DRACUNCULIASIS ERADICATION: THE FINAL INCH

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Abstract. This report summarizes the status of the Dracunculiasis Eradication Program as of early 2005. Nine of the 20 countries that were endemic for this disease when the program began have already interrupted transmission. Asia is free of Guinea worm, and five of the remaining disease-endemic countries reported less than 50 cases each in 2004. Ghana and Sudan each reported 45% of the 16,026 cases in 2004. Except for Sudan, whose reports are delayed, cases in the remaining disease-endemic countries were reduced by 61% during the first quarter of 2005 compared with the same period of 2004. With accelerating momentum towards zero cases in all countries, the recent settlement of Sudan’s north-south civil war, and a new challenge grant from the Bill & Melinda Gates Foundation, the way now seems clear to finish eradicating dracunculiasis by 2009 in Sudan and earlier elsewhere.

“The rule of the final inch . . . The work has been almost completed, the goal almost attained . . . In that moment of fatigue and self-satisfaction it is especially tempting to leave the work without having attained the apex of quality . . . In fact, the rule of the Final Inch consists in this: not to shirk this crucial work. Not to postpone it . . . And not to mind the time spent on it, knowing that one’s purpose lies . . . in the attainment of perfection.”

—Alexander Solzhenitzyn, The First Circle

INTRODUCTION

The global Dracunculiasis Eradication Program (DEP) has accelerated its momentum towards the goal of total eradication since the previous review of the program was published three years ago.1 This paper summarizes the status of the program as of early 2005.

In previous reports, we have described the parasite Dracunculus medinensis, its transmission, prevention, and the strategies and progress of earlier stages of the eradication program.12 The infection (dracunculiasis or guinea worm disease) is transmitted to humans in contaminated drinking water containing copepods (water fleas) that are infected with larvae of the parasite. The larvae are expelled into water by adult worms that emerge through the skin of infected people approximately one year after the people become infected. Emergence of the adult worms is slow, painful, and disabling (though usually not fatal), and therein lies its serious adverse socioeconomic impact on the health, agricultural production, and school attendance of affected populations. Individuals are incapacitated for periods averaging 2–3 months, and more than half of a village’s population may be affected at the same time during the main harvest or planting season. Humans are the only reservoir of infection. Individual infections last only one year, but people do not develop immunity to the parasite. There is no effective treatment or vaccine, but the infection may be prevented by educating villagers about the origin of the disease and about the need to prevent infected persons from entering sources of drinking water, and to always filter their drinking water through a finely woven cloth that removes the copepods; by using Abate® larvicide (temephos; BASF Corporation, Mount Olive, NJ) to kill the copepods and larvae in the open ponds and other stagnant sources of drinking water; and by providing clean drinking water from safe sources such as protected hand dug wells or borehole wells.

This global eradication campaign began at the Centers for Disease Control and Prevention (CDC) in 1980, and was adopted as a sub-goal of the International Drinking Water Supply and Sanitation Decade (1981–1990). Since 1986, the campaign has been led by The Carter Center, in close cooperation with CDC, the United Nations Children’s Fund (UNICEF), and the World Health Organization (WHO). It is implemented by thousands of village volunteers and supervisory health staff in disease-endemic countries, and supported by dozens of donor agencies, governments, foundations, and other institutions.

CURRENT STATUS OF THE CAMPAIGN

By the end of 2004, 9 of the 20 countries that were endemic for dracunculiasis when the campaign began had interrupted transmission of this disease (including all three affected Asian countries), the number of infected persons had been reduced by more than 99% from an estimated 3.5 million persons in 19861 to 16,026 cases in 2004, the number of disease-endemic villages had been reduced from more than 23,000 in 1993 to 3,109 in 2004, and the WHO had officially certified 168 of the world’s 192 countries as free of dracunculiasis. Uganda, which reported more than 126,000 cases of dracunculiasis during its national case search in 1991, reported zero cases for the first time during an entire calendar year in 2004. Nigeria, which reported more than 653,000 cases during its national case search in 1988–1989, reported less than 500 cases, and three other countries (Benin, Ethiopia, and Mauritania) reported only three indigenous cases each (Figure 1 and Table 1).

