

Date: September 26, 2006

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

Subject: GUINEA WORM WRAP-UP #166

To: Addressees

Detect every case. Contain each worm. Trace the source of every sporadic case.

SUDAN: IMPROVED ACCESS IN 2006 YIELDS INCREASED CASES

Sudan continues to report significantly higher numbers of cases of dracunculiasis in 2006 compared to 2005, when uncertainties following the Comprehensive Peace Agreement that was signed in January 2005 to end the long-standing civil war continued to impede access to war-torn areas and reduced reporting even in some accessible areas of south Sudan. As illustrated in Figure 1, Sudan has reported 15,708 cases in 2,415 villages in January-July 2006, which is already nearly triple the 5,569 cases reported by Sudan in all of 2005. All cases are reported from southern Sudan; Sudan's northern states have not reported any indigenous or imported cases so far this year. The cases reported from Sudan comprise 84% of all cases reported globally during the first seven months of 2006. Sudan's peak transmission season is April to October.

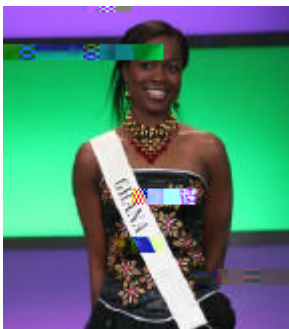
Fully 97% of Sudan's cases in 2006 are reported from only 11 counties (Figure 2). However, the current totals are incomplete, since surveillance is still lagging in Kapoeta East and Awerial Counties, for example, and also in Akobo, Nyriol, and Wuror Counties in northern Jonglei State, where a recent assessment confirmed intense indigenous transmission in past months of 2006, but have not yet established structures for routine reporting. The overall reporting rate for endemic villages, which has been improving steadily in southern Sudan so far this year, is now 73%, compared to 42% in 2005. The endemic areas of Kapoeta and Akobo Counties are doubly important, since they border vulnerable areas of Ethiopia, which has reported two imported cases and one indigenous case in January-August (Figure 3, Table 1).

Aggressive interventions, including the case containment strategy, began in parts of the four main focus areas (Figure 3) early in 2006. Overall intervention indicators reported for endemic villages during January-June (latest update available) were 79% coverage with cloth filters, 56% coverage of the target group for pipe filters, 90% health education coverage, 12% coverage with at least one source of safe drinking water, and 12% coverage with ABATE[®] larvicide. ABATE[®]

[REDACTED]

Center. ABATE was used in only 1.6 % (17) endemic villages in 2005, and none in 2004. In July 2006, UNICEF announced the beginning of a borehole drilling campaign by targeting 54 endemic villages in

GHANA: STATUS OF ACTION PLAN FOR OCTOBER 2006-APRIL 2007



Ghana Guinea Worm Eradication Program
Major Water Project Installation Vs Cases Reported & Percent Change
January 2005 - August 2006*

	Number of Reported Cases of Dracunculiasis: 2005		2006*

Table 1

Number of Cases Contained and Number Reported by Month during 2006*
(Countries arranged in descending order of cases in 2005)

	NUMBER OF CASES CONTAINED / NUMBER OF CASES REPORTED												TOTAL*	CONT.	%
	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER			
SUDAN	0 1 2	0 /	48 /	198 /	2736 /	2479 /	2384 /	/	/	/	/	/	7845 /	15708	50
GHANA	396 /	376 /	266 /	237 /	209 /	177 /	90 /	39 /	/	/	/	/	1790 /	2843	63
MALI	3 /	1 /	0 /	1 /	3 /	14 /	11 /	66 /	/	/	/	/	99 /	108	92
NIGER	2 /	0 /	0 /	1 /	6 /	7 /	11 /	17 /	/	/	/	/	44 /	50	88
NIGERIA	0 /	10 /	0 /	0 /	0 /	0 /	0 /	0 /	/	/	/	/	10 /	15	67
TOGO	1 /	2 /	0 /	0 /	1 /	2 /	0 /	5 /	/	/	/	/	11 /	13	85
BURKINA FASO	0 /	0 /	0 /	0 /	0 /	0 /	1 /	0 /	/	/	/	/	1 /	2	0



NIGER: ALL CASES IN TILLABERI REGION, NO OTHER PROGRESS SO FAR

Niger has reported 50 cases of dracunculiasis in January-August 2006, all of which occurred in Tillaberi Region. Within Tillaberi Region, 44 (88%) cases were reported from Tillaberi District, while 3 of the 6 cases outside of Tillaberi District were imported: one each from Mali, Tera District, and Kollo District. Eighty-eight percent (88%) of the 50 cases reported so far this year were reportedly contained. As Niger enters its peak transmission season (August-November), it has reported 20% more indigenous cases this year than during the same period of 2005 (49 vs. 41). Niger has made little progress over the past four years (2002-2005), reporting 248, 293, 240, and 183 cases, respectively.

