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Risk factors for infection with *Giardia duodenalis* in pre-school children in the city of Salvador, Brazil

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**SUMMARY**

A cross-sectional study of 694 children aged 2 to 45 months selected from 30 clusters throughout the city of Salvador, Bahia (pop. 2.3 million) was carried out as part of a longitudinal study of diarrhoea in order to identify risk factors for infection with *Giardia duodenalis*. Variables studied included three social and demographic factors (such as mother's education and marital status), five relating to the peri-domestic environment (rubbish disposal, open sewers, paving of the street), seven relating to the home itself (house construction, susceptibility to flooding, water supply and sanitation) as well as a score for hygiene behaviour based on structured observation. After multivariate analysis using a hierarchical model, only four significant risk factors were found: (a) number of children in the household under five years (b) rubbish not collected from the house (c) presence of visible sewage nearby, and (d) absence of a toilet. All four were significant at the 1% level.

**INTRODUCTION**

Infection with the protozoan enteric pathogen *Giardia duodenalis* is common, particularly among pre-school children, and not only in poor communities in developing countries. It has been estimated that a global total of some 200 million people are infected [1]. The prevalence of infection varies from 2 to 5% in industrialised countries and from 20 to 30% in the developing countries of the world [2–5].

Most infections with *G. duodenalis* are asymptomatic. Among symptomatic children the most important signs are persistent diarrhoea and loss of weight. However, a wide range of other symptoms has also been noted, including nausea, malabsorption of lactose, carbohydrate, fats, and vitamins A and B₁₂ [6, 7], macrocytic anaemia due to folate deficiency and retardation of growth and development [8, 9].

Transmission of *G. duodenalis* is by the faeco-oral route, and epidemics, as well as endemic cases in the developed countries, have been associated with waterborne transmission [10]. Person to person transmission has also been documented in institutions such as creches and children’s wards where hygiene conditions are less than ideal [11]. The pathogen is found in wild animal reservoirs such as beavers [12], and also in domesticated animals including cattle, cats and dogs [13]. However, most studies of the transmission of this pathogen have investigated epidemic conditions and developed countries, and the environmental epidemiology of endemic giardiasis in developing countries has received relatively little attention [14]. The present study aims to identify environmental risk factors for *G. duodenalis* infection among
pre-school children in the City of Salvador in Northeast Brazil.

METHODS

Study design and population

The study site was the City of Salvador, capital of Bahia State, with a population of approximately 2.3 millions and a population density of 6630 inhabitants/km$^2$ [15]. The sample had originally been selected for a wider longitudinal study of the health impact of sanitation. The sampling has been described in detail elsewhere [16]. First, 30 neighbourhoods were selected, using stratified random sampling to represent the range of environmental conditions found throughout the city. The city was divided into areas with differing degrees of coverage with environmental services such as water supply and excreta disposal, using data from the 1991 national census [15] and a random sample of neighbourhoods chosen from each. Each neighbourhood included a mean of 600 contiguous dwellings, occupying one or more census tracts. A census of each neighbourhood was conducted, giving a listing of all households with children aged from 0 to 3 years, based on the mother’s declaration of the child’s age. A subset of these households was then chosen at random. In households with more than one eligible child, one such child was also selected randomly to be recruited to the study. The collection of stool samples usually took place 6 months (occasionally up to 9 months) after the selection of the original sample. Thus the children were aged up to 45 months at the time of the study.

Collection and examination of stool samples

A numbered, sealable container was given to the mother or carer of each child at home and she was asked to collect a stool sample the following morning. These were collected the next morning and immediately transported under refrigeration to the laboratory for examination on the same day. If the sample was too small or the child’s family did not present a sample, the field worker arranged to collect a new sample on the following day. A single stool sample from each child was examined using the spontaneous sedimentation technique, and was considered positive if *G. duodenalis* cysts were found in the sediment [17].

All children found to be infected were treated with 1.5 ml/kg metronidazole (Flagyl®). Due to operational delays, this took place between 1 and 2 months after collection of the samples.

