



Date: October 5, 2000

From:



WHO Collaborating Center for
Research, Training and Eradication of Dracunculiasis

Subject:

GUINEA WORM WRAP-UP # 106

To: Addressees

Detect Every Case (within 24 hours), Contain Every Worm (immediately)!

GHANA HOLDS NATIONAL REVIEW MEETING IN TAMALE



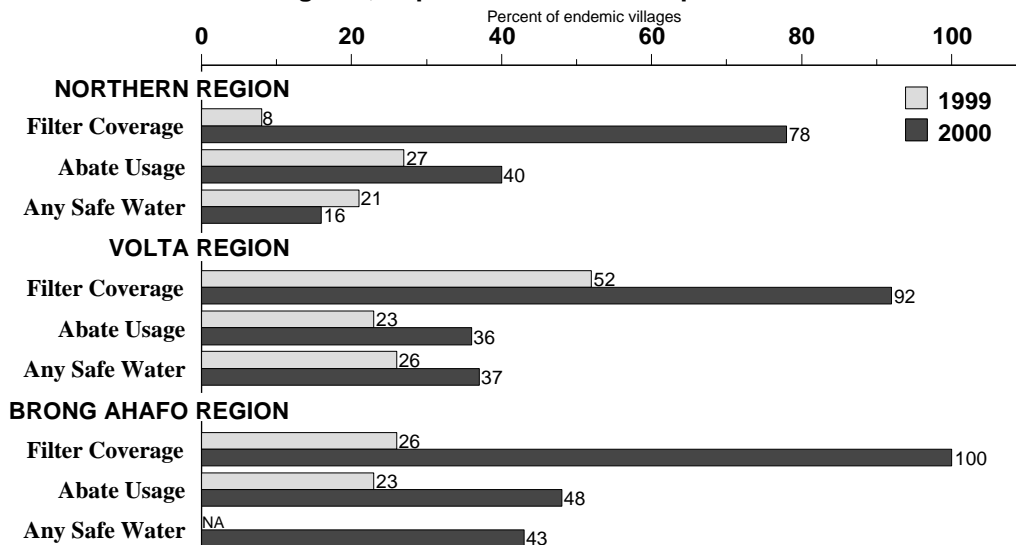
Ghana

On September 18-20, 2000 the Ghana Guinea Worm Eradication Program convened its annual National Program Review meeting in Tamale, Northern Region, for the first time. Over 75 persons participated in the meeting, which was chaired by the National Program Coordinator, Dr. Sam Bugri. Also attending were Deputy Minister of Health, Dr. Moses Adibo; health officials and Guinea worm staff from all regions and the highest endemic districts; several district chief executives from some of the highest endemic districts; a representative of Ghana's Community Water and Sanitation Agency (CWSA); International Commission for the Certification of Dracunculiasis Eradication member, Dr. Fred Wurapa; as well as representatives of Global 2000/The Carter Center, UNICEF, WHO, Centers for Disease Control and Prevention (CDC), and US Peace Corps.

Ghana reported 68 cases of dracunculiasis in August 2000, which is a reduction of -18% from the 83 cases reported in August 1999. This is the sixth consecutive month of reduced cases in Ghana (Figure 2), although the country still has a cumulative 11% increase in cases for January-August 2000 (Figure 3). So far this year, three of the country's ten regions report 96% of Ghana's cases: Northern Region (60%), Volta Region (19%), and Brong Ahafo Region (17%). Large gatherings for funerals and marriages are increasingly recognized as sources of outbreaks.

Figure 1

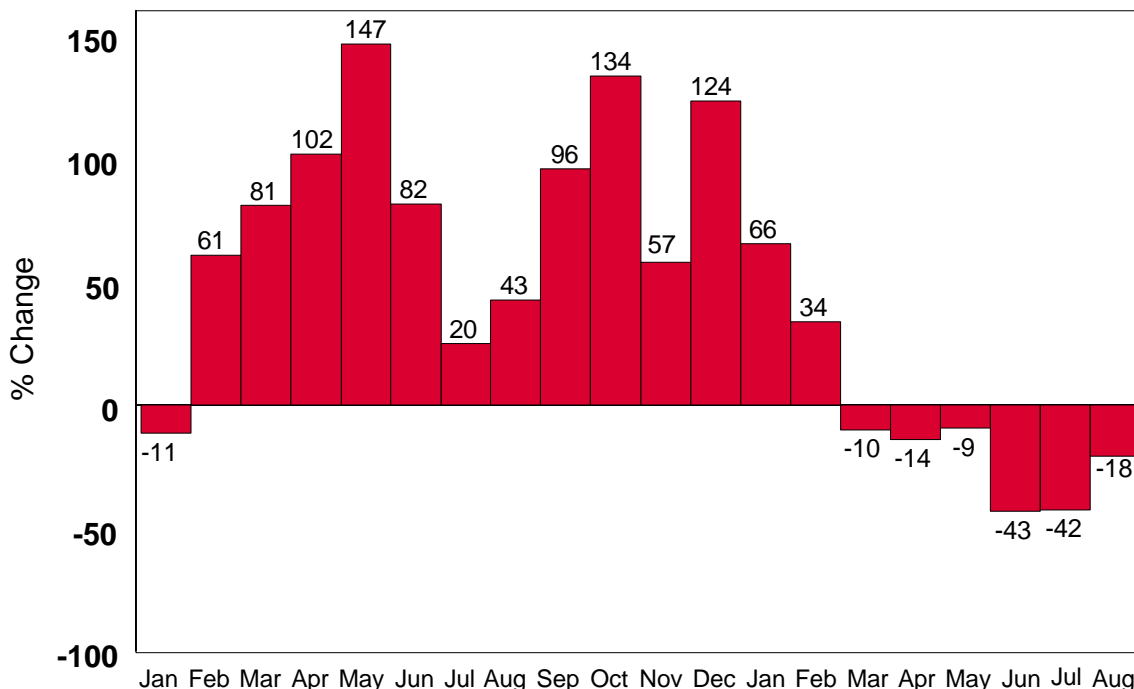
Ghana: Status of Interventions (% of endemic villages) in the Three Highest Endemic Regions, September 1999 and September 2000



