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IN THIS ISSUE

WHO Regional Committee - SEAR

61st Session of the WHO Regional Committee

New Delhi, India, 8-11 September, 2008

सर्वेषम् स्वस्ति भवतु
सर्वेषम् सन्तिर भवतु
सर्वेषम् पूर्णम् भवतु
सर्वेषम् मंगलम् भवतु
May auspiciousness be unto all
May Peace be unto all
May fullness be unto all
May prosperity be unto all

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on behalf of ICCIDD

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ICCIDD Vision, Mission & Dedication

Vision: The vision of ICCIDD is a world virtually free from Iodine Deficiency Disorders with national endeavors to maintain optimal iodine nutrition primarily through consumption of iodised 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 to governments and development agencies, of a continued priority for iodine nutrition, providing technical expertise in a multi disciplinary approach.

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

Editorial

Dear Colleagues,

The ICCIDD team would like to welcome Ms. Karin Hulshof, who has taken charge as the India Country Representative of UNICEF. Dr. Victor Aguayo is the new Chief of Nutrition and Dr. Mohamed Ayoya has joined as the Nutrition Specialist at UNICEF India Country office, New Delhi. We also welcome our colleague in WHO-SEAR, Dr. Kunal Bagchi who has joined as the Regional Advisor for Nutrition.

The 61st Regional Committee of SEAR met at New Delhi. ICCIDD participated as an NGO and made a statement. Dr. Samlee Plianbangchang, Regional Director was re-nominated for a second term. Hearty Congratulations! On the sidelines of this meet, the Health Minister of Bhutan, H.E. Lyonpo Zangley Dukpa paid a visit to the All India Institute of Medical Sciences and met with the Faculty members of the Institute. ICCIDD was the first to share its long and successful partnership between the Royal Government of Bhutan, AIIMS and ICCIDD to achieve sustainable elimination of IDD in Bhutan.

The SEA Nutrition Network met at Hyderabad for their ninth meeting to promote exchange of information amongst the member countries.

The Government of India and UNICEF have launched a five year plan. Nutrition remains first on the development agenda. This was also reiterated in various national meetings and symposiums like, "Third Meeting of the Executive Committee of the National Nutrition Mission" organized by the Ministry of Women and Child Development and "National Nutrition Policy", a symposium organized by the Nutrition Foundation of India. The National Nutrition Week was celebrated from 1-7 September, 2008. It was inaugurated by the Speaker of Indian Parliament, Dr. Somnath Chatterjee.

A short report on Gujarat state initiative for iodized salt under RCH II features in this issue. Also featured is a report on the panel discussion on "Malnutrition an Emergency" organized by the Confederation of Indian Industry and the Ministry of Development of North-Eastern Region in India. MI-ICCIDD Quality Assurance Programme activities are reported here as well as a field situation analysis towards road to achieving sustainable elimination of IDD. On the regional front an update from Sri Lanka and Pakistan is included.

With series of activities at Regional, National and State level, the synergistic efforts towards sustainable elimination of IDD continue.

Dr. Chandrakant S. Pandav

Regional Coordinator - SA Region

Dr Samlee Plianbangchang Re-Nominated as WHO Regional Director for SEAR

61st Session of the WHO Regional Committee

New Delhi, India, 8-11 September, 2008

ICCIDD congratulates Dr. Samlee Plianbangchang for his renomination as the WHO Regional Director for South East Asia region for a second term.

His nomination will be submitted to the 124th Executive Board of WHO at its January 2009 session for ratification.

As Regional Director, Dr. Plianbangchang focused on building the Member Countries' capacity to strengthen their national health programmes. During his first term, WHO set up the South-East Asia Regional Health Emergency Fund to provide immediate relief after a natural disaster strikes. The Fund was activated within hours of cyclone Nargis in Myanmar.

Dr. Plianbangchang's first term as Regional Director was marked by important initiatives such as the establishment of the South-East Asian Public Health Education Institutes Network (SEAPHEIN). He is an expert in international health planning and administration, including programme and project development, coordination and management; epidemiology and human ecology; and public health education and practice.

Dr. Plianbangchang served for 16 years in WHO before retiring as Director of Programme Management in 2000. Before joining WHO, Dr Plianbangchang worked at several key positions in the Ministry of Public Health, Royal Thai Government. He was Director, Technical Division, Department of Medical Services from 1974 to 1981 and was Secretary, National Advisory Board for Disease Prevention and Control and Director of its Office from 1981 to 1985 and Acting Director, Division of International Health, Ministry of Public Health (1981-1982).

Dr. Samlee Plianbangchang graduated with the degree equivalent to M.D. (Medical Doctor) from the University of Medical Sciences in Bangkok; obtained Master of Public Health and Tropical Medicine (M.P.H. & T.M.) and Doctor of Public Health (Dr. P.H.) from Tulane University, and Certificate of Comprehensive Health Planning for Senior Health Administrators from Johns Hopkins University School of Hygiene and Public Health, both in U.S.A. He was certified by the American Board of Preventive Medicine to be specialist in international public health, and by the Thai Medical Council to be specialist in Preventive and Social Medicine; recognized by American Medical Association to be an outstanding physician in 1970; awarded a gold medal by Tulane University for the best doctoral dissertation in 1972; and selected to be member of Delta Omega (ETA Chapter) which is one of the prestigious American public health professional societies.

As in the past, under the leadership of Dr. Plianbangchang, as the Regional Director of WHO-SEAR, ICCIDD pledges its support for elimination of IDD in countries of WHO-South East Asia Region.

ICCIDD congratulates Dr. Samlee Plianbangchang (L) for his renomination as the Regional Director for SEAR. On (R) is Dr. Chandrakant S. Pandav

ICCIDD welcomes Dr. Kunal Bagchi who has joined the WHO-SEAR office as the Regional Advisor for nutrition. Dr. Bagchi has worked as a public health specialist with the UN social development programmes in the countries of South-East Asia, East Africa and Middle East. He served as the Regional Adviser in Nutrition at the WHO Eastern Mediterranean Regional Office, Cairo.

61st Session of the WHO Regional Committee for South-East Asia
Statement of the Regional Coordinator, ICCIDD - South Asia
New Delhi, India, 8-11 September, 2008

May I, on behalf of my colleagues in the International Council for Control of Iodine Deficiency Disorders (ICCIDD) first of all thank the Regional Director for extending invitation to attend the 61st Session of the WHO, Regional Committee for South-East Asia that is being held at New Delhi, India.

ICCIDD is the only organization, globally, which focuses exclusively on the sustainable elimination of iodine deficiency disorders. ICCIDD has been providing over the last 22 years a wide array of expertise including medical, nutritional, salt industry and technical aspects related to IDD. ICCIDD has also played pivotal role in policy formulation by regular interactions with the elected representatives and policy makers.

ICCIDD has been a regular participant in the Annual World Health Assembly (WHA), since 1994. The ICCIDD delegation to the 60th World Health Assembly held in May 2007 was able to convince the WHA to repeat its call, first made in 2005 at the 58th WHA, to implement the recommendation in resolution (WHA58.24) to establish multi-disciplinary national coalitions in order to monitor the state of iodine nutrition every three years.

Only 2 countries out of 11 countries in the South-East Asia Region of WHO (WHO-SEAR) have been able to achieve relatively high rates of coverage (>90%) of household use of iodized salt. The household coverage of adequately iodized salt in the countries of the Region is enumerated in Table 1.

We need to continue to push the USI/IDD agenda collectively with partners. While Bhutan is the only country in the region that has eliminated IDD as a public health problem, the introduction of cyclic monitoring as part of the monitoring process for the first time in the world has worked to the country's advantage. Sri Lanka is another country that is doing well in terms of IDD elimination. A request is being processed from them for an independent external assessment.

Elimination of Iodine Deficiency Disorders will contribute to at least six of the Millennium Development Goals i.e. Eradicate extreme poverty and hunger; Achieve Universal Primary Education; Promote gender equality and empower women; Reduce child mortality; Improve maternal health; Develop a global partnership for development.

