

BMJ Open Optimal iron content in ready-to-use therapeutic foods for the treatment of severe acute malnutrition in the community settings: a protocol for the systematic review and meta-analysis

Aamer Imdad ¹, Melissa François,² Fanny F Chen,² Abigail Smith,³ Olivia Tsistinas,³ Emily Tanner-Smith ⁴, Jai K Das ⁵, Zulfiqar Ahmed Bhutta⁶

To cite: Imdad A, François M, Chen FF, *et al.* Optimal iron content in ready-to-use therapeutic foods for the treatment of severe acute malnutrition in the community settings: a protocol for the systematic review and meta-analysis. *BMJ Open* 2022;**12**:e057389. doi:10.1136/bmjopen-2021-057389

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2021-057389>).

Received 14 September 2021
Accepted 17 February 2022



© Author(s) (or their employer(s)) 2022. Re-use permitted under CC BY. Published by BMJ.

For numbered affiliations see end of article.

Correspondence to
Dr Aamer Imdad;
imdada@upstate.edu

ABSTRACT

Introduction The current standard of care for children with severe acute malnutrition (SAM) involves using ready-to-use therapeutic food (RUTF) to promote growth; however, the precise formulation to achieve optimal recovery remains unclear. Emerging research suggests that alternative RUTF formulations may be more effective in correcting SAM-related complications such as anaemia and iron deficiency. This systematic review commissioned by the WHO aims to synthesise the most recent research on the iron content in RUTF and related products in the community-based treatment of uncomplicated severe malnutrition in children aged 6 months and older.

Methods and analysis We will search multiple electronic databases. We will include randomised controlled trials and non-randomised studies with a control arm. The intervention group will be infants who received RUTF treatments other than the current recommended guidelines set forth by the WHO. The comparison group is children receiving RUTF containing iron at the current WHO-recommended level of 1.9 mg/100 kcal (10–14 mg/100 g). The primary outcomes of interest include blood haemoglobin concentration, any anaemia, severe anaemia, iron-deficiency anaemia, recovery from SAM and any adverse outcomes. We will use meta-analysis to pool findings if sufficient homogeneity exists among included studies. The risk of bias in studies will be evaluated using the Cochrane risk of bias-2. We will use the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach to examine the overall certainty of evidence.

Ethics and dissemination This is a systematic review and will not involve direct contact with human subjects. The findings of this review will be published in a peer-reviewed journal and will guide the WHO's recommendation on the optimal iron content in RUTFs for the treatment of SAM in children aged 6–59 months.

BACKGROUND

The WHO estimates that over 45 million children under the age of five worldwide suffered from wasting (low weight for height) in 2020

Strengths and limitations of this study

- This systematic review commissioned by the WHO will synthesise the most recent research on iron content in ready-to-use therapeutic foods and related products in the community-based treatment of uncomplicated severe malnutrition in children aged 6 months and older.
- We will search several databases for relevant literature and include randomised and non-randomised studies.
- We will assess risk-of-bias for each outcome and use the Grading of Recommendations Assessment, Development and Evaluation to assess the overall quality of evidence.
- We will assess the following outcomes: blood haemoglobin concentration, any anaemia, severe anaemia, iron-deficiency anaemia, recovery rates, all-cause mortality, adverse events, growth outcome and serum levels of micronutrients.
- We will conduct meta-analyses if data are available from more than one study and there is clinical and methodological homogeneity in the included studies.

alone.¹ Children with severe acute malnutrition (SAM) have about sixfold increased mortality risk compared with well-nourished children.² In addition to the risk of mortality, children with SAM are at increased risk of morbidities such as diarrhoea, pneumonia, measles and micronutrient deficiencies, and long-term neurodevelopmental delay.^{2–4} Nutritional rehabilitation of children with SAM is a key intervention that helps treat morbidity and prevent mortality.^{3 5 6} The current standard of care for children with uncomplicated SAM involves using ready-to-use therapeutic food (RUTF) to promote growth⁷; however, the precise formulation to achieve optimal recovery remains unclear.^{6 8} There are ongoing efforts to improve RUTF

to optimise the composition and balance of macronutrients and micronutrients.^{9–11}

SAM involves deficits of several key macronutrients and micronutrients, with studies showing higher rates of anaemia in children suffering from malnutrition.^{12–14} The prevalence of anaemia in severely acutely malnourished children ranges from 40% to 90%, and about half of the anaemia is attributed to iron deficiency.¹⁵ Iron deficiency in severely malnourished children could be due to low intake, increased losses, higher demand and poor absorption. Iron is essential for adequate catch-up growth and neurological development in children with SAM.^{12 16 17} Moreover, recent studies suggest alternative RUTF formulations may be more effective in correcting anaemia and iron deficiency in children with SAM compared with current standard RUTF formulations.^{12 18 19} In addition to the need for sufficient iron intake to treat iron deficiency, it remains unclear whether improving the iron status among the undernourished children increases the risk of complications, including the risk of morbidities such as diarrhoea, malaria and undesired changes in the microbiome.^{20–22} This aspect is especially of concern in malaria-endemic regions in Africa because nearly a third (27%) of all children affected by wasting worldwide reside in Africa.²² Due to the critical role of RUTF in the medical management of children with SAM, more information is needed to generate formulations with optimal iron levels for treatment of anaemia and optimal growth and development in children suffering from malnutrition.^{16–18} A number of recent studies have been completed to assess the optimal dose of iron in RUTF in the community management of SAM, and there is no existing systematic review on this topic.^{12 19 23} Furthermore, WHO has started to synthesise the evidence to update the current guidelines for treating wasting in children. Therefore, this WHO commissioned review aims to synthesise the most recent research on the iron content in RUTF and related products in treating severe malnutrition in children 6–59 months of age.

OBJECTIVE

Primary objective

In children aged 6 months or older with uncomplicated SAM being treated in the community settings, does increased iron dose in RUTF compared with the WHO recommendation for iron fortification of RUTF improve outcomes such as blood haemoglobin concentration, recovery from iron-deficiency anaemia, and so on?

Secondary objective

In children aged 6 months or older with uncomplicated SAM being treated in the community settings, what mechanisms other than increased dose of iron in RUTF (such as type, composition, zinc, phytate content, etc.) can help increase the bioavailability of iron and improve the recovery from iron-deficiency anaemia?

METHODS AND ANALYSIS

We will follow the standard guidelines of the Cochrane Collaboration to conduct the systematic review. We registered a detailed protocol on PROSPERO (ID=CRD42021278006) and would report the systematic review findings according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2020 guidelines.²⁴

Study type

We will consider randomised trials, and that may include individual and cluster randomised trials. We will also consider non-randomised studies if there are not enough randomised studies. The data will be analysed separately for randomised and non-randomised studies. We will include the following non-randomised studies: non-randomised controlled clinical trials and controlled before and after (CBA) studies. Case-control studies, interrupted time series, programme evaluations, case reports, case series and commentaries will be excluded. The definitions of eligible studies design and consideration for inclusion in this review are available in [table 1](#).

