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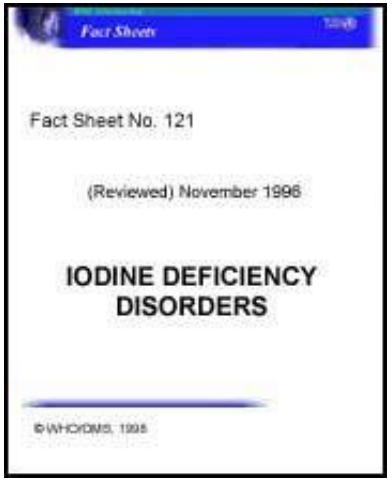

Fact sheet No 121: Iodine Deficiency Disorders - Reviewed November 1996 (WHO, 1996, 2 p.)

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Iodine Deficiency Disorders

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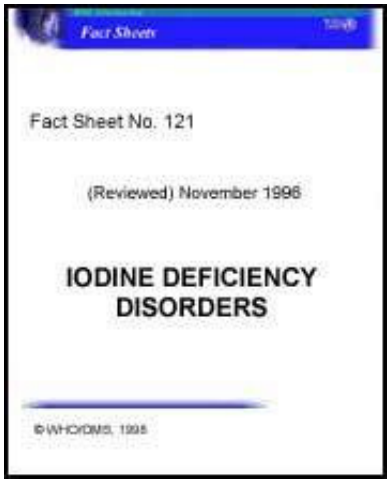

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Iodine Deficiency Disorders

(Reviewed) November 1996

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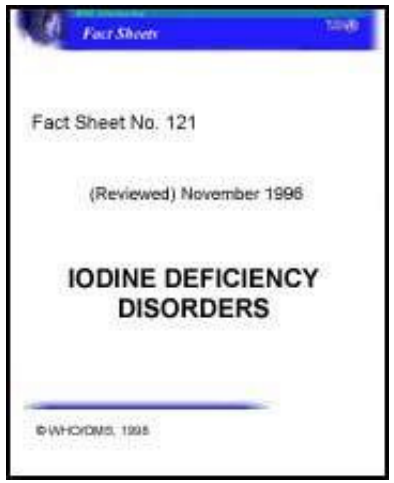

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Iodine Deficiency Disorders

Iodine Deficiency Disorders

Iodine deficiency remains the single greatest cause of preventable brain damage and mental retardation worldwide. WHO estimated in 1990 that 1570 million people, or about 30% of the world's population, were at risk of Iodine Deficiency

Disorders (IDD). In 1995, WHO estimated that the number of people with goitre was 750 million.

Insufficient intakes of iodine in pregnancy and early childhood result in impaired mental development of young children. Even marginal deficiency may reduce a child's mental development by about 10%.

Forty-three million people were estimated to be affected by some degree of IDD-related brain damage, ranging from frank cretinism, spastic diplegia, milder mental retardation, and impaired educability.

The goal for the year 2000 is that at least 90% of edible salt consumed should be adequately iodized, including salt used for animals and salt used in preparation of commonly eaten staple foods such as bread.

A number of areas, particularly west and central Africa, will require additional support to achieve the year-2000 goal.

A mechanism should be established at all facilities producing iodized salt, and at all points of importation, for the quality of iodization to be effectively and routinely monitored and suitable corrective action to be taken.

An assessment of IDD prevalence has now been made in 106 developing countries with a population of over one million people where IDD is recognized to be a public health problem, or would be a public health problem if salt iodization programmes ceased. Despite the magnitude of this global problem, there is a visible growing momentum and measurable success in reducing IDD in many countries.

Many industrialized countries introduced large-scale salt iodization prior to 1960. In Latin America, salt iodization started on a large scale in the 1960s and 1970s, but was not sustained in some countries. Many other countries had regulations or laws requiring salt to be iodized, but these were not enforced and there was little consumer demand for iodized salt. The full magnitude of the problem of marginal deficiency was not widely appreciated, and IDD was considered to be solely a problem of goitre, which occurred only in well-defined areas.

During the first half of the 1990s, 1500 million additional people started to consume iodized salt. Without such efforts, 750 million of these people would have continued to be at risk from IDD. This has been achieved at a cost of about four US cents per beneficiary in external funding assistance.

The present situation of salt iodization by region is summarized in the table below. At the end of 1995, 19 out of 83 countries for which information is available were iodizing more than 90% of all salt produced for human consumption. A further 15 countries have more than 75% of all salt iodized. In these 34 countries, and in many of the remaining 49 countries, the infrastructure to produce iodized salt has already been established and the proportion of salt consumed which is iodized will reach or exceed 90% by the year 2000, provided awareness of the importance of the programme and national and international commitment to it are maintained.

As of February 1996, 57% of the population of 83 developing countries, about 2500 million people, were obtaining an adequate iodine intake through the consumption of iodized salt. Because salt iodization has not been targeted, it is not at present possible to estimate the percentage of people at highest risk of IDD who are consuming iodized salt.

Through the efforts of national governments, WHO, UNICEF, the International Council for Control of Iodine Deficiency Disorders, and the salt industry, and with the support of bilateral development agencies, financial resources required to achieve universal salt iodization (USI) have been mobilized. An estimated US$ 30 million worth of investment in salt iodization has been made available to countries since 1990 from "external" sources, over and above national investments.

Some countries with an IDD public health problem that are unable to fully implement universal salt iodization have been using iodine supplements as a temporary measure. Currently, 38 countries report using iodized oil supplements, up from 21 countries in 1992.

No country has yet been identified in which universal salt iodization has been demonstrated to be impossible or less cost-effective than any feasible alternative.

Alternative or additional strategies may be required in countries or parts of countries where groups at risk of IDD do not purchase iodized salt distributed through normal commercial channels. These may include the free distribution of iodized salt to vulnerable population groups, particularly women of childbearing age, the use of oral, high-dose, iodized oil capsules or the iodization of drinking-water.

Table 1: Consumption of iodized salt, by region

Region	No.of countries in region	Countries with IDD problem & salt info.	population consuming iodized salt	
			Percentage	Total

			Percentage	Total (millions)
Sub-Saharan Africa	**39**	**30**	**56**	**270**
Middle East and North Africa	**16**	**10**	**64**	**124**
Asia	**22**	**14**	**56**	**1609**
Americas	**22**	**19**	**81**	**367**
CEE-NIS	**21**	**10**	**24**	**78**
Developing world	**120**	**83**	**57**	**2448**