Socio-economic and environmental data

Socio-economic and environmental data were collected at the time of recruitment to the study, using a pre-coded questionnaire and observation schedule. The observation schedule included provision for the field workers to note particularly hygienic or unhygienic behaviour by the child and her mother occurring during their visits, which were made twice a week for a year. A composite score was composed of 33 different behaviours, and children were grouped into three categories; those for whom the observed behaviours were mainly unhygienic, those in which hygienic and unhygienic behaviours were observed with roughly equal frequency, and those in which unhygienic behaviour was most commonly observed. Details of the hygiene behaviour observation are given elsewhere [18]. The field workers were all females, with full secondary education. They were selected on the basis of a simulated interview using the study questionnaire, and given a week’s training. The questionnaire itself had been pre-tested in the field. One in ten households was re-interviewed by the supervisor, a trained sociologist, as a quality control measure.

The variables studied fell broadly into four categories: (a) those related to the socio-economic and demographic status of the mother and the household; (b) those reflecting the characteristics of the peri-domestic environment; (c) environmental characteristics of the household itself; and (d) hygiene-related behaviour of the mother and her child (see Table 1).

Statistical analysis

Statistical analysis was carried out using STATA, version 7.0. After bivariate analysis consisting of prevalence ratios (PR) and 95% confidence intervals (CI), the following procedure was used for multivariate logistical regression. The various explanatory variables were grouped in a hierarchical model of the causation of infection [19], with the groups as shown in Table 1. The first stage was to construct a multivariate model including only the socio-economic and demographic variables. All the variables in this group except sex were included, whether or not they were
significant in the bivariate analysis. Those which did
not show an association significant at the 5% level
were removed from the model one by one, the least
significant first. Then all the variables in group (b) (see
Table 1) were added to the model, and the variables
without a significant association were removed one by
one, as before. The process was then repeated with
group (c) and finally group (d). The results were
expressed in terms of odds ratios.

Ethics
Informed consent to participate in the study was
obtained from all study households. Ethical approval
for the study was given by the Ethics Review Board
of the Federal University of Bahia.

RESULTS
Out of a total of 1156 children enrolled in the longi-
tudinal study, stool samples were successfully col-
lected for 694 (60.0%). Of these, 95 (13.7%) were
infected with *G. duodenalis*.

Table 2 shows the results of bivariate analysis of
socio-economic and demographic risk factors. The
prevalence of infection was slightly lower among
children aged less than two years, but there was no
statistically significant association with age or with
sex. Some association was seen with the mother’s
marital status, although this was not significant. On
the other hand, *G. duodenalis* infection showed a sig-
nificant association with the number of children in the
household under 5 years, and also with the mother’s
level of schooling.

All of the peridomestic environmental variables
showed a statistically significant association with
*G. duodenalis* infection (Table 3), but there was a high
degree of association between them. With regard to
the domestic environmental variables (Table 4), sig-
nificant associations with infection were only found
with house type and absence of a toilet in the house,
although the lack of significance of some other vari-
able may be attributable to the small numbers
exposed to them. The prevalence of giardiasis was
in fact lower in households reporting that they boiled
or filtered their drinking water, though this associ-
ation also was not statistically significant.

The unadjusted odds ratio for the hygiene behav-
ior score (Table 5) shows that children whose
mothers were observed to be not particularly careful
in the preparation and handling of foodstuffs, milk
bottle, comforter and utensils had nearly twice
the odds of *G. duodenalis* infection compared to
those whose mothers showed particularly hygienic
behavior. However, the association between hygiene
behavior and the prevalence of giardiasis was not
statistically significant (OR = 1.76; CI 0.83–3.73).