Population

The population of interest is children aged 6 months or older with SAM managed in outpatient settings. The definition of SAM will be based on weight for height Z scores (< -3 SD for WHO growth standards) or mid-upper arm circumference (< 115 mm) or presence of bilateral oedema.²⁵ We will consider studies that included children who were previously admitted to the hospital and are now being rehabilitated in community settings with the help of RUTF. We will exclude studies of children with complicated SAM who are admitted to the hospital, as those participants might have complications such as pneumonia or severe diarrhoea. We will exclude studies done specifically on participants who have chronic diseases, genetic disorders, or congenital anomalies.

Intervention

The intervention of interest is the dose of iron in RUTF other than in the standard RUTF for the treatment of SAM in community settings. We will include studies of iron-fortified RUTF and exclude those studies where iron was given separately as supplements, such as tablets, syrup, multiple micronutrient powder, and so on. We will include studies where RUTF is given as the main intervention, and it met total daily requirements or was given as a supplementary intervention to the usual diet for children with SAM recovering at home. WHO recommends that a standard RUTF should have at least 1.9 mg/100 kcal (or 10–14 mg/100 g) of iron to treat SAM in children 6–59 months of age.²⁵ We will include studies irrespective of the type of RUTF used, that is, standard RUTF versus low milk-based versus non-milk-based versus locally prepared. We will exclude studies where RUTF was given to healthy children to prevent SAM; for treatment of moderate acute malnutrition; and as part of complementary feeding.

Table 1 The definitions of eligible study designs

Study designs	Definition	Notes
RCT or randomised trial	'An experimental study in which people are allocated to different interventions using methods that are random'.	We will include both individual and cluster randomised trials. In individual randomised trials, the randomisation is done at the individual levels, while in cluster randomised trials, the randomisation is based on cluster or groups of individuals. We will also consider factorial design trials where multiple interventions are studied in the same trial.
NRCT or non-randomised trial	'An experimental study in which people are allocated to different interventions using methods that are not random'.	We will avoid using the term quasiexperimental studies as it means differently by different authors. We will exclude the experimental studies where there was no control group.
CBA study	'A study in which observations are made before and after the implementation of an intervention, both in a group that receives the intervention and in a control group that does not'.	We will require two minimum criteria for the inclusion of CBA studies. ► Data collection: we will include CBA studies if the data for the intervention and control groups were collected prospectively in the same time frame. ► Choice of control: we will include CBA studies that include a control at a second site to avoid contamination of the intervention to the control group if the settings and populations are the same for the intervention and control groups.

The definitions of study designs were adopted from The Cochrane Effective Practice and Organization of Care group.³³
CBA, controlled before and after; NRCT, non-randomised controlled trial; RCT, randomised controlled trial.

Comparison

For the primary objective of the review, the comparison group will be children receiving RUTF containing iron at the current WHO-recommended level of 1.9 mg/100 kcal (10–14 mg/100 g) to treat SAM. For the secondary objective of the review, we will consider studies where different types/doses/techniques of RUTF are studied to improve the bioavailability of iron even though the iron content may be the same in all kinds of RUTF given to children. We will exclude studies where the comparison group did not receive any RUTF.

OUTCOMES

Primary outcomes

1. Blood haemoglobin concentration (continuous outcome).
2. Any anaemia (dichotomous outcome, as defined by the authors).
3. Severe anaemia (dichotomous outcome, as defined by the authors).
4. Iron deficiency anaemia (dichotomous outcome as defined by the authors).
5. Recovery from SAM (dichotomous outcome, as defined by the authors).
6. Any adverse events (dichotomous outcome).

Secondary outcomes

1. Serum ferritin level (continuous outcome).
2. Serum zinc level (continuous outcome).
3. Serum copper level (continuous outcome).
4. Serum iron level (continuous outcome).
5. Adverse events: malaria: (as defined by the authors) (dichotomous outcome).
6. Relapse (dichotomous outcome).

7. All-cause mortality (dichotomous outcome).
8. Admission to an inpatient facility. (dichotomous outcome).
9. Withdrawal from the trial (dichotomous outcome).
10. Constipation (<3 bowel movements per week) (dichotomous outcome).
11. Adverse events: diarrhoea (>3 loose stools per day) (dichotomous outcome).
12. Adverse events: pneumonia (as defined by authors) (dichotomous outcome).
13. Weight for age (kg or Z scores).
14. Height for age (cm or Z scores)
15. Weight for height Z score
16. Microbiome outcomes: alpha diversity and beta diversity
17. Neurodevelopmental outcomes (continuous outcome) at 1 year and the longest follow-up.

The term neurodevelopment is a composite term that refers to cognitive, neurological and/or sensory outcomes. This assessment may include intellectual disability as measured on the Mental Developmental Index of the Bayley Scales of Infant Development, gross motor delay measured on the Gross Motor Function Classification System, and so on.

We will consider the data for all the above outcomes at the longest follow-up.

LITERATURE SEARCH

We will conduct systematic electronic queries using key terms in several databases, including PubMed, EMBASE, the Cochrane Central Register for Controlled Trials, Web of Science, CINAHL,

Scopus, LILACS and WHO Global Index Medicus. No search restrictions will be used to exclude studies based on the outcome, publication year, publication status or language. The references of formerly published reviews and recently published studies will be examined for potential inclusion. We will also use the citation tracking function of the included studies in the PubMed to look for any eligible studies. In addition to the above resources, ClinicalTrials.gov will be used to identify studies currently underway. We will also use the clinical trial registration number to find all the relevant studies published from a particular trial. Finally, we will search the grey literature and search the websites of pertinent international agencies such as WHO (including WHO's Reproductive Health Library, electronic Library of Evidence for Nutrition Actions and Global database on the Implementation of Nutrition Action), UNICEF, Global Alliance for Improved Nutrition, International Food Policy Research Institute, International Initiative for Impact Evaluation (3ie), Nutrition International, World Bank, USAID and affiliates (eg, FANTA, SPRING) and the World Food Program. We will also search the abstracts presented in major paediatric conferences such as Pediatric Academic Society meeting. Proposed search strategies for different electronic databases are shown in online supplemental appendix 1.

DATA EXTRACTION AND SYNTHESIS

Selection of studies

Searches from all the databases will be combined in bibliographic software (EndNote), and duplicates will be removed. Two authors will use a three-phase approach in duplicate to screen studies identified from the search for eligibility. In the first phase, authors will screen the titles and abstracts to identify potentially eligible ones; studies selected during this initial phase will then go on to a full-text review as the second phase. Lastly, studies determined to be eligible subsequent to full-text review will undergo data extraction during the third and final phase. The software Covidence V.14²⁶ will be used to assist the screening process. Two authors will independently extract data from screened studies and compare their findings. Potential conflicts will be resolved through discussion, and the senior author on the team may assist as needed to resolve any conflicts. If a study is only available in abstract form, we will write to authors to obtain details on methods and results. If we cannot get full details of the study methods available in the abstract, we will decide about inclusion based on details available in the abstract. If a study is available in a language other than English, we will attempt to complete the translation using local resources. If a study was published in more than one report (multiple publications), we will count those multiple reports as a single study and extract information from all the available reports as needed.

