Chapter Seven

1990

Global Political Support

World Summit for Children

1. The Year of Resolutions
2. ICCIDD Global Action Plan, SCN, Paris, February
3. 5th Board Meeting, Dar es Salaam, February
4. World Health Assembly, May
5. WHO/UNICEF Consultation on IDD & Vitamin A, December
1990 was a peak year in the life of the global program for the elimination of IDD as a public health problem by the year 2000. Three major events occurred in 1990 that were the result of the previous five years of activity following the Delhi Meeting in 1985 at which the ICCIDD had been founded.

These three major events were:

1. The preparation and acceptance of a Global Action Plan for the Elimination of IDD by the international agencies – multilateral and bilateral. This occurred first at the fourth meeting of the IDD Working Group held at UNESCO Headquarters in Paris, 18 February 1990, followed by formal endorsement at the SCN Assembly (February 1990).

2. The passage of a Resolution by the 43rd World Health Assembly (Geneva, May 1990).

3. The World Summit for Children’s (30 September 1990) acceptance of the virtual elimination of IDD by the year 2000 as one of the goals in a list of 27 goals covering a new program for a new era in improving the health and education of children throughout the world, particularly in developing countries.

**ICCIDD Global Action Plan, Paris, February**

In presenting the Global Action Plan (GAP) to the 4th meeting of IDDIWG/CN in Paris on 18 February 1990, Dr Hetzel indicated that it provided a general framework for cooperation between the agencies in order to achieve the goal now accepted by WHO and UNICEF. The plan had been drawn up in the light of the close working relationship that had developed
between the ICCIDD, WHO and UNICEF particularly since 1987. The establishment of the IDD Working Group by the SCN, followed by the regional working groups, provided a necessary basis to maximize the use of resources available. Each agency remained free to further develop its role as it saw fit, in addition to its role in the general cooperative framework outlined.

The purpose of the Global Action Plan was to provide global and regional support for establishing and monitoring effective national IDD control programs. It included activities at national, regional, and global levels. The plan was designed for consideration by interested agencies and, in due course, by donors.

A budget of $2 million was proposed to provide for increased activities at global and regional level, complementary to the activities and funding already provided at national level (by WHO, UNICEF, the World Bank, bilateral agencies and NGOs). Administrative responsibility would be with the individual agencies, with a global coordinating committee composed of representatives of the ICCIDD, WHO, UNICEF with, in addition, the World Bank and bilaterals, depending on their interest in IDD control.

---

**The Executive Summary of the GAP is as follows –**

**Global Action Plan for Elimination of IDD**

The elimination of IDD as a major public health problem has been accepted as a goal for the 1990s by the Joint WHO/UNICEF Committee on Health Policy (January 1989) and more recently by the WHO Executive Board (January 1990).

A Global Action Plan has now been prepared, as natural evolution of the various initiatives taken by the ICCIDD with WHO and UNICEF over the past four years.

The purpose of the plan is the establishment of effective national IDD control programs. It includes activities at the national, regional and global levels.
At the national level, initial assessments, national seminars, communication packages, intersectoral planning with a National IDD Control Commission, evaluation, and monitoring with laboratory services are included. In Indonesia and China, International Working Groups have now been established by ICCIDD in collaboration with WHO and UNICEF.

At regional level, the development of a series of regional IDD working groups provides for the necessary close working relationship between ICCIDD, WHO and UNICEF. The IDD Task Force for Africa has been particularly successful in developing a coordinated strategy involving both multilateral and bilateral agencies.

At the global level, the major function of advocacy and public information, and a global monitoring system are covered, together with continuing expert working groups, and research activity.

An annual report on progress in IDD control is made each year to the SCN, which has also set up an IDD Working Group composed of representatives of multilaterals and bilaterals.

A budget of $2 million is proposed to provide for the increased global and regional support for national programs if the objective of elimination is to be achieved. This budget complements the budgets at national level already supported by UNICEF, WHO, Bilateral and NGO contributions.

Regional support is required for consultancies, workshops, seminars, training courses, and laboratory support to assist national programs.

At the global level, expert working groups, research related to program issues, publications, and coordination activities are included.

The budget proposes the appointment of up to four full-time staff (4 x $100,000 per year) at a short-term professional (STP) level as already operating in WHO, together with increased support for the ICCIDD ($500,000 per year).

Administrative responsibility would be with the ICCIDD Board with an enlarged executive including the board with representatives of WHO, UNICEF, World Bank and the bilaterals.
Since the formal establishment of the ICCIDD in 1986 much progress has been made with IDD control in collaboration with WHO and UNICEF. It is now proposed that this activity be intensified with acceptance of the goal of elimination of IDD as a major public health problem by the year 2000.

No suitable opportunity presented itself for submission of this Plan to WHO and/or UNICEF. Later submission to the Gates Foundation on two separate occasions in 2000 and 2009 was unsuccessful.

The GAP was endorsed by the SCN as follows:

**Terms of Endorsement by the United Nations Administrative Committee on Coordination: Subcommittee on Nutrition (SCN) at its 16th Session (Paris, February 1990)**

A document prepared by the ICCIDD as a Global Action Plan (GAP) for the elimination of IDD as a major health problem by the year 2000 has been endorsed by the Executive Board of WHO, by UNICEF, the World Bank and by the working group on IDD of SCN. GAP takes account of the recent special appointments made by WHO, UNICEF and World Bank to cover the area of micronutrient deficiencies and counts on the cooperation and support of these agencies in the achievement of GAP objectives.

The plan encompasses advocacy, information and monitoring systems at the global level and a series of IDD working groups at the regional level. At the national level, baseline assessment, planning seminars and laboratory services for monitoring and evaluation would be included.

A budget was presented for the Global Action Program. This would total about US$2 million per annum for the period 1990–2000, including staff costs, or US$1.6 million without staff. This represents a
minimal cost proposal and does not include current funding of national level activities promised by multilateral, bilateral and NGOs. Support for this proposal was endorsed by the SCN as follows:

The SCN endorses the plan of action proposed by ICCIDD for global elimination of Iodine Deficiency Disorders (IDD) as a public health problem by the year 2000. The SCN draws attention to the need for financial support to global and regional activities leading to the development of national programs, and in particular to the need for increased and more broadly based support for the ICCIDD.

