concern\(^12,14\). As of 2010, cholera contributed to two deaths per 100,000 people and in 2014, diarrhea contributed to 20 deaths per 100,000 children under the age of five years, with unsafe water being a key risk factor\(^13,15\).

The main objective of this scoping review is to map the available evidence to understand the sources of water among residents in cities in Africa and the relationship between clean water sufficiency and water-borne diseases in urban Africa. This will be achieved by synthesising findings of studies that have been written or published on: a) water sufficiency in cities within Africa; b) consequences of rapid urbanization on water sufficiency in African cities; and c) the linkages between water sufficiency and water-borne diseases in Africa. This scoping review will primarily seek to answer the following question: “what is the water sufficiency in cities in Africa and what is the correlation with water-borne diseases?”

This scoping review will identify the knowledge gaps and areas that need further research and contribute towards informing policies that help Africa achieve one of its Agenda 2063 aspirations on urban populations with adequate basic necessities\(^16\).

Protocol

The scoping review will use the Joanna Briggs Institute methodology guidance for scoping reviews\(^17\) and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) extension guidelines for conducting scoping reviews\(^18,19\).

Inclusion criteria

We will include the following types of papers:
1) Studies describing the water sufficiency or water situation in cities (urban areas with greater than half a million residents) in the African Union member states. Since the classification of a city and urban environments is not standardized\(^2\), we use the population number of areas with >0.5 million people to be consistent with the UN report that estimates one in every three people will reside in cities with at least half a million inhabitants by 2030\(^20\). The list of the cities that meet this criterion have been selected from the United Nations World Urbanization Prospects of 2014\(^21\). Figure 1 shows a map of countries in Africa with the number of cities with a population >0.5 million.

2) Studies on water-borne diseases in cities in the African Union member states. We will focus on the ten emerging water-borne diseases, which are diarrhea, cholera, typhoid, amoebiasis, dysentery, gastroenteritis, cryptosporidium, cyclosporiasis, giardiasis, guinea worm and rotavirus\(^12,14\).

3) Studies published in scientific journals or grey literature from government or non-governmental organizations.

Exclusion criteria

1) Studies conducted in rural areas or cities that have a population less than 500,000
2) Studies conducted in other continents other than the member states of the African Union
3) Studies not written in the English or French language
4) Systematic reviews

Figure 1. Member countries in the African Union and the number of cities with a population greater than half a million residents as of 2014. Source of data: United Nations World Urbanization Prospects, 2014\(^22\).
Information sources and search strategy
Comprehensive literature searches will be done in Embase, MEDLINE, Web of Science and Google Scholar databases. The four databases have been identified as the optimal combination of databases that will guarantee adequate coverage of studies for literature searches23.

The search strategy will take a three step process. The first step will involve carrying out a limited search in MEDLINE, Embase and Web of Science databases to analyse the text words and index terms that are used to describe the articles. The second step will then include a search in all the databases using the keywords and the index terms. In the final step, we will go through the references to identify key articles that might have been missed in the first two steps. The search terms used in the study are seen in Table 1.

Study selection
Once searches have been done in the databases, the title and abstracts will be extracted from the articles. Duplicates will be removed, and the review team will screen the studies using two levels: initial screening and full-text screening. During the initial screening process, three reviewers will read the abstracts of the studies captured by the search terms and weigh them using the inclusion criteria. To ensure consistency in the inclusion criteria, 10% of all the studies will be randomly selected and independently reviewed by two other reviewers. Any inconsistency between the primary and secondary reviewers will be discussed and a consensus reached.

Full text articles will be obtained for the studies that pass the initial screening stage. A Microsoft Excel version 16.36 spreadsheet will be used to store the data that will be extracted. Of the data extracted, 10% will be randomly selected and independently reviewed by two other reviewers. Any consistencies among the reviewers will be discussed and an agreement will be reached.

