

Schistosomiasis: Epidemiological Profile of Cases Reported in Sergipe (2015-2025)

Esquistossomose: Perfil Epidemiológico dos Casos Notificados em Sergipe (2015-2025)

Esquistosomiasis: Perfil Epidemiológico de los Casos Notificados en Sergipe (2015-2025)

RESUMO

Objetivo: O presente estudo teve como objetivo analisar o perfil epidemiológico dos casos notificados de esquistossomose em Sergipe, no período de janeiro de 2015 a julho de 2025, a partir de dados secundários do Sistema de Informação de Agravos de Notificação (SINAN). **Método:** Trata-se de um estudo retrospectivo, transversal e de abordagem quantitativa. Foram incluídos casos notificados em todas as faixas etárias, considerando as variáveis: município de infecção, sexo, raça/cor, faixa etária, escolaridade, forma clínica e evolução dos casos. **Resultado:** Identificaram-se 1.066 registros de esquistossomose no período analisado, com maior concentração em municípios do interior do estado (86,8%). Observou-se predomínio do sexo masculino (55,1%) e de indivíduos pardos (72,0%). Quanto à escolaridade prevaleceu o ensino fundamental incompleto. Clinicamente, a forma intestinal foi a mais frequente (38,3%). O diagnóstico apresentou elevada proporção de resultados positivos em testes qualitativos (41,8%) e quantitativos (43,2%). **Conclusão:** Os achados reforçam a necessidade de fortalecimento das ações de vigilância epidemiológica, ampliação do diagnóstico e tratamento precoce, além da implementação de políticas públicas voltadas à educação em saúde e à melhoria do saneamento básico. Tais medidas são essenciais para reduzir a incidência e os impactos da doença em áreas endêmicas como o estado de Sergipe. **DESCRIPTORES:** Esquistossomose; Epidemiologia; Monitoramento epidemiológico; Vigilância em saúde pública.

ABSTRACT

Objective: This study aimed to analyze the epidemiological profile of reported schistosomiasis cases in Sergipe, from January 2015 to July 2025, using secondary data from the Notifiable Diseases Information System (SINAN). **Method:** This is a retrospective, cross-sectional study with a quantitative approach. Reported cases from all age groups were included, considering the variables: municipality of infection, sex, race/color, age group, education level, clinical form, and case evolution. **Results:** 1.066 schistosomiasis cases were identified during the analyzed period, with a higher concentration in municipalities in the interior of the state (86.8%). A predominance of males (55.1%) and mixed-race individuals (72.0%) was observed. Incomplete primary education prevailed in terms of education level. Clinically, the intestinal form was the most frequent (38.3%). The diagnosis showed a high proportion of positive results in both qualitative (41.8%) and quantitative (43.2%) tests. **Conclusion:** The findings reinforce the need to strengthen epidemiological surveillance actions, expand diagnosis and early treatment, and implement public policies focused on health education and improved basic sanitation. These measures are essential to reduce the incidence and impact of the disease in endemic areas such as the state of Sergipe. **DESCRIPTORS:** Schistosomiasis; Epidemiology; Epidemiological monitoring; Public health surveillance.

RESUMEN

Objetivo: Este estudio tuvo como objetivo analizar el perfil epidemiológico de los casos notificados de esquistosomiasis en Sergipe, desde enero de 2015 hasta julio de 2025, utilizando datos secundarios del Sistema de Información de Enfermedades de Notificación Obligatoria (SINAN). **Método:** Se trata de un estudio transversal retrospectivo con enfoque cuantitativo. Se incluyeron casos notificados de todos los grupos de edad, considerando las siguientes variables: municipio de infección, sexo, raza/color, grupo de edad, nivel educativo, forma clínica y evolución del caso. **Resultados:** Se identificaron 1066 casos de esquistosomiasis durante el periodo analizado, con una mayor concentración en los municipios del interior del estado (86,8 %). Se observó un predominio de hombres (55,1 %) y de personas mestizas (72,0 %). Predominó la educación primaria incompleta en cuanto al nivel educativo. Clínicamente, la forma intestinal fue la más frecuente (38,3 %). El diagnóstico mostró una alta proporción de resultados positivos tanto en las pruebas cualitativas (41,8 %) como en las cuantitativas (43,2 %). **Conclusión:** Los hallazgos refuerzan la necesidad de fortalecer las acciones de vigilancia epidemiológica, ampliar

