ERADICATION OF DRACUNCULIASIS

A HANDBOOK

FOR INTERNATIONAL CERTIFICATION TEAMS

World Health Organization

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1. INTRODUCTION

The successful eradication of smallpox in 1979 led public health experts to identify other potential diseases that could be eliminated or eradicated. The Thirty-fourth World Health Assembly in 1981 noted in resolution WHA34.25 that the elimination of dracunculiasis (guinea-worm disease) as a public health problem and the prevalence of the disease could serve as measurable indicators of progress for the Safe Drinking Water Supply and Sanitation Decade (1981–1991). The Thirty-ninth World Health Assembly in 1986 endorsed in resolution WHA39.21 a combined strategy of provision of safe drinking-water sources, active surveillance, health education, vector control and personal prophylaxis. The resolution called on affected Member States to establish plans of action for eliminating dracunculiasis, to give high priority to providing safe sources of drinking-water in endemic areas and to intensify national surveillance of the disease. The Forty-fourth World Health Assembly in 1991 further resolved to eradicate dracunculiasis and urged WHO to initiate country-by-country certification of elimination. In response, the WHO Director-General set up the International Commission for the Certification of Dracunculiasis Eradication (ICCDE) in 1995; its first meeting was convened in 1996. The ICCDE drew up the certification criteria and procedures for assessing whether the criteria were met by countries requesting certification. For formerly endemic countries and those countries requiring verification, the ICCDE commissions an International Certification Team (ICT) to visit the country and conduct an in-depth review by audit of surveillance reports and field visits. WHO issued guidelines for the ICT to assist the teams and ensure a common standard of assessment[1]. By the end of 2013, the ICCDE had met nine times and certified 197 countries, areas and territories of 185 WHO Member States. The ICTs have made assessment visits to 20 countries (Annex 1). Based on their experience accrued over these years, this handbook is issued as an update to the earlier guidelines and is expected to assist future ICTs in ensuring consistency in the assessment of the remaining countries.

2. CERTIFICATION CRITERIA

In countries known to have been endemic for the disease, the certification of dracunculiasis-free status will depend on the lapse of time since the last known indigenous case occurred and the intensity and effectiveness of surveillance procedures. Surveillance is a continuous process which should start during a national eradication programme and be continued for at least 3 years beyond the occurrence of the last known indigenous case. This period shall be sufficient to assess whether or not the elimination of transmission has been achieved. In countries which did not have an eradication programme, the country in consultation with WHO will implement appropriate

[1] Eradication of dracunculiasis: guidelines for International Certification Teams. Geneva: World Health Organization; 2000 (WHO/CDS/CEE/DRA/2000.12 Rev 1).

surveillance methods. As the programme moves towards the global eradication target, the Commission will provide appropriate guidance and recommendations.

The ICCDE at its first meeting in 1996 finalized the criteria for certification based on the status of dracunculiasis in different countries. For practical purposes, countries were classified into three groups: (Group A) countries, then endemic for dracunculiasis; (Group B) countries, where less than 3 years had elapsed since achieving zero indigenous cases (pre-certification stage); and (Group C) countries, where 3 or more years had elapsed since reporting the last indigenous case or where dracunculiasis was not known to have been reported (certification stage). Group C was further divided in two subgroups: those where the data obtained were uncertain, making it unclear whether dracunculiasis transmission had been interrupted effectively and definitely; and those which were well known to have had no transmission for many decades.

Three principal mechanisms were established to facilitate certification efforts:

i. The establishment of the ICCDE. This Commission is charged with the evaluation of the evidence presented by countries claiming to be dracunculiasis-free and seeking WHO certification of eradication. The ICCDE has recommended certification strategies, guidelines and criteria for WHO for the process of certifying dracunculiasis eradication (Annex 1).

ii. A dracunculiasis certification cell within the WHO dracunculiasis eradication programme serving as the secretariat to the ICCDE. The recommendations and advice of the ICCDE will be included in its report to the Director-General of WHO, who will decide upon and implement the daily activities of the certification process.

iii. The composition of a global panel of experts from which ICT members are selected. The aim of the ICT is to visit countries that have requested certification and have submitted appropriate evidence demonstrating that dracunculiasis transmission has been interrupted in their territory.