The relevance of the studies in answering the research objective will be identified and studies that are not relevant will be removed and a reason for excluding the study will be recorded. In this stage, another 10% of the studies will be sampled and shared with the secondary reviewer who will exclude or include the studies based on their relevance to the study objective. Consensus will be reached for any discrepancies in the studies among the four reviewers.

Presentation of results
If there are enough studies designed in a similar way reporting on effect of water deficiency on health outcomes in a consistent manner, we will then be able to calculate heterogeneity (I^{2}) for the subset of included studies that follow a similar design. The index of heterogeneity (I^{2}) statistic) will be calculated from the sum of the squared deviations of the estimate of each study from the overall estimate and weighted by the influence of the study on the calculation of the overall estimate. We will look at the risk bias in the study level and characterize whether the metrics of water scarcity and health are a representative of the whole urban population or only a subgroup. We will use R software version 3.6.1 to carry out the analysis^24.

Cluster analysis will be performed to bring similar studies together using agglomerative hierarchical clustering using Ward’s method, which is used in other scoping reviews^25. The optimal number of clusters will be chosen to ensure the inner homogeneity and external heterogeneity of a cluster is balanced.

### Table 1. Search terms that will be used to select studies from the different electronic databases and research repositories.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Search terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Huambo OR Luanda OR Cotonou OR “Abomey-Calavi” OR “Abomey Calavi” OR Ouagadougou OR Bobo-Dioulasso OR “Bobo Dioulasso” OR Beninjumbura OR Younde OR Yaounde OR Douala OR Bangui OR Ndjamena OR Brazzaville OR Pointe-Noire OR “PointeNoire” OR Abidjan OR Bouake OR Kinsasha OR Cairo OR “Al Qahirah” OR Al-Ghahirah OR Alexandria OR “Al-Iskandariyah” OR “Al Iskandariyah” OR “Al Iskandaryah” OR “Port Said” OR “Buri Said” OR “Addis Ababa” OR Caire OR Libreville OR Banjul OR Accra OR Kumasi OR Conakry OR Nairobi OR Mombasa OR Monrovia OR Antananarivo OR Lilongwe OR “Blantyre-Limbe” OR “Blantyre Limbe” OR Bamako OR Nouakchott OR Casablanca OR “Dar-el-Beida” OR “Dar el Beida” OR Rabat OR Nampula OR Tete OR Oms OR Marrakech OR Tangier OR Tanger OR Maknes OR Msikenes OR Agadir OR Maputo OR Matola OR Niamey OR Lagos OR Kaduna OR Akure OR Kano OR Abuja OR Agra OR Kigali OR Dakar OR Freetown OR CapeTown OR Durban OR Pretoria OR “Port Elizabeth” OR Bloemfontein OR “Dar es Salaam” OR Arusha OR Mbeya OR Lome OR Kampala OR Kigwe OR Lusaka OR Harare OR Bulawayo OR “Benin City” OR Enugu OR Ibadan OR Ikorodu OR Ikorin OR Jos OR Maiduguri OR Nnewi OR Onitsha OR Oshogbo OR Owerrri OR “Port Harcourt” OR Sokoto OR Umuahia OR Oyo OR Wari OR Zaria OR Hargeysa OR Merca OR Mogadishu OR Mogadisho OR Johannesburg OR Soshanguve OR Vereeniging OR Khartoum OR “Ali Khartum” OR “Ali Khartum” OR Nyala OR Saffaqis OR Tunis OR Mwanza OR Zanzibar OR Ndola OR Algiers OR “El Djazair” OR Wahrnan OR Oran OR Bukavu OR Kananga OR Kisangani OR Lubumbashi OR “Mbouzi-Mayi” OR “Mbouzi Mayi” OR Tshikapa OR Djibouti OR “Al-Mansurah” OR “Al Mansurah” OR “As-Suways” OR “As Suways” OR Asmara OR “Sekondi Takoradi” OR Banghazri OR Missrafa OR Tarabulus OR Tripoli</td>
</tr>
<tr>
<td>Exposure</td>
<td>water AND (scarc* OR intermittent OR break* OR ratio* OR deficit OR deficien* OR unavailable* OR continu* OR interrupt* OR stress OR supply OR sufficient* OR insufficient*)</td>
</tr>
<tr>
<td>Outcome</td>
<td>“water borne” OR “water-borne” OR cholera OR typhoid OR diarrheaa OR diarrhoea OR amoebiasis OR dysentery OR gastroenteritis OR cryptosporidii OR cyclosporiasis OR giardiasis OR “guinea worm” OR “guinea worms” OR rotavirus</td>
</tr>
</tbody>
</table>
The study locations will be geocoded, and the data will be presented using digital maps that will depict the water sufficiency in these different cities and compare this with the World Resource Institute Aqueduct Global map, which depicts water stress for the countries in our study. Hotspot maps of the number of studies that have been carried out on waterborne diseases in the different cities will be presented and this will be compared with the water sufficiency maps to observe whether the same cities that have high cases of waterborne diseases are the same cities that have high water insufficiency. These maps will enable researchers to identify areas that have gaps in knowledge and identify future research needs.

