résumés/abstracts

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E. M'Bokolo — *The Plague and Urban Society in Dakar: The 1914 Epidemic.*

Despite outbreaks occurring in various coastal cities since the turn of the century, the authorities in Dakar were taken by surprise when the plague reached the city in 1914. The epidemic lasted for one year and spread into the hinterland despite the attempts to cordon the urban area as soon as the disease had been identified. The sanitary precautions imposed by the administration were generally opposed by the African population, partly because they ran against the grain of beliefs and customs, partly because they looked (and often actually were) discriminatory. The news of the war in Europe also contributed to this negative attitude which impeded the action of the medical service.


The Sahel is a meeting area of the Saharan and Sudanic climates, economies and cultures, and also of epidemics. The rainy season pathology is not the same for nomadic pastoralists and sedentary agriculturists: the 'lean cows' season of the former, at the end of the dry season, is not the same as the latter’s 'empty granaries' period when the rains end up. Due to their nomadism and seasonal dispersal, pastoralists, while they are especially exposed to the pathology associated with cattle, benefit far less than agriculturists from the action of the medical services.


The last sleeping-sickness epidemic in West Africa ended around the middle of the present century after laying waste a wide area (over 200 000 patients in French West Africa in 1939). A few centres of infection subsist to this day. The ecology of its vector, the *Glossina* fly, makes it a riverine forest disease which appears whenever men, through their activities and because of the density of population, come into close contact with the vector. The re-occupation of formerly deserted valleys tends to bring about a rebirth of dangerous epidemiological situations.

J.-J. Picq & G. Remy — *Epidemiological Aspects and Geographic Distribution of River-Blindness in French-Speaking West Africa.*

The disease occurs all over the zone south of 15° N, its repartition following the hydrologic network. Endemicity is in reverse proportion to the demographic
importance of villages; there are few urban foci. River blindness partly explains low human densities in valleys. There is no sure explanation of the higher infection rate in savannah areas since in the forest, etiological factors are the same.

J. Delmont — *Malaria and Seasonal Climate Variations in the Sudanic Savannah of West Africa.*

Malarial infection rates in the West African savannah follow the yearly hygrometric cycle which reaches its peak during the rainy season when conditions for the reproduction of *Anopheles* mosquitoes are met. The variations are far more important than in forest areas where the hygrometric index is more or less constant.

G. Remy — *A Man-Borne Disease: Guinea-Worm in the Sahel.*

Recent enquiries on the disease in the pre-Saharan belt of West Africa show a degree of differentiation in local endemicity, resulting in a diversity of clinical aspects according to the endemicity rate. Children's infection and polyparasitosis become important only when the endemicity level is rather high.


A short history of the fight against widespread endemic diseases from the pioneer efforts of Dr. Jamot against sleeping-sickness to the creation, in 1960, of the international OCCGE (Organization for Coordination and Cooperation against Endemic Diseases). The methods devised since the early thirties to check the spread of trypanosomiasis and leprosy (especially the mobile teams operating in the countryside) have been extended to other endemic diseases: malaria, river blindness, ancylostomiasis, etc. The present trend, implemented by the national health services as well as by the World Health Organization, is oriented toward an enlarged vaccination program and the development of primary care systems.