

**Memorandum**

Date July 25, 1986

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

Subject **GUINEAWORM WRAP-UP #13**

To Addressees

INTERNATIONAL ACTIVITIESWORKSHOP ON DRACUNCULIASIS IN AFRICA

The first African Regional Workshop on Dracunculiasis (Guinea Worm Disease) was convened at the Palais des Congres in Niamey, Niger on July 1-3, 1986. Over 50 participants attended, including representatives of 14 of the 19 African countries affected by the disease (Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Ethiopia, Guinea, Mali, Niger, Nigeria, Senegal, Sudan, Togo, Uganda). The objectives of the workshop were to assist member States to:

- review the progress made to date in establishing a reasonable baseline for the necessary surveillance;
- clarify the extent of the disease and its adverse socioeconomic impact;
- review the various intervention measures and strategies available for guineaworm control and their relative cost-effectiveness; and
- identify areas in which specific research is required.

The three-day workshop provided the participants an opportunity to discuss their experiences with the disease, seek and intensify effective measures for its control and elimination, and gain a better understanding of the severity of its impact on the health and productivity of the populations affected by this crippling disease. During the meeting, numerous qualitative and anecdotal examples of the negative socioeconomic effects of dracunculiasis were cited. These included: temporary disability lasting for months or even up to a year in some victims; unusual but not rare permanent disability; sterility; common absenteeism from school; and substantial agricultural losses.

Among the topics discussed at the workshop were the efforts made by Burkina Faso, Côte d'Ivoire, Nigeria, and Togo in applying measures for the control and elimination of dracunculiasis. Also discussed were national plans of varying degrees intended to control or eliminate the disease, such as those that now exist in Benin, Burkina Faso, Côte d'Ivoire, Niger, Nigeria, Togo, and Uganda.

The workshop unanimously endorsed WHA resolution 39.21 (reproduced in the previous issue of Guineaworm Wrap-Up) and expressed hope that the resolution will be reviewed and supported by the African Regional Committee of WHO at its September 1986 meeting. Invitations were also extended to OCCGE (L'Organisation de Coordination et Coopération pour la Lutte Contre les Grandes Endemies), OCEAC (Organisation de Coordination pour la Lutte Contre les Endemies en Afrique Centrale), and WAHC (West African Health Council) to increase their roles in the control and elimination of dracunculiasis.

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WORKSHOP RECOMMENDATIONS

Considering the social and economic impact of dracunculiasis and the necessity to break the epidemiologic cycle of the disease as a way to attain the social objectives of Health For All in the Year 2000 (HFA/2000), workshop participants formulated some recommendations on the steps to be taken for the control and elimination of the disease. These recommendations are directed to the Governments of the countries affected by the disease, the international organizations within the United Nations, and intergovernmental, non-governmental, and donor agencies.



I. Governments affected by dracunculiasis are invited to:

1. Put in place or reinforce a national surveillance system based on obligatory notification of cases of the disease.
2. Separate the reporting of dracunculiasis from other filarial infections.
3. Utilize preferentially active surveillance and passive and sometimes combined methods to gather reliable data to be used to notify cases to bordering countries and interested organizations (principally WHO/AFRO), but above all as a basis for appropriate decisions and actions.
4. If possible, before the end of 1987, develop a national plan of action with precise objectives and a specific operating strategy.
5. Increase the inter- and intra-sectorial cooperation (particularly with water services) to maximize the impact of disease control activities.

6. Utilize mass media to sensitize and mobilize people through publicizing a better understanding of the epidemiologic cycle of the disease and how to apply simple and effective measures that will eliminate the disease.
7. Collaborate closely with neighboring countries to coordinate actions to implement strategies to combat the disease.
8. Demonstrate their national commitment by providing in their national budgets the necessary funds to put their action plans into effect.
9. Organize every two years national meetings on the control and research of dracunculiasis.

II. World Health Organization (WHO):

The Director General and Regional Director (AFRO) of the WHO are invited to:

1. Assist countries in putting together coherent and effective plans of action.
2. Reinforce its cooperation with the countries by placing at their permanent disposition epidemiologic officials to be based at the Subregional Office, Bamako, and eventually at headquarters.
3. Facilitate training health personnel in this subject.
4. Improve "feedback" to the countries on the epidemiologic situation and the development of control programs.
5. Assist in mobilizing extra-budgetary funds to sustain the action plans of member countries.
6. Support operational research on dracunculiasis by specifying it as a part of the budget of the Tropical Disease Research (TDR) Programme.
7. Establish epidemiologic standards.
8. Assure the follow-up of regional workshops on the control and operational research on the disease during the first quarter of 1989.

