Iron supplementation in early childhood: health benefits and risks1–3

Lora L Iannotti, James M Tielsch, Maureen M Black, and Robert E Black

ABSTRACT
The prevalence of iron deficiency among infants and young children living in developing countries is high. Because of its chemical properties—namely, its oxidative potential—iron functions in several biological systems that are crucial to human health. Iron, which is not easily eliminated from the body, can also cause harm through oxidative stress, interference with the absorption or metabolism of other nutrients, and suppression of critical enzymatic activities. We reviewed 26 randomized controlled trials of preventive, oral iron supplementation in young children (aged 0–59 mo) living in developing countries to ascertain the associated health benefits and risks. The outcomes investigated were anemia, development, growth, morbidity, and mortality. Initial hemoglobin concentrations and iron status were considered as effect modifiers, although few studies included such subgroup analyses. Among iron-deficient or anemic children, hemoglobin concentrations were improved with iron supplementation. Reductions in cognitive and motor development deficits were observed in iron-deficient or anemic children, particularly with longer-duration, lower-dose regimens. With iron supplementation, weight gains were adversely affected in iron-replete children; the effects on height were inconclusive. Most studies found no effect on morbidity, although few had sample sizes or study designs that were adequate for drawing conclusions. In a malaria-endemic population of Zanzibar, significant increases in serious adverse events were associated with iron supplementation, whereas, in Nepal, no effects on mortality in young children were found. More research is needed in populations affected by HIV and tuberculosis. Iron supplementation in preventive programs may need to be targeted through identification of iron-deficient children. Am J Clin Nutr 2006;84:1261–76.

KEY WORDS  Iron, supplementation, children, development, growth, infection

INTRODUCTION
Iron deficiency has been considered an important risk factor for ill health (1) and is estimated to affect 2 billion people worldwide (2). Concerns have been raised about the effects of iron deficiency in children on their health and development, which have led to recommendations for supplementation of all children of certain ages in populations with a high prevalence of anemia (2). This recommendation for a preventive iron intervention will reach both children in need of additional iron and children without that need. This nondiscrimination may be acceptable if no harm is done by the iron supplementation, especially in those children who receive no benefit. Although some studies suggest risks with iron supplementation, it is important to determine whether these risks are generally supported by available evidence and whether they can be mitigated with altered recommendations regarding iron supplementation. The focus of this review was to examine the evidence for the health benefits and risks of preventive iron supplementation in children aged <5 y in developing countries.

Iron is essential for all tissues in a young child’s developing body. Iron is present in the brain from very early in life, when it participates in the neural myelination processes. Other roles that would affect growth and immune function have been postulated (3). Iron, which is essential to both the host and invading pathogens, must be carefully regulated to promote optimal conditions that preserve the health of young children. Furthermore, iron can interfere with the absorption of other nutrients and, in excess, can generate free radicals that impair cellular functions and suppress enzymatic activity (4, 5).

Iron supplementation for children <5 y old is recommended on the basis of anemia prevalence (Table 1). Low-birth-weight infants are at high risk of iron deficiency, and the current recommendation is that they receive supplementation from 2 mo through 2 y of age. Anemia prevalence, determined by hemoglobin status, is used as a practical indicator because of the relative difficulty in collecting additional markers of iron deficiency. The consumption of iron-poor complementary diets (lacking iron-fortified foods or heme iron) is also used to justify supplementation in infants and preschool-aged children. Complementary foods, even with continued breastfeeding, must contribute nearly 100% of dietary iron for young children because breast milk contains little iron (6). Other prevention and control approaches for iron deficiency—such as food fortification,
dietary improvements, and treatment of hookworm and other helminth infections—were not considered in this review.

The objective of this review was to evaluate the health benefits and risks of iron supplementation as a strategy to prevent iron deficiency in children 0–4 y old. Evidence (primarily) from randomized placebo-controlled trials (RCTs) provided the basis for this assessment because these designs allow causal inference that is not possible with cross-sectional or quasi-experimental designs.

We conducted a literature review in PubMed (National Library of Medicine, Bethesda, MD) to identify studies meeting several criteria. The review was limited to RCTs published after 1980 and targeting young children 0–59 mo of age who were living in developing countries. Oral iron supplementation, as prevention and not therapy, was the intervention examined in comparison with placebo and, in a few studies, in comparison with other micronutrients. Trials of iron fortification or parenteral iron were excluded. In certain circumstances when data were scarce, as in the case of iron supplementation and HIV infection or tuberculosis, some observational studies were reviewed to suggest possible relations that should be further investigated with RCTs.

Twenty-six RCTs were identified for this review. If recent meta-analyses of RCTs have been performed, results are given, even though selection criteria such as the age of the children may have differed slightly. The outcomes examined in these iron supplementation trials were grouped into the following categories: anemia and iron status, development (including cognition, motor skills, and language), growth, morbidity, and mortality. To highlight particular findings, these outcome categories were then placed within the sections of the review as either benefits or risks. However, findings were not consistent across many of these outcomes, and this variability deserves careful consideration when policy is made for programs in countries throughout the world.

BENEFITS OF IRON SUPPLEMENTATION IN EARLY CHILDHOOD

Possible beneficial effects of iron supplementation in young children are primarily in the realms of anemia prevention and improvements in developmental outcomes.

Anemia

Anemia may be due to iron deficiency (inadequate iron intake, poor iron absorption, or excess iron losses), insufficient hematopoiesis (eg, from vitamin B-12 deficiency), loss of blood (hemorrhagic anemia), premature red blood cell plasma membrane rupture (hemolytic anemia), deficient or abnormal synthesis of hemoglobin (eg, thalassemia), or destruction of bone marrow (aplastic anemia) (7). In developing countries, the prevalence of anemia among preschool-aged children is 42%, and the regions most affected regions are Southeast Asia, Central and East Africa, and the Eastern Mediterranean (8). Hemoglobin concentrations are most often used for anemia screening. In children 6–59 mo old, anemia is defined as hemoglobin <110 g/L or hematocrit <0.33 L/L (9).

Evidence of the effect of iron supplementation on anemia outcomes is widely available. Studies usually incorporate iron status indicators, such as serum ferritin or transferrin saturation. One meta-analysis of 21 data sets from iron supplementation RCTs in children ranging in age from 0 to 12 y found a significant difference in the mean change in hemoglobin concentrations between treatment and control groups of 7.8 g/L, or an effect size of 1.49 (95% CI: 0.46, 2.51) (10).

Of the studies we examined for development, growth, and infectious disease outcomes (Tables 2, 3, and 4), 13 reported significantly increased hemoglobin concentrations and reduced anemia prevalence associated with iron supplementation of young children (11–15, 19, 23, 30, 31). Eleven studies showed improvements in other iron status indicators: serum iron, serum ferritin, transferrin saturation, and free erythrocyte protoporphyrin (11, 13, 15, 16, 19, 20, 23, 24, 30–32). Of the 5 studies reporting no significant effect on hemoglobin concentrations in the entire sample or particular strata (11, 16, 17, 24, 32), 4 showed improvements in iron status markers (11, 16, 24, 32). This inconsistent effect on hemoglobin concentrations may be indicative of the varied causes of anemia in these study populations. Sustained significant (P = 0.022) improvements in hemoglobin concentrations 7 mo after a 3-mo treatment period were found in one study (21), whereas another study found that only serum ferritin concentrations remained significantly higher in the treatment group 6 mo after cessation of supplementation (31). Hemoglobin improvements appeared to be related to baseline status (11, 17) and to exposure to anemia risk factors in addition to iron deficiency (ie, residence in malarial endemic regions) (16, 32).

