Abstract

When we see about the awareness of the people in the world it is low due to that the peoples are suffered from goiter disease and other problems related to iodized and this problem are also faced in our country especially in Tigray Mekelle city. Despite numerous educational programmes to create awareness about iodized salt and iodine deficiency disorders (IDD), a survey conducted in the in Mekelle in 2012 revealed that the goiter rate stood at 18.8%; and 78.1% of households consumed iodized salt, which is below the goal of the IDD programme in Ethiopia which aimed at 90% household consumption of iodized salt by the end of 2015 and sustaining the gains by 2012. It was therefore, considered timely to investigate the knowledge levels and the extent of utilization of iodized salt among the people living in Mekelle, and with the lowest intake (76.4%) of iodized salt based on findings of the 2012 survey. This was a descriptive cross-sectional study. It was conducted among a total of 280 household members, mainly in charge of meal preparation, who were interviewed using a structured interview guide. A combination of cluster and simple random sampling techniques was used to select the respondents from all the respondents. The study revealed that 75.6% of households in the district consumed iodized salt (including households described as occasional users of iodized salt), and knowledge of iodized salt was quite high, as 72% of the respondents knew that not every salt contained iodine. In addition, 69.3% indicated that an inadequate intake of iodized salt can lead to the development of goiter. Despite the high awareness level, only 64.6% of respondents indicated that they exclusively used iodized salt for cooking. The main reason given by exclusive users of common salt was that the price of iodized salt is a little higher than that of common salt. Although majority of the respondents are aware of the importance of iodized salt and iodine deficiency disorders, only 64.6% exclusively used iodized salt, suggesting that respondents’ high knowledge levels did not necessarily translate into an increase in the number of households who used iodized salt. Existing laws and policies on universal salt iodization and quality assurance of iodized salt from the production stage to the distribution/selling stage should be enforced.

Keywords: IDD; Goiter; Mekelle City; Iodized Salt.

Background

Iodine-deficiency disorders (IDDs) are some of the public health problems that confront 118 countries worldwide, and approximately 1.5 billion people are at risk of preventable IDDs [1-3]. The vulnerable groups particularly at risk include pregnant women, infants and children. In some cases, the developing fetus is affected in the womb [3-5]. Iodine is required to synthesize thyroid hormones which control the body’s metabolic rate, and its deficiency results in problems such as abortions, stillbirths, congenital abnormalities, cretinism, goiter and impaired mental function, squinting and mutism [6-10].

In Ethiopia, it is estimated that 100,000 children born each year are at risk of intellectual impairment because of iodine deficiency. Approximately 15,600 (13%) of these babies are severely impaired and are unable to develop properly, which results in an average of 22 million dollars loss in productivity each year in Ethiopia Most of these affected children are also held back by reduced intelligence and mental dullness which are enormous negative educational implications of iodine deficiency [11].

It has been recommended that most developing countries battling with IDD can address the problem in a cost effective way by adding iodine to universally consumed products such as common salt, as done in most industrialized countries [12-16].

In Tigray, the first baseline survey on the state of IDDs in 27 districts was conducted between 2005 and 2007, and the findings revealed a varying degree of endemicity ranging from mild
to severe Total Goiter Rates (TGR). On the basis of a baseline survey conducted in 2005, it was found out that IDD was serious in 23% of the 100 surveyed districts [18]. In most of the surveys conducted, the method employed to measure the thyroid volume of subjects was thyroid palpation.

A market survey conducted in Mekelle 2008 revealed that the level of patronage of iodized salt was 95.7%. However, this figure dropped to 52% in 2010 [21]. In addition, the market survey showed that 58% of salt sold in markets was iodized, yet below 20 ppm, compared with the mandated iodization level of between 25 and 45 ppm [18, 21]. Consequently, it was concluded that the National Salt Iodization Committee and the United Nations’ target of 90 per cent plus of Universal Salt Iodization has not been achieved. Latterly after one year other survey conducted in 2009 revealed that the median urinary iodine level was 77 “g/L, with a range of 28 “g/L to 183 “g/L, and another study conducted among school children revealed that the median urinary iodine concentration was “g/L [19].