Ghana and Sudan each reported 45% of all cases in 2004. Ghana’s program appears to have finally ended a decade of disappointing stagnation that followed disruptive ethnic fighting in its most disease-endemic area in 1994, achieving a 44% reduction in cases during the last half of 2004 compared with the same period a year earlier, and a reduction of 59% during the first three months of 2005 compared with the same three months of 2004. Beginning in 2002, more than 6,500 members of Ghana Red Cross Society Mothers Clubs were mobilized to help conduct surveillance for cases and health education in
disease-endemic villages, thus supplementing the manpower of existing village volunteers. Since 2003, the Government of Ghana has allocated more than US $3 million for improved water supplies in disease-endemic villages, as well as more funding for other aspects of its program.

Sudan, which has long been the main obstacle to completing the global campaign, reduced its reported cases by 51% between 2002 and 2003 (from 41,493 cases to 20,299), and by 67% (to 7,266 cases) between 2003 and 2004, despite the civil war. It followed up that epidemiologic achievement with the important political news of a signed Comprehensive Peace Agreement to formally end the 21-year-old civil war early in 2005, thus opening the way to access the remaining disease-endemic areas of Sudan. Sudan ended indigenous transmission of dracunculiasis in its northern states in 2002, so all remaining disease-endemic areas are in the war-torn south. The Sudan Guinea Worm Eradication Program distributed more than seven million pipe filters for personal protection of inhabitants traveling or displaced from home in 2001, held more than 100,000 health education sessions annually in 2002, 2003, and 2004, and distributed a cumulative total of more than 3.5 million household cloth filters in 2001–2004, covering approximately 89% of all households in accessible villages. The extraordinary effort in which The Carter Center joined an initiative of Health and Development International, and Norwegian industry and government, to manufacture and distribute more than nine million pipe filters in Sudan in 2001–2002, was followed by another exceptional effort in which Norwegian medical students raised more than $200,000 in their Humanitarian Action Campaign in 2003 for providing enough first aid kits for containment of dracunculiasis cases throughout Sudan for more than a year.

The main problem area remaining in west Africa outside of Ghana comprises seven districts in the contiguous tri-border area of Burkina Faso (Djibo, Gorom Gorom), Mali (Ansongo, Gourma Rharous, Gao), and Niger (Tera, Tillaberi), where nomadic Black Tuaregs are the group at highest risk. The affected areas of Mali and Niger contain most of the remaining cases in this area (328 and 179, respectively, of 530 total cases reported from the tri-border area in 2004). Insecurity delayed access by Mali and Niger’s programs to this area for two or three years. In 2003 and 2004, Mali improved supervision of village volunteers, increased distribution of cloth and pipe filters, and conducted its first “Worm Weeks” of intensive health education and mobilization of inhabitants in the highest disease-endemic zones. A special initiative to provide safe water sources to several high-priority, disease-endemic villages in the relevant areas of Mali and Niger (also Togo) is being implemented in 2005. After a dramatic public speech in which he declared his “profound disappointment” with the progress of his country’s Guinea Worm Eradication Program, the president of Mali replaced that program’s national manager in February 2005.

Nigeria, which with Sudan and Ghana was a long-time member of the “big three” disease-endemic countries, continued to ratchet up its interventions as it reduced cases and expanded the guinea worm-free areas of the country. Between 2001 and 2004, for example, the proportion of disease-endemic Nigerian villages that had at least one source of safe drinking water increased from 51% to 71%, the proportion of
Table 1