Development

Iron supplementation has been hypothesized to have benefits in children that prevent possible detrimental effects of iron deficiency during development. The pace of neurologic development in young children aged 0–4 y is rapid, including critical periods of neural circuit formation and myelination occurring in the brain. Iron’s role in the brain is likely to be multifaceted and...
<table>
<thead>
<tr>
<th>Study and location</th>
<th>Sample size by supplement</th>
<th>Dosage and duration</th>
<th>Eligibility and exclusion criteria</th>
<th>Baseline status</th>
<th>Outcome measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black et al, Bangladesh (17)</td>
<td>6–12 mo old</td>
<td>Total: 221</td>
<td>43 Multivitamin group; 49 Iron group; 49 Iron + zinc group</td>
<td>Age 6 mo; not receiving formula; MUAC ≥10 mm; no obvious neurologic disorders, physical disabilities, or chronic illness</td>
<td>Hemoglobin ≥90 g/L, iron deficiency</td>
<td>Development and iron supplementation</td>
</tr>
<tr>
<td>Idjradinata and Pollitt, Indonesia (11)</td>
<td>12–18 mo old</td>
<td>Total: 126</td>
<td>50 Iron-deficient, nonanemic group; 29 Iron-sufficient group</td>
<td>Attending clinic at Padjadjaran University; birth weight &gt;2500 g; singleton; no major congenital anomalies or perinatal complications; no jaundice treated with phototherapy; no hospital admission or supplementation with iron or vitamins during the 6 mo before enrollment; no clinically identified neurologic delay; no chronic illness or hyperactivity; no abnormal hemoglobin or thrombocytopenia; weight, length, and head circumference within 2 SD of reference standards</td>
<td>Hemoglobin ≤105 g/L, TS ≤10%; iron-deficient, nonanemic group: hemoglobin ≤120 g/L, TS ≤10%; serum ferritin ≤12 µg/L, ferritin-12 µg/L</td>
<td>Development and iron supplementation</td>
</tr>
<tr>
<td>Lind et al, Indonesia (18)</td>
<td>6 mo old</td>
<td>Total: 666</td>
<td>166 Iron group; 164 Iron + zinc group; 167 Zinc group; 169 Placebo group</td>
<td>Resident in Purworejo, Central Java; singleton infants; age &lt; 6 mo; Exclusions: metabolic or neurologic disorders; handicaps affecting development, feeding, or activity; severe or protracted illnesses; normal hemoglobin &lt; 90 g/L</td>
<td>Hemoglobin 114 g/L (hemoglobin &lt;100 g/L observed in 41%; hemoglobin &lt;110 g/L and ferritin &lt;12 µg/L in 8%)</td>
<td>Development and iron supplementation</td>
</tr>
<tr>
<td>Lozoff et al, Costa Rica (15)</td>
<td>22–33 mo old</td>
<td>Total: 86</td>
<td>60 Iron-supplemented group; 27 Nonanemic iron-supplemented group; 27 Nonanemic group</td>
<td>Resident of periurban area Desamparados; birth weight ≥2500 g; singleton birth; free of acute or chronic medical conditions</td>
<td>Hemoglobin ≥6 g/L; free erythrocyte protoporphyrin 3.5 ± 173.6 µg/dL, packed RBC ferritin 4.4 ± 4.7 µg/L, TS 8.4 ± 2.6%</td>
<td>Development and iron supplementation</td>
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TABLE 2 (Continued)

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</tr>
</thead>
<tbody>
<tr>
<td>Lozoff et al, Guatemala (12)</td>
<td>6–24 mo</td>
<td>Total: 64</td>
<td>Ferrous ascorbate (5 mg · kg⁻¹ · d⁻¹) or placebo 1-wk duration</td>
<td>Residents of Guatemala City; hemoglobin &lt;105 or &gt;120 g/L; no birth complications, acute or chronic illness, neonatal distress, congenital anomalies, developmental retardation, generalized malnutrition, or iron therapy during the previous mo; mature infants</td>
<td>Anemic group: hemoglobin 95 ± 9 g/L; serum iron 34.5 ± 9.3 μg/dL; TS 7.9 ± 3.1 μg/L; serum ferritin 4.0 ± 5.0 μg/L; free erythrocyte protoporphyrin 166.6 ± 100.1 μg/dL packed RBCs; Nonanemic group: hemoglobin 126 ± 5 g/L; serum iron 00.7 ± 2.3 μg/dL; TS 16.9 ± 6.4%; serum ferritin 14.4 ± 9.3 μg/L; free erythrocyte protoporphyrin 67.9 ± 28.5 μg/dL packed RBCs</td>
<td>Bayley MDI; Bayley PDI</td>
<td>Deficits at baseline in psychomotor development and mental development indexes were not reversed in 6–8 d of treatment</td>
</tr>
<tr>
<td>Soewondo et al, Indonesia (13)</td>
<td>&lt;5 y</td>
<td>Total: 127</td>
<td>Iron (50 mg/d) or placebo 2-mo duration</td>
<td>Female head of household works as tea picker; husband present in household; one preschool-age child present; family lives on a farm</td>
<td>IDA group: hemoglobin &gt;110 g/L plus 2 of the following: ferritin &lt;12 μg/L, TS &lt;16%, free erythrocyte protoporphyrin &gt;1.77 mmol/L, RBCs</td>
<td>Discrimination learning; three oddity learning tasks; PPVT</td>
<td>IDA associated with visual attention and concept acquisition, corrected by iron treatment; No effect in iron-replete children</td>
</tr>
<tr>
<td>Stoltzfus et al, Zanzibar (16)</td>
<td>6–59 mo old</td>
<td>Total: 614</td>
<td>Ferrous sulfate (10 mg/d) Mebendazole (500 mg) 12-mo duration</td>
<td>Resident of Kengeja village on Pemba; age eligibility for language development scale was 12–48 mo and for motor development scale was 12–36 mo</td>
<td>97% were anemic (hemoglobin &lt;110 g/L); 18% were severely anemic (hemoglobin &lt;70 g/L)</td>
<td>Language; motor score</td>
<td>Language development improved 0.8 points (range: 0.2–1.4) on 20-point scale; Motor development improved in children with hemoglobin &lt;90 g/L; Interaction with baseline hemoglobin (P = 0.015)</td>
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<table>
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</tr>
</thead>
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<td>Walter et al, Chile (14)</td>
<td>12 mo old</td>
<td>Total: 196 Iron group: 102 Placebo group: 94</td>
<td>Iron (45 mg/d) 10-d duration</td>
<td>Residents of well-defined geographical area</td>
<td>Anemic group: hemoglobin 100 ± 9 g/L; MCV 62 ± 5 μL; iron and iron-binding capacity 6.8 ± 2.9%; serum ferritin 5.4 μg/L; free erythrocyte protoporphyrin 195 ± 103 μg/dL packed RBCs Non-anemic iron-deficient group: hemoglobin 121 ± 7 g/L; MCV 70 ± 4 μL; iron and iron-binding capacity 12.2 ± 0.7%; serum ferritin 11.9 μg/L; free erythrocyte protoporphyrin 108 ± 33 μg/dL packed RBCs Control group: hemoglobin 127 ± 8 g/L; MCV 76 ± 3 μL; iron and iron-binding capacity 16.7 ± 6.3%; serum ferritin 19.8 μg/L; free erythrocyte protoporphyrin 78 ± 13 μg/dL packed RBCs</td>
<td>Bayley MDI; Bayley PDI</td>
<td>No treatment effect was observed for mental and psychomotor development after 10 d or 3 mo No differences by baseline status After 3 mo of iron treatment, anemia was corrected</td>
</tr>
</tbody>
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1 MUAC, midupper arm circumference; BSID, Bayley Scales of Infant Development; HOME, Home Observation Measurement of Environment; PDI, Psychomotor Development Index; IDA, iron-deficiency anemia; MDI, Bayley Mental Development Index; TS, transferrin saturation; RBC, red blood cell; PPVT, Peabody Picture Vocabulary Test; MCV, mean corpuscular volume.
TABLE 3
Growth and iron supplementation

