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The future of onchocerciasis control in Africa

The battle against onchocerciasis in Africa has been led by the Onchocerciasis Control Programme in West Africa (OCP, 1974–2002) and the African Programme for Onchocerciasis Control (APOC). Both programmes aim to eliminate onchocerciasis as a disease of public-health importance and as an obstacle to socioeconomic development. Over the long term, as a health and development programme, OCP has achieved its goals in ten of 11 West African countries.¹ Since OCP started in 1974, no child born in the region has gone blind because of onchocerciasis. However, the disease itself has not been eradicated. Some residual infections exist, and persistent in-country conflicts preclude full access to control in some countries. These challenges need attention and active surveillance from national health authorities. Here, we briefly take stock of the effort to combat onchocerciasis in Africa, and present highlights of the Summit of Partners of Onchocerciasis Control, held in Yaoundé, Cameroon, on Sept 26–27, 2006.²

APOC was launched in 1995. Within 12–15 years, it seeks to establish sustainable community-directed treatment with ivermectin,³ to protect more than 102 million people. It is one of the first partnerships established to

control a neglected tropical disease, and operates as a strong and unique grouping of 19 African countries, 20 donor countries and organisations, 12 international non-governmental development organisations (NGDOs), 30 local non-governmental organisations, a private-sector company (Merck), and 117 000 communities. 14 million people received ivermectin in 1997. Currently, via APOC, more than 40 million people receive regular ivermectin treatment through a community drug-distribution mechanism, helping to avert 500 000 disability-adjusted life years (DALYs) a year, at US\$7 a DALY.⁴

In community-directed treatment with ivermectin, the programme has enabled access to onchocerciasis treatment in neglected and hard-to-reach areas in countries during or after conflict. APOC also targets and serves extremely poor populations, helping strengthen national health systems to build local capacity where services are weakest. One reason for OCP/APOC's sustained success has been integration of research within the framework of activities, mainly through the Special Programme for Research and Training in Tropical Diseases. This integration has enabled the programmes to be highly innovative and collaborative in the development, assessment, and use of new instruments and methods, and has led to evidence-based strategies, such as the implementation of community-directed interventions. This integration of research into control will continue in the new strategy.

APOC is planned to close in 2010, but the battle against onchocerciasis has not yet been won. Every effort must be made to ensure that the substantial financial investments in OCP and APOC, drug donations worth more than \$1.5 billion, and the success of the past, are sustained for the future.

In view of such challenges, the meeting in Yaoundé aimed to share and review recommendations from a working group on the strategic overview of the future of onchocerciasis control in Africa.⁵ The meeting brought together various partners of APOC and OCP, African Ministers of Health, donor agencies, NGDOs, national onchocerciasis coordinators, representatives from Merck,

Panel: Yaoundé Declaration on onchocerciasis control in Africa²

We, as African Ministers of Health:

Express our commitment to work together to accelerate the elimination of river blindness as a public-health and socioeconomic development problem in all countries

Call for the intensification of control activities and surveillance in postconflict countries and countries with pockets of co-endemicity of onchocerciasis and loiasis (tropical eye worm)

Endorse the conclusions of the working group on the future of APOC and its recommendations to extend the life of APOC to 2015 and enlarge its activities to ex-OCP countries

Recommend strongly that APOC provide a scientific evidence base to determine the steps, the period, and the area where ivermectin treatment could be stopped in close consultation with affected countries

Urge endemic countries to make annual budgetary commitment for onchocerciasis control activities as part of PRSP and in line with MDGs

Declaration signed by following countries: Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo Brazzaville, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Ghana, Guinea Bissau, Guinea Conakry, Kenya, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Sudan, Tanzania, Togo, and Uganda.

those involved in neglected tropical diseases, and the private sector. After the review, the African Ministers of Health made the Yaoundé Declaration (panel).²

The declaration also welcomes the longstanding commitment of donors and NGOs to onchocerciasis control and the pledge of Merck to provide ivermectin for as long as is needed. It also urged donors and development partners to support macrofilaricide research and onchocerciasis surveillance.

The battle against onchocerciasis can only be won through a sustained effort and contribution from all parties involved. The Yaoundé meeting showed a renewal of the commitment from the African health ministers as well as the partners to take the effort in onchocerciasis control further. This momentum must be maintained.

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We dedicate this Comment to three colleagues, Enyinnaya Uchechukwu from Nigeria, and Ruhiso Moshi and Kanyika Nakijwa from Tanzania, who tragically died in the ADC plane crash on Oct 29, 2006 in Abuja, Nigeria. They were on a mission to Kebbi State to assess the performance of the onchocerciasis control programme at community and frontline health-facilities. We thank WHO/African Regional Office Director Luis Gomes Sambo for his leadership, care, and support in facilitating the recovery and return of their bodies to their families.

We declare that we have no conflict of interest.

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Confessions of a condom lover

My devotion to condoms spans nearly three decades. I have steadfastly helped my agency provide billions and helped develop new ones, including the female condom. I have bemoaned the condom gap in Africa,¹ and I believe condom promotion with sex workers (along with fewer clients) in concentrated epidemics has been the most important intervention in the entire HIV pandemic. But I see major limitations of condoms and abstinence in the intractable high-prevalence generalised hyperepidemics still raging in certain southern African countries.

First, many men (and some women) do not like using condoms. Use is especially low in established relationships. In Kenya in 2003, only 1–2% of married women used condoms for contraception.² Such low use in established relationships is troubling because concurrent regular sexual partnerships are critical in generalised epidemics, partly because the very high infectiousness of new infections allows for rapid transmission through continuing sexual networks.³ Second, condoms provide about 90% protection if used correctly and consistently,⁴ but use is typically inconsistent. In Rakai, Uganda, inconsistent use was almost four times as common as consistent use.⁵ Third, as with all prevention technologies, people might

believe that they can engage in risky sex with impunity so long as they use (or plan to use) condoms.⁶ Evidence from Uganda has shown that such condom disinhibition is real.⁷

Condoms are important for individual protection, especially for high-risk situations including discordant couples. Disappointingly, however, it is difficult to see much effect in generalised epidemics. In South Africa, for example, with 48 million people in 2004, public programmes provided 346 million condoms, and condom use at last sex was high, especially among single people aged 15–24 years (69%).⁸ Yet infection continues apparently unabated.

What of abstinence? One question is whether abstinence promotion can work, especially when young women may be coerced into sex. Nevertheless, young people do have enough agency to postpone sexual debut somewhat, as seen in Uganda and eastern Zimbabwe.^{9,10} But primary abstinence is only practicable for young people, and such narrow shifts in debut have only modest effect. Moreover, the gap between age at first sex and marriage is often narrow. For example, in Malawi, median age at first intercourse is 17.3 years for women and that at marriage is

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