Data extraction

A data extraction form was designed to support the review and data extraction process (online supplemental

document 1). Two authors will independently extract the data and compare their findings. Any conflict will be resolved by discussion and with the help of the senior author on the team if needed. The following information will be extracted for each study where available: study design (randomised controlled trial, quasirandomised experimental design or cohort study, CBA study), study site (country/region), study year, study type, intervention (dose of iron and dose of RUTF, duration, frequency and composition), exposures, comparison, outcomes, whether the results were adjusted for confounders and risk of bias. To avoid reviewer bias, we are deciding a priori the order of preference for extracting outcomes when data might be available in several formats. For randomised studies, we will prefer data that require the least manipulation by authors or inference by reviewers. We will extract the raw values (eg, means and SDs) rather than calculated effect sizes (eg, Cohen's d). For mortality data, we will give preference to denominators in the following order: number with the definite outcome known (or imputed as described below), number randomised and child years. For morbidity outcomes to which both survivors and non-survivors may have contributed data (eg, the incidence of pneumonia), we will give preference to child years, number with the definite outcome known, and number randomised.

Studies with missing data

We will document attrition during data extraction. If data are missing for some cases, or if reasons for dropout are not reported, we will contact the trial authors to request the full data. If the authors report the missing data and report results using imputations for the missing data, we will use the latter. If a study does not report the SD for the continuous outcome and the SD cannot be calculated from the reported data (such as SE, CI, p value), we will write to the authors to request the data for SD. If the SD data are not available from authors, we will use SD from a similar study that has a similar study population. We will prefer to use the final values of a continuous outcome for a given follow-up. If the final values are not available but the difference between the end and the start of the study, we will write to authors to request the final values. If the final values are not available, we will use the difference or rate of change. We will use the data based on intention-to-treat analysis. If the data for intention-to-treat analysis is not given in the study, we will create our own intention-to-treat analysis for participants with known outcomes. If there is significant attrition between the randomised participants versus participants completing the study, we will include such a study but will investigate further with sensitivity analysis.

Assessment of risk of bias in included studies

The risk of bias in studies will be evaluated using the Cochrane risk of bias (ROB 2.0) and Cochrane ROBINS-I for non-randomised and observational studies.^{27 28} Two review authors will independently assess and agree on

Table 2 Sample table to describe the studies that address delivery mechanism to increase the bioavailability of iron via RUTF in children 6 months and older with severe acute malnutrition

Study	Study participants	Formulations used	Comparison group	Outcomes	Notes
-					
-					
-					

RUTF, ready-to-use therapeutic food.

the risk of bias for the individual studies for an outcome. The discussion will resolve any disagreements, and if no agreement can be made, the senior review author will be consulted. We will assess the effect of assignment to intervention (the intention-to-treat effect) for randomised trials by addressing five domains of signalling questions in ROB-2 including: bias arising from the randomisation process, bias due to deviations from intended interventions, bias due to missing outcome data, bias in the measurement of the outcome and bias in the selection of the reported result. Each domain will receive a ranking of one of the following: low risk of bias, some concerns of bias, or high risk of bias. We will include quotes from the study for each signalling question as evidence for our ranking decision. The overall risk of bias will be determined based on the lowest ranking for individual domains. For example, if only one domain, 'some concerns,' is ranked, then the overall risk of bias will be 'some concerns'.

Data synthesis

The findings from the systematic review will be reported both qualitatively and quantitatively. A narrative synthesis will be used to report the characteristics of all included studies. We will also narratively describe the data in a table for the secondary objective of this review (table 2). A random-effects meta-analysis will be employed when at least two studies possess sufficient clinical and methodological uniformity for synthesis for the primary objective of the review. We will use the generic inverse method to pool the studies in the meta-analysis. The software RevMan will be used for statistical analysis.²⁹ Dichotomous outcomes will be assessed using relative risk effect sizes and presented with 95% CIs. In the case of morbidity outcomes, we will combine all available data whenever possible if outcomes are measured in different ways. For example, we will include all types of diarrhoea (mild, moderate and severe) as a dichotomous value (yes/no) if participants had greater than 3 instances of loose stools per day. We will include the occurrence of anaemia, iron-deficiency anaemia and pneumonia throughout the study as dichotomous values (yes/no). We will pool the data for continuous outcomes to obtain an average mean difference and report it with its 95% CI. If data are reported in different units (eg, few studies report weight in kg and the others report in Z scores), we will use a standardised mean difference effect size and report it with its 95% CI. We will pool the data separately from randomised and

observational studies. If an observational study reports both adjusted and unadjusted values, we will use the adjusted values for meta-analysis.

We will consider the following pairs of comparisons:

High iron content in RUTF versus WHO standard iron content in RUTF

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach will be used to evaluate overall evidence quality using the software GRADEpro.³⁰ The GRADE approach is a comprehensive framework used to assess the overall quality of evidence for an outcome using characteristics such as study design, heterogeneity, directness of evidence, risk of bias, publication bias and precision of effect estimates.³¹ The results of the GRADE assessment will be included in a summary of the findings table. The table will contain quality ratings characterised as very low (we have very little confidence in the effect estimate), low (we have limited confidence in the effect estimate), moderate (we have moderate confidence in the effect estimate; the true effect is likely close to the estimate of the effect) or high (we have high confidence that the true effect lies close to that of the estimate of the effect) based on the primary outcomes of each study (table 3). The study will be started on 18 February 2022, and hope to be completed by 18 April 2022.

Patient and public involvement

No patient or public involvement was considered in the preparation of this protocol.

UNIT OF ANALYSIS ISSUES

Multiple-arm trial

Studies with multiple treatment arms will be included if eligible. For multiple-arm trials, we will include data so that the only difference between the groups is the use of iron in RUTF.

Cluster trials

Cluster assignment trials will be analysed together with individually randomised trials. We will use the cluster-adjusted values; if the trial results are not adjusted for cluster design, we will adjust the result by methods given in the Cochrane³² handbook for systematic reviews.

Assessment of heterogeneity

Statistical heterogeneity of effect sizes within any given meta-analysis will be assessed using the χ^2 , I^2 and tau statistics. We will assess statistical heterogeneity by visual

Table 3 The criteria for the Grading of Recommendations Assessment, Development, and Evaluation approach to examine the overall certainty of evidence³¹

Study design	Quality of evidence	Lower certainty score if	Higher certainty score if
Randomised trial	High	Risk of bias ▶ 1 Serious ▶ 2 Very serious Inconsistency ▶ 1 Serious ▶ 2 Very serious	Large effect +1 Large +2 Very large Dose–response +1 evidence of a gradient
	Moderate	Indirectness ▶ 1 Serious ▶ 2 Very serious	All plausible confounding would: +1 Reduce a demonstrated effect
Observational study	Low	Imprecision ▶ 1 Serious ▶ 2 Very serious	+1 Suggest a spurious effect when results show no effect
	Very low	Publication bias ▶ 1 Likely ▶ 2 Very likely	

inspection of forest plots, performing the χ^2 test (assessing the p value), and calculating the Tau² and I² statistics. Statistical heterogeneity will be considered significant if the p value is <0.10, I² value exceeds 50%, and the examination of forest plots shows substantial variability in the effect of the intervention. We will perform subgroup analysis to determine the reasons for any identified statistical heterogeneity.

Assessment of reporting bias

Small study and publication bias will be assessed using funnel plots and regression tests for funnel plot asymmetry when a meta-analysis includes at least 10 studies.

