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First Meeting of the Regional Working Group for IDD Elimination

A Report
WHO/SEARO, New Delhi, India, 29-30 September 2005

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CONTENTS

Page

Annexes

1. INTRODUCTION

The Ninth Meeting of Health Secretaries from Member States in WHO's South-East Asia Region reviewed the iodine deficiency disorders (IDD) situation in the Region in July 2004 and a summary of the discussion was presented to the Fifty-seventh Session of the WHO Regional Committee for South-East Asia in Kurumba, Maldives, in September 2004. The Committee endorsed the recommendations made by the Health Secretaries and adopted a resolution (SEA/RC57/R4), urging Member States to reaffirm their commitment to early and sustainable elimination of IDD and for WHO/SEARO to assist Member States in enhancing advocacy and awareness and provide technical support to various components of the IDD control programme. The Committee also endorsed the establishment of a Regional Working Group for IDD Elimination to accelerate the progress towards sustainable elimination of IDD in the Region. The Regional Working Group was therefore constituted in 2004 with members representing programme managers (public health), salt industries, laboratories, academicians and collaborating partners from the UN and other agencies.

The main objectives of the group are to periodically review the country situation using the ICCIDD/UNICEF/WHO recommended process indicators and identify critical gaps/constraints that retard progress towards achieving Universal Salt Iodization (USI) and to establish contact with the highest level in the political and administrative hierarchy in each of the countries for enlisting their support to accelerate progress towards USI in the shortest possible time.

After completing a desk review to address the first objective, the first meeting of the Regional Working Group for IDD Elimination was held in WHO/SEARO , New Delhi, India from 28-29 September 2005.

2. OPENING SESSION

Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO/SEARO delivered the opening remarks of Dr Samlee Plianbangchang, WHO

Regional Director for South-East Asia. Dr Samlee expressed concern that iodized salt coverage in the Region was only 66%. He pointed out that the Regional Office had been supporting IDD activities for many decades which had contributed substantially to policy formulation and actions by governments towards the sustainable elimination of iodine deficiency disorders. Dr Samlee said he was pleased to see that the concerned agencies and experts from some countries had joined together to address the problem in a more systematic manner. In conclusion, he reiterated WHO's commitment to support sustainable progress towards IDD elimination.

Dr Rukhsana Haider, Regional Adviser, Nutrition for Health and Development, WHO/SEARO, New Delhi, welcomed all the participants (See Annex 1 for list of participants) and explained the context and objectives of the meeting.

The objectives of the meeting were:

(1) To identify mechanisms for advocating and strengthening IDD control/prevention programmes in WHO Member States;

(2) To maximize cooperation and coordination between governments, partner agencies, concerned stakeholders and WHO, and

(3) To follow up actions at country and regional levels for implementing the WHO Regional Committee and World Health Assembly Resolutions for IDD elimination.

The outcome of the meeting will be to develop a regional plan of action, specifying key areas for focus by countries and support to be provided by (or required from) agencies. See Programme of Meeting at Annex 2.

Dr Eric-Alain Ategbo, UNICEF India Country Office, and Mr S. Sundaresan, Salt Commissioner, Government of India, were nominated as Chairpersons for the first day and Mr Bejon Misra, Chief Executive of the non-government organization (NGO), "VOICE", for the second day. Mr Gyambo Sithey, Programme Manager, IDD Control Programme, Bhutan, and Dr Anchita Patil, WHO Consultant, were nominated as rapporteurs.

3. PLENARY SESSION

Rapid Appraisal of Progress towards IDD Elimination in Countries of the South-East Region (SEAR)

The findings of the desk review were presented by Dr Abdullah Dustagheer. The rapid appraisal was conducted through email contacts with national IDD programme managers as well as their WHO and UNICEF counterparts and information was provided through questionnaires. The review and analysis were presented in the areas of: (i) policy implementation and programme management, (ii) information, communication and advocacy, (iii) universal salt iodization and (iv) monitoring system. Ten countries provided the relevant information except Timor-Leste which does not yet have an IDD elimination programme. The key interventions being carried out in the ten countries, were reviewed, as well as the key constraints and critical actions needed to achieve USI by 2007, followed by plenary discussions. See Annex 3 for a summary of the main findings of the desk-review; the full report will be circulated soon.

The participants were then divided into two groups for further discussions on key constraints, critical actions needed and development of a work plan for accelerating the achievement of the IDD elimination goal in the Region.