<table>
<thead>
<tr>
<th>Study and location</th>
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<tr>
<td>Angeles et al, Indonesia (19)</td>
<td>2–5 y old</td>
<td>Total: 76, Iron: 39, Placebo: 37</td>
<td>Ferrous sulfate (30 mg/d) 2-mo duration</td>
<td>WAZ between −2 and −3 SDs; Hemoglobin &gt; 80 to &lt;110 g/L; Ferritin &lt;120 μg/L</td>
<td>Iron group: hemoglobin 102 ± 9 g/L; Placebo group: hemoglobin 103 ± 8 g/L; WAZ = −2.33; HAZ = −1.83; WHZ = −1.48</td>
<td>Weight, height, dietary intake, hemoglobin, serum ferritin, fever (temperature &gt; 37°C); diarrhea (&gt;4 watery stools/d); RTI</td>
<td>Increases in height and HAZ in treatment group were larger than those in control group (P &lt; 0.01); hemoglobin, serum ferritin, and MCV improved significantly. Frequency of fever, respiratory infections, and diarrhea was significantly less in treatment group. Study was adjusted for food intake effect on growth; decreased morbidity in supplementation group is suggested to have mediated the growth increase.</td>
</tr>
<tr>
<td>Dewey et al, Sweden and Honduras (26)</td>
<td>4–9 mo old</td>
<td>Total: 131</td>
<td>Ferrous sulfate (1 mg · kg⁻¹ · d⁻¹) from 4 to 6 mo of age and then ferrous sulfate (1 mg · kg⁻¹ · d⁻¹) from 7 to 9 mo of age</td>
<td>Gestational age ≥37 wk; birth weight &gt; 2500 g; no chronic illness; maternal age ≥16 y; infant exclusively breastfed at 4 mo (received &lt;90 mL infant formula/d since birth); mother intended to continue breastfeeding until infant age 9 mo</td>
<td>Hemoglobin 90 g/L</td>
<td>Blood samples at 4, 6, and 9 mo (hemoglobin, ferritin, erythrocyte zinc protoporphyrin, MCV, plasma transferrin receptor); C-reactive protein; stool frequency, consistency, cough, fever, nasal congestion or discharge, diarrhea, vomiting, or skin rash; morbidity by pediatrician diagnosis</td>
<td>Reduced gains in length in children 4–6 mo old and hemoglobin ≥110 g/L in iron group. Weight gain lower in the infants receiving iron for 6–9 mo than in those receiving placebo within lower ferritin subgroup. No significant effect on morbidity, but diarrhea was less common at 4 mo in infants in both Honduras and Sweden who had baseline hemoglobin &lt; 110 g/L; infants with hemoglobin ≥110 g/L at baseline had more diarrhea. From age 4 to 6 mo, hemoglobin and ferritin improved; from age 6 to 9 mo, iron status indicators improved but not hemoglobin; IDA was significantly reduced at 9 mo.</td>
</tr>
<tr>
<td>Domelkof et al, Sweden and Honduras (23)</td>
<td>4 mo old</td>
<td>Total: 478</td>
<td>Iron (10 mg/d) + zinc (10 mg/d) 6-mo duration</td>
<td>Age: resident of any of 6 adjacent villages in West Java; exclusion based on chronic or severe illness, severe clinical malnutrition, or congenital anomalies</td>
<td>Hemoglobin and plasma ferritin not reported at baseline; Iron-supplemented group baseline status: WAZ = −0.68; HAZ = −0.89; WHZ = 0.77</td>
<td>Anthropometric measures; hemoglobin, eggs/g feces</td>
<td>No effect on growth; hemoglobin plasma ferritin concentrations significantly higher in iron-treated group.</td>
</tr>
<tr>
<td>Dijkstra et al, Indonesia (20)</td>
<td>3–5 y old</td>
<td>Total: 140</td>
<td>Iron (60 mg/d) + albendazole 3-mo duration</td>
<td>Age 3–5 y; resident of semi-rural area of southern Benin; exclusion: no acute disease</td>
<td>Hemoglobin 10.1 g/L; 76% were anemic (hemoglobin &lt; 110 g/L)</td>
<td>Anthropometric measures; hemoglobin, eggs/g feces</td>
<td>No effect on growth in study groups or stratified groups by nutritional and hemoglobin status.</td>
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### TABLE 3 (Continued)

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Idjradinata et al, Indonesia (27)</td>
<td>12–18 mo old</td>
<td>Total: 47</td>
<td>Ferrous sulfate (3 mg · kg⁻¹ · d⁻¹) 4-mo duration</td>
<td>Birth weight &gt;2500 g; singleton pregnancy; no major congenital anomalies or perinatal complications; no jaundice treated with phototherapy; no hospital admission or supplementation with micronutrients during the 6 mo before enrollment; no chronic illness or folk acid deficiency; hemoglobin &gt;80 g/L, no signs of abnormal hemoglobin or thalassemia; weight, length, and head circumference &gt;2 SDs of reference standards</td>
<td>Iron-replete group: hemoglobin &gt; 120 g/L; TS &gt;10%; serum ferritin &gt;12 μg/L</td>
<td>Weight, length, and arm circumference (bi-weekly); morbidity (pediatric diagnosis); illness incidence (gastrointestinal, upper or lower respiratory tract infection) for 2 wk</td>
<td>Reduced rate of weight gain in iron group (x ± SE: 0.106 ± 0.011 versus 0.070 ± 0.011 kg/2 wk, P = 0.02) No significant differences in length and arm circumference No significant difference in respiratory or gastrointestinal infections (Other confounding factors not corrected for)</td>
</tr>
<tr>
<td>Lind et al, Indonesia (18)</td>
<td>6-mo old</td>
<td>Total: 666</td>
<td>Iron (10 mg/d) Zinc (10 mg/d) 6-mo duration</td>
<td>Resident in Purworejo, Central Java; singleton infants &lt; 6 mo old; exclusions: metabolic or neurologic disorders; handicaps affecting development, feeding, or activity; severe or protracted illness; hemoglobin &lt;90 g/L</td>
<td>Hemoglobin 114 g/L (hemoglobin &lt;110 g/L observed in 4%); hemoglobin &lt;110 and ferritin &lt;12 μg/L (observed in 8%) WAZ = −0.42 HAZ = −0.57 WHZ = −0.02</td>
<td>Anthropometric indexes; developmental indexes (BSID); morbidity</td>
<td>No effect of iron alone on growth but iron + zinc significantly improved knee-heel length as compared with placebo; iron significantly improved BSID psychomotor development index as compared with placebo; no effect on morbidity</td>
</tr>
<tr>
<td>Majumdar et al, India (25)</td>
<td>6–24 mo old</td>
<td>Total: 150</td>
<td>Iron-replete group: iron (2 mg · kg⁻¹ · d⁻¹) 4-mo duration Iron-deficient group: iron (6 mg · kg⁻¹ · d⁻¹) 4-mo duration</td>
<td>Birth weight &gt;2500 g; singleton pregnancy; weight, length, and head circumference &gt;2 SDs of NCHS reference; diet of adequate protein, calories, and micronutrients; exclusions: major congenital anomaly or perinatal complications, hospital admission or iron supplementation during the months before enrollment, chronic illness, anemia beyond iron deficiency, or recent blood transfusion</td>
<td>Hemoglobin 139 g/L Iron-replete group: hemoglobin &gt;110 g/L, serum ferritin &gt;12 μg/L, L, TS &gt;10% Iron-deficient group: hemoglobin 50–110 g/L, serum ferritin &lt;12 μg/L, L, TS &lt;10%</td>
<td>Anthropometric indexes (weight, length, head circumference)</td>
<td>In iron-deficient children, significantly greater mean monthly weight gain (P &lt; 0.001) and linear growth (P &lt; 0.001) In iron-replete children, significantly less weight gain (P &lt; 0.001) and linear growth (P &lt; 0.001)</td>
</tr>
<tr>
<td>Palupi et al, Indonesia (22)</td>
<td>2–5 y old</td>
<td>Total: 194</td>
<td>Ferrous sulfate (15 mg/wk) 2-mo duration</td>
<td>Registered at village health center</td>
<td>Hemoglobin 113 g/L WAZ = 1.84 HAZ = 1.92 WHZ = −0.85</td>
<td>Worm infestation (as indicated by stool microscopy)</td>
<td>No effect on changes in height or weight (SD was large for increase in hemoglobin concentration in both iron and placebo groups; no hookworm prevalence and no additional effect of anthelmintic treatment)</td>
</tr>
<tr>
<td>Rahman et al, Bangladesh (28)</td>
<td>0.5–6 y old</td>
<td>Total: 317</td>
<td>Ferrous gluconate (15 mg/d) + vitamins A, D, and C 1-y duration</td>
<td>Resident in poor periurban community of Dhaka; exclusions: congenital abnormality, metabolic disorder, or any clinical sign of anemia</td>
<td>WAZ = −2.4 HAZ = −2.3 WHZ = −1.3</td>
<td>No no hemoglobin reported</td>
<td>No differences in weight or height increments between intervention and control groups No differences when stratified by age or nutritional categories</td>
</tr>
<tr>
<td>Rosado et al, Mexico (24)</td>
<td>1.5–3 y old</td>
<td>Total: 219</td>
<td>Ferrous sulfate (20 mg/d) Ferrous sulfate + zinc (15 mg/d) 12-mo duration</td>
<td>Resident in 1 of 5 rural communities</td>
<td>Hemoglobin 108 g/L WAZ = 1.6 HAZ = −1.6 WHZ = −0.7 Serum ferritin group: Placebo: 20.1 ± 44.6 Iron: 21.2 ± 38.1 Zinc: 18.5 ± 15.8 Zn + iron: 14.7 ± 15.6</td>
<td>RTI (runny nose, common cold, sore throat, cough, diarrhea (maternal reporting); fever (maternal reporting))</td>
<td>No effect on growth velocity or body composition Zinc and zinc + iron significantly decreased diarrhea (P &lt; 0.01) and disease episodes (P &lt; 0.03) No effect with iron alone</td>
</tr>
</tbody>
</table>

