multidisciplinary professionals from more than 100 countries, committed to providing technical assistance to national programs for the elimination of IDD in 1986.

World Health Assembly (WHA), in 1986 recommended the need for effective programmes of prevention and control of iodine deficiency disorders. This was followed by other resolutions related to elimination of iodine deficiency disorders. The World Summit for Children in 1990 also endorsed the goal of virtual elimination of IDD by 2000.

The WHO policy of Universal Salt Iodization (USI) was widely adopted which requires iodization of all food for human and animal consumption by the use of iodized salt (25-40 mg / per kg). Simple practical methods for monitoring – by the measurement of salt iodine and urine iodine were developed and promoted on a large scale with the technical assistance of ICCIDD. Combination of controlled trials and animal studies established that brain damage can be prevented by correction of iodine deficiency before pregnancy.

The global problem of iodine deficiency was redefined in 1983 by a population concept, with an easy acronym – the concept of the iodine deficiency disorders (IDD) – referring to all the effects of iodine deficiency in a population, that can be totally prevented by correction of iodine deficiency with special emphasis on brain damage and not just to goitre and cretinism. An economic argument was also put forward with study showing an annual loss of US$700 million a year in Germany. Each dollar dedicated to IDD Prevention would lead to a productivity gain of US$28 according to a World Bank estimate.

A report with a proposal for a global prevention programme was prepared and submitted to the United Nations Administrative Committee on Coordination Sub-Committee on Nutrition (ACC/SCN) early in 1985 to bridge the gap between research on the subject of iodine deficiency and brain damage and its application in public health programmes throughout the world. The report included a proposal to establish International Council for Control of Iodine Deficiency Disorders (ICCIDD). This was followed by the creation of the International Council for Control of Iodine Deficiency Disorders (ICCIDD) supported by WHO and UNICEF with 700 multidisciplinary professionals from more than 100 countries, committed to providing technical assistance to national programs for the elimination of IDD in 1986.

Succession of regional meetings by ICCIDD with the assistance of WHO and UNICEF led to establishment of national prevention programmes for IDD in many countries between 1987 and 1998. Establishment of the Network for the Sustained Elimination of Iodine Deficiency occurred in 2002 in collaboration with the international salt industry. This network of multilateral and bilateral agencies played a major role in success of IDD elimination programmes.

Elimination of IDD has been a major public health success story. Some of the reasons for this success are following:

1. Adoption of the goal of elimination of IDD by 2000 by World Summit on Children in 1990
2. The WHO/UNICEF policy of Universal Salt Iodization (USI)
3. Redefining the problem of iodine deficiency through a population concept of IDD
4. Technical assistance provided by The International Council for Control of Iodine Deficiency Disorders (ICCIDD) supported by WHO and UNICEF with 700 multidisciplinary professionals from more than 100 countries
5. Simple practical methods for monitoring developed with assistance of ICCIDD
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Vision: The vision of ICCIDD is a world virtually free from Iodine Deficiency Disorders. This includes national endeavors to maintain optimal iodine nutrition primarily through consumption of iodized salt, which should be made easily available and affordable for all people for all times.

Mission: The mission of ICCIDD is to provide a focused advocacy for iodine nutrition to governments and development agencies. This is done by providing technical expertise in a multi-disciplinary approach on a regular basis.

Dedication: ICCIDD dedicates itself to programmes fully supported at the national level for permanent, sustained success and works with all partners and national entities towards that end.

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Dear Colleagues,

There has been a tremendous global progress in elimination of Iodine Deficiency Disorders and it has been a major success story of public health. ICCIDD, WHO and UNICEF has played a major role in this through promotion of Universal Salt Iodization, advocacy and technical support to country programmes. In this issue we bring out the story of development of a global programme for elimination of brain damage due to iodine deficiency. We are also bringing out the salient features of Global Iodine Status 2011 in this issue. This study reports that more than 70% of world’s school aged children has adequate iodine intake. It is heartening to note that countries in the South-East Asia region have been making a steady progress.

We are also featuring The State of World’s Children 2012 in this issue which reports that there is a gross urban–rural disparity in micronutrient deficiency. However, the good news is that companies across the world are willing to use iodized salt in processed foods and are in favour of a legislative framework in this regard. There is good news from India as well. The Union Government has decided to reduce the basic customs duty from 5% to 2.5% and excise duty from 10% to 6% on iodine in the general budget for 2012-2013. This will help in reduction of cost of potassium iodate and spur the manufacturers of iodized salt to maintain adequate iodization of salt. In another welcome development, Government of Rajasthan has also decided to promote the use of iodized salt.

Ethiopia is designated as a priority country by ICCIDD. The 13th World Congress on Public Health was held in Addis Ababa and I got a chance to visit the country and establish linkages with public health professionals in Ethiopia. The Deputy Minister for Health from DPR Korea visited All India Institute of Medical Sciences, New Delhi last month. We got a chance to discuss the Iodine Deficiency Disorder elimination activities in DPR Korea and avenues for further collaboration. In this issue, we are also reporting on this global event.

India, Uttar Pradesh is one of the ‘make or break’ state in fight against elimination of Iodine Deficiency Disorders. We bring the report on workshop and training programme on Universal Salt Iodization (USI) in Uttar Pradesh in this issue. We hope that this initiative will help in achieving USI in the state.