4. SHARING OF EXPERIENCES BY PARTICIPANTS

Participants shared the following experiences regarding the implementation of the IDD elimination programme in different countries:

- The Bhutan success story in IDD elimination;
- The "mission approach" to USI in India in the 1990s;
- Challenges facing the IDD elimination programme in Bangladesh;
- Rapid progress in Madagascar towards achieving IDD elimination;
- Efforts in Sri Lanka to increase iodized salt production;
- Opportunities in Indonesia to accelerate progress towards USI;

- Monitoring issues in Thailand;
- WHO support for and concerns on IDD elimination in the Region;
- The support of the Micronutrient Initiative to countries in the Region;
- UNICEF perspective on key constraints and challenges, and
- Role of a consumer protection NGOs in promoting USI.

Please see Annex 4 for details on these experiences.

5. PRIORITY CONSTRAINTS IDENTIFIED DURING THE GROUP WORK

Participants were divided into two groups as follows:

Group 1 (countries having adequate supplies of iodized salt (IS): BHU, INO, MMR, NEP, THA.

Group 2 (countries having inadequate supplies of iodized salt (IS): BAN, DPRK, IND, MAL, SRL, TLS.

Only the underlined countries were represented at the meeting.

The priority constraints identified by the two working groups were as follows:

Group 1 – Countries having adequate supplies of iodized salt

- Waning interest from collaborating partners and policy makers on IDD
- Cross border movement of non-iodized or non-adequately iodized salt
- Lack of standard iodine level requirement at production, retail and household level
- Lack of recommendation for upper limit for iodine in salt
- Weak enforcement of USI legislation regarding iodine standards

- Poor quality monitoring at production level, leading to improper iodine level
- Decrease in demand of iodized salt with disappearance of visible IDD
- Need to improve demand for iodized salt
- Raising the issue of iodine excess in salt by several countries (Bhutan, Indonesia and Thailand, Sri Lanka)
- Multiple food items iodized in some countries. This has also raised the issue of iodine excess
- Move in priority from Nutrition to Food Safety
- Existence of a large number of small salt producers, leading to difficulty in monitoring and standardization

Group 2 – Countries having inadequate supplies of iodized salt

- Poor coordination
- Large number of small-scale producers
- Increasing cost of potassium iodate (KIO3), SIP, maintenance & training
- Weak market signal to the producer
- Inadequate know-how about salt iodization
- Inadequate iodization capacity (e.g. Sri Lanka)
- Low availability of iodized salt in rural and remote areas
- Infiltration of non-iodized salts
- Low priority leading to poor enforcement of legislation
- Lack of comprehensive and effective information, education and communication (IEC) strategies
- Inadequate communication channels
- Lack of funds to roll out communication strategies
- Improper monitoring at all levels from production to consumption
- Lack of adequate manpower for monitoring
- Inadequate monitoring information network
- No link between monitoring and enforcement

6. WORK PLAN 2005 - 2007

The work plan identified the following key areas for focus by countries and for support by agencies:

Advocacy

(1) Regional (SEARO) level re-advocacy meeting aimed at political leadership either as a stand alone meeting or piggy backed on another public health/development meeting.

(2) National level re-advocacy meetings in SEAR countries aimed at high officials, programme managers and decision makers in relevant sectors

(3) Reactivate national and sub-national level alliances for IDD elimination (including consumer/civil society/media groups/ education and salt producers).

Quality Assurance (QA) of Iodized Salt and Monitoring System

(1) Review existing QA procedures in place at iodized salt production level, and at national and regional laboratories and support capacity building (induding protocol improvement, training and technical support).

(2) Standardize/harmonize salt iodine levels and urinary iodine excretion (UIE) levels within parameters set by WHO/UNICEF/ICCIDD guidelines.

(3) Link monitoring system to corrective action where needed

Communication

(1) Change focus of communication from goitre control to prevention of brain damage.

(2) Develop/implement comprehensive communication strategy (see *UNICEF-India IDD communication strategy*)

Small producers

(1) Training of small producers in process of iodization

(2) Explore possibility of establishing KIO3 facility at regional level

(3) Marketing support/strategy for small producers.

(4) Form salt producers' cooperatives or associations

(5) Replacement/maintenance of salt iodization plants

(6) Improving distribution of iodized salt to difficult-to-reach groups or areas.

See Annex 5 for the detailed Work Plan 2005-07.

