A Guinea Worm Success Story
Togo Twenty Years Later

Reprinted with permission of WorldView Magazine/National Peace Corps Association, this story is written by former Peace Corps Volunteer Susan Henderson, MD, MPH about her return trip to Togo 20 years after her initial Peace Corps experience. Dr. Henderson went to Togo in 2011 as a Centers for Disease Control and Prevention (CDC) Medical Officer on assignment to the World Health Organization (WHO) as a consultant to certify the eradication of Guinea worm. She now works as a clinical and public health consultant in Beijing, China.*

Dr. Henderson, conducting Guinea Worm Knowledge interviews with villagers in the Maritime Region, Togo.

In 1991, I headed off as a new college graduate to work as a Peace Corps volunteer (PCV) in the recently established Guinea Worm Eradication Program in Togo, West Africa. Guinea worm was endemic in Togo and other sub-Saharan African countries. CDC, WHO, Carter Center, and Peace Corps had recently launched a program with an ambitious goal of complete eradication by 1995. My days were spent in the heat biking out to villages with my Togolese counterpart where we trained community volunteers on surveillance techniques, Guinea worm disease, filter use and other prevention strategies. Those initial months were challenging as we addressed the misconception that Guinea worm was a curse from the gods, while maintaining cultural sensitivity and respect. One of the highlights of my service was meeting President Jimmy Carter, when he met with PCVs during his visit to the capital to assess the program's impact. In 1993, my service was over and I left, as many volunteers do, feeling as if I had learned more than I contributed. In the subsequent years since my service, the incidence of Guinea worm declined; however, it was not until 2008 when no further cases were detected in Togo.

My work in Peace Corps had stimulated a personal interest in public health. Although I initially pursued medical training and residency in internal medicine, ultimately, I returned to the idea of prevention and treatment of disease in populations, rather than individuals. In 2011, I had only been working as a Medical Officer at the CDC for six months when the opportunity arose to travel to Togo as a WHO consultant to certify the eradication of Guinea worm. It was an incredible opportunity to take advantage of; one that I would not have had in clinical medicine. In June 2011, I traveled to Togo as part of an international team that consisted of physicians, public health practitioners, interpreters, and host country nationals. The first several days were spent meeting the team and breaking into smaller groups, reviewing the country report that had been prepared earlier in the year, and planning the trip. The next eight days were labor intensive as my group of three drove out to the villages to interview regional officials, local health educators, and villagers on their documentation and knowledge of Guinea worm disease. I was reminded of my work as a PCV, except this time my work was more focused. We reconvened in the capital, Lome, and discussed the results of our work. All four teams visited 97 villages and interviewed 946 people. No cases of Guinea worm were observed. We prepared the rough draft of a report summarizing our findings and presented it to the Minister of Health.

Returning to Togo was bittersweet for me. On one hand, I was thrilled to see that the parasitic disease that had once plagued the villagers, among whom I lived and worked, was gone. Children were now able to attend school and farmers could work in the fields. While I was in the maritime region, I worked with the same Togolese Guinea worm representative that I had worked with as a PCV. Once again, we conducted interviews with villagers as we had 20 years prior, with me speaking French and him translating to Ewe, the local language (even though I could communicate in Ewe, it was more efficient to have him translate). I had seen the cycle of Guinea worm come full circle; it was rewarding to visit previously endemic villages where children, when shown a picture of Guinea worm, had never seen a single case. On the other hand, I was disappointed that more progress had not been made in terms of infrastructure changes. The roads and buildings had deteriorated significantly in the time since I had first lived there.

I returned to my position as a Medical Officer at the CDC and once again, experienced reverse culture shock, though not nearly as severe as twenty years prior. At the CDC, an Epidemic Intelligence Service (EIS) Officer had recently done a presentation about an outbreak of Guinea worm in Chad. In addition to this outbreak in Chad, only three countries in the world remain endemic with Guinea worm disease (South Sudan, Ethiopia, Mali). As Dr. Sharon Roy, the CDC Medical Officer who coordinated my visit stated, the eradication process "must be done in a vertical manner." Having seen the progress that had been made in disease eradication first hand using this approach, I have to agree that this is the best way to accomplish this goal.

*This image depicts the subcutaneous emergence of a white, spaghetti-like female Guinea worm, **Dracunculus medinensis**, from a sufferer's left foot.*

*See: http://www.peacecorpsconnect.org/
Also, see CDC's website: http://www.cdc.gov/parasites/guineaworm/index.html