Subgroup analyses

1. Settings: country—low-income country versus middle-income country versus high-income country.
2. Type of RUTF: standard RUTF versus non-standard.
3. Role of RUTF: RUTF as main treatment versus RUTF as a supplementary intervention.
4. Type of participants: studies that included children with HIV versus studies with children without HIV.
5. Age: <24 months versus 24–59 months versus >59 months.
6. Hospitalisation: children hospitalised (due to medical complication) prior to starting RUTF versus children not hospitalised prior to starting RUTF.
7. Iron compound (formulation/chemical compound and amount).
8. Dose: the intervention groups with a dose of iron greater than the standard WHO RUTF versus intervention group receiving dose lower than the standard WHO RUTF.
9. Anaemia status: children with anaemia at the baseline versus without anaemia at the baseline.
10. Time of follow-up: 1 month versus 3 months versus 6 months follow-up and the longest follow-up.

Sensitivity analyses

1. Studies with a high risk of bias.
2. Random vs fixed-effect model.

Amendments

We will do the literature searches, screening of titles, selection of studies, data extraction and analysis according to the aforementioned plan described in this protocol. If we do any additional analysis or change any of the a priori strategies, we will clearly describe that in the Methods and analysis section.

Consent for publication

The authors give consent for the publication of the review.

ETHICS AND DISSEMINATION

This is a systematic review and will not involve direct contact with human subjects. The findings of this review will be published in a peer-reviewed journal and will guide the WHO's recommendation on the optimal iron content in RUTF for the treatment of SAM in children aged 6–59 months.

Author affiliations

¹Department of Pediatrics, Division of Pediatric Gastroenterology, Hepatology and Nutrition, SUNY Upstate Medical University, Syracuse, New York, USA

²College of Medicine, SUNY Upstate Medical University, Syracuse, New York, USA

³Library Sciences, SUNY Upstate Medical University, Syracuse, New York, USA

⁴College of Education, University of Oregon, Eugene, Oregon, USA

⁵Department of Pediatrics, Aga Khan University, Karachi, Pakistan

⁶Center of Excellence in Women and Child Health, The Aga Khan University, Karachi, Pakistan

Acknowledgements We are very thankful to Allison Daniel, Jaden Bendabenda, Lisa Rogers and Maria De Las Nieves Garcia Casal for their input to improve this protocol.

Contributors AI and MF wrote the first draft of the manuscript. AS and OT developed the search strategy. ET-S provided the support for methodology. ZAB, FFC and JKD provided the support for the content being evaluated in the review. All authors edited and reviewed the manuscript. AI is the guarantor of the review.

Funding This work is funded by World Health Organization grant no 202712614. WHO provided technical support for this work and guided the development of PICO (Population, Intervention, Comparison, Outcome) question for this review.

Competing interests None declared.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Supplemental material This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by BMJ. BMJ disclaims all liability and responsibility arising from any reliance placed on the content. Where the content includes any translated material, BMJ does not warrant the accuracy and reliability of the translations (including but not limited to local regulations, clinical guidelines, terminology, drug names and drug dosages), and is not responsible for any error and/or omissions arising from translation and adaptation or otherwise.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution 4.0 Unported (CC BY 4.0) license, which permits others to copy, redistribute, remix, transform and build upon this work for any purpose, provided the original work is properly cited, a link to the licence is given, and indication of whether changes were made. See: <https://creativecommons.org/licenses/by/4.0/>.

