

# AN OVERVIEW OF VENEREAL DISEASE PROGRAMS IN BRITAIN, WEST GERMANY, DENMARK, AND SWEDEN, WITH IMPLICATIONS FOR CANADA<sup>1</sup>

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*Venereal disease programs tend to differ a good deal from one country to the next. Even in a limited geographic area such as Western Europe, marked variations exist in many major areas of activity—including case reporting, contact tracing, treatment services, and health education. The present report reviews VD programs in four European countries, points out similarities and differences between them, and notes various approaches that might advance the campaign against venereal disease in Canada, the author's home country.*

## Introduction

The author was awarded a WHO Travel Fellowship to study venereal disease control and family planning programs in Britain, West Germany, Denmark, and Sweden. Accordingly, he spent two weeks in each country between December 1974 and February 1975. The present report deals with the venereal disease aspects of his work, summarizing the venereal disease programs observed in the four countries, comparing them to the program in Canada, and suggesting some possible ways in which Canada's program might be improved.

## VD Incidence Rates and Trends

Since statistics for England are published separately from those for Wales, Scotland, and Northern Ireland and were more readily available, gonorrhoea and syphilis rates

for England have been used in place of those for Britain as a whole.

### *Gonorrhoea*

Table 1 compares the incidence of reported gonorrhoea cases, by sex, in each of the four countries during 1973 with the incidence in Canada. For reasons which will become apparent, the incidence of reported cases probably gives a fairly realistic idea of the true incidence in Denmark, England, and Sweden; but it almost certainly represents an underestimate of the true incidence in both West Germany and Canada. The true incidence in West Germany probably fell between the incidence in England and the incidence in the two Scandinavian countries, while the true incidence in Canada probably exceeded even that in the Scandinavian countries.

Table 2 shows trends in the incidence of reported gonorrhoea cases over the five-year period 1969-1973. Since under-reporting does not necessarily affect trends, the trends indicated for West Germany and Canada may well reflect the actual situation. The

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**Table 1. Incidence of reported gonorrhoea cases, by sex, in England, West Germany, Denmark, Sweden, and Canada (1973).**

Country	Cases per 100,000		
	Male	Female	Both sexes
England	167.4	87.0	126.1
West Germany	191.3	67.2	126.6
Denmark	384.4	278.3	331.0
Sweden	339.0	311.0	325.0
Canada	277.6*	139.9*	205.2

\*Excluding Nova Scotia and Prince Edward Island, which do not report sex or age.

figures presented suggest that in England the incidence increased, in West Germany and Denmark it fell slightly after reaching a peak in 1972, in Sweden it dropped markedly after 1970, and in Canada it rose rapidly throughout the five-year period.

### *Syphilis*

Table 3 compares the incidence, by sex, of reported infectious syphilis cases in each of the four countries during 1973 with the incidence in Canada that year. Although the criteria for reporting syphilis varied from country to country, every effort was made to ensure consistency in the compilation of these figures.

Because syphilis has more serious implications than gonorrhoea, under-reporting of syphilis is likely to be less of a problem. The data shown indicate that West Germany had about three times the case rate of England in 1973, while the two Scandinavian countries and Canada had roughly twice the English rate.

One of the most striking features of this table is the high male to female incidence ratio, a ratio found to exceed five and a half to one in Denmark and six to one in England. This marked departure from the traditional ratio of approximately two to one reflects the increasing concentration of syphilis among homosexual males. Venereologists in London, for instance, estimated

**Table 2. Five-year trends in the incidence of reported gonorrhoea cases for both sexes in England, West Germany, Denmark, Sweden, and Canada (1969-1973).**

Country	Cases per 100,000				
	1969	1970	1971	1972	1973
England	108.3	115.7	121.6	115.3	126.1
West Germany	—	116.8*	123.8	132.5	126.6
Denmark	264.1	301.5	312.9	342.0	331.0
Sweden	430.0	484.0	472.0	388.0	325.0
Canada	129.0	147.6	158.7	189.9	205.2

\*Rate based on notifications during second half of 1970.

**Table 3. Incidence of reported infectious syphilis cases, by sex, in England, West Germany, Denmark, Sweden, and Canada (1973).**

Country	Cases per 100,000		
	Male	Female	Both sexes
England	5.8	0.9	3.3
West Germany	14.1	5.1	9.4
Denmark	11.0	1.9	6.4
Sweden	8.3	2.3	5.3
Canada	9.0*	2.3*	5.6

\*Excluding Nova Scotia and Prince Edward Island, which do not report sex or age.

that homosexual males accounted for 75 to 80 per cent of the infectious syphilis in that city.

