Triple fortification of salt with microcapsules of iodine, iron, and vitamin A¹–³

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ABSTRACT

Background: In many developing countries, children are at high risk of goiter, vitamin A deficiency, and iron deficiency anemia.

Objective: We aimed to develop a stable, efficacious salt fortified with iodine, iron, and vitamin A.

Design: A novel spray-cooling technique was used with hydrogenated palm oil to package potassium iodate, micronized ferric pyrophosphate, and retinyl palmitate into microcapsules (mean particle size: 100 μm). We used the microcapsules to create triple-fortified salt (TFS) with 30 μg I, 2 mg Fe, and 60 μg vitamin A/g salt. After storage trials, we compared the efficacy of TFS with that of iodized salt in a 10-mo, randomized, double-blind trial in goitrous schoolchildren (n = 157) who had a high prevalence of vitamin A deficiency and iron deficiency anemia.

Results: After storage for 6 mo, losses of iodine and vitamin A from the TFS were ±12–15%, and color was stable. In the TFS group, mean hemoglobin increased by 15 g/L at 10 mo (P < 0.01), iron status indexes and body iron stores improved significantly (P < 0.05), and mean serum retinol, retinol-binding protein, and the ratio of retinol-binding protein to prealbumin increased significantly (P < 0.01). At 10 mo, prevalences of vitamin A deficiency and iron deficiency anemia were significantly lower in the TFS group than in the iodized salt group (P < 0.001).

Conclusion: Newly developed microcapsules containing iodine, iron, and vitamin A are highly stable when added to local African salt. TFS was efficacious in reducing the prevalence of iron, iodine, and vitamin A deficiencies in school-age children. Am J Clin Nutr 2004;80:1283–90.

KEY WORDS Iodine, iron, vitamin A, deficiency, triple fortification, salt, anemia, goiter, children, Morocco

INTRODUCTION

Iron deficiency anemia (IDA), vitamin A deficiency (VAD), and the iodine deficiency disorders (IDD) affect >30% of the world’s population (1, 2). These deficiencies often coexist in children in developing countries (3, 4). IDA interferes with the thyroidal metabolism of iodine and may reduce the efficacy of iodine prophylaxis (3). VAD may impair iron metabolism and aggravate anemia (5). In Africa, universal salt iodization is effective against IDD (6), but the control of IDA and VAD on a national scale remains a challenge (7, 8). Finding suitable vehicles for fortification with iron and vitamin A in rural Africa is difficult. Salt may be such a vehicle, particularly in poor areas of subsistence farming, where salt is one of very few regularly purchased food items (4, 9). Triple fortification of salt could be highly effective because of the beneficial interactions of iron, iodine, and vitamin A in metabolism (5, 10, 11). The addition of all 3 micronutrients to a single foodstuff might cost less than separate fortification programs.

However, ensuring the bioavailability of iron and the stability of iodine and vitamin A in fortified salt is difficult. Water-soluble iron compounds—the compounds in which the iron is most bioavailable—react with moisture and impurities in salt, and that causes unacceptable changes in color (12, 13). In the presence of ferrous iron and moisture, losses of iodine and vitamin A from a fortified salt would be high (14, 15). Ferric pyrophosphate (FePP) is a poorly soluble iron compound that is white; its addition to salt produces negligible color change or iodine loss in low-grade salt (14). Although most commercial forms of FePP with mean particle sizes ≥ 10 μm have low relative bioavailability (7), a smaller particle size increases the absorption of FePP (16).

Encapsulation can reduce iron-mediated color change in fortified salt (4) and may increase the stability of iodine and vitamin A. Mannar and Diosady (13) reported that iodine stability in salt significantly increased when potassium iodide was coated with maltodextrin. Encapsulation of vitamin A increases its stability in salt (15) and may allow the use of a less expensive form of vitamin A than that typically used to fortify dry mixes (17). Encapsulation of iron in hydrogenated oils at substrate-to-capsule ratios of ≥ 50:50 is not likely to compromise bioavailability (4, 18). Zlotkin et al (19) showed the efficacy of microencapsulated ferrous fumarate plus ascorbic acid supplied as sprinkles to weaning foods.