ORCID iDs

Aamer Imdad <http://orcid.org/0000-0002-7026-0006>

Emily Tanner-Smith <http://orcid.org/0000-0002-5313-0664>

Jai K Das <http://orcid.org/0000-0002-2966-7162>

REFERENCES

- United Nations Children's Fund (UNICEF), World Health Organization, International Bank for Reconstruction and Development/The World Bank. *Levels and trends in child malnutrition: key findings of the 2021 edition of the joint child malnutrition estimates*. Geneva: World Health Organization, 2021.
- Schroeder DG, Brown KH. Nutritional status as a predictor of child survival: summarizing the association and quantifying its global impact. *Bull World Health Organ* 1994;72:569–79.
- Dipasquale V, Cucinotta U, Romano C. Acute malnutrition in children: pathophysiology, clinical effects and treatment. *Nutrients* 2020;12. doi:10.3390/nu12082413. [Epub ahead of print: 12 Aug 2020].
- Mwene-Batu P, Bisimwa G, Baguma M, et al. Long-Term effects of severe acute malnutrition during childhood on adult cognitive, academic and behavioural development in African fragile countries: the Lwiro cohort study in Democratic Republic of the Congo. *PLoS One* 2020;15:e0244486.
- Woeltje MM, Evanoff AB, Helmink BA, et al. Community-Based management of acute malnutrition for infants under 6 months of age is safe and effective: analysis of operational data. *Public Health Nutr* 2021;1–10.
- Das JK, Salam RA, Saeed M, et al. Effectiveness of interventions for managing acute malnutrition in children under five years of age in low-income and middle-income countries: a systematic review and meta-analysis. *Nutrients* 2020;12. doi:10.3390/nu12010116. [Epub ahead of print: 01 Jan 2020].
- WHO W, UNCSN, UNICEF. *Community-based management of severe acute malnutrition. A joint statement by the World Health Organization, World Food Programme, United Nations Standing Committee on Nutrition, United Nations Children's Fund*. Geneva: World Health Organization, 2007.
- Weisstaub G, Medina M, Pizarro F, et al. Copper, iron, and zinc status in children with moderate and severe acute malnutrition recovered following WHO protocols. *Biol Trace Elem Res* 2008;124:1–11.
- Potani I, Spiegel-Feld C, Brixi G, et al. Ready-To-Use therapeutic food (RUTF) containing low or no dairy compared to standard RUTF for children with severe acute malnutrition: a systematic review and meta-analysis. *Adv Nutr* 2021;12:1930–43.
- Schoones A, Lombard MJ, Musekiwa A, et al. Ready-To-Use therapeutic food (RUTF) for home-based nutritional rehabilitation of severe acute malnutrition in children from six months to five years of age. *Cochrane Database Syst Rev* 2019;5:CD009000.
- Shokry E, Sadiq K, Soofi S, et al. Impact of treatment with RUTF on plasma lipid profiles of severely malnourished Pakistani children. *Nutrients* 2020;12. doi:10.3390/nu12072163. [Epub ahead of print: 21 Jul 2020].
- Akomo P, Bahwere P, Murakami H, et al. Soya, maize and sorghum ready-to-use therapeutic foods are more effective in correcting anaemia and iron deficiency than the standard ready-to-use therapeutic food: randomized controlled trial. *BMC Public Health* 2019;19:806.
- Savadogo LGB, Zoetaba I, Ilboudo B, et al. Impact of anemia on mortality and nutritional recovery among hospitalized severely malnourished children in Burkina Faso. *Open Journal of Pediatrics* 2014;04:115–20.
- Thakur N, Chandra J, Pemde H, et al. Anemia in severe acute malnutrition. *Nutrition* 2014;30:440–2.
- Kangas ST, Salpéteur C, Nikiéma V, et al. Vitamin A and iron status of children before and after treatment of uncomplicated severe acute malnutrition. *Clin Nutr* 2020;39:3512–9.
- Babirekere-Iriso E, Mortensen CG, Mupere E, et al. Changes in whole-blood PUFA and their predictors during recovery from severe acute malnutrition. *Br J Nutr* 2016;115:1730–9.
- Jones KDJ, Ali R, Khasira MA, et al. Ready-To-Use therapeutic food with elevated n-3 polyunsaturated fatty acid content, with or without fish oil, to treat severe acute malnutrition: a randomized controlled trial. *BMC Med* 2015;13:93.
- Lopriore C, Guidoum Y, Briend A, et al. Spread fortified with vitamins and minerals induces catch-up growth and eradicates severe anemia in stunted refugee children aged 3–6 Y. *Am J Clin Nutr* 2004;80:973–81.
- Bahwere P, Balaluka B, Wells JCK, et al. Cereals and pulse-based ready-to-use therapeutic food as an alternative to the standard milk- and peanut paste-based formulation for treating severe acute malnutrition: a noninferiority, individually randomized controlled efficacy clinical trial. *Am J Clin Nutr* 2016;103:1145–61.
- Soofi S, Cousens S, Iqbal SP, et al. Effect of provision of daily zinc and iron with several micronutrients on growth and morbidity among young children in Pakistan: a cluster-randomised trial. *Lancet* 2013;382:29–40.
- Paganini D, Zimmermann MB. The effects of iron fortification and supplementation on the gut microbiome and diarrhea in infants and children: a review. *Am J Clin Nutr* 2017;106:1688S–93.
- Sazawal S, Black RE, Ramsan M, et al. Effects of routine prophylactic supplementation with iron and folic acid on admission to hospital and mortality in preschool children in a high malaria transmission setting: community-based, randomised, placebo-controlled trial. *Lancet* 2006;367:133–43.
- Irena AH, Bahwere P, Owino VO, et al. Comparison of the effectiveness of a milk-free soy-maize-sorghum-based ready-to-use therapeutic food to standard ready-to-use therapeutic food with 25% milk in nutrition management of severely acutely malnourished Zambian children: an equivalence non-blinded cluster randomised controlled trial. *Matern Child Nutr* 2015;11 Suppl 4:105–19.
- Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71.
- WHO. *Management of severe malnutrition: a manual for physicians and other senior health workers*, 1999.
- Covidence systematic review software vhi, Melbourne, Australia. Available: www.covidence.org
- Sterne JA, Hernán MA, Reeves BC, et al. ROBINS-I: a tool for assessing risk of bias in non-randomised studies of interventions. *BMJ* 2016;355:i4919.
- Sterne JAC, Savović J, Page MJ, et al. Rob 2: a revised tool for assessing risk of bias in randomised trials. *BMJ* 2019;366:i4898.
- Review Manager (RevMan) [Computer program]. Version 5.3. Copenhagen: The Nordic Cochrane Centre TCC. Version 5.3. Copenhagen: The Nordic Cochrane Centre, The Cochrane Collaboration. 2014.
- GRADEpro GDT: GRADEpro Guideline Development Tool [Software]. McMaster University, 2020 (developed by Evidence Prime, Inc.). Available from grade.pro.org.
- Guyatt G, Oxman AD, Akl EA, et al. Grade guidelines: 1. Introduction-Grade evidence profiles and summary of findings tables. *J Clin Epidemiol* 2011;64:383–94.
- Higgins JPT, Cumpston M. *Cochrane Handbook for systematic reviews of interventions* version 6.2, 2021. Available: <https://training.cochrane.org/handbook/PDF/v6.2>
- (EPOC) CEPaOoC. What study designs can be considered for inclusion in an EPOC review and what should they be called? 2021. Available: <https://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/EPOC%20Study%20Designs%20About.pdf>

Appendix 1: Search strategies for different electronic databases

PubMed

("Iron"[MeSH Terms] OR "iron, dietary"[MeSH Terms] OR "Iron"[Title/Abstract] OR "56Fe"[Title/Abstract] OR "Fe"[Title/Abstract] OR "ferro"[Title/Abstract] OR "ferrum"[Title/Abstract]) AND ("food, formulated"[MeSH Terms] OR "food, fortified"[MeSH Terms] OR "RUTF"[Title/Abstract] OR "RUTFs"[Title/Abstract] OR "ready to use therapeutic food*"[Title/Abstract] OR "ready to use therapeutic feed*"[Title/Abstract] OR "therapeutic food*"[Title/Abstract] OR "therapeutic diet*"[Title/Abstract] OR "enriched food*"[Title/Abstract] OR "enriched diet*"[Title/Abstract] OR "fortified food*"[Title/Abstract] OR "fortified diet*"[Title/Abstract] OR "supplemented food*"[Title/Abstract] OR "supplemental food*"[Title/Abstract] OR "supplementary food*"[Title/Abstract] OR "supplement food*"[Title/Abstract] OR "supplemented diet*"[Title/Abstract] OR "supplemental diet*"[Title/Abstract] OR "supplementary diet*"[Title/Abstract] OR "supplement diet*"[Title/Abstract] OR "RUSF"[Title/Abstract] OR "RUSFs"[Title/Abstract] OR "ready to use supplemental food*"[Title/Abstract] OR "ready to use supplementary food*"[Title/Abstract] OR "lipid based nutrient supplement*"[Title/Abstract] OR "LNS"[Title/Abstract]) AND ("Severe Acute Malnutrition"[MeSH Terms] OR "Malnutrition"[MeSH Terms] OR "Cachexia"[MeSH Terms] OR "Wasting Syndrome"[MeSH Terms] OR "Severe Acute Malnutrition"[Title/Abstract] OR "SAM"[Title/Abstract] OR "Malnutrition"[Title/Abstract] OR "malnourish*"[Title/Abstract] OR "Cachexia"[Title/Abstract] OR "nutritional deficien*"[Title/Abstract] OR "undernutrition"[Title/Abstract] OR "deficient nutrition"[Title/Abstract] OR "undernourish*"[Title/Abstract] OR "wasting"[Title/Abstract] OR "wasted"[Title/Abstract]) AND ("Infant"[MeSH Terms] OR "Child"[MeSH Terms] OR "infant*"[Title/Abstract] OR "infancy"[Title/Abstract] OR "baby"[Title/Abstract] OR "babies"[Title/Abstract] OR "newborn*"[Title/Abstract] OR "neonat*"[Title/Abstract] OR "neo nat*"[Title/Abstract] OR "child*"[Title/Abstract] OR "toddler*"[Title/Abstract] OR "youth"[Title/Abstract] OR "juvenile*"[Title/Abstract] OR "girl*"[Title/Abstract] OR "boy"[Title/Abstract] OR "boys"[Title/Abstract] OR "preschool*"[Title/Abstract] OR "pre school*"[Title/Abstract])

CINAHL

S1 (MH "Infant+")

S2 (MH "Child+")

S3 TI (infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR "neo nat*" OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR "preschool*")

S4 AB (infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR "neo nat*" OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR "preschool*")

S5 S1 OR S2 OR S3 OR S4

S6 (MH "Iron")

S7 TI (iron OR 56Fe OR Fe OR ferro OR ferrum)

