DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)
Memorandum

Date: November 10, 2003

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

Subject: GUINEA WORM WRAP-UP #137

To: Addressees

STOP GUINEA WORM NOW: Prevent it! Avoid it! Filter it! Report it!

PROGRAM REVIEW FOR FRANCOPHONE COUNTRIES MEETS IN OUAGADOUGOU

Representatives of the remaining endemic francophone countries met in Ouagadougou, Burkina Faso for their annual Program Review on October 20-22, 2003. The Burkinabe Minister of Health, Mr. Alain Yoda opened the meeting. The seven countries concerned have reduced their collective reported cases of dracunculiasis by -37% (from 2,326 to 1,467) and the number of villages reporting one or more cases by -14% (from 478 to 409) during the first nine months of 2003, compared to the same period of last year. As before, nearly one-half (200) of this year's villages that reported one or more cases reported only one case each. Importantly, 80 villages reporting 5 or more cases accounted for 65% of all cases reported. Media coverage of the meeting was very good, and included local newspapers, radio and television, Associated Press, Voice of America, and BBC. The Guinea worm film "Yoro, the Empty Granary" was shown on national television, as were interviews with the national coordinator and a few other participants, and a report of the closing ceremony. A brief sketch of each of the countries' status during January – September 2003 follows (see also Tables 1 and 2).

Togo reported 537 cases (33 of them imported from Ghana) in 125 villages, which is a reduction of -42% in cases. Of the villages reporting one or more cases, 64 reported only one case each and 23 villages reported five or more cases each. 76% of cases were reportedly contained (vs. 62% in 2002). The program reduced cases in the villages where it intervened in 2002 by -68%. The reduction of cases in districts where case containment centers are being used is -59%, vs. -27% reduction in districts without case containment centers. This program intensified its health education during 2003, including more "Worm Weeks", theater, radio, billboards, teaching in schools, town criers, and a rap song. Togo's peak transmission season is October through February.

Mali reported 518 cases from 128 villages, which is a reduction of -6% in cases. Of the villages reporting one or more cases, 52 reported only one case each and 41 villages reported five or more cases each. 52% of cases were reportedly contained (vs. 55% in 2002). The program reduced cases in villages where it intervened in 2002 by -36%. So far in 2003, 90% of cases reported are in the three eastern districts of Gao, Ansongo and Gourma Rharous. The program is improving interventions among the Black Touareg population, which is at highest risk (74% of all cases so far). Mali's peak transmission season is August through October.

Burkina Faso reported 171 cases from 66 villages, which is a reduction of -59% in cases. Of the villages reporting one or more cases, 35 reported only one case each and only 4 villages reported five or more cases each. 58% of cases were reportedly contained (vs. 75% in 2002). The program reduced cases in villages where it intervened in 2002 by -80%. Health education and filter coverage have improved over the past year, and this program could break transmission in 2004. Burkina's peak transmission season is May through October.

Table 1

Program Review: Status of Interventions as of September 30, 2003*

Country	% Change in villages where GWEP intervened 2002	Cases		Villages				
		# Reported	% cases contained	Number endemic	Provided Health Education (IEC)	100% of Households with filters	Protected with Abate	with 1+ source of safe water
Togo	-68%	531	76%	125	100%	81%	82%	43%
Mali	-36%	518	52%	128	100%	100%	14%	23%
Burkina Faso	-80%	171	58%	66	83%	100%	41%	88%
Niger	-10%	164	60%	62	100%	97%	32%	18%
Cote d'Ivoire	-92%	46	45%	11	83%	73%	73%	80%
Benin	-74%	25	100%	11	100%	100%	100%	82%
Mauritania	-82%	9	78%	6	100%	100%	33%	71%
Total	-62%	1464	64%	409	97%	93%	46%	43%

* provisional

Table 2

Program Review: Status ofEndemic Villages as of September 30, 2003*

Country	Endemic Villages			# cases (9 months)		
	Number	Reported 1 case only	Reported 5+ cases (# cases)	2002	2003	% change
Togo	125	64	23 (369)	930	537	-42%
Mali	128	52	41 (376)	553	518	-6%
Burkina Faso	66	35	4 (97)	427	171	-59%
Niger	62	37	9 (85)	105	164	43%
Cote d'Ivoire	11	2	2 (20)	192	40	-79%
Benin	11	6	1 (7)	85	25	-71%
Mauritania	6	4	0 (0)	34	9	-74%
Total	409	200	80 (954)	2326	1464	-37%