A lot of progress needs to be made in the other priority countries of the region as well. There is a wealth of knowledge in many successful programs and most important thereof is the knowledge of lessons learnt on key issues with regards to sustainability.

Table 1: Household coverage of iodized salt in SEAR Countries

S. No.	Country Name	Household Coverage	S. No.	Country Name	Household Coverage
1.	Bhutan	96%	6.	Nepal	63%
2.	Sri Lanka	94%	7.	Myanmar	60%
3.	Bangladesh	84%	8.	Thailand	58%
4.	Indonesia	73%	9.	India	51%
5.	Timor-Leste	72%	10.	Maldives	44%
			11.	DPR Korea	40%

The lessons learnt from the more successful countries are:

1. Hold regular National Advocacy events to assure that all actors in the field are informed, active and participating.
2. Hold regular National and Sub National monitoring activities and report them widely to demonstrate not only progress but where problems are being encountered.
3. Maintain constant public information on the problems of iodine deficiency and the dangers of absence of iodine.
4. Sustain high level national political commitment across the board.

For those countries that have achieved success, the challenge is to sustain the success. They should be provided a platform to share the success with other countries, not only in IDD and Nutrition fora but also in other fora where success story of any programme is being discussed.

This is not the time to rest. The effort should be more vigorous now. How challenging it is to change the perception? Even after 25 years of scientific research, the problem of IDD is still largely perceived as equivalent to "Goiter". People consider it a cosmetic problem and hence a low priority issue. But goiter is only "Tip of the iceberg". According to WHO, IDD is the single most important cause of mental retardation and it is totally preventable. Focus should be more on the implications that iodine deficiency has on the intelligence Quotient (IQ) of the child and the contribution of elimination of IDD to at least six of the Millennium Development Goals. It is the quality of the human resources development that should be of concern and NOT just goiter!

What is needed is coming together of policy makers and scientific fraternity. Together they can start an odyssey into future ably supported by our partners of private sector and the iodized salt producers. Together they would lead towards a world devoid of IDD, and a healthy society, thus, fulfilling the right of every child to optimal physical and mental development.

Mr. Chairman, in Iodine Deficiency Disorders: We know the answer to "What needs to be done?" It is very simple, daily consumption of adequately iodized salt is a healthy habit! We must now accelerate and share our efforts to find the answer to, "How is it to be done?" ICCIDD is committed to be a partner in terms of moving ahead with, "How it is to be done?"

WHO SEARO is working with the regional office of ICCIDD in developing a region-specific protocol for the quality control/assurance and monitoring of national IDD control programmes. Similar collaboration of efforts exist in improving technical capacities of Member States through technology transfer e.g. production of potassium iodate in Myanmar with possible technical support from India.

Health Minister of Bhutan Visits AIIMS

Visit of Delegation led by H.E. Lyonpo Zangley Dukpa

New Delhi, India,11 September, 2008

A delegation led by H.E. Lyonpo Zangley Dukpa, Hon'ble Minister for Health, Royal Government of Bhutan visited the All India Institute of Medical Sciences on 11th September, 2008, for an interactive meeting with the Faculty of this prestigious institution. Dr. Chandrakant S. Pandav was the first faculty member to share experiences of long association of AIIMS with Bhutan in elimination of IDD.

Bhutan was the first country in the South Asia region to have achieved elimination of IDD as a public health problem and AIIMS/ICCIDD played a key role in it.

Dr. Pandav later presented the Hon'ble Minister a copy of the citation which was presented earlier by AIIMS to Bhutan on achieving elimination of IDD. Dr. Pandav cited this association as a very good one and hoped the Bhutan continues with its cyclic monitoring to sustain the success and extended full support of AIIMS and ICCIDD. He also shared that delegations from Bhutan have been trained on a regular basis at the ICCIDD laboratory, New Delhi for quality control of iodized salt.

Bhutan Health Minister is greeted by WHO-SEAR, Regional Director, Dr. Samlee Plianbangchang and Dr. C.S. Pandav. The Citation to the Royal Government of Bhutan is on the right.

Members of Bhutan Salt Enterprises receiving the certificate after successful training at ICCIDD laboratory.

L to R: Dr. Chandrakant.S. Pandav, Dr. M.G. Karmarkar, Mr. Dawa Gyeltsen, Mr. Subrata Chanda

SEA Nutrition Network Meets to Promote Effective Exchange of Information

National Institute of Nutrition (NIN)

24-26 September, 2008

The IX meeting of the Joint WHO- FAO Southeast Asia Nutrition Research-cum-Action Network was held at the National Institute of Nutrition (NIN), Hyderabad, India from 24th to 26th September 2008. The three day meeting was an endeavor to promote effective exchange of information among the member countries and partnering organizations/institutions. Participants drawn from diverse fields of food and nutrition like researchers, academia, and policy implementation of the 11 member states took part in the meeting. Representatives from UN organizations like WHO, FAO, UNICEF, ICCIDD and World Food Programme also participated in the meeting.

Alongside discussing the ways and means to revitalize the network, the meeting also focused on the rising food prices in the region and its impact on household food insecurity. The participants also shared some successful programmes and experiences in the management of mild, moderate and severe malnutrition using community-based strategies. Special sessions discussed recent interventions to combat and control micronutrient malnutrition especially Iodine Deficiency Disorders (IDD) and Iron Deficiency Anaemia. Through group activities, the workshop participants looked into future research needs and evidence-based interventions for management of malnutrition; exchanged views on making the micronutrient deficiency control and prevention programmes successful by bridging the gap between research and action and explored the possibility of behavioral change communication in control and prevention of anaemia.

For IDD, the groups reviewed the country experiences in IDD control programmes. The main issues discussed included Universal Iodization and Quality Assurance and Regulation. It was apparent that the small producers have a key role in ensuring iodized salt supply and require transfer of technology. In addition, the group also discussed the importance of quality control from production to consumption end. The groups felt the need to consider sustainability of programme components of NIDDCP.

About the network

The network was established in 1990. WHO-SEARO & WHO Collaborative Centres in Nutrition were instrumental in forming the Network. The Member Countries include Bangladesh, Bhutan, DPR Korea, India, Indonesia, Myanmar, Nepal, Republic of Maldives, Sri Lanka, Thailand and Timor-Leste.

Objectives of the Network

To optimize regional expertise for linking nutrition research to country programmes in order to address existing nutritional problems prevailing in the Region.

In accordance with the consensus of the members, WHO-SEARO has designated the National Institute of Nutrition (NIN), Hyderabad, India as the new secretariat for the Southeast Asia Nutrition-cum-Action Network. NIN takes over the baton from Mahidol University, Thailand.

Objectives of the Secretariat

1. Communicating and maintaining information flow among network members
2. Support and follow-up on recommendations of the Network Meetings
3. Increase awareness and promote direct communication among network members

Working Together to Reach All of India's Children:
Government of India and UNICEF Launch Five-Year Plan of Action

New Delhi, 21 August, 2008

Ms. Renuka Chowdhury, Hon'ble Minister of State (Independent Charge), Woman and Child Development and Dr. Karin Hulshof, Representative, UNICEF India jointly launched the GOI-UNICEF Programme of Co-operation, 2008-2012 on 21 August, 2008. The joint initiative is designed to help India achieve its national development goals while ensuring that no child is left behind as India moves forward.

About one fifth of the world's children live in India. The country's progress is key to meeting the Millennium Development Goals (MDGs). The joint plan focuses on the reduction of India's infant mortality and maternal mortality rates (IMR and MMR), fighting malnutrition, tackling HIV, providing quality education, ensuring safe water and environmental sanitation and providing child protection. UNICEF is to engage further with civil society and establish innovative partnerships to promote the well-being and survival of India's children. UNICEF works in close partnership with other United Nations agencies, the World Bank, bilateral partners, the private sector and international and national non-governmental organizations.