Statement by Director-General of World Health Organization

Participants at the SCN 16th Session on 19 February 1990 received ACC/SCN and WHO papers that included a January draft Resolution to the 43rd World Health Assembly on prevention and control of iodine deficiency disorders, and an important Report (EB85/18 dated 8 December 1989) by the Director-General of WHO, Dr H Nakajima, to the 85th Session of the WHO Executive Board. Its title was ‘Infant and child nutrition’. The section ‘Prevention and control of iodine deficiency disorders: recent progress’ is reproduced as Appendix 7.1.

5th Annual ICCIDD Board Meeting, Dar es Salaam, 26–27 February 1990

The Fifth ICCIDD Board Meeting noted the greatly expanded activities that had occurred during 1989 as reported in the previous chapter. Dr Greaves of UNICEF reported that the Secretary General of the UN had invited Heads of State to a World Summit for Children to be held at the United Nations in New York on 30 September 1990. He had prepared a concise statement on IDD in consultation with the Executive Director. Mr Haxton commented that the thaw in the Cold War had provided a new opportunity to point out the needs of children as a priority for development.

The endorsement of the Global Action Plan by the SCN was noted with
satisfaction. All Regional Coordinators were advised that the acceptance of the GAP by WHO, UNICEF, the World Bank and the bilateral agencies meant that they could approach these agencies with much more confidence than in the past. Initial approaches to WHO would be most useful at regional level, while initial approaches to UNICEF would be most useful at country or global level. A series of excellent regional reports were tabled by the Regional Coordinators.

Scientific publications were noted, including the Elsevier volume, the monograph on *Iodine and the Brain* and the first ICCIDD manual, *A Practical Guide to the Correction of Iodine Deficiency* by J T Dunn and F van der Haar; 50,000 copies were printed with the support of the Dutch Government Cooperation Program. Subsequently French and Spanish translations were also printed. This publication has been very successful in widely disseminating the major steps in an iodization program. A further 20,000 copies of the IDD Brochure in three languages were being printed in Delhi. A booklet entitled *Introducing the ICCIDD*, printed in 1989 (2000 copies) and including a membership directory, was widely distributed. Dr Dunn reported continued quarterly publications of the *IDD Newsletter*: 3500 were printed each time; 1000 were mailed directly, the others were sent by bulk postage to the Regional Coordinators, UNICEF and WHO Offices.

A budget was submitted for 1990 and 1991 with two major components:

1. A core ICCIDD budget of $214,000 made up of $US100,000 UNICEF and $US114,000 from AIDAB.

2. A supplementary budget of $495,000 for special projects undertaken by ICCIDD usually in collaboration with WHO and for UNICEF.

A brief report was made on the recent second PEG course in Brussels. There were 40 participants representing 30 countries including 15 from Africa. The course directors were Dr André Ermans and Dr P Bourdoux. In the evaluation the participants pointed out that the course had been strong in pathological physiology, but weaker on management aspects. Great credit was due to the Brussels group for the excellent organisation of the course.

Subsequent to the board meeting, the 4th meeting of the IDD Task Force for Africa was held; the Tanzanian national meeting followed.
Progress in the First 5 Years

The Executive Director presented a summary of programs over the first five years (1985–1990).

ICCIDDD and the UN system

   a. Goitre and cretinism: prevention of cretinism (PNG)
   b. Other defects: animal models
   c. Iodine and brain development
   d. The major preventable cause of mental deficiency

   a. Population at risk of IDD – 1 billion
   b. New concept – IDD
      i. Fetus
      ii. Neonate
      iii. Child
      iv. Adult
   c. IDD block to socioeconomic development
   d. Suitable mass technology
      i. Salt
      ii. Oil
   e. Assessment and monitoring

   b. State of art book – National program model
   a. IDD Task Force for Africa–Anglophone, Francophone
   b. SE Asia, Middle East, China, Indonesia


   a. World Health Assembly (1990) – 167 member states
   b. Children’s Summit (1990) – UN – 70 heads of state

7. CDC/Atlanta for training (1991)
   a. Management training – Africa, Asia, Middle East

8. Funding
   a. CIDA
   b. USAID
   c. Japan

---

The ICCIDD and the Task Force for Africa

1. **Expert network** (global, multidisciplinary, 300 members) including the regional coordinators

2. **Close working relations** with WHO and UNICEF in intercountry meetings (Africa, Asia) and in Regional Working Groups (e.g. IDD Task Force for Africa, Working Groups in Asia) (fig 1)

3. **Expert working groups** (with WHO)

4. **Publications**
5. **Training** – assistance at regional and national level

6. **Research** – as expert advisor on highly specialised issues, of which there are many

7. **Consultancies** – to help develop new control programs or monitor and evaluate existing programs

8. **Communication** – with the UN system through the Subcommittee on Nutrition (SCN) and the global IDD Working Group

These activities are now being increased through the support of the other agencies: WHO, UNICEF and the bilaterals. The expansion of the work coordinated by the IDD Task Force for Africa since 1987 offers an excellent example for further development.