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New Delhi 110029

Dr. Chandrakant S. Pandav
Regional Coordinator-South Asia Region
70% of the School Age Children globally have sufficient Iodine Intake - Global Iodine Status 2011

Degree of public health importance of iodine nutrition in SAC based on median UIC in 2011

![Map of global iodine status](image)

**Figure 1: National Iodine Status based on Urinary Iodine Concentrations in School Age Children**

Iodine deficiency remains a major public health threat globally as it is the most common cause of preventable brain damage. Only a few countries like Switzerland, some of the Scandinavian countries, the US, Australia and Canada were completely iodine sufficient before 1990. Universal Salt Iodization has since been vigorously promoted and implemented as a safe, cost-effective and sustainable strategy across the world to achieve iodine sufficiency. According to the latest reports, 71% of the world’s population consumes adequately iodized salt. Median Urinary Iodine Concentration (UIC) among the school age children has been increasingly used as a marker of iodine nutrition in the population. World Health Assembly in a resolution in the year 2005 urged its member states to monitor the iodine nutrition regularly. A study was done by researchers from ICCIDD to estimate the current global status of iodine nutrition as many countries have conducted national level surveys since the previous review of global iodine status by the World Health Organization (WHO) in 2007.

This new global estimate of iodine status includes the most recent country data from 193 countries in the world in the timeframe of 1993-2011. Country data from the WHO VMNIS Micronutrients Database was obtained along with a thorough search of the published literature in various databases, other reports and documents and to identify data from on-going or unpublished surveys, iodine scientists around the world were contacted through the ICCIDD network of national focal points as well as through the regional offices of WHO and UNICEF. UIC from school age children was used for this global estimate.

For estimation of global iodine status, only those surveys were included which had used a cross-sectional population based sample frame, standard UIC assay technique and reported at least one of the following: Median and/or mean UIC (µg/L). Prevalence of inadequate iodine intake: the proportion of population with UIC <100µg/L. UIC distribution: the proportion of population within the categories <20, 20-49, 50-99, 100-199, 200-299, or ≥ 300µg/L. In case of unavailability of national data, sub-national data with
samples of more than 100 were included. In such case, if two or more surveys in school age children of the same administrative level were available from different locations, they were pooled into a single weighted summary measure. If no UIC data was available for any country, prevalence estimate was not made. However, in countries where only few summary measures were available, missing variables were derived using the regression analysis using the models derived from UIC studies compiled in the WHO VMNIS Micronutrients Database.

The median UIC obtained from the data was used to classify countries according to threshold criteria of public health importance of iodine nutrition. National, regional and global populations with inadequate iodine intake were estimated on the basis of proportion of population with UIC <100 µg in each country.

The current estimates are based on nationally representative surveys from 115 countries and sub-national surveys from 33 countries. UIC data from 45 countries were not available. Of the 115 national surveys, 58 were conducted since 2007. Available UIC data covers 96.1% of the world's population of school age children. In South-East Asia Region of WHO, UIC data was not available for DPR Korea, Thailand and Timor-Leste.

According to current estimates, 29.8% of the school age children amounting to 240.9 million have insufficient iodine intake. Of these, 5.2% had severely insufficient iodine intake, 8.1% had moderately insufficient iodine intake and 15.9% had mildly insufficient iodine intake. (Figure 2).

The global prevalence of insufficient iodine intake among children has fallen over from 36.5% in 2003 to 31.5% in 2003 and 29.8% in 2011. According to the current estimates, iodine intake is adequate in 69 countries, inadequate in 32 countries, more than adequate in 36 countries and excessive in 11 countries. Of the 32 countries with inadequate iodine intake, 23 are mildly deficient and 9 are moderately deficient. No country is categorized as severly deficient. (Figure 1)

There has been a remarkable improvement in the global iodine status over last one decade but the strong regional differences remain. Steady progress has been observed in the South-East Asia region. Despite remarkable progress, 1.88 billion of the global population including 541 million in South-East Asia region, still have inadequate iodine intake. A sustained global effort is required to achieve optimum iodine nutrition among those who have not yet achieved it. An important strategy will be to strengthen national coalitions that include iodine scientists, national ICCIDD focal points, government partners, national and international agencies, the healthcare sector, and salt producers.

![Figure 2 : Proportion (%) of School age Children at risk for mild, moderate and severe iodine deficiency, by WHO region, 2011](image-url)
In the South-East Asia region, 31.8% of the school age children amounting to 76 million have insufficient iodine intake. The proportion of school age children with insufficient iodine nutrition was 33.8% in Bangladesh, 13.5% in Bhutan, 34.4% in India, 16.3% in Indonesia, 43.1% in Maldives, 34.3% in Myanmar, 27.4% in Nepal, and 30% in Sri Lanka. (Table 1)

