

This International Task Force for Disease Eradication (ITFDE) was constituted with support provided by the Bill & Melinda Gates Foundation to The Carter Center. The main goals are to review progress in the field of disease eradication over the past decade since the previous ITFDE (1989-1992), review the status of selected diseases, and make recommendations regarding opportunities for eradication or better control of certain diseases (e.g., demonstration project, targeted research).

The Task Force members are: Sir George Alleyne, Pan American Health Organization; Dr. Yves Bergevin, UNICEF; Dr. David Heymann, World Health Organization; Dr. Jeffrey Koplan, Centers for Disease Control and Prevention; Mr. James Lovelace, The World Bank; Dr. Adetokunbo Lucas, Nigeria; Professor David Molyneux, Liverpool School of Tropical Medicine; Dr. Mark Rosenberg, Task Force for Child Survival and Development; Dr. Harrison Spencer, Association of Schools of Public Health; Dr. Dyann Wirth, Harvard School of Public Health; Dr. Yoichi Yamagata, Japan International Cooperation Agency, and Dr. Donald Hopkins, The Carter Center. Nine of the twelve members attended the first meeting, which was held at The Carter

Introduced into the Americas during the African slave trade, onchocerciasis officially exists in thirteen foci scattered over six countries: 4 in Guatemala, 3 each in Mexico and Venezuela, and 1 each in Brazil, Colombia and Ecuador. The number of people currently at risk of the disease is 544,009, of whom 429,920 are eligible for treatment, in 1,969 endemic communities, including 211 hyper-endemic communities. The overwhelming majority of persons at risk are in Mexico (39%), Guatemala (37%) and Venezuela (18%). The main vectors concerned are: in Mexico and Guatemala

1996), Mexico-Chiapas (16% in 1995, 7% in 1997), and Venezuela-North (29% in 1998, 2% in 1999). Data from the baseline and first evaluation of sentinel communities regarding prevalence of _____ are available from _____

1. The scientific feasibility of eliminating ocular morbidity and interrupting onchocerciasis transmission in the Americas, using currently available tools, is clear.
2. The primary remaining concern is whether all six programs can reach and maintain at least

for pauci-bacillary cases and one year for multi-bacillary cases. The frequency of Dapsone-resistant strains has increased. Relapse rates are usually less than one percent for multi-bacillary cases. A slightly larger percentage of treated persons will still harbor viable bacilli. No suitable preventive is available.

In 1991, the World Health Assembly adopted a resolution that called for the “elimination” of leprosy “as a public health problem”, to a prevalence of “less than 1 case/10,000 population, by 2000”. The intervention strategy calls for early diagnosis and treatment of cases at the community level, ideally integrated into the general health services. WHO began making MDT available free of charge in 1995. According to WHO, by the end of 2000, the number of cases of leprosy had been reduced from 5.4 million in 1985, to 753,000, and the number of countries with more than 1 case/10,000 population was reduced from 122 to six (Brazil, India, Madagascar, Mozambique, Myanmar, Nepal; countries with populations of less than one million persons or with fewer than 100 cases registered are not included). The current goal is to complete the campaign by 2005, for which period US\$6 million per year as well as the required supplies of drugs for providing free treatments have been donated to WHO. Reduction in the length of chemotherapy from 24 to 12 months, and the ten year old campaign to “eliminate” the disease are the main advances since the review by the previous ITFDE.

Some qualifiers to the progress of the campaign were discussed. The target prevalence rate of 1 case per 10,000 population is still relatively high. Much of the impressive reduction in the number of active cases is statistical, since patients who complete a course of MDT are considered cured (most are), and are removed from case registries. Thus, a case of leprosy is now defined as an infected person who requires, but has not yet received or completed a course of MDT. Despite the apparent reduction in prevalence, the number of new cases detected annually (incidence) has not yet declined: 738,000 new cases were diagnosed in 2000 (this probably reflects the long incubation period). The quality and reliability of surveillance and case

This report was presented by Dr. Daniel Colley of the Centers for Disease Control and Prevention (CDC) and Dr. Michael Reich of Harvard School of Public Health.

WHO estimates that about 200 million persons are infected with schistosomes (about 170 of them in sub-Saharan Africa), of whom 120 million have symptoms, including 20 million persons with severe disease. Between 20,000 and 200,000 persons are estimated to die of this disease annually. Despite significant progress in controlling schistosomiasis over the past two decades, increases in population in some endemic countries have kept global prevalence about the same as it was when the previous ITFDE reviewed this disease. This infection is very focally distributed. Multiple points of attack on the parasite's life cycle are available, including health education to promote hygienic practices (hard to show efficacy), vector control (expensive), and mass chemotherapy (best current control measure), but implementing them is a challenge. Diagnosis of intestinal schistosomiasis (*S. japonicum*) prevalence about the s191.7 491.5581 5c

1. Schistosomiasis is not eradicable using currently available tools.
2. It is possible to achieve much better control of the vast morbidity from schistosomiasis now, and the Schistosomiasis Control Initiative could potentially become a significant step in that direction.
3. More research is needed. Priority targets include development of simpler diagnostic methods for intestinal schistosom

An insecticidal paint has also been developed. A cost benefit