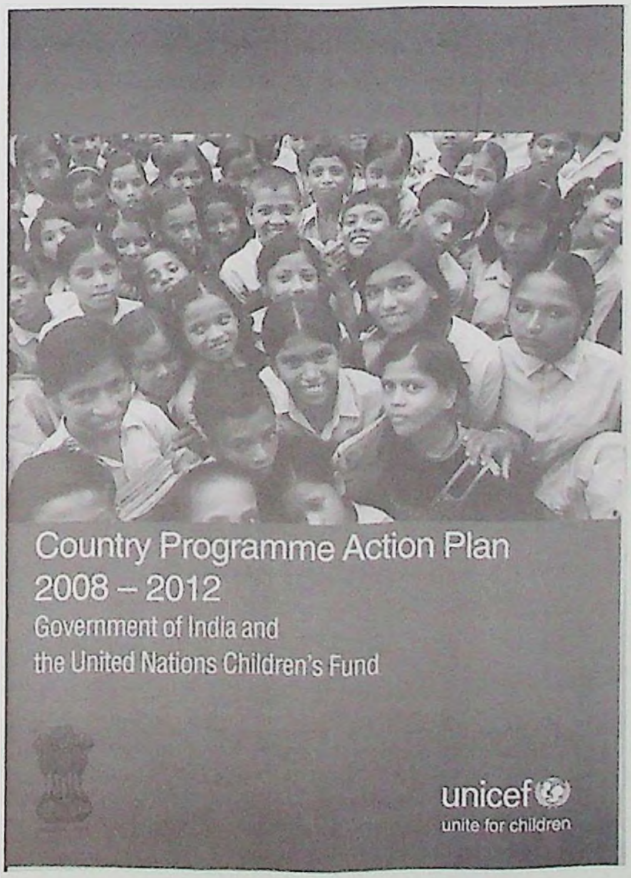
Goal and Objectives

The overall goal of the 2008-2012 Country Programme is to advance the fulfillment of the rights of all women and children in India to survive and thrive, develop, participate and be protected by reducing social inequalities based on gender, caste, ethnicity or region.

The Reproductive and Child Health programme aims to reduce infant mortality rates (IMR) from 58 to 28 per 1,000 live births, and maternal mortality rates (MMR) from 301 to 100 per 100,000 live births within five years. The main interventions will revolve around enhancing access to and more equitable coverage of immunization, child survival and maternal care, while strengthening health systems.

The Child Development and Nutrition programme focuses on improving the nutritional status of the mother and child, by promoting breast feeding, appropriate complementary foods and feeding practices, micronutrient nutrition, the control of anaemia and the care of children with severe malnutrition. Anticipated

Setting new goals: Minister of State for Women and Child Development Ms. Renuka Chowdhury with Representative of UNICEF Dr. Karin Hulshof during the launch of the GOI-UNICEF programme of co-operation 2008-12 in New Delhi.



results include the reduction in the level of malnutrition, significant reduction in micronutrient deficiencies and prevention of malnutrition in children below three years.

The Child Environment programme aims to improve the availability of clean and safe water availability, its management, conservation and equitable allocation, as well as access to sanitation and adoption of critical hygiene practices. Key results include sustainable access to and use of safe water and basic sanitation services.

The Child Protection programme seeks to protect children from violence, exploitation and abuse by including promoting the Juvenile Justice Act, child labour laws and other related legislation. Key results include strengthened policies, budgets, laws, norms, guidelines and tracking systems on children in need of care and protection and the establishment of child protection units at the state level.

The Education programme works to ensure more children enroll, stay in school and complete elementary education. UNICEF is seeking to improve learning outcomes, completion rates and literacy levels amongst disadvantaged groups. Key results include increased enrolment, retention, achievement and completion rates in elementary education.

The Children and AIDS programme aims to reduce vulnerabilities, slow down the rate of new infections and mitigate the impact of HIV and AIDS among children 0-18 years old. Prevention is focused on the most at risk and vulnerable young people. Key results include providing a comprehensive package of services to prevent mother-to-child transmission of HIV to 40 per cent of all HIV-positive pregnant women, appropriate care and treatment to HIV-positive infants and the reduction of stigma.

The Social Policy, Planning, Monitoring and Evaluation programme is improving systems for data gathering, analysis and dissemination to support evidence-based programme planning and advocacy. The Behaviour Change Communication programme helps to strengthen the Government's capacity for communication for behaviour and social change, including entertainment education and cross-sectoral communication. The Advocacy and Partnerships programme is building a voice for children through parliament, civil society organizations, media, celebrities and sports endorsements and campaigns to ensure children's rights.

Almost 80 per cent of India is vulnerable to natural disasters, which cause extensive damage to lives and livelihoods every year. The Emergency Preparedness and Response programme works with the Government for the fulfillment of the rights of children and women in humanitarian crises.

Geographic Focus

At a national level, UNICEF works closely with the central government in ensuring that children's rights are reflected and resourced in policies and programmes. The seven states of Bihar, Uttar Pradesh, Rajasthan, Orissa, Madhya Pradesh, Jharkhand and Chhattisgarh are the focus of intensive programming, innovations and social mobilization to accelerate progress in child survival and development. In addition, focused interventions in Assam, West Bengal, Maharashtra, Gujarat, Andhra Pradesh, Karnataka, Tamil Nadu and Kerala are supported with advocacy and policy development. In 17 "Integrated Districts" UNICEF is concentrating its efforts on community empowerment, behaviour change and quality service delivery.

Exhibition to Celebrate National Nutrition Week Inaugurated

National Nutrition Week

1-7 September, 2008

A two-day long exhibition on nutrition awareness for women and children was inaugurated at the India Gate lawns. It was organized by the Ministry of Women and Child Development and the Food and Nutrition Board.

Ms. Renuka Chowdhury, Hon'ble Minister of State for Women and Child Development, said the purpose of the exhibition was to create awareness among people about nutritious food and healthy living, during the National Nutrition Week (Sep 1-7).

The minister, addressing the inauguration ceremony, said: 'A majority of Indian women and children are prone to micro-nutrient and calcium deficiency which are not known to many. They are faced with health hazards due to lack of nutrition awareness.' Well-nourished children tend to have a higher IQ and better cognitive ability. While medicines are not a solution, nutrition awareness is the only prevention,' she maintained.

Dr. Somnath Chatterjee, Speaker of Lok Sabha, inaugurated the exhibition. He said that nutrition awareness was essential for sustainable growth in a country where 41 percent of the population is comprised of children. 'Foetal and early childhood malnutrition has lifelong consequences on growth and development of our country. Therefore, investment in child nutrition today will give manifold returns in the future.'

Speech of UNICEF Representative to India, Dr Karin Hulshof

Government of India and UNICEF Launch Five-Year Plan of Action

New Delhi, 21 August, 2008

Good morning, Honourable Minister (Independent Charge), Ministry of Women & Child Development, Ms. Renuka Chowdhury; Secretary, Women & Child Development, Mr. Anil Kumar and senior staff from your Ministry; UN Resident co-ordinator, Dr. Maxine Olsen; Representatives from the central government, ministries, Representatives of state governments, Development partners, Media representatives, and, of course, my own staff from our state offices and the Delhi office.

A very warm welcome to all of you. Last weekend, I had my first opportunity to celebrate India's Independence. 61 eventful years. I come slightly late to this journey, of course, but it is a privilege to be here. For most of these past 61 years, UNICEF has also been growing with India. From the first exciting and difficult years following Independence, through periods of growth and strife, UNICEF, I feel has retained its unique mission in this country. So, today, as we officially launch the next five year plan of cooperation between the Government of India and UNICEF, I would like to reflect on three points: One.....on what I perceive to be the relevance of UNICEF's mission in today's India. Two...how the way we work is evolving. And, three...why I believe UNICEF to be a unique and special partner to India, its people, and particularly, its children. Some judge progress by rates of economic growth. And, by many measures, the growth of India's Gross Domestic Product has been extraordinary in recent years. However, as we know, not everyone benefits equally. And a just society recognizes this, and tries to make things right. Which brings me to my first point. The relevance of UNICEF's mission in India today. Our mandate from the United Nations General Assembly is to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. Here, there is still important work to meet basic needs. Such as reducing child mortality and morbidity. Tackling the crisis of severe malnutrition. Promoting a safe and clean environment. Reducing disparities between boys and girls in the classroom. Helping young people protect themselves from HIV. We have set out with the Government of India, state governments, civil society and development partners, including other agencies within the U.N. Family, a concrete, measurable, five-year plan of action that aims to fulfill children's rights. In that regard, our Mission is as relevant as ever.