1. WAZ, weight-for-age z score; HAZ, height-for-age z score; MCV, mean corpuscular volume; WHZ, weight-for-height z score; RTI, respiratory tract infection; IDA, iron deficiency anemia; TS, transferrin saturation; BSID, Bayley Scales of Infant Development; NCHS, National Center for Health Statistics.
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<td>Angeles et al, Indonesia (19)</td>
<td>2–5 y old</td>
<td>Total: 76, Placebo: 37</td>
<td>Ferrous sulfate (30 mg/d) 2-mo duration</td>
<td>WAZ between −2 and −3 SD; Hemoglobin &gt;80 to &lt;180 g/L; Ferritin &lt; 120 μg/L</td>
<td>Iron group: hemoglobin 102 ± 9 g/L, Placebo group: hemoglobin 103 ± 5 g/L, WAZ &lt; −2.53, HAZ &lt; −2.33, WHZ &lt; −1.48</td>
<td>Weight, height, dietary intake; morbidity; serum ferritin; fever (temperature &gt; 37°C); diarrhea (&gt;4 watery stools/d); respiratory tract infection</td>
<td>No significant difference in respiratory infections, asthma, and diarrhea significantly less in treatment group. Hemoglobin, serum ferritin, and MCV significantly improved.</td>
</tr>
<tr>
<td>Berger et al, Togo (31)</td>
<td>6–36 mo old</td>
<td>Total: 197, Iron: 100, Placebo: 97</td>
<td>Iron betaineate (2–3 mg · kg⁻¹ · d⁻¹) 3-mo duration 9-mo follow-up</td>
<td>Resident in selected village; aged 6–36 mo; hemoglobin ≥ 80 g/L</td>
<td>Iron group: hemoglobin 989 ± 11.6 g/L, TS 18.3 ± 10.1%, serum ferritin 109.2 ± 110.6 μg/L, free erythrocyte protoporphyrin 105 ± 63 μg/dL packed RBCs</td>
<td>Upper RTI, lower RTI: malaria; parasite density measured smear; diarrhea; cutaneous infection; fever; worms</td>
<td>No effect on incidence of infections or malaria. After adjustment for baseline status, no significant difference.</td>
</tr>
<tr>
<td>Chippaux et al, Togo (33)</td>
<td>6–36 mo old</td>
<td>Total: 190, Iron: 95, Placebo: 95</td>
<td>Iron betaineate (2.5 mg · kg⁻¹ · d⁻¹) 3-mo duration 9-mo follow-up</td>
<td>Hemoglobin ≥80 g/L</td>
<td></td>
<td>Malaria (smear positive); antibody titers</td>
<td>No effect on infant susceptibility to malaria or immune response.</td>
</tr>
<tr>
<td>Dewey et al, Honduras and Sweden (26)</td>
<td>4–9 mo old</td>
<td>Total: 131</td>
<td>Ferrous sulfate (1 mg: kg⁻¹ · d⁻¹) Iron (4–9 mo) Placebo (4–6 mo) + iron (6–9 mo) 9-mo follow-up</td>
<td>Gestational age ≥37 wk; birth weight ≥2500 g; no chronic illness; maternal age ≥16 y; infant exclusively breastfed at 4 mo (received &lt;90 mL infant formula/d since birth); mother intended to continue breastfeeding until 9 mo of age</td>
<td>Hemoglobin &gt;90 g/L</td>
<td>Blood samples at 4, 6, and 9 mo (hemoglobin, ferritin, erythrocyte zinc protoporphyrin, mean corpuscular volume, plasma transferrin receptor, C-reactive protein; birth weight; weight, length, and head circumference by month; nutrient intake in complementary foods; morbidity by maternal record on a calendar (soil frequency; stool consistency; cough, fever, nasal congestion or discharge; diarrhea, vomiting, or skin rash); Morbidity by pediatrician diagnosis</td>
<td>No significant effect on morbidity in the data from Honduras and Sweden.</td>
</tr>
<tr>
<td>Domellof et al, Honduras and Sweden (23)</td>
<td>12–18 mo old</td>
<td>Total: 47, Iron: 24, Placebo: 23</td>
<td>Ferrous sulfate (3 mg · kg⁻¹ · d⁻¹) 4-mo duration</td>
<td>Birth weight ≥2500 g; singleton pregnancy; no major congenital anomalies or perinatal complications; no jaundice treated with phototherapy; no hospital admission or supplementation with micronutrients during the 6 mo before enrollment; no chronic illness or folic acid deficiency; hemoglobin &gt;80 g/L; no signs of abnormal hemoglobin or thalassemia; weight, length, and head circumference 2 SDs of reference standards</td>
<td>Iron-replete hemoglobin group: &gt;120 g/L; TS &gt;10%; serum ferritin &gt;12 μg/L</td>
<td>Weight, length and arm circumference (biweekly); morbidity (pediatrician diagnosis); illness incidence (gastrointestinal or upper or lower respiratory tract infection for 2 wk)</td>
<td>No significant difference in respiratory or gastrointestinal infections. Reduced rate of weight gain in iron group (3 ± SE: 0.106 ± 0.010 vs. 0.070 ± 0.011; kg/2 wk, P = 0.02).</td>
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<thead>
<tr>
<th>Study and location</th>
<th>Age group</th>
<th>Dosage and duration</th>
<th>Eligibility and exclusion criteria</th>
<th>Baseline status</th>
<th>Outcome measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lind et al, Indonesia (18)</td>
<td>6 mo old</td>
<td>Total: 666 Iron: 166 Zinc: 164 Placebo: 169</td>
<td>Ferrous sulfate (10 mg/d) Zinc (10 mg/d) Iron (10 mg) + zinc (10 mg)</td>
<td>Resident in Purworejo, Central Java; singleton infants; &lt; 6 mo old; exclusions: metabolic or neurologic disorders; handicaps affecting development, feeding, or activity; severe or protracted illness; hemoglobin &lt; 90 g/L</td>
<td>Hemoglobin 114 g/L (hemoglobin &lt; 110 g/L observed in 41%; hemoglobin &lt; 110 and ferritin &lt; 12 μg/L observed in 8%) WAZ = 0.42 HAZ = 0.57 WHZ = 0.72</td>
<td>Anthropometric indexes; development indexes (BSID); morbidity</td>
</tr>
<tr>
<td>Mebrahtu et al, Tanzania (32)</td>
<td>6–59 mo old</td>
<td>Total: 614 Households stratified by age and randomly assigned to receive iron or placebo, and then children stratified by iron allocation and randomly assigned to mebendazole</td>
<td>Ferrous sulfate (10 mg/d) Mebendazole (500 mg)</td>
<td>Resident of Kengeja village on Pemba</td>
<td>94.4% were anemic (hemoglobin &lt;110 g/L) 17% were severely anemic (hemoglobin &lt;70 g/L) 80% were infected with <em>Plasmodium falciparum</em> 48.1% had HAZ &lt; −2</td>
<td>Blood films were assessed monthly for prevalence and density of infection</td>
</tr>
<tr>
<td>Menendez et al, Tanzania (27)</td>
<td>2 mo old</td>
<td>Total: 832</td>
<td>Ferrous glycine sulfate (2 mg · kg⁻¹ · d⁻¹) Delagrim malaria prophylaxis 4-mo duration 10-mo follow-up</td>