The improvements in interventions by the three key regions since last year's review meeting are shown in Figure 1. Among the recommendations of this year's review were that monthly meetings be held at all levels of the program to review the status of interventions, and that high priority be given to ensuring that all households in all endemic villages be provided with cloth filters before the next peak transmission season begins in late October. All of the districts which presented and the Volta Region representatives used line-listings and maps in summarizing their programs. Data from the line-listings and reports of the four highest endemic districts (Map 1) are summarized in Table 1. These four of Ghana's 110 districts reported 53% of all cases in Ghana in January – August, 2000. Northern Region's pioneering drama troupe has performed its Guinea worm skit for over 90,000 persons in 74 endemic communities since November 1999, and it was reported that residents of some communities have started to publicly label certain community members as behaving like specific characters in the play. Atebubu District has also formed a drama group consisting of 10 women, and Kete-Krachi District's drama troupe from the Krachi Secondary Technical School has performed in 2 communities and plans to reach 20 more communities before the peak transmission season. Significant efforts are underway or planned for providing new or rehabilitated water sources in parts of Northern and Volta Regions, especially. Some of the different incentives being used to reward the work of village volunteers include provision of gum boots in Atebubu District, provision of cutlasses and bicycles in Kete-Krachi District (as well as participation in other health activities such as broader community-based surveillance, ivermectin distribution, or polio National Immunization Days), and provision of free medical care in Nanumba District. Northern Region has also begun using a new performance appraisal checklist by which supervisors must earn proportions of their monthly allowance in exchange for achieving specific tasks or targets. The two most frequently cited constraints were inadequate transportation and inadequate or delayed funding.

Other key recommendations from the meeting included the need to convene a similar review in the heart of the remaining endemic area six months from now; to strengthen active surveillance for dracunculiasis by using National Immunization Days (NIDs) for polio immunization and by extending the Community-Based Surveillance (CBS) system throughout the country; and to establish an Interagency Coordinating Committee (ICC) as a forum for exchanging information, planning, and mobilizing resources among relevant agencies and ministries of the government as well as external partners of the program. Deputy Minister of Health Dr. Adibo closed the Review by stating his intention to demand monthly reports on the program.

Figure 2 **Ghana Guinea Worm Eradication Program**
Percent Change Monthly: January 1999 - August 2000



In July and August, Dr. David Opare, District Director of Health Services for Atebubu District in Brong Ahafo Region, began distributing a monthly newsletter to update all concerned on the latest developments in Atebubu's fight to eradicate dracunculiasis. The first two issues highlight preparations by the District Assembly and Global 2000 to provide safe drinking water to Fawomang, Wokasua, and Nwomwam villages (ranking 3,4 and 8 in Atebubu's line-listing), and the holding of successful durbars to promote awareness at Komfourkrom, Parembo, and Fawomang, on August 16 and 18. Bravo Atebubu!