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Received April 2, 2004.
Accepted for publication June 3, 2004.
IDA, VAD, and IDD are common in rural Morocco (4, 20, 21), and salt is regularly consumed there at a rate of 5–15 g/d (4). To develop a TFS for this region, we used a novel spray-cooling process to encapsulate FePP, potassium iodate, and retinyl palmitate in hydrogenated oil in a single processing step. To set the fortification level of the TFS, we measured salt, vitamin A, and iron intakes from the local diet. We then tested the stability and acceptability of our TFS and its sensory effects in local meals. Finally, we compared the efficacy of the TFS to that of iodized salt (IS) in a randomized double-blind trial in schoolchildren.

SUBJECTS AND METHODS

The study was done in villages in the Rif Mountains of northern Morocco, an area of endemic goiter (20). The villages are 500–600 m above sea level and have a temperate climate, with an 8-mo dry season (temperature range: 22–34 °C; x rainfall: 23 cm/mo), and a 4-mo damp season (temperature range: 10–22 °C; x rainfall: 77 cm/mo). The population is of mixed Berber and Arab descent. This region is isolated from commercial routes, >95% of the population is rural, and most available food is produced locally on small farms (22).

Measurement of salt consumption, iron and vitamin A intakes, and iron bioavailability

To establish the optimal fortification level for the TFS, we needed to know local salt, vitamin A, and iron intakes and the estimated bioavailability of iron from the diet. Three-day weighed food records were kept in 50 households randomly selected from local census rolls. Households were asked to continue with their usual food choices and their traditional ways of cooking and serving foods. To account for seasonal variations, 24 households were studied in the damp season and 26 in the dry season. Over 3 consecutive days, edible portions of all foods and beverages consumed were weighed on a Kern 440–53 scale (Kern & Sohn GmbH, Albstadt, Germany) that is accurate to ± 1 g.

In this region, meals consist of 1 or 2 dishes placed in the center of the table, from which all family members eat with their hands. We therefore estimated individual food consumption by using the unit of consumption (UC) formula of the Department of Agriculture of Morocco (22): for each male ≥14 y old, UC = 1.0; for each female ≥10 y old, UC = 0.8; and for each male <14 y old and each female <10 y old, UC = 0.3 + 0.05 × age, with age measured in years. Nutrient intakes were calculated from the food-composition table of the Moroccan Ministry of Agriculture (23) and from the Food and Agriculture Organization food-composition table for Africa (24). In addition, local legumes, cereals, and vegetables were directly analyzed for iron and phytic acid content. Dietary iron bioavailability was estimated by using the algorithms of Tseng et al (25) and Reddy et al (26) and adjusted for body iron stores (27). Vitamin A intakes were calculated as retinol activity equivalents (RAEs) by using a conversion factor of 12 µg β-carotene to 1 µg retinol for a mixed fruit-and-vegetable diet (28, 29).

Development of the iron, iodine, and vitamin A microcapsules

In our food engineering laboratory in Zürich, we used a newly developed, single-step, spray-cooling technique to build microcapsules containing iodine, iron, and vitamin A. The components were FePP that was micronized by being ground to a mean particle size of ≈2.5 µm (Dr Paul Lohmann, Emmenthal, Germany), potassium iodate (Riedel-de Haen, Hannover, Germany) that was micronized by being ground to a mean particle size of ≈6 µm (K8 Beadmill; Bühler, Uzwil, Switzerland), and vitamin A as liquid retinyl palmitate at 1.7 million IU/g, which was stabilized with 10 mg of butylated hydroxytoluene/1 million IU (BASF, Burgbernheim, Germany).

The 3 nutrients were coated with hydrogenated palm oil (Nutriswiss, Lyss, Switzerland) with a melting point of 63 °C and containing 1% lecithin (Loders Croklaan, Wormerveer, Holland). Palm oil was chosen over soybean oil because of palm oil’s higher melting point and lower cost and because of concerns about the acceptability of genetically modified soybeans.

To produce the microcapsules, a specifically designed, stainless-steel, cold-spraying tower (Schmidlin, Affoltern, Switzerland) and specifically modified two-phase nozzles were used. The palm oil was heated to 85 °C, and a suspension containing the 3 nutrients was made. The suspension was then passed through a screw pump (Scheerle, Stockborn, Germany), atomized with the use of air as the second medium, and cooled with the use of partially evaporated liquid nitrogen (15, 30).