Table 4 shows trends in the incidence of reported infectious syphilis cases during the five-year period 1969-1973. In general, the incidence in West Germany and Denmark appears to have been fairly static, but in England and Sweden it seems to have risen steadily since 1970, and in Canada it appears to have increased rapidly after 1971.

#### Reporting Disease Cases

The term "venereal disease" (VD) has been replaced in Britain with the term

"sexually transmitted disease" (STD). In England, all STD clinics submit quarterly statistical reports to the Department of Health and Social Security (see Figure 1). These reports cover the whole range of sexually transmitted diseases—including not just the traditionally recognized venereal diseases (gonorrhoea, syphilis, chancroid, lymphogranuloma venereum, and granuloma inguinale), but also trichomoniasis, candidiasis, scabies, pediculosis pubis, genital herpes, genital warts, molluscum contagiosum, and non-specific genital infections (such as non-specific urethritis). The names of patients are never reported, even by physicians in private practice.

In West Germany, legislation introduced

**Table 4. Five-year trends in the incidence of reported infectious syphilis cases for both sexes in England, West Germany, Denmark, Sweden, and Canada (1969-1973).**

Country	Cases per 100,000				
	1969	1970	1971	1972	1973
England	2.6	2.4	2.5	2.6	3.3
West Germany	—	10.3*	9.2	9.5	9.4
Denmark	4.6	6.2	5.8	6.5	6.4
Sweden	4.7	4.0	4.1	4.6	5.3
Canada	4.7	4.2	3.6	4.4	5.6

\*Rate based on notifications during second half of 1970.

## FIGURE 1

FORM SBH 60

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Return for the quarter ended 31 DEC 1974 to be made by  
Physicians in charge of treatment centres

## SEXUALLY TRANSMITTED DISEASES

Name and address of centre: .....

.....

	<u>PART A</u> <u>NEW CASES OF SYPHILIS</u>	TOTAL	MALE	FEMALE
A1	Primary			
A2	Secondary			
A3	Latent in the first two years of infection			
A4	Cardio vascular			
A5	Of the nervous system			
A6	All other late and letent stages			
A7	Congenital aged under 2 years			
A8	Congenital aged 2 years and over			
	TOTAL OF LINES A1 to A8			
	<u>PART B</u> <u>NEW CASES OF GONORRHOEA</u>			
B1	Post-pubertal infections			
B2	Pre-pubertal infections			
B3	Ophthalmia neonatorum			
	TOTAL OF LINES B1 to B3			
	<u>PART C</u> <u>NEW CASES OF OTHER GENITAL INFECTIONS</u>			
C1	Chancroid			
C2	Lymphogranuloma Venerium			
C3	Granuloma Inguinale			
C4	Non-specific genital infection			
C5	Non-specific genital infection with arthritis			
C6	Trichomoniasis			
C7	Candidiasis			
C8	Scabies			
C9	Pubic lice (pediculosis pubis)			
C10	Herpes simplex			
C11	Warts (condylomata acuminata)			
C12	Molluscum Contagiosum			
	TOTAL OF LINES C1 to C12			
	<u>PART D</u> <u>NEW CASES OF OTHER CONDITIONS</u>			
D1	Other treponemal diseases			
D2	Other conditions requiring treatment in the centre			
D3	Other conditions not requiring treatment in the centre			
	TOTAL OF LINES D1 to D3			
	GRAND TOTAL OF PARTS A, B, C & D			

PART E AGE GROUPS OF NEW CASES

	AGE GROUP	SYPHILIS (lines A1 & A2)			GONORRHOEA (line B1)		
		TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
1	Under 16						
2	16 and 17						
3	18 and 19						
4	20 to 24						
5	25 and over						
	TOTAL LINES 1 to 5						

PART F LOCALITIES IN WHICH INFECTIONS TOOK PLACE

	PRIMARY & SECONDARY SYPHILIS (Lines A1 and A2)	TOTAL	MALE	FEMALE
1	In locality of centre			
2	Elsewhere in Great Britain and Northern Ireland			
3	Outside Great Britain and Northern Ireland			
4	Not known			
	TOTAL OF LINES 1 to 4			
	POST PUBERTAL GONORRHOEA (line B1)			
5	In locality of centre			
6	Elsewhere in Great Britain and Northern Ireland			
7	Outside Great Britain and Northern Ireland			
8	Not known			
	TOTAL OF LINES 5 to 8			

PART G CONTACT ACTION AND DIAGNOSES

	SYPHILIS	TOTAL	MALE	FEMALE
1	Contact action taken ie number of contacts sought			
2	Contacts attending with syphilis			
3	Contacts attending, syphilis not diagnosed			
	GONORRHOEA			
4	Contact action taken ie number of contacts sought			
5	Contacts attending with gonorrhoea			
6	Contacts attending, gonorrhoea not diagnosed			

PLEASE REFER TO ACCOMPANYING NOTES

Signed .....