Map 1

Ghana Dracunculiasis Eradication Program

Number of Cases of Dracunculiasis Reported by District: January - July 2000*

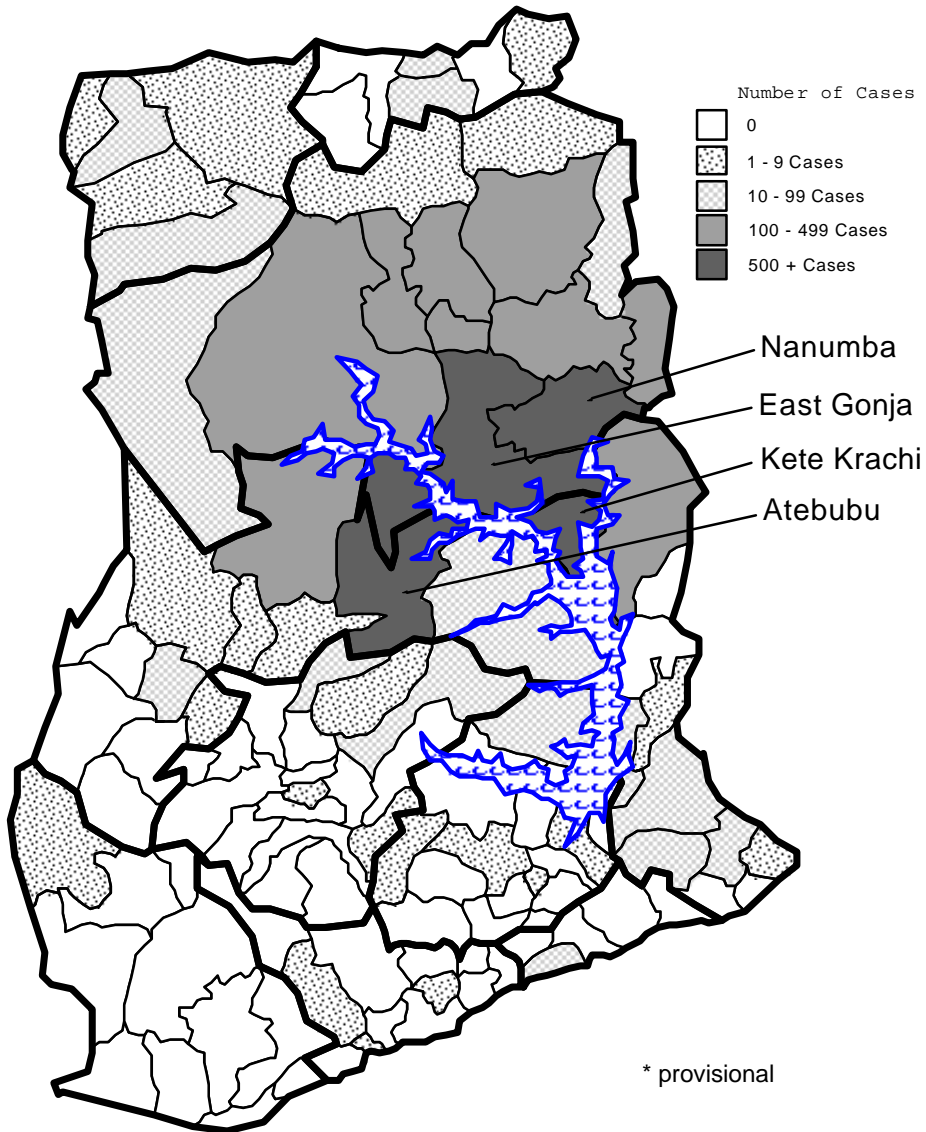


Table 1

Ghana Line Listing of Interventions: Four Highest Endemic Districts, September 2000

District (Region)	GW Cases Jan. – Aug. 2000	Villages Reporting 1 ≥ cases Jan. – Aug 2000	% Endemic Villages			Health Education, ¹ Community Mobilization
			Filter Coverage	Abate Usage	Any Safe Water	
Nanumba (N.R.)	1015	132	67%	17%	16%	2,4,10,12
Atebebu (B.A.R.)	743	36	100%	40%	35%	1,2,3,4,6,10,12
Kete Krachi (V.R.)	727	71	87%	40%	49%	1,2,3,4,6,9,10,12
East Gonja (N.R.)	704	114	100%	29%	41%	4,6,10,12

¹ Code: Health education:

- | | |
|---|--|
| <ol style="list-style-type: none"> 1. flip charts/demonstration of copepods in water 2. t-shirts/Guinea worm cloth 3. durbar (public ceremony) 4. posters 5. radio (news messages, songs, jingles) 6. schools | <ol style="list-style-type: none"> 7. churches/mosques 8. local chief/political/traditional leader 9. market strategy (megaphone, pagivolts, banners; for surveillance and education) 10. theater/drama 11. video/slide show 12. other |
|---|--|
- N.R. = Northern Region
B.A.R. = Brong Ahafo Region
V.R. = Volta Region

SUDAN: ENDING TRANSMISSION IN NORTHERN STATES, SETBACKS IN SOUTH



Sudan

At its annual Program Review, which was held in Nairobi, Kenya September 25-26, Sudan's Guinea Worm Eradication Program (SGWEP) reported on impressive gains toward eliminating transmission of dracunculiasis in the ten northern states. So far this year (January-July), only 10 indigenous cases have been reported, in only two of the northern states, compared to 68 indigenous cases during the same period of 1999— a reduction of 85%. Another 35 cases were imported into northern states from endemic areas of southern Sudan (78% imported cases vs. 48% imported cases in January– July 1999). The 45 cases occurred in 21 villages, and 78% were contained. (The peak transmission season in Sudan is May–September). Overall, 92% of the endemic northern villages have at least one source of safe water, as a result of exemplary collaboration among the SGWEP, UNICEF, and the National Water Corporation. Sixty-four percent (64%) of endemic northern villages have cloth filters in all households, and Abate is being used in 20%. In May, the minister of health of North Kordofan announced a significant reward for the reporting of any indigenously transmitted case. Except for problems due to insecurity in parts of South Kordofan (Nuba Mountains, part of which was accessed this year) and Blue Nile States, West Kordofan and Sennar States are judged most likely of the ten northern states, if any, to have any indigenous cases in 2001.

Progress in the southern states has been limited so far this year, because of increased insecurity (more evacuations and bombardments compared to 1999), and withdrawal of international Non-Governmental Organizations (NGOs) from 548 endemic villages because of the dispute over signing a Memorandum of Understanding with the Sudan Relief and Rehabilitation Association (SRRA). Another 456 endemic villages were detected in 2000, 202 of them in active searches associated with National Immunization Days (NIDs) conducted by the polio eradication program. Thus, most overall indices of interventions have declined, despite distribution of 364,134 cloth filters, 125,131 pipe filters, conduct of 30,196 health education sessions, and training or retraining of 2,543 village volunteers and supervisors this year in areas accessed by Operation Lifeline Sudan (OLS). As of July 1999, only 28 endemic villages, all in GOS–accessed areas, were using Abate, but in July 2000, Abate was being used in 114 endemic villages, including 37 GOS and 77 OLS–accessed areas. Many of the cloth filters were purchased by some of the 33 partner NGOs involved in the program. The World Food Program (WFP) provided 11.3 metric tons of food, and a Tutor's Guide, developed by the World Health Organization (WHO) in collaboration with Global 2000 in support of the training sessions, which aim to reach each village volunteer twice a year, has begun

to be distributed. The status of interventions for all–Sudan are summarized in the national line–listing in Table 2 (these data are updated by the program monthly).