The smooth, spherical capsules are 40% substrate and 60% capsule and have a mean particle size of ≈100 µm. The microcapsule characteristics were chosen to 1) achieve sufficiently high attraction-interaction forces to reduce segregation when the microcapsules were mixed with larger salt grains (1 local salt grain size: ≈1.5 mm); 2) optimize handling of the product; 3) adjust the kinetics of the release of the micronutrients from the capsules; and 4) maintain a ratio of surface to volume that was adequate to protect the nutrients. During the production of the compound, losses of vitamin A and iodine are ≈35% and 20%, respectively, because of oxidation during heating and spraying. These anticipated losses are compensated for by spraying at an iron:iodine:vitamin A ratio of 1 mg:15 µg:50 µg (an average) to achieve the final target ratio for fortification, ie, 1 mg:12 µg:≈30 µg.

Fortification of salt

One local cooperative supplies nearly all salt for the villages in the study; the salt is produced in drying ponds by using water from a salty spring. The salt (95.4% NaCl) is not washed or ground, and it has a milky-white color and an average grain size of ≈1.5 mm. Its moisture content is <1% during the dry season but 3–4% during the damp season. It contains 2.5% CaSO4, <0.1% MgSO4, and <2 ppm iodine. Although Morocco legislated mandatory salt iodization in 1997, financial constraints have not yet allowed this local cooperative to begin iodization. To prepare the IS, iodine was added as reagent-grade potassium iodate (Sigma & Aldrich, Buchs, Switzerland) at a concentration of 25 µg/g salt. The TFS was fortified at a concentration of 2 mg Fe, 25 µg I, and 60 µg vitamin A/g salt with the use of microcapsules. First, to prepare the IS and TFS, concentrated mixes were made by adding 840 mg KIO3 and 480-g microcapsules, respectively, to 2-kg salt batches with the use of a small, electric, rotating-drum mixer (MINI 80; Engelsmann, Ludwigshafen, Germany) at 26 rpm for 10 min. The 2-kg mixes were then added to 18-kg batches of salt by using a large, electric, rotating-drum mixer (ELTE 650; Engelsmann) at 30 rpm for 10 min.
emphasized that the new salt should be used for all cooking and central supply at the local health center. At baseline, the study salt was dispensed directly to the head of the household from a during the 10-mo study to supply all household needs. The household was provided with 2 kg salt at the beginning of each the basis of a per capita salt intake of 7–12 g/d and local census investigators and households were blind to group assignment. On iodine, iron, and vitamin A content at each monthly mixing. Both IS and TFS were prepared as described above. For monitoring, triple-fortified with 25

Sensory testing
To evaluate potential sensory changes in local foods, IS and TFS were added to meals prepared by local women in their kitchens. Each type of salt was added in parallel in identical

Acceptability testing
To judge the acceptability of TFS and IS after 10 mo of household salt use during the efficacy study, an interview was done in ≈50% of households in the IS (n = 41) and TFS (n = 30) groups. The female head of household, who was blind to group assignment, answered forced-choice questions on patterns of salt use, color and taste acceptability, and overall satisfaction with the salt (see Results).

Laboratory analyses
Whole blood was transported on ice to the local laboratory. Hemoglobin was measured in whole blood (refrigerated and measured on the same day as collection) with the use of an Acti
counter (Beckman Coulter, Krefeld, Germany). Anemia was defined as a hemoglobin concentration < 12 g/L in children aged ≥ 12 y and < 115 g/L in children aged 5–11 y (33). ZnPP was measured in washed red blood cells (refrigerated and mea

Stability testing
The IS and TFS were stored locally for 6 mo as 2-kg batches in closed low-density transparent polyethylene bags that were kept indoors and out of direct sunlight. A 6-mo study was done to approximate the time required for the production, distribution, and consumption of salt in this region. After storage for 0, 2, 4, and 6 mo, 30-g salt aliquots (n = 3) were taken for measurements of iodine concentration in the IS and TFS and of vitamin A concentration in the TFS. Color stability was determined by reflectance colorimetry as well as by panel visual inspection of unmarked samples side-by-side on white backgrounds.

Efficacy study
The subjects were children 6–14 y old from 2 neighboring primary schools. Informed written consent (or, if the parents were illiterate, oral consent) was obtained from the parents, and oral assent was obtained from the children. The Swiss Federal Institute of Technology in Zürich and the Ministry of Health in Rabat, Morocco, gave ethical approval for the study. All children in the 2 schools were invited to participate in the 10-mo study; all (n = 159) accepted and were enrolled. At baseline, weight and height were measured, and a spot urine sample was collected for measurement of urinary iodine (UI). Five milliliters of whole blood was collected by venipuncture for measurement of hemoglobin, serum ferritin (SF), whole-blood zinc protoporphyrin (ZnPP), serum transferrin receptor (sTfR), serum retinol (SR), retinol-binding protein (RBP), prealbumin (transthyretin; TTR), and C-reactive protein (CRP).