Our Mission in India also contributes to a wider, all-encompassing agenda for the world's people as set out in the Millennium Development Goals. Though this plan that we are launching with the Government today, UNICEF recommits itself to working within the U.N. context to support India in achieving the MDGs.

India's responsibility with one-fifth of the world's children is special. Let me give you just two examples.

35% of all under-weight children under the age of five, globally, 55 million children are in India. And... 29% of the world's population some 740 million people in India do not have access to improved sanitation.

Today, with the launch of this five year plan, we share the burden and the opportunity with you to make this a better world for children to thrive.

UNICEF's mission also requires us to be committed to ensuring special protection for the most disadvantaged children, children who are victims of extreme poverty, conflict, disasters, all forms of violence and exploitation, and those with disabilities. Which brings me to my second point how we will work differently in this new country programme. When we analyzed our work over the past five years, in preparation for this current country programme, we were guided in our thinking by a discourse that was shaping India's own thinking about the balance between economic and social development....as demonstrated by the Prime Minister's often cited concern about the need for social inclusion. A disaggregated analysis showed that children from certain tribal communities, castes and minority communities account for the largest gaps in development indicators. And their ability to avail of services, to take full advantage of the government's increasing investments in social development, is at times hampered by extreme poverty, exploitation and exclusion. To that complex situation, we again used data to help focus our programming on key states, and within those states, critical districts where basic needs are less likely to be

met and where the forces of social exclusion are most pronounced. And, we will do that by working closely with Government counterparts both here in Delhi and in States to deepen the impact of India's flagship programmes, such as the National Rural Health Mission, S.S.A (Sarva Shiksha Abhiyhan), the Total Sanitation Campaign, I.C.D.S. (Integrated Child Development Services), and state-level programmes. UNICEF is very conscious that the Government is investing more than ever before in social development. We are committed to bringing our experience and technical advice to help develop and strengthen these strategies, propose innovations, monitor and assess work in the field, and analyze the results of these investments on the lives of children. At the same time, UNICEF remains deeply committed to the work it does with 'its boots on the ground'. We will be at the policy table with the Centre and States, but we will come with our direct knowledge of working with communities, through piloting new ideas, and by making a tangible, direct difference in the lives of children.

Our tradition of delivering vaccines, experimenting with safe water technologies, piloting innovations such as sick newborn care units in district hospitals and developing multiple-language teaching aids in tribal schools will continue.

I believe that our discourse at the policy level is only as relevant as the experience we bring to the table.

And this brings me to my third, and final, point. I have described what I believe to be the continued relevance of UNICEF's Mission in India. And, what I hope can be achieved together with Government and other partners in this new country programme.

But how we work together is key. UNICEF enjoys a close collaboration with Government across many Ministries including Women & Child Development, Health & Family Welfare, Rural Development, Education, Labour and many others.

We are committed to presenting Government and other partners with the best available technical advice...with direct experience from the field...as well as best practice from around the world.

Madam Minister, I am particularly excited about our working with your Ministry of Women and Child Development. I believe the technical input we are providing to the new ICDS programme with its focus on children under the age of three is of critical importance to addressing issues of malnutrition.

As is the work we do together on communication. I would like to congratulate you on the launch of your media campaign yesterday on the girl child, domestic violence and malnutrition. I know our staff worked closely with your Ministry on that. And, I hope that over these next few months, we can build this even further into a national communication strategy for improved infant feeding practices.

UNICEF commits in this action plan to achieve results as part of a wider contribution of the U.N. in India. Whether it is together with W.H.O. on polio, UNDP on emergency response, the World Food Programme on malnutrition, UNFPA on gender equality...UNICEF will increasingly look for complementarity and cohesion in its work with other U.N. bodies.

We will also continue our strategic partnership with established donors, such as the U.K. Department for International Development, the U.S. Agency for International Development, Rotary International and the Government of Norway. We will bring together new partnerships to work for children in India such as the one we have recently established with IKEA.

In achieving our goals, national and international NGOs as well as the media in India and abroad are important partners to UNICEF. We count on their experience and knowledge of communities, while also informing, mobilizing and acting as effective catalysts for change.

Over these five years, UNICEF will make a substantial financial contribution of around $700 million to India.

More than $200 million will come from UNICEF's own core resources, which is even more than previously anticipated. And, I feel very optimistic about strong donor interest and support. So far in 2008, we have a commitment of more than $200 million from partners for the work that we do, and I feel confident about raising further support over the next few years.

In addition, UNICEF expects to do around half a billion dollars in procurement services, helping to ensure vaccine supply and other essential drugs and equipment for India.

And, then perhaps, our most special asset. UNICEF's extensive network of 13 field offices, working in 15 states, and our Delhi staff a combined workforce of close to 500 people.

Here we have our best opportunity to engage directly with state governments...providing technical support, helping to identify and fill gaps, and to advocate for the fulfillment of children's rights. I am delighted that so many state government counterparts and our State Representatives could be here today.

Together, you are the key to success over these next five years.

This period is crucial to the pace of India's progress in meeting the MDGs. It is a challenge, but one that we are prepared to meet, together with all of you.

Thank you.

ICCIDD Welcomes UNICEF Team

Meets UNICEF Representative to Discuss the Roadmap to USI

4 September, 2008

ICCIDD has been discussing with partner agencies the need for meeting soon to build the road map for USI in India. One of the key partners is UNICEF and ICCIDD met with the new UNICEF Chief Dr. Karin Hulshof to discuss the way forward.

This meeting was preceded by a meeting with UNICEF Chief for Nutrition Dr. Victor Aguayo and the UNICEF Nutrition Specialist Mohamed Ayoya on 5th June, 2008.

As a follow up to this meeting UNICEF has initiated a review discussion on the current status of USI as a prelude to the meeting between the partners. Both organizations hoped to come up with a roadmap soon for the next three years to reach the goal of USI.

UNICEF, GAIN, MI and ICCIDD of the partnership would like to see over the next years among respective agencies to help India achieve USI.

ICCIDD Team Greets the New Team at India Country Office-UNICEF

L to R: Dr. Arijit Chakrabarty, Program Manager ICCIDD, Dr. Mohamed Ayoya, Nutrition Specialist UNICEF, Dr. Karin Hulshof, India Country Representative, Dr. Chandrakant S. Pandav, Regional Coordinator-South Asia ICCIDD, Ms. Saroja Narayanan,Senior Project Officer ICCIDD

L to R: Dr. Mohamed Ayoya, Nutrition Specialist UNICEF, Dr. Victor Aguayo, Chief of Nutrition UNICEF, Dr. M.G. Karmarkar, President ICCIDD

ICCIDD Reviews Salt Iodization in Sri Lanka

The national survey conducted by Medical Research Institute of the Ministry of Healthcare and Nutrition, Sri Lanka in 2005 on iodine nutrition has indicated that Sri Lanka has achieved the indicators for sustainable elimination of IDD identified by the joint committee of WHO/UNICEF/ICCIDD.

Sri Lanka has requested for an external review with the WHO and their request is being processed at the WHO-SEAR office, New Delhi. It is in this context that Dr. Pandav met with the key officials of Ministry of Healthcare and Nutrition and requested them to continue with their endeavor towards sustainable elimination of IDD in Sri Lanka. Dr. Pandav extended ICCIDDs full support in this endeavour.

