ONCHOCERCIASIS

Delivering The River Blindness Cure

Over two years ago, Merck & Co., a New Jersey pharmaceutical firm, announced that it would give away the world's supply of a drug to combat onchocerciasis, a disease with 85 million potential victims, most of them in Africa. (see *Africa News*, October 31, 1988)

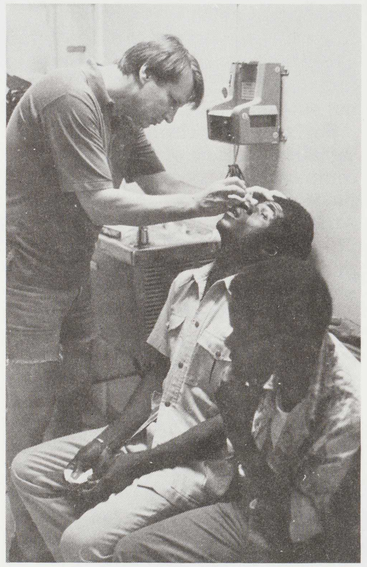
That was the good news. The bad news is that 26 months after Merck chair P. Roy Vagelos made the announcement, only 800,000 people have been treated or stand to receive the drug, ivermectin in the near future. In Africa, where onchocerciasis, or river blindness, is endemic in 27 countries, only 250,000 people are covered by current distribution plans.

The roadblocks to successful worldwide distribution of Mectizan – the trade name by which ivermectin is known – range from the logistical challenges of serving people in remote areas to the lack of funds available in cash-starved Third World treasuries. But according to John R. Babson, a former president of the Washington, D.C.-based Eye Foundation, the most pressing problem to date has been the absence of an umbrella organization to coordinate the effort.

While Merck followed up its announcement by appointing a Mectizan Expert Committee made up of noted tropical medicine experts to screen applications for the drug from governments and private groups, the company has no plans to fund or otherwise assist direct distribution campaigns.

The World Health Organization has made tremendous strides in the fight against river blindness in Africa with its Onchocerciasis Control Program (OCP), which began in 1974 as a spraying program to eradicate the blackfly that spreads river blindness by hosting the culprit parasite. The OCP was the first group whose plan to distribute Mectizan was approved by the Mectizan Expert Committee, which is based at the Carter Center in Atlanta. And the OCP is the only program supported by U.S. Agency for International Development (AID) funds – Congress allocated $2.5 million to the program in 1988, $5 million in 1989, and the Congressional foreign assistance package includes another $5 million for OCP next year.

But given the number of people



Merck & Co.

Prior to releasing ivermectin in 1987, the manufacturer, in cooperation with the World Health Organization and others, tested the drug in infected areas throughout West Africa.

served by the OCP – 250,000 people in Guinea, Guinea-Bissau, Mali, Benin, Sierra Leone, Ghana, Cote d'Ivoire, Burkina Faso, Togo, Senegal and Niger – the program remains, says, Babson, "just a drop in the bucket."

More telling, he says, is the cost incurred by the OCP. For every dose of Mectizan distributed, the OCP spends $13 to $14, a figure Babson calls "much too high."

Last year, Washington, D.C.-based Africare, in conjunction with the Nigerian ministry of health, applied to the Mectizan Expert Committee for permission to administer a Mectizan program in the west African nation. The OCP does not operate in Nigeria, despite the fact that half of all Africans at risk for contracting river blindness live in that country. Africare has stepped into the breach with a program that will serve 90,000 Nigerians between 1988 and 1990 – at a cost of $3 to $4 per application of Mectizan.

"That proves that PVOs (private voluntary organizations) can operate more cheaply than the WHO," says Babson, "and the more of them that get involved, the better."

As effective as the WHO effort has been for those it serves, the United Nations agency recognizes that where river blindness is concerned, it cannot go it alone. The group has called repeatedly on donor governments and private organizations for help, and this week, WHO officials are meeting in the Hague with representatives of the OCP and the World Bank to brainstorm on possible sources of funding for onchocerciasis eradication efforts.

Another participant at the meeting, Dean J. Thomas Hamrick of the Tulane University Medical Center's School of Public Health and Tropical Medicine, has spearheaded a unique program in the U.S. that could have important ramifications for the fight against river blindness.

Last October, Hamrick announced that the school – which has over 2,000 graduates, many of whom are high-level officials in countries where river blindness is endemic – would serve as a facilitator for Mectizan distribution programs, assigning technical staff and working with its own network of graduate health workers to:

- help governments in endemic countries assess their needs where river blindness is concerned and develop plans to deal with the disease;
- help establish a network for the communication of issues surrounding Mectizan distribution;
- organize and conduct workshops and meetings to promote the involve-

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AIDS

"Global Solidarity" Called For in AIDS Fight

MARSEILLES, FRANCE – "It is a terrible mistake to think that this epidemic is under control, or that this epidemic has peaked, or that this epidemic is over. It is none of those," says Dr. Jonathan Mann, director of the World Health Organization's Global Programme on AIDS.