Because each participating family shared a monthly salt portion (see below), children were randomly divided by household into 2 groups. Group 1 (IS group) was given IS, ie, salt fortified with 25 μg I/g salt. Group 2 (TFS group) was given TFS, ie, salt triple-fortified with 25 μg I, 60 μg vitamin A, and 2 mg Fe/g salt. IS and TFS were prepared as described above. For monitoring, 30-g aliquots (n = 6) of the salts were taken and measured for iodine, iron, and vitamin A content at each monthly mixing. Both investigators and households were blind to group assignment. On the basis of a per capita salt intake of 7–12 g/d and local census data indicating an average of 7.5 members/household, each household was provided with 2 kg salt at the beginning of each mo during the 10-mo study to supply all household needs. The salt was dispensed directly to the head of the household from a central supply at the local health center. At baseline, the study was carefully explained to the participating families, and it was emphasized that the new salt should be used for all cooking and food preparation, as well as at the table. This message was reinforced at each of the monthly salt distributions. At 5 and 10 mo, all baseline measurements were repeated. After completion of the study, all remaining children with IDA or VAD were treated with oral iron [60 mg Fe (as ferrous sulfate) for 4 d/wk for 12 wk] or oral vitamin A (200 000 IU as a single dose; 32).

Color stability was determined by reflectance colorimetry as well as by panel visual inspection of unmarked samples side-by-side on white backgrounds.
TABLE 1
Color and iodine and vitamin A concentrations in the iodized salt (IS) and triple-fortified salt (TFS) at mixing and after 2, 4, and 6 mo of storage

<table>
<thead>
<tr>
<th>Length of storage (mo)</th>
<th>Lightness&lt;sup&gt;2&lt;/sup&gt;</th>
<th>ΔE&lt;sup&gt;3,4&lt;/sup&gt;</th>
<th>Iodine&lt;sup&gt;3&lt;/sup&gt;</th>
<th>Vitamin A&lt;sup&gt;5&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IS</td>
<td>TFS</td>
<td>IS</td>
<td>TFS</td>
</tr>
<tr>
<td></td>
<td>µg/g salt</td>
<td>µg/g salt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>80.9 ± 0.88</td>
<td>79.82 ± 0.26</td>
<td>0.88 ± 0.09</td>
<td>9.01 ± 1.05</td>
</tr>
<tr>
<td>2</td>
<td>80.3 ± 0.45</td>
<td>79.87 ± 0.31</td>
<td>1.28 ± 0.43</td>
<td>9.17 ± 0.07</td>
</tr>
<tr>
<td>4</td>
<td>80.7 ± 1.01</td>
<td>79.73 ± 0.38</td>
<td>0.96 ± 0.09</td>
<td>9.02 ± 0.28</td>
</tr>
<tr>
<td>6</td>
<td>80.3 ± 0.75</td>
<td>79.59 ± 0.11</td>
<td>1.34 ± 0.73</td>
<td>9.02 ± 0.52</td>
</tr>
</tbody>
</table>

<sup>1</sup> All values are ± SD.
<sup>2</sup> Lightness scale: 1 = black, 100 = white.
<sup>3</sup> ΔE, absolute color difference between TFS or IS and an IS reference sample.
<sup>4</sup> Significant main effect of fortification, P < 0.001 (ANOVA).
<sup>5</sup> Significant main effect of time, P < 0.001 (ANOVA).

RESULTS

Salt, iron, and vitamin A intakes and iron bioavailability

Fifty families comprising a total of 322 subjects (median age: 19 y; range: 2–74 y) kept the 3-d weighed food records. Mean (±SD) salt intake for adult males and females was 12.1 ± 2.9 g/d, respectively. For children aged 6–14 y, mean salt intake was 7.3–11.6 g/d, and mean iron intake was 9.2–14.5 mg/d, 97% of which was nonheme iron. Because the diet was high in phytic acid and low in ascorbic acid, estimated nonheme iron bioavailability was 1–4.3%. For children aged 6–8 y and 9–13 y, total vitamin A intakes were 206 ± 67 and 288 ± 71 µg RAE/d [ie, 48–52% of the recommended dietary allowance (28)], of which 69% came from retinol in animal foods and 31% from carotenoids from plant foods.