<td>Birth weight &gt;1500 g; PCV &gt; 25% at 8 wk; exclusions: congenital malformation, congenital or neonatal infection</td>
<td>P + P group: PCV 33.3 ± 5.6 1 + P group: PCV 33.4 ± 5.0 1 + I group: PCV 33.0 ± 5.3</td>
<td>Malaria (axillary temperature &gt;35.5°C with asexual <em>P. falciparum</em> parasitemia of any density)</td>
</tr>
<tr>
<td>Mitra et al, Bangladesh (34)</td>
<td>2–48 mo old</td>
<td>Total: 349 Iron: 172 Placebo: 177</td>
<td>Ferrous gluconate (15 mg/d) Vitamin A 8-mo duration</td>
<td>Exclusions: critically ill, congenital malformations, metabolic disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palupi et al, Indonesia (122)</td>
<td>2–5 y old</td>
<td>Total: 194 Iron: 96 Placebo: 98</td>
<td>Ferrous sulfate (15 mg/week)</td>
<td>Registered at village health center</td>
<td>Hemoglobin &lt;112 ± 10 g/L</td>
<td></td>
</tr>
<tr>
<td>Rosado et al, Mexico (24)</td>
<td>1.5–3 y old</td>
<td>Total: 219 Iron: 109 Placebo: 110</td>
<td>Ferrous sulfate (20 mg/d) Ferrous sulfate + zinc methionine 12-mo duration and follow-up</td>
<td>Resident in 1 of 5 rural communities; age as stated</td>
<td>Hemoglobin 108 g/L WAZ = −1.6 HAZ = 1.6 WHZ = 0.7 Serum ferritin group: Placebo: 20.1 ± 44.6 Iron: 21.2 ± 38.1 Zinc: 189 ± 15.8 Zinc + iron: 147 ± 15.6</td>
<td>RTI (runny nose, common cold, sore throat, cough); diarrhea (maternal reporting); fever (maternal reporting)</td>
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<tr>
<th>Study and location</th>
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<th>Outcome measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sazawal et al, Tanzania (36)</td>
<td>1–35 mo old</td>
<td>Total: 24 076</td>
<td>Ferrous sulfate (12.5 mg)&lt;br&gt;Folic acid (50 µg)&lt;br&gt;Zinc (10 mg)&lt;br&gt;Tablet daily for children &gt; 12 mo old; half-tablet for children &lt;12 mo old</td>
<td>Age; resident on island of Pemba; no severe malnutrition; substudy exclusion: hemoglobin &lt;70 g/L</td>
<td>Serious adverse events; all-cause mortality; cause-specific mortality; hospitalizations; malaria (parasite count and fever), meningitis, diarrhea, dysentery, pneumonia</td>
<td>12% greater risk of mortality or severe illness leading to hospitalization with iron and folic acid (2–23%; ( P = 0.02 ))&lt;br&gt;16% greater risk of adverse events due to malaria (2–32%; ( P = 0.03 ))&lt;br&gt;No effect with cumulative dose</td>
<td>Substudy findings: in iron-deficient anemic children, iron and folic acid treatment significantly reduced the risk of adverse events (RR: 0.51; 95% CI: 0.31, 0.83; ( P = 0.006 )) In iron-replete children, the trend was toward greater risk of adverse events: with anemia (RR: 2.00; 95% CI: 0.46, 8.75; ( P = 0.36 )); without anemia (RR: 1.51; 95% CI: 0.54, 3.98; ( P = 0.41 ))</td>
</tr>
<tr>
<td>Smith et al, Gambia (37)</td>
<td>6 mo–5 y old</td>
<td>Total: 213</td>
<td>Ferrous sulfate in orange juice (3–6 mg · kg(^{-1} \cdot )d(^{-1} ))</td>
<td>Hemoglobin and MCV &lt;3% of reference population&lt;br&gt;Exclusion: infants with hemoglobin &lt;50 g/L</td>
<td>Malaria (axillary temperature &gt;37.5 °C with ( P. falciparum ) positivity)</td>
<td>Significantly increased fever-associated severe malaria in iron-treated group than in placebo group</td>
<td></td>
</tr>
<tr>
<td>Tielsch et al, Nepal (30)</td>
<td>1–35 mo old</td>
<td>Total: 25 490</td>
<td>Placebo, iron and folic acid, zinc; iron and folic acid + zinc</td>
<td>1–35 mo living in study area</td>
<td>All cause mortality; secondary: cause-specific mortality; incidence or severity of diarrhea; dysentery; ARI, clinic utilization</td>
<td>No effect on mortality; iron and folic acid (HR 1.03, 95% CI: 0.78, 1.37) or iron and folic acid + zinc (HR 1.00, 95% CI: 0.74, 1.34) No significant differences in attack rates for diarrhea, dysentery, or respiratory infections Greater risk of “other infections” and deaths in iron and folic acid group</td>
<td></td>
</tr>
<tr>
<td>van den Hombergh et al, Tanzania (35)</td>
<td>&lt;30 mo old</td>
<td>Total: 100</td>
<td>Ferrous sulfate (200 mg/d)&lt;br&gt;Folic acid</td>
<td>Hemoglobin ≤ 50 g/L; positive smear for malaria parasites; exclusions: cerebral malaria, nonfalciparum malaria, sickle cell anemia, other significant illness</td>
<td>Malaria (smear positive); pneumonia; other infections</td>
<td>No effect on rate of parasitemia or parasitic density Increase in morbidity from other causes in iron group (( P = 0.004 )) Significant difference in pneumonia incidence; higher in iron group (( P = 0.004 ))</td>
<td></td>
</tr>
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1 WAZ, weight-for-age \( z \) score; HAZ, height-for-age \( z \) score; WHZ, weight-for-height \( z \) score; MCV, mean corpuscular volume; TS, transferrin saturation; RTI, respiratory tract infection; RBC, red blood cell; NA, not applicable; BSID, Bayley Scales of Infant Development; P + P, placebo + placebo; I + P, iron + placebo; D + P, Deltaprim malaria syrup + placebo; D + I, Deltaprim malaria syrup + iron; PCV, packed cell volume; ARI, acute respiratory infection: bpm, beats/min; RR, risk ratio; HR, hazard ratio.
has not been fully elucidated. Iron in oligodendrocytes is required for proper myelination of the neurons used in sensory systems (visual, auditory) and learning and interacting behaviors (38). Dopaminergic neurotransmitter systems related to behavioral development (eg, inhibition, affect, attention processing, and extraneous motor movements) are sensitive to changes in iron status. Iron is also a cofactor for enzymes that synthesize neurotransmitters such as tryptophan hydroxylase (serotonin) and tyrosine hydroxylase (norepinephrine, dopamine) (39). Iron deficiency has been linked to changes in neuronal metabolism in the hippocampus and prefrontal projections where memory processing occurs (40).

