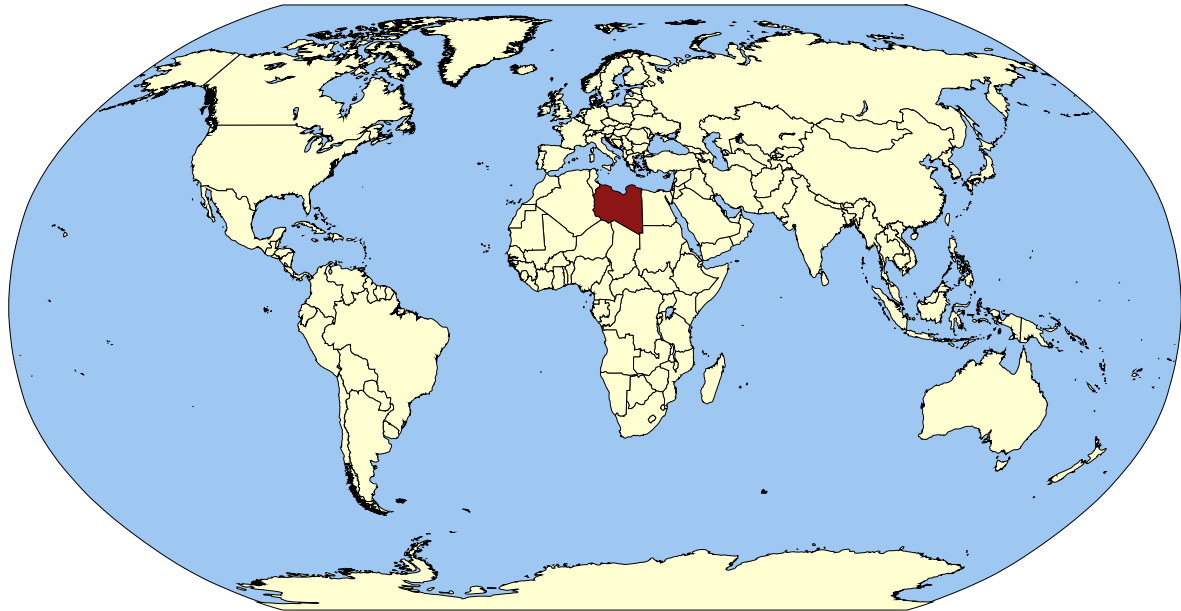


# Libya



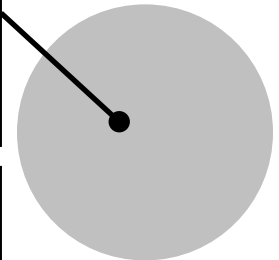
## The History of Schistosomiasis in Libya

The first recorded case of schistosomiasis in the Libyan Arab Jamahiriya (Libya) dates to 1925. *Schistosoma haematobium* and *S. mansoni* are focally endemic in Libya, and prevalence has been estimated at 5% since 2003 [1]. The geography of the country, dominated by vast tracts of dry, sandy areas with high-salinity water, is not conducive to widespread colonization of snail intermediate hosts, so their distribution is patchy [2]. *S. haematobium*, transmitted via the snail intermediate hosts *Bulinus truncatus* and *B. globosus* in Libya, was first identified in the Ghat region in 1957, but no human infection was recorded for many years. *B. truncatus* is known to be endemic in one remaining area in Alfogaha [3]. More recently, Darnah has been identified as a localized area of risk for *S. haematobium* [4]. *S. mansoni*, transmitted via *Biomphalaria alexandrina* snails, is currently locally endemic at the Taourga oasis [3].

## Schistosomiasis in Libya [8]

No preventative chemotherapy was required in Libya as of 2013.\*

\*Nonetheless, country prevalence estimates are incomplete.



## Overview of Libya [9]

- » Population in 2015: 6,411,776
- » Official Language: Arabic
- » Capital: Tripoli
- » Transitional Government
- » Percentage of Population with Access to Improved Drinking Water in 2012: 54.4%
- » Percentage of Population with Access to Improved Sanitation in 2011: 96.6%

## Schistosomiasis Control Programs in Libya

Prevalence in the Taourga oasis community of about 21,000 individuals was as high as 39.8% in school-aged children in 1999. Control, which included screening and treatment of the whole population with directed praziquantel treatment, mechanical and biological snail control, and education, was initiated in the late 1990's and as of 2007 prevalence in that community has dropped to 3%, and all infections were identified as *S. mansoni*. Mass treatment was planned to continue on a yearly basis until elimination is achieved, alongside biological control of snails so as to avoid the use of chemical molluscicides [3]. Data is scant and inconsistent on overall schistosomiasis trends in Libya. However, as of 2013, Libya did not require the use of preventative chemotherapy to treat schistosomiasis [8].

Schistosomiasis in Libya has been restricted to a few focal areas, or "oases." Control strategies in Libya have focused on first using snail control, and then focal chemotherapy. Data on success is scant, but Libya's strategies are considered effective.

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