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Country</th>
<th>Median UIC (µg/L)</th>
<th>% with UIC &lt;100 µg/L (95% CI)</th>
<th>Number with a UIC &lt;100 µg/L (6-12 y,000)</th>
<th>General population (,000)</th>
<th>Classification of iodine intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bangladesh</td>
<td>163</td>
<td>33.8 (31.9-35.7)</td>
<td>7555</td>
<td>50258</td>
<td>Adequate</td>
</tr>
<tr>
<td>2</td>
<td>Bhutan</td>
<td>217</td>
<td>13.5 (11.6-15.4)</td>
<td>13</td>
<td>98</td>
<td>More than adequate</td>
</tr>
<tr>
<td>3</td>
<td>DPR Korea</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>India</td>
<td>154</td>
<td>34.4 (33.7-35.0)</td>
<td>59347</td>
<td>420765</td>
<td>Adequate</td>
</tr>
<tr>
<td>5</td>
<td>Indonesia</td>
<td>229</td>
<td>16.3 (13.9-18.7)</td>
<td>4948</td>
<td>39099</td>
<td>More than adequate</td>
</tr>
<tr>
<td>6</td>
<td>Maldives</td>
<td>115</td>
<td>43.1 (39.9-46.3)</td>
<td>17</td>
<td>136</td>
<td>Adequate</td>
</tr>
<tr>
<td>7</td>
<td>Myanmar</td>
<td>124</td>
<td>34.3 (31.8-36.8)</td>
<td>1990</td>
<td>16451</td>
<td>Adequate</td>
</tr>
<tr>
<td>8</td>
<td>Nepal</td>
<td>188</td>
<td>27.4 (25.9-28.9)</td>
<td>1419</td>
<td>8209</td>
<td>Adequate</td>
</tr>
<tr>
<td>9</td>
<td>Sri Lanka</td>
<td>153</td>
<td>30.0 (27.9-32.1)</td>
<td>694</td>
<td>6258</td>
<td>Adequate</td>
</tr>
<tr>
<td>10</td>
<td>Thailand*</td>
<td>117</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Timor-Leste</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Total-WHO SEARO region</td>
<td>-</td>
<td>31.8</td>
<td>76000</td>
<td>541300</td>
<td>-</td>
</tr>
</tbody>
</table>

This report has been abstracted from the article titled “Global iodine status in 2011 and trends over the past decade”. The whole article is available on Andersson M, Karumbunathan V, Zimmermann MB. Global iodine status in 2011 and trends over the past decade. J Nutr. 2012 Apr;142(4):744-50.

Table -1 : Current Status of IDD in WHO South-East Asian Countries

*MOH Cyclic Monitoring Data for pregnant women, 2009
Urban Poor Children are more likely to be undernourished: UNICEF’s The State of the World’s Children 2012

Focus of the recently released “The State of the World’s Children 2012” is on the status of children in Urban World. Under nutrition contributes to more than a third of under-five deaths globally. Poverty and its consequences like poor environment and housing conditions, inadequate access to food, safe water and health care, and failure of social protection is the main reasons for under nutrition in low income countries.

The rural-urban gap in nutrition has narrowed in recent decades – essentially because the situation has worsened in urban areas. In many countries, disparities in child nutrition between rich and poor urban communities were greater than those between urban and rural areas. Even among the apparently well fed – those who receive sufficient calories to fuel their daily activities – the ‘hidden hunger’ of micronutrient malnutrition is very common. Without these micronutrients, children are in increased danger of death, blindness, stunting and lower IQ.

Table 1: Percentage of Household consuming iodized salt in countries of South-East Asia Region (2006-10)

<table>
<thead>
<tr>
<th>Country</th>
<th>% of Household consuming iodized salt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>84</td>
</tr>
<tr>
<td>Bhutan</td>
<td>96</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>25</td>
</tr>
<tr>
<td>India</td>
<td>51</td>
</tr>
<tr>
<td>Indonesia</td>
<td>62</td>
</tr>
<tr>
<td>Maldives</td>
<td>44</td>
</tr>
<tr>
<td>Myanmar</td>
<td>93</td>
</tr>
<tr>
<td>Nepal*</td>
<td>80</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>92</td>
</tr>
<tr>
<td>Thailand</td>
<td>47</td>
</tr>
<tr>
<td>Timor- Leste</td>
<td>60</td>
</tr>
</tbody>
</table>

*Nepal Demographic and Health Survey 2011

By 2050, 70 per cent of all people will live in urban areas. Already, 1 in 3 urban dwellers lives in slum conditions; in Africa, the proportion is a staggering 6 in 10. The impact on children living in such conditions is significant. From Ghana and Kenya to Bangladesh and India, children living in slums are among the least likely to attend school. And disparities in nutrition separating rich and poor children within the cities and towns of sub-Saharan Africa are often greater than those between urban and rural children.

Anthony Lake
Executive Director, UNICEF
Companies across the world are willing to use iodized salt in processed food:
A study on use of Iodized salt in Processed Foods in Select Countries around the World

The World Health Organization (WHO) and UNICEF have promoted Universal Salt Iodization as a safe, cost-effective and sustainable strategy to achieve optimum iodine nutrition among the population. Traditionally USI strategy has focussed on iodization of only table salt and not in all forms of human salt consumption. In many countries, however, the major form of salt intake is through processed foods in which iodized salt is rarely used. The countries where the focus is only on iodization of table salt may not achieve optimum iodine nutrition. Keeping in mind the importance of use of iodized salt in processed foods, Institute of Food Technologists (IFT), Chicago, USA undertook a project assisted by Micronutrient Initiative to assess the extent to which iodized salt is used in processed foods.

The project was conducted in two phases; phase 1 consisted of desk review to assess the consumption pattern of processed foods in 39 countries around the world whereas in phase 2 electronic survey was conducted among food processors and detailed telephone interviews was conducted with a small sample of select company representatives from 16 countries. For phase 1, the countries selected from South East Asia region were Bangladesh, India, Indonesia and Nepal; for Phase 2, the countries selected from the region were Bangladesh, India and Indonesia.

The study found typically the consumption of processed food is in the form of minimally processed foods such as bread and cheese, but that they do not frequently consume what are considered processed foods in “Western” society (packaged, prepared foods). Consumption of processed food is based on income and region in the country. The consumption of processed food was more in more affluent sections of the society, related to their purchasing capacity.

Commonly consumed processed foods were rice, wheat, sugar, edible oils, preserved fruits and juices, and fish in Bangladesh; roti (bread), butter, milk, buttermilk, yogurt, ice cream, cakes, jam, noodles, ketchup, and French fries in India; rice, corn, wheat flour, rice noodles, bread, dry and wet cake, pasta, corn flour products, and sugar in Indonesia; and Flour, rice, sugar, noodles, biscuits, soft drinks, vegetable ghee and oil, powdered milk, and milk in Nepal. The review found that the consumption of processed food is increasing in South-East Asia across different economic and regional stratum.