S8 AB (iron OR 56Fe OR Fe OR Ferro OR ferrum)

S9 S6 OR S7 OR S8

S10 (MH "Food, Formulated")

S11 (MH "Food, Fortified")

S12 TI (RUTF OR RUTFs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR RUSF OR RUSFs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid-based nutrient supplement*" OR LNS)

S13 AB (RUTF OR RUTFs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR RUSF OR RUSFs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid-based nutrient supplement*" OR LNS)

S14 TI((enriched OR fortified OR supplement* OR therapeutic) W1 (food* OR diet*))

S15 AB((enriched OR fortified OR supplement* OR therapeutic) W1 (food* OR diet*))

S16 S10 OR S11 OR S12 OR S13 OR S14 OR S15

S17 (MH "Cachexia")

S18 (MH "Malnutrition")

S19 (MH "Wasting Syndrome")

S20 TI ("Severe Acute Malnutrition" OR SAM OR Malnutrition OR malnourish* OR Cachexia OR undernutrition OR undernourish* OR wasting OR wasted)
 S21 AB ("Severe Acute Malnutrition" OR SAM OR Malnutrition OR malnourish* OR Cachexia OR undernutrition OR undernourish* OR wasting OR wasted)
 S22 TI (nutrition* N1 deficien*)
 S23 AB (nutrition* N1 deficien*)
 S24 S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23
 S25 S5 AND S9 AND S16 AND S24
 S26 S25 Exclude MEDLINE records

Embase

#1 'iron'/exp OR 'iron intake'/exp
 #2 iron:ti,ab OR 56fe:ti,ab OR fe:ti,ab OR ferro:ti,ab OR ferrum:ti,ab
 #3 #1 OR #2
 #4 'ready to use therapeutic food'/exp OR 'fortified food'/exp OR 'ready to use supplementary food'/exp OR 'lipid based nutrient supplement'/exp OR 'dietary supplement'/exp
 #5 ((enriched OR fortified OR supplement* OR therapeutic) NEXT/1 (food* OR diet*)):ti,ab
 #6 rutf:ti,ab OR rutfs:ti,ab OR 'ready to use therapeutic food*':ti,ab OR 'ready to use therapeutic feed*':ti,ab OR rusf:ti,ab OR rusfs:ti,ab OR 'ready to use supplemental food*':ti,ab OR 'ready to use supplementary food*':ti,ab OR 'lipid based nutrient supplement*':ti,ab OR lns:ti,ab
 #7 #4 OR #5 OR #6
 #8 'malnutrition'/exp OR 'wasting syndrome'/exp OR 'cachexia'/exp
 #9 (nutrition* NEAR/1 deficien*):ti,ab
 #10 'severe acute malnutrition':ti,ab OR sam:ti,ab OR malnutrition:ti,ab OR malnourish*:ti,ab OR cachexia:ti,ab OR undernutrition:ti,ab OR undernourish*:ti,ab OR wasting:ti,ab OR wasted:ti,ab
 #11 #8 OR #9 OR #10
 #12 'infant'/exp OR 'infancy'/exp OR 'baby'/exp OR 'newborn'/exp OR 'toddler'/exp OR 'child'/exp OR 'preschool child'/exp OR 'juvenile'/exp OR 'girl'/exp OR 'boy'/exp
 #13 infant*:ti,ab OR infancy:ti,ab OR baby:ti,ab OR babies:ti,ab OR newborn*:ti,ab OR neonat*:ti,ab OR neo nat*:ti,ab OR child*:ti,ab OR toddler*:ti,ab OR youth:ti,ab OR juvenile*:ti,ab OR girl*:ti,ab OR boy:ti,ab OR boys:ti,ab OR preschool*:ti,ab OR 'pre school*':ti,ab
 #14 #12 OR #13
 #15 #3 AND #7 AND #11 AND #14
 #16 #15 NOT [medline]/lim

SCOPUS

(TITLE-ABS (iron OR 56fe OR fe OR Ferro OR ferrum)) AND ((TITLE-ABS (enriched OR fortified OR supplement* OR therapeutic) PRE/1 TITLE-ABS (food* OR diet*)) OR (TITLE-ABS (rutf OR rutfs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR rusf OR rusfs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid-based nutrient supplement*" OR lns))) AND ((TITLE-ABS (nutrition* W/1 deficien*)) OR (TITLE-ABS ("Severe Acute Malnutrition" OR sam OR malnutrition OR malnourish* OR cachexia OR undernutrition OR undernourish* OR wasting OR wasted))) AND (TITLE-ABS (infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR neo-nat* OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR pre-school*)) AND NOT INDEX (Medline)

CENTRAL

#1 MeSH descriptor: [Iron] in all MeSH products
 #2 MeSH descriptor: [Iron, Dietary] explode all trees
 #3 Iron:ti,ab OR 56Fe:ti,ab OR Fe:ti,ab OR ferro:ti,ab OR ferrum:ti,ab
 #4 #1 OR #2 OR #3
 #5 MeSH descriptor: [Food, Formulated] explode all trees
 #6 MeSH descriptor: [Food, Fortified] explode all trees
 #7 ((enriched OR fortified OR supplement* OR therapeutic) NEXT (food* OR diet*)):ti,ab

#8 (ready NEXT to NEXT use NEXT therapeutic NEXT food*):ti,ab
 #9 (ready NEXT to NEXT use NEXT therapeutic NEXT feed*):ti,ab
 #10 (ready NEXT to NEXT use NEXT supplemental NEXT food*):ti,ab
 #11 (ready NEXT to NEXT use NEXT supplementary NEXT food*):ti,ab
 #12 (lipid NEXT based NEXT nutrient NEXT supplement*):ti,ab
 #13 rutf:ti,ab OR rutf:ti,ab OR rusf:ti,ab OR rusfs:ti,ab OR lns:ti,ab
 #14 #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13
 #15 MeSH descriptor: [Severe Acute Malnutrition] explode all trees
 #16 MeSH descriptor: [Malnutrition] explode all trees
 #17 MeSH descriptor: [Cachexia] explode all trees
 #18 MeSH descriptor: [Wasting Syndrome] explode all trees
 #19 (nutrition* NEAR/1 deficient*):ti,ab
 #20 (severe NEXT acute NEXT malnutrition):ti,ab
 #21 sam:ti,ab OR malnutrition:ti,ab OR malnourish*:ti,ab OR cachexia:ti,ab OR undernutrition:ti,ab OR undernourish*:ti,ab OR wasting:ti,ab OR wasted:ti,ab
 #22 #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21
 #23 MeSH descriptor: [Infant] explode all trees
 #24 MeSH descriptor: [Child] explode all trees
 #25 infant*:ti,ab OR infancy:ti,ab OR baby:ti,ab OR babies:ti,ab OR newborn*:ti,ab OR neonat*:ti,ab OR neo NEXT nat*:ti,ab OR child*:ti,ab OR toddler*:ti,ab OR youth:ti,ab OR juvenile*:ti,ab OR girl*:ti,ab OR boy:ti,ab OR boys:ti,ab OR preschool*:ti,ab OR pre NEXT school*:ti,ab
 #26 #23 OR #24 OR #25
 #27 #4 AND #14 AND #22 AND #26
 #28 "accession number" near pubmed
 #29 #27 NOT #28