Table 2. Variables to be extracted from the articles for full-text screening.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Authors</td>
<td>Authors of the article</td>
</tr>
<tr>
<td>2 Publication type</td>
<td>Thesis, article</td>
</tr>
<tr>
<td>3 Title of the article</td>
<td>Full title</td>
</tr>
<tr>
<td>4 Year of publication</td>
<td>Year the article was published or written</td>
</tr>
<tr>
<td>5 Geographical scope of the study</td>
<td>City / cities the study was conducted</td>
</tr>
<tr>
<td>6 Study type</td>
<td></td>
</tr>
<tr>
<td>7 Duration of the study (if applicable)</td>
<td></td>
</tr>
<tr>
<td>8 Rate of urbanization</td>
<td>Metric, population of the city</td>
</tr>
<tr>
<td>9 Water demand / supply</td>
<td>Main water source, main water distributor, water demand</td>
</tr>
<tr>
<td>10 Water sufficiency</td>
<td>Frequency of water sufficiency, water rationing</td>
</tr>
<tr>
<td>11 Water-borne diseases</td>
<td>Diarrhea, cholera, typhoid, amoebiasis, dysentery, gastroenteritis, cryptosporidium, cyclosporiasis, giardiasis, guinea worm, rotavirus</td>
</tr>
<tr>
<td>12 Water-borne disease cases</td>
<td>Lab-confirmed / self-reported / clinically diagnosed</td>
</tr>
<tr>
<td>13 Water sufficiency</td>
<td>Metric, proportion of urban population with sufficient water supply, proportion of urban population with insufficient water supply</td>
</tr>
<tr>
<td>14 Main source of water scarcity metric</td>
<td>Consumer / service provider</td>
</tr>
<tr>
<td>15 Proportion of population with water-borne diseases</td>
<td>Metric</td>
</tr>
<tr>
<td>16 Area proposed for future research</td>
<td></td>
</tr>
</tbody>
</table>

Ethics and dissemination
The study did not require any ethical approval. The findings will be published in a scientific peer-reviewed journal.

Study status
Currently, we are doing the literature searches in the MEDLINE, Embase, Web of Science and Google Scholar databases and extracting the titles and abstracts from the articles which will be used in the initial screening process.

Data availability
No data are associated with this article.

References

7. Gleick PH: Basic water requirements for human activities: Meeting basic

Publisher Full Text


Open Peer Review

Current Peer Review Status: ? ?

Version 1

Reviewer Report 24 August 2020

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David Musoke

Department of Disease Control and Environmental Health, School of Public Health, Makerere University College of Health Sciences, Kampala, Uganda

Generally, this is a well written protocol for the scoping review which is likely to generate key information concerning water and related diseases in cities in Africa. However, my main concern as detailed below is the need to explore other water indicators beyond sufficiency as they also contribute to water borne diseases.

Abstract:

- The background in the abstract is very wordy and therefore can be made more succinct.
- Use of statistics in the background of an abstract is discouraged due to the inability to cite accordingly.