Stability and sensory testing

Color stability and the iodine and vitamin A content of the IS and TFS at 0, 2, 4, and 6 mo after mixing are shown in Table 1. Colorimetry showed no significant difference between IS and TFS in the L color value and no significant color change in the IS and TFS over 6 mo of storage. The ΔE of ≈9 is due to the slight difference in color between the TFS (light beige) and the IS (milky white). There was no significant difference between TFS and IS in iodine content during storage; both salts lost ≈15% of their iodine content after 6 mo. The TFS lost ≈12% of its vitamin A content after 6 mo. In the triangle testing that compared IS with TFS, there was no significant difference in color, odor, or taste (or all three) between the fortified salts in any of the traditional foods. Three of the foods tested — bread, charia, and couscous—were pale and mild-tasting.

Efficacy trial

The baseline characteristics of the children in the IS (n = 83) and TFS (n = 74) groups were age of 10.6 ± 2.4 and 10.4 ± 2.1 y, sex ratio (girls:boys) of 40:43 and 33:41, weight of 31.2 ± 9.9 and 29.4 ± 8.3 kg, and height of 1.34 ± 0.14 and 1.34 ± 0.12 m, respectively. Randomization at the household level was effective; there were no significant differences between groups in these baseline characteristics or in the other characteristics presented in Tables 2, 3, and 4. Of the 159 children who began the study, 157 completed it; 2 children in the TFS group moved away. In the monitoring of
TRIPLE FORTIFICATION OF SALT

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TABLE 2
Hemoglobin, transferrin receptor (TIR), zinc protoporphyrin (ZnPP), serum ferritin (SF), and body iron concentrations and the prevalence of iron deficiency anemia (IDA) in the iodized salt (IS) and triple-fortified salt (TFS) groups over 10 mo

<table>
<thead>
<tr>
<th>Time (mo)</th>
<th>Hemoglobin&lt;sup&gt;1&lt;/sup&gt;</th>
<th>TIR&lt;sup&gt;2&lt;/sup&gt;</th>
<th>ZnPP&lt;sup&gt;3&lt;/sup&gt;</th>
<th>SF&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Body iron&lt;sup&gt;5&lt;/sup&gt;</th>
<th>IDA&lt;sup&gt;6&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IS g/L TFS</td>
<td>IS mg/L TFS</td>
<td>IS µmol/mol heme TFS</td>
<td>IS µg/L TFS</td>
<td>IS mg/kg TFS</td>
<td>IS n (%)</td>
</tr>
<tr>
<td>0</td>
<td>116 ± 9&lt;sup&gt;7&lt;/sup&gt; 114 ± 9</td>
<td>7.5 ± 2.4 8.0 ± 3.4</td>
<td>50 ± 36 47 ± 27</td>
<td>15.2 (7.1, 25.9)&lt;sup&gt;8&lt;/sup&gt; 15.2 (7.0, 24.7)</td>
<td>1.23 ± 2.64 1.07 ± 2.95</td>
<td>28 (34) 23 (31)</td>
</tr>
<tr>
<td>5</td>
<td>116 ± 11 124 ± 12&lt;sup&gt;8&lt;/sup&gt; 7.0 ± 1.9 5.9 ± 1.5&lt;sup&gt;6&lt;/sup&gt;</td>
<td>49 ± 37 34 ± 20&lt;sup&gt;6&lt;/sup&gt;</td>
<td>19.0 (7.3, 38.2) 30.7 (11.9, 80.2)&lt;sup&gt;8&lt;/sup&gt;</td>
<td>2.21 ± 2.79&lt;sup&gt;5&lt;/sup&gt; 4.43 ± 2.25&lt;sup&gt;5&lt;/sup&gt;</td>
<td>23 (28) 5 (7)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>115 ± 8 129 ± 10&lt;sup&gt;8&lt;/sup&gt; 7.7 ± 2.4 5.8 ± 1.4&lt;sup&gt;6&lt;/sup&gt;</td>
<td>32 ± 35 27 ± 19&lt;sup&gt;8&lt;/sup&gt;</td>
<td>15.0 (6.9, 28.1) 31.2 (12.8, 79.9)&lt;sup&gt;8&lt;/sup&gt;</td>
<td>1.08 ± 3.10 4.69 ± 2.13&lt;sup&gt;5&lt;/sup&gt;</td>
<td>24 (29) 4 (5)</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> Significant treatment × time interaction, P < 0.001 (ANOVA).
<sup>2</sup> Significant difference between time-and-group model and time-only model, P < 0.001 (logistic regression).
<sup>3</sup> Reflects time (all such values).
<sup>4</sup> Geometric mean ± 1 SD and +1 SD in parentheses (all such values).
<sup>5</sup> Significantly different from baseline: <sup>5</sup> P < 0.05, <sup>7</sup> P < 0.01.
<sup>6</sup> Significant difference between time-and-group model and time-only model, <sup>5</sup> P < 0.05, <sup>7</sup> P < 0.01.

