Public Health Services
Agency for Toxic Substances
DEPARTMENT OF HEALTH & HUMAN SERVICES and Disease Registry

Date June 15, 1998

From WHO Collaborating Center
Research, Training and Eradication of Dracunculiasis

Subject GUINEA WORM WRAP-UP #79

To Addresses

Detect Every Case, Contain Every Worm!

NEEDED: BETTER SUPERVISION OF VILLAGE-BASED HEALTH WORKERS

Over the past several years, evaluations and consultations to national Guinea Worm Eradication Programs have consistently highlighted the importance and frequent inadequacy of supervision of village-based health workers and/or village volunteers in almost every program which has been reviewed. Programs must correct this crucial weakness in order to stop transmission in the remaining endemic areas. If village-based workers don=t do their jobs properly, programs cannot succeed. It is a major responsibility of staff at national and district levels of Guinea Worm Eradication Programs to ensure that village-based health workers get the support they need in order to perform their duties correctly.

The three essential duties of village-level workers are:

- to actively search for cases of dracunculiasis in the areas for which they are responsible, record information about each patient in a village case register, and report any cases detected monthly. The standard of performance for this task is that every case should be detected within 24 hours of emergence of the worm;

- to apply appropriate containment measures immediately after discovery of each case; and

- to help mobilize and educate their communities to report cases immediately, prevent entry of patients into drinking sources, always filter unsafe drinking water, seek provision of safe sources of drinking water, and cooperate with the use of Abate.

Regular, effective supervision of village-based workers (VBW) is the key to helping them perform their essential tasks well. Supervisors should visit each village-based worker at least monthly (twice a month if possible), and use a checklist to make sure that all important activities are reviewed. The quality and quantity of supervisory visits are both important. If conducted properly, such regular supportive visits will serve as inservice training, thereby helping and encouraging each VBW to improve his or her performance until the desired level is attained, and then to maintain that level of performance. In addition to providing a checklist for supervisory visits, programs should ensure that all supervisors at each level have the support they need to do their jobs. For example, suitable transportation (motorbikes, bicycles, fuel, maintenance, etc.) when needed, sufficient compensation so that field supervisors are paid for extra expenses when they are away from the office, and adequate supplies (replenishments for first aid kits, forms, filters, any appropriate incentives or rewards, if applicable) to leave with the VBWs. Programs should also establish clear priorities for the highest endemic geographic areas on which to concentrate scarce time, fuel, and other resources for assuring regular supervision.

NUMBER OF CASES CONTAINED AND NUMBER REPORTED BY MONTH DURING 1998*
(COUNTRIES ARRANGED IN DESCENDING ORDER OF CASES IN 1997)

COUNTRY	NUMBER OF CASES CONTAINED / NUMBER OF CASES REPORTED													
	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL*	% CONT.
SUDAN	379 / 1194	459 /												

The process of a supervisory visit to an endemic village should routinely

a) begin with a courtesy call and interview of the village chief,

b) proceed to a review of records and discussion of activities with the VBW,

c) include spot checks and interviews of a few individuals and households in the village, and at one or more ponds, if appropriate, and

d) review and discuss findings with the VBW and the chief, compliment strong points, make suggestions for correcting any deficiencies, and replenish supplies, if necessary. Supervisors of the supervisors should check whether these steps are routinely conducted in villages visited by the first line supervisors. The program in southeastern Nigeria has found that other members of a village Task Force for Guinea Worm Eradication can help provide oversight for their VBW.

Review of supervisory checklists developed in Ghana, Niger, and Uganda suggests the following elements for such a list:

General:

- Does the village chief know who the VBW is, and what he or she is supposed to do? Does he understand the life cycle of Guinea worm and interventions against it? Does the chief believe the VBW is performing his/her duties satisfactorily?

- Are the geographic area, population, households to be covered of manageable size for one VBW?

- Are the VBW=s other duties and/or volunteer status such that he or she can perform Guinea worm duties satisfactorily?

Active surveillance:

- Does the VBW have transportation (if needed)?

