



Memorandum

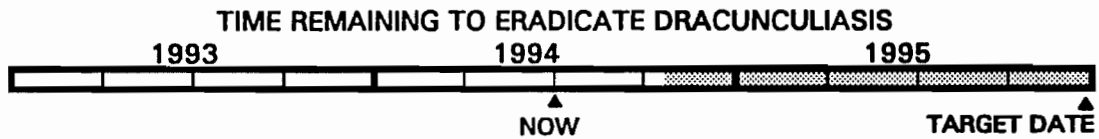
Date Oct. 20, 1994



From WHO Collaborating Center for
Research, Training, and Eradication of Dracunculiasis

Subject GUINEA WORM WRAP-UP #45

To Addressees



USAID, CARTER CENTER JOIN FORCES FOR FINAL ASSAULT ON GW



In an impressive grant signing ceremony held in the Treaty Room at the Department of State in Washington, D.C. on October 1, the administrator of the United States Agency for International Development (USAID), J. Brian Atwood, presented the chairman and founder of The Carter Center, former President Jimmy Carter, with a grant of \$3.5 million. The award, to be made over three years to The Carter Center's Global 2000 project, is to help in the completion of the global initiative to eradicate dracunculiasis. The funds will be used for costs associated with mobilizing eradication efforts and providing short-term expert technical assistance to endemic countries.

In presenting the grant, Mr. Atwood said, "The elimination of Guinea Worm disease will make a dramatic difference in the lives of tens of thousands of people throughout Africa and Asia. The result will be more effective development in these areas which can be sustained for years to come." Former President Carter, who accepted the grant on his 70th birthday, remarked that "This accomplishment will have many valuable legacies in addition to the eradication [of dracunculiasis]. One of the most important will be that it will hold out hope that other diseases can be eradicated with this type of world-wide cooperation."

Also speaking at the hour-long ceremony, which was attended by about 100 persons and highlighted the contributions of the American corporate community to the campaign against dracunculiasis, were the president of Precision Fabrics Group, Mr. Lanty Smith; the president of American Cyanamid Company's agricultural division, Dr. Mark Atwood; and a representative of the DuPont Company, Ms. Celeste Boykin. DuPont and Precision Fabrics Group have donated over a million square yards of nylon filter material to the African campaign, while American Cyanamid has donated supplies of the temephos (Abate) used to control the copepod vectors of dracunculiasis. The ceremony celebrated the partnership among the three U.S. corporations, The Carter Center, and USAID. The ambassadors to the United States from Ghana, Mali, and Sudan also attended, as did the U.S. assistant secretary of state for Africa, Mr. George Moose. A copy of the "commemorative certificate" which was signed at the ceremony is reproduced on page 16.

CARTER VISITS MAURITANIA, GHANA, CHAD

GLOBAL 2000



Former U.S. President and Mrs. Jimmy Carter made their seventh annual trip to Africa in support of the initiative to eradicate dracunculiasis. Accompanied by the executive director of the Carter Center, Dr. John Hardman, and Global 2000 senior consultant Dr. Donald Hopkins, between August 29 and September 6, the chairman of Global 2000 met with the heads of state, ministers, and other governmental officials, donor agency representatives, and heads of the national Guinea Worm Eradication Programs in Mauritania, Ghana, and Chad to discuss the current status of the eradication effort and to encourage intensified action as the campaign enters its final stages. The heads of state and ministers of health in all three countries pledged their countries' support until the disease is eradicated. In Ghana, President and Mrs. Carter also personally presented the 1994 Jimmy and Rosalynn Carter Award for Guinea Worm Eradication to Dr. Sam Bugri, the national program coordinator of Ghana's GWEP. The award cites Dr. Bugri "for outstanding dedication and achievement as director of Ghana's Guinea Worm Eradication Program since 1988." Present at the award ceremony were the Ghanaian minister of health, Commodore S.G. Obimpeh (rtd), the minister of agriculture, Mr. Ibrahim Adam, and recipients of the 1992 and 1993 awards in Ghana.

President Carter also reviewed briefly the status of the campaign in Cote d'Ivoire with the minister of health, foreign minister, national program coordinator, Peace Corps representatives, and other officials of that country, during stopovers at Abidjan airport. In Chad, President Carter and Dr. Roy Vagelos, chairman of Merck Corporation, which donates the drug Mectizan to fight onchocerciasis (river blindness), also visited a village where onchocerciasis is endemic. After leaving Chad, President Carter was briefed on the status of the Ethiopian campaign by the minister of health and program officials in that country. Global 2000 director of operations, Mr. Andrew Agle, also accompanied the president in Ghana and Ethiopia.

GENERAL TOURE VISITS NIGER, CONGO, CHAD, BURKINA FASO



General Amadou Toumani Toure, former head of state of Mali and president of the Intersectorial Committee for Guinea Worm Eradication in Mali, who had arrived in Niamey to meet with President Carter there, served as keynote speaker at the meetings of Niger government and program officials and donor agency representatives, which were scheduled for the Carter visit in early September. General Toure also met with the president of Niger, Mr. Mahamane Ousmane. (President Carter's visit was cancelled because of aircraft problems).

General Toure went from Niamey to Brazzaville, where he attended the annual meeting of African ministers of health, and again advocated support for eradication of dracunculiasis by 1995, in speeches to the WHO Regional Committee for Africa, and to a launching ceremony for the "Africa 2000 Initiative" on water and sanitation.

In early October, General Toure attended the Program Review of five endemic francophone countries in N'Djamena, Chad, where he also discussed dracunculiasis eradication with the prime minister, Mr. Kassire Coumakoye, and with the Chadian president, Colonel Idriss Deby. From N'Djamena, General Toure went to Ouagadougou, Burkina Faso, where he held similar discussions with the Burkinabe president, Captain Blaise Compaore, before returning to Bamako.

MAURITANIA: REVISED PLAN OF ACTION



The ministry of health has completed a revised plan of action intended to help implement case containment and begin monthly reporting of cases, in a drive to accelerate progress towards eradication by the end of 1995. The plan was presented to a group of donor representatives during President Carter's visit in August. Of \$850,000 needed to implement the plan between September 1994 and December 1995, over \$350,000 is already available from UNICEF (including funds provided by Canada), Global 2000 (funds provided by Norway), and the Government of Mauritania. Peace Corps is also providing support in kind. Other donors are considering the plan.

During their discussion, President Maayouia Ould Taya told President Carter, "I guarantee you to give all support and instructions to concerned authorities for efforts needed to meet the deadline [for dracunculiasis eradication]". One of the earliest manifestations of the Mauritanian government's increased resolve came in September, when the president and the minister of health named a former minister of health, Dr. Ndiaye Kane, to chair the intersectoral committee for Guinea worm eradication. Drs. Phuc Nguyen Dinh of CDC, Alhousseini Maiga of ITECH, and Ernesto Ruiz-Tiben of Global 2000 consulted with the national program coordinator, Dr. Sidi Mohamed, in Mauritania earlier in August. In August, this program also began using Abate for vector control, which has been very well received by the affected populations where it has been used so far. 88% of endemic villages have received cloth filters.