Group A: Countries endemic for dracunculiasis

Chad, Mali, Ethiopia and South Sudan (status as of beginning of 2014)

Group A countries are those in which dracunculiasis transmission is known to occur and where surveillance and control operations are essential. While this group of countries may not immediately be concerned about certification, they may need to document the evidence that the interventions applied led to the interruption of transmission. This evidence shall be the basis for applying for certification when the country eventually interrupts transmission. In Group A countries it is essential to:

i. Enhance the sensitivity of case detection nationwide by maintaining a high degree of public awareness of dracunculiasis and its eradication. Awareness campaigns must be monitored periodically to assess the coverage and comprehensiveness of messages, particularly in remote rural areas where the potential risk for transmission is considered to be highest.

ii. Maintain compulsory notification of dracunculiasis cases by all units (i.e. primary health-care posts, health centres and hospitals) of the national disease-surveillance system.

iii. Maintain village-based surveillance and capacity for case containment in each village currently and formerly affected by dracunculiasis for at least 3 years after interrupting transmission.

iv. Maintain a record in all endemic villages that reported dracunculiasis infections, and indicate for each rumour and each confirmed case whether it was imported or indigenous by tracing the case to its origin.

v. Integrate surveillance of dracunculiasis with that of other diseases or other health and development activities[1].

vi. Introduce a reward system at an appropriate time to detect any hidden foci of infection.

Group B: Countries in the pre-certification stage

Ghana, Kenya and Sudan (status as of beginning of 2014)

Group B countries are those of Group A in which zero reporting of cases has been achieved and where a reliable and extensive surveillance system is maintained. Pre-certification stage surveillance activities must be sustained for at least 3 years. In these countries it is essential to:

i. Maintain the sensitivity of case detection nationwide by sustaining a high degree of public awareness of dracunculiasis and the risk it represents. Surveillance can be sustained by:

   a. stressing the importance and need of reporting cases of dracunculiasis;

   b. establishing a reward system for reporting cases;

   c. responding quickly to any declaration of suspected cases or rumours within 24 hours.

ii. Conduct awareness campaigns periodically and assess regularly the coverage and comprehensiveness of messages, particularly in remote rural areas where the potential for

dracunculiasis is highest (villages without safe sources of drinking-water and situated near borders with other countries still affected by dracunculiasis, or in a formerly endemic area).

iii. In countries that have reached zero cases, it would be too costly to maintain a nationwide surveillance system specifically for the disease during the 3-year pre-certification period, in order to meet the requirements for certification. Thus it is essential that surveillance for dracunculiasis be integrated with that of other diseases, i.e. the Integrated Disease Surveillance and Response (IDSR) system, the vaccination of children, and other national health surveillance and control initiatives.

iv. Maintain surveillance activities in formerly endemic villages for at least 3 years after reporting of the last indigenous case and investigate all rumours within 24 hours to rule out dracunculiasis.

v. Notify cases of dracunculiasis by all units (i.e. primary health-care posts, health centres and hospitals) of the national disease-surveillance system compulsorily.

vi. Maintain a register of dracunculiasis cases in order to (i) note any suspected cases of infection reported or discovered during the pre-certification period; (ii) indicate that each confirmed case was either imported or indigenous by tracing the case to its origin in a dracunculiasis-endemic area; and (iii) ascertain that all reports were well documented.

vii. Conduct at least one active case detection survey during the pre-certification period, village-by-village, in any area which may have been formerly endemic. Searches should be conducted preferably during the presumed transmission season using case recognition picture cards and the local vernacular name for dracunculiasis. School-based and market-based surveys as well as surveys at religious gatherings, in refugee camps and among other places where people congregate in addition to relevant data collected by non-governmental organizations (NGOs) working in the field can be useful in eliciting information about villages where cases might have occurred.

Group C: Countries in the certification stage