Dracunculiasis eradication campaign: status of interventions during 2004

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of reported cases (indigenous) in 2004</th>
<th>Number of reported cases (imported) in 2004</th>
<th>% of all cases reported that were contained during 2004</th>
<th>No. of villages/localities with interventions applied in 2003 and 2004</th>
<th>% of cases where interventions were applied in 2003-2004</th>
<th>No. reporting one or more cases</th>
<th>No. reporting only imported cases</th>
<th>No. reporting indigenous cases</th>
<th>% of cases reporting monthly</th>
<th>% of all households</th>
<th>% using Abate†</th>
<th>% more than 100 pounds</th>
<th>% provided health education†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>7,268</td>
<td>7</td>
<td>66%</td>
<td>1,478</td>
<td>-12%</td>
<td>1,017</td>
<td>344</td>
<td>673</td>
<td>100</td>
<td>67</td>
<td>23</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>7,266</td>
<td>0</td>
<td>12%</td>
<td>3,046</td>
<td>-74%</td>
<td>2,145</td>
<td>8</td>
<td>2,137</td>
<td>100</td>
<td>100</td>
<td>64</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>495</td>
<td>0</td>
<td>85%</td>
<td>319</td>
<td>-66%</td>
<td>106</td>
<td>24</td>
<td>85</td>
<td>100</td>
<td>100</td>
<td>73</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>Mali</td>
<td>354</td>
<td>3</td>
<td>66%</td>
<td>237</td>
<td>-57%</td>
<td>121</td>
<td>19</td>
<td>102</td>
<td>100</td>
<td>100</td>
<td>70</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Niger</td>
<td>233</td>
<td>7</td>
<td>73%</td>
<td>128</td>
<td>-18%</td>
<td>75</td>
<td>30</td>
<td>45</td>
<td>100</td>
<td>100</td>
<td>49</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Togo</td>
<td>232</td>
<td>46</td>
<td>72%</td>
<td>206</td>
<td>-58%</td>
<td>100</td>
<td>54</td>
<td>46</td>
<td>100</td>
<td>100</td>
<td>96</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>35</td>
<td>25</td>
<td>65%</td>
<td>89</td>
<td>-70%</td>
<td>33</td>
<td>23</td>
<td>10</td>
<td>100</td>
<td>100</td>
<td>47</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Côte d'Ivoire</td>
<td>20</td>
<td>1</td>
<td>20%</td>
<td>17</td>
<td>-50%</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>100</td>
<td>100</td>
<td>74</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Benin</td>
<td>3</td>
<td>1</td>
<td>100%</td>
<td>13</td>
<td>-90%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>3</td>
<td>14</td>
<td>88%</td>
<td>10</td>
<td>-88%</td>
<td>13</td>
<td>10</td>
<td>3</td>
<td>100</td>
<td>100</td>
<td>50</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mauritania</td>
<td>3</td>
<td>0</td>
<td>100%</td>
<td>11</td>
<td>-77%</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>100</td>
<td>100</td>
<td>91</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>0</td>
<td>1</td>
<td>100%</td>
<td>10</td>
<td>-100%</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15,912</td>
<td>107</td>
<td>42%</td>
<td>5,564</td>
<td>-54%</td>
<td>3,625</td>
<td>516</td>
<td>3,109</td>
<td>81</td>
<td>71</td>
<td>17</td>
<td>36</td>
<td>91</td>
</tr>
</tbody>
</table>

*Kenya (a non-endemic country) reported seven cases of dracunculiasis imported from Sudan.
† The base of the percentage is the number of villages/localities where the program applied interventions during 2003 and 2004.

...
cercarialis Eradication Programs of Sudan, Ghana, and Nigeria that was hosted by The Carter Center in Atlanta in September 2003 and attended by Dr. Jong-Wook Lee, the director general of WHO, General Gowon of Nigeria, and Kul Gautam, the deputy executive director of UNICEF, as well as by President Carter and ministerial level representatives from Ghana, the Government of Sudan, and the Sudan People’s Liberation Movement. President Carter, Dr. Lee of WHO, and Mr. Gautam of UNICEF made a joint visit to Ghana in February 2004, visited disease-endemic villages, and met with the President of Ghana to discuss Ghana’s Dracunculiasis Eradication Program. In May 2004, President Carter visited the World Health Assembly and met with the ministers of health or their representatives from all of the remaining disease-endemic countries, in the presence of high-ranking officials from WHO and UNICEF, and the chairman of the International Commission for the Certification of Dracunculiasis Eradication. The ministers signed a “Geneva Declaration” in which they pledged to finish eradicating dracunculiasis by 2009 (for Sudan) or before (for all other disease-endemic countries). The entire World Health Assembly then adopted a formal resolution (WHA 57.9) that endorsed the same goal and target date. Meanwhile, in 2004, the prime minister of Togo and the ministers of health of Benin, Burkina Faso, Niger, and Togo visited disease-endemic villages in their respective countries.

The Carter Center provided some assistance to the Division of Parasitic Diseases at CDC in its recently successful effort to develop a DNA probe to reliably distinguish between *D. medinensis* of humans and *D. insignis* species, which affect other animals. A recent report describes this new tool, which is badly needed in the final stages of the eradication campaign.