III. Intergovernmental, Non-Governmental, and Bilateral Organizations:

They are requested to collaborate closely with responsible government officials and WHO representatives in the countries to:

1. Mobilize external resources in supporting the national plans of action.

2. Sustain operational research on dracunculiasis including studies of the impact of the disease on agricultural production and the effectiveness of disease control interventions.

IV. Cooperation with Onchocerciasis Control Programme (OCP):

The participants in the Workshop have appreciated the outstanding success of the OCP. Given that the ecological zones of onchocerciasis and dracunculiasis often overlap, and considering the new policy of OCP in the acceleration of HFA/2000 on the basis of primary health care, the participants strongly invite the OCP Director, the Regional Director of WHO (AFRO), the Director General of WHO, their collaborators, and the governments to rapidly study the possibility of integrated or complementary action in surveillance and vector control.

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NATIONAL ACTIVITIES



BENIN

An OCCGE team is completing a survey of dracunculiasis to be completed later this year. A multidisciplinary team will study the disease in 10 villages of the most affected province beginning in October this year. Their national plan for the control of dracunculiasis includes water supply and health education; they also intend to start using temephos. Over 5% of the population are affected in hyperendemic areas; the prevalence in some villages is 26%. Dracunculiasis is officially reportable in Benin.

CAMEROON

Dracunculiasis occurs as a limited focus in the northern Mandara mountains area. However, other scattered foci were recently discovered in the southern areas, especially near the Nigerian border. Water supply sources in Mandara are completely mapped. Some areas began using some temephos in 1983. Since then, 1,650 cases were reported in 1984 and 691 in 1985. The disease is now officially reportable. A consultant from CDC/USAID began in July 1986 to assist in preparing a national plan for the control and elimination of dracunculiasis.

COTE D'IVOIRE

The national objective of the country is the eradication of dracunculiasis. Its main control measure since 1982 is water supply, backed by health education. Several international agencies are assisting the vast rural water supply effort. Cases of dracunculiasis are sought by active surveillance. The results, so far, provide evidence of a dramatic impact: a reduction of total annual cases from 67,123 in 1966; to 4,971 in 1976; to 592 cases in 1985!

ETHIOPIA

Although the disease is officially reportable in Ethiopia, it is greatly underreported as in most endemic countries. Eleven of 15 provinces reported the disease in recent years, but no reports have been received from the other provinces. In 1985, only 770 cases were reported for the whole country. No control strategy or a national plan of action has as yet been defined, but the intention is to integrate the attack on dracunculiasis with malaria and other efforts in the Vectorborne Disease Control Programme.

INDIA

In the seventh five-year plan (1986-1990), highest priority for provision of safe water supplies is being given to villages affected by guineaworm. About 75% of guineaworm affected villages had already been provided with safe water by the end of 1985, and all endemic states had begun applying temephos in unsafe drinking water sources by the end of the same year. Incidence of dracunculiasis for the entire country declined by 25% between 1984 and 1985, from 40,443 cases down to 30,134 cases (provisional), after having declined 10% between 1983 and 1984. Between 1983 and 1985, the total number of affected villages in India declined from 11,332 to 7,600.

TOGO

Compulsory reporting of guineaworm has been in effect in Togo since November 1983. A total of 1,839 cases were reported in 1984; 1,456 cases in 1985. The sub-prefecture of Bassar is highly endemic; however, there were sharp declines in prevalence between 1980-1985 in the sub-prefectures of Tone, Nyala, Haho, Kloto, and Zio. UNICEF and Peace Corps are assisting the Ministries of Public Health and Education in an eradication programme in parts of the Plateau (began in 1985), Maritime (1986), and Central (1987) regions. Their efforts include health education in affected communities and schools. In 1982 the Division of Epidemiology estimated the true annual incidence of dracunculiasis in Togo at over 440,000 cases. USAID's rural water and sanitation project from August 1980 to September 1987 in the Plateau and Savana regions is using dracunculiasis as an impact indicator. The project by the World Neighbors/Evangelical Church of Togo in Kati village of the Agu sub-prefecture (about 3,000 inhabitants) used health education alone as their strategy from 1981 to mid-1983, and then began the construction of nine wells, to date. The result is a reduction from 928 cases in 1981 to 7 cases in 1985.

UGANDA

Dracunculiasis occurs mainly in the northeast part of the country. The population at risk is: 3.05 million. The disease is officially reportable, with 6,230 cases reported in 1984 and 4,070 cases in 1985. An action program was formulated in 1983, and an interministerial steering committee was established. Their control strategies involve using water supply (with UNICEF assistance), health education, surveillance, and treatment of patients. With population movements, the disease appears to be spreading to other parts of the country.



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