Over the three year period (1987–1989) funding support has been available for IDD programs in Africa as follows:

**ICCIDDD**  
Regional Seminar, Yaoundé 1987  
Participants in the 1st, 2nd and 3rd meetings of the IDD Task Force for Africa  
Programs in Burkina Faso, Cameroon, Zaire, Botswana, Tanzania, Zimbabwe  
Salt iodation missions in Burkina Faso, Senegal, Sierra Leone, Cameroon, Zaire, Kenya, Tanzania, Malawi, Zambia, Lesotho, Burundi, Rwanda

**UNICEF**  
Regional Seminar, Yaoundé 1987  
Programs in Mali, Nigeria, Togo, Congo, Zaire, Kenya, Tanzania, Zimbabwe, Malawi, Lesotho, Madagascar  
Seminar Nairobi-Salt iodation and Communication 1988  
Third Meeting of IDD Task Force for Africa

**WHO**  
Regional Seminar, Yaoundé 1987
Participants in Third IDD Task Force for Africa 1989
Programs in Burkina Faso, Mali, Senegal, Cameroon, Congo, Burundi, Rwanda, Zaire, Ethiopia, Kenya, Malawi, Botswana

Salt iodation missions in Burkina Faso, Mali, Senegal, Cameroon, Zaire, Burundi, Rwanda, Kenya, Tanzania, Malawi, Lesotho

Seminar on Salt Iodation and Communication, Nairobi 1988

**IDRC** Programs in Liberia, Zaire, Kenya

**Holland** Salt iodation, Tanzania

**SIDA** Programs in Tanzania, Zimbabwe

**AIDAB** Consultancy on iodine laboratories, Harare, Nairobi and Dar es Salaam, Harare: laboratory equipment for regional centre
The 43rd World Health Assembly, 7–17 May

The 43rd World Health Assembly was held in Geneva in May 1990. Much preparatory work went into passing the WHA Resolution about IDD on 14 May. The Australian delegation was led by Dr David de Souza of the Australian High Commission in London. The Executive Director of ICCIDD was a member of the delegation as adviser.

Statement by Dr Basil Hetzel, ICCIDD, to World Health Assembly, 8 May 1990

Prevention and Control of Iodine Deficiency Disorders

Agenda Item 17

Thank you Mr Chairman, Delegates to the WHA and members of the Secretariat.
I. Introduction

In 1986 at the 39th WHA, Australia, together with 22 other countries, sponsored a Resolution which was unanimously carried, calling for more aggressive action directed to the prevention and control of iodine deficiency disorders (IDD). Indeed the Resolution pointed out that a large measure of control could be achieved in the next five to ten years. In 1990, four years later, the Executive Board has decided in Resolution R6 now before this WHA that in the light of the progress already achieved, WHO shall aim at eliminating IDD as a major public health problem in all countries by the year 2000.

Australia wishes to strongly support the Resolution of the Executive Board. Australia has already demonstrated its strong commitment to the objective with its support of a major bilateral program with the People’s Republic of China. It has also supported from its foundation the International Council for Control of Iodine Deficiency Disorders, a network of some 300 professionals dedicated to the development of effective national IDD control programs. The ICCIDD is honoured by the recognition given to it in the Resolution. It has also been supported
by UNICEF, WHO, the Government of Italy and the Government of Holland. I am privileged to be the Executive Director of the ICCIDD.

II. What is IDD and why is it important?

IDD refers to all the effects of iodine deficiency on growth and development. These are most evident on fetal, infant and child development – particularly fetal survival and brain development. In the adult a massive prevalence of hypothyroidism affecting physical and mental energy is evident. As a result IDD are now seen as a major impediment to social and economic development. In many countries there is now much anecdotal evidence that correction of iodine deficiency has given new life to iodine deficient communities – evident in greater productivity, improved school performance of children and better quality of life for the whole community.

III. Progress in prevention and control

Notable progress has been made since 1986 as reported in the WHA document. This has come about as a result of the establishment of a close working relationship between the ICCIDD, WHO and UNICEF at global, regional and national levels.

Progress has been particularly notable in Africa where more than 20 countries are now in the course of developing national programs while Ethiopia, Zaire and Cameroon have begun national programs. Regional WHO/UNICEF/ICCIDD working groups have now been established in all WHO regions with the prime function of fostering national IDD control programs.

IV. A global action plan

The global action plan designed to achieve the goal of elimination of IDD as a major public health problem by the year 2000 has now been developed by the ICCIDD and endorsed by the UN agencies and key bilaterals at the recent ACC/SCN 16th Session (Paris 1990). This plan calls for $2 million a year for global and regional support directed to the establishment of national IDD control programs. These activities include an escalation of the workshops, training programs,
publications and expert assistance already operating within the ICCIDD/WHO/UNICEF framework of cooperation. This escalation is required to achieve the objective of elimination of IDD by the year 2000.

V. Requirement for achievement of elimination

Most important is the conviction that this can be achieved. In 1978 the Director General of WHO and Executive Director of UNICEF stated that ‘it was a crime for a single child to be born suffering from the effects of iodine deficiency on brain development’.

Since 1978 many millions have been born suffering from this defect, now estimated to affect 20 million people. The WHA Report estimates that there were 1 billion at risk of the effects of iodine deficiency.

The cost involved in the elimination of IDD as a public health problem is estimated by the ICCIDD to be 5 cents per head per year for the iodization of salt. This means $50 million for 1 billion people at risk. Probably half of this population is already covered; the challenge is to complete the task which would require $25 million per year from government, inter-government and bilateral sources.

Australia suggests that the WHA commits itself by supporting the Resolution. There is a great opportunity for a spectacular success for the UN System by the year 2000.

WHA Resolution, 14 May

The 43rd World Health Assembly passed Resolution WHA43.2, which commends governments, intergovernmental agencies and nongovernmental organisations – in particular the International Council for Control of Iodine Deficiency Disorders (ICCIDD) – on their efforts to prevent and control the condition, which was described originally by Dr David Marine and reiterated by Dr Basil Hetzel, Executive Director of ICCIDD, as one that ‘is so easy to prevent that it is a crime to let a single child be born mentally handicapped for that reason’.

The WHA decided that, in view of the encouraging progress achieved since 1986 and the promising potential of current and planned national
prevention and control programs, the World Health Organization ‘shall aim at eliminating iodine deficiency disorders as a major public health problem in all countries by the year 2000’.

The Assembly urged Member States of WHO to continue to give priority to the prevention and control of iodine deficiency disorders through appropriate nutrition programs as part of primary health care. It also requested the Director General of WHO to continue to monitor the incidence and prevalence of iodine deficiency disorders and to reinforce the technical support provided to member states of WHO in this connection.

In a report submitted by the Director General of WHO to the World Health Assembly in May 1990, it was estimated that the relatively modest sum of US$2 million would be required for global and regional support for each of the next ten years to promote the development of national iodine deficiency disorder programs with the objective of eliminating iodine deficiency disorders throughout the world.