The National Steering Committee on elimination of IDD has decided to prepare a preliminary report identifying strengths and gaps of the IDD elimination programme. This report has been forwarded to the WHO Representative for Sri Lanka by the Ministry of Healthcare and Nutrition on 12 August, 2008.

He also shared with them key findings of the awareness programmes of IDD in Ratnapura district of Sri Lanka. This study was funded by the ICCIDD office of Sri Lanka.

Ministry to Educate Students in Pakistan about Iodine Deficiency

http://www.dailytimes.com.pk/default.asp?page=2008%5C05%5C16%5Cstory_16-5-2008_pg7_24

The Health Ministry plans to request the Education Ministry to incorporate information on iodine deficiency, prevention and control into the primary curriculum, said Dr. Zareefuddin Khan on Thursday.

Dr. Khan told reporters during a briefing here that the Nutrition Wing had trained 1,000 teachers in Punjab and 200 in Balochistan to educate students on the significance of iodine in their diet.

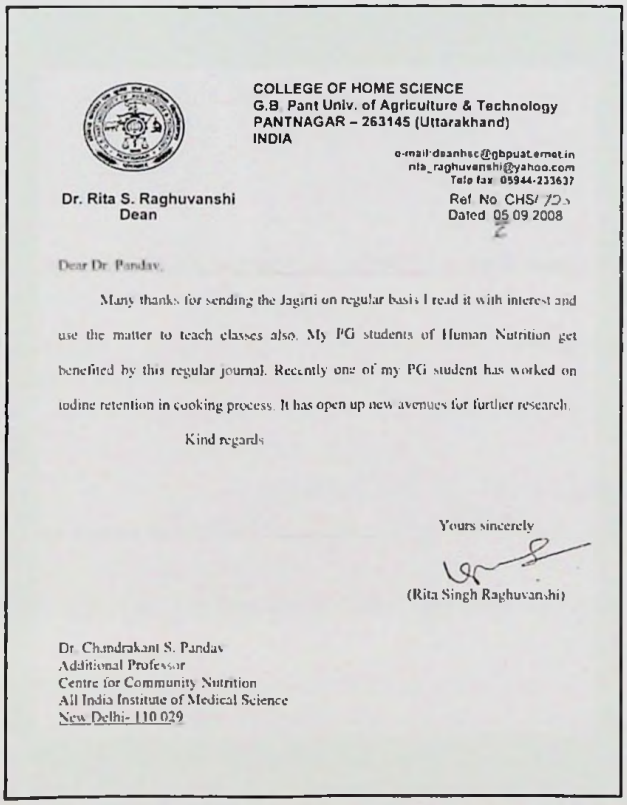
He said training of school teachers in Sindh and the North West Frontier Province (NWFP) was underway.

Dr. Khan said that the Nutrition Wing had sent a draft of proposed legislation to the cabinet to promote the use of iodized salt in the country in an attempt to fight Iodine Deficiency Disorders (IDDs).

He said, the programme was being implemented in 65 target districts to educate salt processors and health managers monitoring the iodization process and iodine deficiencies to prevent IDDs becoming a significant health problem in the country.

Steps would be taken to control iodine deficiency by 2013 and promote universal salt iodization by 2010, Assistant Director General of the Nutrition Wing, Dr. Agha Mehboob said.

Jagriti Used as Reference Material in Home Science College



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Dr. Rita S. Raghuvanshi
Dean

Ref. No. CHS/ 705
Dated 05 09 2008

Dear Dr. Pandav,

Many thanks for sending the Jagriti on regular basis I read it with interest and use the matter to teach classes also. My PG students of Human Nutrition get benefited by this regular journal. Recently one of my PG student has worked on iodine retention in cooking process. It has open up new avenues for further research.

Kind regards

Yours sincerely

(Rita Singh Raghuvanshi)

Dr. Chandrakant S. Pandav
Additional Professor
Centre for Community Nutrition
All India Institute of Medical Science
New Delhi- 110 029

From

Dr. Rita S. Raghuvanshi

Dean

College of Home Science

G.B. Pant University of Aggriculture & technology

Pantnagar (Uttarakahand)

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Kind regards

-Sd-

Rita Singh Raghuvanshi

6 September, 2008

National Nutritional Policy - Essential Elements

Symposium by Nutrition Foundation of India

New Delhi, 27-28 June, 2008

India has accorded high priority to improvement in health and nutritional status of its citizens. National Nutrition Policy, 1993 provided the policy framework, strategies for improving nutritional status of the population and set the goals 2000 AD. The new century has witnessed the emergence of dual nutrition burden in India; while under-nutrition and micronutrient deficiencies remain the major public health problems, over-nutrition and associated non-communicable diseases are increasingly seen especially among urban and affluent segments of the population.

A clear need was felt for focused and comprehensive interventions aimed at improving the nutritional and health status of individuals in all sections of the population.

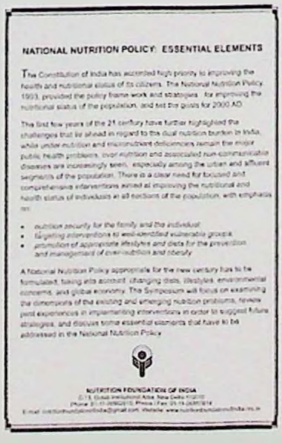
The symposium reviewed existing and emerging nutrition problems, past experiences in implementing interventions and discussed some essential elements which have to be addressed in the National Nutrition Policy.

The symposium was well contributed with presentations from illustrious speakers and well informed delegates. Delegates included the academia, representatives from the Government, NGOs and development sector organizations. ICCIDD was represented by Dr. Arijit Chakraborty.

Following is the list of presentations deliberated upon:

1. Dr. M. S. Swaminathan: Towards a Nutrition Secure India
2. Dr. Pronab Sen: Issues in defining of poverty line and their implication to the National Nutrition Policy
3. Dr. N. C. Saxena: Supplementary Feeding Programmes in many National Nutrition Programmes like the ICDS, Mid Day Meal Programme
4. Dr. Sivakumar: Newer trends in nutrient requirements, dietary standard and balanced diet
5. Dr. Shanti Ghosh: Under 2 the critical age: Programme priorities must change
6. Dr. Sarath Gopalan: Nutrition in Medical Curriculum
7. Dr. Mahtab Bamji: Community initiatives for improving health, nutrition, environment and livelihood security
8. Dr. Kamala Krishnaswamy: Infrastructure requirements for an effective Nutrition Policy
9. Mr. Sanjay Nandan: Mid Day Meal Programme in Gujarat
10. Dr. B. Sesikeran: Fortification with reference to iodine and iron and iodine fortification
11. Dr. Subadra Seshadri: Initiatives for enabling Home Science Colleges to play an effective role in National Nutrition programmes
12. Dr. Kalyan Bagchi: Nutrition in elderly
13. Dr. Ramesh Bhat: New policy and programme initiatives to ensure food safety in India
14. Dr. Prema Ramachandran: Nutrition Monitoring and Surveillance
15. Dr. H. P. S. Sachdev: Improving Micronutrient status of Indian Children
16. Dr. Srinath Reddy: Practical steps addressing the escalation of chronic degenerative diseases in the National Nutrition Policy
17. Dr. Prema Ramachandran: Nutrition Problems in women

L to R: Dr. C. Gopalan, Dr. M.S. Swaminathan, Dr. Prema Ramachandran



NATIONAL NUTRITION POLICY: ESSENTIAL ELEMENTS

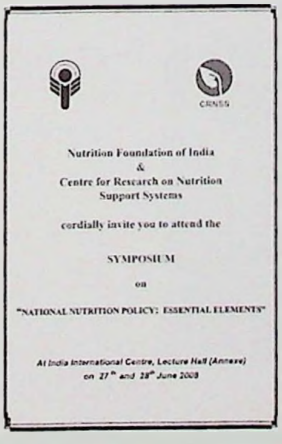
The Constitution of India has accorded high priority to improving the health and nutritional status of its citizens. The National Nutrition Policy, 1993, provided the policy frame work and strategies for improving the nutritional status of the population, and set the goals for 2000 AD.