* provisional

Niger reported 164 cases from 62 villages, which is an increase in cases of 43%. 60% of the cases were reportedly contained, which is the same as in 2002. Of the villages reporting one or more cases, 37 reported only one case each and only nine villages reported five or more cases each. The program reduced cases in villages where it intervened in 2002 by -10%. (Interventions began late in the year in many of these villages. The program only gained access to endemic areas of Tillaberi district, which shares the border and a nomadic population with adjoining districts of Mali and Burkina Faso, in late 2002, because of previous insecurity). Tillaberi District has reported 79% of all Niger's cases so far this year, and 88% of Niger's cases are in Black Touaregs. The peak transmission season is July through November. Niger will hold its national review meeting in Tillaberi on December 9-11.

Cote d'Ivoire reported 40 cases from 11 villages, which is a reduction of -79% in cases. 45% of the cases were reportedly contained, compared to 96% in 2002. Of the villages reporting one or more cases, 2 reported only one case each and only 2 villages reported five or more cases each. The forty cases reported so far are all in government held areas, mostly Tanda (29 cases) and Bondoukou (10 cases) Districts, where UNICEF has recently provided 30 new wells in endemic villages. Unconfirmed rumors of 7 other cases were noted from insecure areas: one from Bouna (October), 5 from M'Bahiakro (October), and one case allegedly exported from Seguela to Burkina Faso in August. The program reduced cases in villages where it intervened in 2002 by -92%. The peak transmission season in Cote d'Ivoire is December-April.

Benin reported 25 cases from 11 villages, which is a reduction of -71% in cases. 100% of cases were reportedly contained (compared to 91% last year), including 17 (68%) who were hospitalized. Of the 11 villages reporting one or more cases, 6 reported only one case each and only 1 village reported five or more cases. The program reduced cases in villages where it intervened in 2002 by -74%. UNICEF has provided safe drinking water sources to the village of Tchetti that reported most of Benin's cases in 2002. This

program may break transmission this year: **Benin has reported no indigenous cases in the eight months since January**! Benin's peak transmission season is September through January.

Mauritania reported 9 cases from 6 villages, which is a reduction of -74% in cases. 78% of cases were reportedly contained, compared to 56% contained in 2002. Of the 6 villages reporting one or more cases, 4 reported only one case each, and none reported five or more cases. The program reduced cases in villages whewhe