Table 2

Sudan Guinea Worm Eradication Program Line-Listing by State January – July 2000

State	Number Endemic Villages	Number of Cases	Percent Contained	Endemic Villages				
				Percent Reporting	Percent Health Education	Percent Full Filter Coverage	Percent Any Safe Water	Percent Abate
Warab	1716	6857	37	18	28	20	34	0
Jongoli	2081	6141	34	21	30	8	21	0
Buheirat (Lakes)	1160	3011	22	43	58	32	46	1
Bahr al Jabal	325	1373	55	56	80	7	34	0
East Equatoria	288	901	67	38	52	10	55	4
Upper Nile	199	836	31	20	15	0	21	1
W Bahr al Gazaar	232	553	60	82	83	71	97	3
N Bahr al Gazal	782	385	72	60	58	41	81	0
W Equatoria	435	238	60	26	49	35	33	14
Unity	170	107	34	44	42	14	25	0
Sinnar	9	6 (x)	57	100	56	56	56	56
N Darfur	10	(9)	100	100	100	100	100	100
S Kordufan	13	4 (5)	56	100	85	0	92	0
W Kordufan	38	(9)	100	100	21	95	97	0
White Nile	6	(3)	100	100	100	33	83	0
S Dulfur	3	(1)	100	100	67	67	100	0
Blue Nile	5	0		100	100	0	100	40
Khartoum	1	0		100		0	100	0
Total Sudan	7473	20477	38	33	43	22	40	2

(x) denotes number of cases imported from southern Sudan

Despite the constraints, a few southern areas have recorded advances against the worm this year. In West Bahr Al-Ghazal State, where 187 endemic villages are accessed by OLS and another 45 by the Government of Sudan (GOS), Medecin Sans Frontieres-Belgium (MSF-B) reports a reduction of -27% in cases in Wau County, to 470 for January-July this year compared to the same period of 1999, even though the percentage of reporting from endemic villages increased from 78% to 94% over the same period. In an area of ~150 endemic villages in Adior Payam of Yirol County (Buheirat/Lakes State), Comitato Collaborazione Medica (CCM) reports a reduction of -91%, from 3,331 cases (January–August 1999) to 293 cases (January -July 2000). And in the GOS-accessed areas (196 endemic villages) of Bahr Al-Jabal and East Equatorial States, the number of cases reported was reduced by -47% (from 969 to 512 cases) for the same seven month period of 1999 and 2000, while reporting rates increased from 70% to 79%. The number of cases exported from southern Sudan have declined from at least 175 in 1998 (all to neighboring countries; the number exported to northern Sudanese states is unknown for that year), to 121 in 1999 (114 to northern Sudan, 7 to neighboring countries), to 47 in January–July this year (35 to northern Sudan, 12 to Central African Republic, Ethiopia, Kenya, and Uganda).

More than 50 persons participated in the Program Review for the SGWEP, including representatives of the Government of Sudan, the Sudan Relief and Rehabilitation Association (SRRA), the Relief Association of Southern Sudan (RASS), WHO, UNICEF, the Centers for Disease Control and Prevention (CDC), The Carter Center/Global 2000, and over a dozen NGOs. The recommendations made to the SGWEP are summarized on the next page.

SUDAN GUINEA WORM ERADICATION PROGRAM RECOMMENDATIONS FROM REVIEW MEETING SEPTEMBER 25th – 26th, 2000 NAIROBI, KENYA

The SGWEP should advocate for additional transportation capacity where needed (vehicles, motorcycles, bicycles and animals).

The SGWEP needs to provide pipe filters to cover target populations, including agricultural and nomadic settlements.

International partners should advocate the possibility of negotiating “safe days” (cease fire) to enable pertinent and life saving interventions, such as the distribution of GWEP supplies and immunizations, to take place in currently inaccessible areas.

Mobilization of endemic communities and selection and training of village volunteers (and supervisors) should be implemented with the goal of promoting sustainability (even if external assistance is disrupted) of program activities.

The SGWEP should consider establishing a small reward for reporting of cases in the ten northern states of the country.

The SGWEP should continue to increase use of Abate in appropriate areas.

The SGWEP should give high priority to conducting active surveillance and interventions in Naita and Akobo areas when feasible because of the great risk of exporting cases to Ethiopia from those areas.

The SGWEP needs to monitor the status of safe water (including the status of hand pumps) in all accessible endemic villages on a monthly basis and report those in disrepair to water sector organizations.

The SGWEP should increase the involvement of local partners such as County Health Departments in program implementation in order to increase local capacity and strengthen sustainability.

The SGWEP should continue to encourage all partners to participate in coordination meetings.

The SGWEP should continue to focus efforts in Western Equatoria and Lakes Regions.

The SGWEP needs to continue to monitor the proper use of filter cloths.

The SGWEP should collaborate with the Polio Campaign in an effort to increase health education, supervision and identification of endemic villages [specifically in house to house surveillance in Western Equatoria and Lakes Regions].

The SGWEP should strengthen collaboration and establish formal links with the civil society groups active in some highly endemic areas.

The SGWEP, in conjunction with the partners needs to increase efforts (with communities, village volunteers, and supervisors) to promote greater understanding that the SGWEP is a community program (the work is voluntary).