One possible explanation for Niger's lack of progress is suggested in Table 2. Nearly half (48%) of all cases detected during January-July 2006 were reported from localities where all cases were reportedly contained in 2005. Some of these apparent failures may have occurred because of migrants moving into a locality, but others may have occurred because one or more known cases were not truly contained, or because not all cases that occurred in the locality were detected in 2005.

Table 2

District	Zone	Locality	Cases 2005	2005 Not Contained	Cases 2006
Kollo	Kollo	Kaba	0	0	3
Tera	Dargol	Bandio	0	0	1
Tillaberi	Ayorou I	Tinizagaz (Mali)	0	0	5
Tillaberi	Ayorou I	Tinimouzou	0	0	1
Tillaberi	Tillaberi	Toubawat	0	0	5
Tillaberi	Tera	Tinfat	0	0	2
Tillaberi	Famale	Bellaye	0	0	2
Tillaberi	Famale	Bibiyargou	0	0	1
Tillaberi	Famale	Innamares	1	0	1
Tillaberi	Famale	Tounkous	1	0	1
Tillaberi	Ayorou I	Timana	2	0	9
Tillaberi	Sarakoira	Loumban	2	0	6
Tillaberi	Ayorou I	Tegazaratene	2	0	3
Tillaberi	Sarakoira	Sarlis	2	0	1
Tera	Dargol	Tchiringui	3	0	1
Tillaberi	Famale	N'bossey	4	0	1
Tera	Dargol	Zano	17	0	1
Tera	Tillaberi	Tillaberi	1	1	1
Tillaberi	Sarakoira	Intakaret	3	1	5
Total Cases			38	2	50

2005 Locality Type	Cases 2006	%
Cases from localities where cases were not contained in 2005	6	12.0%
Cases from localities where cases were 100% contained in 2005	24	48.0%
Cases from "new" localities (0 cases in 2005)	20	40.0%
Total Cases	50	100%

District	Zones	Locality	Cases 2005	2005 Not Contained	Cases 2006	Zone Total Cases 2006	%
Tillaberi	Ayorou I	Tegazaratene	2	0	3	12	50.0%
		Timana	2	0	9		
	Famale	Innamares	1	0	1	3	12.5%
		Tounkous	1	0	1		
		N'bossey	4	0	1		
Sarakoira	Loumban	2	0	6	7	29.2%	
	Sarlis	2	0	1			
Tera	Dargol	Tchiringui	3	0	1	2	8.3%
		Zano	17	0	1		

IN BRIEF

Uganda. On September 20th, the Ministry of Health appointed seven members of the National Certification Committee on Guinea Worm Disease Eradication in Uganda.



Togo. The Government of Togo has appointed a new Minister of Public Health. The minister is Mr. Charles Kondi Agba who replaces Madame Suzanne Aho. The new minister previously served as minister of public health immediately before Madame Aho. With only 13 cases reported through August, Togo is in a tight race with Nigeria (15 cases) to see which country will report the fewest number of cases this year, and which will be the first to stop transmission of dracunculiasis.

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Ethiopia. The Ethiopian Dracunculiasis Eradication Program has reported only one indigenous case so far in 2006. However insecurity reportedly worsened in Gambella Region in August. Formerly endemic South Omo Zone suffered significant flooding in the same month.

A WHO INTERNATIONAL CERTIFICATION TEAM (ICT) EVALUATES PRE-CERTIFICATION ACTIVITIES IN CAMEROON.

A World Health Organization International Certification Team (ICT) visited Cameroon during September 1-28. The ICT was led by Dr. Alhouseini Maiga s0Cs,0298pc -0.12i12 v8 e fT 0 rumo1d Cs,alleghe 236 TCs,0298d.4 C

TRANSITIONS

We are delighted to welcome Dr. Mohamed Abdur Rab back to the Guinea Worm Wars! Dr. Rab, who was recently appointed WHO's Representative to Sudan, was formerly national program coordinator of Pakistan's Guinea Worm Eradication Program. His experience in Pakistan's achievement and certification of eradication will be helpful. Welcome Dr. Rab!

THREE CIRCLES OF CONTAINMENT

Containment of transmission **in the individual**: isolate patients in case containment houses or similar primary health care facilities; monitor case containment rates.

Containment of transmission **in the household**: provide cloth filters and teach villagers how to use them; monitor proportion of endemic villages with such filters in all households.

Containment of transmission **in the community**: provide timely, effective, complete treatments of water sources with ABATE® Larvicide, educate villagers to prevent GW patients from contaminating drinking water, help provide safe sources of drinking water; monitor all three of these.

When implemented well, in combination with active surveillance, any one of these three barriers to transmission of dracunculiasis would completely halt further spread of the disease in an endemic area. The fact that transmission continues, or even increases, despite the claimed deployment of all of these in many areas, is a measure of how imperfectly programs have applied the three barriers to transmission.

DEFINITION OF CASE CONTAINMENT

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

- 1.