The first few years of the 21 century have further highlighted the challenges that lie ahead in regard to the dual nutrition burden in India, while under nutrition and micronutrient deficiencies remain the major public health problems, over nutrition and associated non-communicable diseases are increasingly seen, especially among the urban and affluent segments of the population. There is a clear need for focused and comprehensive interventions aimed at improving the nutritional and health status of individuals in all sections of the population, with emphasis on:

- nutrition security for the family and the individual
- targeting interventions to well-identified vulnerable groups
- promotion of appropriate lifestyles and diets for the prevention and management of over-nutrition and obesity

A National Nutrition Policy appropriate for the new century has to be formulated, taking into account changing diets, lifestyles, environmental concerns, and global economy. The Symposium will focus on examining the components of the existing and emerging nutrition problems, review past experiences in implementing interventions in order to suggest future strategies, and discuss some essential elements that have to be addressed in the National Nutrition Policy.

NUTRITION FOUNDATION OF INDIA



Nutrition Foundation of India
&
Centre for Research on Nutrition Support Systems

cordially invite you to attend the

SYMPOSIUM

on

"NATIONAL NUTRITION POLICY: ESSENTIAL ELEMENTS"

At India International Centre, Lecture Hall (Annexe) on 27th and 28th June 2008

View of the delegates

National Nutrition Mission Calls for Special Intervention to Check Malnutrition.

3rd Meeting of the Executive Committee

New Delhi, 8 July, 2008

The third Meeting of Executive Committee of National Nutrition Mission was held under the Chairpersonship of Ms. Renuka Chowdhury, Minister of State for Women and Child Development.

Ms. Renuka Chowdhury, Chairperson of the Executive Committee reaffirmed her commitment to place nutrition first on the development agenda and cited recent initiatives taken by the Women and Child Development Ministry like universalization of ICDS with quality, proposed Rajiv Gandhi Scheme of Empowerment of Adolescent Girls and expansion and strengthening of Food and Nutrition Board. She also stressed on the need for a clear priority to be accorded from the period of pregnancy to first three years of life to prevent under nutrition as early as possible and to avoid cumulative irreversible damage across generations. She also announced that new WHO child growth standards will be soon be introduced in India to effectively track progress, recognizing child nutrition as a sensitive indicator for national development.

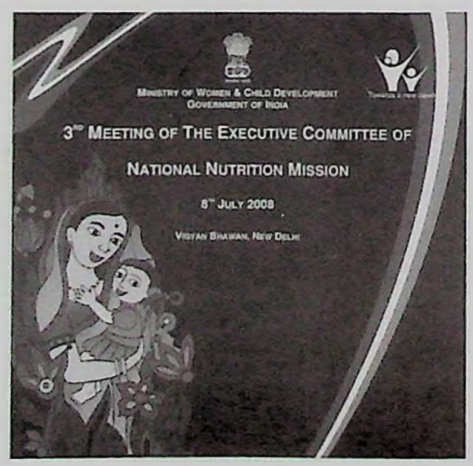
Mr. Anil Kumar, Secretary, Ministry of WCD reiterated the need for giving priority to optimal Infant and Young Child Feeding (IYCF) and called for recognizing IYCF counseling as a distinct service in ICDS, with enhanced resources investment. He explained the major challenges facing the country like, persistently and unacceptably high levels of young child under nutrition, multiple deprivations, under nutrition, gender discrimination and poverty.

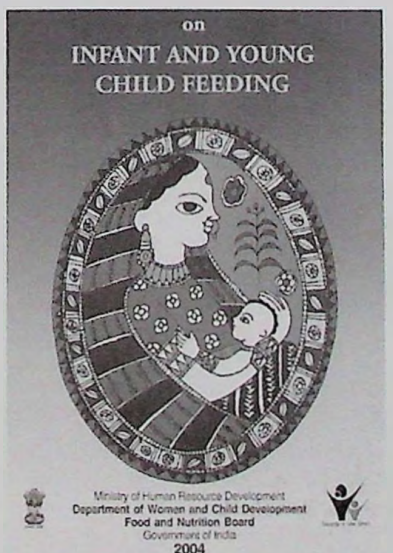
The Secretary called for cooperation of all sectors in identifying, implementing and monitoring nutrition so that a comprehensive approach is adopted to reduce maternal and young child malnutrition.

The Executive Committee discussed in detail high impact interventions such as maternal and new born care, early and exclusive breast feeding for the first six months, appropriate complementary feeding, timely and complete immunization, Vitamin A supplementation, IFA supplementation and universal usage of adequately iodized salt. The need to give adequate focus on micro- nutrient fortification was also highlighted. After detailed discussions following decisions were taken by the Committee.

1. A strategy for special intervention from the period of pregnancy to first two years of life of a child may be formulated for high burden districts to prevent under nutrition and to avoid cumulative irreversible damage.
2. A special strategy needs to be formulated for focused attention on grade III and grade IV malnutrition.
3. A task force comprising of Experts may be constituted to look into various aspects of micronutrient fortification.

The meeting ended with a suggestion that immediate action may be taken on the above mentioned three crucial issues which are important to respond to the call of Prime Minister, Dr. Manmohan Singh on urgent action to reduce infant and young child under nutrition and mortality.





Malnutrition Affects India's GDP by 1 %

Panel Discussion, Malnutrition an Emergency: What it Costs the Nation

New Delhi, 30 June, 2008

India can increase its gross domestic product (GDP) by one per cent if the country is able to address one quarter of the malnutrition, says Ms. Veena S. Rao, Secretary of the Ministry of Development of North-Eastern Region in India.

Speaking at a panel discussion on 'Malnutrition an Emergency: What it costs the Nation', jointly organized by Confederation of Indian Industry (CII) and the Ministry in New Delhi on Monday, Ms. Rao said that the increase in GDP would be possible as more than 50 per cent malnutrition is not related to poverty, but to lack of awareness.

She further pointed out that the number of people suffering from malnutrition far exceeded the numbers of those living below the poverty line (BPL).

"It is an inter-generational, inter-sectoral problem that needs multi-sectoral solutions," Ms. Rao added.

The Secretary said that malnutrition was an unaddressed gap in the country's development agenda and urged the industry to ensure that high energy-low cost food was made available to the poor.

Responding to Ms. Rao's appeal to the industry, Britannia Industries MD Ms. Vinita Bali said it was important that the industry should not wait for the government to legislate and incentivise the promotion of nutritious food products instead it must adopt a proactive approach in this regard.

Speaking on the occasion, United Nations Children's Fund (UNICEF) Child Nutrition and Development Chief Dr. Victor Aguayo said that one-third to one-half of all child deaths in India are due to malnutrition, making it one of the biggest causes of child deaths.

"For the country to tackle this crisis effectively, the root cause of malnutrition must be addressed through appropriate prevention strategies," Dr. Aguayo said.

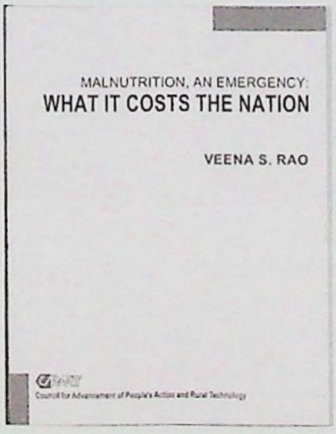
He further stressed that the consequences of child under nutrition were enormous and there was, in addition, an appreciable impact of under nutrition on productivity so that a failure to invest in combating nutrition reduces potential economic growth.

The UNICEF's Child Nutrition Chief suggested that practices like exclusive breast feeding for the first six months, initiation of complementary foods at six months of age, timely immunization, proper hygiene and sanitation can play a major role in addressing the problem of under-nutrition among children under two years of age.