After construction of a multivariate logistical re-
gression model as described above, only four poten-
tial risk factors remained as significant determinants

<table>
<thead>
<tr>
<th>Group</th>
<th>Variables studied</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Socio-economic, demographic</td>
<td>Age and sex of child, Number of children &lt;5 years in household, Mother’s education and marital status</td>
</tr>
<tr>
<td>(b) Peri-domestic environment</td>
<td>Whether rubbish collected from house, Frequency of rubbish collection, Presence of rubbish heap near house, Presence of visible sewage near house, Paving of street</td>
</tr>
<tr>
<td>(c) Domestic environment</td>
<td>House construction (permanent/shack), House floor (earth or planks/cement), Susceptibility to flooding during rain, Piped water supply in house, Intermittence of water supply, Presence/absence of a toilet, Whether drinking water boiled</td>
</tr>
<tr>
<td>(d) Mother’s/child’s hygiene behaviour</td>
<td>Composite score (mainly positive/neutral/mainly negative)</td>
</tr>
</tbody>
</table>
of *G. duodenalis* infection. These were: (a) number of children less than 5 years old in the household, (b) rubbish not collected from the house (c) presence of visible sewage near the house, and (d) non-possession of a toilet. The odds ratios and 95% confidence intervals for these are shown in Table 6.

**DISCUSSION**

In some ways, the present study is complementary to the study by Newman et al. [20] also conducted in urban Northeast Brazil. While the latter examined the factors associated with symptoms among children...
who were already infected with *G. duodenalis*, our study examined the risk factors for infection, whether or not it was symptomatic. The overall prevalence of infection (13.6%) found in our study of children aged 12–45 months was slightly higher than that reported by Newman et al. (8.8%). This is understandable as the latter followed up children from birth, although most children were aged over 12 months before their first infection was detected.

The absence, in our data, of an association with any of the three variables related to water supply is striking in view of the studies from industrialised countries which have underlined the role of water in transmission. Studies in rural Africa [14] and urban Brazil [21] have found no significant association between *G. duodenalis* infection and the quality of the water used by the household for drinking. A low quantity of water used for hygiene was significantly associated with giardiasis in the former [14], but in the latter [21] the presence of a piped water connection, normally associated with substantial improvements in hygiene, was not. Indeed in a third study, in Colombia [22], piped water was found to be associated with a greater risk of infection.

The Brazilian study mentioned above [21] found [on bivariate analysis] that, giardiasis was associated with low socio-economic status (represented by household income and parents’ education). We also found an association with the mother’s education on

<table>
<thead>
<tr>
<th>Table 4. Domestic environmental risk factors for infection with <em>G. duodenalis</em> among pre-school children in Salvador, Brazil 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variables</td>
</tr>
<tr>
<td>Domestic environmental factors</td>
</tr>
<tr>
<td>Type of house</td>
</tr>
<tr>
<td>Permanent construction</td>
</tr>
<tr>
<td>Shack</td>
</tr>
<tr>
<td>Floor material</td>
</tr>
<tr>
<td>Cement</td>
</tr>
<tr>
<td>Earth or planks</td>
</tr>
<tr>
<td>Separate kitchen</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>House floods during rain</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Water supply</td>
</tr>
<tr>
<td>Piped connection</td>
</tr>
<tr>
<td>No piped connection</td>
</tr>
<tr>
<td>Reliability of water supply</td>
</tr>
<tr>
<td>Regular</td>
</tr>
<tr>
<td>Intermittent</td>
</tr>
<tr>
<td>Domestic water storage vessel</td>
</tr>
<tr>
<td>Adequate</td>
</tr>
<tr>
<td>Inadequate</td>
</tr>
<tr>
<td>Presence/absence of a toilet</td>
</tr>
<tr>
<td>Present</td>
</tr>
<tr>
<td>Not present</td>
</tr>
<tr>
<td>Drinking water boiled or filtered</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 5. Hygiene behaviour score as a risk factor for infection with <em>G. duodenalis</em> among pre-school children in Salvador, Brazil 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>Hygiene behaviour</td>
</tr>
<tr>
<td>Mainly positive</td>
</tr>
<tr>
<td>Neutral</td>
</tr>
<tr>
<td>Mainly negative</td>
</tr>
</tbody>
</table>
bivariate analysis, but this association was no longer significant when controlled for other variables using multivariate analysis.