- Is the VBW=s notebook, case register, or other form filled out correctly? Verify 3 or 4 entries with the patients themselves. What is the average time between emergence of the worm and when it was reported to the VBW for cases reported over the past month?

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Community mobilization/health education:

- Does the VBW understand the life cycle of Guinea worm and is the VBW able to teach this to others? Speak with members of a few households and ask how dracunculiasis is contracted and how it is prevented.

- Were any public talks or other Guinea worm activities conducted in this community in the past month? How and when were messages about Guinea worm disease conveyed to these villagers most recently (posters, songs, talks, schools, religious or political leaders, etc.)?

- If villagers are using pond water for drinking, observe which ponds are being used, determine if they were treated with Abate, and try to observe if villagers filter their water when they collect it.

- Have villagers dug a hand dug well? Do they cooperate with the use of Abate (if applicable)? Are all appropriate control measures in place in this village? If not, why not?

In summary, the basics of good supervision require that supervisors:

Take the time to do a proper visit (plan ahead and limit the number of localities per day). [Niger : 3-4 localities per day]

Look at the VBW=s work (don=t be satisfied with verbal responses only; the supervisor should verify with his or her own eyes whether cases are contained, filters distributed and used properly, etc.)

Listen carefully to the chief, VBW, and villagers

Emphasize the basics of prevention, case containment, and surveillance (review case definitions, key prevention messages, etc.)

GHANA: NORTHERN REGION REDUCES CASES BY 73% IN APRIL!

Ghana=s Northern Region reported 191 cases of dracunculiasis in April 1998, compared to 720 cases in April 1997 -- a reduction of 73%! Northern Region, still the most endemic region in the country, reported reductions of 50 %, 61%, and 60% in January, February, and March 1998, respectively. Five of the country=s 10 regions (Ashanti, Eastern, Greater Accra, Upper East, Western) reported zero indigenous cases in April.

UGANDA: KOTIDO DISTRICT REDUCES CASES BY 72% IN May!

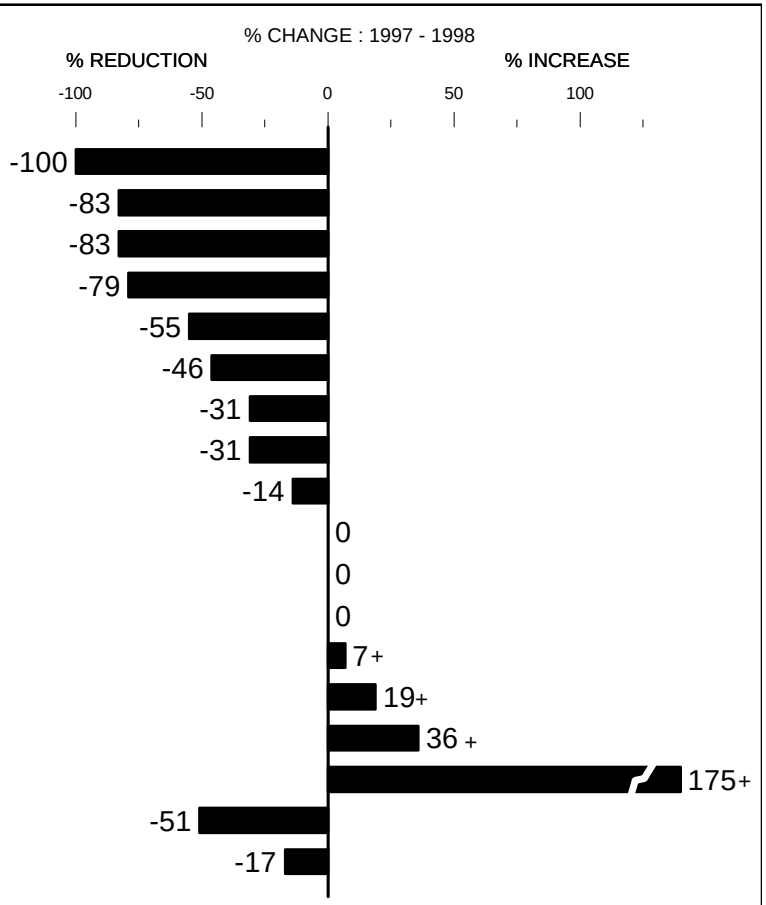
Uganda=s Kotido District reported 153 cases of dracunculiasis in May 1998, compared to 489 cases in May 1997 -- a reduction of 69%! The 349 fewer cases this year for one