Most often, iodized salt was found to be used only in food products where it was mandated by law and companies didn’t appear to use iodized salt in product categories that do not require it (or for products sold in countries that do not require it. In Bangladesh, the law mandates all edible salt to be iodized. However, due to illegal smuggling of relatively cheaper non-iodized salt may lead to use of non-iodized salt in processed food. In India, based on production figure, authors concluded that use of iodized salt in processed food to be a common practice; however 2 survey respondents did not report use of iodized salt in processed food. In Indonesia, iodized salt was used in some of the processed food products while some respondents were not sure about it.

The potential challenges reported in use of iodized salt in processed food were trade barriers; increased costs; lack of resources and technical capability; lack of enforcement; instability of iodine; potential equipment and process overhauls; competing priorities; and consumer misconceptions. The respondents also indicated the willingness of food companies to use iodized salt in food products; however, the use of iodized salt in food products may need to be mandated by law and effectively monitored as an incentive for a company to invest, and to create a level playing field in the industry.

Suggested approaches to get food companies to voluntarily use iodized salt in food products include outreach and education to company nutrition departments, who would then recommend changes to top levels of management. Additionally, a strong educational campaign for consumers on how to address IDD through the use of iodized salt in food processing could provide an incentive for companies to meet consumer demand. Companies did indicate that they would be open to localized educational efforts to inform select company representatives about iodine nutrition.

This article is an abstract of the report titled “Use of Iodized Salt in Processed Foods in Select Countries around the World and the Role of Food Processors”. 
The 13th World Congress on Public Health was held in Addis Ababa, Ethiopia from April 23-27, 2012. The congress was organized by the Ethiopian Public Health Association and World Federation of Public Health Associations. Approximately 4,000 public health researchers, academics, scientists, educators, programmers, policy makers and student representatives from 120 countries deliberated upon various issues and challenges in public health during the congress. More than 1500 posters and papers were presented by around 800 researchers during the congress.

The theme of the Congress was “Towards Global Health Equity: Opportunities and Threats.” Achievement in terms of health Millennium Development Goals (MDGs) was extensively debated in the congress. The congress debated various strategic approaches aimed at increasing equitable and sustainable access of the world’s population, specifically the poor, to quality essential health services. It was underscored during the conference that the achievement of the MDGs will require intensive efforts and increased equitable and sustainable access to health services for poor. The congress also discussed various other issues like right to health, social justice, diversity and inclusion, climate change, extreme poverty and hunger, and state of health services across the globe. The congress also deliberated upon the various infectious diseases like malaria, AIDS and tuberculosis, non-communicable diseases with premature death due to myocardial infection, stroke and cancer and the issue of nutrition including iodine deficiency disorders. Emerging public health topics like public health genomics were also widely discussed in the congress. The congress provided an opportunity to address these critical issues through evidence-based and transparent interaction among the global public health community such that the key stakeholders would benefit from the knowledge gained and experiences exchanged. The congress also allowed the participants to gain a greater understanding of international public health issues, approaches and strategies.

The Indian Public Health Association (IPHA) delegation consisted of Professor Madhumita Dobe, Prof. Sandip Kumar Ray, Prof. Thomas Matthew and was led by the National President Dr. Chandrakant S. Pandav (Regional Coordinator, South Asia, ICCIDD) Dr. Pandav interacted with Hon’ble Health Minister of Ethiopia, Dr. Tedros Adhanom Ghebreyesus. He also shared with them that ICCIDD has identified Ethiopia as one of the important countries for Iodine Deficiency Disorders (IDD) activities. ICCIDD delegation led by Professor Izzeldin S. Hussein, Sub Regional Coordinator (Gulf, Arab and North Africa) and Prof. Vincent Assey, ICCIDD Board Member, Tanzania, will be soon visiting Ethiopia to learn about the progress of USI and identify areas that require further attention so as to sustain elimination of IDD.

The 13” World Congress on Public Health concluded with the adoption of Addis Ababa Declaration. It called on all governments and stakeholders to safeguard and promote the essential values of public health which include, but are not restricted to good governance, solidarity, equity and fairness, empowerment and participation, and social justice to achieve the highest possible standards of health for all. It also pledged to promote and facilitate the linkage between the academic and public health association communities, advocate for the utilization of evidence as the basis for formulating healthy public policy and informing practice to reduce health inequity, make health equity an integral part of local, national and global policy, among others. It called on the World Health Organization to take up its leadership role on global public health and to revisit all the MDGs from a public health perspective to ‘close the gap.’ It also called on all governments and all parties to recognize and live up to their responsibility for global health equity and urged the various communities represented at the congress to engage with their governments and other stakeholders, including their national public health associations, to formulate and put into place the conditions that support healthy environments and healthy communities and the attainment of health equity.
World Health Organization (WHO) has released a draft report on Micronutrients 2010-11 (WHO/NMH/NHD/EPG/12.1), 2012). This report summarizes the achievements of WHO in the area of micronutrients, with a focus on the advances in upgrading and expanding the Vitamin and Mineral Nutrition Information System (VMNIS) and preparation of new evidence-informed guidelines for micronutrient interventions.