Lead and other neurotoxic metals that impair early childhood development have been shown to be absorbed during iron deficiency (41). Iron is recognized as sharing the divalent metal transporter 1 (DMT1) with both lead and cadmium (42). No studies investigating reduced lead absorption as an outcome of iron supplementation met the criteria for this review. One RCT in Mexican school-age children, 51% of whom had blood lead concentrations ≥10 µg/dL, found no effect of a 6-mo regimen of iron supplementation on cognitive performance (43) or parent or teacher ratings of behavior (44).

A meta-analysis of RCTs examining iron in relation to development in children included trials of oral iron supplementation, fortified milks and cereals, and parenteral iron. Significant beneficial effects on mental development for children who were anemic or iron deficient at baseline and for all children >7 yr old were reported (45). The standardized mean difference (SMD) for the mental development score, a composite of different tests assessing the same aspect of mental development, was 0.30 (95% CI: 0.15, 0.46; P < 0.001). This is a modest effect, equivalent to 1.5 to 2 Intelligence Quotient Points. In younger children (aged <27 mo), no effect of iron supplementation on mental development was detected. Motor development was not found to be improved through iron supplementation (SMD: 0.09; 95% CI: −0.08, 0.26; P = 0.28) (35).

Of the 8 RCTs identified for this review that addressed developmental outcomes, 5 found some possible benefits of iron supplementation (11, 13, 16–18), but the importance of many of these effects on later academic performance is unknown (Table 2). One study in Bangladesh found that a weekly dose of 20 mg ferrous sulfate over 6 mo significantly reduced developmental losses in orientation engagement (exploration), whereas placebo did not affect the losses with age (17). A study in Indonesia found that iron supplementation for 4 mo resulted in higher motor and mental development scores on the Bayley Scales for Infant Development II (BSID) in children with iron deficiency anemia, but not in children who were iron deficient without anemia or who were iron replete (11). In contrast, a trial in Guatemala that provided supplementation for only 1 wk found no benefit of iron supplements when testing with the BSID was used (12). In Chile, another trial of short-term (10 d) iron supplementation also found no benefit when testing by BSID was used (14). The third study that found no developmental effects of iron treatment was conducted in Costa Rica and was of longer duration but had a smaller sample than the other 2 studies had (15). Two Indonesian studies with longer supplementation periods (6 and 2 mo, respectively) indicated positive development outcomes: one related to motor development as assessed by BSID in all children (18), and the other related to visual attention and concept acquisition only in children with iron deficiency anemia (13). A Zanzibar study found that iron supplementation given for 12 mo was associated with more rapid achievement of language milestones in all children and motor milestones in the more anemic children (16).

The BSID is probably the most well standardized, widely used assessment of infant development in the world, and it has been sensitive to deviations in early development associated with iron status. However, the BSID is a global assessment that may obscure subtle differences in neurobehavioral development. Evidence for developmental continuity in cognitive functioning suggests the importance of variability in early processing skills, such as those associated with iron deficiency, and of the modifying effects of the home environment and the family’s socioeconomic status (46). Thus, estimates of the effects of iron status during infancy on school-age measures of academic performance may be enhanced by the combination of a well-standardized assessment of development such as the BSID, measures of specific neurobehavioral processes thought to be sensitive to iron deficiency, and consideration of the home and family environment.

### RISKS OF IRON SUPPLEMENTATION IN EARLY CHILDHOOD

Because iron is not easily eliminated from the body, attention has been paid to circumstances in which excess iron may be absorbed or used inappropriately. An overabundance of iron may catalyze the generation of hydroxyl radicals through the Fenton reaction (47). Chronic iron overload has been studied in the context of hemochromatosis (48), and these studies may provide insight into the mechanisms and clinical manifestations of excess iron. Tissue injury, in particular that to the liver, may result from the generation of free radicals, but evidence also exists of intracellular damage. Extensive studies and reviews have looked at oxidative damage to DNA, proteins, and lipids (49, 50).

Excess iron may be detrimental to cognitive, motor, and behavioral development, although this detrimental effect is likely limited to cases of genetically susceptible children. Children with mutations in the gene encoding pantothenate kinase 2 (PANK2) have neuronal brain iron accumulation that is manifest in dystonia, dysarthria, rigidity, and early death (51). Animal models have shown potential neurologic dysfunctions associated with dietary iron overload early in life (53); evidence for these effects in humans is less clear.

From the murine model, it is known that iron supplementation can result in the generation of free radicals (49) and will increase intestinal susceptibility to peroxidative damage in an iron-deficient state (53). Known defense systems in the body protect against free radical damage. In young children, lactoferrin from breast milk may be used for iron chelation, although this process is largely thought to produce mostly antiinfective properties. Antioxidants such as selenium or glutathione also are known to protect against free radical damage. Malnourished children with kwashiorkor or marasmus may be deficient in antioxidants, which leaves them susceptible to potential harm due to excess iron (54, 55). Other mechanisms besides the generation of free radicals have been postulated for the observed negative effects of iron supplementation, including potential interference with absorption of other essential nutrients (5, 56), the growth and proliferation of invading pathogens, and the suppression of enzyme activity in host defense (3).
Growth

In the early months and years of life, infants and young children pass through a crucial period of growth that may not be regained later in life. Results from trials of iron supplementation overall have not found significant growth effects, even in anemic children, though some studies have shown an adverse effect, especially in iron-replete children. Dietary iron may inhibit the absorption of other essential growth-promoting nutrients such as zinc, although a recent review of trials found no conclusive evidence of this association (56). Iron supplementation may lead to increased morbidity and, consequently, to reduced dietary intakes, poor nutrient absorption, and negative energy balance (57).

A meta-analysis of RCTs examining vitamin A, iron, and multimicronutrient interventions in children aged <18 y found that, in the 21 iron-supplementation RCTs identified, no significant effect on growth was reported (10). The overall effect size was 0.09 (95% CI: −0.07, 0.24) for height and 0.13 (95% CI: −0.05, 0.30) for weight, and negligible differences in height gain (0.007 cm) and weight gain (0.012 kg) were found between treatment and controls. When the studies were stratified for baseline hemoglobin status, the lack of significant differences remained, although the effect size for height gain was greater in subjects who were anemic at baseline (0.21; 95% CI: −0.14, 0.56) than in those who were not anemic (0.02; 95% CI: −0.14, 0.18) (10).