Web of Science

#1 TI=(iron OR 56fe OR fe OR ferro OR ferrum)
 #2 AB=(iron OR 56fe OR fe OR ferro OR ferrum)
 #3 #1 OR #2
 #4 TI=(RUTF OR RUTFs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR "therapeutic food*" OR "therapeutic diet*" OR "enriched food*" OR "enriched diet*" OR "fortified food*" OR "fortified diet*" OR "supplemented food*" OR "supplemental food*" OR "supplementary food*" OR "supplement food*" OR "supplemented diet*" OR "supplemental diet*" OR "supplementary diet*" OR "supplement diet*" OR RUSF OR RUSFs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid based nutrient supplement*" OR LNS)
 #5 AB=(RUTF OR RUTFs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR "therapeutic food*" OR "therapeutic diet*" OR "enriched food*" OR "enriched diet*" OR "fortified food*" OR "fortified diet*" OR "supplemented food*" OR "supplemental food*" OR "supplementary food*" OR "supplement food*" OR "supplemented diet*" OR "supplemental diet*" OR "supplementary diet*" OR "supplement diet*" OR RUSF OR RUSFs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid based nutrient supplement*" OR LNS)
 #6 #4 OR #5
 #7 TI=(nutrition* NEAR/1 deficient*)
 #8 AB=(nutrition* NEAR/1 deficient*)
 #9 TI=("Severe Acute Malnutrition" OR sam OR malnutrition OR malnourish* OR cachexia OR undernutrition OR undernourish* OR wasting OR wasted)
 #10 AB=("Severe Acute Malnutrition" OR sam OR malnutrition OR malnourish* OR cachexia OR undernutrition OR undernourish* OR wasting OR wasted)
 #11 #7 OR #8 OR #9 OR #10
 #12 TI=(infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR "neo nat*" OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR "pre school*")

#13 AB=(infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR "neo nat*" OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR "pre school*")

#14 #12 OR #13

#15 #3 AND #6 AND #11 AND #14

LILACS

((mh:("Iron")) OR ((mh:("iron, dietary"))) OR ((ti:(iron OR 56fe OR fe OR ferro OR ferrum))) OR ((ab:(iron OR 56fe OR fe OR ferro OR ferrum))) AND ((mh:("food, formulated")) OR ((mh:("food, fortified"))) OR ((ti:(rutf OR rutfs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR "therapeutic food*" OR "therapeutic diet*" OR "enriched food*" OR "enriched diet*" OR "fortified food*" OR "fortified diet*" OR "supplemented food*" OR "supplemental food*" OR "supplementary food*" OR "supplement food*" OR "supplemented diet*" OR "supplemental diet*" OR "supplementary diet*" OR "supplement diet*" OR rusf OR rusfs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid based nutrient supplement*" OR lns))) OR ((ab:(rutf OR rutfs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR "therapeutic food*" OR "therapeutic diet*" OR "enriched food*" OR "enriched diet*" OR "fortified food*" OR "fortified diet*" OR "supplemented food*" OR "supplemental food*" OR "supplementary food*" OR "supplement food*" OR "supplemented diet*" OR "supplemental diet*" OR "supplementary diet*" OR "supplement diet*" OR rusf OR rusfs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid based nutrient supplement*" OR lns)))) AND ((mh:("Severe Acute Malnutrition")) OR ((mh:("Malnutrition"))) OR ((mh:("cachexia"))) OR ((mh:("wasting syndrome"))) OR ((ti:("Severe Acute Malnutrition" OR sam OR malnutrition OR malnourish* OR cachexia OR "nutritional deficien*" OR undernutrition OR "deficient nutrition" OR undernourish* OR wasting OR wasted))) OR ((ab:("Severe Acute Malnutrition" OR sam OR malnutrition OR malnourish* OR cachexia OR "nutritional deficien*" OR undernutrition OR "deficient nutrition" OR undernourish* OR wasting OR wasted)))) AND ((mh:(infant)) OR ((mh:(child))) OR ((ti:(infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR "neo nat*" OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR "pre school*")) OR ((ab:(infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR "neo nat*" OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR "pre school*")))) AND (db:("LILACS"))

Global Index Medicus

((mh:("Iron")) OR ((mh:("iron, dietary"))) OR ((ti:(iron OR 56fe OR fe OR ferro OR ferrum))) OR ((ab:(iron OR 56fe OR fe OR ferro OR ferrum))) AND ((mh:("food, formulated")) OR ((mh:("food, fortified"))) OR ((ti:(rutf OR rutfs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR "therapeutic food*" OR "therapeutic diet*" OR "enriched food*" OR "enriched diet*" OR "fortified food*" OR "fortified diet*" OR "supplemented food*" OR "supplemental food*" OR "supplementary food*" OR "supplement food*" OR "supplemented diet*" OR "supplemental diet*" OR "supplementary diet*" OR "supplement diet*" OR rusf OR rusfs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid based nutrient supplement*" OR lns))) OR ((ab:(rutf OR rutfs OR "ready to use therapeutic food*" OR "ready to use therapeutic feed*" OR "therapeutic food*" OR "therapeutic diet*" OR "enriched food*" OR "enriched diet*" OR "fortified food*" OR "fortified diet*" OR "supplemented food*" OR "supplemental food*" OR "supplementary food*" OR "supplement food*" OR "supplemented diet*" OR "supplemental diet*" OR "supplementary diet*" OR "supplement diet*" OR rusf OR rusfs OR "ready to use supplemental food*" OR "ready to use supplementary food*" OR "lipid based nutrient supplement*" OR lns)))) AND ((mh:("Severe Acute Malnutrition")) OR ((mh:("Malnutrition"))) OR ((mh:("cachexia"))) OR ((mh:("wasting syndrome"))) OR ((ti:("Severe Acute Malnutrition" OR sam OR malnutrition OR malnourish* OR cachexia OR "nutritional deficien*" OR undernutrition OR "deficient nutrition" OR undernourish* OR wasting OR wasted))) OR ((ab:("Severe Acute Malnutrition" OR sam OR malnutrition OR malnourish* OR cachexia OR "nutritional deficien*" OR undernutrition OR "deficient nutrition" OR undernourish* OR wasting OR wasted)))) AND ((mh:(infant)) OR ((mh:(child))) OR ((ti:(infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR "neo nat*" OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR "pre school*")) OR ((ab:(infant* OR infancy OR baby OR babies OR newborn* OR neonat* OR "neo nat*" OR child* OR toddler* OR youth OR juvenile* OR girl* OR boy OR boys OR preschool* OR "pre school*")))) AND (collection_gim:("IMSEAR" OR "IMEMR" OR "WPRIM"))

Author	Publication year	Name of Data Extractor	Form: conference abstract only (1), journal publication (2), multiple publications of the same trial (3)	Study Design	Study Setting		Population
					Country	Year(s) of Data Collection	Description of Participants Inclusion Criteria

Exclusion Criteria	% Female (N) (Give for total study population)

	Macronutrient composition of RUTF in the intervention group		Iron dose/100g of RUTF in the experimental group	Zinc dose/100 mg of RUTF in the experimental group	Frequency of RUTF (packets per day)
Total number of eligible participants in all the study groups					

Duration of intervention RUTF (How many days of intervention was given)	Characteristic of comparison		Study confounders		What outcome did authors report	Notes
	Standard RUTF? (Yes or No)	Iron content in Standard RUTF (Normal dose is 10-14 mg/100 g)	Were results adjusted for confounders? (Y/N) (Fill only for observational studies)	What confounders were considered?		