COTE D'IVOIRE: PEACE CORPS ASSISTS K.A.P. STUDIES



Provisional results of KAP (knowledge-attitude-practices) studies undertaken by Peace Corps Volunteers in three highly endemic villages in the central-west region of Bouafle (compiled from interviews with 47 villagers) reveal the following: 1) that nearly 75% of villagers interviewed correctly identified consumption of contaminated water as the sole mode of transmission of dracunculiasis (less than one-third of the respondents could state how the water became contaminated); 2) that nearly two-thirds recognized that dracunculiasis can be prevented and ultimately eliminated from their community, and over 75% could name at least one control measure that could accomplish that; and 3) that nearly all villagers interviewed had filtered stagnant drinking water at least once, but fully 85% of the women and 75% of the men interviewed stated that they filtered their drinking water daily, including water to be carried out to the fields when they are farming. Over 90% of the respondents demonstrated correct filtering techniques and presented nylon filters that were in good condition. (*Summary provided by PCV Michael Gregory*).

National program coordinator, Dr. Henri Boualou, his assistant Peace Corps volunteer Ms. Michele Spring, and Peace Corps director Ms. Cynde Robinson participated in the briefing for former U.S. President Jimmy Carter and the Ivoirian minister of health, Mr. Kacou Guikahue Maurice, during the president's stopover at Abidjan airport in August. It is believed that fewer than 400 villages will have reported one or more cases of dracunculiasis during 1994 by the end of the year. All such known currently endemic villages have been provided filter material in 1994, and most have had two trained village-based health workers for over a year. Over 3,000 posters provided by UNICEF and WHO were distributed to all endemic areas in September/October. Overall, about 95% of endemic villages in Cote d'Ivoire already have or are scheduled to receive at least one source of safe drinking water by the end of 1995. All

UNICEF drilling rigs are assigned to priority endemic areas. UNICEF is also sponsoring repairs of broken pumps in Bondoukou and Daloa. Vector control began in August, and will be expanded as the rains end in October. Case containment will also begin in October-November. The president of Cote d'Ivoire will review the current status of five health programs, including the Guinea Worm Eradication Program, twice a year, beginning this December.

BENIN: PROGRAM RENOVATIONS

A total of 1,827 cases of dracunculiasis have been reported to the Benin GWEP through the end of August 1994 (1,141 of them from Zou Department) in a restoration of monthly reporting (Table 1). However, the number of villages actually reporting these cases among the 2,306 presumed endemic villages under surveillance is not yet known and, partly for that reason, the coverage of endemic villages by trained village-based health workers and by safe water supplies is also uncertain. Coverage of endemic villages by dracunculiasis-specific health education (IEC) is believed to be 100%. Implementation of case containment and vector control are to begin in November-December. UNICEF/Benin, which has provided most of the external funding for this program over the past several years, is ordering more of the "Guinea worm cloth" from Faso Fani to be used as an incentive for village-based health workers. The USAID mission to Benin is expected to provide \$0.5 million in support for the program in 1995. *(This update is from the report presented by the national coordinator Mr. Julien Dossou-Yovo, and program epidemiologist Dr. Victor Hounkonnou, at the Program Review in N'Djamena in early October.)*

Recent consultations by Dr. Marjorie Pollack and Mr. Harry Godfrey of Global 2000 and Dr. Sandy Cairncross of ITECH identified three key programmatic problems: inadequate distribution of cloth filters, possibly significant under recognition of endemic villages, and inability to distinguish currently endemic villages (for monitoring and prioritization of interventions and supervision) among the 2,306 villages under surveillance. At present, the program is concentrating on getting interventions (especially cloth filters) in place in the known endemic villages before the peak transmission season begins late this year; on identifying other (presently unrecognized) endemic villages; and on implementing case containment in all endemic areas starting as soon as possible this year. Re-training of key personnel from all six regions of the country was held September 25-29 at Bohicon in Zou Department, with participation by Dr. Cairncross, Mr. Godfrey, and by Mr. Danvide Bertin of UNICEF/Benin. Re-training of village-based personnel will be conducted in November-December. The program is also conducting a validation survey by questionnaire to determine which villages in the country are currently endemic. The nominal prices for fabricated filters which had been charged for the purpose of partial cost recovery have been reduced by 50% (to 25 or 50 CFA--\$0.05 or \$0.10--depending on the size), and persons who are unable to pay will be provided filters immediately "on credit" to prevent cost being a barrier to complete coverage.

SUDAN: MUCH MORE TO DO

Sudan has identified 393 known endemic villages (Figure 3). Several hundred village-based health workers have been trained and deployed so far in 1994, and cloth filter material distributed. However, the proportion of the known endemic villages that has been reached by these measures is not yet known. Although the Sudanese delegation did not attend the Program Review in Nairobi in September as planned, there were reports at that meeting of imported cases into Ethiopia, Kenya, and Uganda amongst refugees from Sudan. The encouraging beginning of control measures in Sudan will need to be followed up by intensified mobilization in all accessible endemic areas during the dry season which begins in October.

Table 1 MONTHLY REPORTING OF CASES OF DRACUNCULIASIS IN 1994
(COUNTRIES ARRANGED IN DECENDING ORDER OF INCIDENCE DURING 1993)

updated: October 18, 1994

COUNTRY	ANNUAL INCIDENCE IN 1993	NUMBER OF CASES REPORTED DURING 1994												YEAR TO DATE TOTAL*			
		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC				
NIGERIA	75,752	4650	3698	3141	2736	2235	2544	2481	657								20641
UGANDA	42,852	1044	782	1072	1206	1157	964	980									7205
NIGER	25,346				306	686	2586	6019	2081	288							11966
GHANA	17,918	834	494	793	888	1144	706	587	304	228							5978
BENIN	16,334	467	499	304	181	118	90	72	96								1827
MALI	12,011	101	122	228	148	504	752	1079	891								3825
TOGO	10,349	477	419	361	213	217	228	241	222	111							2489
BURKINA FASO	8,281	103	231	118	487	540	1041	1085	761								4366
COTE D'IVOIRE	8,034	538	582	452	773	517	615	308	131								3916
MAURITANIA	3,533	0	0				176										176
SUDAN	2,984		136		169												305
CHAD	1,231	67	5	0	1	3	124	60	161								421
ETHIOPIA	1,120*	1	40	28	128	95	266	210	153								921
SENEGAL	815	0	0	0	0	2	17	42	38	39							138
INDIA	755	0	2	1	23	47	70										143
CAMEROON	72	0	0	0	1	5	7	4	5	7							29
KENYA	35*	3	20	0	0	2	6	0	0								31
PAKISTAN	2	0	0	0	0	0	0	0	0	0							0
TOTAL*	223,642	8285	7030	6498	7260	7272	10192	13168	5500	673	0	0	0	0	0	0	65878