ETHIOPIA: ONLY 56 CASES IN JANUARY–AUGUST



Ethiopia

Ethiopia has reported only 56 cases of dracunculiasis, 4 of them imported from Sudan, during January–August 2000. This includes the entire peak transmission season of April–August. This is a reduction of -77% from the 225 indigenous cases that were reported during the same period of 1999. Thirty-seven (97%) of the 38 cases reported from seven villages in Gambella Region were reportedly contained, and 16 (89%) of the 18 cases reported from six villages in South Omo region were reportedly contained. Thirty of this year’s cases occurred in a single village (Terkodi) in Abobo District of Gambella Region; all 30 were cared for in special Guinea worm stations. All endemic villages have a trained health worker, are reporting monthly, have cloth filters in 100% of households, and have received health education. Abate is being used for vector control in 24%, and 44% of endemic villages have at least one source of safe drinking water. For the second consecutive year, control measures were aided by a severe drought in 2000. Access to Akobo District of Gambella Region is still limited however, due to sporadic insecurity, but a search for cases was conducted there in collaboration with polio National Immunization Days in April–May 2000. For operational reasons, authorities in OLS-accessed areas of southern

Sudan have assumed responsibility for conducting surveillance and control measures in the Naita area, adjoining South Omo. Gambella Region is now the key to interruption of dracunculiasis transmission in Ethiopia. Maintaining elimination will require particularly effective surveillance along Ethiopia's long common border with Sudan.

The new National Program Coordinator, Dr. Gzahegn Tesfaye, led Ethiopia's representatives, which included ministry of health, UNICEF, Carter Center/Global 2000 and WHO officials, to the Program Review in Nairobi on September 27. Recommendations from the Review are summarized below.

ETHIOPIA DRACUNCULIASIS ERADICATION PROGRAM RECOMMENDATIONS FROM REVIEW MEETING SEPTEMBER 27th 2000 NAIROBI, KENYA

The EDEP should conduct awareness campaigns in non-endemic districts.

The EDEP should consider a case survey in Bani Shangoal with stress on Matakal Woreda (with feed back given to SGWEP).

The EDEP needs to conduct a case search in Jor Woreda as soon as possible to assess the status of Guinea worm disease.

The EDEP partners are urged to provide safe water to the remaining endemic villages.

Explore possibility of utilizing guards, (Pond Caretakers) to promote water filtering and prevent contamination at the water source.

The EDEP needs to perform a case search in Akobo areas, which should be verified with initiative interventions (using NIDs and other means).

The EDEP needs to extend surveillance along the border of Sudan and work with NIDs to actively search for unknown endemic villages.

Health authorities and other concerned parties in Sudan and Ethiopia should hold border meetings to discuss cross border issues related to Guinea worm eradication.

EDEP should collaborate with the Polio Campaign (NIDs) to conduct active case searches and seek to detect unknown endemic villages.

The EDEP should develop a plan defining roles and responsibilities for each Partner in preparation for 2001 (by December 1, 2000).

The EDEP should consider increasing and extending its reward to include non-endemic areas and intensifying publicity.

Participants and Organizations represented at this Program Review Meeting request WHO and the International Commission for Certification of Dracunculiasis Eradication to advocate the Government of Ethiopia regarding Ethiopia's commitment to the World Health Assembly to eradicate dracunculiasis, and about the urgent need to provide its full support to the EDEP to enable the successful completion of the national eradication effort, including the 3-year pre-certification period.

Global 2000, UNICEF, and WHO should continue to help the Ethiopia Dracunculiasis Eradication Program to maintain the eradication of Guinea worm disease on the agenda of the Ministry of Health until there is clearly no indigenous transmission.

The Ministry of Health of Ethiopia should consider establishing a National Commission to prepare Ethiopia's Country Report that will be submitted to WHO in advance of certification.

The EDEP should stimulate the MOH to urge all its health units to report all cases of Guinea Worm disease as soon as possible.

Table 3

**Number of cases contained and number reported by month during 2000*
(Countries arranged in descending order of cases in 1999)**

COUNTRY	NUMBER OF CASES CONTAINED / NUMBER OF CASES REPORTED													CONT.
	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL*	
SUDAN	457 / 1200	460 / 878	429 / 757	446 / 1060	1360 / 4927	1811 / 4781	375 / 1528	/	/	/	/	/	5338 / 15131	35
NIGERIA	707 / 1263	455 / 1021	651 / 1137	368 / 754	346 / 630	323 / 444	336 / 497	321 / 493	/	/	/	/	3507 / 6239	56
GHANA	1737 / 1896	1214 / 1523	706 / 902	450 / 661	485 / 596	201 / 237	94 / 125	30 / 68	/	/	/	/	4917 / 6008	82
BURKINA FASO	7 / 9	7 / 7	19 / 44	93 / 187	231 / 325	196 / 269	53 / 211	/	/	/	/	/	606 / 1052	58
NIGER	1 / 1	2 / 2	0 / 0	2 / 3	23 / 39	67 / 106	116 / 177	187 / 363	/	/	/	/	398 / 691	58
TOGO	63 / 89	38 / 53	36 / 52	15 / 34	49 / 70	44 / 54	48 / 73	11 / 17	/	/	/	/	304 / 442	69
BENIN	40 / 53	20 / 29	11 / 17	9 / 9	0 / 0	1 / 2	3 / 3	0 / 0	/	/	/	/	84 / 113	74
COTE D'IVOIRE	25 / 26	63 / 69	15 / 42	5 / 32	6 / 17	16 / 45	12 / 12	23 / 26	/	/	/	/	165 / 269	61
MALI	5 / 5	0 / 0	0 / 0	5 / 5	5 / 13	6 / 11	14 / 28	19 / 29	/	/	/	/	54 / 91	59
UGANDA	4 / 4	2 / 2	3 / 4	11 / 11	14 / 16	10 / 10	12 / 24	8 / 15	/	/	/	/	64 / 86	74
MAURITANIA	0 / 0	0 / 0	0 / 0	0 / 0	1 / 1	4 / 5	1 / 7	/	/	/	/	/	6 / 13	46
ETHIOPIA	0 / 0	0 / 0	2 / 2	26 / 26	11 / 12	4 / 4	9 / 9	1 / 2	/	/	/	/	53 / 55	96
C.A.R. [^]	0 / 7	0 / 9	0 / 2	0 / 0	0 / 1	0 / 9	0 / 4	/	/	/	/	/	0 / 32	0
CAMEROON **	0 / 0	0 / 0	0 / 0	0 / 0	0 / 0	0 / 0	0 / 0	1 / 1	/	/	/	/	1 / 1	
CHAD	0 / 0	0 / 0	0 / 0	0 / 0	0 / 0	0 / 0	0 / 0	0 / 0	/	/	/	/	0 / 0	
TOTAL*	3046 / 4553	2261 / 3593	1872 / 2959	1430 / 2782	2531 / 6647	2683 / 5977	1073 / 2698	600 / 1014	0 / 0	0 / 0	0 / 0	0 / 0	15497 / 30223	51
% CONTAINED	67	63	63	51	38	45	40	59					51	