7. CLOSING OF THE MEETING

The closing remarks at the meeting were made by Dr P.T. Jayawickramarajah, Director a.i. of the Department of Family and Community Health, WHO-SEARO. He congratulated the participants for developing a practical work plan and highlighted the following areas to accelerate progress towards reaching the IDD elimination goal:

- The need to ensure political leadership for IDD elimination, not only at the top level, but also (and more importantly) at sub-national levels, especially for large countries like India, Bangladesh and Indonesia.
- The importance of regular networking with focal points from all sectors at country level; and that
- Communication cannot be done in isolation, but should be linked with other areas of concern for greater interest and impact.

8. VENUE AND TIMING OF THE NEXT MEETING

The next meeting of the IDD Regional Working Group is tentatively scheduled for April/May 2006 at WHO-SEARO in New Delhi, India.

Annex 1

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Annex 2

PROGRAMME

Day 1, Thursday, 29 September 2005

0830–0900	Registration of participants
0900–1000	**Inaugural Session** • Welcome • Inaugural address by the Regional Director, WHO, South-East Asia Region (WHO/SEAR) • Introduction of participants Group photograph followed by Tea/Coffee Break
1000–1030	Presentation of the main findings of the desk review
1030–1100	Tea
1030–1130	Group work on key constraints impeding elimination of IDD (2 groups)
1130–1230	Plenary presentations on key constraints Discussions
1230–1330	Lunch
1330–1500	**Sharing experiences: input provided for IDD programmes – agencies and other members**
1500–1530	Tea/Coffee Break
1530–1630	Group work on critical actions needed to achieve goal of IDD elimination within 2006-7

Day 2, Friday, 30 September, 2005

0830–0900	Group work on critical actions needed to achieve goal of Iodine Deficiency Disorders Elimination within 2006-2007
0900–1000	Plenary presentations on critical actions needed Discussion
1000–1030	Tea/Coffee Break

1030–1130	Group work on regional plan of action for 2005-2007 (activities, timeframe, responsibilities of individual agencies, budget, external support required
1130–1230	Plenary presentation of regional plan of action, discussion and next steps
1230–1330	Lunch
1330–1500	Two working groups will be formed to address the actions required for the countries as below: • Group I – (those with adequate supplies of IS): BHU, INO*, MMR*, NEP, THA* • Group II – (those with inadequate supplies of IS): BAN*, DPRK, IND*, MAL, SRL*, TLS * Countries having a large number of salt producers
1500–1530	Tea/Coffee Break
1530–1630	Concluding Session

Annex 3

Rapid Appraisal of Progress towards IDD Elimination in South-East Asia Region (SEAR) Countries

SUMMARY OF THE MAIN FINDINGS OF THE DESK REVIEW

1. Objectives of the Desk Review

The objectives of the desk review were:

- To assess recent progress made by 10 countries of the SEA Region (except Timor-Leste);
- Identify constraints/gaps that retard progress towards achieving Universal Salt-Iodization (USI), and
- Determine critical actions to be taken to achieve IDD elimination goal by 2007

2. Key Interventions being Implemented by SEA Countries to Accelerate Progress towards Reaching USI

2.1 Policy formulation/implementation and programme management

- Reinforcement of IDD/USI coordination mechanism;
- Strengthening enforcement of USI policy/legislation;
- Capacity strengthening of keys stakeholders, including salt producers and distributors, IDD teams, health workers.

2.2 Information, communication and advocacy:

- Advocacy and re-advocacy at national and sub-national levels to strengthen government commitment to eliminate IDD
- Enhancing public awareness to increase demand for iodized salt, including targeting of audience segments (school children, pregnant women, consumers, salt producers, traders, public officials) and increasing use of mass media

2.3 Universal salt iodization

- Supporting the salt industry to increase and improve iodized salt (IS) production, including improvement of management process, appropriate technology and incentives. Indonesia is empowering small farmers. DPRK is still using iodized oil as a short-term measure.
- Improving IS distribution (coverage, packaging, marketing, warehousing, control).

2.4 Monitoring system

- Improving monitoring of IS at all levels (household, retail, production and point of entry)
  - strengthen lab capacities (networking, training, equipment)
  - improve reporting and feedback
- Conducting IDD surveys to track progress towards IDD elimination and inform policies.

