Monitoring and estimation of iodine content of edible salt in urban areas of Meerut district, after four decades of Universal Salt Iodization

Dilutpal Sharma¹, Amit Vasant Despande², Naved Ahmad³, Akash Gupta*⁴ and Sana Nafees⁵

¹Associate Professor, Department of Biochemistry, School of Medical, Sciences and Research, Greater Noida-201306, U.P.  
²Assistant Professor, Department of Community Medicine, Mamta Medical College, Khammam A.P.  
³Tutor, Department of Biochemistry, Rama Medical College and Hospital, Pilakhuwa-245304, Hapur, U.P.  
⁴Assistant Professor, Department of Biochemistry, Rama Medical College and Hospital, Pilakhuwa-245304, Hapur, U.P.  
⁵Phd Scholar, Department of Medical Elementology and Toxicology, Faculty of Science, Jamia Hamdard University, New Delhi.

*Correspondence Info:  
Dr. Akash Gupta,  
Assistant Professor,  
Department of Biochemistry,  
Rama Medical College and Hospital, Pilakhuwa-245304, Hapur, U.P. India  
E-mail: akash_inspace@yahoo.com

Abstract

Objective: It is estimated that 200 million people in India are exposed to the risk of iodine deficiency disorders (IDD). To protect future generations, Universal Salt Iodization (USI) is the mainstay of the intervention. So, we carried out the study to estimate salt iodine content at the house hold and retail level in urban areas of Meerut district of Uttar Pradesh.

Method: A total no of 64 (48 from house hold and 16 from retail) samples of salt were estimated by iodometric titration method for the iodine content. Legal requirement for iodine level in India ranges from 30 parts per million (ppm) at retail level and 15ppm at consumer level.

Results: We found that at retail level the range of concentrations of iodine in salt samples from Shiv Kunj, Krishna Vihar, Yadav colony, Ratan nagar. At retail level the range of concentration of iodine in salt sample was 26.5 to 33.6 ppm, 28.8 to 34.6 ppm, 31.3 to 36.8 ppm, 29.6 to 32.6 ppm respectively, while at house hold level were 12.7 to 34.6 ppm, 15.1 to 33.9 ppm, 15.8 to 38.4 ppm, 15.2 to 29.6 ppm respectively.

Conclusion: Our study reveals a positive new momentum that reflects changes in India’s salt industry. These changes include better production, better refining and iodization practices, improvement in salt quality, improvement to packaging, effective monitoring to iodine levels from production to consumption and better consumer awareness in the urban areas.

Key words - Iodine Deficiency Disorder (IDD), Iodometric titration, Universal Salt, Iodization (USI), Urinary Iodine (UI)

1. Introduction

IODINE (atomic mass unit 126.9) is an essential component of the hormones produced by the thyroid gland¹. It is an essential micronutrient in human growth² and an essential component of thyroid hormones that is triidothyronine (T3) and tetra iodothyronine (T4)³. The WHO recommendation for adequate daily iodine intake of 150 micro gram per day for man and non pregnant, non lactating women, 250 microgram per day for pregnant and lactating womenand a daily intake of iodine of 90 micro gram for preschool children (0-59 months) ad 120 micro grams for school children (6-12 yrs)⁴. When these physiological requirements are not met in a given population, a series of functional and developmental abnormalities occur. They are grouped under the general heading of “iodine deficiency disorders” or IDD⁵. The term IDD was coined and became widely recognized as a spectrum of related disorders potentially affecting 1.5 billion individuals. Programmes against IDD have clear political appeal because its human, economic and social consequences could be averted by a low-cost intervention, USI. Since 1990, elimination of IDD has been an integral part of many national nutrition strategies⁶.

Salt iodization remains the most cost effective way of delivering iodine and of improving cognition in iodine-deficient populations⁷. Worldwide the annual cost of salt iodization is estimated at US$ 0.02-0.05 per child covered; the costs per child death averted are US$ 1000 and per disability-adjusted life year (DALY) gained are US$34-36⁸. Looked at in another way, before widespread salt iodization, the annual potential losses attributable to iodine deficiency in the developing world have been estimated to be US$35.7 billion as compared with an estimated US$0.5 billion annual cost for salt iodization, i.e. a 70:1 benefit cost ratio⁹.

Globally, since 1990 the number of households using iodized salt has risen from less than 20% to more than 70%, dramatically reducing iodine deficiency¹⁰. This effect has been spurred by a coalition of international organizations, including the ICCIDD, WHO, the Micronutrient Initiative and UNICEF, working closely with national IDD control committees and the salt industry; this informal partnership was established after the world summit for children in 1990. It has been funded by Kiwanis International, the Gates Foundation and country aid programs. Currently, WHO estimates that nearly 2 billion individuals have an insufficient iodine intake, including one third of all school age children¹¹. Almost one third of the population lives in areas of iodine deficiency¹².