The subjects were examined for goiter by the palpation method, and every tenth subject examined provided urine for urinary iodine determination. The median urinary iodine level for the subjects was 1.6 micrograms/dl. Seventy two percent (72%) of the subjects had urinary iodine level less than 2 “g/L, 24% had urinary iodine levels in the range 2-5 “g/L and the remainder had urine iodine in the range 5-10 “g/L. The researchers suggested that further studies should be conducted to determine the cause(s) of the IDD endemic [22]. The ignorance of people regarding the importance and sources of iodine to the body could be a contributory factor to this public health problem.

Apart from a survey which was conducted in 2009 to assess household utilization of iodized salt, no other survey has been conducted in the district. Hence the need to undertake this survey to provide current information regarding the utilization of iodized salt in Mekelle.

The main objectives of the study, then, were to assess the perceptions, knowledge and practices of people in respect of the use of iodized salt, and to ascertain the current consumption rate of iodized salt in zone. The survey also assessed the iodine concentrations of salt consumed in households in the district.

Methods

Sample and Sampling Procedure

Administratively, the Mekelle has four sub-cities with a total population of approximately 219,818 people [30].

A total sample size of 280 households was randomly selected from all the seven sub-districts in the district. Individuals aged 18 years and above in these households who were responsible for preparing meals constituted the subjects for the study.

A combination of cluster and simple random sampling techniques was used to select households to participate in the study. This was deemed appropriate because of the multiple strata (sub-cities, communities and households structure) in the district. Forty respondents from 40 households were randomly selected from each of the seven clearly demarcated administrative sub-cities. From each sub-district, four communities were randomly selected for the study. Ten respondents were interviewed in each of the 28 communities, resulting in a total number of 280 respondents representing 280 households in the district.

Instrument

A structured questionnaire with both open-ended and closed-ended questions was used as an interview guide by the researchers to collect the data. The questionnaire was developed employing some questions from similar studies conducted in, Mongolia [3] and South Africa [7]. The questionnaire was reviewed by the zone Director of Health Services and a public health nutritionist and it was deemed appropriate for use in the communities where the study took place. The questionnaire included a section for observing the type of salt used by households and methods of storage, and the determination of iodine levels in samples of salt used by households, employing the rapid testing kits.

Data Collection Procedure

Prior to the administration of the questionnaire, the instrument was pre-tested in 20 households in two communities not selected for the actual study in the district. The necessary modifications and corrections were made on the questionnaire before it was finally administered in the study area. Six Disease Control Field Technicians were trained to assist the researchers in collecting the data. Informed consent was obtained from both heads of the households and the respondents before the interview was conducted.

In each household, permission was sought to run tests on samples of the salt used for cooking to determine their iodine levels. The tests were conducted using the rapid testing kits [31, 32]. To determine the iodine levels in the salt samples, colour charts on the kit corresponding to values of 0.1-25 ppm, 25.1-50 ppm, 50.1-75 ppm and 75.1-100 ppm were used.

Data Analysis

At the end of the interviews, questionnaires were checked for completeness and internal consistency. The Statistical Package for the Social Sciences (SPSS) programme software (version 15.0) was used for data entry, and descriptive statistics tests were conducted for the items which were summarized by frequencies and percentages.

Results

Socio-Demographic Status of Respondents

Socio-demographic information on the study participants is presented in Table 1. As shown in Table 1, the majority 242 (86.4%) were females, suggesting that in the Mekelle setting women are usually responsible for meal preparation. It also suggests that health education and awareness programmes which seek to promote the consumption of iodized salt should aim at targeting women groups and organizations at the community level.

Knowledge of Respondents Regarding Iodized Salt and Iodine-Deficiency Disorders

Responses given by the study participants to the knowledge ques-
Majority of the respondents (69.3%) indicated that when household meals are prepared without iodized salt, the possible outcome may be goiter. Fifty percent (50%) of the respondents did not agree that iodine deficiency can lead to growth retardation, particularly in children. Regarding storage of iodized salt, 43% did not know that iodine is volatile and therefore escapes into the atmosphere when exposed. Majority (60%) of the respondents indicated that the taste of iodized salt is different from that of common salt.