Background:

- Whereas the background has focused on water sufficiency (quantity), it is important for the authors to consider describing other key water indicators such as coverage, quality, cost and continuity that also contribute to the occurrence of water borne diseases.
- The background may be strengthened by providing information on the various sources of water used in urban settings in Africa, both improved and unimproved.
- Water statistics for 2015 are used yet more recent literature is available.
- Whereas the study aim is on water sufficiency, other parameters as noted above have a direct contribution to water borne diseases. It is therefore not clear how these parameters are to be considered in the scoping review.

Protocol:

- In the inclusion criteria, other water indicators noted above should be considered.
○ The exclusion criteria in principle should not be the opposite of the inclusion criteria but rather any predefined conditions that will be used to omit any studies that would have met the inclusion criteria.

○ The exposure search terms as well as variables (Table 2) may also include the various water indicators beyond quantity.

○ The use of the term ‘emerging diseases’ may need to be justified.

○ The choice of selection of the 10 ‘diseases’ also needs to be justified.

○ The outcome and independent variables to be considered in the review need to be described explicitly in the protocol.

**Is the rationale for, and objectives of, the study clearly described?**
Yes

**Is the study design appropriate for the research question?**
Yes

**Are sufficient details of the methods provided to allow replication by others?**
Partly

**Are the datasets clearly presented in a useable and accessible format?**
Not applicable

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Environmental and Public Health including water, sanitation and hygiene.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

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Author Response 03 Dec 2020

**Mutono Nyamai**, University of Nairobi, Nairobi, Kenya

*The background in the abstract is very wordy and needs to be more succinct*

○ We have substantially shortened the ‘background’ section of the abstract in order to make it more succinct.

*Use statistics in the background of an abstract is discouraged*

○ We have removed statistics from the background section of the abstract.

*It is important for the authors to consider describing other key water indicators such as coverage, quality, cost and continuity that also contribute to the occurrence of water borne diseases.*

○ In order to limit the scope of this review we have specifically focused on insufficiency,
as well as large African cities with population of more than 0.5 million AND selected 
waterborne diseases/symptoms/etiological agents AND water situation. In order to 
address other water indicators like cost, coverage, etc. and how they may be possible 
confounders, we will extract this information from the articles during the full text 
screening process as highlighted in Table 2, point 10.

The background may be strengthened by providing information on the various sources of water 
used in urban settings in Africa, both improved and unimproved.

- We agree with the reviewer and have therefore edited line 60 so that it now includes 
  the main sources of water used in urban areas in the African content.

Water statistics for 2015 are used yet more recent literature is available.

- Paragraph 2 and 3 have been updated to include the recent statistics from the 
  UNICEF/WHO Joint Monitoring Program report.

Whereas the study aim is on water sufficiency, other parameters as noted above have a direct 
contribution to water borne diseases. It is therefore not clear how these parameters are to be 
considered in the scoping review.

- These parameters have been included in Table 2 which highlights the variables that 
  will be extracted from the articles during the full-text characterisation process. We 
  will report how they contribute to waterborne diseases.

In the inclusion criteria, other water indicators noted above should be considered.

- Point 10, Table 2 lists the other indicators which will be extracted from the articles 
  during the full-text screening process.

The exclusion criteria in principle should not be the opposite of the inclusion criteria but rather 
any predefined conditions that will be used omit any studies that would have met the inclusion 
criteria.

- We agree with the reviewer and have therefore modified the exclusion criteria and 
  only listed conditions that will omit studies that meet the inclusion criteria.

The exposure search terms as well as variables (Table 2) may also include the various water 
indicators beyond quantity.

- Point 10 of Table 2 has been updated to include other indicators of water supply 
  (frequency of water supply, water rationing, cost, coverage, quality).

The use of the term ‘emerging diseases’ may need to be justified.

- Based on the advice from the first reviewer, this term has been omitted from the 
  protocol.