The International Research on Infant Supplementation (IRIS) analysis is a recent pooled-data analysis that compared the findings from RCTs of supplementation in infants aged 6–12 mo in Indonesia, Peru, South Africa, and Vietnam. The 4 supplementation groups were daily iron supplementation, daily multiple micronutrients, weekly multiple micronutrients, and placebo. As compared with placebo, iron treatment had no significantly different effect on weight or height gains over the course of the 6-mo trials. Changes in hemoglobin and plasma ferritin concentrations were significantly larger in the iron group than in the placebo group (58).

In the current review, the 10 identified studies had varied results (Table 3). In 2 studies, iron supplementation had a significant positive effect on height or length gains and height-for-age z score (19, 25), and low baseline hemoglobin and iron deficiency appeared to be associated with this effect in both studies. The study in Indonesia adjusted for dietary intake in the assessment of the effect on growth and concluded that a decrease in morbidity in the supplementation group may have mediated the growth effect (19). In India, iron supplements were randomized within iron-replete and iron-deficient strata of children. Monthly weight gain and linear growth increased significantly (both: P < 0.001) in iron-deficient children but not in iron-replete children (25). This study was the only 1 of the 10 to find improvements in weight gain associated with iron supplementation.

Three of the 10 studies, including one described above that found improvements in iron-deficient children (25), reported significant reductions in weight gains in the iron treatment groups (25–27); 2 of these studies also found reductions in linear growth in those groups (25, 26). The study in Honduras found that, in infants aged 4–6 mo with baseline hemoglobin ≥110 g/L, length gains were less than those in infants who received placebo (26). This study also examined iron treatment effects in a population of breastfed infants in Sweden and found lower gains in length and head circumference in supplemented infants aged 4–9 mo. Infection did not appear to influence growth outcomes. Similarly, the study in India found an adverse effect of iron supplementation on weight gain and linear growth in iron-replete children aged 6–24 mo (25). In Indonesia, the negative effect was seen only on weight, and no effect was found on length or arm circumference (27). In the remaining 6 reviewed studies, no effect of iron supplementation was reported for either weight or height (18, 20–22, 24, 28).

From the available literature, it appears that iron supplementation may be of limited or no benefit for growth; the few studies that showed a benefit found it primarily in the children with iron deficiency at baseline. Evidence suggests that iron supplementation in young children without iron deficiency may jeopardize optimal height and weight gains.

Morbidity due to infectious disease

Growing concern about the effect of iron supplementation on increased susceptibility to infection has prompted several studies to examine this relation. The physiologic process most commonly implicated is that of the enhanced growth of pathogens from available iron in tissues. Iron is an important nutrient both for host requirements and for the metabolism of invading pathogens. Nutritional immunity involves iron-withholding defense systems that include hypoferremia, a condition in which the amount of iron available for parasites and other organisms is reduced by the activity of iron-binding proteins (59). Another pathway proposed in defense against parasitic infection in particular is one in which iron inhibits the expression of inducible nitric oxide synthase (iNOS), which subsequently downregulates the formation of nitric oxide in macrophages. Nitric oxide appears to be critical to macrophage defense against Plasmodium falciparum (60).

The influence of iron supplementation on infection may be differentiated by such variables as increased incidence, duration, or severity of infection. One meta-analysis of 28 RCTs examining iron (oral, parenteral, and fortified foods or beverages) found that the pooled estimate of the incidence rate ratio for all infectious illnesses, including respiratory tract infection, diarrhea, malaria, and other infections, was not elevated in iron-supplemented children (61). A higher risk of diarrhea (incidence rate ratio: 1.11; 95% CI: 1.01, 1.23; P = 0.04) was found, however, in those given iron than in those given placebo. A nonsignificant increase in malaria was also observed in the iron-supplemented group (incidence rate ratio: 1.06; 95% CI: 0.94, 1.24). Interpretation of these findings should consider that several of the studies screened for and included only anemic children. Moreover, the trials used forms of iron administration other than supplements, including parenteral iron (3 studies) and fortified beverages or foods (5 studies). The age of the study participants also varied from 2 d to 14 y, and the inclusion and exclusion criteria were heterogeneous.

Our review identified 16 RCTs of oral iron supplementation for infants and young children in developing countries with infectious disease outcomes (Table 4) (16, 18, 19, 22, 24, 26, 27, 29–37). The methods applied to measure morbidity varied greatly across studies. Five studies used clinical measures, 4 studies used blood or stool samples for assessment, and the remaining 7 combined these approaches. Of the 4 studies finding an association between iron supplementation and infection, 3 used the combined approach, with both blood and clinical measures of morbidity.

Four studies in our review reported adverse outcomes related to iron supplementation. In Bangladesh, in children aged <12 mo, iron supplementation resulted in a 49% increase (P = 0.03)
in the number of episodes of dysentery (34). An earlier study in the Gambia that included only children who were anemic at baseline (hemoglobin <3rd percentile of reference population) found that iron treatment was associated with an increase in fever-associated severe malaria (37). Although 2 small studies in Tanzania found no infection-related adverse effects with iron supplements (29, 32), a third study from Tanzania found, in children with severe anemia (hemoglobin ≤ 5.0 g/L), a significantly higher incidence of pneumonia in the iron group (both: \( P = 0.004 \)) (35).

A large trial conducted in Zanzibar, Tanzania \((n = 24,076)\) found a 12% (95% CI: 2%, 23%) greater risk of severe illness leading to hospitalization or death and a 16% (95% CI: 2%, 32%) greater risk of adverse events due to malaria associated with iron and folic acid supplementation (36). To further examine the effects of supplementation on hematologic and zinc status and morbidity, a substudy in Zanzibar \((n = 2413)\) was also carried out. In this analysis, supplement effect was assessed by iron and anemia status. Children with iron-deficiency anemia who were being treated for malaria and other infections had a significantly \( (P = 0.006) \) lower risk of adverse events (eg, hospitalization or death) \((RR: 0.51; 95\% CI: 0.31, 0.83)\) associated with concomitant treatment with iron and folic acid than did those given placebo. Those who were iron replete (with or without anemia) showed a trend toward a greater risk of adverse events when they were iron supplemented, but the substudy sample size lacked sufficient power to detect statistically significant differences. In addition, any apparent adverse effects of iron supplementation in the iron-replete groups may have been mitigated by the more extensive diagnosis and treatment services provided by the substudy than by the routine government services in the larger study.

Only one study in Indonesia \((n = 76)\) found a positive effect for reduced frequency of fever, respiratory infection, and diarrhea associated with iron supplementation in children aged 2–5 y (19). In infants with hemoglobin <110 g/L at baseline in Honduras, a trend toward a lower risk of diarrhea was seen in the iron-supplemented group \((OR: 0.11; 95\% CI: 0.01, 1.08; P = 0.06)\), but no similar reverse trend was seen in infants with hemoglobin ≥110 g/L (26). In the current study, however, the combined analysis, which included Swedish infants randomly assigned to iron supplementation and placebo, found a significant protective effect against diarrhea with iron supplementation in infants with hemoglobin <110 g/L \((OR: 0.21; 95\% CI: 0.04, 0.95; P = 0.04)\) and an adverse effect among those with hemoglobin ≥110 g/L \((OR: 2.4; 95\% CI: 1.0, 5.8; P = 0.05)\). The remaining 10 studies of the review found no effect on morbidity associated with iron supplementation of young children.