el diagnóstico y el tratamiento precoz, e implementar políticas públicas centradas en la educación para la salud y la mejora del saneamiento básico. Estas medidas son esenciales para reducir la incidencia y el impacto de la enfermedad en zonas endémicas como el estado de Sergipe.

DESCRIPTORES: Esquistosomiasis; Epidemiologia; Monitoreo epidemiológico; Vigilancia en salud pública.

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ID Carlos Daniel Oliveira da Silva
Medical student. Tiradentes University (UNIT), Estância, SE, Brazil.
ORCID: <https://orcid.org/0009-0006-0416-985X>

ID Clesimary Molina Evangelista Martins
Master's Degree in Public Health (University of Brasília – UNB). Graduate in Physical Therapy and Physical Education (Tiradentes University – UNIT). Professor at Tiradentes University (UNIT), SE, Brazil.
ORCID: <https://orcid.org/0000-0003-2342-6779>

ID Nara Michelle Moura Soares
Doctorate in Public Health (Federal University of Santa Catarina – UFSC). Master's degree in Physical Education (Federal University of Sergipe – UFS). Graduate in Physical Education (Federal University of Sergipe – UFS). Lecturer at Tiradentes University (UNIT), SE, Brazil.
ORCID: <https://orcid.org/0000-0001-9910-1730>

ID Bianca Fernanda Evangelista
Master's degree in Applied Health Sciences (UFS-

-SE). Bachelor's degree in Social Work. Lato Sensu postgraduate degree in Health Auditing, Planning, and Management. Bachelor's degree in Social Communication – Advertising and Publicity.
ORCID: <https://orcid.org/0000-0003-3410-6869>

ID Licia Santos Santana
Doctorate and Master's Degree in Gynecology and Obstetrics (USP – Ribeirão Preto). Specialist in Women's Health. Professor at Tiradentes University (UNIT), Brazil.
ORCID: <https://orcid.org/0000-0002-4720-8293>

ID Fernanda Dantas Barro
Master's degree in Industrial Biotechnology. Bachelor's degree in Nursing. Professor at Tiradentes University (UNIT), Sergipe, Brazil.
ORCID: <https://orcid.org/0000-0001-9155-1665>

ID Camila Gomes Dantas
PhD in Industrial Biotechnology (Tiradentes University – UNIT). Professor at Tiradentes University (UNIT), Brazil.
ORCID: <https://orcid.org/0000-0002-3018-1848>

INTRODUCTION

Schistosomiasis is a parasitic disease with acute or chronic progression, endemic in several regions of the world and prevalent in tropical and subtropical areas, such as Brazil. It is characterized by high morbidity and mortality and has a strong relationship with socioeconomic and environmental determinants, constituting a significant public health problem. The disease is caused by six species of the genus *Schistosoma* capable of infecting humans: *S. mansoni*, *S. haematobium*, *S. japonicum*, *S. mekongi*, *S. interca-*

latum, and *S. guineensis*. However, in the Americas, *S. mansoni* is the main etiological agent, responsible for almost all reported cases ⁽¹⁾.

According to data from the World Health Organization (WHO), presented in the 2023 Global Neglected Tropical Diseases Dashboard, approximately 253.8 million people worldwide needed preventive treatment for schistosomiasis, with about 2.27 million in the Americas. In Brazil, it is estimated that approximately 1.5 million people live in risk areas, mainly in the Northeast and Southeast regions ⁽²⁾. This high epidemiological burden reflects not only the

persistence of the transmission cycle, but also the social and environmental determinants that sustain the endemic disease, such as poor sanitation and social inequalities ⁽¹⁻³⁾.