3. Critical Gaps/Constraints faced by Country IDD Elimination Programmes

3.1 Policy formulation/ implementation and programme management

- Weak enforcement of existing USI legislation is by far the most important weakness in this area
- Weak coordination or lack of a multisectoral body (DPRK and THA);
- Lack of qualified manpower (MAL), high staff turnover (THA) or inadequate human resource capacity at local level (INO).
- Lack of financial resources (BHU)

3.2 Information, communication and advocacy

- Lack of awareness on IDD and the importance of USI by stakeholders (public, salt producers and traders, officials, etc.) is the most important weakness in this area
- Low demand for quality IS and preference for cheaper crystal salt or low grade salts.

3.3 Universal salt iodization

- The large number of small salt producers not iodizing salts or not adhering to iodization standards is the most important constraint in this area
- Inadequate market incentives to IS producers
- IS not included in Public Distribution System
- Dilapidated or worn-out salt iodization plants resulting in low production capacity
- Certain recurrent costs still supported by external agencies (potassium iodate, packing materials …); should cost be shifted to consumers or subsidized?

3.4 Monitoring system

- Inadequate/non-efficient mechanism linking monitoring to enforcement is the most important weakness in this area
- Cross-border infiltration of non-iodized or inadequately iodized salt; leakage through road transportation system in India.

4. Critical Actions Needed to Achieve USI by 2007

4.1 Policy formulation/implementation and programme management

- National IDD Commission to strengthen commitment from central government; MOH to strengthen its collaboration and support to the Ministry responsible for salt industry
- Establish/expand existing IDD committees/task-forces to include salt industry, consumer organisations, and the education and media sectors
- Enforcement of existing USI legislation at all levels (develop implementing regulations)
- Ensure adequate financial resources/budget (internal & external)
- Strengthen staff capacity at all levels, especially for monitoring

4.2 Information, communication and advocacy

- Develop a comprehensive communication strategy to strengthen advocacy efforts and increase public awareness that includes:

- Community-based social mobilization campaign
- School awareness campaign
- Awareness through pre-natal care contacts
- Mass communication (radio, TV, mobile phone)

4.3 Universal salt iodization

- Plan for sustainable production of iodized salt, including support to small salt producers;
- Implement measures to reach the remaining population not consuming iodized salt: distribution and marketing;
- Construct/rehabilitate salt iodization plants to sustain/increase iodization capacity;
- Rationalize iodization levels to ensure the cost/effectiveness of the process;
- Carry out iodization of salt at wholesale level (where useful).

4.4 Monitoring system and research

- Improve monitoring system (production, retail and household levels, and inland transport and points of entry) with linkage to enforcement procedures;
- Support operational research with relevant partners, including efforts to understand the socio-cultural and ecological reasons for persistence of IDD, which are essential for sustainability of iodine nutrition.

Please refer to the full report of the desk-review (to be circulated soon) for details and country-specific information.

Annex 4

SHARING OF EXPERIENCES REGARDING IDD CONTROL A SUMMARY

Chairperson: Mr S Sundaresan.

Rapporteur: Dr Anchita Patil.

Mr S Sundaresan, the Salt Commissioner of **India** gave an example of the "mission approach" (the Rajiv Gandhi Mission) used in the State of Madhya Pradesh in the 1990s to tackle the IDD problem. School children were used to create awareness in the community regarding IDD and the use of iodized salt for its control. It was a known fact that there was no quality check on the salt that was transported by road. But, at that time, there were only a few entry-points into the State. This was taken advantage of and salt transported in trucks into MP was tested on the spot for iodine content. Trucks carrying salt not meeting the required standards were sent back to the producer. Though no legal action was taken, this act in itself was sufficient to deter producers from sending such salt into the State again. During this period, access to iodized salt in Madhya Pradesh rose to 95%. But, after the withdrawal of this mission in the late 1990s, things are slipping back to the same reduced rates of iodized salt access.

Mr Sathyapal Jayapal from the **Micronutrient Initiative** (MI) Asia Office gave an overview of the actions of his agency regarding IDD control. He said that MI was specifically looking into the production of iodized salt and was not into the demand creation aspect. MI is presently supporting salt iodization efforts in India, Bangladesh, Pakistan, Nepal, Sri Lanka and Indonesia in collaboration with ICCIDD, UNICEF and other agencies. The support included: helping small-scale producers to improve the quantity and quality of iodized salt (IS) produced (e.g. setting up or rehabilitating salt iodization plants, provision of KIO_3 at subsidized rates, training); double fortification of salt (with iodine and iron); IDD survey; study of cross-border salt movement; and IS distribution through the Public Distribution System (PDS).