Warning that the world must not be "lulled into complacency," Mann said in an interview that the low or declining rates of infection in some groups of the world's populations may not remain stable.

At the fourth annual International Conference on AIDS and Associated Cancers in Africa held here in October, Mann appealed for "global solidarity" to battle the growing epidemic. In a somber opening address, the World Health Organization (WHO) official predicted that about nine times as many adults will develop AIDS in the coming decade compared to those who become ill during the 1980s. Citing the projections of a panel of experts known as the "Delphi Study," Mann said that "if this prediction holds, the cumulative total of adult AIDS cases might reach five to six million by the year 2000."

The implications for Africa are alarming. As many as half the cases worldwide are expected to occur in sub-Saharan Africa. Forty-eight African countries have officially reported at least one case as of last month, and the WHO estimates that roughly 300,000 people have developed AIDS to date.

Another 2.5 million people may be infected with HIV, the virus that causes AIDS. According to WHO expert, Dr. James Chin, by the close of this century, the continent can expect a "tenfold increase in clinical cases of AIDS."

The consequences for African children are particularly dire. In Africa, HIV is mainly transmitted through heterosexual contact, and women have been as affected as men. Thirty percent of the children born to HIV-infected mothers are expected to develop AIDS. Chin predicts that by 1992, a million people in sub-Saharan Africa will be AIDS sufferers, and some 200,000 of them will be children.

The Marseilles conference was the most important gathering of AIDS experts since the international conference on the disease in Montreal last June. More than a thousand health professionals and scientists from Africa, Europe and the U.S. shared over a hundred presentations about the status of epidemiology, diagnostics and virus research on the fatal disease.

Among the major trends discussed were the intensification of the epidemic in areas already affected – notably central and southern Africa – and the spread of the disease into west Africa.

Researchers from Central African Republic, which was among the first countries to have a problem with AIDS, report that the prevalence of HIV infection in the capital Bangui, has doubled every year from 1984 to 1988. Roughly eight percent of the population between 15 and 45 years of age are now infected, and infection rates in women are significantly higher than in men.

Scientists from the west African country of Cote d'Ivoire say that only a few years ago the presence of HIV was very low in the Ivorian population. Epidemiologists there were preoccupied with the appearance of a second strain of the human immunodeficiency virus, called HIV2.

But recent data from Ivorian population surveys suggest that more than seven percent of the urban population is infected with at least one of the two viruses. Experts are concerned about the potential for the disease to spread throughout west Africa, as workers from across the region, who flock to Abijdan for employment return home for periodic visits. Surveys from towns along the trade routes of central Africa continue to show that mobility is a central factor in the spread of the fatal disease.

The rising occurrence of AIDS in women, noted earlier in central Africa, has been further illustrated by a series of studies done in Uganda. The east African country straddles the hard hit region stretching from central Africa to the western shores of Lake Victoria. Over a two-year period, women in these population-based studies were more likely to be infected with HIV than men, and they contracted it at an earlier age.

Surveillance at one antenatal clinic in the Ugandan capital Kampala shows a steep rise in the rate of HIV infections among pregnant women to 24 percent this year.

As epidemiologists continue to track the emergence of HIV2, which has been concentrated in west Africa, the actual course of the illness caused by HIV2 is still under debate. At the Marseilles conference, researchers who are following a group of prostitutes in Senegal, presented data suggesting that the second strain of HIV spreads more slowly and is less aggressive in triggering AIDS. But a French team offered conflicting findings, suggesting that HIV2 is just as aggressive as the original strain of the AIDS-causing virus.

The role of risk factors in AIDS transmission has been the focus of numerous studies from Zaire, Kenya, Lesotho, Tanzania and Central African Republic. All lend further evidence to the theory that the number of sexual contacts and the presence of sexually transmitted diseases – particularly genital ulcers – significantly increase the risk of transmitting HIV.

On the other hand, circumcision among men may reduce the risk of their contracting AIDS, according to the preliminary findings of a team from Kenya. After surveying population-based data from 42 countries, analyzing the levels of HIV infections in various areas, and factoring in the custom of male circumcision among major ethnic groups, they conclude that uncircumcised males run a higher risk of becoming infected with HIV.

One encouraging piece of news is the WHO prediction that 40 percent of the new infections projected for the coming decade could be prevented through aggressive AIDS control efforts. There is already some evidence of rising condom use in Kinshasa, Zaire and in Central African Republic, although Africa does not yet have definitive evaluation of prevention efforts compa-