Physician in charge of treatment centre

in 1969 (which became effective on 1 July 1970) has made it compulsory for any physician treating a contagious venereal disease case to report the case to the health office for the district where he practices, without mentioning the patient's name or address. Only the traditionally recognized venereal diseases are notifiable. Items to be reported include the diagnosis and the patient's age, sex, and marital status. Federal and Land (provincial) statistics are based upon cumulative data provided by these reports.

In Denmark, every physician is required to give the health office of the county where he practices a weekly statistical report on all infectious disease cases, including common colds. The traditionally recognized venereal diseases are listed individually. The form provides space for reporting the cases of each disease by age and sex, and requests some additional information on each syphilis patient. Physicians in venereal disease clinics—and even medical officers of health, who have a time-honored responsibility for treating venereal diseases—use the same reporting forms as all other physicians. No patients' names are reported unless a patient defaults from treatment.

In Sweden, the reporting system is similar to that in West Germany. Any physician who treats a patient with a venereal disease must submit a report to the health office of the county where he practices. This is the same kind of report that he submits for any other notifiable communicable disease case, except that the patient's name and address are omitted. The list of reportable venereal diseases follows the standard pattern.

In most provinces of Canada, a physician who treats a patient with a venereal disease is required to submit an individual report to the provincial health department (either directly or through the local health unit, depending upon the province). Each report identifies the patient by name. This lack of anonymity in the Canadian reporting system is disliked by physicians as well as by patients, and it undoubtedly contributes to

the under-reporting which is known to occur, especially in the case of gonorrhoea.

### VD Treatment Services

Britain is amply provided with special clinics for the treatment of sexually transmitted diseases. There are over 200 such clinics in England alone, all or nearly all of them hospital-based and all administered by the hospital system. These clinics are staffed or supervised by specialists (consultants in venereology), and all treatment is free. Clinic locations are well-advertised in public lavatories, and most people who suspect they have a venereal disease go straight to a clinic. Those who consult a general practitioner first are usually referred to a clinic, partly because the general practitioners recognize the need for specialized investigation and contact tracing, and partly because physicians paid on a per capita rather than a fee-for-service basis<sup>3</sup> see little point in duplicating a service already being provided. There are a few venereologists in the large cities who do private consultant practice on a part-time basis outside the National Health Service, but the volume of patients seen by them is small compared to the numbers attending clinics.

In West Germany, venereal disease treatment is provided almost entirely by general practitioners and by dermatology specialists who also practice venereology. The patient does not need to be referred by a general practitioner in order to visit a specialist's office, but he does require a doctor's referral in order to visit any kind of hospital outpatient clinic except one with a university affiliation. Some local health departments provide VD consultative services, but the particular city health depart-

<sup>3</sup>Under the provisions of the National Health Service, every person must register with the general practitioner of his choice; the general practitioner then receives from the state an annual fee for each patient on his list.

ment visited by the author referred patients requiring treatment to private physicians.

If a patient consults the local health department, or if his physician finds him to be suffering from a notifiable infection and reports the case to the local health office, the patient need not produce a sickness insurance card to cover the cost of treatment. This enables young people to escape the embarrassment of having to ask their parents for the family's sickness insurance card.

In Denmark, people who suspect they have a venereal disease may go either to a public clinic (usually hospital-based), to a general practitioner, or to a specialist in dermatology and venereology, as they prefer. If they go to a public clinic, treatment is free. If they choose to consult a physician in his private office, the cost of treatment (including the cost of drugs) is covered in whole or in part by the national health insurance scheme, depending on the patient's income level.

Services in Sweden are similar to those in Denmark. People suspecting that they have a venereal infection may choose between going to a hospital outpatient clinic, to a district medical officer, or to a private practitioner. If a district medical officer considers it necessary to refer the patient to a specialist (a dermatovenereologist), the district officer assumes this responsibility. There is normally a basic charge of SKr 12 (around US\$2.75) for each visit to a hospital outpatient clinic or to a district medical officer. But this fee is waived for patients requesting a VD examination and for those in whom the diagnosis of a recognized venereal disease is confirmed. By the same token, there is normally a maximum charge of SKr 15 (around US\$3.50) for drugs, but this charge is also waived if the treatment is for a venereal disease.