Study (name, year)	Hemoglobin at longest follow up		
	No of events in interventional RUTF	Total number in interventional RUTF	number of events in control RUTF group

	Summary estimate of intervention RUTF vs. Standard RUTF (OR, RR, HR)		Intervention
number of participants in control RUTF group	notes	notes	Mean

RUTF		Control RUTF		Intervention in RUTF	
SD	Number in F	Mean	SD	Number in t	median IQR



Number in ζ Median IQR Number in η

Summary estimate (mean difference or Standardized mean difference)

group

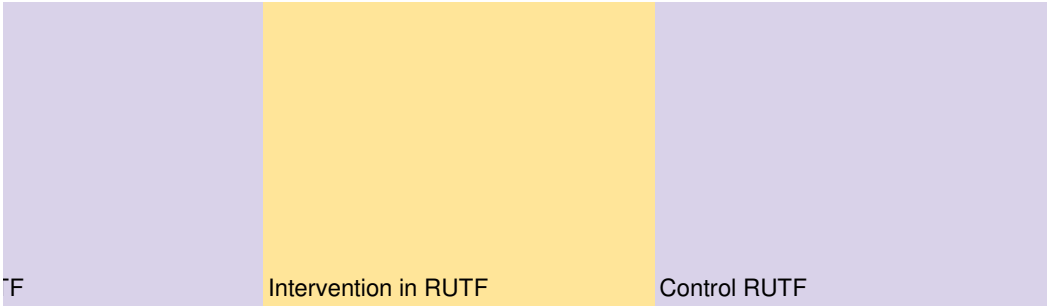
Notes

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1		Anemia at longest follow up				Summary estimate of intervention RUTP vs. Standard RUTP (OR, 95% CI)		Intervention RUTP			Control RUTP			Intervention in RUTP		
2	Study design, report	No of events in interventional RUTP	RUTP	control RUTP group	RUTP group	notes	notes	Mean	SD	RUTP	Mean	SD	control RUTP	Median	IQR	group

	Q	R	S	T
1	Control RUTP			Summary estimate (mean difference or standardised mean difference)
2				
	Median	Q1	IQR	

Study (name, year)			
	Iron deficiency anemia at longest follow up		
	No of events in interventional RUTF	Total number in interventional RUTF	number of events in control RUTF group

	Summary estimate of intervention on RUTF vs. Standard RUTF (OR, RR, HR)		Intervention RUTF				Control RUT
number of participants in control RUTF group	notes	notes	Mean	SD	Number in RUTF interventional group	Mean	



SD	Number in the control RUTF group	median	IQR	Number in group	Median	IQR	Number in group

Summary estimate (mean difference or
Standardized mean difference)



Study (name, year)	SAM Recovery at longest follow up				Summary estimate of intervention RUTF vs. Standard RUTF (OR, RR, HR)	
	No of events in interventional RUTF	Total number in interventional RUTF	number of events in control RUTF group	number of participants in control RUTF group	notes	notes

Study (name, year)	Adverse effects at longest follow up				Summary estimate of intervention RUTF vs. Standard RUTF (OR, RR, HR)
	No of events in interventional RUTF	Total number in interventional RUTF	number of events in control RUTF group	number of participants in control RUTF group	notes

notes

Study (name, year)	Adverse effects at longest follow up				Summary estimate of interventio n RUTF vs. Standard RUTF (OR, RR, HR)	
	No of events in intervention al RUTF	Total number in intervention al RUTF	number of events in control RUTF group	number of participants in control RUTF group	notes	notes

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Study Name	Intervention RUTF			Control RUTF			Intervention in RUTF			Control RUTF			Summary esti
2		Mean	SD	Number in RUTF inter	Mean	SD	Number in the	median	IQR	Number in gro	Median	IQR	Number in group	
3														
4														

Study (name, year)	Adverse effects at longest follow up				Summary estimate of interventio n RUTF vs. Standard RUTF (OR, RR, HR)	
	No of events in intervention al RUTF	Total number in intervention al RUTF	number of events in control RUTF group	number of participants in control RUTF group	notes	notes

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T		
1	Study ID (Last name and year) Z scores								Kg							Change in weight (Kg) or Z scores						
2	Intervention				Control				Intervention				Control				Intervention				Control	
3	Mean		SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		
4																						
5																						

	U
1	Comments
2	
3	
4	
5	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T		
1	Study ID (Last name and year)								Kg							Change in weight (Kg) or Z scores						
2	Intervention				Control				Intervention				Control				Intervention				Control	
3	Mean		SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		
4																						
5																						

	U
1	Comments
2	
3	
4	
5	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	Study ID, last name and year								Centimeters						Change in height (cm) or Z score						Comments
2																					
3	Intervention				Control				Intervention				Control				Intervention				Control
4		Mean	SD	Number in group	Mean	SD	Number in group		Mean	SD	Number in group	Mean	SD	Number in group	Mean	SD	Number in group	Mean	SD	Number in group	
5																					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T					
1	Study ID (Last name and year)								Z scores							Centimeters					Change in height (cm) or Z scores				
2	Intervention				Control				Intervention				Control				Intervention				Control				
3		Mean	SD		Number in group	Mean	SD		Number in group	Mean	SD		Number in group	Mean	SD		Number in group	Mean	SD		Number in group				
4																									
5																									

	U
1	Comments
2	
3	
4	
5	
6	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T						
1	Study ID, last name and year								Z scores						Centimeters						Change in height (cm) or Z scores					
2																										
3																										
4																										
5																										
6																										
7																										
8																										
9																										
10																										
11																										
12																										
13																										
14																										
15																										
16																										
17																										
18																										
19																										
20																										
21																										
22																										
23																										
24																										
25																										
26																										
27																										
28																										
29																										
30																										
31																										
32																										
33																										
34																										
35																										
36																										
37																										
38																										
39																										
40																										
41																										
42																										
43																										
44																										
45																										
46																										
47																										
48																										
49																										
50																										
<																										

	U
	Comments
U	
U	
U	
U	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T					
1	Study ID, last name and year	Z scores								Risk				Change in BMR or Z scores											
2		Intervention				Control				Intervention				Control				Intervention				Control			
3		Mean	SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group		Mean	SD	Number in group	
4																									
5																									

	U
	Comments
U	
U	
U	
U	

Study ID (Last name and year)	Z scores			BMI			Change in BMI or Z scores			Comments					
	Intervention			Control			Intervention				Control				
	Mean	SD	Number in gro	Mean	SD	Number in gro	Mean	SD	Number in gro	Mean	SD	Number in gro	Mean	SD	Number in group

Study ID (Last name and year)	Z scores			BMI			Change in BMI or Z scores			Comments					
	Intervention			Control			Intervention				Control				
	Mean	SD	Number in gro	Mean	SD	Number in gro	Mean	SD	Number in gro	Mean	SD	Number in gro	Mean	SD	Number in group