In India, despite intensive efforts to promote iodized salt, only about half of the population is covered, and coverage is especially poor in low socioeconomic populations¹³,¹⁴.
It is estimated that 200 million people are at risk of IDD in India\textsuperscript{15} and more than 71 million suffer from goitre and other forms of IDD\textsuperscript{16}. The main strategy for control of IDD – salt iodization – was adopted by the world health assembly in 1993 and established as a UN General Assembly’s Special Session on Children goal in 2002. Salt has been chosen as a vehicle because of its wide spread consumption and the extremely low cost of iodization\textsuperscript{17}. The concept of adding iodine to salt began with the French chemist Boussingault, who in the beginning of the 19\textsuperscript{th} century stated “Je ne doute nullement qu’en repandant l’usage des sels faiblement iodifières, le goitre ne disparaîtra complètement…” (I have no doubt that addressing the use of low iodifieds salt, goiter disappears completely)\textsuperscript{18}.

Since then, salt iodization has become progressively the main approach to control iodine deficiency throughout the world, as it has proven as effective measure through rigorous monitoring and evaluation.

Worldwide, salt iodization is an ongoing effort springing from the recognition in the 20\textsuperscript{th} century that inexpensive spraying of commercial salt with iodide can reverse IDD\textsuperscript{19}. USI was made compulsory in India in 1998, although it was revoked in 2000 and again reinstated in 2005\textsuperscript{20}. Iodization of salt is an effective and sustainable public health strategy to prevent and control iodine deficiency and has been ongoing in several countries for over 60 years. Iodization of salt is currently undertaken following the universal salt-iodization initiative\textsuperscript{21-23}. In India the salt should contain at least 15 ppm iodine to provide the normal requirements of 150 microgram per day to the population i.e. at consumer level. It is usually necessary to iodize the salt at higher levels (30 ppm or more) to compensate for the loss of iodine during storage and distribution i.e. at retailer and production level\textsuperscript{24}. So we conducted a study to find out the level of iodine in edible salt at consumer i.e. household level and at retailer level, as no such study has been done in this area since last 13 yrs.

2. Material and method

The present study was done in Meerut a district of Uttar Pradesh to assess the progress being made in IDD elimination through USI. The study was approved by the ethical committee of institution and was conducted by the department of biochemistry in collaboration with community medicine of Subharti Medical College, Meerut. Salt samples were collected from areas coming under the Urban Health and Training Centres (UHTC) of the institute i.e. Shiv Kunj, Krishna Vihar, Yadav Colony, Ratan Nagar of Meerut district. In each urban area 12 household were chosen systematically using the chief’s house as the centre point. A structured questionnaire was generated which gave information on type of salt whether coarse or fine, package available, brand name, whether it was labelled iodized or not, method of salt storage. Similarly four shops were chosen randomly from each of the urban area for estimation of iodine in salt. A structured questionnaire was also generated which gave information on brand name of salts, their prices, whether they were labelled iodized or not and also how long it was stored in the shop. Different companies have their salt packed in different quantities. Packets of different brands/compa (Tata, Captain Cook, i-shakti, Aashirvad, Cinnamor) were collected and stored for analysis for retail content of iodine. In case of household level about 10 grams (2 teaspoons) of salt from each house was collected and kept in a closed plastic bag in dark room till analysis was done.

An iodometric titration method\textsuperscript{25} was used for analysing the iodine content of salt samples. This was done in laboratory of the department of biochemistry. A total of 10g of salt was dissolved in distilled water and made up to 50 ml solution. 1ml of 2N sulphuric acid and 5ml 10% potassium iodide was added. The liberated iodine was titrated with sodium thiosulfate solution using 1ml of 1% starch indicator near the end of titration. The level of thisoulate in the burette was recorded and converted to ppm using a conversion table recommended by Mannard and Dunn\textsuperscript{26}. Preparations of 0.005 M sodium thiosulfate (Na\textsubscript{2}SO\textsubscript{3}), 2N sulphuric acid (H\textsubscript{2}SO\textsubscript{4}), 10% potassium iodide (Kl) and soluble chemical starch were performed according to the methods of Mannard and Dunn\textsuperscript{26}.

2.1. Statistical method

Statistical analysis was done using Microsoft Excel 2007 and scientific calculator. The results were expressed as mean ± standard deviation (SD), median and standard error of mean (SEM).