* NATIONAL CASE SEARCH UNDERWAY
• PROVISIONAL

ETHIOPIA: MOVING QUICKLY TO CASE CONTAINMENT



Having completed its case search, Ethiopia is moving quickly to the case containment stage in all 95 currently endemic villages, which are in only two areas of the country: Gambella and South Omo. Already 87% of the endemic villages have trained village-based health workers, are reporting monthly, and have received health education about dracunculiasis, and cloth filters. Monthly reports so far confirm the existence of year-round transmission (Table 1). Although only 4% of the endemic villages have access to safe drinking water now, all have been targeted by UNICEF-assisted efforts to receive safe sources of drinking water by December 1995. Thirty-two percent of endemic villages have begun case containment; 4% are using vector control. The main remaining constraint for this program is the extreme isolation of one of the affected districts in the Gambella Region, Akobo. Special arrangements are being explored or made for reaching that district, including two motor boats to be made available by UNICEF/Ethiopia, and possible use of a helicopter. The Ethiopian program is being led by Dr. Seyoum Tatischeff and Mr. Teshome Gebre, with the close assistance of Ms. Della Dash of UNICEF/Ethiopia.

GHANA: RESTORING CASE CONTAINMENT IN NORTHERN REGION

During the first eight months of 1994, Ghana reported a total of 5,751 cases of dracunculiasis, in 1,036 endemic villages, including 241 new endemic villages (Figure 1, Table 1). This is a reduction of 61.7% from the 15,038 cases that were reported for the same period of 1993. Of 2,419 villages under surveillance (2,178 villages which had at least one case in 1993, plus the 241 new endemic villages as of 1994 so far), 98.4% reported on time for August. Intensive interventions (case containment) are being restored to the areas of the highly endemic Northern Region that were disrupted by ethnic violence earlier this year. National and regional program leaders have agreed to assign at least one outside assistant, including several Guinea worm coordinators from other regions of Ghana, to work in each of the endemic districts of the Northern Region. These outside assistants will help train local village-based workers by demonstrating case containment procedures in working with them one-on-one in their villages over several weeks or months.

Three regions achieved 100% containment of cases in August: Brong-Ahafo, Central, and Eastern. Most of Ghana's uncontained cases are in the areas of recent conflict in the Northern Region (Figure 2). In June, July, and August this year, 3, 3, and 5 of Ghana's ten regions, respectively, reported zero indigenous cases of the disease (Table 2). Ghana has notified Burkina Faso through WHO of cases from that country who were detected in Ghanaian markets near the border of the two countries. (*Based on the report of Dr. Sam Bugri, national program coordinator for the 1994 Program Review.*)

NORWEGIAN HIGH SCHOOL STUDENTS FIGHT GUINEA WORM IN MALI

Dr. Anders Seim of Health and Development International reports that students in an Oslo high school collected a total of 384,000 Norwegian kroner (about US\$ 56,000) for development work in Goundara, Mali, an area with 25 villages and about 12,000 inhabitants in heavily-endemic Kayes Region. Funds raised by the students will be used for Guinea worm eradication, literacy, and helping to build a road to facilitate marketing farm produce. The Norwegian Santal Mission already supports a Malian nurse in the area who has been distributing cloth filters and educating the population about prevention of the disease.

Figure 1 NUMBER OF CASES OF DRACUNCULIASIS REPORTED IN NIGERIA, UGANDA, GHANA, BURKINA FASO, TOGO, AND INDIA: 1993 - 1994

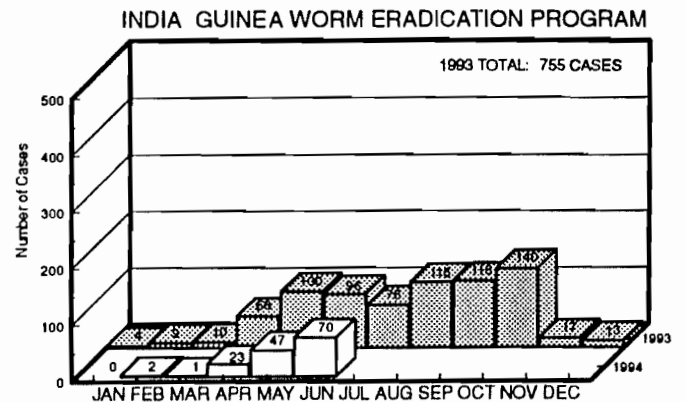
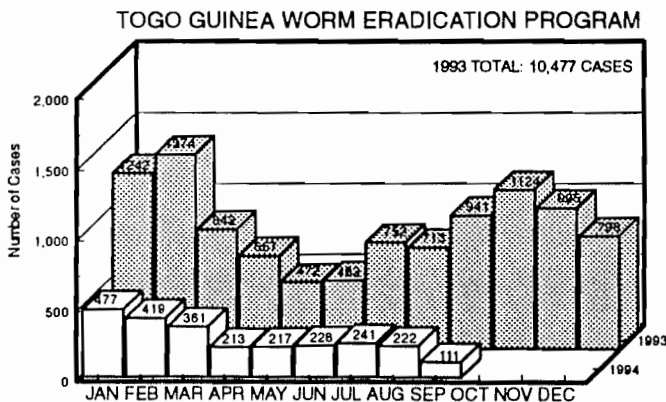
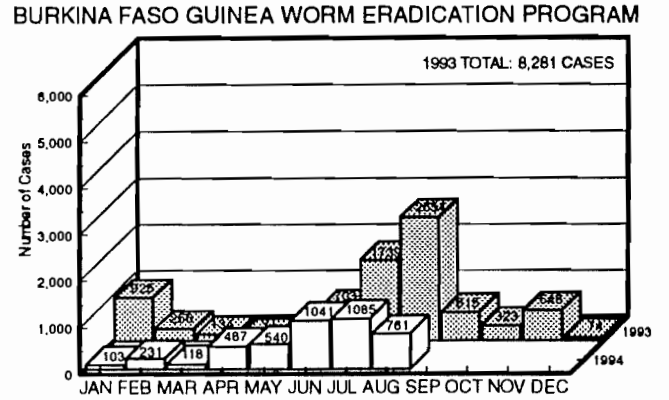
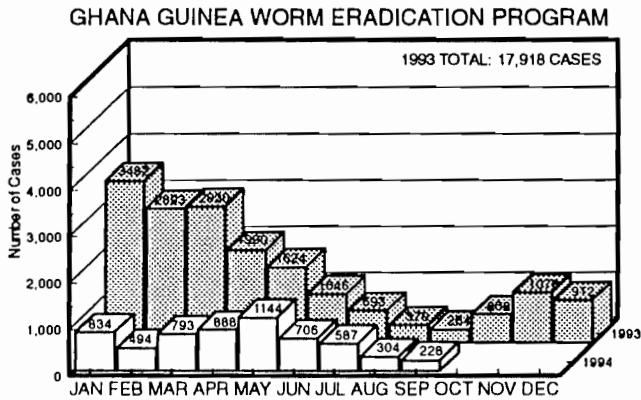
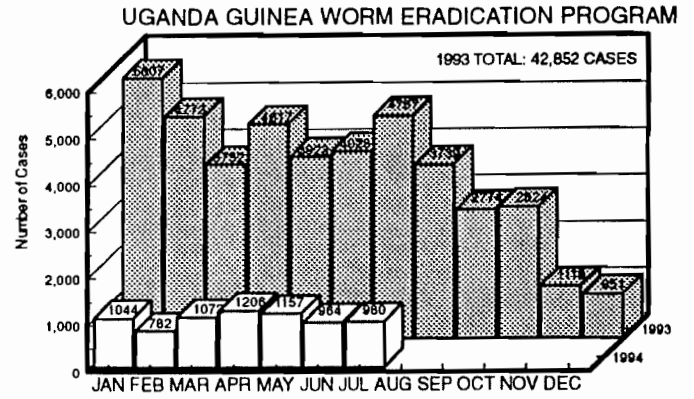
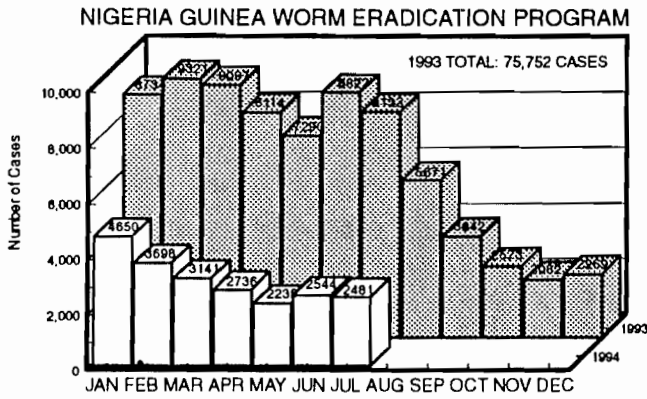