**DISCUSSION**

The accelerating reduction in cases of dracunculiasis in virtually all of the remaining disease-endemic areas over the past three years is a welcome and timely development since momentum towards dracunculiasis eradication resumed in 2000 (Figures 4–6). The recent and long-awaited political agreement to bring peace to southern Sudan removes at last the single most important obstacle to completing this eradication campaign. We still believe that 4–5 years of peace will be required before Sudan reaches zero cases, but with the invaluable head start and experience Sudan’s Guinea Worm Eradication Program gained since the four-month “Guinea Worm Cease-Fire” that President Carter negotiated in 1995, Sudan is now well on its way. A new challenge in post-war southern Sudan will be to ensure that this eradication effort, and that for polio, are given priority by all concerned because of their necessarily singular natures as eradication programs. Although it is only one of many diseases, and usually is not fatal, eradicating dracunculiasis can be a powerful, broad-
based “engine for development” in post-war southern Sudan, by improving agricultural production and school attendance; developing village-based surveillance; building local capacity by screening and training village-based health workers; fostering the organization and functioning of village-based development committees; providing on-the-job managerial, planning, supervisory, and monitoring experience; promoting extension of clean drinking water sources to the most deprived villages; and providing a tangible, highly visible “Peace Dividend”, in addition to eliminating dracunculiasis from its most important remaining stronghold.

Analysis of Sudan’s impressive reduction in cases of dracunculiasis over the past two years shows that the dramatic decrease is the net result of several factors, although overall reporting rates are comparable for 2002, 2003, and 2004 (72–77% of disease-endemic villages reporting). They include a complex mixture of over-reporting, under-reporting, formerly reporting areas becoming inaccessible, new reporting from areas being accessed for the first time (especially after the cease-fire that began in October 2002 as part of the ultimately successful political negotiations), as well as decidedly effective interventions by the program during those years, as outlined earlier. It is impossible to ascertain the precise contributions of each of these factors to the net result, but any doubt that the recent reductions in Sudan’s cases are real and substantial is dispelled by the observation that the number of villages reporting zero cases of dracunculiasis among a cohort of 3,279 disease-endemic villages reporting from January 2001 through August 2004 has steadily increased from 1,443 in 2001 to 2,957 during January–August 2004, whereas the number of disease-endemic villages reporting 1–4 cases and villages reporting ≥ 5 cases has decreased annually since 2001. The number of villages reporting ≥ 5 cases in this cohort decreased from 1,288 in 2001 to 173 during January–August 2004, a reduction of 87%. Moreover, the number of cases exported from southern Sudan to northern Sudanese states and neighboring countries also decreased by a remarkable 51%, from 69 to 34, between 2003 and 2004.

The importance of mobilizing political leaders and strong political will has been illustrated repeatedly throughout this campaign. As described in the previous review,1 involvement of former Nigerian head of state General Yakubu Gowon, and former head of state, now President Amadou Toumani Toure of Mali, with their sustained, passionate advocacy throughout Nigeria and the francophone disease-endemic countries, are major factors in the recent successes of those programs. In Uganda, which is another former member of the highest disease-endemic country club, the Dracunculiasis Eradication Program also benefited from consistent support by the country’s political and public health leaders. As also mentioned in the previous review, these advantages were greatly complemented by the generous funding provided by a grant from the Bill & Melinda Gates Foundation in 2000, and both the political and financial advantages have come to fuller realization during the most recent three years of the program that are the subject of this review. Continuity of financial
support was assured by another generous challenge grant from the Bill & Melinda Gates Foundation in March 2005. Insecurity continues to hinder operations in some important areas such as Akobo District in Ethiopia, and Côte d’Ivoire, for example, even though the main impediment of Sudan’s civil war is now over (significant insecurity still remains in parts of southern Sudan). Complacency and apathy are still important concerns in some quarters and among some health personnel, but this is most often manifest now by lack of urgency in responding to suspected cases of dracunculiasis, and by inadequacy of surveillance for dracunculiasis in formerly disease-endemic areas or areas not disease endemic in most African countries concerned, including many that have reduced or apparently eliminated the disease at great cost. One final factor that has become more evident in recent years is the existence of neglected marginalized populations such as the Black Tuaregs of Mali and Niger, and the Konkomba ethnic group in Ghana and Togo, who dominate some of the pockets of disease remaining, but who were previously overlooked and/or their significance unrecognized, by the respective Dracunculiasis Eradication Programs.

With the increasing momentum summarized above, the Peace Agreement in Sudan, and the new challenge grant from the Bill & Melinda Gates Foundation, the way now seems clear to meet the revised target date for completing the eradication of dracunculiasis. And not a year too soon. We are now in the realm of The Final Inch.

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