Turning to Canada, venereal disease treatment there is available from private physicians and from provincial or municipal clinics. However, provincial and mu-

nicipal clinics are usually located only in major cities, some of them are not hospital-based, and some do not provide treatment for patients found to have infections other than those officially listed as venereal diseases. A patient covered by medical care insurance is usually not charged for a visit to a private physician, and drugs are provided free to patients with confirmed venereal disease cases if a report is submitted to the provincial health department.

### Treatment of Minors

In Britain, West Germany, and Canada a physician who treats a minor without parental consent is legally liable to a charge of assault, but it seems that physicians in Britain and Canada are usually prepared to take that risk. In Denmark, on the other hand, a physician consulted by a minor for a VD problem is not required to get in touch with the minor's parents, and in Sweden he is expressly forbidden to do so.

### Contact Tracing

In England at least one social health worker is assigned to each STD clinic for the purpose of interviewing patients, particularly those with syphilis or gonorrhoea, in an attempt to ascertain the source of their infection and to identify persons who may have been infected by them. The patient is given an opportunity to trace his or her own contacts, and to facilitate this task is provided with one or more contact slips (see Figure 2). The patient's partner is asked to attend a clinic in person and to present the slip, which is returned to the originating clinic as soon as the presence or absence of disease in the partner has been confirmed. The system works well, and substantially reduces the time and effort the social health worker must devote to tracing contacts at the patient's home, place of work, or elsewhere.

FIGURE 2

PLEASE MAKE SURE YOU BRING THIS FORM WITH YOU WHEN YOU ATTEND

HOSPITAL OF ORIGIN:

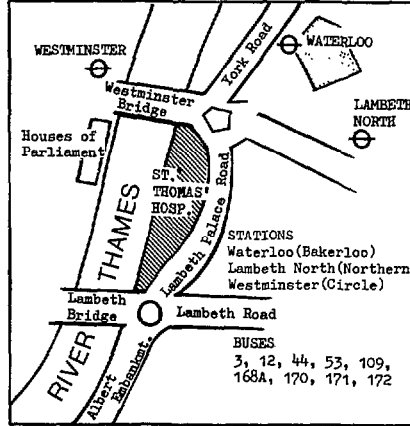
**St. Thomas' Hospital,**  
Lambeth Palace Road.

Dr. C.S. Nicol  
Dr. J. Barrow

Males and Females  
Mon - Fri. 9 30 am - 6.00 pm

NO APPOINTMENT REQUIRED

Ref.No.....  
Diagnosis.....  
Date.....



PLEASE RETURN TO ISSUING HOSPITAL

HOSPITAL :

Ref.No..... Diagnosis.....  
Date.....

In West Germany, the physician who reports a case of VD is asked to obtain as much information from the patient as possible concerning the identity of contacts, and to record this on the report form submitted to the district health office. It would appear, however, that the information provided is usually insufficient, only

rarely enabling field workers from the local health office to trace the contact or contacts involved.

Until 1973, Danish law obligated venereal disease patients to reveal information about their sexual contacts. And although patients can no longer be compelled to divulge such information, most can still be



persuaded to do so. A physician who diagnoses a venereal disease is often prepared to go to considerable trouble to elicit the necessary information from his patient, and he himself may ask the contacts to present themselves for examination. In most public clinics the patients are interviewed by social workers, who also do the contact tracing. A contact who fails to heed a request to appear for an examination may be ordered to appear, and can be forcibly compelled to do so.

In Sweden, the physician who reports a case of VD is expected to obtain enough information from the patient concerning the identity of contacts so that county health authorities can trace these contacts by mail, telephone, or personal visit and ask them to appear for examination. In public clinics the patients are interviewed by social workers, as in Denmark, but the follow-up of the contacts is undertaken by the county health authorities. If a contact is not reported to have appeared at a clinic within a reasonable time, the request is followed by an order, and if this is ignored the contact may be apprehended by the police.

In Canada, it is up to the physician reporting a VD case to indicate whether he himself will take responsibility for tracing contacts or whether he requires the assistance of public health personnel. If he asks for assistance, the information he obtains from the patient is passed along to a public health nurse for follow-up.