"Malnutrition in children was a contributing factor to more than half of all child mortality cases, while malnutrition in mothers accounted for a substantial proportion of neonatal mortality,"said Professor Dr. Vinod Paul, Department of Pediatrics, AIIMS.

In this regard, he suggested that priority be given to strengthening the primary healthcare system from community-based interventions to the first referral-level facility at which emergency obstetric care is available.

Earlier, welcoming the panelists of the discussion, CII North East Council Chairman Mr. Dipankar Chatterji pointed out to the concerns of the industry over malnutrition and said that social



Iodized Salt as Maternal and Child Health Intervention

Gujarat State Initiative under RCH II Programme

Reported by Dr. Vikas Desai, Additional Director, Family Welfare, Gujarat

Reduction in childhood mortality and morbidity is one of the major goals of Reproductive and Child Health (RCH) program in Gujarat state. In view of slow progress in decline of infant mortality and childhood mortality which goes unmatched with the economic development indicator in the state, it was decided to adopt multi pronged approach towards reduction of pregnancy wastage, low birth weight, micronutrient deficiency and to promote optimum growth and development of children.

One of the major initiative was to promote use of Iodized salt. Household coverage of iodized salt in Gujarat state is 55% , with inter district range of 35% to 88% in 2007.

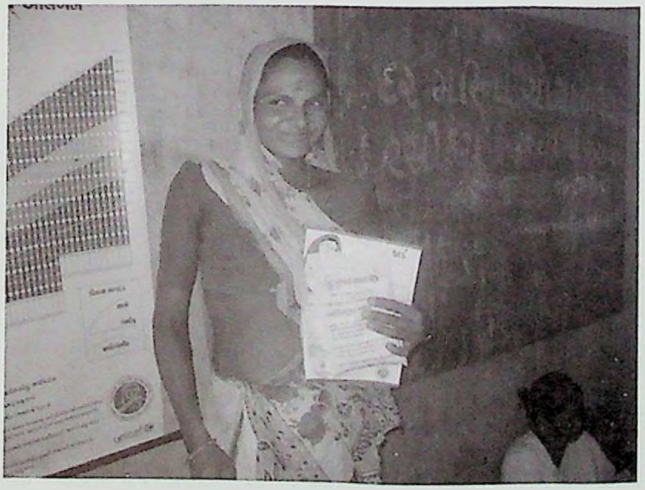
This indicates that iodized salt rate is reasonably satisfactory in the state but the group in higher need due to geographical location is still not adequately covered by iodine prophylaxis. It was felt that Information Education Communication (IEC) and salt supply alone may not probably ensure the adequate iodine supply to the tribal and rural area. The only alternative was to develop a sure shot iodine supply mechanism, at least to the most vulnerable group among the vulnerable.

This has been attempted through initiative under RCH II in Gujarat. To ensure adequate iodine intake, free iodized salt is given to pregnant and breast feeding women on "MAMTA Divas" (Health and Nutrition Day). Pregnant women and breast feeding women of infants are given free 1.5 kilograms of Iodized salt as a prophylactic micronutrient supplement on their visit to "MAMTA Divas" every month.

"MAMTA Divas" is organized on fixed day every month in all villages as a joint programme of Ministry of Health & Family Welfare and ICDS (Ministry of Women & Child Development). All pregnant women and nursing mothers of infants and preschool children of the village are covered for all preventive and promotive services like growth monitoring, early detection and treatment, immunization, prophylactic drug supplement and counseling.

This ensures adequate iodine intake in the family, growth and development of foetus and of infant who is mainly dependent on breast milk for nutrition. Not only that the process of Iodized salt supply shall also provide opportunity to counsel the women for use of iodized salt on a regular basis irrespective of the current subsidy.

Women being counseled on "Mamta Diwas"



Women receive iodized salt on "Mamta Diwas"

MI-ICCIDD Quality Assurance Programme
Training Workshop in Tamil Nadu
Tuticorin, 24 July, 2008

The Micronutrient Initiative has launched the Quality Assurance Programme in India under a joint venture with ICCIDD, New Delhi. The programme envisages to improve the quality of iodized salt produced by the producers who are being supported by the MI subsidy of potassium iodate. MI has established laboratories at the production centers to monitor the iodization quality.

The first training workshop was conducted at Gandhidham wherein 9 chemists and programme personnels of MI were trained and the laboratory inspected by the ICCIDD team comprising of Professor M.G. Karmarkar, Senior Advisor ICCIDD, Dr. Chandrakant S. Pandav, Regional Coordinator ICCIDD and Dr. Arijit Chakrabarty, Consultant ICCIDD. The interactive session was duplicated at Tuticorin wherein 14 chemists and programme personnels were trained and the laboratory inspected.

Glimpses of the training workshop at Tuticorin

Satisfactory Work at Gandhidham Laboratory
ICCIDD Reviews Gandhidham Laboratory
Gandhidham, 12 September, 2008

Dr. M.G. Karmarkar made a review visit to the Gandhidham laboratory. He also trained the programme personnels of MI, the method to detect adulteration of potassium iodate with potassium bromate.

Both qualitative and quantitative methods were explained and detailed protocol has been given to them. In quantitative analysis for determining the amount of bromate in potassium iodate powder as well as method of analysis the quantity of bromate in iodized salt was explained to them. The adulteration of cheaper potassium bromate with potassium iodate is a serious problem as bromate is harmful for the health of human beings. This methodology will help in detecting bromate adulteration.

The functioning of this laboratory and the results they are getting are satisfactory. Mr. Dinesh Thacker and his team are doing an excellent job.

Road to Achieve Sustainable Salt Iodization in India
Field Situation Commentary

Pankaj Jain, Regional Program Manager - Salt Program, MI

Iodine is an important micronutrient. Lack of iodine in diet can lead to Iodine Deficiency Disorders (IDD) that can cause miscarriages, stillbirths, brain disorders and retarded psychomotor development, speech and hearing impairments as well as depleted levels of energy in children. Iodine deficiency is the single most important and preventable cause of mental retardation worldwide.

It has been estimated that 200 million people in India are exposed to the risk of IDD (Vir, 2000) and more than 71 million suffer from goiter and other IDD (MoHFW, 2005). Iodine deficiency can be prevented by using salt that has been fortified with iodine. All states and union territories were advised to issue notifications banning the sale of salt that was not iodized. The ban on non-Iodized salt was lifted in September, 2000, but it was re-imposed in November, 2005. However, this notification came into effect after May, 2006, but by then most of the field work for NFHS-3 had been completed.

Among the households that had their salt tested, just over half (51%) were using iodized salt that was adequately iodized. There has been practically no change since NFHS -2, when 50% of the households were using adequately Iodized salt. In NFHS -3, 25% were using inadequately Iodized salt, and the remaining 25% of salt was not iodized at all. The use of iodized salt was much higher at 72% in urban areas as compared to 41% in the rural areas. There is also a sharp rise in the use of iodized salt as the wealth of household increased; it was observed that 85% of the household in the highest wealth quintile used Iodized salt as compared to only 30% in the lowest wealth quintile. Hence, there is a need to make adequately iodized salt available to the lower as well as the upper middle class staying especially in the rural areas.

It may be observed that the use of iodized salt varies dramatically from one state to another. These variations may be attributed to a number of factors, i.e the place of production, mode of transportation, enforcement efforts, difference in pricing structure, state regulations, storage patterns, type of salt being used etc.

Salt to Kerala is mainly supplied by road from Tamilnadu where 74% of the households have access to adequately Iodized salt. Tamilnadu also supplies salt to other states like Orissa, Andhra Pradesh and Karnataka where the access to adequately iodized salt is 39.6%, 31% and 43% respectively. Similarly, Gujarat supplies salt to entire Northeast states where the coverage varies from 71.8% in Assam to 93.8% in Manipur whereas the availability of adequately iodized salt in Madhya Pradesh and Uttar Pradesh is 36.3% and 36.4% which is also being provided from the same state of Gujarat. While analyzing the situation it could be found that those states which have better availability of adequately iodized salt are either catered by single or two agents or by monopoly processor.