**Respondents' Practices Regarding the Use of Iodized Salt**

Figure 1 depicts exclusive users of iodized salt and common salt, and users of both iodized and common salt. The results revealed that majority (64.6%) of the respondents use iodized salt exclusively, whereas 26.8% of the respondents used both common and iodized salt. The respondents who indicated that they used both salts said it was partly due to shortage of iodized salt on the market at certain times. In addition, others indicated that they were unable to distinguish iodized salt from unionized salt sold on the markets. On the other hand, 8.6% of the respondents reported that they used common salt exclusively, and they attributed this practice to the unavailability of iodized salt on the market. Others indicated that iodized salt was expensive compared with common salt and this influenced their decision to use common salt. Responses given to other questions assessing the practices of respondents are presented in Table 3. The results revealed that majority (51.4%) indicated that they had been using iodized salt for less than five years whereas only 3.6% reported that they had used iodized salt for 16 years and above. The findings show that there has been a remarkable increase in the number of people who consume iodized salt over the past decade.

**Iodine Content in Household Salt**

The majority (75.6%) of the respondents consumed salt with an iodine level of 25 PPM and above, whereas 9.4% and 5.9% consumed salt with an iodine content of less than 25 PPM and 0 PPM respectively, as shown in Table 4. The Ethiopian Standards Board requires that the iodine content in salt should not be less than 50 PPM at the production point; and it is expected to be at 25 PPM at the retail level.

The study participants were asked to suggest measures or strategies to make more people consume iodized salt in the district. The suggestions summarized in Table 5 indicate that a high proportion of the participants (42.3%) thought that the mass media should be actively used to educate the populace about the importance of iodized salt to human health. Others (29.7%) suggested that health workers at the community level should educate people on the importance of consuming iodized salt. This means that public health workers will have to strategize their activities to reach the hard-to-reach parts of the district. Only 2.2% of the respondents suggested that the District Assembly should assist salt distributors to form associations to facilitate effective monitoring to prevent the influx into the market of unionized salt which is usually cheaper than iodized salt.

**Discussion**

Ethiopia, as in most developing countries, iodization of salt is the...
major strategy that has been employed to help avert the public health effect of iodine deficiency disorders (IDDs). The peoples of Mekelle would become aware of iodized salt and its importance to human health and wellbeing. A significant proportion of the respondents (39.9%) indicated that their major source of information about iodized salt was the FM radio, which could be attributed to the high number of radio stations in the country, especially the three stations in the Mekelle. A similar study conducted among rural households also revealed that over 95% of the study participants knew about iodized salt and IDDs mostly through educational programmes broadcast on radios and televisions [3]. Forty two respondents, representing 16.6% indicated that the television and health workers were their main sources of information regarding iodized salt. This low percentage could also be attributed to the fact that majority of the people are not likely to have access to public health educational messages propagated through the electronic media or by health workers in the communities. These findings suggest that even though the use of the electronic media is one effective way to improve and sustain peoples’ use of iodized salt, settler cocoa farmers, a considerable section of the population in the district, are likely to be left out and may not have access to these educational programmes.

The findings regarding why the intake of iodized salt is important show an improvement over the findings of a similar study conducted by Tekle Belachew (2003) [2] in 30 selected districts from all the nine regions of Ethiopia within a period of three years (2003-2005) in which it was reported that 1.1% and 0.4%

Table 2. Knowledge and perceptions of household food caterers about iodized salt and iodine-deficiency disorders.