Table 2

**GHANA GUINEA WORM ERADICATION PROGRAM
NUMBER OF CASES REPORTED: 1994**

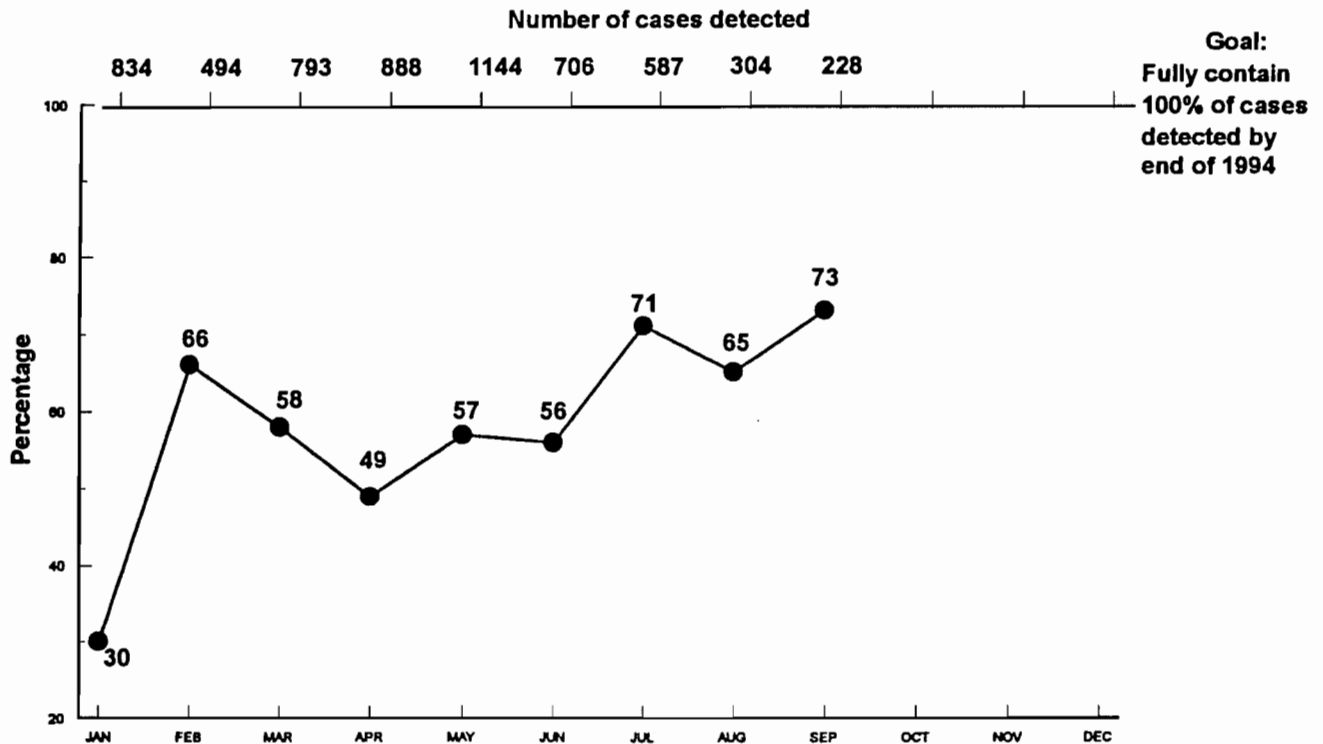
REGION	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Ashanti	23	40	19	31	5	16	5	6					145
Brong Ahafo	53	46	61	34	11		21	16					242
Central*	77	75	55	36	60	8							312
Eastern	47	7	49	58	38	35	15	9					258
Greater Accra*		1	1										3
Northern	364	205	457	560	900	583	445	227					3741
Upper East*	5	16	16	6	4	9	8						66
Upper West		9	4	53	45	18	23						152
Volta	249	78	128	102	63	37	69	43					769
Western	16	17	3	8	18								62
TOTAL	834	494	793	888	1,144	706	587	304	0	0	0	0	6,760

■ = 0 Cases Reported

- * Greater Accra had 1 Imported case in July which was contained.
- * Central Region had 1 imported case in August.
- * Upper East Region had 2 imported cases in August.

Figure 2

**Ghana Guinea Worm Eradication Program
Percentage of cases detected during 1994 that were fully contained***



* A case is contained if the worm was extracted prior to emergence, or the individual received controlled immersion and/or occlusive bandaging until completely expelled, and 1) it has been verified that the case has not contaminated a drinking water source, and 2) the case has been verified within 7 days as contained by a supervisor from the zonal or district level or by a worm extractor.