Schistosomiasis is caused by six species of the genus *Schistosoma* capable of infecting humans, with *S. mansoni* being the main agent in the Americas. Its biological cycle involves the elimination of eggs in feces, the hatching of miracidia in water, and their penetration into snails of the genus *Biomphalaria*, their intermediate host. In these snails, cercariae multiply and are released, infecting humans through their skin. In the body, they

transform into schistosomula, migrate to the liver, and reach maturity in the mesenteric veins, where they produce new eggs. Some of these eggs remain trapped in the tissues, triggering significant chronic inflammatory reactions responsible for manifestations such as hepatic fibrosis and portal hypertension^(4,5,6).

Clinically, the infection presents in a polymorphic form, ranging from asymptomatic or oligosymptomatic cases, which constitute the majority of cases, to severe forms, with hepatosplenic involvement and risk of death. In addition, parasite eggs and antigens can reach extrahepatic organs, causing pulmonary, renal, thyroid, neurological, and even reproductive manifestations, contributing to the burden of disease and compromising the quality of life of individuals⁽¹⁻⁴⁾.

In diagnosis, direct laboratory methods, such as the detection of eggs in stool samples using the Kato-Katz technique, remain the standard recommended by control programs. However, new approaches are gaining ground, such as molecular tests (PCR) and more sensitive immunoenzymatic assays, which can aid in the identification of infections with low parasite load⁽¹⁻³⁾. Treatment, in turn, is based on praziquantel, made available by the Unified Health System (SUS), which is highly effective, safe, and relatively simple to administer, although its dosage involves the ingestion of several tablets, proportional to the patient's weight.

Despite these advances, schistosomiasis remains a major public health problem in Brazil. The continued transmission is related to the lack of universal basic sanitation, population exposure to contaminated water bodies, and difficulty in accessing health services. As a result, the disease continues to have a significant impact on the social and economic development of endemic communities⁽³⁻⁷⁾.

In the state of Sergipe, the chal-

lenge is significant: of the 75 municipalities, 51 are considered endemic, according to the State Health Secretariat (SES). The relevance of the issue led to the approval of State Law No. 9,700/2025, which establishes the State Schistosomiasis Awareness Week, held annually in September, with the aim of strengthening educational and preventive actions^(8,9).

Given this scenario, it is essential to understand the main epidemiological indicators of schistosomiasis in Sergipe, considering sociodemographic aspects, diagnostic methods used, treatment adherence, and associated complications. Thus, this study aims to qualitatively analyze the epidemiological profile of reported cases of schistosomiasis in Sergipe from 2015 to 2025, contributing to more effective disease control strategies.

METHOD

This is a retrospective, cross-sectional study with a quantitative approach, developed from the analysis of records from the Ministry of Health's Notifiable Diseases Information System (SINAN). The study included children and adults reported with schistosomiasis in the analyzed period, considering the variables: municipality of infection, gender, race/color, age group, education level, clinical form, and evolution of cases. Cases without laboratory confirmation were excluded.

Because it used secondary data in the public domain, this research was exempted from review by the Research Ethics Committee, in accordance with Resolution No. 510, dated April 7, 2016, of the National Health Council.

Initially, quantitative data were tabulated and analyzed using descriptive statistics, with calculation of absolute and relative frequencies, distributed annually and according to the categories of each variable. To

represent the temporal evolution of cases, a time series figure was constructed with the total number of notifications from 2015 to 2025. The spatial distribution of the disease was presented using a choropleth map of the municipalities of Sergipe, created in Microsoft Excel, relating the geographical location to the cumulative number of cases in the period. In addition, a consolidated table was constructed with the number of annual cases according to clinical and sociodemographic variables. All statistical analyses were conducted using Jamovi software, version 2.3.