| Question/Responses                                      | n (%)  |
|---------------------------------------------------------|--------|
| Heard about iodized salt                                |        |
| Yes                                                     | 253(90.4) |
| No                                                      | 27(9.6)  |
| Source of information about iodized salt                |        |
| Radio                                                   | 101(39.9) |
| Friends/relatives                                       | 68(26.9) |
| Television                                              | 42(16.6) |
| Health workers                                          | 42(16.6) |
| Why intake of iodized salt is important?                |        |
| To cure goitre                                          | 92(32.9) |
| To remain healthy                                       | 88(31.4) |
| To prevent iodine-deficiency disorders (IDDs)           | 65(23.2) |
| To grow well                                            | 26(9.3)  |
| Better than other salt                                  | 2(0.7)   |
| Do not know                                             | 7(2.5)   |
| The result of cooking with un-iodized salt              |        |
| Goiter/swollen thyroid glands                            | 194(69.3) |
| Low blood level                                         | 30(10.7) |
| Stunted growth in children                              | 24(8.6)  |
| Growing lean/thin                                       | 22(7.9)  |
| Do not know                                             | 5(1.8)   |
| Others                                                  | 5(1.8)   |
| Every salt contains iodine                              |        |
| Yes                                                     | 78(28.0) |
| No                                                      | 202(72.0) |
| Salt obtained from the sea already contains iodine in the right quantities to support human growth and ensure optimal health |        |
| Yes                                                     | 116(41.0) |
| No                                                      | 164(59.0) |
| Iodine deficiency can expose children to mental retardation |        |
| Yes                                                     | 162(58.0) |
| No                                                      | 118(42.0) |
| Iodine deficiency can lead to growth retardation        |        |
| Yes                                                     | 140(50.0) |
| No                                                      | 140(50.0) |
| Iodine content reduces when iodized salt is not stored in enclosed containers |        |
| Yes                                                     | 159(57.0) |
| No                                                      | 121(43.0) |
| Taste of iodized salt is different from that of common salt |        |
| Yes                                                     | 167(60.0) |
| No                                                      | 113(40.0) |
of the respondents indicated that iodized salt prevents goiter and improves the overall health of the individual respectively. It can be inferred that as a result of increased knowledge regarding the importance of using iodized salt and the effects of its deficiency in the diet of an individual, there has also been an increase in the consumption rate of iodized salt as indicated in Figure 1 and Table 3. The knowledge levels of respondents can be described as above average, reflected in the responses of 72% of the respondents who indicated that every salt does not contain iodine. Similarly, the majority of the respondents knew that inadequate intake of iodized salt resulted in the development of goiter. On the other hand, 60% of the respondents indicated that the taste of iodized salt is different from that of common salt, corroborating the report of a similar study conducted in Mongolia, that more than half of the study participants indicated that the taste of iodized salt was not the same as that of common salt. However, in a double-blind study using the same respondents, it was revealed that they could not distinguish the taste differences between iodized and unionized salt [3]. This misconception regarding the differences between the taste of common salt and iodized salt should be corrected through educational messages, particularly because it can act as a barrier and prevent people from using iodized salt.

Some non-users and occasional users (respondents who used both common salt and iodized salt) reported that common salt was cheaper compared with iodized salt, which influenced their decision in choosing common salt. This finding is supported by a similar study which also reported that the majority of occasional users and non-users of iodized salt indicated that the price of iodized salt was slightly higher than that of common salt [3]. As asserted by Yamada et al. (1998) [3], generally, iodized salt costs more than common salt because of the additional processing cost involved in fortifying common salt with iodine.

A high proportion (57%) of the respondents knew that the iodine content of iodized salt reduces when it is not stored in enclosed containers, by virtue of its volatile characteristic. The findings of a study conducted by Sebotse et al. (2009) [7], indicated that when iodized salt was not stored in closed plastic bags, sealed waterproof materials or closed containers, iodine losses occurred leading to a reduction in the iodine content of the salt before it is consumed.

The finding that 75.6% of respondents consumed iodized salt indicates a slight reduction in the intake of iodized salt compared with the other Regional Annual Health Sector Report [30] based on that year’s household survey which revealed that approximately 77% of the people living in mekelle consumed iodized salt. The present finding suggests that the initial effort by health workers and other collaborators in the dissemination of information to sensitize and create awareness about the importance of consuming iodized salt might be declining. Similarly, it is likely that programmes broadcast through radio stations are also declining. The implication of these findings is that if health education activities are not stepped-up, this downward trend will continue. Other reasons that have been given for the failure of most developing countries to achieve 90% utilization of iodized salt include politi-

| Table 3. Practices of respondents regarding the use of iodized salt. |
|---------------------------------------------------------------|
| **Practices of Respondents (n = 263)** | **N (%)** |
| **Duration of use of iodized salt** | |
| Less than 5 years | 130 (49.5) |
| From 6-10 years | 94 (35.7) |
| From 11-15 years | 20 (7.6) |
| 16 years and above | 9 (3.4) |
| Cannot remember | 10 (3.8) |
| **Type/Nature of salt used** | |
| Coarse | 15 (5.7) |
| Granular | 13 (5.0) |
| Fine | 235 (89.3) |
| **Brand names of salt used by respondents** | |
| Self | 10 (3.8) |
| Annapurna | 49 (18.6) |
| Unknown | 204 (77.6) |
| **Type of container used to store salt at home** | |
| Container with a lid | 165 (62.6) |
| Container without a lid | 30 (11.5) |
| Polythene bag | 38 (14.5) |
| Rubber sachet | 30 (11.5) |

| Table 4. Iodine content in household salt samples tested. |
|-------------------------------------------------------------|
| **Iodine Content** | **No.** | **%** |
| 0 PPM | 13 | 5 |
| Less than 25 PPM | 51 | 19.4 |
| 25 PPM and above | 199 | 75.6 |
| **Total** | 263 | 100 |
Conclusions