CAMEROON: 67% REDUCTION IN CASES; 7 IMPORTATIONS FROM NIGERIA



Through the end of September, 18 endemic villages in Cameroon had reported 29 cases of dracunculiasis in 1994, as compared to 72 cases reported from 19 villages in 1993. Fifteen of the endemic villages in 1994 had only one case, but the village of Kangaleri had 10 cases. Seven of the 1994 cases were apparently imported from Borno State in Nigeria (1 in July, 2 in August, and 4 in September), and have been cross-notified to Nigeria via WHO. Since five of Cameroon's cases in 1993 were also imported from Borno State, Nigeria, the reduction in indigenous cases in Cameroon from 1993 to 1994 so far has been 67.2%. Drs. Amos Sam-Abbenyi and Dama Mana of Cameroon report that 20 of the 29 cases this year (68.9%) were fully contained.

The nine "uncontained" cases, in which the worms were detected more than 24 hours after emergence, included the seven cases believed to have been imported from Nigeria. Vector control is being used in five of the endemic villages (28%), including Kangaleri. Eight of the endemic villages (including Kangaleri) are without any source of safe drinking water.

NIGERIA: POLITICAL DIFFICULTIES IMPEDE THE PROGRAM



A total of 20,624 cases of dracunculiasis were reported in the first 6 months of 1994, which is a reduction of 60% as compared to the 51,383 cases that were reported in the same period of 1993. About 60% of endemic villages reported on time in 1993 (within 45 days of the end of the month), compared to about 70% of endemic villages reporting on time (within 30 days of the end of the month) in 1994 (72% in June)

(Figure 1, Table 1). Nigeria has also increased the proportion of endemic villages under case containment to 13.4% (530 villages; 461 in northeast zone and 69 in southeast zone), and is now using vector control in 593 endemic villages (15%). However, NIGEP's ability to continue its impressive accomplishments in 1994 is being jeopardized by political actions, strikes, and shortages of fuel. Delays in clearance of filter material from the port of Lagos, for example, prevented the program from providing new filter material to each household before the beginning of the peak transmission season (June-September) in northern states. A total of 2,481 cases were reported from 2,516 villages in July 1994 (compared to 5,671 cases in July 1993), a reporting rate of 64%, because of the problems just described (rates of reporting from the four zones of the country in July were 21% in southwest, 41% in northeast, 75% in southeast, and 93% in northwest). Eight of the 30 states and the Federal Capitol Territory (Abuja, Akwa Ibom, Anambra, Edo, Kaduna, Kogi, Lagos, and Yobe) continue to report zero cases through July 1994.

MALI: JICA INCREASES ASSISTANCE FOR SAFE WATER IN ENDEMIC VILLAGES



Japan
International
Cooperation
Agency

The Japan International Cooperation Agency (JICA), which in February this year agreed to provide nearly 5 billion CFA francs (about US\$ 6.7 million) in assistance for rural water supply in the endemic areas of Mali (see Guinea Worm Wrap-Up #42), concluded a supplementary agreement with the Government of Mali in July to double the level of assistance for the project to 10 billion CFA francs. This will provide Mali with 500 new wells, beginning late in 1994. Meanwhile, the percentage of endemic villages which have received cloth filters has increased to over 69%. Vector control has begun, and case containment is in place in over 100 (8%) of the 1,324 villages classified as endemic. In the highly endemic district of Douentza in Mopti Region, however, 48 of the

187 endemic villages (26%) still did not have a trained village-based health worker as of September, even though that district began receiving support as a pilot project area one or two years before the national campaign began. Recent reports of cases in the Gao Region have not been confirmed because of insecurity in that area. The same problem has so far prevented conduct of the case search in Timbuktu Region.

WHO ESTABLISHES DRACUNCULIASIS ERADICATION UNIT



The director-general of the World Health Organization has established a unit of Dracunculiasis Eradication (DRA) in the Division of Control of Tropical Diseases, which took effect from August 1, 1994. Dr. Philippe Ranque, who has worked in support of dracunculiasis eradication efforts at WHO headquarters since 1988, was named chief of the new unit. Dr. Ranque's office has recently advised the Government of the Republic of Guinea regarding that country's preparations for certification of dracunculiasis eradication, and Dr. Ranque is preparing to visit Uzbekistan later this year for the same purpose. At the XXVIIth meeting of the Interagency Coordinating Group for Dracunculiasis Eradication, which was held in Washington, D.C. on October 6, Dr. Fernando Beltran of WHO's Pan American Health Organization reported that PAHO plans to begin preparations for the certification process in the Americas during the annual meeting of its country representatives in early December.

CDC ORIENTATION ON DRACUNCULIASIS ERADICATION

A one-day orientation on dracunculiasis eradication for about 85 selected CDC staff was held at the Carter Center of Emory University on September 15, 1994. Over the next 14 months, volunteers from this CDC group will be on call to help national programs strengthen village-based surveillance systems, implement case containment, and monitor and evaluate program activities, if needed.