Mr Gyambo Sithey (National Programme Manager) gave an overview about progress in **Bhutan**. This is the only country in the Region that has achieved elimination of IDD (according to the 10 indicators). But, after

elimination, the country is facing a lack of funds from donors and agencies and it is proving difficult to sustain the activities required for elimination. Bhutan is also seriously thinking about the introduction of double fortified salt with help from UNICEF. But, until that is done, they do not want to disturb the existing process of USI. However, the country is concerned with the quality assurance of iodized salt, particularly excess iodine level.

Dr Rukhsana Haider, NHD, **SEARO**, gave the background for the present meeting. She said that the process started following an inter-agency meeting in India last year. The desk review was then commissioned to find out the status in various countries in the Region. This meeting was held to follow-up the same. She also mentioned that she had recently visited a Member State and had noted the unfortunate situation whereby commitments made at meetings were not followed up with action in the country. She had also heard that a few surgeons were opposing the use of IS universally as they feared it would cause thyroid cancer.

Mr Abdullah Dustagheer (Consultant) shared his experiences of working in **Madagascar** with UNICEF. That country started its IDD elimination Programme in the 1990's with strong advocacy and political commitment. Active leadership was provided by the Ministry of Health and there was an excellent partnership with the Ministry of Industry and Trade. The initial use of iodized oil provided a convincing demonstration through the dramatic fall in goitre rates. The salt iodization programme was rapidly set up with UNICEF and World Bank support and within 5 years TGR and UIE rates improved to recommended levels. The USI process was accelerated because 50% of the salt consumption was supplied by one large producer and 25% by a few medium salt producers. A system of sentinel sites monitoring was set up at the start of the programme and provided regular annual data on key IDDE indicators. The country is close to reaching the IDD elimination goal.

Dr Eric Alain Ategbo from **UNICEF, India,** highlighted a few roadblocks in achieving USI and IDD elimination (specifically in the Indian context) and ways to deal with them. These roadblocks are: IDD elimination/USI is perceived as an agency-driven agenda; weak enforcement of USI legislation; weak monitoring (especially at production level); inadequate access to iodized salt in urban slums, rural and remote areas; and actual production of IS far below production capacity (potential).

To deal with all these issues, he suggested the following as potential solutions: (i) need to raise IDD as a priority issue on the political agenda (a multi-stakeholder National Alliance/Coalition will be useful in this regard); (ii) need to intensify partnership with the salt industry to understand the role of the market in generating demand for IS; (iii) partnership with civil society – IS should be raised as a consumer rights issue; and (iv) need to improve the coordination and monitoring systems and develop with a comprehensive monitoring plan.

Mr Bejon Misra, the CEO of **VOICE**, a consumer forum in India said that they were looking into the issue of ensuring quality of foodstuffs (including iodized salt) by working with BIS (Bureau of Indian Standards). In 1999 they compared a few leading salt brands and exposed those with less than the required iodine levels through their magazine. They intend to repeat the exercise again in the near future.

Prof. Quazi Salamatullah from **Bangladesh** highlighted some of the issues in his country: (i) there were two ministries responsible for the programme: Industry and Health, and coordination between the two was often a problem; (ii) a study was carried out to assess the desirable level of iodine in salt. It was found that if the iodine level in salt were 10-15 ppm, some members of the household were not receiving adequate iodine as per UIE levels. However, if the levels were 20-25 ppm, all members received adequate iodine, (iii) they were trying to define an upper limit for iodine because samples of salt containing iodine as high as 100 ppm had been found in surveys.

Mr Mahinda Gunawardena (National Coordinator, ICCIDD) from **Sri Lanka** said that: (i) A post-tsunami assessment of damage to the salt industry is being carried out; (ii) efforts are under way to increase the iodization capacity of the three major IS producers with the goal to make them self-sufficient and leave it to the cottage industry for packaging and distribution.

Dr Dini Latief, STP Nu trition, WHO-SEARO, shared her experiences in **Indonesia**. The country had developed a National Plan of Action for IDD elimination for 2005-2010 that strengthens measures for reaching USI. The problem in Indonesia is also that of many small-scale producers. She felt that 'law enforcement' alone will not work. What is needed is a 'social norm enforcement' wherein USI is seen in terms of human rights.