The choice of selection of the 10 ‘diseases’ also needs to be justified

- We have modified this to exclude ‘10 diseases’. The ‘Definitions’ section now classifies 
  waterborne diseases, symptoms and etiological agents of diarrheal diseases, and 
  includes justifications where appropriate.

The outcome and independent variables to be considered in the review need to be described 
explicitly in the protocol.

- As this is a scoping review rather than a systematic review, we will focus on the 
  methods of the included studies, as opposed to their findings or examination of 
  effect sizes derived for outcomes variables. This will form the inputs to the cluster 
  analysis, so we do not have an outcome and an independent variable given the 
  nature of the type of review we will be conducting.
The paper outlines a protocol for a scoping review of the links between sufficiency of water supply and water-borne diseases in cities in the African region. In the protocol, the authors propose to conduct a search of both peer reviewed and grey literature on water sufficiency in African cities of >500,000 residents and 'ten emerging water-borne diseases'.

The authors attempt to address pertinent questions regarding water supply in the African region. However, the protocol in its current state reads like a decent initial draft, that now requires refinement and sharpening. There are several areas that are unclear. I have tried to offer what I hope is useful criticism.

The rationale for, and objectives of the study are somewhat unclear.
Per the protocol, the question to be answered is: 'what is the water sufficiency in cities in Africa and what is the correlation with water-borne diseases?' There are several concerns with the scope, definition of terms, and assessment criteria that make the rationale and objectives of the review somewhat unclear. These are outlined below.

The study design is not entirely appropriate for the research question.
The protocol requires further development and elaboration, primarily in the outcome variables of interest i.e. the waterborne diseases. The central idea in the protocol seems to be linking water insufficiency to the 'ten emerging waterborne diseases'. There are several concerns here.

1. The terminology needs to be clarified and standardized:
   -Diarrhoea is a symptom of several diarrhoeal diseases, including cholera and typhoid. Classifying it as a disease in itself is inaccurate.
   -Gastroenteritis is a set of symptoms (including diarrhoea, vomiting, nausea) arising from intestinal infection, so again, classifying it as a disease in itself is inaccurate.
   -Cryptosporidium and rotavirus are microorganisms / aetiological agents that cause diarrhoeal diseases, but are not diseases in themselves.
   -Guinea worm is a parasite, not a disease in itself. Diarrhoea is not a typical symptom of dracunculiasis (guinea worm disease).
2. What criteria were used to classify the 'emerging' diseases? This should be clearly described.
   - The question whether the diseases / symptoms / infectious agents listed in the protocol are 'emerging' is highly debatable. The paper cited on some of the said emerging diseases is from 16 years ago - it is fair to say that the landscape has changed a lot since then.
   - The GEMS 2013 study on aetiology of moderate-severe diarrhoea in low-income countries highlighted rotavirus, ETEC, Cryptosporidium and Shigella as the main pathogens of concern. There are likely more recent studies on this, which the authors are advised to look up.
   - Guinea worm disease / dracunculiasis has been eradicated in most countries, with about 30 cases per year (sometimes less) now reported from 3 or 4 countries in Africa, so it is unclear how it could be termed an emerging disease.

3. If the hypothesis is that water insufficiency leads to waterborne disease, how is the insufficiency determined? E.g. if City X has a published water rationing schedule in which water is supplied 12 hours per day for 7 days a week, vs City Y that intermittently supplies water 2 days a week - are the households in both cities water insufficient? I have no bright ideas on this, but it may be food for thought.

4. Most diarrhoeal cases in literature are self-reported, thus aetiological info will likely be limited.
   - Is there some weighting that would be assigned to studies based on the depth of information on the waterborne disease(s) provided? Studies reporting on the aetiology of the diarrhoeal disease may arguably carry more weight than those only reporting diarrhoea / gastroenteritis, which may not necessarily be waterborne.

Some definition of terms and scope is required for the review to be replicated by others.

It is unclear how 'water sufficiency' is defined within the scope of the review. E.g. for households living in slums, water insufficiency may arise from the slum not being connected to the network. Are they within the scope of the review?