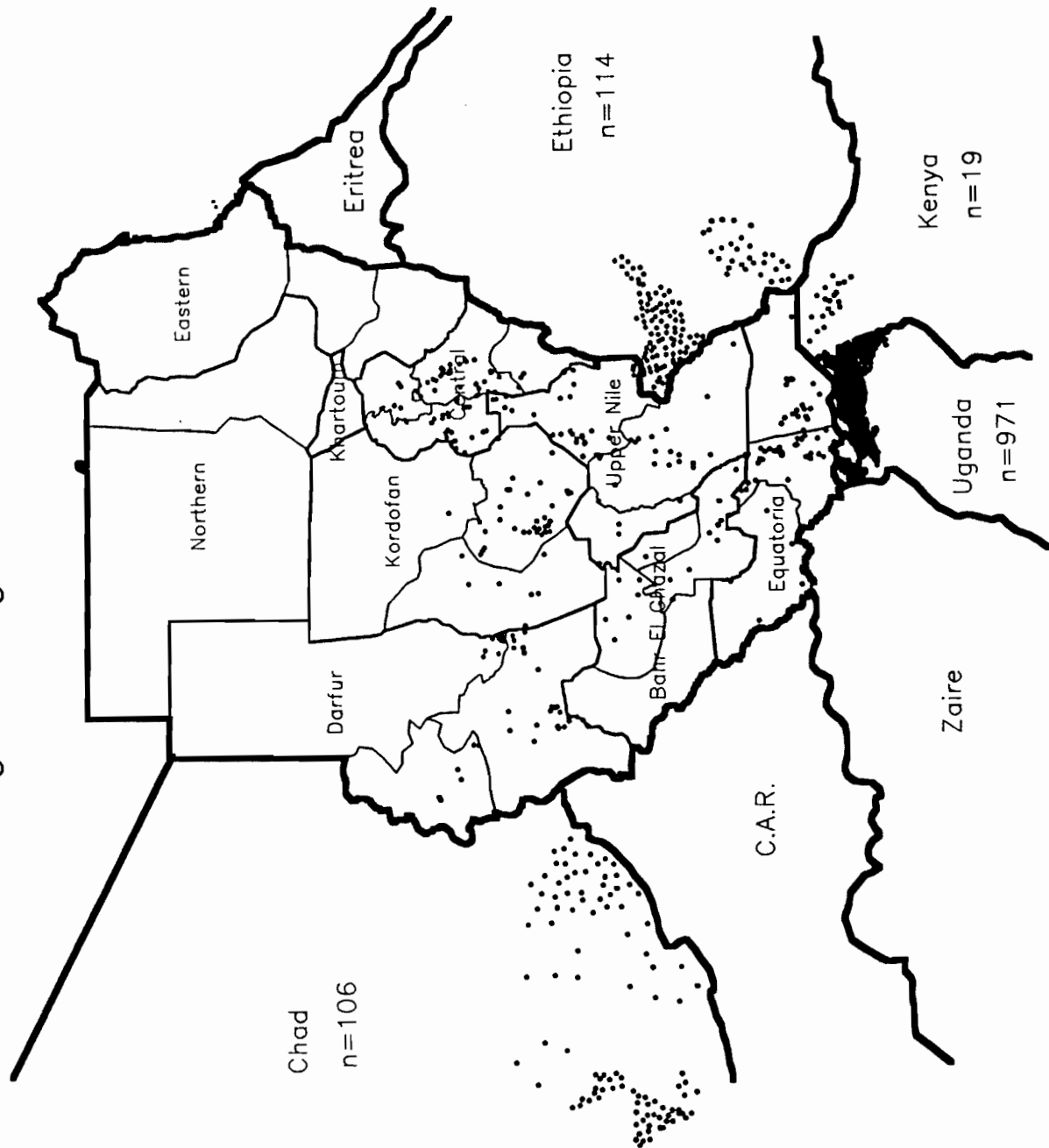
1994 PROGRAM REVIEWS

- The 1994 Program Review for English-speaking endemic countries was held in Nairobi, Kenya on 19-23 September. Ethiopia, Ghana, Kenya, Nigeria, and Uganda were represented. Sudan was not.
- The 1994 Program Review for Benin, Cameroon, Chad, Niger, and Togo was held in N'Djamena, Chad on October 10-14. The meeting in Chad was held under the patronage of the prime minister, Mr. Kassire Coumakoye, who personally attended the opening and closing ceremonies, along with the minister of health, Mr. Noudjalbaye Ngaryanan.
- The final 1994 review for the programs of Burkina Faso, Cote d'Ivoire, Mali, Mauritania, and Senegal, will be held in Dakar, Senegal, on November 14-18. Each of this year's reviews have and will feature a panel discussion of case containment and other aspects of the last stages of eradication.

RECENT PUBLICATIONS

WHO, 1994. Dracunculiasis eradication - Update, Chad. Wkly Epidemiol Rec, 69:217-218.

Figure 3 Guinea Worm Endemic Villages in Sudan (n=393) and Neighboring Countries, 1994



In Brief:

Chad. Cloth filters and health education about dracunculiasis have been extended to all 106 endemic villages. A trained village-based health worker is in place in all endemic villages except for 18 villages in Salamat Prefecture (83%), which were inaccessible during the rainy season. Sixty-nine percent of endemic villages have or are scheduled to receive a safe source of drinking water by the end of 1994. Monthly reporting of cases is still poor (30%). Implementation of case containment and vector control measures are planned to begin in October 1994. A meeting of national and prefectural personnel was held in N'Djamena October 17 and 18, immediately following the Program Review. U.S. Peace Corps has assigned Ms. Sandra Schreiber, a second year PCV, to work full-time with the national program coordinator, Dr. Gagde Hinn-Dandje.

Kenya. Case searches have so far detected 31 active cases in 19 endemic villages (9 in Trans Nzoia, 7 in northern Turkana, and 3 in West Pokot). Sixteen of the known endemic villages (84%) have at least one intervention (trained village-based health worker, health education, or cloth filters) in place. The remaining suspected endemic areas are to be searched before the end of 1994.

Niger. Trained village-based health workers are now in place in 89% of 1,078 endemic villages; health education has been conducted in 92%; some cloth filters have been distributed to nearly all endemic villages, of which 616, or 52% have coverage of 100% of households; 75% of endemic villages have or are scheduled to get at least one source of safe water by the end of 1995; vector control is being used in 6%; and case containment is underway in 3.7%. Only 28% of endemic villages reported (6,019 cases) in the month of July 1994. So far, 11,906 cases have been reported this year (Table 1). Mr. Harou Oumarou has been appointed deputy coordinator to the program, joining the national program coordinator, Mr. Sadi Moussa.

Togo. 2,484 cases of dracunculiasis have been reported from 357 villages through September of 1994, a reduction of 66.8% from the 7,487 cases reported in the same period of 1993 (Figure 1). 969 villages are under surveillance, including 28 newly endemic villages found in 1994 so far. Case containment and vector control interventions will begin in November this year. A number of cases believed to have been imported from Benin and from Ghana have been alleged by local authorities, but details of such cases have not been reported to national authorities, who therefore have not cross-notified the cases to the suspected countries of origin through WHO.

Uganda. A recent review of surveillance reports spearheaded by Global 2000 consultant, Mr. Larry Dodd, revealed that only 971 villages in the country reported one or more cases in the past year. This is a substantial reduction from the 2,677 endemic villages identified during the case search, and thus will permit the program to focus its efforts much more efficiently. 7,205 cases were reported for the first seven months of 1994, a reduction of 77.1% from the 31,456 cases reported for the country in the same period of 1993 (Figure 1). Case containment and vector control interventions are scheduled to begin in October. A new Global 2000 resident advisor, Mr. Elvin Hillier, recently retired after more than 30 years with CDC, will arrive in Uganda in late October.

Yemen. National case search will begin in October, according to Dr. Abjul-Hakeem Al-Kholani. Preliminary information acquired during a consultation to Yemen by Dr. Trenton Ruebush of CDC shows no current cases of dracunculiasis had been detected through the end of September this year, despite the widely publicized reward provided by Health and Development International.

CANADA SUPPORTS ERADICATION EFFORTS VIA UNICEF



Agence canadienne de
développement international

The Canadian International Development Agency (CIDA) agreed in August to provide 8,770,410 Canadian dollars (about US\$ 6.36 million) through UNICEF to assist dracunculiasis eradication efforts in 14 endemic African countries. The funding is available for use in the year beginning September 1994. This new support is intended to help countries strengthen their surveillance and interventions against dracunculiasis, mostly other than rural water supply. The countries concerned are Benin, Burkina Faso, Cameroon, Chad, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Mali, Mauritania, Nigeria, Sudan, Togo, and Uganda.

LATE BREAKER: DRACUNCULIASIS IN ADRAR REGION, MAURITANIA

*(Communicated by Dr. Sidi Mohamed Ould Mohamed Lamine, Coordinator
National Guinea Worm Eradication Program)*

In October 1994, the Directorate for Health and Social Action (DRASS) of Adrar region reported 67 cases of dracunculiasis from the city of Atar (capital of the region) to the national Guinea Worm Eradication Program (GWEP). A team sent by the GWEP confirmed the reported cases. During surveys conducted in the most affected areas of the city, it was learned that patients tended not to consult at health facilities because of the social stigma attributed to the disease. The survey detected an additional 38 cases, all previously unreported. Most of the patients denied any travel out of Atar during the past several years. Additional spot surveys in 3 of the 4 departments of the Adrar region failed to detect cases outside of Atar.

