

Republic of Congo



The History of Schistosomiasis in Congo

Both forms of human schistosomiasis, urinary and intestinal, have been described in the Republic of the Congo since the 1920's when the disease was introduced, potentially by migrant workers constructing a railway from Pointe-Noire to Brazzaville. Several population centers in the south of the country such as N'kayi, Loubomo (now Dolisie), Kibangou, Loudima-Gare, and Kayes had historically been major foci of infection throughout the 1960's, although other major cities in the region such as Brazzaville reported relatively low prevalence of urinary schistosomiasis (4.8% of all cases) during the same time period [1].

It is known that *S.haematobium* is endemic to the southernmost departments of Lékoumou, Niari, Kouilou, Pointe Noire, Bouenza, Pool, and Brazzaville, while the northern departments appear to have a much lower prevalence of the disease, with at least *S.haematobium* being entirely non-endemic to Sangha.

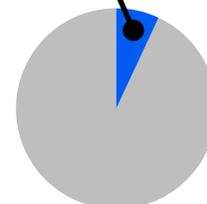
A likely explanation for the prevalence of schistosomiasis in the south and the near absence in the north of Congo Republic is the variable environment. Conditions in the south are generally favorable for snail intermediate hosts, while the northern half of the country is much less favorable on account of the soil and water being very acidic and poor in calcium [3].

Schistosomiasis in Congo [8]

2% of children requiring treatment were treated in 2014

7.2% of the population requires preventative chemotherapy for schistosomiasis

88% of the population that requires treatment are school aged children

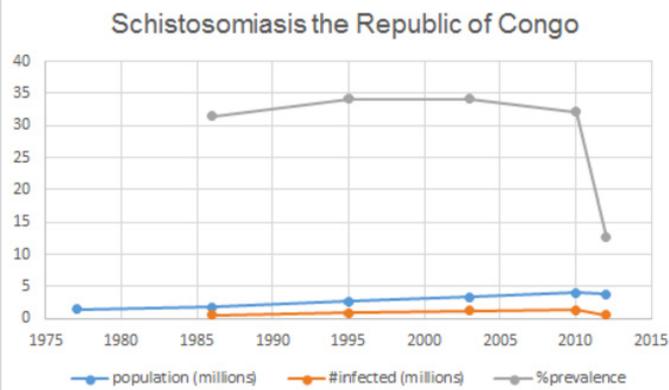


Overview of Congo [9]

- » Population in 2015: 4,755,097
- » Official Language: French
- » Capital: Brazzaville
- » Presidential Republic
- » Percentage of Population with Access to Improved Drinking Water in 2015: 76.5%
- » Percentage of Population with Access to Improved Sanitation in 2015: 15%

Prevalence of Schistosomiasis

The full extent of schistosomiasis risk is unknown due to minimal effort in mapping or control, and current estimates of prevalence reflect historical estimates unchanged by contemporary efforts to map the true distribution of the disease [10].



Control of Schistosomiasis

In 1979, The Health, Population, and Nutrition Division of the German Agency for Technical Cooperation (GTZ) began a large scale control program aimed at reducing prevalence of schistosomiasis in the Republic of Congo, as well as in Mali and Madagascar. The project mainly involved large scale distribution of praziquantel, the cheap and relatively risk free drug-of-choice for most modern schistosomiasis control efforts [4]. At the same time, an attempt at snail control was initiated in the Niari Valley, consisting of seasonal and focal treatment with niclosamide [5]. It is not clear to what extent the two efforts were related. The program targeted the major endemic regions of Bouenza, Niari, and Kouilou, where an estimated 65% of the population of 580,000 were infected [6]. While there is no data for the overall change in prevalence of schistosomiasis across the entire control area, the percent change in prevalence at eight major foci is known. For the Population centers of Loubo-mo, Kibangou-Poste, Kayes, Kikango, Koumina, N'Kayi, Loudima-Gare, and Sinda, prevalence of schistosomiasis changed from an average of ~65.16% in 1980 to 1981, to an average prevalence of ~15.84% from 1982 to 1984 following drug distribution. Unfortunately follow-up data was not reported from the major foci of Malela, Tsatsa-Yombe, M'Boubissi, and M'Boukou Massi [3]. In areas where prevalence was greater

than 10%, health education was also given to administrative health authorities as well as villagers. In areas where prevalence was below 10%, control activities were postponed [6].

Although comprehensive and quantitative data is lacking, it is known that for the duration of the control effort, prevalence of schistosomiasis dropped dramatically at all the major foci [3]. Interestingly, locations with initially low levels of infection showed little change despite the control effort. While the program showed that prevalence of schistosomiasis could be quickly and safely reduced in highly infected areas by mass distribution of praziquantel, reinfection occurred rapidly when treatment was suspended [4]. Soon after control efforts in the Republic of Congo ended in 1984, incidence of schistosomiasis rebounded to pre-control levels by 1986 [2]. Further attempts at schistosomiasis control were likely made difficult due to the eruption of violent conflicts within the country and neighboring countries since the 1990s, and no national control efforts have been implemented since 1984 [7].

References

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