The knowledge on iodized salt of people in charge of preparing household meals in the district is relatively high, as most (90.4%) of them knew about iodized salt. However, their knowledge levels were not translated into or reflected in their practices as only 64.6% of households exclusively used iodized salt for cooking and 75.6% of the samples of salt tested had an iodine content of ≥ 25 ppm. A commendable practice of a good proportion (62.6%) of the respondents was the storage of salt in enclosed containers or water proof materials to prevent iodine losses. The research also revealed that, continual and effective use of the electronic media for broadcasting health education programmes in addition to house-to-house visits by public health workers to target populations with no access to the electronic media will help to sustain and improve on the utilization of iodized salt in the district.

Recommendations and Suggestions for Further Study

On the basis of the findings of the study, recommendations made include the following: In the propagation of educational messages, great effort should be made to correct misconceptions regarding the differences between the tastes of iodized and common salt.

As part of technical surveillance and laboratory services to ensure quality assurance, Environmental Health Workers in the country should be trained by the ministry of health on how to conduct iodine tests, and they should be supplied with the rapid test kits to enable them monitor whether salt sold in marketplaces are adequately fortified with iodine, as part of their routine food inspection activities in the district.

Environmental health workers should be empowered by law to prosecute or take legal action against salt sellers found selling salt that is not iodized and also manufacturers who do not comply with the universal salt iodization Act. The Food and Drugs Board should enforce laws that will require all salt produced to bear brand names and contact addresses of manufacturers in order to easily identify unionized products.

To address the issue of the inability of some consumers to distinguish between iodized salt and uniodized salt, a logo could be inscribed on all recommended brands of iodized salt by the Ethiopian Standards Board and the Food and Drugs Board to enable consumers, particularly people without any formal education, to identify approved iodized salt brands on the market.

Lastly, regarding the settler mekelle who do not have access to information broadcast through the mass media, perhaps interpersonal communication by disease control officers, public health nurses and other health workers will be a more effective means to disseminate health information to them, as this was reported to be effective in a similar study conducted in Peru. A suggestion for further study is the need to assess the iodine status of school children and pregnant women in particular, which should include the determination of Urinary Iodine Concentration (UIC) levels as recommended by the WHO. This is because these two groups are described as the most vulnerable groups confronted by iodine deficiency disorders.

References

[1]. Laurant P, Nohr S (2002) Iodine intake and prevention of thyroid disorders. Surveillance is needed 7: 45-46.
[2]. Takele L, Belachew T, Bekele T (2003) Iodine concentration in salt at household and retail shop levels in Shebe Town, South West Ethiopia. East Af Med J 80(10): 532-539.
[3]. Yamada C, Oyunchimeg D, Igar T, Butrumur D, Oyunbileg M, et al. (1998) Knowledge, attitudes, and practices of people in Ulaambaet, Mongolia, with regard to iodine-deficiency disorders and iodized salt. Food Nutri Bull 19(4): 353-358.
[4]. Maberly GF (1994) Iodine deficiency disorders. Contemp Sci Issues 124(14): 773-778.
[5]. Gaitan E, Dunn JT (1992) Epidemiology of iodine deficiency. Trends Endocrinol Metab 3: 170-175.
[6]. Sebotse K (2009) Endemic goiter in Senegal: thyroid function, etiological actors and treatment with oral iodized oil. Acta Endocrinol (Copenh) 158: 149-154.
[7]. World Health Organization (2007) Assessment of iodine deficiency disorders and monitoring their elimination: a guide for programme managers. (3rd edn), World Health Organization, Geneva.
[8]. King SF, Burgess A (1993) Nutrition for developing countries. 2nd edition. Oxford University Press, New York.
[9]. Boyages G, Halpern JP (1993) The neurology of endemic cretinism: a study of two endemics. Brain 114: 825-841.
[10]. Administrative Committee on Coordination/Subcommittee on Nutrition (ACC/SCN) (1993) Second Report on World Nutrition Situation. The International Food Policy Research Institute (IFPRI), Washington.
[11]. WHO (1994) Indicators for Accessing Iodine Deficiency Disorders and Their Control through Salt Iodization. WHO/NUT, Geneva. micronutrient series No.6.
[12]. WHO/UNICEF/ICCIDD (2001) Assessment of the Iodine Deficiency Disorders and Monitoring Their Elimination. World Health Organization.
[13]. World Health Organization (2001) Ending Iodine Deficiency Forever: A Goal within Our Grasp. World Health Organization, Geneva.