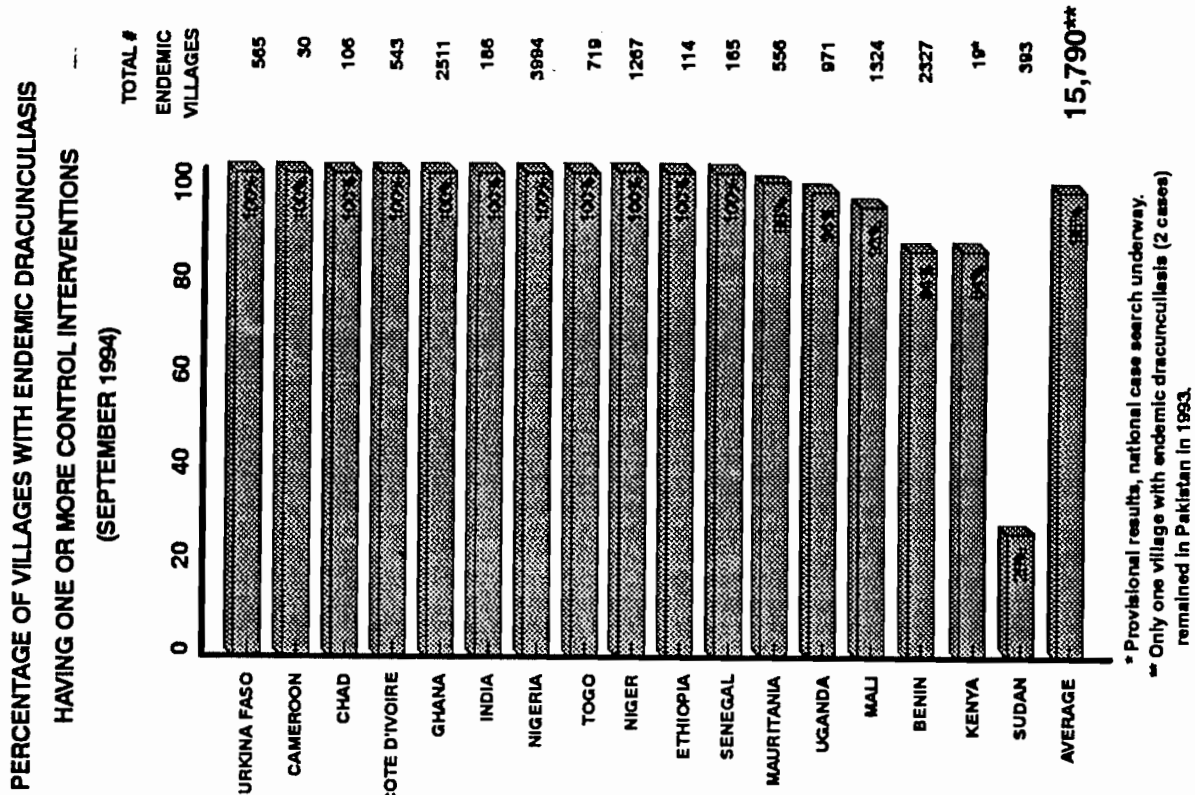
Provision of safe drinking water in Atar is inadequate. Drinking water is sold by tank truck drivers who collect it from wells located 18 kms from Atar. Water from these wells is not always available, as they dry out seasonally. In the dry season, as water becomes scarcer, the truck operators obtain water from all available sources, including ponds.

In cooperation with the Adrar DRASS, the following actions have been taken: epidemiologic surveys; entomologic surveys of water collections (no cyclops found); medical care of patients (including surgical extraction and bandaging of lesions), provision of filters to and education of the patients and their households; creation of a Regional Commission, presided over by the region's Governor, to increase public awareness about the disease and to distribute filters to each family. As this outbreak was reported at the end of the rainy season, the investigating team was precluded from applying Abate because of the many potential drinking water sources and their large size. Recent communications indicate that new cases continue to be reported by health authorities in Atar.

Editorial Comment

The outbreak in Atar provides two important messages to all national eradication programs in Africa. Firstly, the importance of maintaining a high level of public awareness about the eradication campaign to help identify existing cryptic foci of disease (which may unexpectedly become known as dracunculiasis incidence diminishes in surrounding areas or as knowledge about the disease and its eradication become more widespread). Secondly, it illustrates the need to have a capacity to react rapidly to such emergencies. Mauritania's GWEP is to be commended for the speed with which it investigated this outbreak and the immediate implementation of control interventions.