RESULTS

Between January 2015 and July 2025, 1,066 cases of schistosomiasis were reported in Sergipe (Table 1). The data collected were described according to clinical and sociodemographic variables, allowing the epidemiological profile of the disease in the state to be outlined⁽¹⁰⁾.

Regarding clinical forms, the intestinal form was predominant (408 cases; 38.3%), followed by the hepatosplenic form (71 cases; 6.7%). The acute (26 cases; 2.4%) and hepato-intestinal (33 cases; 3.1%) forms were less frequent. It should be noted that in 463 records (43.4%), the information was ignored or not filled in.

Regarding the qualitative diagnosis, positivity was observed in 446 cases (41.8%). There were also 239 tests not performed (22.4%) and 330 records ignored/blank (31.0%). Negative results corresponded to 51 cases (4.8%). The quantitative diagnosis also showed high positivity, with one or more eggs detected in 461 cases (43.2%).

Regarding clinical outcome, most records were listed as ignored/blank (664 cases; 62.3%). Among those reported, cure was observed in 326 cases (30.6%) and no cure in 15 (1.4%). There were 46 deaths attributed to

schistosomiasis (4.3%) and 15 deaths from other causes (1.4%).

The education variable had a high proportion of unknown/blank data (331 cases; 31.1%). Among the reported records, incomplete 1st to 4th grade elementary school stood out (185 cases; 17.4%), followed by incomplete 5th to 8th grade (137 cases; 12.9%). Other categories included 4th grade completed (65 cases; 6.1%),

elementary school completed (56 cases; 5.3%), incomplete high school (57 cases; 5.3%), and higher education completed (41 cases; 3.8%).

In terms of gender, there was a slight predominance of males (587 cases; 55.1%) over females (479 cases; 44.9%). Regarding color/race, the brown category predominated (768 cases; 72.0%), followed by white (142 cases; 13.3%) and black (78 cases;

7.3%). Yellow (7 cases; 0.7%) and indigenous (4 cases; 0.4%) were less frequent, while unknown/white accounted for 67 cases (6.3%).

Furthermore, regarding place of residence, it was found that most cases occurred in municipalities in the interior of the state (925 cases; 86.8%), while the capital, Aracaju, concentrated 141 cases (13.2%) throughout the series.

Table 1. Annual distribution of schistosomiasis cases according to clinical and sociodemographic variables in Sergipe from 2015 to 2025

Clinical and sociodemographic variables		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total
Type Clinical	Ignored/Blank	105	33	31	63	39	31	31	32	51	37	10	463
	Intestinal	33	54	51	43	34	12	35	51	39	39	17	408
	Hepatointestinal	1	4	1	3	7	4	3	3	3	4	-	33
	Hepato-splenic	4	7	7	7	10	7	5	9	12	1	2	71
	Acute	1	9	4	2	3	2	1	-	2	1	1	26
	Other	7	7	5	7	11	2	6	6	8	5	1	65
Qualitative Diagnosis	Ignored/Blank	68	29	27	38	33	24	19	35	24	28	5	330
	Positive	55	57	46	58	43	21	41	44	50	22	9	446
	Negative	7	7	5	4	6	1	2	10	4	4	1	51
	Not achieved	21	21	21	25	22	12	19	12	37	33	16	239
	Total	151	114	99	125	104	58	81	101	115	87	31	1066
Quantitative Diagnosis	One or more eggs	90	34	44	57	43	17	37	41	52	34	12	461
Desfecho	Ignored/Blank	92	72	66	85	74	39	45	47	72	52	20	664
	Healing	56	34	28	33	22	12	27	42	34	28	10	326
	No cure	-	3	2	1	1	1	2	1	2	2	-	15
	Deaths from Schistosomiasis	2	5	3	4	4	5	6	9	3	4	1	46
	Death from other causes	1	-	-	2	3	1	1	2	4	1	-	15
Faixa etária	<1 year	2	1	-	3	-	-	-	-	-	-	-	6
	1-4 years	5	2	1	2	2	-	3	2	2	3	-	22
	5-9 years	10	7	6	6	3	2	3	4	4	1	1	47
	10-14 years	15	12	10	8	5	2	3	7	9	2	2	75
	15-19 years	8	12	8	11	6	3	7	6	8	5	1	75
	20-39 years	52	32	42	40	37	10	23	28	32	21	10	327
	40-59 years	28	32	25	40	34	30	28	36	33	39	15	340
	65-69	12	3	4	1	3	5	-	4	8	4	1	45
	70-79 years	4	4	1	6	2	2	9	4	8	2	1	43
	≥ 80 years	5	-	-	-	2	1	2	4	3	3	-	20
Sexo	Male	74	71	57	71	52	41	51	48	57	50	15	587
	Women	77	43	42	54	52	17	30	53	58	37	16	479