eradication efforts in Kotido and Moroto Districts: AObservations in the villages strongly suggest that, although the system to fight Guinea worm disease, i.e., village volunteers, sub-county supervisors, medical kits, monthly meetings, filters, Abate application, has been put in place, what is lacking on all levels is the attitude that >Guinea worm transmission should be stopped as of today= and that >fulfilling my task is a vital and indispensable contribution to achieving that aim=@.

Uganda plans to hold a National Guinea Worm Eradication Day in Moroto District on July 21st. The main

PERCENTAGE OF ENDEMIC VILLAGES REPORTING AND PERCENTAGE CHANGE IN NUMBER OF CASES OF DRACUNCULIASIS DURING 1997 AND 1998 *, BY COUNTRY

COUNTRY	ENDEMIC VILLAGES: 1998 NUMBER	% REPORTING	CASES REPORTED 1997	1998	% CHANGE : 1997 - 1998
MAURITANIA (3)	83	84	4	0	-100
SUDAN (3)	5749	16	13785	2341	-83
CHAD (5)	10	100	12	2	-83
BURKINA FASO (5)	211	NR	620	129	-79
MALI (4)	259	75	80	36	-55
GHANA (4)	951	100	5445	2922	-46
BENIN (4)	236	94	251	173	-31
UGANDA (5)	253	99	842	578	-31
ETHIOPIA (5)	52	100	169	146	-14
CAMEROON (5)	1	100	0	0	0
SENEGAL (5)	1	100	0	0	0
YEMEN (3)	5	100	0	0	0
COTE D'IVOIRE (4)	116	100	718	768	7+
NIGERIA (4)	1307	99	4671	5545	19+
TOGO (4)	204	NR	299	408	36 +
NIGER (5)	396	99	84	231	175+
TOTAL*	9877	52	26980	13280	-51
TOTAL (without Sudan)*	4128	96	13195	10939	-17



* Provisional: includes 1 case imported into Cameroon from Nigeria in May

(3) Denotes number of months for which reports were received, e.g., Jan. - Mar., 1998

NR Not Reported

containment, and improve the supply of filters and Abate.

Drilling rigs have been deployed to Borwashe and Cha-Chile villages of Bama LGA, Borno State. Cha-Chile accounted for 11 of the 18 cases of dracunculiasis exported from Nigeria to Cameroon in 1997. The provision of safe sources of drinking water in Borwashe and Cha-Chile villages is a joint effort of the Borno State and Bama LGA authorities, residents of Borwashe and Cha-Chile villages, NIGEP/Global 2000, UNICEF, and WHO to eliminate transmission of dracunculiasis from these villages this year.

The NE Zone has began to implement a strategy to educate community leaders and members about the need for them to participate more effectively with efforts to halt transmission of dracunculiasis in their communities. LGA authorities and NIGEP are to educate District Heads (i.e., paramount chiefs) about the need to have all village chiefs in their jurisdiction understand why it is necessary to prohibit individuals with emerging Guinea worms from entering any source of drinking water, and the practice of Ashekia@ (i.e., the use of red hot iron to treat persons with abscesses caused by Guinea worms). The collaboration will require that District Heads enforce the rules, and NIGEP to provide health education, cloth filters, medical supplies with which to treat persons with Guinea worm lesions, and Abate to treat contaminated ponds.

The **A. G. Leventis Foundation** has announced a donation of 15 motorcycles to The Carter Center for the Guinea Worm Eradication Program in Nigeria.