The full text of the Resolution appears as Appendix 7.2.

Appendix 7.3 reproduces the text of the WHO media release about elimination of IDD by 2000 after passage of the Resolution.

Appendix 7.4 contains Dr Basil Hetzel’s memo to the Australian Mission at WHO.

Appendix 7.5 presents the ICCIDD Newsletter report of the passage of the Resolution.
The leaders from 71 countries attending the Summit included President George Bush, USA; Prime Minister Margaret Thatcher, UK; and Prime Minister Brian Mulroney, Canada.

The World Summit for Children

The Executive Director of the ICCIDD, Dr Basil Hetzel, was invited to the 1990 World Summit for Children. The invitation read:

On behalf of the Prime Minister of Canada, the President of Egypt, the President of Mali, the President of Mexico, the Prime Minister of Pakistan and the Prime Minister of Sweden, it is my honour to invite you to be present on the occasion of the 1990 World Summit for Children, which Their Excellencies have initiated.

While the World Summit is, of course, a meeting of Heads of State or Government, the Opening and Concluding Sessions of the Summit, on Sunday 30 September 1990, will be conducted in the General Assembly Hall of the United Nations, which will allow an invited audience of international, regional and national officials and leaders of government, institutions, organizations and public action. The six Initiators are pleased to invite you to be among this select assembly to witness the world’s first global summit.

In response to this invitation 71 world leaders gathered together with 80 representatives of the United Nations and major nongovernmental organisations at the World Summit for Children. The event focused unprecedented public attention on the needs of children everywhere and reinforced the objectives of the Convention on the Rights of the Child. It was the largest gathering of world leaders in history to address the death and suffering that affect infants and young children daily.
The summit resulted in unanimous endorsement of a plan to address children’s needs. The major goals of the Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s are:

- reduction of under-five child mortality rates existing in 1990 by one third or to a level of 70 of 1000 live births, whichever is the greater reduction
- reduction of maternal mortality rates by half of 1990 levels
- universal access to safe drinking water and to sanitary means of excreta disposal
- universal access to basic education and completion of primary education by at least 80 per cent of primary school age children
- reduction of the adult illiteracy rate to at least half of its 1990 level (the appropriate age group), with emphasis on female literacy
- protection of children in especially difficult circumstances, particularly in situation of armed conflict.

Included in the Plan, in Section II, Supporting Goals; Part B: Nutrition, was the goal of elimination of Iodine Deficiency Disorders.

**B – Nutrition**

(i) Reduction in severe, as well as moderate malnutrition among under-5 children by half of 1990 levels

(ii) Reduction of the rate of low birth weight (2.5kg or less) to less than 10%

(iii) Reduction of iron deficiency anaemia in women by one third of the 1990 levels

(iv) Virtual elimination of iodine deficiency disorders

(v) Virtual elimination of Vitamin A deficiency and its consequences, including blindness

(vi) Empowerment of all women to breast feed their children exclusively for four to six months and to continue breast feeding, with complementary food, well into the second year

(vii) Growth promotion and its regular monitoring to be institutionalised in all countries by the end of the 1990s
(viii) Dissemination of knowledge and supporting services to increase food production to ensure household food security.’

Further information about the World Summit for Children is provided in Appendix 7.6.

WHO/UNICEF Consultation on IDD & Vitamin A, Geneva, 6–7 December

At the WHO/UNICEF Consultation on IDD and Vitamin A, held in Geneva in December 1990, a review of published papers was carried out, from which the following conclusions were drawn.

1. Review of evidence available on epidemiology and prevention of IDD
The total population at risk was in excess of 1 billion with 200 million with goitre and 20 million with mental defect related to iodine deficiency. It was also noted that iodine deficiency was the major cause of preventable mental deficiency in the world today.

It was agreed that iodine deficiency had a significant adverse effect on child survival and development and that these effects can be totally prevented by correction of the iodine deficiency with iodized oil or iodized salt.

2. Use of iodized oil
All aspects of the pharmacology of iodized oil given either by injection or by mouth, in excess of 60 million doses of iodized oil, had been given over the past 15 years in Asia, Africa and Latin America.

Iodized oil had been remarkably free of side effects (rarely an abscess may occur at the site of injection), and these were not considered to be of public health significance.

Recent data indicated that injection of 1 ml (480 mg iodine) lasted 3 years, while the oral administration of the same dose lasted 1-2 years. Pregnancy was not a contraindication.

More research was required on the interaction of iodized oil with Vitamin
A and the oral polio virus and steps had been taken for this to be carried out.

3. Interaction with the EPI program

The EPI program included 500 million contacts with the primary health care system. The EPI program, at its recent GAG meeting in Cairo, had indicated its willingness to include iodized oil administration as an addition to the current regime of immunization.

Current experience with mass iodized oil injection programs in Nepal, Indonesia and Zaire was reviewed. Manpower and costs were significant and a merging with the EPI program presented obvious advantages in administration, economical use of resources and a more comprehensive approach.

The following specific strategies were agreed for iodine deficient areas and regions:

(i) Women of reproductive age should receive an iodized oil injection (1 ml 480 mg of iodine) at the time of the first child immunization visit. Present data indicated that the coverage for first child immunization was about 80 per cent. This meant that this measure would cover 80 per cent of women of reproductive age. The single intramuscular injection of 1 ml would correct iodine deficiency for a period of three years during which time pregnancy was likely to occur.

(ii) Pregnant women at the time of tetanus toxoid administration should receive an injection of iodized oil. This usually occurs late in pregnancy so that the early period would not be covered. But the post-partum period and a subsequent likely pregnancy would be covered by the three year period.

(iii) Children for the first two years of life should receive oral oil (0.5 ml 240 mg iodine) at the first immunization visit and again at the final immunization visit for measles vaccination (at nine months of age). This would cover most of the first two years of life, which is the time of maximum brain growth.

