The Republic of Benin achieved full independence from France in 1960 [1]. Historically known as the Kingdom of Dahomey, Benin was a central player in the slave trade for hundreds of years, from the seventeenth century until the abolishment of slavery [1]. The earliest schistosomiasis national surveys in Benin reveal approximately 30 thousand people infected with *S. haematobium* in 1955, which represents about 2% of the population of Benin at that time [2]. However, uncertainty in the early national prevalence estimates due to wide variations in prevalence from locality to locality, ranging from 4-60%, led to a reassessment of early country-level prevalence. In the mid 1980’s, *S. haematobium* infected 35.5% of Benin’s population, with 1.4 million people infected from the entire country’s almost 4 million at risk [3, 4]. The prevalence of *S. mansoni* has historically been lower (0.5% countrywide in the 1980’s [4] and 2.5% in 2012 [5]) and isolated to a few foci [4]. Recent data suggest that the situation has not improved in Benin, with current national schistosomiasis prevalence estimates of 35.5% in 2003 [6], 33.1% (3.2 million) in 2010 [6], and 30% (2.6 million) infected in 2012 [5].

**Overview of Benin [1]**

- Population in 2015: 10,448,647
- Official Language: French
- Capital: Porto-Novo
- Republic
- Percentage of Population with Access to Improved Drinking Water in 2015: 77.9%
- Percentage of Population with Access to Improved Sanitation in 2015: 19.7%

---

**The History of Schistosomiasis in Benin**

The Republic of Benin achieved full independence from France in 1960 [1]. Historically known as the Kingdom of Dahomey, Benin was a central player in the slave trade for hundreds of years, from the seventeenth century until the abolishment of slavery [1]. The earliest schistosomiasis national surveys in Benin reveal approximately 30 thousand people infected with *S. haematobium* in 1955, which represents about 2% of the population of Benin at that time [2]. However, uncertainty in the early national prevalence estimates due to wide variations in prevalence from locality to locality, ranging from 4-60%, led to a reassessment of early country-level prevalence. In the mid 1980’s, *S. haematobium* infected 35.5% of Benin’s population, with 1.4 million people infected from the entire country’s almost 4 million at risk [3, 4]. The prevalence of *S. mansoni* has historically been lower (0.5% countrywide in the 1980’s [4] and 2.5% in 2012 [5]) and isolated to a few foci [4]. Recent data suggest that the situation has not improved in Benin, with current national schistosomiasis prevalence estimates of 35.5% in 2003 [6], 33.1% (3.2 million) in 2010 [6], and 30% (2.6 million) infected in 2012 [5].
Despite recognition of the schistosomiasis problem in Benin since the mid 20th century, national schistosomiasis control efforts did not begin until recent years. In 2008, the pharmaceutical company Merck KGaA donated 6 million praziquantel tablets to the World Health Organization (WHO), with the tablets slated for Nigeria, Benin, and Madagascar [7]. Needless to say, Benin’s control efforts focused primarily on mass drug administration (MDA) using these donated drugs. That first year in 2008, Benin reported to the WHO that 51,433 people were treated for schistosomiasis, which represented <1% of the population needing treatment in Benin at the time [8]. In 2010, the MDA program was scaled up to address 16% of the population in need, treating 364,697 out of about 2.2 million people requiring treatment. Since then, MDA efforts have been reported every other year, with 5% or less of the population in need treated each year, according to the records at WHO [8].

Looking Ahead

All in all, Benin’s schistosomiasis history represents an all-too-familiar story for the Sub-Saharan African region: the endemic schistosomiasis problem has been known for decades, but little if any concerted control has been organized until recently. The praziquantel donations made by Merck KGaA started in 2008 and is slated to continue until 2020. This represents an opportunity for Benin to achieve some morbidity reductions for the lucky few people that receive praziquantel. But, the low and inconsistent coverage has contributed to only modest headway on national schistosomiasis prevalence in Benin since control began.

References


Content by Susanne Sokolow. Layout and Design by Chloe Rickards and Cheryl Butner. 2016.