Water deficiency, water scarcity and water insufficiency are used throughout the protocol. Do these terms all have the same meaning within the context of the review?

Other comments:
1. What is the reference for the 53% of diarrhoeal cases being from Africa? The paper by Bain et al. cited as ref #13 actually reports 53% of water sources in Africa being faecally contaminated, but does not refer to this 53% as the diarrhoeal disease burden from the African region.

2. Table 2, variable 14 lists 'consumer' under 'Main source of water scarcity metric'. What does this mean? How are consumers sources of water scarcity?

3. Water scarcity is not the only reason for intermittent supply. See for example review by Galaitsi et al. (2016).

4. In the abstract, sentence 2: The 2015 statistic is not static, so somewhat inaccurate to quote as: 'As of 2015, xx people do not have access to safe drinking water'. Actually, the most
recent estimate is that 1 in 3 do not have access to safe drinking-water.

References

Is the rationale for, and objectives of, the study clearly described?
Partly

Is the study design appropriate for the research question?
Partly

Are sufficient details of the methods provided to allow replication by others?
Partly

Are the datasets clearly presented in a useable and accessible format?
Not applicable

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Public health, water quality, water policy and regulation

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 03 Dec 2020

Mutono Nyamai, University of Nairobi, Nairobi, Kenya

The terminology needs to be clarified and standardised:
- Diarrhoea is a symptom of several diarrhoeal diseases, including cholera and typhoid. Classifying it as a disease in itself is inaccurate.
- Gastroenteritis is a set of symptoms (including diarrhoea, vomiting, nausea) arising from intestinal infection, so again, classifying it as a disease in itself is inaccurate.
- Cryptosporidium and rotavirus are microorganisms / etiological agents that cause diarrhoeal diseases but are not diseases in themselves.

- Guinea worm is a parasite, not a disease in itself. Diarrhoea is not a typical symptom of dracunculiasis (guinea worm disease).
  - In lines 94 – 103, we have clarified the terminology and improved the classification of waterborne diseases, symptoms and etiological agents as follows:
    - Waterborne disease: includes cholera, typhoid, amoebiasis, cyclosporiasis and giardiasis diseases.
    - Symptoms of waterborne diseases: focus on diarrhea, dysentery and gastroenteritis.
    - Etiological agents of diarrheal diseases: include cryptosporidium and
rotavirus.
- We added a key definitions section after the introduction which aims to clarify any ambiguity and standardise the terminology.
- We also removed guinea worm from our search strategy in Table 1 (line 140).

What criteria were used to classify the 'emerging' diseases? This should be clearly described.
- The question whether the diseases / symptoms / infectious agents listed in the protocol are 'emerging' is highly debatable. The paper cited on some of the said emerging diseases is from 16 years ago - it is fair to say that the landscape has changed a lot since then.
- The GEMS 2013 study on etiology of moderate-severe diarrhoea in low-income countries highlighted rotavirus, ETEC, Cryptosporidium and Shigella as the main pathogens of concern. There are likely more recent studies on this, which the authors are advised to look up.

- Guinea worm disease / dracunculiasis has been eradicated in most countries, with about 30 cases per year (sometimes less) now reported from 3 or 4 countries in Africa, so it is unclear how it could be termed an emerging disease.
- We have removed the terminology “emerging diseases” as the reference was outdated and its use as a term was ambiguous, as highlighted by the reviewer. In turn, we have changed the emphasis of the paper to mainly focus on the diseases/symptoms/ etiological agents. As mentioned, we specifically define these in the ‘Definitions’ section in lines 89-99.
- We looked at the GEMS 2013 and GEMS 2019 study which highlighted cryptosporidium, enteropathogenic Escherichia, shigella and rotavirus as the main pathogens of concern. We decided to focus on rotavirus and cryptosporidium in our scoping review. Globally, rotavirus was the leading etiology for diarrhea mortality among all ages[1] while cryptosporidium had the highest number of deaths with the pathogen present in children between 12-23 months[2].
- We agree with the reviewer that dracunculiasis is not an emerging disease as it has been eradicated in most countries hence it has been removed from our inclusion criteria.

