Research/Recherche

Strategies for dracunculiasis eradication

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In 1991 the Forty-fourth World Health Assembly declared the goal of eradicating dracunculiasis (guinea worm disease) by the end of 1995. This article summarizes the recommended strategies for surveillance and interventions in national dracunculiasis eradication programmes. It is based on personal experience with dracunculiasis programmes in Ghana, Nigeria and Pakistan. Three phases are described: estab-

tions; and case containment. The relevance of dracunculiasis eradication activities to strengthening of primary health care in the three countries is discussed briefly. Similar strategies would help eradicate this disease in the remaining endemic countries.

own lives and other benefits resulting from the elimination of this disease. Priority should be given to those endemic villages or areas that manifest the

[illegible]

most willingness to help themselves.

necessary to develop plans of action for each endemic state or region. In most instances, it will be advisable for the programme to also establish or

[illegible]

make use of an existing intersectoral committee or

[illegible]

The fundamental difference between an eradication programme and a control programme is critical to understanding the need for some of the strategies recommended in this paper. While a control programme may aim to reduce the incidence of a disease until the disease is no longer a public

national task force in order to facilitate mobilization and coordination of the diverse governmental and other agencies whose contributions are needed, such as the government ministries concerned with health, water supplies, and information.

National secretariats in support of the national

on village-based workers, one or more in each known endemic village, to maintain village-based case registers and provide monthly reports of cases as they occur. The advantages of the latter system are that it provides more accurate surveillance,

The third Nigerian survey in 1990–91 covered the known endemic local government areas only, and included intervention measures, after which that programme began converting to village-based monthly reporting, using primary health care workers where

Fig. 1. **Schema for a dracunculiasis eradication programme.**

demand for cloth filters by providing timely supplies

liasis are also only a small fraction of all such

The programme in Pakistan has from its incep-

tion relied exclusively on health education, use of

cloth filters, and

Table 1: Key activities of dracunculiasis eradication programmes

in Pakistan from the beginning of 1990 (*6*); orientation to the new strategy began in February, two months before the onset of the transmission season. Key elements of this strategy, compared to the previous strategy in Pakistan, were the use of new case investigation forms for VIs and sector supervisors, which ensured that all the appropriate questions were asked and all the prescribed control measures were carried out, whenever a case occurred, and use of revised performance criteria to encourage and monitor the promptness with which these measures

it is expected that Pakistan will probably have no more indigenous cases of dracunculiasis.

WHO will expect recently endemic countries to maintain adequate surveillance for at least three years following the last indigenous case, so that they may qualify for certification of elimination. Thus surveillance is also the key to documenting the eradication process.

Discussion

45 000 cases in 1983, had reduced its annual cases by

country, while the UNICEF mission to Nigeria and the

lutte contre les copépodes hôtes intermédiaires au

vées à des situations particulières, soigneusement

References

for Disease Eradication. *Morbidity and mortality*