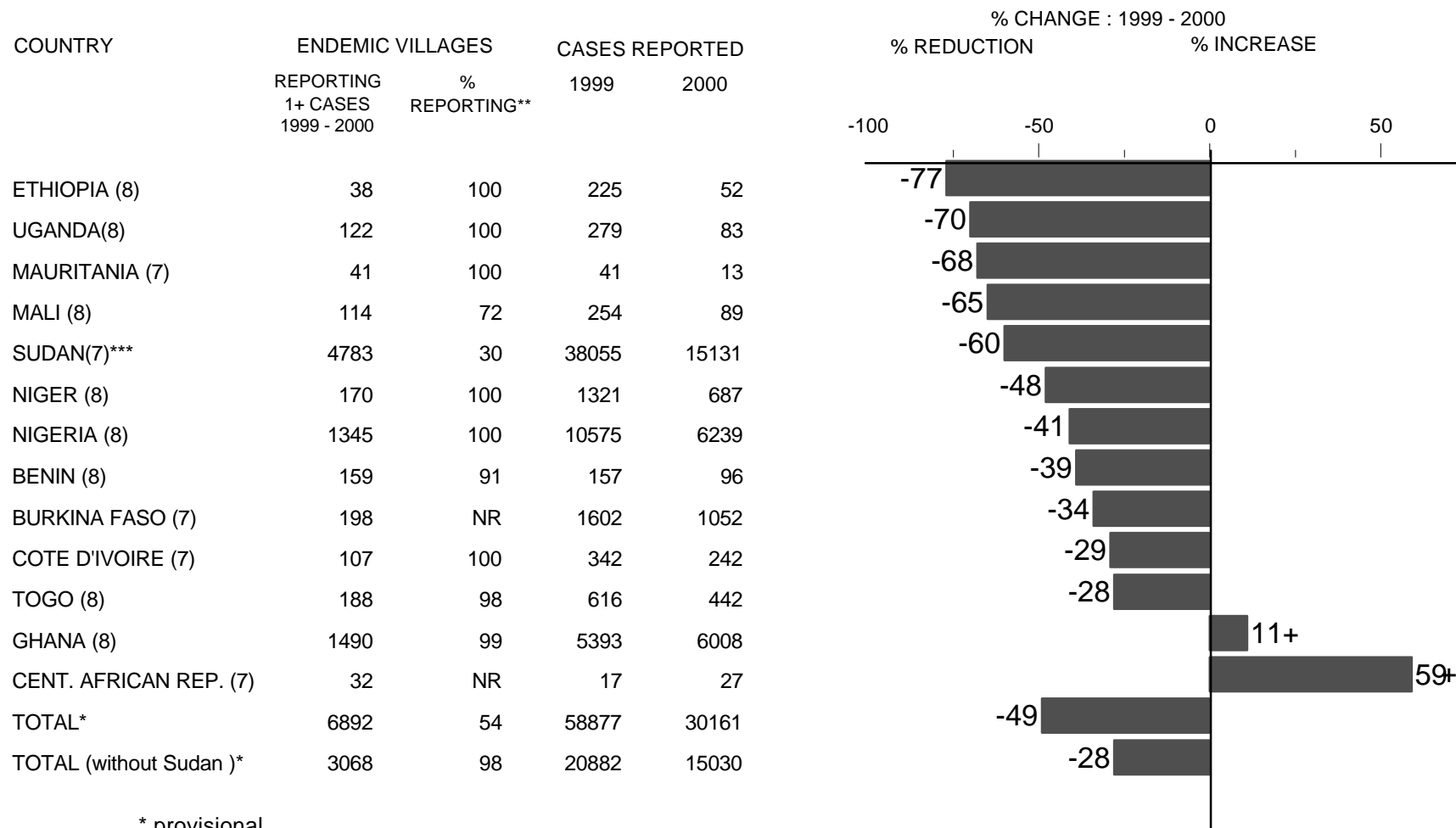
* Provisional

** Cameroon reported 1 case imported from Nigeria in August.

[^] So far, 3 of the 32 cases reported by Central African Republic as Guinea worm disease were confirmed to be onchocerciasis. Allegedly 2 cases were imported from Democratic Republic of Congo in January

Figure 3

Percentage of Endemic Villages Reporting and Percentage Change in Number of Indigenous Cases of Dracunculiasis During 1999 and 2000*, by Country