Another variable, striking by its absence from the final list of risk factors, was the hygiene behaviour score, derived from structured observations made during the home visits. In a study of diarrhoea symptoms in the same group of children [18] the association with this hygiene score was significant and stronger than for all other risk factors, supporting the view that the score was a genuine measure of hygiene standards.

More generally, the differences between the results reported here and those of that diarrhoea study suggest that the transmission of giardiasis is subject to different factors, and may even follow different routes, than the transmission of other diarrhoea pathogens. This conclusion is also supported by the finding of high prevalences of giardiasis in children in day-care centres in the developed countries, although the incidence of diarrhoea among them is not high [23].

Of the risk factors whose statistical significance remains following multivariate analysis, the number of children in the household under five years of age is easily understood in terms of the higher prevalence of infection among young children [21] and the likelihood of transmission between children within the domestic domain. The number of young children in the household is often associated with crowding (persons/room), and this may be the reason why crowding appeared as a risk factor for symptomatic giardiasis in the results of Newman et al. [20].

The second and third significant risk factors – lack of rubbish collection, and visible sewage near the house – are related to peridomestic conditions rather than to hygiene within the home. This fits with the finding that giardiasis is often more prevalent among children over 2 years than the youngest toddlers [14], as the latter are less likely to be allowed to wander into the neighbourhood. Certainly it would help to explain why domestic hygiene behaviour was not significantly protective from *G. duodenalis* infection, if most of the transmission occurs in the public and not the domestic domain [24].

The presence of an open sewer near the house has been found to be associated with infection of Brazilian children with other faecal pathogens [25, 26]. Exposure to open sewers can be seen as analogous to exposure to untreated wastewater used for irrigation [27] although, in the latter, the associated risk seems to stem from the consumption of the irrigated vegetables rather than from wastewater contact [28]. Children are more likely to have contact with wastewater exposed in the peridomestic environment than in the fields.

A number of studies have found an excess risk of diarrhoeal disease associated with deficient solid waste management near the home [29]. Domestic refuse in Brazil contains a substantial amount of faecal contamination, as 5% of it consists of used toilet paper and disposable nappies, even in low-income areas [30]. There are several possible mechanisms by which refuse could promote the transmission of *G. duodenalis* to children. Children can be seen playing on rubbish heaps near their homes, so that direct contact is the most obvious of these. In addition, rubbish in the residential environment may breed houseflies, which have been shown to transmit a quarter of endemic diarrhoea in some communities [31]. However, similar proportions of mothers in households with and without an infected child complained of fly problems (33/92 vs. 157/536; RR = 1.29, CI 0.87–1.91), so that this seems unlikely to explain the association that we found. The third mechanism is that rubbish heaps may also attract stray dogs and rats, which are themselves infected with *G. duodenalis* [32].

The fourth risk factor – possession of a toilet – has been found to be protective from *G. duodenalis* infection in emergency camps in Colombia [222], but not in rural Africa [14]. The importance of sanitation may be a function of population density. It may also be that ownership of a toilet sometimes appears protective.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds ratio</th>
<th>P value</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of children in family &lt;5 years</td>
<td>2.08</td>
<td>0.001</td>
<td>(1.32–3.27)</td>
</tr>
<tr>
<td>Solid waste disposal</td>
<td>1.97</td>
<td>0.005</td>
<td>(1.22–3.16)</td>
</tr>
<tr>
<td>Presence of visible sewage near house</td>
<td>1.85</td>
<td>0.009</td>
<td>(1.16–2.96)</td>
</tr>
<tr>
<td>Absence of a toilet</td>
<td>2.51</td>
<td>0.004</td>
<td>(1.33–4.71)</td>
</tr>
</tbody>
</table>

Table 6. Risk factors for infection with *Giardia duodenalis* in Salvador, Brazil; results of multivariate logistical regression
because it reflects higher socio-economic status or greater awareness of hygiene, rather than the hygienic advantages of the toilet per se [18].

ACKNOWLEDGEMENTS

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