Aliquots of salt taken at the monthly mixings, the iron and vitamin A concentrations in the TFS group were 2.2 ± 0.8 mg and 64.4 ± 19.6 µg/g salt, respectively. The iodine concentrations in the IS and TFS groups were 22.9 ± 3.0 and 24.5 ± 4.2 µg/g salt, respectively. The prevalence of an elevated CRP was 4–6% in both groups at all timepoints, and there was no significant difference in mean CRP or in the prevalence of elevated CRP between groups (data not shown).

The changes in iron status are shown in Table 2. Mean hemoglobin at 10 mo was significantly greater in the TFS group than in the IS group (P < 0.01). All indexes of iron status (SF, TIR, and ZnPP) and body iron stores were significantly improved at 10 mo in the TFS group (P < 0.02). The changes in vitamin A nutrition during the study are shown in Table 3. Mean retinol, RBP, and RBP:TTR increased significantly in the TFS group (P < 0.01). At 10 mo, the prevalence of VAD and low vitamin A status was significantly lower in the TFS group than in the IS group (P < 0.001).

There were no significant differences in median UI between the groups throughout the study. The baseline median (range) UI in the IS and TFS groups was 12 (2–70) and 10 (4–127) µg/L, respectively, which indicated severe IDD (6). At 10 mo, the median (range) UI in the IS and TFS groups was 104 (22–1784) and 97 (23–927) µg/L, respectively. The median UI in both groups was significantly higher at 10 mo than at baseline (P < 0.0001), and it was near the WHO/International Council for the Control of the Iodine Deficiency Disorders cutoff (>100 µg/L) for iodine sufficiency (6).

Acceptability testing

The results of interviews done after 10 mo of household salt use are shown in Table 4. Both salts were universally used in both the IS and TFS households, and there were no significant differences in acceptability of salt color, salt taste in foods, and overall acceptability between groups. However, 16% of the IS and 32% of the TFS heads of households noted a slight color change in one or more foods (mainly egg and milk dishes) when the respective salts were added. These color changes were mild and sporadic and did not affect overall acceptability. In similar foods, color changes were not detected in the triangle sensory testing of IS and TFS done before the efficacy study.

DISCUSSION

To our knowledge, this is the first published report of successful triple fortification of salt with iron, iodine, and vitamin A. Several factors contributed to this success. First, because ferrous iron causes rapid color change and iodine losses when added to}

TABLE 3
Serum retinol and retinol-binding protein (RBP) concentrations, ratio of RBP to transcypretin (TTR), and prevalence of vitamin A deficiency (VAD) and low vitamin A status in the iodized salt (IS) and triple-fortified salt (TFS) groups over 10 mo

<table>
<thead>
<tr>
<th>Time (mo)</th>
<th>Retinol&lt;sup&gt;7&lt;/sup&gt;</th>
<th>RBP&lt;sup&gt;8&lt;/sup&gt;</th>
<th>RBP:TTR&lt;sup&gt;9&lt;/sup&gt;</th>
<th>VAD&lt;sup&gt;10&lt;/sup&gt; (SR &lt; 0.07 µmol/L)</th>
<th>Low vitamin A status&lt;sup&gt;11&lt;/sup&gt; (0.07 µmol/L ≤ SR &lt; 1.05 µmol/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>µmol/L IS TFS</td>
<td>IS mg/L TFS</td>
<td>IS IS TFS</td>
<td>IS TFS n (%)</td>
<td>IS TFS n (%)</td>
</tr>
<tr>
<td>0</td>
<td>0.91 ± 0.14&lt;sup&gt;4&lt;/sup&gt; 0.93 ± 0.17</td>
<td>21.1 ± 9.3 21.2 ± 11.0</td>
<td>0.23 ± 0.16 0.25 ± 0.18</td>
<td>13 (15) 9 (12)</td>
<td>58 (70) 42 (57)</td>
</tr>
<tr>
<td>5</td>
<td>0.94 ± 0.15 1.14 ± 0.13&lt;sup&gt;3&lt;/sup&gt;</td>
<td>24.7 ± 9.1 29.6 ± 10.21</td>
<td>0.32 ± 0.17&lt;sup&gt;5&lt;/sup&gt; 0.35 ± 0.17&lt;sup&gt;5&lt;/sup&gt;</td>
<td>11 (13) 0 (0)</td>
<td>51 (61) 30 (41)</td>
</tr>
<tr>
<td>10</td>
<td>0.91 ± 0.15 1.18 ± 0.12&lt;sup&gt;3&lt;/sup&gt;</td>
<td>22.4 ± 8.8 32.8 ± 11.1&lt;sup&gt;7&lt;/sup&gt;</td>
<td>0.26 ± 0.15 0.38 ± 0.14&lt;sup&gt;5&lt;/sup&gt;</td>
<td>14 (17) 1 (1)</td>
<td>53 (64) 23 (31)</td>
</tr>
</tbody>
</table>