Apart from the EPI program, the group noted that salt iodization should also be in force. Administration of oral oil to school children through the school
system was another option in addition to the EPI program recommendations. Monitoring of neonates by measurement of the thyroid stimulating hormone (TSH) using blood spots on filter paper, was strongly recommended at the time of the first immunization visit in addition to the measurement of urine iodine in school children and adults. This would indicate the need for continuance of the administration of iodized oil through the EPI program.

4. The global action plan for the elimination of IDD
The global action plan (GAP) proposed by the ICCIDD and endorsed by the ACC/SCN (16th Session, Paris 1990) was reviewed and approved. The urgent need for additional funding support of global and regional levels for national IDD Control Programs was noted if the target of the virtual elimination of IDD by the year 2000 was to be met. It was agreed that a great opportunity existed for achievement of the great goal of elimination of IDD.
Appendix 7.1

Section of Report of Director General of WHO to 85th Session of WHO Executive Board

PREVENTION AND CONTROL OF IODINE DEFICIENCY DISORDERS: RECENT PROGRESS

WHO has striven since its inception to support member states in their efforts to prevent and control iodine deficiency disorders (IDD). In 1986, in its resolution WHA39.31, the Thirty-ninth World Health Assembly requested the Director General inter alia to give all possible support to member states in assessing the most appropriate approaches to preventing and controlling IDD, to collaborate with them in monitoring the incidence and prevalence of IDD and to report to the Health Assembly on progress achieved. In recent years the regional committees for Africa, the Americas and Southeast Asia have also called for more action in this area.

Following the adoption of Resolution WHA39.31, WHO prepared a strategy and proposal for a multi-agency 10-year program of support to countries. As a result of a historic joint WHO/UNICEF MEETING held in 1985 at WHO’s Southeast Asia Regional Office, the International Council for Control of Iodine Deficiency Disorders (ICCIDD), was conceived and was formally inaugurated in Kathmandu the following year. It helps to develop and strengthen national IDD control programs through its six regional coordinators and a global, multidisciplinary network of nearly 300 scientists, economists, technicians, health professionals and national IDD program managers. The reduction of IDD to a level below public health significance in all regions was among the nutrition program targets adopted for the Eighth General Program of Work (1990–1995).

Finally, the elimination of IDD (no new cases of goitre, IDD handicap or cretinism) was included in the WHO/UNICEF strategy for improved nutrition of mothers and children in the developing world that was presented
to the twenty-seventh session (January 1989) of the UNICEF/WHO Joint Committee on Health Policy.

IDD has been eliminated in a number of countries, following effective implementation of national control programs and as a result of overall social and economic development. The time is right for a major global thrust to eliminate IDD finally in all remaining affected countries. Scientific knowledge, combined with inexpensive and effective technology and accumulated practical experience in its application, brings this objective within reach, provided sustained national and international action can be maintained on an appropriate scale. Much has already been accomplished since 1986 and this portion of the report discusses the current global prevalence of IDD in the light of the national and international action being taken. It also outlines goals that some member states have already set for themselves.

**NATURE AND EXTENT OF THE PROBLEM**

Iodine deficiency is a major risk factor for the physical and mental growth and development of at least 1000 million people (fig 1) who live in iodine deficient environments around the world. Iodine is an essential trace element that was
present in abundance during the primordial phase of the earth’s development; it has since been leached from topsoil by glaciation, snow, rain and flooding. The most severely iodine deficient areas are the vast mountainous regions of the Himalayas, the Andes and the European Alps, and parts of China.

The biological importance of iodine is due to the fact that it is essential for thyroid hormone production; the tragedy of its deficiency lies in the easily preventable, but largely irreversible, brain damage that occurs during fetal growth and infant development. Endemic goitre is the most visible manifestation of environmental iodine deficiency; other, more severe, effects include retarded fetal brain development, spontaneous abortion; stillbirths and infant deaths. A deficiency of iodine later in infancy and childhood causes mental retardation, delayed motor development, growth failure and stunting, lethargy, neuromuscular disorders (including squint and paralysis), and speech and hearing defects.

Awareness of both the significance of IDD and the need to act to eliminate it has increased strikingly – nationally and internationally – in the past five years. IDD surveillance activities – assessment, monitoring and evaluation – have been intensified in all WHO regions, leading to a much clearer picture of global prevalence and trends. Estimates of the magnitude of the problem are reasonably sound for South-East Asia and Latin America, at least in terms of goitre rates. Estimates for the African, European and Eastern Mediterranean Regions, however, are still only approximate. Vital information relating to the broad spectrum of mental sub-normality and to handicap and reduced educability, which are estimated to affect at least 20 million people worldwide, is unfortunately rarely available, or only very scantily reported, in most regions.

The Director General went on to review the current status of the prevalence of IDD in the six WHO Regions:

IDD has been virtually eliminated in **North America**, most of **northern Europe, Australia** and **New Zealand**, mainly through salt iodization, assisted by the increased dietary intake of iodine that is associated with social and economic development.

In the **African region** the WHO Regional Committee has recently adopted a series of resolutions on IDD prevention and control: In 1987 it urged an acceleration of control measures; In 1982 it pressed for universal
salt iodization in countries concerned; and in 1989 it called for elimination of IDD as a significant public health problem in the region by the year 2000.

A significant outcome of a major workshop organised by WHO, UNICEF and ICCIDD in Yaoundé in 1987 was the establishment of the Regional IDD Task Force for Africa, which monitors the implementation of a regional strategy for IDD control that supports member states in developing or strengthening their national programs. The task force has met on three occasions.

Data on the nature and magnitude of IDD have been assembled for 36 countries, 14 of which have carried out surveys since 1987. National IDD control programs, using iodized salt or iodized oil, are successfully under way in Algeria, Congo, Ethiopia, Kenya, Malawi, Mali, the United Republic of Tanzania and Zaire. National IDD control programs have been formulated in two other countries and are being drawn up in eight more. National seminars have been conducted in ten countries and a regional seminar has been held on salt iodization and information.