3. Result

The Range of iodine content of various salt samples of UHTC (Urban Health & Training centre) Multan nagar is as follows. At retail level the range of concentration of iodine in salt samples was 26.5 to 33.6 ppm, for shiv kunj, 28.8 to 34.6 ppm for krishna vihar, 31.3 to 36.8 ppm for yadav colony and 29.6 to 32.6 ppm for ratan nagar respectively and at house hold level it was 12.7 to 34.6 ppm for shiv kunj, 15.1 to 29.6 ppm for krishna vihar, 15.8 to 38.4 ppm for yadav colony and 15.2 to 29.6 ppm for ratan nagar respectively (Table).

<table>
<thead>
<tr>
<th>UHTC</th>
<th>Category</th>
<th>No of Samples</th>
<th>Mean ±SD</th>
<th>Iodine content range (ppm)</th>
<th>Median</th>
<th>SEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shiv Kunj</td>
<td>Household</td>
<td>12</td>
<td>21.5±3.2</td>
<td>12.7-34.6</td>
<td>19.2</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>Retail</td>
<td>4</td>
<td>30.4±3.3</td>
<td>26.5-33.6</td>
<td>30.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Krishna Vihar</td>
<td>Household</td>
<td>12</td>
<td>20.8±1.6</td>
<td>15.1-33.9</td>
<td>18.5</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Retail</td>
<td>4</td>
<td>31.3±2.6</td>
<td>28.8-34.6</td>
<td>31.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Yadav Colony</td>
<td>Household</td>
<td>12</td>
<td>20.7±3.8</td>
<td>15.8-38.4</td>
<td>18.4</td>
<td>1.9</td>
</tr>
<tr>
<td></td>
<td>Retail</td>
<td>4</td>
<td>34.5±2.5</td>
<td>31.3-36.8</td>
<td>35.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Ratan Nagar</td>
<td>Household</td>
<td>12</td>
<td>19.5±4.3</td>
<td>15.2-29.6</td>
<td>18.4</td>
<td>1.2</td>
</tr>
<tr>
<td></td>
<td>Retail</td>
<td>4</td>
<td>31.2±1.5</td>
<td>29.6-32.6</td>
<td>31.3</td>
<td>0.7</td>
</tr>
</tbody>
</table>

*SEM (standard error of mean)
SD (Standard Deviation)

4. Discussion

In 1999, it was estimated that of the 130 countries in the world having had a past iodine deficiency problem of public health significance, 58% of households had access to iodized salt as compared to five to ten per cent in 1990\textsuperscript{27-28}. A study reported that iodine deficiencies are major public health problems in India; only 51% of Indian households are using adequately iodized salt\textsuperscript{29}. A study in Rajasthan reveals that salt iodine content was ≥ 15mg/kg in 41.9% of the households and 23% used non iodized salt\textsuperscript{30}. Other reports stated that the consumption of iodized salt varied in respect of socioeconomic condition\textsuperscript{31}. Kapil et al\textsuperscript{32} in their study found that 53% of the school going children of Meerut were consuming salt with an iodine content of less than 15 ppm. Also a recent study in Orissa reported the use of 45% and 47.7% of adequately-iodized salts at the households and retail outlets respectively\textsuperscript{33}. In our study of edible salt analysis in the urban areas of Meerut district of U.P. salt samples that are collected from UHTC Multanaggar and the adjoining colonies coming under the health centre i.e Shiv Kunj, Krishna Vihar, Yadav Colony, Ratan Nagar, we have found that around 4% of the household samples from the urban area were having iodine content less than 15 ppm below the recommended level for the consumers by WHO/UNICEF/ICCIDD.
5. Conclusion

Iodine deficiency is a serious problem. The need to eliminate iodine deficiency is very clear based on the widespread damaging effects and the large number of people affected. Salt iodization is by far the most important population based intervention for IDD control. Efforts toward establishing and sustaining national salt iodization programmes have accelerated over recent years. Effective partnerships have been forged between relevant UN agencies, national and international NGOs, and the salt industry, increased awareness amongst consumer regarding iodization of salt and its demand. Salt iodization is not an end in itself but only a means to achieve optimal iodine nutrition. It is why besides monitoring iodized salt quality, iodine status also needs to be monitored. Our study reveals a positive new momentum that reflects changes in India’s salt industry. These changes include better production, effective monitoring to iodine levels from production to consumption and better consumer awareness in the urban areas. As UI is a good marker of the recent dietary iodine intake, it is, therefore, the index of choice for evaluating correction of iodine deficiency so we further like to elaborate our study to UI status of the studying population.

References