During 2010-2011, the efforts of WHO headquarters and its regional offices were focussed largely on establishing a process for developing and updating evidence informed guidelines for micronutrient interventions and biomarkers as well as upgrading and expanding the Vitamin and Mineral Nutrition Information System (VMNIS). During this period, sixteen evidence-informed guidelines for micronutrient interventions were published and new tools and resources were developed to support Member States and their partners in successfully implementing effective micronutrient interventions. The guidelines were developed or updated included guidelines for Vitamin A Supplementation in children, pregnant and post partum women; guidelines for iron supplementation among children, menstruating and pregnant women; guidelines for use of multiple micronutrient powders for home fortification of foods consumed by children and pregnant women; and guidelines for prevention and treatment of pre-eclampsia and eclampsia.

During the biennium, research studies were undertaken on the biological and biochemical pathways underlying neonatal vitamin A supplementation and on the development of models to assess the burden of vitamin and mineral deficiencies by WHO and its collaborating institutions. During this period, technical reports were also prepared on neonatal Vitamin A supplementation research priorities, estimating appropriate levels of vitamins and minerals for food fortification programmes and technical consultation on vitamin A in newborn health.

VMNIS website and over 100 documents related to micronutrients are now published in 6 WHO official languages by WHO. This has enabled WHO to guide public health practices more effectively, reach out to international audiences who need it, and achieve better health outcomes worldwide. This multilingual communication has helped in improving global health. WHO continues its commitment to coordinate the universal call to scale up nutrition actions by increasing multilateral work on technical and policy agendas at the global, regional and country level with the core group of United Nations agencies and international partners dealing with micronutrient interventions in public health.
Iodized Salt Distribution through Public Distribution System (PDS)

Various States/Union Territories have started distribution of iodized salt through Public Distribution System.

<table>
<thead>
<tr>
<th>S. No.</th>
<th>State</th>
<th>Variety</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kerala</td>
<td>Non-Refined</td>
</tr>
<tr>
<td>2</td>
<td>Tamil Nadu</td>
<td>Non-Refined</td>
</tr>
<tr>
<td></td>
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<td>Refined</td>
</tr>
<tr>
<td>3</td>
<td>Karnataka</td>
<td>Non-Refined</td>
</tr>
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<td></td>
<td></td>
<td>Refined</td>
</tr>
<tr>
<td>4</td>
<td>Gujarat</td>
<td>Non Refined</td>
</tr>
<tr>
<td>5</td>
<td>Chattisgarh</td>
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</tr>
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<td>6</td>
<td>Madhya Pradesh</td>
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<td>7</td>
<td>Rajasthan</td>
<td>Non Refined</td>
</tr>
<tr>
<td>8</td>
<td>Tripura</td>
<td>Non Refined</td>
</tr>
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<td>9</td>
<td>Himachal Pradesh</td>
<td>Non Refined</td>
</tr>
<tr>
<td>10</td>
<td>Sikkim</td>
<td>Packed iodised (PDS)</td>
</tr>
</tbody>
</table>

Source – Annual Report 2010-2011, Salt Department, Ministry of Commerce and Industry, Government of India
improving access to primary healthcare). Policy formulation process was found to be systematic and responsive to international and national activities in the realm of knowledge mobilisation. However, there are some gaps identified in policy formulation process and included processes without adequate documentation of past, overlapping goals and targets, and institutional challenges. This was followed by a presentation reviewing the Integrated Child Development Services (ICDS) programme and nutrition component of National Rural Health Mission (NRHM). It was found that ICDS and NRHM incorporate all the essential direct nutrition-specific inputs and majority of the essential inputs were promoted through evidence-informed interventions.

Partnerships and Opportunities to Strengthen and Harmonize Actions for Nutrition in India (POSHAN) is a 4-year initiative which aims to build evidence on effective actions for nutrition and support the use of evidence in decision-making. POSHAN hold a consultation on the nutrition landscapes in India on 19th June, 2012 in New Delhi. The objectives of the consultation were to share findings from POSHAN’s inception activities and obtain feedback on key research priorities and potential strategies for knowledge mobilization to tackle under nutrition in India. The consultation was attended by the spectrum of professionals from government, academia, non-governmental international and national organizations, and civil society groups working in the field of nutrition.

At the beginning of the programme, presentation was made on “Partnerships and Opportunities for Strengthening and Harmonizing Actions on Nutrition in India”. This presentation focussed on the Indian policy landscape that supports globally accepted essential actions to tackle under-nutrition and the use of evidence in policy formulation and how it is documented. The key findings were that there is large number of policies addressing major areas of public health nutrition need and there is substantial focus on essential actions. However, the policy format is variable. Indirect actions are seen as key in impacting nutrition landscape; and there is stress on convergence (e.g. economic empowerment of women, food security, strengthening of India’s Public Distribution System, improving access to primary healthcare). Policy formulation process was found to be systematic and responsive to international and national activities in the realm of knowledge mobilisation.

Stakeholder landscape was also presented during the consultation. Stakeholder landscape was prepared using participatory discussions with various stakeholders. At the end of the consultation, knowledge mobilisation landscape for nutrition in India. It put forward the nature and roles of the knowledge networks and systems that form part of the knowledge mobilisation landscape for nutrition in India. In India, Knowledge networks are organized in the form of virtual networks that are moderated, e.g. Solution Exchange, Child Health Nutrition Knowledge Network (CHNKN), Physical networks that are managed by a secretariat e.g. Coalition for Sustainable Nutrition Security and National Neonatology Forum, and Knowledge systems which are information repositories e.g. NCHRC, NHSRC, NIPCCD and NIN. Most network play a role at informing policy or practice and focus on strengthening programme practice. The benefits of these networks include cost-effective consultation process, wide reach and keep members abreast of experiences and materials generated by various agencies in a single platform. It was suggested that networks need to highlight evidence of things that are not known as opposed to what is already known about nutrition, a common portal or internet site for information which disseminates information on all aspects of nutrition is desirable (NRP), and networks need to track effectiveness, through better design and understanding of the sector.
Government of India slashes excise and custom duty on iodine: Major relief to Universal Salt Iodisation program in India

- Government support provides a relief from escalating international market prices of iodine

Iodine Deficiency Disorder (IDD) is the single most important cause of preventable brain damage worldwide. Every year, 8 million children are born in India unprotected from brain damage caused by iodine deficiency. Universal Salt Iodisation (USI) is the primary strategy adopted by Government of India to control IDD under National Iodine Deficiency Disorder Control Programme (NIDDCP).