<sup>1</sup> Significant treatment × time interaction, P < 0.001 (ANOVA).
<sup>2</sup> VAD = serum retinol < 0.07 µmol/L. Significant difference between time-and-group model and time-only model, P < 0.001 (logistic regression).
<sup>3</sup> Significant difference between baseline: <sup>3</sup> P < 0.05, <sup>7</sup> P < 0.01.
<sup>4</sup> Significant different from IS: <sup>4</sup> P < 0.05, <sup>6</sup> P < 0.01, <sup>8</sup> P < 0.02.
in developing countries is not confined to these groups. It can affect young women, school-aged children, and adolescents. Thus, food fortification with vitamin A is an attractive option, but finding suitable food vehicles has been difficult. The biological efficacy, but not the effectiveness, of vitamin A–fortified oil (45, 46), margarine (45, 47, 48), monosodium glutamate (49, 50), and cereal flours (51–53) has been shown. The efficacy and program effectiveness of sugar fortification in Central America are well established (54, 55). However, in much of rural Africa and Southeast Asia, oils, margarine, flours, and sugar either are not widely distributed or are not consumed by the neediest persons. Salt could be a good vehicle, because, in poor regions of subsistence farming in Africa and Indonesia, it is one of the few regularly purchased food items (9, 56, 57).

However, there are several potential limitations to the use of salt as a vehicle for vitamin A and iron. First, it is important that the usual amount of salt consumed by the target population be large enough. If not, the vitamin A and iron concentrations will be too high, which will cause technical and cost problems. According to 3-d weighed food records, per capita salt consumption in rural Ivory Coast is 6–9 g/d (9); in rural Morocco, it is 6–15 g/d (4). To maximize the potential efficacy of our intervention trial, we fortified the salt with high concentrations of vitamin A (60 μg/g) and iron (2 mg/g). In a long-term fortification program, concentrations could be lower. For example, consumption in the household of 6–8 g salt fortified with 20 μg vitamin A/g would provide approximately one-third of the recommended dietary allowance for 4–6-y-old children and approximately one-fifth of the recommended dietary allowance for pregnancy (28). A second potential barrier to salt fortification is, paradoxically, its low price: fortification could lead to a large increase in its price. Although the annual cost to supply the same amount of vitamin A through salt could be similar to that for cereal flours and sugar, the margin of increase in the product price would be higher for salt. Therefore, fortified salt might not be able to compete with nonfortified salt, unless the government mandated fortification by all producers or unless prices were maintained by subsidies.

To set the fortification level for iron in the salt, 3-d weighed food records were done to measure salt intakes and the estimated bioavailability of iron from the local diet. Our measured intakes of salt may have been somewhat high, because food records tend to overestimate true salt intake (58). To reduce the prevalence of IDA, our fortification goal was to provide ≈0.5 mg absorbed Fe/d to the children in the study. On the basis of local intakes of 7–12 g salt/d by children, a relative bioavailability of 70% of the micronized FePP, and an anticipated dietary iron absorption of 2–4%, we fortified the TFS with 2 mg Fe/g salt. The total dose of Fe delivered by the TFS during the 10-mo trial was ≈5.4 g, which is based on a study period of 300 d, mean salt intakes of 9 g/d in children, and a fortification level of 2 mg Fe/g salt. The mean increase in total-body iron in the TFS group was ≈105 mg, whereas the mean decrease in total-body iron in the IS group was ≈10 mg. On the basis of these data, the mean daily gain in total-body iron in the TFS group was ≈0.4 mg, which suggests that ≥2% of the fortification iron was absorbed during the 10-mo trial. In previous trials, iron-fortified foods that have clearly improved the iron status in target populations include infant formula and cereal (59, 60), sugar (61), curry powder (62), and fish sauce (63). It is noteworthy that, in these successful trials, the iron-fortified food was consumed with an enhancer of iron absorption (ascorbic acid or EDTA), which was added to