Table 3

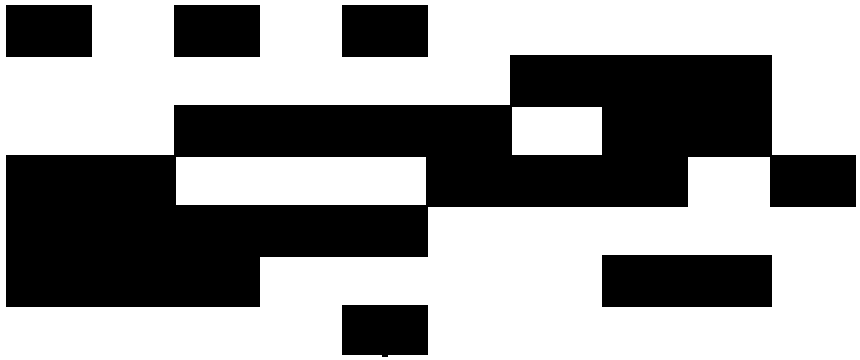
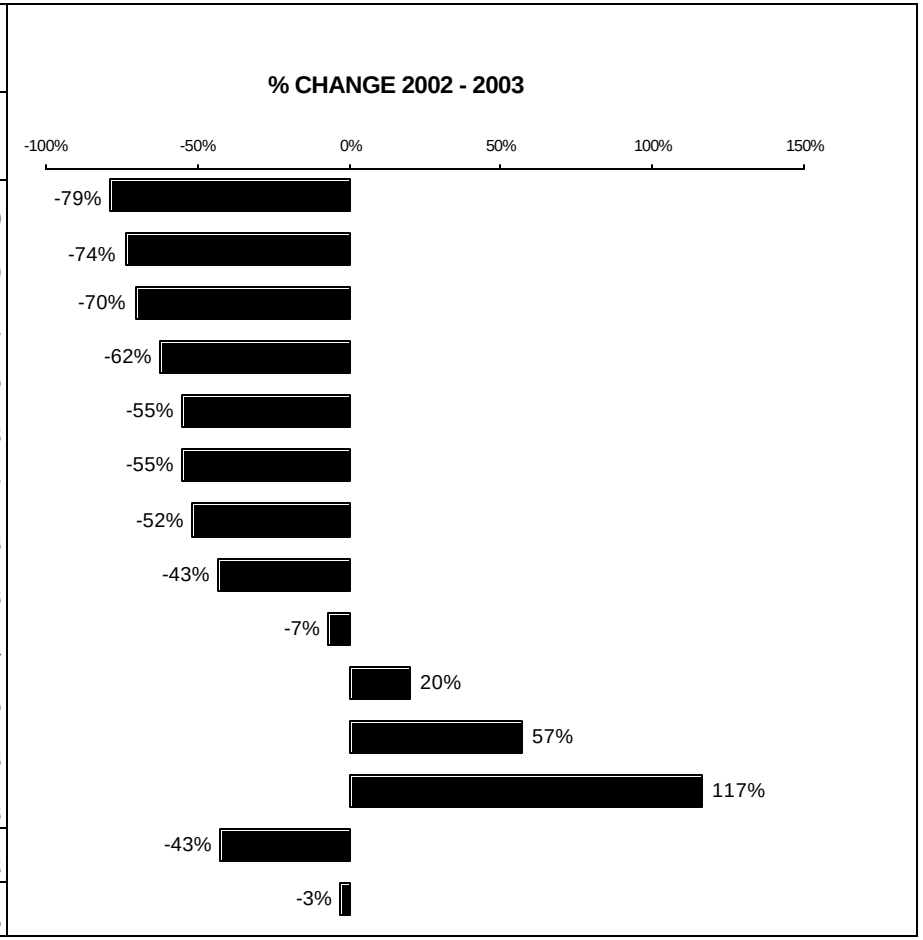


Figure 2

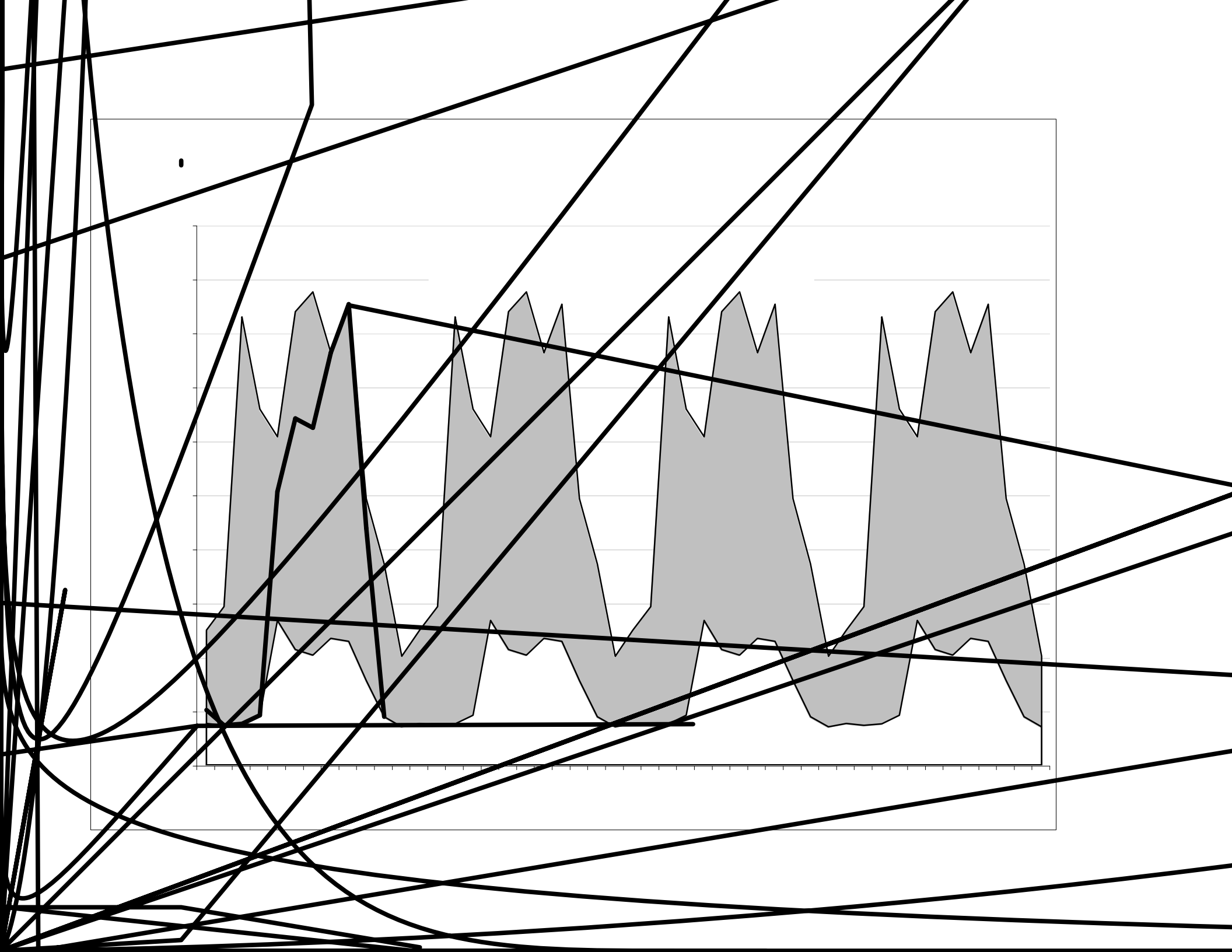
Number of Villages/Localities Reporting Cases of Dracunculiasis in 2002, Percentage of Endemic Villages Reporting in 2003*, Number of Indigenous Cases Reported During the Specified Period in 2002 and 2003*, and Percent Change in Cases Reported