Color/breed	Ignored/Blank	13	10	6	8	3	4	3	7	6	4	3	67
	White	20	18	9	22	12	4	14	11	16	8	8	142
	Black	4	8	5	17	9	1	5	7	10	8	4	78
	Yellow	-	-	2	2	1	-	-	-	2	-	-	7
	Brown	112	78	77	76	79	49	59	76	80	66	16	768
	Indigenous	2	-	-	-	-	-	-	-	1	1	-	4
Education	Ignored/Blank	80	42	39	39	24	16	15	26	33	11	6	331
	Illiterate	4	7	2	4	6	4	4	4	4	2	3	44
	1st to 4th grade incomplete	15	28	21	28	14	15	14	13	14	22	1	185
	4th grade complete EF	9	4	7	9	10	2	5	9	6	3	1	65
	5th to 8th grade incomplete	18	12	6	13	16	6	8	13	16	21	8	137
	Complete elementary education	6	2	5	6	8	1	8	7	8	5	-	56
	Incomplete high school education	3	6	3	7	5	3	7	8	7	7	1	57
	Incomplete higher education	1	2	1	-	-	1	3	3	2	1	1	15
	Complete higher education	1	-	5	5	3	5	6	6	6	2	2	41
	Not applicable	12	3	1	7	2	1	5	3	5	3	1	43
Place of Residence	Aracaju - SE	6	14	7	8	6	7	11	23	25	28	6	141
	Other municipalities - SE	145	100	92	117	98	51	70	78	90	59	25	925

Legend: (-) represents unreported cases.

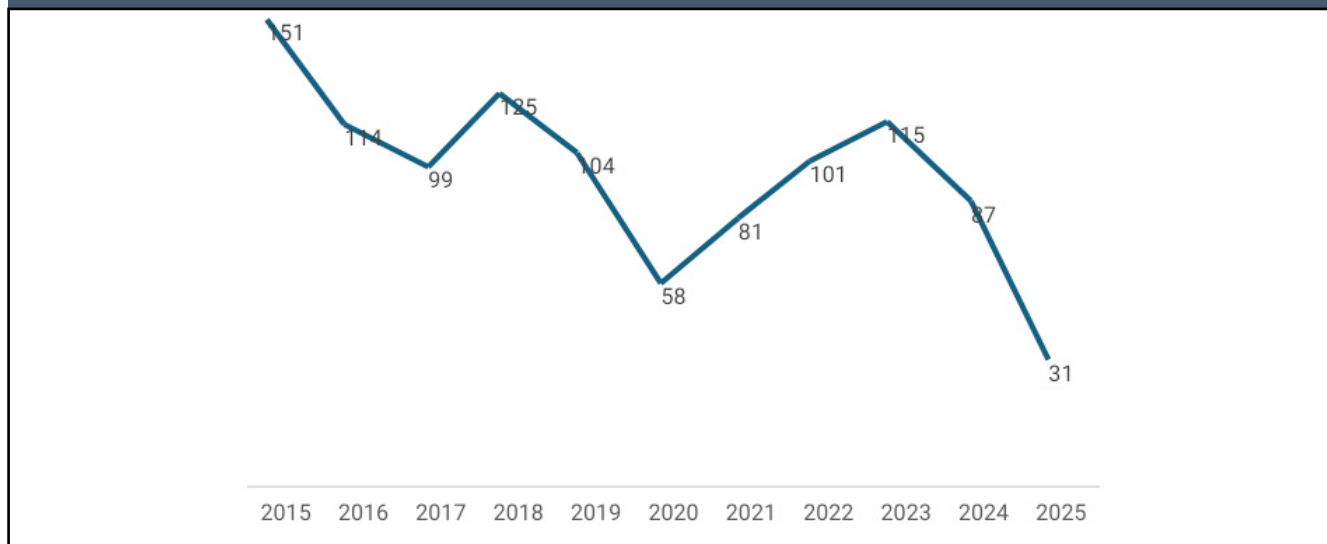
Source: own elaboration (2025), based on SINAN data.