Salt iodization presents an unusual opportunity for the region because so many countries have to import salt, from the relatively few that export it (mainly Ethiopia, Ghana, Kenya, Namibia, Senegal and the United Republic of Tanzania). The Regional IDD Task Force has raised this issue with the Regional Directors of WHO and UNICEF, who have referred it to the Organization of African Unity. Much of the salt in East Africa is already iodized. The major producer for West Africa, in Senegal, has agreed to negotiate terms for iodization. Cameroon has recently agreed to iodize the salt it produces and Ghana, Nigeria, and Zaire plan to conduct feasibility studies for this purpose. A laboratory for urinary iodine analysis has been established in Zimbabwe.

In the region of the Americas IDD has been eliminated from a number of countries (Canada and the USA, for example) by using iodized salt as part of nationwide food-fortification efforts. It has persisted in countries of the Andean Region, primarily in rural areas where iodized salt is not available. Recently, the Joint WHO/UNICEF Nutrition Support Program, using the principles of social mobilization (i.e. public education and community participation), began to intensify salt iodization programs in Bolivia and Peru, complemented by iodized oil (administered orally and by injection) in isolated areas where the distribution of iodized salt is difficult or where there is a high prevalence
of endemic cretinism. In Ecuador an effective national control program that includes the distribution of iodized salt by a single private company has been successful.

More up to date reviews of IDD status are required in a number of countries, including Argentina, Brazil, Chile, Colombia, Mexico, Uruguay and Venezuela. Quick assessments have already been undertaken in Paraguay and the Central American countries (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama). The Organization is supporting the development of a regional epidemiological surveillance initiative, in keeping with the goal that member states of the region have set for themselves – the elimination of IDD as a significant public health problem by the year 2000.

The fortieth session of the WHO Regional Committee for the Americas/XXXIII Meeting of the Directing Council of PAHO (September 1988) approved the Organization’s food and nutrition policies, which include IDD prevention and control. On this basis an expanded program for the control of IDD in Latin America was launched through joint action supported by PAHO/WHO, UNICEF and ICCIDD.

In the South-East Asia region remarkable progress in IDD control has been achieved in the last decade. This is particularly gratifying, since the largest global concentration of populations affected by IDD is in this Region. It is estimated that more than 100 million people have goitre, over 4 million suffer from cretinism and some 13 million are affected by significant mental or motor handicaps attributable to iodine deficiency. Nevertheless, decreases in IDD are now being recorded in Bhutan, Indonesia, Nepal and Thailand following the implementation of programs using iodized oil and salt.

In 1981 the WHO Regional Committee for South East Asia urged Member States to reduce the prevalence of endemic goitre to below 10% by the year 2000. Since then WHO, in collaboration with UNICEF, has provided technical and financial support to IDD-affected countries for national surveillance efforts, the establishment of iodized salt and oil programs, training and education, iodine laboratories and operational research. An important outcome of a joint WHO/UNICEF/ICCIDD meeting held in New Delhi in 1989 was the strengthening of the regional IDD control program, backed by a newly established regional IDD working group.
Following a WHO-supported national IDD survey in Bangladesh, an intensive program of iodized oil distribution, combined with compulsory salt iodization, has begun. In India a reappraisal of salt iodization has led to new legislation, making it compulsory by 1992. Greater delegation of responsibility to the state level and the holding of educational seminars have contributed to a more effective program and the initiative is being closely monitored, particularly in the north; meanwhile the use of iodized oil is under consideration for dealing with the severe IDD found in the Ganges Valley. A seminar in Indonesia in 1989 reviewed the progress of the national IDD control program, which began in 1974 using both iodized salt and oil. More than 10 million injections of iodized oil have been given, successfully preventing cretinism. A working group composed of representatives of the Government of Indonesia, health training and research institutions, WHO, UNICEF and ICCIDD, has been established to guide the national program.

WHO, UNICEF and ICCIDD are also continuing their support of vigorous national control programs in Bhutan, Myanmar and Nepal, the final IDD elimination efforts of Thailand, and new national control initiatives in the Democratic People’s Republic of Korea and Sri Lanka.

In the Eastern Mediterranean region IDD is a major public health problem in thirteen countries and it is estimated that at least 12 million people are affected. Until recently there has been little public awareness of the
widespread nature of the problem, except for Pakistan. However, the holding of a WHO regional meeting in 1987 was instrumental in changing this situation. Guidelines for developing national IDD programs were published and a regional IDD working group was established in 1989. National plans are being developed in Egypt, the Islamic Republic of Iran, Iraq, the Libyan Arab Jamahiriya and the Sudan.

In the **Western Pacific region**, China, which has an estimated 370 million people at risk, has declared its intention of eliminating IDD by 1995. Iodized salt and oil (ten million doses) have been used on a vast scale, with substantial success. The Ministry of Public Health, in conjunction with WHO, UNICEF and ICCIDD, has established an international working group for IDD control.

National control programs are under way in Papua New Guinea, the Philippines and Vietnam, all of which have areas with severe IDD.

Democratic Kampuchea and the Lao People’s Democratic Republic also have areas with severe iodine deficiency and detailed assessment and program development are required.

**A GLOBAL ACTION PLAN FOR ELIMINATING IDD BY THE YEAR 2000**

In view of the nature of the problem and the recent progress achieved in many countries, the goal of eliminating IDD by the end of the century would seem to be realistic provided that political will and adequate human and financial resources can be mobilised. In June 1989, therefore, WHO, in collaboration with ICCIDD and UNICEF, developed a draft global action plan for eliminating IDD by continuing and reinforcing the national and international initiatives described above. The plan sets out implementation objectives and the strategies to be followed and specifies the resources required at regional and global levels to develop and strengthen national IDD control programs.

Experience shows that the successful control of IDD depends on considerably more than appropriate technology; it also requires accurate problem assessment and active public information, followed by a dynamic process of program planning, implementation, consultancies on salt iodization and the establishment of iodine laboratories to assist in assessing IDD status and maintaining the quality of national programs; pharmacological research on
oral iodized oil; technical consultations and publications; and the development of a global system for monitoring the prevalence of IDD. It is estimated that, in order to ensure that all of these aspects are sustained on an appropriate scale, the relatively modest sum of US$2 million will be required for each of the next 10 years.