Country	Villages		Indigenous Cases Reported	
	Reporting 1+ cases in 2002	% Reporting 2003	2002	2003
Cote d'Ivoire (9)	25	100%	188	40
Mauritaina (9)	18	100%	34	9
Benin (9)	31	100%	70	21
Burkina Faso (9)	133	98%	415	156
Sudan (8)	4233	65%	30061	13448
Nigeria (10)	557	100%	2857	1287
Togo (10)	228	100%	1114	533
Ethiopia (10)	12	100%	23	13
Mali (9)	183	88%	551	514
Niger (10)	77	100%	188	226
Ghana (10)	739	100%	4161	6533
Uganda (9)	19	100%	6	13
Total	6255	74%	39668	22793
Total- Sudan	2022	99%	9607	9345



(9) Indicates month for which reports were received, e.g., Jan. - Sept. 2003

* Provisional



DOES YOUR PROGRAM HAVE SPECIFIC MEASURABLE OBJECTIVES FOR 2004?

Every national Guinea Worm Eradication Program should be preparing quantifiable objectives for 2004. To aid in this, the following are draft objectives which may be adapted or modified as appropriate. As indicated, it would also be useful to include the current level of attainment for each objective:

1. Contain >80% of all cases reported (now: xx%)
2. Of cases admitted to Case Containment Centers, admit >75% within 24 hours of emergence of the worm [if available] (now: xx%)
3. Contain >50% of all cases in Case Containment Centers [if available] (now: xx%)
4. Maintain 100% coverage with adequate cloth filters in >95% of endemic villages (now: xx%)
5. Provide pipe filters and appropriate education on their use and care to all eligible populations [if available] (now: xx.%)
6. Monitor provision of adequate functioning sources of safe drinking water in the 20 most endemic communities (now: xx%)
7. Perform spot checks for copepods in # targeted endemic villages each month (now: #)
8. Conduct a Worm Week in each of the highest endemic districts (now: #)
9. Ensure that all primary and secondary schools in the top 20 endemic districts teach about prevention of dracunculiasis (consider using the WHO comic book and teacher's manual) (now: xx%).
10. Ensure radio messages (news, jingles, skits, public service announcements) are broadcast at least twice weekly during the peak transmission season by all available stations in the highest endemic areas of the country (now: frequency)