Iodine in the form of potassium iodate is mixed with raw salt for production of iodized salt in India. Iodine, the raw material for manufacture of potassium iodate, is not produced in India and is imported from countries like Chile, Japan, Belgium and Indonesia. The price of iodine has increased three fold in international market in recent months. As result of this escalation in price of raw iodine in international market, the cost of potassium iodate increased Rs. 1100 per kg in 2010 to Rs. 3300 recently.

The sustained effort by the Office of the Salt Commissioner under the able leadership of Mr. M. A. Ansari bore fruit. The Hon’ble Finance Minister, Government of India in a landmark initiative announced reduction in Basic Customs Duty on iodine from 5% to 2.5% and Excise duty on from 10% to 6% in the general budget for 2012-2013. This will give some relief to the iodised salt manufacturers and spur them to maintain the adequate level of iodization of salt.

This exponential rise in the prices of raw iodine and consequentially potassium iodate posed a serious threat to Universal Salt Iodization program in India. Iodized salt manufacturers will not be able to pass on the increased cost to the salt consumer due to highly competitive market. Significant proportion of iodised salt manufacturers might resort to supply of inadequately iodized salt to cut down the cost. The Office of the Salt Commissioner of India and the National Coalition for Sustained Iodine Intake (NCSII) jointly held consultations with various stakeholders of USI and IDD program in India to find a solution to this grave threat. It was unanimously decided that the group should appeal to Government of India to waive off the customs and excise duties on iodine and potassium iodate to mitigate the effect of increase international prices of iodine. A detailed representation was submitted to this effect with the relevant government agencies including the finance ministry of Government of India.

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It is important to note at this point is the prices of iodine in international market are still very high. The reduction in excise and basic customs duty, though a welcome step, only partially offsets the increased prices of potassium iodate. It is imperative that the Government of India exhibiting its complete endorsement of Universal Salt Iodisation program waive off all duties currently being levied on iodine and potassium iodine. So, it is important that intensive and sustained advocacy measures are initiated by the civil society and other USI and IDD stakeholders for total abolition of all duties on iodine and potassium iodate. Universal salt iodization has prevented the loss of four billion IQ points in India in last 20 years. The cumulative cost of waiving off customs and excise duties on iodine will amount to only 200 million rupees annually, which is Rs. 0.16 per person per year! This cost is insignificant when compared to its contribution to protecting the brain development of children born in India.
Dr. Swati Tiwari from Department of Endocrinology, Molecular Medicine & Biotechnology at SGPGIMS have already imparted titration skills to more than 400 science students of class XI & XII in seven schools of Gonda, Bahraich, Shrawasti, Sidhart Nagar, Basti and Gorakhpur.

The two day workshop was attended by 20 analysts and teachers. Trainees were imparted skills of reagent making as well as nuances of titration methodology. They were also educated in various aspects of Quality Assurance (QA) and Quality Control (QC). With a small beginning of developing partnership, UNICEF, SGPGIMS & ICCIDD partnership is expected to go a long way in setting up state level technical resource center for quality assurance and quality control at SGPGIMS. Mr. M. A. Ansari, Salt Commissioner to Government of India, the chief guest in his inaugural address lamented about less than satisfactory coverage of USI in Uttar Pradesh and also the lack of trained manpower to analyze the iodine content of salt with a degree of confidence. He appreciated the fact that tertiary care institution like SGPGIMS has taken upon itself to impart such training and expressed satisfaction with built-in quality assurance and quality control measures in this workshop cum hands on training program.

Secondly, it was decided to train chemistry teachers from seven schools under Human Resource Development program of a Department of Science and Technology, Government of India. Under this scheme faculty and staff teams led by Prof M. M. Godbole, Dr. Subhash Yadav and
State level coalition Workshop conducted in Lucknow to push for Universal Salt Iodization
14 June, 2012, Lucknow

As per Coverage Evaluation Survey (CES) 2009, household consumption of adequately iodized salt in India has increased by 17% points (54.1% in CES 2006 to 71.1% in CES 2009). In contrast, Uttar Pradesh the most populous state of India has reported only a marginal increase of 7.8% (from 34.7% in CES 2006 to 42.5% in CES 2009) points in consumption of adequately iodised salt.

Strong leadership and ownership is required for strengthening monitoring and managing & coordinating implementation which are critical to reviving the Universal Salt Iodization (USI) programme. For effective and sustained implementation of USI programme it is important that there is greater coordination and regular interaction between the various stakeholders involved in salt production, marketing and consumption. Since the stakeholders are from diverse field there is a need for Government led Coordinating Authority which can convene a meeting of the stakeholders.