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**TABLE 4**

Acceptability of iodized salt (IS) and triple-fortified salt (TFS) containing iodine, iron, and vitamin A after 10 mo of use.  

<table>
<thead>
<tr>
<th>Salt</th>
<th>IS</th>
<th>TFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>1) Salt quantity used monthly in the household?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤1 kg</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>1–2 kg</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td>2 kg (amount distributed monthly to each study household)</td>
<td>52</td>
<td>47</td>
</tr>
<tr>
<td>&gt;2 kg</td>
<td>24</td>
<td>30</td>
</tr>
<tr>
<td>2) Salt consumed every day by children?</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>3) Salt used for all foods during cooking and at table?</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>4) Salt changed the color of foods?</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>5) Salt color acceptable in damp and dry seasons?</td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td>6) Salt taste acceptable in all foods?</td>
<td>96</td>
<td>100</td>
</tr>
<tr>
<td>7) Salt acceptable overall?</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

1 Significantly different from IS, P < 0.02.

2 Significantly different from IS.
overcome absorption inhibitors. In the present study, despite the high phytic acid content of the diet, iron fortification of salt without an enhancer significantly improved iron status.

Several factors may have contributed to efficacy in this study. Most children ate 3 main meals, as well as midmorning and midafternoon snacks, all of which contained measurable amounts of salt. Thus, iron absorption was likely enhanced by the repeated delivery of small doses throughout the day, because the fractional absorption of noneheme iron increases with decreases in dose (64). Another potential reason for the clear effect on iron and vitamin A status is that, in this region, there is a low rate of infection and inflammation (the prevalence of elevated CRP was only 5%) and no malaria, and diarrheal disease and hookworm are rare (M Bousfiha, personal communication, 2001). Therefore, IDA and VAD are mainly due to low intakes rather than to greater losses. Moreover, the low prevalence of infection or inflammation (or both) in this region increased our ability to rely on SF and SR concentrations to clearly define IDA and VAD and detect changes in status (65, 66).

The introduction of IS into an area of long-standing iodine deficiency carries some risk. The most serious and common complication of salt iodization is iodine-induced hyperthyroidism (IIH; 67). In most cases, IIH is mild and transient and does not produce clinical symptoms. The medical staff of the local health center was made aware that our introduction of IS might increase the risk of IIH among older people in the community with nodular goiters, and the staff members were instructed in managing any cases that might occur. However, no cases of IIH were reported during the study period.

Global control of deficiencies of iron, iodine, and vitamin A requires an integrated approach that includes dietary diversification, targeted supplementation, and food fortification. A stable and efficacious TFS could be a useful new fortification strategy, particularly in rural Africa and South and Southeast Asia. Our TFS meets the 3 basic requirements of a useful fortified food for these regions: (1) salt is an indigenous commodity regularly consumed by the target population (women and young children) and produced at a few centralized sites; (2) the TFS was nearly indistinguishable from iodized salt in sensory tests and was universally accepted; and (3) all 3 nutrients in the TFS were stable during storage and showed good bioavailability. However, because the performance of a TFS may vary according to climate and salt quality, these studies will need to be repeated in other countries, eg, in tropical regions of Africa and Southeast Asia. Moreover, for this strategy to be useful on a national scale, the issue of the large price increment of a TFS—due to the costs of fortification, storage, and distribution as well as the costs of installing local production facilities in less developed countries—remains to be resolved.

We thank the participating children and teachers and the staff at the Brikcha Health Center. We offer special thanks to Rabie Rahmouni (Brikcha, Morocco); Mohammed El-Yazami (Chefchaouen, Morocco); and Max Brikcha Health Center. We offer special thanks to Rabie Rahmouni (Brikcha, Morocco); Mohammed El-Yazami (Chefchaouen, Morocco). We thank Dr. Paul Lohmann GmbH KG (Emmerthal, Germany) for providing the retinyl palmitate; and Task Force Sight 2000; 75:743–8.