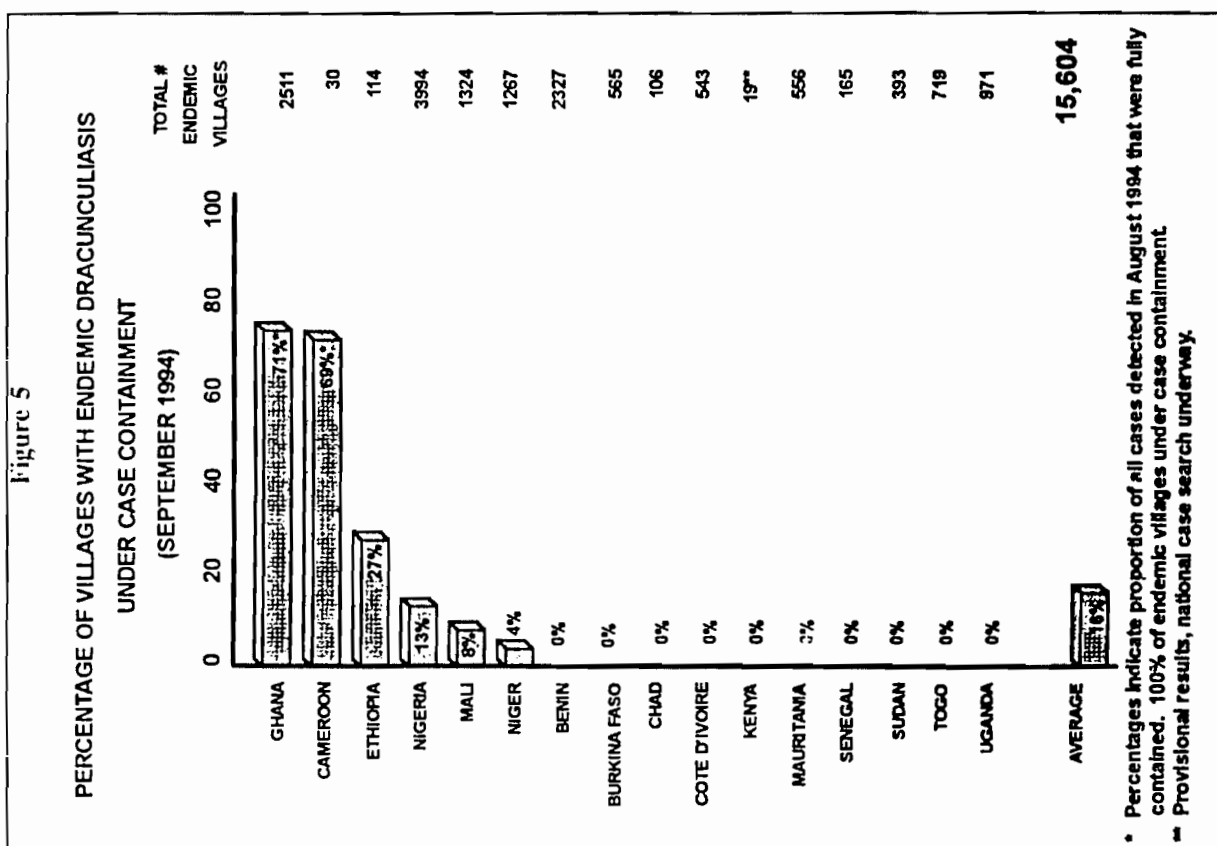
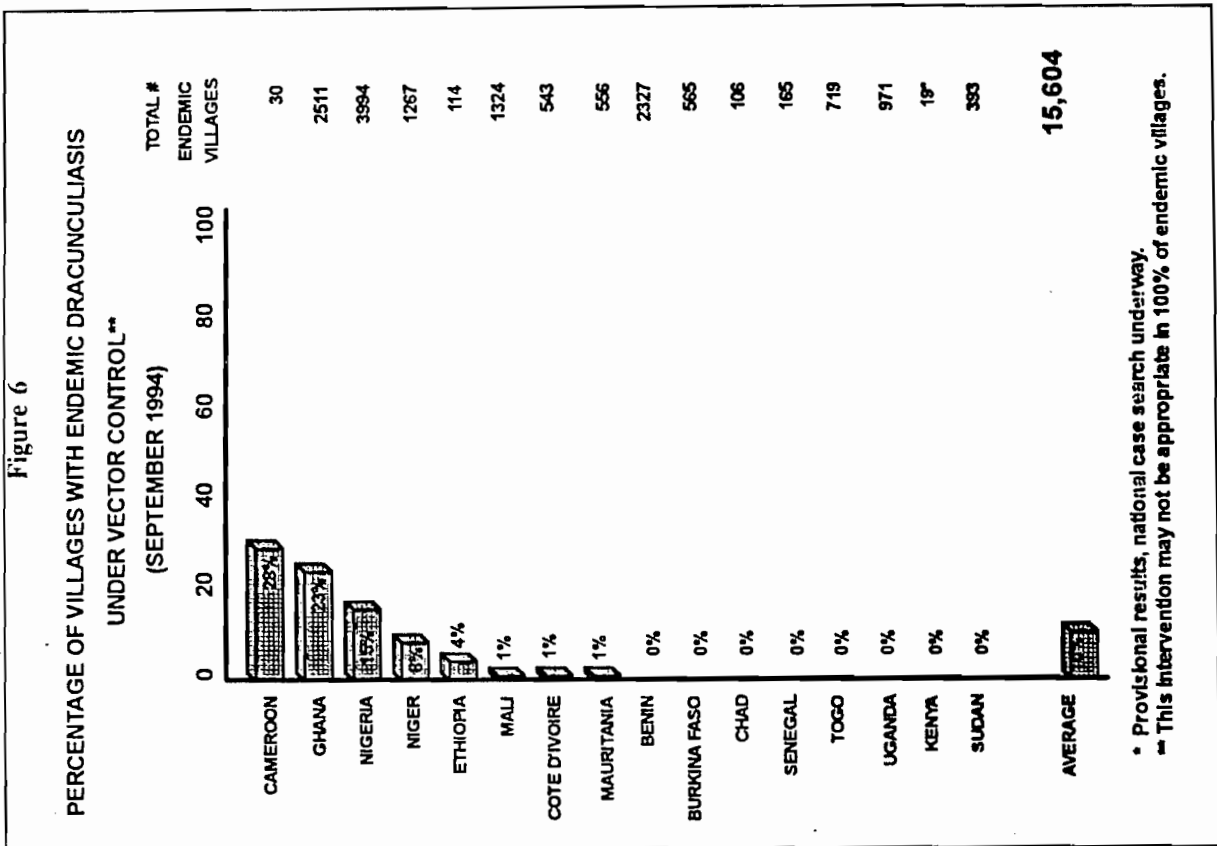
Figure 4



EDITORIAL

Fourteen months to target zero!

The first of November will mark the beginning of the final 14 months before the target date of December 31st, 1995 for halting transmission of dracunculiasis. All endemic countries except Sudan are already intervening in nearly all known endemic villages (Figure 4). The priority of priorities for endemic countries between now and the end of 1994 should be to get case containment into place in ALL of their remaining endemic villages. The closer countries come to that ideal, the higher will be their chances of interrupting transmission in 1995. Case containment is learned by doing it, and the more experienced health workers at all levels of eradication programs are with implementing that strategy when 1995 begins, the more effective they will be. As of mid-October, there is much more to be done in implementing this strategy in endemic African countries (Figure 5), including selective use of vector control (Figure 6). Intensifying social mobilization is the other priority companion intervention to the case containment strategy. Francophone countries, for example, should begin making plans for their common National Guinea Worm Eradication Day, which will occur again April 30, 1995. Each endemic country should also be tracking the number of villages which actually report one or more case(s) in 1994. Those villages are the ones to which programs should prepare to direct priority attention for case containment interventions in 1995.





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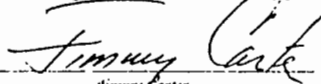
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FOR THE GUINEA WORM ERADICATION PROGRAM IN AFRICA

Under this International Initiative to Eradicate Guinea worm, this acknowledges the leadership role of the Carter Center in mobilizing the global community to make Guinea worm the second disease ever to be eradicated from the world. This campaign focuses on Africa, promotes sustainable development, builds capacity, and encourages public/private partnerships - all of which supports U.S.A.I.D. development policies and objectives.


Jimmy Carter
FOR THE CARTER CENTER

U.S. Department of State
OCTOBER 1, 1994


J. Brian Atwood
FOR USAID

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Inclusion of information in Guinea Worm Wrap-Up does not constitute "publication" of that information.

For information about the GW Wrap-Up, contact Virginia G. Sturwold, EdD, writer-editor, CDC/IHPO, F-03, 1600 Clifton Rd., NE, Atlanta, GA 30333, U.S.A. FAX: (404) 639-0277.



CDC is the WHO Collaborating Center for Research, Training, and Eradication of Dracunculiasis.