Gujarat, Rajasthan and Tamilnadu put together produces more than 95% of total salt in India. But the household availability of adequately iodized salt in these states is 55.7%, 40.8% and 41.3% respectively. In addition to this, the status of availability in immediately neighbouring states to salt producing states like Haryana (neighbouring state to Rajasthan) is 55.3%; Madhya Pradesh (neighbouring state to Gujarat and Rajasthan) is 36.3% and Karnataka is 43%. Hence, this can be attributed that wherever the salt is being transported through road, the availability of iodization is less in compared to the salt transported through railhead. This is due to the fact that the Salt Department does not monitor the quality of salt transported by road.

From this analysis, the following conclusions can be drawn:

1. There is connivance between the processors and middlemen to exploit the ignorance of the consumers. This phenomenon thrives under the absence of a strong quality monitoring mechanism at production level. Taking advantage of this situation the salt processors supply different quality of Iodized salt to different states. However, due to the efforts of the Salt Department, the quality of iodization is better when the salt transported by rail as compared to road.
2. The processors do not have the capacity or availability of user friendly system for monitoring quality of iodization.
3. The quality of iodization is better in states where there are few buying agents.
4. Coverage of Iodized salt is low in salt producing and neighboring states due to easy access of inadequately Iodized salt by road.

Poda salt (Big Crystal), produced in Gujarat is being mainly supplied to Uttar Pradesh and Madhya Pradesh for human consumption. The observed coverage of Iodized salt in these states is contributed by refined salt which meets 30% of its demand. UP consumes 558,166 MT of Poda salt per year, which is inadequately iodized. Similarly, 58,811 MT of Poda salt per year is being consumed in MP, which amounts to around 25% of the total salt requirement of the state.

In order to address these challenges, it is critical to shift the pattern of consumption from crystal salt to crushed-washed or higher

grades of salt. However, it is also crucial to understand that mere shifting consumer preferences is not enough to ensure availability of adequately iodized salt at consumer level. The Poda salt poses technological and commercial challenges. Since the crystals are irregular and large it is not possible to iodize uniformly. The problem of inadequately iodized salt gets magnified because this variety is mainly sold in bulk packing of 50 kgs and not in small pouches of 1 kg.

There is also a challenge with crushing Poda salt and storing it. Crushing Poda salt results in formation of a very hard lumps which are difficult to break. Lumps are formed due to presence of impurities. Therefore, it is necessary to develop a process to improve the quality of Poda salt so that it can be converted to storable crushed salt. Another disincentive to the processors for not crushing Poda salt is the because of no incremental profit margin to them in doing so.

It is an established fact and even stated by Salt Department that the country has adequate capacity to produce Iodized salt. But the point to be realized is that there is an uneven distribution of processing capacity. As a result of this, the processors end up either producing non-Iodized salt or use devices like knap sac sprayers that produce inadequately Iodized salt. This necessitates the need for improvement of existing under-performing equipment and introduction of new equipment.

Most of the salt production in India is characterized by the use of low technology, labour intensive, solar evaporation process in coastal areas which have scanty rainfall. Raw salt is produced by low paid labour on piece rate basis. The product is cheap, has long shelf life and has insignificant losses even when stored in the open.

In order to appraise the economic aspect of salt iodization at processors end, it is important to understand the cost structure of production of different grades of salt. As stated above, a wide variety of salt for food application or 'iodized salt' as it is now being called, is available in the market.

It may also be observed that cost incurred on iodization is minimal. Most of the cost to salt is added by the components of handling, packaging and transport. Marketing and distribution is controlled by financially strong merchants and processors. Though there is fragmentation at production level, at marketing level there is consolidation. This phenomenon becomes more acute as value addition on salt increases during production of different grades of salt. The requirement of marketing strength increase as salt is upgraded from crystal-crushed, crushed and washed to finally refined salt. Iodization also improves when the packaging is changed from bulk 50 Kg sacs to small 1 kg pouches.

It may be observed that in case of crystal salt, the salt merchants have a tendency to compromise on the iodine levels as cost towards iodization is 16.6% of the cost of raw salt and 9.6% of the total cost. Handling cost in production of crystal salt has been reduced in Gujarat with the use of mechanical loaders, whereas for other states it continues to be an additional cost element. Due to this labour component of cost, additional cost towards iodization increases to 23.3% of the raw salt cost and 13.5% of the total cost. The other cost elements being fixed and beyond their control of salt merchants, compromise on addition of potassium iodate is the immediate factor that they can manipulate in order to maintain their profit margins.

In the light of this inherent nature of salt industry in India, the iodization levels improve as salt moves up on the value addition ladder. It has been observed that with shift in production from "Phoda" to crstal salt to powdered/refined salt, the iodization levels have improved. Since, the most vulnerable population belonging to low socio-economic status still continues to consume "Phoda" or crystal salt primarily, we need to develop cost effective processes to ensure adequate iodization as well as show profitability to the producers in their product.

The author is the Regional Program Manager - Salt Program of The Micronutrient Initiative

PEARLS OF WISDOM

"Many physicians would be surprised to learn that more than a hundred years ago, iodine was .called "The Universal Medicine", and was used in several clinical conditions. Nobel Laureate Albert Szent Györgyi, the physician who discovered Vitamin C in 1928, commented: "When I was a medical student, iodine in the form of KI was the universal medicine. Nobody knew what it did, but it did something and did something good".

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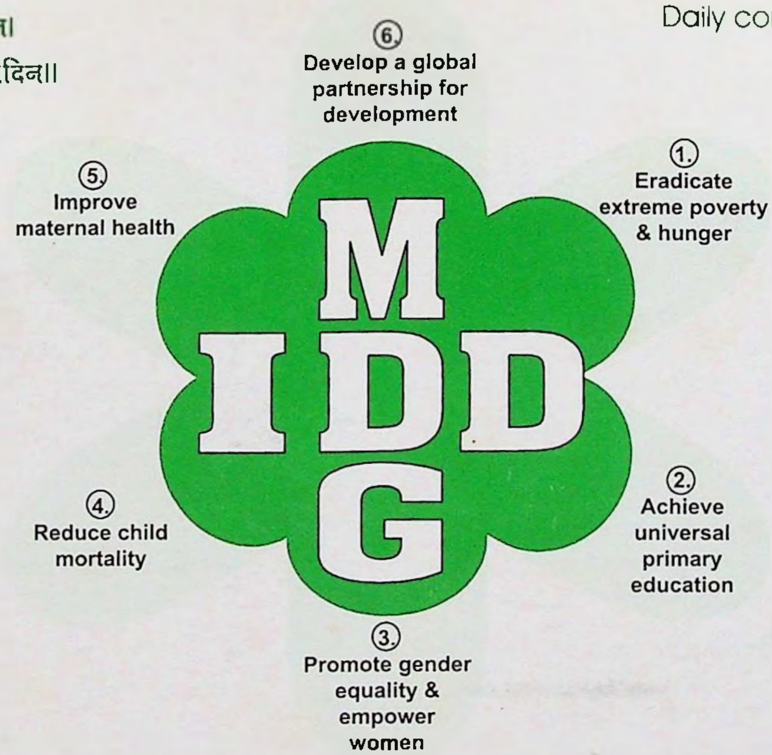
बुद्धि और स्वास्थ्य सुरक्षित हरदिन।।

Daily consumption of Iodised sa
is a healthy habi

IODINE DEFICIENCY DISORDERS



MILLENNIUM DEVELOPMENT GOALS

ICCIDD

IQ+ "Iodine Quota Intelligence Quotient"

In preparing this issue we gratefully acknowledge the support from:

Micronutrient Initiative
Solutions for hidden hunger

Centre for Community Medicine - AIIMS

unicef

Materials for publication, subscription request, comments may be sent to: Dr. Chandrakant S Pandav, Room No 28, CCM Building, Old OT Block, All India Institute of Medical Sciences, New Delhi 110029 E-mail: cpandav@iqplusin.org