The Thirty-ninth World Health Assembly called on the Director General to coordinate, with other intergovernmental and nongovernmental agencies, the launching and management of international action to combat iodine deficiency disorders. The Executive Board may wish to recommend to the Forty-third World Health Assembly that it reaffirm WHO’s commitment in this regard; declare, in the light of progress made since 1986, that the Organization’s goal shall be to eliminate IDD by the year 2000; urge all Member States concerned to develop or enhance their national IDD control efforts, through appropriate nutrition programs as part of primary health care; and request the Director General to mobilise new technical and financial resources to support national IDD control programs in the manner described above.
Appendix 7.2

FORTY-THIRD WORLD HEALTH ASSEMBLY

Agenda item 17

PREVENTION AND CONTROL OF IODINE DEFICIENCY DISORDERS

The Forty-third World Health Assembly,

Having considered the report of the Director-General on infant and young child nutrition, in particular regarding the progress achieved in preventing and controlling iodine deficiency disorders;

Recalling resolution WHA39.31 on the prevention and control of iodine deficiency disorders;

1. COMMENDS governments, intergovernmental and bilateral agencies, and nongovernmental organizations, in particular the International Council for Control of Iodine Deficiency Disorders:

   (1) on their efforts to prevent and control iodine deficiency disorders and to support related national, regional and global initiatives;

   (2) on the encouraging progress achieved since 1986, through joint activities in many countries, towards the elimination of iodine deficiency disorders as a major public health problem throughout the world;

2. DECIDES that, in view of the progress already achieved and the promising potential of current and planned national prevention and control programmes, WHO shall aim at eliminating iodine deficiency disorders as a major public health problem in all countries by the year 2000;

3. URGES Member States to continue to give priority to the prevention and control of iodine deficiency disorders through appropriate nutrition programmes as part of primary health care;

4. REQUESTS that the Joint FAO/WHO Expert Committee on Food Additives verify the effectiveness and safety of the long-term use of potassium iodide and potassium iodate to fortify salt for the prevention and control of iodine deficiency disorders;

5. REQUESTS the Director-General:

   (1) to continue to monitor the incidence and prevalence of iodine deficiency disorders;

   (2) to reinforce the technical support provided to Member States, on request, for assessing the most appropriate approaches to preventing and controlling iodine deficiency disorders;

   (3) to mobilize additional technical and financial resources to permit those Member States in which iodine deficiency disorders are still a significant problem to develop or expand their programmes for the prevention and control of these disorders;

   (4) to report to the Health Assembly by 1996 on progress achieved in preventing and controlling iodine deficiency disorders.

Twelfth plenary meeting, 14 May 1990

= = =

A43/VR/12
Appendix 7.3

WHO Media Release, May 1990

Iodine Deficiency Disorders eliminated by the year 2000

The 43rd World Health Assembly, meeting in Geneva in May 1990, unanimously passed a resolution which decided that, in view of the progress already achieved and the promising potential of current and planned national programs to prevent and control iodine deficiency disorders, the World Health Organization (WHO) shall aim at eliminating such disorders in all countries by the year 2000.

At present nearly one billion people still live in iodine deficient areas. However, iodine deficiency is so easy to prevent that ‘it is a crime to let a single child be born mentally handicapped for that reason’ says Dr Basil Hetzel, Executive Director of the International Council for Control of Iodine Deficiency Disorders.
WORLD HEALTH ASSEMBLY URGES ELIMINATION OF IDD BY YEAR 2000

The 43rd World Health Assembly in May 1990 passed a resolution (WHA43.2) commending governments, intergovernmental and bilateral agencies and nongovernmental organizations, in particular the International Council for Control of Iodine Deficiency Disorders (ICCIDDD), on their efforts to prevent and control IDD. The Assembly decided that, in view of the encouraging progress achieved since 1986, and the promising potential of current and planned national prevention and control programs, the World Health Organization "shall aim at eliminating iodine deficiency disorders as a major public health problem in all countries by the year 2000."

The Assembly urged Member States of WHO to continue to give priority to the prevention and control of iodine deficiency disorders through appropriate nutrition programs as part of primary health care. It also requested the Director-General of WHO to continue to monitor the incidence and prevalence of iodine deficiency disorders and to reinforce the technical support provided to Member States of WHO in this connection.

In a report submitted by the Director-General of WHO to the World Health assembly in May 1990, it was estimated that the relatively modest sum of US $2 million would be required for global and regional support for each of the next ten years to promote the development of national iodine deficiency disorder programs with the objective of eliminating iodine deficiency disorders throughout the world.

The Assembly expressed the hope that substantial progress can be announced by the Director-General of WHO in his report to the Assembly in 1996 on progress achieved in preventing and controlling iodine deficiency disorders.

The text of the resolution is as follows:

The Forty-third World Health Assembly, Having considered the report of the Director-General on infant and young child nutrition, in particular regarding the progress achieved in preventing and controlling iodine deficiency disorders;
Recalling resolution WHA39.31 on the prevention and control of iodine deficiency disorders;

1. Commends governments, intergovernmental and bilateral agencies and nongovernmental organizations, in particular the International Council for Control of Iodine Deficiency Disorders:
(a) on their efforts to prevent and control iodine deficiency disorders and to support related national, regional and global initiatives;
(b) on the encouraging progress achieved since 1986, through joint activities in many countries, towards the elimination of iodine deficiency disorders as a major public health problem throughout the world;
2. Decides that, in view of the progress already achieved and the promising potential of current and planned national prevention and control programs, WHO shall aim at eliminating iodine deficiency disorders as a major public health problem in all countries by the year 2000;
3. Urges Member States to continue to give priority to the prevention and control of iodine deficiency disorders through appropriate nutrition programs as part of primary health care;
4. Requests that the Joint FAO/WHO Expert Committee on Food Additives verify the effectiveness and safety of the long-term use of potassium iodide and potassium iodate to fortify salt for the prevention and control of iodine deficiency disorders;
5. Requests the Director-General:
(a) to continue to monitor the incidence and prevalence of iodine deficiency disorders;
(b) to reinforce the technical support provided to Member States, on request, for assessing the most appropriate approaches to preventing and controlling iodine deficiency disorders;
(c) to mobilize additional technical and financial resources to permit those Member States in which iodine deficiency disorders are still a significant problem to develop or expand their programs for the prevention and control of these disorders;
(d) to report to the Health Assembly by 1996 on progress achieved in preventing and controlling iodine deficiency disorders.
Appendix 7.5