### Malaria

Malarial infection contributes to the development and severity of anemia through the destruction of parasitized red blood cells, through immune mechanisms including the destruction of unparasitized red cells, and through dyserythropoiesis (7). Its relation to iron status is less well characterized. Other studies have found that additional risks may be associated with malarial infection and iron supplementation in children, which has increased the attention the public is directing toward this association. Of the 7 studies identified in our review, 5 (29, 31–33, 35) showed no significantly greater risk in the iron supplementation groups and 2 (36, 37) indicated a greater risk of adverse events due to malaria. Only 3 of these studies did not use anemia as an enrollment criteria \((24, 30, 36)\); one of these studies, the trial in Zanzibar, was the only study of malarial outcomes with adequate power to detect serious adverse events or mortality (36). That study found a 16% (95% CI: 2%, 32%; \( P = 0.02 \)) greater risk of serious adverse events due to clinical malaria in the treatment groups that received iron (iron + folic acid and iron + folic acid + zinc groups) than in the placebo groups. More specifically, this group had an elevated risk of illnesses with clinical signs of cerebral malaria and a malaria-positive blood film \((RR: 1.22; 95\% CI: 1.02, 1.46; P = 0.03)\). Cerebral malaria as a cause of death was increased by 70% \((RR: 1.70; 95\% CI: 1.08, 2.68; P = 0.02)\) in the iron + folic acid treatment group.

### HIV

The risks and benefits of iron supplementation in HIV-positive children have not been extensively studied. No RCTs were identified in this age category. Globally, 2.2 million children aged <15 y are living with HIV/AIDS; most of them live in sub-Saharan Africa and South and Southeast Asia (36). Numerous risk factors for compromised health, that may be either diminished or exacerbated by iron supplementation are present in children born to HIV-positive mothers. Evidence from a review of observational studies suggests that infants born to HIV-positive mothers are at greater risk of low birth weight (63); low-birth-weight infants are currently recommended to receive iron supplementation from 2 to 23 mo of age. Moreover, infants born to HIV-positive mothers may have compromised iron nutriture (64) and, conversely, may be susceptible to iron overload through antioxidant deficiencies (65).

Before highly active antiretroviral therapy (HAART), which remains largely unavailable in developing countries, iron loading was observed in various tissues of HIV-positive adults, including bone marrow, brain, muscle, liver, and spleen (66). Evidence from a study of HIV-positive, iron-deficient pregnant women in Africa found no relation between the severity of HIV disease and iron status indicators \(\text{ie, hemoglobin, ferritin, transferrin receptor, HIV load, and CD4}^+\text{ lymphocyte count}\) (67). One RCT in a small group of HIV-infected adults \((n = 45)\) in Kenya found no differences in viral load between the placebo and the iron-supplemented groups after 4 mo of follow-up (68). Further research is needed in developing countries, especially in young children \(\text{infect}ed or \text{non}infected) and those born to HIV-positive mothers.

### Tuberculosis

Approximately one-third of the world’s population is infected with *Mycobacterium tuberculosis*, the pathogen that causes tuberculosis. The incidence of tuberculosis has increased dramatically with the HIV/AIDS epidemic (69). Whereas we found no RCTs examining the effect of iron supplementation on tuberculosis in young children, this research may be necessary. Iron has been shown to enhance the growth of *M. tuberculosis* in mice (70). The loading of iron in macrophages where this bacterium grows may both facilitate its acquisition of iron and inhibit cellular defense systems (71). However, in a study of anemia in adult males with pulmonary tuberculosis, no differences were found in the recovery rates between iron-supplemented and placebo groups (72). Another study examined retrospective exposure to dietary iron and found a significant increase in the odds of tuberculosis with high iron, after adjustment for HIV status and...
liver function (71). These studies highlight the need for more investigation, particularly in young children.

Overall mortality

Two additional RCTs that investigated infection outcomes examined the risk of mortality related to oral iron supplementation. As stated above, the study in Tanzania found a trend toward a greater risk of mortality in the iron + folic acid treatment groups, which is consistent with the increase in hospitalization for severe infectious diseases (36). Serious adverse events were mainly attributed to malaria. In Nepal, no effect was found for total mortality (30). In “other infections” (including sepsis, hepatitis, meningitis, and gastrointestinal infections) category of cause-specific mortality, a significant increase was seen in the relative risk in the iron + folic acid treatment group compared with placebo group. Cautious interpretation of these findings is warranted given the limited reliability of cause of death data. A 70% reduction in severe anemia was seen with iron supplementation, but it did not lead to a reduction in mortality.

CONCLUSIONS: BALANCE OF BENEFITS AND RISKS

Twenty-six studies were assessed in this review; they reported various effects associated with preventive iron supplementation in children aged 0–4 y. The outcomes of anemia, development, growth, infectious disease morbidity, and mortality were considered, and the following conclusions were drawn.

For anemia, hemoglobin concentrations were consistently increased in iron-supplemented children who were anemic or had iron-deficient anemia at baseline. Improvements or increases in iron status indicators were also associated with iron supplementation in both iron-deficient and iron-replete children at baseline, although the response was less in the latter group. Iron supplementation may have had some positive effects on a number of developmental outcomes, primarily through reducing preexisting deficits or preventing losses over time in cognitive and motor skill development among preschool-aged children who were iron deficient or anemic before supplementation. Treatment at lower doses for 2–12 mo appeared to be more beneficial than very short courses of supplementation. The variations in developmental responses to iron supplementation, combined with the poor or unknown correlations of the measured outcomes with long-term cognition, make interpretation or quantification of the possible benefits difficult.

In terms of growth, we found evidence from trials of various sizes for significant adverse effects on weight gains in iron-replete subgroups of young children. For height or linear growth, results varied. Two studies found a positive effect of iron supplementation on height increases in iron-deficient children, but 2 found a negative effect and 2 found no effect on height or length in iron-replete children.

With respect to infectious disease morbidity and mortality outcomes, our review found mixed evidence for increased incidence, duration, or severity of all infections in association with iron supplementation. Nearly all of the studies to date have been too small to enable examination of severe disease events or deaths. The only trials of sufficient size for these outcomes are those in Nepal and Zanzibar. In Nepal, no benefit or adverse effect of iron + folic acid supplements on mortality was found in young children. In Zanzibar, clear evidence shows that iron + folic acid supplementation, in a population of children with high rates of malaria and other infectious diseases and with limited access to disease-control programs, results in a significant increase in serious adverse events, including deaths. Additional evidence from this setting suggests that the degree of infectious-disease treatment and the child’s baseline iron status are critical determinants of who benefits and who is harmed in terms of serious infectious-disease outcomes when the population is provided low-dose oral iron supplements. Insufficient data are available on iron supplementation in relation to HIV or tuberculosis outcomes for conclusions to be drawn about possible benefits or risks.

One general conclusion that may be drawn from this analysis is that baseline hemoglobin and iron status indicators appear to be important determinants of these outcomes (Table 5). Our review found this through results from 12 trials screening for and including children according to hemoglobin or iron status at baseline (11–15, 19, 25, 29, 32, 33, 35, 37) and 8 trials that later stratified or adjusted for hemoglobin and iron status parameters in analyses associating supplementation with various outcomes (16–18, 21, 22, 26, 28, 36). In the first case of screening or restriction design, the ability to generalize to the larger population may be absent, although several studies showed effects with screening in all outcome categories. Larger, well-designed RCTs were among those finding differential effects of baseline hemoglobin and iron status markers on development, growth, and morbidity outcomes that support this conclusion. Only 2 studies reported an interaction between iron supplementation and initial

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