number of cases per year over a time series of almost 10 years. The lowest number of reported cases occurred in 2020, the most critical year of the

COVID-19 pandemic, and the highest number of cases was recorded in 2015.

Furthermore, Figure 1 shows the

Figure 1. Total number of schistosomiasis cases in Sergipe from 2015 to 2025.

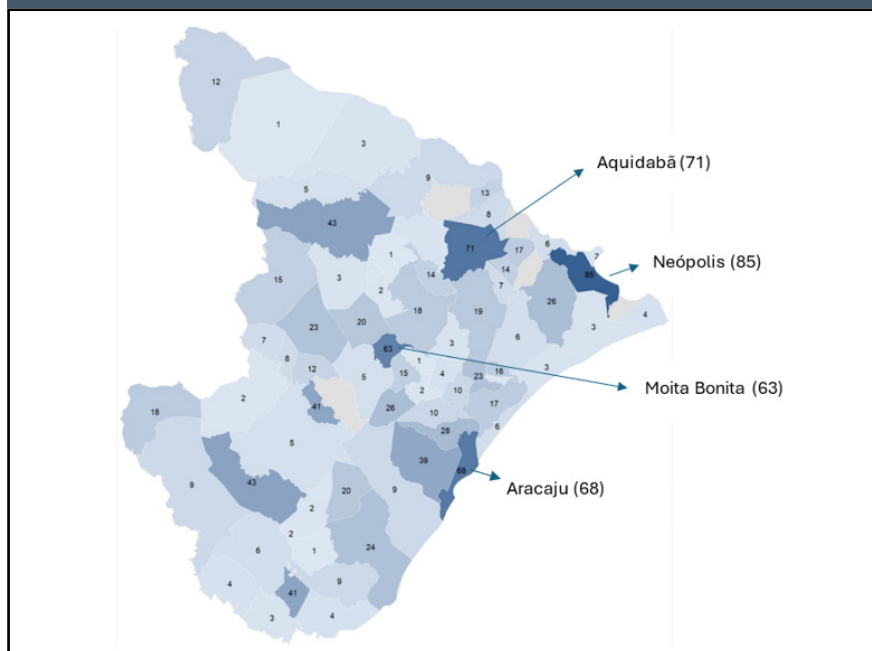


Source: own elaboration (2025), based on data from SINAN.

Finally, the municipalities with the highest number of cases were Neópolis (85 cases), Aracaju (68), Moita Bonita (63), Riachão do Dantas and Nossa Senhora da Glória (43 cases

each), and Estância (41). The choropleth map shows the geographic distribution of reported cases in the years studied (Figure 2).

Figure 2. Geographic distribution of reported cases of schistosomiasis by municipality in Sergipe from 2015 to 2025



Legend: darker colors represent a higher number of cases.

Source: own elaboration (2025), based on SINAN.

DISCUSSION

This study analyzed the cases of schistosomiasis reported in Sergipe between 2015 and 2025, outlining the epidemiological profile of the disease in the state. The findings revealed relevant patterns that allow us to understand the persistence of the endemic disease in specific areas and the factors that condition its maintenance.