INTERNATIONAL COUNCIL FOR CONTROL OF IODINE DEFICIENCY DISORDERS

TO Australian Mission, Geneva
FROM Dr Basil S Hetzel, Executive Director, ICCIDD
RE 43rd World Health Assembly, Geneva, 1990
Prevention and Control of Iodine Deficiency Disorders
Agenda Item 17

At the Australian Mission Luncheon to WHA delegates on 15 May, Dr H Nakajima, in responding to the remarks of the leader of the Australian Delegates to the World Health Assembly, commended the Australian initiative regarding the prevention and control of iodine deficiency disorders (IDD).

Dr Nakajima also referred to his responsibility for continuity of negotiations with Japanese industry (Mitsubishi) regarding subsidy of supplies of iodine required for supplementing the diet of over 600 million people in Asia who were at risk of developing IDD due to living in an iodine deficient environment (iodine deficient soil).

Negotiations with Japanese industry had been initiated by Dr Basil Hetzel of Australia who is Executive Director of the International Council for Control of Iodine Deficiency Disorders (ICCIDD) – see further enclosed folder and copy of WHA Resolution Agenda Item 17.

The ICCIDD (funded partly by AIDAB) was specifically commended in the Resolution for its work on the control of IDD since its establishment in 1986.

Basil S Hetzel
WHO Geneva
15 May 1990
Appendix 7.6

The World Summit for Children

In association with the World Summit in New York, mini-summits and events were held around the world. National and community meetings, seminars, workshops, parliamentary debates and legislative action for children were brought to a close one week before the Summit with candlelight vigils around the world. An estimated one million people lit candles in a symbolic circling of the globe which started at dusk in Antarctica and New Zealand, followed by Australia and the countries of Asia, the Middle East, Africa, Europe and the Americas. The vigils included music, dance and prayer.

The message of the vigils was a challenge to the international community to act urgently to save the lives of an estimated 40,000 young children who continued to die needlessly every day from preventable disease.

The Plan of Action for implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s included the following goals.

I. MAJOR GOALS FOR CHILD SURVIVAL, DEVELOPMENT AND PROTECTION

(a) Between 1990 and the year 2000, reduction of infant and under-5 child mortality rate by one third or to 50 and 70 per 1,000 live births respectively, whichever is less;

(b) Between 1990 and the year 2000, reduction of maternal mortality rate by half;

(c) Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under-5 children by half;

(d) Universal access to safe drinking water and to sanitary means of excreta disposal;

(e) By the year 2000, universal access to basic education and completion of primary education by at least 80% of primary school age children;

(f) Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to at least half its 1990 level with
emphasis on female literacy;

(g) Improved protection of children in especially difficult circumstances.

II SUPPORTING/SECTORAL GOALS

A – Women’s health and education

(i) Special attention to the health and nutrition of the female child and to pregnant and lactating women;

(ii) Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many;

(iii) Access by all pregnant women to pre-natal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies;

(iv) Universal access to primary education with special emphasis for girls and accelerated literacy programs for women.

B – Nutrition

(i) Reduction in severe, as well as moderate malnutrition among under-5 children by half of 1990 levels;

(ii) Reduction of the rate of low birth weight (2.5kg or less) to less than 10%;

(iii) Reduction of iron deficiency anaemia in women by one third of the 1990 levels;

(iv) Virtual elimination of iodine deficiency disorders;

(v) Virtual elimination of Vitamin A deficiency and its consequences, including blindness;

(vi) Empowerment of all women to breast feed their children exclusively for four to six months and to continue breast feeding, with complementary food, well into the second year;

(vii) Growth promotion and its regular monitoring to be institutionalised in all countries by the end of the 1990s;
(viii) Dissemination of knowledge and supporting services to increase food production to ensure household food security.

C – Child Health

(i) Global eradication of poliomyelitis by the year 2000;
(ii) Elimination of neonatal tetanus by 1995;
(iii) Reduction by 95% in measles deaths and reduction by 90% of measles cases compared to pre-immunisation levels by 1995, as a major step to the global eradication of measles in the longer run;
(iv) Maintenance of high level of immunisation coverage (at least 90% of children under one year of age by the year 2000) against diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis and against tetanus for women of child bearing age;
(v) Reduction by 50% in the deaths due to diarrhoea in children under the age of five years and 25% reduction in the diarrhoea incidence rates;
(vi) Reduction by one third in the deaths due to acute respiratory infections in children under five years.

D – Water and sanitation

(i) Universal access to safe drinking water;
(ii) Universal access to sanitary means of excreta disposal;
(iii) Elimination of guinea-worm disease (dracunculiasis) by the year 2000.

WE CAN AFFORD IT

In the 1990 edition of *The State of the World’s Children*, UNICEF estimated that making available today’s low-cost solution to child health problems (which include accelerated immunisation, diarrhoea therapy and the other priorities listed in the Affirmation of Bangkok) would prevent almost 100 million needless child deaths in the next decade. The cost was estimated at US$2.5 billion per year.
According to UNICEF, $2.5 billion was in 1990:

- as much as United States companies spend each year to advertise cigarettes;
- as much as the Soviet Union spends on vodka each month;
- 2% of the poor world’s own arms spending;
- the approximate cost of five Stealth bombers;
- 10% of the European Economic Community’s annual subsidy to its farmers;
- as much as the developing world is paying every week to service its debt;
- as much as the world as a whole spends on the military everyday

Given such statistics, UNICEF’s Executive Director James P Grant wrote:

> It is impossible to accept for one moment the notion that the world cannot afford to prevent the deaths and the malnutrition of so many millions of its young children.

---