SIX ENDEMIC COUNTRIES WITH CASE CONTAINMENT CENTERS

Table 4 summarizes data reported so far during 2003 from six endemic countries where Case Containment Centers are being used to help voluntarily isolate and care for persons with dracunculiasis. The documented efficacy of such centers in Togo is mentioned elsewhere in this issue. The two key indices listed in the table track the programs' ability to admit as many of their cases as possible into such centers; and to admit as many of them as possible before or within 24 hours of emergence of the worm. By tracking these two indices, programs can monitor the efficacy of their surveillance (detection of cases early), and their coverage of remaining cases. Programs are urged to monitor not only such averages, but to investigate the reasons why individual patients (" outliers") fall outside of the desired norms, e.g. admission before or within 24 hours of emergence of the worm. Such investigations can help to detect and improve deficiencies. Individual centers should aim to improve their indices each month compared to the previous month.

Table 4

Country	Number of CCCs	Number and % of all cases admitted to CCCs			Number and % of all addmissions to CCCs within 24 hrs of worm emergence		
Ghana (9)	22	1708	/ 6262	27%	1217	/ 1708	71%
Nigeria (10)	15	551	/ 1287	43%	323	/ 402	80%
Togo (10)	11	78	/ 537	15%	32	/ 78	41%
Mali (9)	1	10	/ 521	2%	8	/ 8	100%
Burkina Faso (9)	4	95	/ 171	56%	54	/ 95	57%
Benin (90	4	17	/ 25	68%	9	/ 17	53%

(9) Indicates month for which reports were received, e.g., Jan. - Sept. 2003

ANDERS SEIM WINS NORWAY'S COVETED KARL EVANG AWARD

Norway's Minister of Development Cooperation, Hilde Johnson, presented the Karl Evang Health Education Award to Dr. Anders Seim, founder of Health and Development International (HDI), at a ceremony in Oslo during the annual Karl Evang Seminar on October 20, 2003. This is the first time that the award has been given for work in international health. The award is named for Dr. Karl Evang, Norway's surgeon general for many years, who was one of the public health leaders who helped found the World Health Organization. Dr. Seim announced that he will donate the prize money, 35,000 Norwegian kroner (approximately US$5,OOO) to Health and Development International to help Norwegian medical students travel to Sudan in follow up to their successful 2002 Humanitarian Action Campaign (see: Guinea Worm Wrap-Up #136). BRAVO! and CONGRATULATIONS, Anders!!!

Figure 3

Distribution by Country of 22,793 Indigenous Cases of Dracunculiasis Reported During 2003*

PROGRAM REVIEW OF THE DRACUNCULIASIS ERADICATION PROGRAMS IN FRENCH-SPEAKING COUNTRIES

General Recommendations

1. Guinea Worm Eradication Programs (GWEPs) should develop plans of action (for 2004) with measurable and quantifiable objectives as soon as possible and submit these plans to partner organizations (for consideration and funding).
2. GWEPs should ensure that the frequency of active surveillance in endemic villages is in consonance with the first standard for case containment, which requires all cases to be detected within 24 hours of the emergence of a Guinea worm.
3. GWEPs should investigate those communities that report cases anew to determine the true incidence, to confirm whether endemic transmission has re-occurred, and the probable origin of the disease.
4. GWEPs should integrate in their disease surveillance plan those formerly endemic villages that are at high risk of the re-introduction of the disease from nearby endemic villages.
5. GWEPs should seek to obtain the full support of traditional opinion leaders of nomadic population groups for the interventions against the disease, notably the correct use and care of filters and mobilization of their communities to take action against the disease.

Specific Recommendations

Cote d'Ivoire

1. The GWEP should, without fail, conduct searches for cases of dracunculiasis in the formerly endemic districts of Bouna, Dabakala, Mankono, and Vavoua.
2. The GWEP should organize and conduct quarterly meetings with in-country partner organizations.

Mali

1.


AFRICA Today
Voice of the Continent
JIMMY CARTER
Africa's Good Samaritan
Former US president uses his clout to fight Guinea worm on the continent
The Carter Center
NIGERIA: SEARCH FOR PEACE IN NIGER DELTA
LIBERIA: DAWN OF A NEW ERA
IVORY COAST: THREAT TO PEACE PROCESS