A total of 1,066 cases were reported during the period, with the highest number recorded in 2015 and the lowest in 2020. The reduction observed in that year probably does not reflect a real drop in incidence, but rather underreporting associated with the impact of the COVID-19 pandemic, which over-

whelmed health services and reduced diagnostic and surveillance capacity. This situation was widely reported in different notifiable diseases during the pandemic period⁽¹¹⁾.

The spatial distribution showed that most cases occurred in inland municipalities (86.8%), while the capital accounted for only 13.2%. This pattern reflects both the higher population density of these areas and the environmental and socioeconomic conditions that favor transmission, such as poor sanitation, occupational contact with contaminated water (irrigated agriculture, artisanal fishing), and recreational activities in rivers. Previous studies corroborate this relationship between social vulnerability, environmental conditions, and the persistence of schistosomiasis in rural areas⁽¹⁻¹²³⁾.

Regarding the sociodemographic

profile, there was a predominance of males (55.1%), a finding consistent with the literature, which relates this higher prevalence to greater exposure to risky activities. The most affected age group was economically active adults, which reinforces the association between the disease and occupational activities. The predominance of cases among brown individuals (72.0%) may reflect social and racial inequalities, since black and brown populations are more frequently exposed to conditions of vulnerability and face barriers to accessing health services⁽¹¹⁾.

The analysis of educational attainment revealed a predominance of incomplete elementary school education, reinforcing the relationship between low educational attainment, social vulnerability, and increased risk of exposure. However, the high proportion of missing data (31.1%) limits more robust inferences and highlights weaknesses in the completion of SINAN forms, a recurring situation in Brazilian epidemiological studies.

In the clinical setting, the intestinal form predominated (38.3%), followed by the hepatosplenic form (6.7%), while acute forms were less frequent (2.4%). This finding may be related to the oligosymptomatic or asymptomatic nature of the initial forms, hindering early diagnosis and favoring progression to chronic forms, associated with greater clinical complications and risk of death. In this context, active screening strategies in endemic areas are essential for early detection and prevention⁽¹³⁾.

The diagnosis showed a high proportion of positive results in both qualitative (41.8%) and quantitative (43.2%) tests, consistent with the persistence of active transmission in the state. However, the high frequency of tests not performed or ignored compromises the accuracy of surveillance. It should be noted that the Kato-Katz method, considered the gold standard in Brazil, was not specified in the notification forms, which limits more specific analyses of

the diagnosis.

Regarding clinical outcome, most records were listed as ignored/blank (62.3%), evidencing failures in follow-up and monitoring of cure. Among the reported cases, a cure rate of 30.6% was observed, consistent with the effectiveness of praziquantel, the only drug available and widely used in Brazil ⁽¹⁴⁾. Despite its high efficacy, the 46 deaths from schistosomiasis identified (4.3%) reflect persistent failures in early diagnosis and access to treatment, especially in vulnerable areas.

Thus, the findings reinforce that schistosomiasis remains an important public health problem in Sergipe, conditioned by social, environmental, and structural factors. The high proportion

of incomplete data in SINAN limits more accurate analyses and points to the need for training health teams in filling out notification forms. Furthermore, the results highlight the urgency of public policies that strengthen basic sanitation, health education, active screening, and expanded access to timely diagnosis and treatment, with the aim of reducing morbidity and mortality and interrupting the chain of disease transmission.

CONCLUSION

The study showed that schistosomiasis remains an important public health problem in Sergipe, with a higher incidence among adult men with low

levels of education and living in rural areas, reflecting the influence of social determinants of health. The concentration of cases in the interior of the state and the predominance of more advanced clinical forms reinforce inequalities in access to timely diagnosis and treatment. The incompleteness of the SINAN records highlights the need to improve epidemiological surveillance. Addressing schistosomiasis requires continuous intersectoral actions, with an emphasis on health education, strengthening primary care, and investing in sanitation, which are essential to reduce transmission and the burden of disease in Sergipe.

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