Dracunculiasis Eradication Campaign
Reported Importations of Cases of Dracunculiasis: 1998

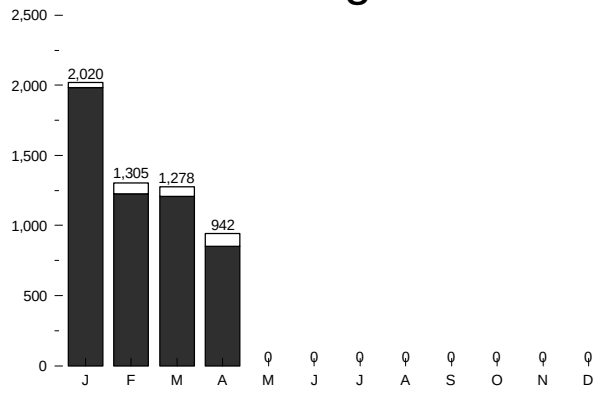
From	To	Cases			
		Month	Number	Contained	Notified*
Burkina Faso	Niger	January	1	1	1
Ghana	Benin	January	4	4	4
Libya??	Ghana	January	1	1	1
Nigeria	Cameroon	May	1	1	1
	Benin	January	1	1	?
		April	1	1	?
	Niger	February	2	2	?
		April	1	1	1
		May	1	?	?
Sudan	Uganda	March	5	5	5
		April	13	13	13
		May	37	12	37
Total			68	42	63

* Notified to country of origin through WHO.

NUMBER OF CASES OF DRACUNCULIASIS REPORTED: 1998

(Number of cases reported that were contained are shaded black)

Nigeria



Côte d'Ivoire

Sudan

Togo

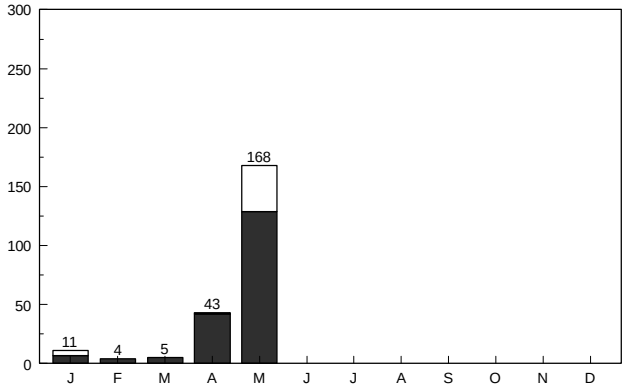
Ghana

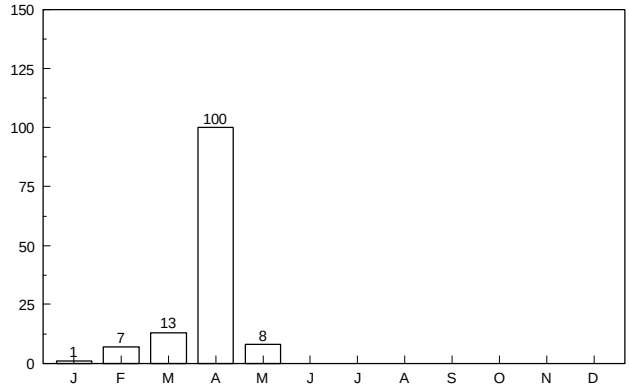
Benin

NUMBER OF CASES OF DRACUNCULIASIS REPORTED: 1998

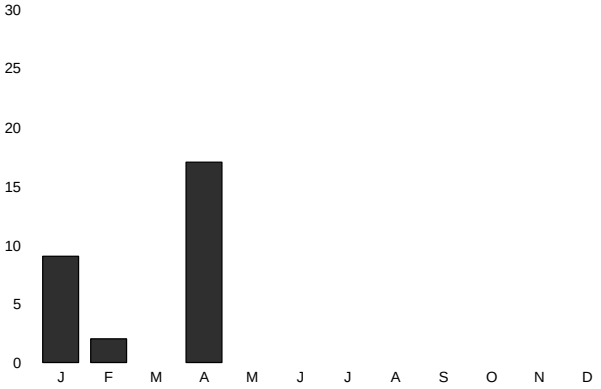
(Number of cases reported that were contained are shaded black)