With the objective of strengthening Universal Salt Iodization programme and galvanizing departments for increased involvement in the programme, a state level coalition workshop was convened on 14th June 2012 under the chairmanship of Mission Director, National Rural Health Mission (NRHM), Uttar Pradesh. The workshop was graced by the Salt commissioner, Government of India. It was also attended by representatives from various government departments which have a role to play in successful implementation of this programme. These included Department of Health, NRHM, Food and Drug Administration (FDA), State Health Institute, ICDS, Mid Day Meal (MDM), Medical colleges and training institutions like SIHFW. Development partners UNICEF and the Micronutrient Initiative (MI) provided technical support.

Following an overview of the global and national prevalence of IDD, status of NIDDCP and universal salt iodization programme in Uttar Pradesh, the need for setting up a multisectoral coalition for accelerating USI was emphasized. The Salt commissioner emphasized a need for action in four key areas- 1 pushing for supply of adequately iodised salt in the public distribution system to ensure reach to the most marginalized and excluded, 2 need for strict enforcement of food standard and regulatory standards 3 need for IEC and communication strategy and 4 quality monitoring of the programme.

Thereafter, roles of each of the stakeholders were delineated, and opportunities to address supply and demand concerns relating to iodized salt consumption were identified. Commitment was sought from each department on their respective roles in strengthening the programme. An interactive discussion led to a consensus on the establishment of a state steering committee composed of representatives from Departments of Health, ICDS, MDM, FDA and Food and civil supplies. The coalition would be expected to work towards greater advocacy and informed decision making with regards to USI in the state.

The key decisions which were taken during the meeting were as follows:-

- Appointment of nodal officers for monitoring the implementation of the programme at district and block levels.
- Inclusion of IDD as a component of trainings conducted by the state training institutes
- Promote use of adequately iodized salt in Government run programmes of ICDS and MDM,
- Encourage legal enforcement through monitoring by food inspectors of Food and Drug Administration and
- Advocate for availability of adequately iodised salt at subsidized rates in PDS supply chain. Monitoring component will also be strengthened through routine testing of salt samples of both salt suppliers and consumers.
- The matter of Uttar Pradesh not been surveyed for more than 25 years for IDD prevalence was discussed and it was agreed that such a survey has become eminent.

Delegates of the Workshop
Rajasthan Promotes the use of Iodized Salt

They have identified 14 districts in the state where the use of iodized salt is common. He said that in all these districts, a survey would be conducted to find out how many households are not consuming iodized salt.

The iodized salt coverage study 2010 conducted in rural areas of eight states by Micronutrient Initiative (MI), an international non-profit agency, and Indian Coalition for Control of Iodine Deficiency Disorders shows that the availability of adequately iodized salt at the household in Rajasthan has improved substantially from 29.2% in NFHS 3 in 2005-06 to 50.2% in 2010.

MI president Venkatesh Mannar said that since Rajasthan is one of the largest salt producing states, it is necessary that the salt is iodized properly.

He said that MI, in collaboration with UNICEF and Global Alliance for Improved Nutrition (GAIN) has supported Salt Commissioner’s office to set up web-based management information system which can track the real time information on quality and quantity of iodized salt.

Besides, the health department has given the responsibility to check salt, if it contains iodine or not. On each Thursday (day of vaccination), each ANM would test at least 10 samples of salt from as many households as possible. The ANMs, Anganwadi workers and ASHA workers would counsel on each Thursday to the people to consume only iodized salt.

The Rajasthan state government has stepped up efforts to stop the use of non-iodized salt, which is a major cause of goiter and other iodine deficiency disorders. The health department has sought the support of other departments including education, food and civil supplies and salt commissionerate for the purpose.

The education department has been directed to ensure that the mid-day meal supplied in government schools contain only iodized salt. Since a large number of schoolchildren are being given mid-day meals, the health department hopes that this would help in reducing the cases of iodine deficiency among children and ensure their proper mental and physical growth.

It also directed the food and civil supplies department that salt supplied through public distribution system should be properly iodized.

Mr. B R Meena, Director of Health Services, Rajasthan said: “Our main aim is to feed iodized salt only. For the purpose, we have sought the cooperation of various government departments. The deficiency of iodine could cause serious health and mental problems among the children.”
Coalition for Sustainable Nutrition Security in India Calls for Focus on Gender and Equity for Nutrition Security in India

A meeting of Coalition for Sustainable Nutrition Security in India was convened May 15, 2012 in Constitution Club, New Delhi. The meeting was attended by various representatives from government and non-governmental sectors working in the field of nutrition.

Professor MS Swaminathan, Chair of the Coalition for Sustainable Nutrition Security in India, opened the meeting with a welcome note and briefed on the objectives of the meeting. In his opening remarks, he emphasised the life cycle approach from conception to cremation. The most vulnerable but most neglected segment is the first 1000 days of life starting from conception to the first two years of life of the child. He highlighted the need to review social protection measures and identify gaps in social protection schemes to address nutrition in a more holistic manner. Effectiveness of different governance mechanisms need to be adopted for addressing nutrition security issues. He appreciated the recent initiative of Delhi Government to launch the State Nutrition Mission.

Dr Rajiv Tandon, co-ordinator of the coalition, presented an update on Nutrition Coalition since its transition to Save the Children from October 2011 to date.

The meeting also marks the release of the report on ‘Global Lessons in Achieving Nutrition Security and their Application to the Indian Context’ by Prof. Swaminathan and Mr James Browder from USAID. The report was developed by the research team of Public Health Foundation of India, with technical assistance from the former Secretariat of the Coalition, The Vistaar Project, and funded by USAID. The aim of this report is to summarise and present information on countries that have been successful in lowering malnutrition rates and to identify aspects of their approach that may be beneficial in the Indian context, as well as to assist policymakers and programme leaders working toward nutrition security in India.