If the hypothesis is that water insufficiency leads to waterborne disease, how is the insufficiency determined? E.g. if City X has a published water rationing schedule in which water is supplied 12 hours per day for 7 days a week, vs City Y that intermittently supplies water 2 days a week - are the households in both cities water insufficient? I have no bright ideas on this, but it may be food for thought.
- In this scoping review, the term ‘water insufficiency’ relates to water quantity, where we used the World Health Organisation’s (WHO) international benchmark of less than 50 litres of piped water per person per day[3], as highlighted in lines 49-51. We also included the definition of water insufficiency as used in this paper on line 102.
- In order to address instances such as that which the reviewer gives as an example, we will record how water insufficiency was assessed in the papers and if there are enough articles that use methods for characterising water insufficiency, a categorical variable depicting the methods used will form an input within the cluster analysis. We highlight this in point 13 of Table 2.

Most diarrhoeal cases in literature are self-reported, thus etiological info will likely be limited.
- Is there some weighting that would be assigned to studies based on the depth of information on the waterborne disease(s) provided? Studies reporting on the etiology of the diarrhoeal disease...
may arguably carry more weight than those only reporting diarrhoea / gastroenteritis, which may not necessarily be waterborne.

○ In order to address the concern raised by the reviewer on majority of the studies on diarrheal cases being self reported, we will differentiate studies with self-reports from those with etiological characterisation of pathogens. The differences will then be inputted into the planned cluster analysis of study methods (see lines 173-178).

It is unclear how ‘water sufficiency’ is defined within the scope of the review. E.g. for households living in slums, water insufficiency may arise from the slum not being connected to the network. Are they within the scope of the review?

Water deficiency, water scarcity and water insufficiency are used throughout the protocol. Do these terms all have the same meaning within the context of the review?

○ We have now specifically outlined how we define water insufficiency in the new ‘Definitions’ section (line 93). We will use the WHO definition of less than 50 litres per person per day as water insufficiency (line 102). One of the variables extracted from the included studies is the use of the WHO water insufficiency definition, as highlighted in Table 2 point 14.

○ Informal settlements are within the scope of this review. Water is often distributed in informal settlements through water kiosks or public taps[4]. Study setting (informal versus formal) would be included as a study characteristic within cluster analysis, to help examine if different methods and study designs are adopted in such settings.

○ We agree with the reviewer that water scarcity, water deficiency and water insufficiency were used throughout the protocol and to remove any ambiguity, we will focus on water insufficiency but include water scarcity and water deficiency in our search terms to ensure we do not miss out any articles on water insufficiency.

What is the reference for the 53% of diarrhoeal cases being from Africa? The paper by Bain et al. cited as ref #13 actually reports 53% of water sources in Africa being faecally contaminated, but does not refer to this 53% as the diarrhoeal disease burden from the African region.

○ We have removed this reference and restructured the sentence (see lines 68-69).

Table 2, variable 14 lists ‘consumer’ under ‘Main source of water scarcity metric’. What does this mean? How are consumers sources of water scarcity?

○ The term “consumer” was removed from point 14 in Table 2.

Water scarcity is not the only reason for intermittent supply. See for example review by Galaitisi et al. (2016).

○ We agree with the reviewer that water scarcity is not the only reason for intermittent supply. We have addressed this issue in lines 46-49, which captures the main drivers of insufficient water supply as reported by Galaitisi et al[5].

In the abstract, sentence 2: The 2015 statistic is not static, so somewhat inaccurate to quote as: ‘As of 2015, xx people do not have access to safe drinking water’. Actually, the most recent estimate is that 1 in 3 do not have access to safe drinking-water.

○ Based on the second reviewer's comment about removing statistics from the abstract, this statement has been removed.


[2] Diarrhoeal disease and subsequent risk of death in infants and children residing in low-
income and middle-income countries: analysis of the GEMS case-control study and 12-month GEMS-1A follow-on study
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30541-8/fulltext


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