* provisional

** %endemic villages in 2000 reporting monthly

*** 2,596 (35%) of 7,392 endemic villages are not accessible to the program

Figure 4

DISTRIBUTION BY COUNTRY OF ORIGIN OF 43 CASES OF DRACUNCULIASIS EXPORTED TO OTHER COUNTRIES DURING JANUARY - AUGUST 2000

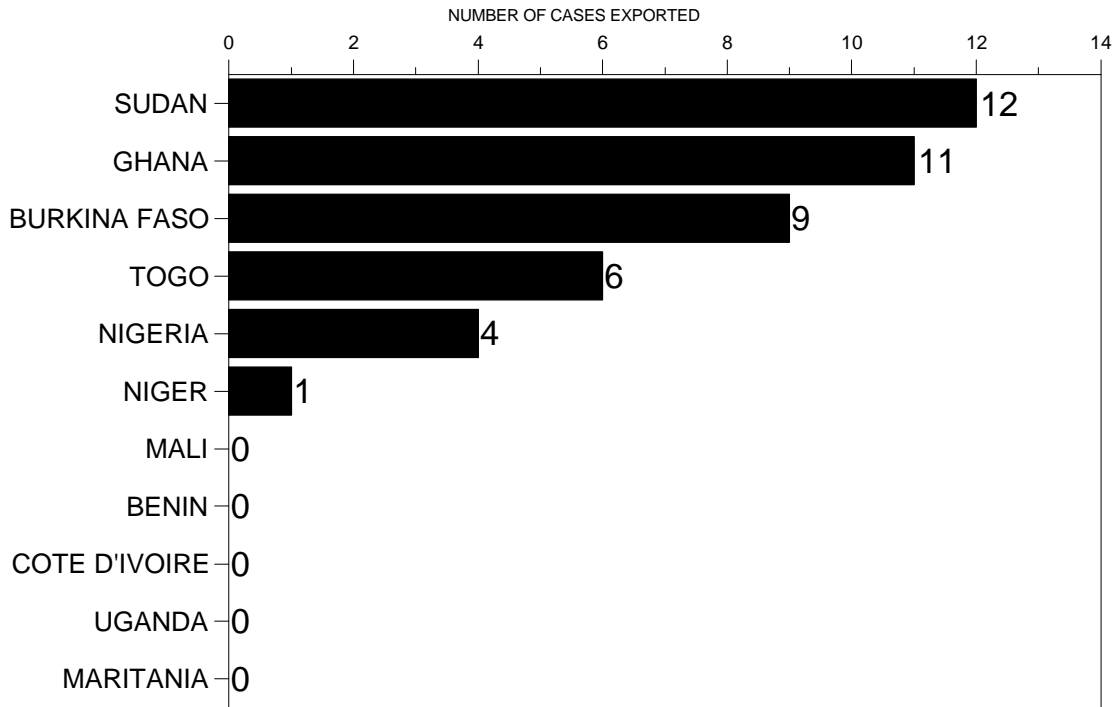
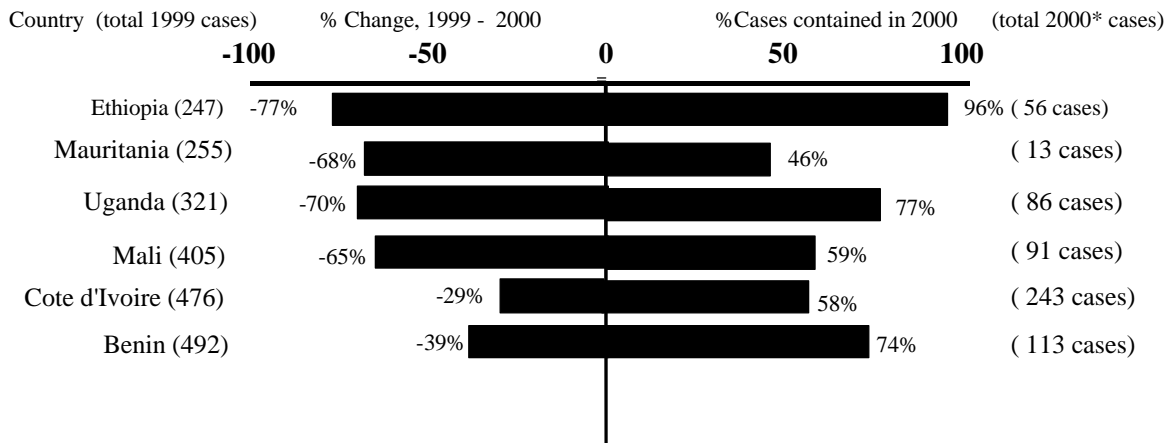


Figure 5

% Reduction in Dracunculiasis Cases from 1999 and % Cases Contained in 2000* for Six Least Endemic Countries



Ideally, both bars should be as close to 100% as possible. This % reduction in cases measures the effectiveness of work in 1999. The % cases contained here measure the quality of work in 2000. All six of these countries should be going all out to stop transmission in 2000. Mali, Mauritania, and Cote d'Ivoire need to contain larger populations of their new cases.

UGANDA RECORDS 70% REDUCTION IN CASES FOR SECOND CONSECUTIVE YEAR



Uganda

Uganda reports a total of 86 cases in 40 villages, including 3 cases imported from Sudan, in January-August 2000. This includes the entire peak transmission season of April-July. This is a reduction of -70% from the 279 indigenous cases reported in 87 villages during the same period of 1999. Sixty-six (77%) of this year's cases were contained; a lower than expected figure due largely to 11 "surprise" cases discovered in a village in August. All endemic villages are reporting monthly, receiving health education, and have cloth filters in 100% of households. Pipe filters are very popular among the Karamajong. All but three endemic villages (in an insecure area of Moroto) are using Abate. UNICEF has supported targeted provision of safe water sources in endemic villages for several years, and will be joined in that by an Italian corporation in Kotido and Moroto Districts. The program doubled the reward for reporting of a case to 20,000 shillings (~US\$13) this year, and pilot tested case isolation in Kotido Hospital (the latter aided by food provided by WFP). Dracunculiasis is included in the minimum health care package of the ministry of health, and the program has cultivated strong support from local political authorities. An innovative Pond Care Takers strategy, and intensive supervision are also credited for the program's effectiveness. Guinea worm workers were described as the backbone of surveillance for polio in endemic areas. Despite the sporadic insecurity that affects all three endemic districts remaining (Kitgum, Moroto, Kotido), prospects for interrupting transmission this year are believed to be good in Kitgum and Kotido. Moroto District is now the key to final success in Uganda.