Dr Archana Singh, PHFI, presented the highlights of the report. The key take home messages are focus on equity and gender to achieve nutrition security. Creation an enabling environment within basic health care, immunization, and sanitation can improve the nutritional status.

It was also informed during the meeting that Integrated Child Development Services (ICDS) MIS is being revised and the number of registers at the Anganwadi Centre (AWC) level has been reduced. The ICDS programme has been scaled up from 5,000 AWCs to 1.4 million AWCs. There is a lack of uniformity in implementing WHO new growth standards across the country. ICDS good practices need to be scaled up and extend the use of Mother and Child Protection Cards.

The meeting was concluded with the suggestion that all stakeholders should share their experiences and models with Coalition Secretariat for review and dissemination for better nutrition programming.
Iron Fortified Iodized Salt Launched

Tata Chemicals, the Indian leading salt manufacturer and marketer announced the launch of packaged iron fortified iodized salt across major cities of India on 5th April, 2012. Tata Salt Plus is aimed at addressing and eradicating the prevalence of iodine deficiency through salt, one of the most widely consumed food essentials.

Tata Salt Plus is priced at Rs. 20 for 1 Kg and is the result of a research on double fortification technology and premix led by National Institute of Nutrition (NIN), Hyderabad. This technology was used for commercial purpose after studies on bio-availability across the population strata conducted and published by NIN. In April 2011, the Prime Minister’s Office directed that salt available through government food programs including ICDS, mid-day meal and Public Distribution System be fortified with iron and iodine.

Speaking on the launch, Mr. R. Mukundan, Managing Director, Tata Chemicals said, “We are proud to unveil Tata Salt Plus which we believe is an important embodiment of our company’s vision to serve society through science. We were pioneer in packaged iodized salt, which helped the country in addressing iodine deficiency and which has brought about a significant drop in the number of goitre cases. Now, via Tata Salt Plus, we turn our focus to help our consumers fight iron deficiency anemia as well by offering an affordable, organic way in which to help meet established daily iron and iodine requirements”.

Tata Salt Plus- Iron fortified iodized salt will be available in metro and smaller cities over next few months.
Third Grains Conference was organized on 1 May 2012 at India International Centre, New Delhi by Assocom India. The knowledge partner for this conference was Texas Agricultural Lifetime Leadership (TALL), USA. Dr. B. C. Gupta, IAS, Secretary, Department of Food and Public Distribution, Government of India made the inaugural remarks on the occasion. The Grain Conference brought together several distinguished participants including high ranking government officials, scientists, corporate leaders and other stakeholders apart from farm experts, growers and academics from abroad.

The country has embarked on the 12th Five Year Plan (2012-2017) with the theme ‘Faster, Sustainable and More Inclusive Growth’. In the previous three Plan periods, annual average farm growth had consistently fallen far short of the target. However, the country has made enormous progress in terms of overall GDP growth, making India one of the world’s fastest growing significant economies. Rising incomes, existing low level of consumption and demographic pressure are driving demand for a wide variety of goods and services higher. The key sectors of growth include food, clothing, energy, housing & infrastructure, healthcare, education as also leisure & entertainment.

Food production growth continues to trail demand growth. This results in tightening supplies, dependence on imports and volatile prices. Inflation hits the poor the hardest. Agriculture is the critical sector that can meet the theme of the 12th Plan by contributing to faster, sustainable and more inclusive growth. A farm growth of 4 percent is imperative to support the 9 percent GDP growth target. As a tropical country, India is a lot more vulnerable to the adverse effects of global warming. The country may not exactly be food insecure today, but availability is likely to tighten in the coming years. Nutrition security is a big challenge for a vast majority of the poor, especially in the rural areas. Strengths in agriculture need to be leveraged to deliver health and nutrition to the poor.

The conference deliberated the newer challenges confronting the farm sector. Land constraints, looming water shortage and climate change were some of them. Strategies for achieving food and nutrition security was also discussed during the meeting.

Recommendations of the conference:
- Strengthen the input delivery system – seeds, fertilisers and agro-chemicals of requisite quality must be accessible to growers at affordable prices. Flow of bank credit to small and marginal farmers must improve.
- Rapidly expand irrigation facilities – water is the most critical input for agriculture. Water resources must be managed scientifically.
- Infuse technology – InfoTech, agri biotech, satellite tech and nuclear agriculture are modern technologies that can boost farm production and productivity in addition to scientific pre-harvest and post-harvest practices. Farm extension system must be revived.
- Step up public investment in agriculture including investment in rural infrastructure - warehouses, cold chains, marketing yards and grading houses.
- Use ICT to deliver price and market information to growers.
- Build capacity among growers to withstand market forces and price volatility.
- Incentivise private sector investment in contract farming, rural infrastructure and so on.
- Set up research - growers - industry interface;
- To minimise grain mono-cropping in some regions, incentivise cultivation of legumes for crop rotation.
- We need a transparent system of program evaluation and monitoring of policy implementation. Accountability for performance is the key. We need outcomes commensurate with outlays.
- To ensure access to protein and calorie, include pulses and edible oil in the public distribution system.

Mr. B. C. Gupta, Secretary, Department of Food and Public Distribution,
Succession of regional meetings by ICCIDD with the assistance of WHO and UNICEF led to establishment of national prevention programmes for IDD in many countries between 1987 and 1998. Establishment of the Network for the Sustained Elimination of Iodine Deficiency occurred in 2002 in collaboration with the international salt industry. This network of multilateral and bilateral agencies played a major role in success of IDD elimination programmes. Elimination of IDD has been a major public health success story.

- Basil Hetzel

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