Dr Visith Chavasit (Institute of Nutrition, Mahidol University) from **Thailand** highlighted the following points: (i) KIO_3 was being distributed

free to all producers; small-scale producers were still mixing KIO_3 by hand; (ii) Screening tests showed that the iodine content in salt ranged from 0-800 ppm; shortage of manpower of Food Department for QC; (iii) innovative approaches being used - use of high school laboratories to test the salt from small-scale factories and training of medium-scale factories in the titration method; (iv) surveys showed UIE was too high a few years ago and is too low at present; (v) research is being conducted on the possibility of adding iodine to iron tablets to be given during pregnancy and lactation.

Dr Anchita Patil from the **WHO India** country office explained that WHO was supporting the Government of India on four fronts insofar as IDD control is concerned: (i) conduct of National IDD Survey 2002-2003; (ii) capacity building of programme managers and other stakeholders; (iii) IEC activities and multi stakeholder workshops for advocacy; (iii) supplies for strengthening state monitoring cells and laboratories.

Dr Rajan Sankar (UNICEF-India) was asked by the chairperson to describe the results of studies on iodine losses from production to consumption. One study on crystal iodized salt transported in 50 kgs bags from Gujarat to Sikkim showed a maximum iodine loss of 30% from point of production to point of consumption, even in the worst case scenario of a 10 month lag period. In another study by the Marine Salt Research Institute in Bhavnagar, crystal iodized salt was kept in the open, exposed to rain and sun for 12 months. After all the extreme conditions, the loss in iodine was only 50%. The main conclusion was that with better quality of raw salt, better packaging and reduction in transit time, the loss of iodine from salt was negligible.

Dr Rajiv Tandon from **USAID** emphasized the commitment of USAID towards USI. He mentioned that USAID funds were routed through UNICEF in this venture. He, on behalf of USAID, wanted to know if we could look 'beyond USI'? As we were behind target for achieving the IDD elimination goal, he wanted the group's comments on the role of iodized oil for pregnant women through the health system. Various participants commented that although this could be a short-term emergency measure (used initially by some countries), it would not be a cost-effective measure once a USI programme is under way. Concerns about duplication of efforts and logistical problems to reach target groups through the health system were also raised. It was pointed out that there are a number of WHO technical reports and recommendations regarding the use of iodized oil to which participants can refer for further information and guidance.

Annex 5

WORK PLAN 2005- 2007

Key Constraints	Key Actions	Lead agencies	Time Line
Decreasing interest in IDD elimination 1. At government level 2. At international agency level	1. Regional (SEARO) level re-advocacy meeting aimed at political leadership either as a stand alone meeting or piggy backed on another public health/development meeting. 2. National level re-advocacy meetings in SEAR countries aimed at high officials, programme managers and decision makers in relevant sectors. 3. Reactivate National and sub-national level alliances for IDD elimination (including consumer / civil society/media groups/education and salt producers)	WHO UNICEF	May 06
Quality assurance of iodized salt and monitoring system 1. Excess and inadequate iodine in salt 2. High median urinary iodine excretion 3. Poor utilisation of monitoring system leading to corrective action	1. Review existing QA procedures in place at iodized salt production level, and for national and regional laboratories and support capacity building (including protocol improvement, training and technical support). 2. Standardize/harmonize salt iodine levels and UIE levels within parameters set by WHO/UNICEF/ICCIDD guidelines. 3. Link monitoring system to corrective action where needed	ICCIDD WHO UNICEF	Dec 2005
Communication Decreasing interest with disappearance of visible manifestations of iodine deficiency	1. Change focus of communication from goitre control to prevention of brain damage 2. Develop/implement comprehensive communication strategy (see *UNICEF-India IDD communication strategy*)	WHO UNICEF	Sept 05

Key Constraints	Key Actions	Lead agencies	Time Line
Small salt producers 1. Lack of technical know-how 2. Lack of marketing skills 3. Inability to access potassium iodate	1. Training of small producers in process of iodization 2. Explore possibility of establishing KIO facility at regional level 3. Marketing support/strategy for small producers. 4. Form salt producers' cooperatives or associations 5. Replacement/mainten ance of salt iodization plants 6. Improving distribution of iodized salt to difficult to reach groups or areas.	MI and UNICEF (Country specific support). WHO/UNICEF would explore the possibility of involving UNIDO/UNDP and WFP.	Initiate Action by Dec 2005