[14]. ICCIDD (2000) Iodine Status Worldwide. World Health Organization Global Database on Iodine Deficiency. World Health Organization, Geneva.

[15]. ICCIDD (2008) Progress of Household Consumption of Iodated Salt in Some African Countries. Iodine Deficiency Disorders Newsletter 31: 71-78.

[16]. Asibey-Berko E (1995) Prevalence and Severity of Iodine Deficiency Disorders in Ghana. In Proceedings of the National Workshop on Iodine Deficiency Disorders in Ghana held in Accra, Ghana. University of Ghana, Ghana. 15-23.

[17]. Selby H (2011) Stakeholder Campaign on the Use of Iodated Salt in Ghana. [http://allafrica.com/stories/201110060258.html].

[18]. ICCIDD, Egbuta J (2001) Annual Report on Current Iodine Deficiency Disorder Situation. Network for Sustained Elimination of Iodine Deficiency 180 Elgin Street, Suite 1000, Ottawa, ON Canada. http://www.iodinenetwork.net/countries/Ghana.html website.

[19]. Amoah AGB, Asibey-Berko E, Ayettey OM, Addo F, Agyepong E, et al. (2004) Feasibility of thyroid ultrasonography in field studies in a developing country. Ghana Afr J Med Sci, 33(2): 161-164.

[20]. Asibey-Berko E, Amoah AG, Addo F, Agyepong E (1998) Endemic goiter and urinary iodine levels in rural communities in the Bolgatanga and Bulsa Districts of the upper East Region of Ghana. East Afr Med J 75: 501-503.

[21]. Asibey-Berko E, Zlotkin SH, Yeung GS, Nti-Nimako W, Ahunu B, et al. (2007) Dual fortification of salt with iron and iodine in women and children in rural Ghana. East Afr Med J 84(10): 473-480.

[22]. WHO/UNICEF/ICCIDD (2001) Assessment of Iodine Deficiency Disorders and Monitoring their Elimination. WHO/NHD/01.1. WHO, Geneva.

[23]. UNICEF/MI (2004) Vitamin and Mineral Deficiency: A Global Progress Report. The Micronutrient Initiative, Ottawa.

[24]. Ghana Health Service (2007) Annual Report for the Year, 2007. Ghana Health Service, Accra.

[25]. Ethiopia Health Service (2000) Annual Report for the Year. Ethiopia Health minister, Addis Ababa.

[26]. Ethiopia Health Service (2009) Achieving Universal Salt Iodization: Ghana National Strategy II, 2009-2011. Addis Ababa Health Service, Accra.

[27]. Directorate Amhara Regional Health (2007) Annual Health Sector Report for the Year. Second, Bahirdar.

[28]. Narasinga R, Ranganathan S (1985) A Simple field kit for testing iodine in salt. Food Nutr Bull 7(4): 70-72.

[29]. Dustin JP, Ecoffey JP (1978) A field test for detecting iodine-enriched salt. Bull World Health Org 56(4): 657-658.

[30]. Dunn JT (1996) Seven deadly sins in confronting endemic iodine deficiency, and how to avoid them. J Clin Endocrinol Metab 81: 1332-1335.

[31]. Medeiros-Neto GA (1988) Towards the eradication of iodine deficiency disorders in Brazil through a salt iodination programme. Bull WHO 66: 637-642.

[32]. Thilly CH, Hetzel BS (1980) An Assessment of Prophylactic Programs: Social, Political, Cultural, and Economic Issues. In Endemic Goiter and En
demic Cretinism. John Wiley, New York. 475-490.

[33]. Quick RE, Gerver ML, Palacios AM, Beingolea L, Vargas R, et al. (1996) Using a Knowledge, attitudes and practices survey to supplement findings of an outbreak investigation: cholera prevention measures during the 1991 epidemic in Peru. Int J Epidemiol 25: 872-878.

[34]. Delange F (2000) Iodine Deficiency: A Fundamental and Clinical Text. In The thyroid. (8th edtn), Lippincott Williams and Wilkins, Philadelphia. 295-315.