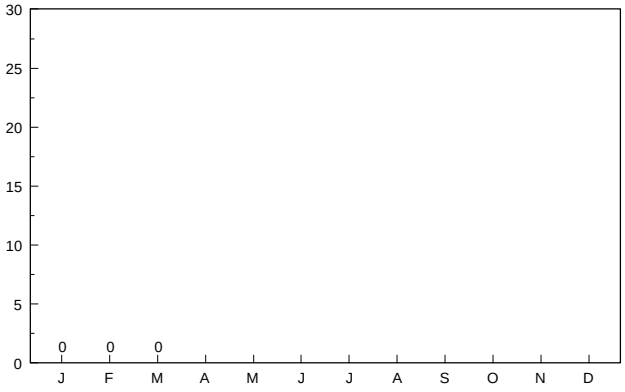
Burkina Faso





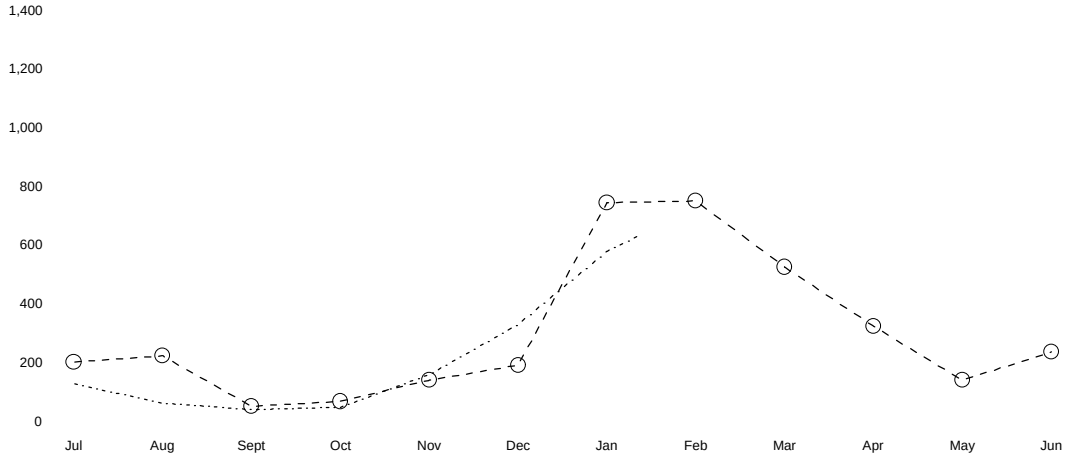
Mauritania





Uganda

Ethiopia


1,400
1,200
1,000
800
600
400
200
0
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun

UNICEF RECEIVES $2.8 MILLION FOR GUINEA WORM FROM UN FOUNDATION

Dr. Jane Zucker has provided a copy of the press release describing a grant provided to UNICEF by the new United Nations Foundation that was established last year by CNN=s Ted Turner. The Foundation announced in May a grant totaling US$2.8 million to be provided to UNICEF over three years for Guinea worm eradication in Africa. This was the largest of six grants made by the Foundation to UNICEF. The first year of funding ($964,000) from the grant will be allocated as follows (in addition to $25,000 for regional coordinations):

Ghana: $250,000 for Savelugu water supply
Burkina Faso: $154,000 for disease control, $ 170,000 for water supply
Mauritania: $290,000 for disease control, $75,000 for water supply

IN BRIEF:

Ethiopia has received $39,600 from the World Health Organization for Guinea worm activities in 1998.

Health authorities in Libya have informed the World Health Organization that no evidence of dracunculiasis was found during a visit to Sebha by the staff of the national ministry on March 22nd-25th. In January 1998, Ghana reported having investigated a case of dracunculiasis in a man who reported having lived in ASabaha@, Libya from September 1996 through August 1997 (Guinea Worm Wrap-Up #76).

RECENT PUBLICATIONS

Velema JP, 1997. A time to eradicate and a time to control. [Letter], Trop Med & Intl Hlth, 2:1107.

Watts S, 1998. An ancient scourge: the end of dracunculiasis in Egypt. Soc. Sci. Med., 46:811-819.

Watts S, 1998. Perceptions and priorities in disease eradication: dracunculiasis eradication in Africa. Soc. Sci. Med., 46:799-810.

For information about the GW Wrap-Up, contact Trenton K. Ruebush, MD, 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.

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