In Nigeria, Guinea Worm Chapter Nears End

As spring brings new life and growth across the United States, a country on the other side of the world celebrates a new beginning too. Nigeria is poised to close the book on Guinea worm disease and look forward to a time when the anguish of the disease will no longer haunt its people.

Once the most Guinea worm-endemic country in the world, Nigeria reached a major milestone when it reported zero cases of Guinea worm disease in September and October 2005 for the first time.

In the last five months of 2005 and January 2006, traditionally the country’s peak transmission season, the country reported only five cases, compared to 148 cases during the same period in 2004. The 97 percent reduction in cases indicates a major breakthrough in the country’s journey to stop transmission.

“Nigeria’s progress is a huge step forward in a very important country,” said Dr. Donald Hopkins, associate executive director of health programs at The Carter Center. “As the most populated country in Africa, Nigeria’s amazing progress in the fight against Guinea worm disease sets a fast pace for the remaining endemic countries to end this painful chapter in human history.”

Shortly after eradication efforts began in Nigeria in 1988, more than 653,000 cases of Guinea worm disease were reported, the highest number of cases ever documented for any country. To combat the scourge, The Carter Center, in partnership with Nigeria’s Ministry of Health, helps promote health education to communities throughout the country, emphasizing the importance of water treatment using ABATE® larvicide and water filtration methods to eliminate the spread of the disease.

The astounding success of the Nigeria program is due to the hard work of village volunteers, Carter Center and Ministry of Health staff, and former Nigeria Head of State General (Dr.) Yakubu Gowon. Thanks to these efforts, it is possible that Nigeria will end transmission in 2006.

Trachoma, cont.

with young children, who form the primary pool of infection, mothers are exposed to the repeated infection that can lead to severe trachoma and blindness. Three out of four people blinded by trachoma in Ethiopia are women.

Transmission of the disease occurs when bacteria move from the eyes of children to the eyes of an uninfected person via the feet of eye-seeking flies, mothers’ shawls, bed sheets, towels, or simply touching hands to eyes. Recurring infections lead to the inward turning of eyelashes that causes corneal abrasion and eventual blindness.

The Carter Center follows the four-pronged approach to controlling trachoma endorsed by the World Health Organization. Called the SAFE strategy, the method involves surgery, antibiotic therapy, facial cleanliness, and environmental improvement. The Center supports surgery and antibiotic treatment but emphasizes facial cleanliness and environmental improvement in its program because improved hygiene practices are most likely to lead to sustained trachoma prevention. And education about good hygiene is the best way to stretch limited resources to reach the most people.

One example of how the Center’s focus on good hygiene has improved the lives of people in trachoma-endemic villages is the rapid expansion of latrine construction in Africa. With overwhelming support from village leaders and low building costs, communities in Ethiopia, Nigeria, Mali, and Niger have surpassed latrine construction goals. Safe disposal of human feces limits breeding opportunities for the species of fly that transmits trachoma.

With its emphasis on preventing trachoma through education, the Carter Center Trachoma Control Program is making a difference for a new generation—a generation that can look forward to a lifetime of sight.

To date, 11 countries have stopped Guinea worm transmission: Benin, 2004; Mauritania, 2004; Uganda, 2003; Central African Republic, 2001; Chad, 1998; Cameroon, 1997; Yemen, 1997; Senegal, 1997; India, 1996; Kenya, 1994; Pakistan, 1993.

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