The only recommendation for the Ugandan program at its Program Review on September 27 was that the program "should try and strengthen coordination with partners along the border with Sudan in an effort to eliminate the spread of Guinea worm disease."

JIMMY AND ROSALYNN CARTER AWARD TO UGANDA'S DR. RWAKIMARI

Dr. John Bosco Rwakimari, the National Program Coordinator (NPC) of Uganda's Guinea Worm Eradication Program, has been awarded the Jimmy and Rosalynn Carter Award for Guinea Worm Eradication for the year 2000. The presentation was made on behalf of President and Mrs. Carter and The Carter Center by Dr. Donald Hopkins following Dr. Rwakimari's presentation at Uganda's Program Review in Nairobi, Kenya on September 27. Dr. Rwakimari became NPC early in 1998, when the country still reported nearly 900 indigenous cases of dracunculiasis, and soon after the phased withdrawal of Global 2000's resident advisor. Despite those challenges, as well as continued sporadic insecurity in the remaining endemic areas, under Dr. Rwakimari's dynamic leadership, Uganda's GWEP reduced dracunculiasis cases by -70% for two consecutive years: from 899 indigenous cases in 1998 to 83 indigenous cases in 2000. His systematic approach to problem solving and supervision in Uganda's program has been combined with his maintenance of effective support by national and local political leaders and external partners, including establishment of the first national commission for dracunculiasis eradication in Africa. The Jimmy and Rosalynn Carter Award was established by President and Mrs. Jimmy Carter for Nigeria and Ghana (then the two highest endemic countries in the world) during the first Program Review for Ghana and Nigeria's GWEPs at The Carter Center in Atlanta in 1991. This is only the second time that a special award has been made to someone outside of those two countries.

IN BRIEF:

Benin: reports ZERO cases for August! This is the second month of zero cases reported by Benin in 2000 (vs no zero case months in 1999 or before) Bravo Benin!

Niger: Tahoua and Tillabery Regions have reported spectacular reductions of -82% (from 223 cases in January – August 1999 to 41 cases in January – August 2000) and -77% (from 565 to 130 cases over the same periods), respectively. Unfortunately, Zinder Region reports no change (518 vs 517 cases) over that period. More important, Zinder also reports the lowest case containment rate (55%) in the country, and did not have enough filters for 100% coverage of its endemic villages this year.

DEFINITION OF CASE CONTAINMENT

A case of Guinea worm disease is contained if all of the following conditions are met:

1. The patient is detected before or within 24 hours of worm emergence; and
2. The patient has not entered any water source since the worm emerged; and
3. The village volunteer has properly managed the case, by cleaning and bandaging until the worm is fully removed, and by giving health education to discourage the patient from contaminating any water source (if two or more emerging worms are present, the case is not contained until the last worm is pulled out); and
4. The case is verified by a supervisor within 7 days of worm emergence (to confirm that the case is Guinea worm, and that it has been properly contained).

RECENT PUBLICATIONS

Nunn, JF, TappE, 2000. Tropical diseases in ancient Egypt. Trans Royal Soc Trop Med & Hyg. 94(2):147-153

GRAHAM CHRISTIE

With great sadness and regret we announce the passing of Mr. Graham Christie, a consultant on behalf of Global 2000/The Carter Center to Ghana's Guinea Worm Eradication Program. Mr. Christie became ill while working in Northern Region's East Gonja District, and died on Sunday, September 17. A retired public health advisor from CDC, Mr. Christie had served two previous consultancies for Global 2000 in 1999 and 2000, both in Brong Ahafo Region's Atebubu District. Although he was new to Africa and to Guinea worm disease in the beginning, he learned quickly, and impressed everyone with his effectiveness, creativity, and enthusiasm, which were fueled by his obvious great enjoyment and satisfaction with what he was doing. He helped field test the acceptability of pipe vs hat filters for personal use by farmers and other itinerant workers, stressed the importance of getting the villagers themselves actively involved in the program, personally arranged for a friend in the United States to develop sketches for non-verbal communication of health messages, and manifest his dedication to Ghana's program and people in many other ways. His observations were cited anonymously more than once in the Guinea Worm Wrap-Up. He died on the eve of Ghana's first national program review to be held in the middle of the endemic zone. Participants stood for a moment of silence in his memory at the opening of the review. He will be sorely missed. We extend our condolences to his wife, sons, and granddaughter. May God bless you, Graham.

*Inclusion of information in the Guinea Worm Wrap-Up does not constitute "publication" of that information.
In memory of BOB KAISER.*

For information about the GW wrap up, contact Dr. Daniel Colley, Acting Director, WHO Collaborating Center for Research, Training, and Eradication of Dracunculiasis, NCID, Centers for Disease Control and Prevention, F-22, 4770 Buford Highway, NE, Atlanta, GA 30341-3724, U.S.A. FAX: (770) 488-4532. The GW Wrap-Up web location has changed to <http://www.cdc.gov/ncidod/dpd/parasites/guineaworm/default.htm>



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