The situation is somewhat different for patients attending public clinics. In this case there is an opportunity for a skilled interviewer, who may also be a public health nurse, to elicit more detailed information, and the chances for successful contact tracing are thereby improved.

### Health Education

England's Health Education Council plays an active role in producing posters and pamphlets for use in anti-VD cam-

paigns. Some local health authorities also produce posters advertising both clinic services and a telephone information service. Pamphlets about sexually transmitted diseases are distributed by the Family Planning Association, and a booklet on the subject costing 15 pence (about 25 cents) is published by the British Medical Association.

In West Germany, pamphlets containing information about venereal diseases and their prevention are published by some of the provincial voluntary health associations and by the family planning association "Pro Familia." A particularly informative pamphlet is produced by the federally supported health education agency *Bundeszentrale für Gesundheitliche Aufklärung*. This agency also publishes a superb sex education atlas for use in schools; it is well endowed with diagrams to illustrate the anatomy and physiology of the male and female reproductive systems. Unfortunately, in some parts of the country the atlas never reaches the population for which it was intended.

Most of the VD-related health education activity in Denmark seems to emanate from the national health education agency *Komiteen for Sundhedsoplysning*. This agency produces pamphlets and also publishes a twice-yearly information bulletin about VD which is widely distributed to health professionals, educational institutions, and public libraries.

In Sweden, most of the VD-related health education activity is performed by the health education branch of the National Board of Health (known as the HVUD) and the Swedish Association for Sex Education (known as the RFSU). The HVUD produces pamphlets (including one in twelve languages) and a VD news bulletin similar to the one in Denmark. The RFSU, which has an international reputation for high-quality visual aids, has been conducting a vigorous anti-VD campaign through the prominent display of posters and distribu-

tion of pamphlets. This is the same organization which many years ago lobbied successfully for introduction of compulsory sex education in schools beginning at age seven. An even more unique feature of the RFSU is the fact that it derives two-thirds of its revenue from the sale of condoms.

In Canada, pamphlets about VD are produced and distributed by most provincial health departments and by the Department of National Health and Welfare. Most provincial health departments also maintain film libraries from which films may be borrowed to show to school audiences and other vulnerable groups.

### Other Observations

#### *England*

The extension of statistical reporting in England to all sexually transmitted diseases has led to the observation that nonspecific genital infections are about 1.4 times as common as gonorrhoea in both sexes combined, and that nonspecific urethritis is about 1.8 times as common as gonorrhoea in males. Research (much of it at the Whitechapel Clinic of the London Hospital) has identified *Chlamydia* as the most frequent etiologic agent.

The increasing attention focused on sexually transmitted diseases in recent years has led to the recognition of venereology as a specialty in its own right rather than a subspecialty of dermatology. The British Postgraduate Medical Federation organizes two courses a year leading to the Diploma in Venereology of the Society of Apothecaries of London. In addition, the Royal College of Physicians of London has further broadened the scope of the specialty, referring to it as genito-urinary medicine.

Many of the STD clinics in Britain are still housed in old hospital basements, and many still have separate entrances for men and women leading in directly from the street. This arrangement does nothing to

remove the stigma from VD. However, a notable exception is provided by James Pringle House, adjacent to the Middlesex Hospital, where there is a dignified entrance leading to a single reception office for both men and women, where patients are seen by appointment instead of being made to wait, and where the cordiality and the decor combine to relieve patients of their anxiety and to retain their sense of dignity and self-esteem.

#### *West Germany*

Before visiting West Germany the author was led to believe that brothels were licensed by the state, but this proved to be a misapprehension. Prostitution is illegal. In some German cities, however, there is a tacit tripartite agreement between prostitutes, police, and public health authorities whereby the prostitutes will not be harassed by the police as long as they confine their activities to recognized houses in specified districts and present themselves regularly for medical examination. In one city visited by the author the medical examinations consisted of weekly smears (but not cultures) from the cervix and urethra and a quarterly serologic test for syphilis. Working with a population of 250 prostitutes distributed among eight houses, about 60 cases of gonorrhoea were diagnosed annually by this means alone.

#### *Denmark*

The State Serum Institute in Copenhagen has a large *Neisseria* department which serves as a WHO International Reference Center. Among its other activities the Center monitors the drug sensitivity of gonococcal strains from Greenland—thereby assisting the campaign against gonorrhoea in that dependency, where a population of 50,000 inhabitants has been producing about 10,000 cases per year.

Vending machines that sell condoms seem

more plentiful in Denmark than in England, West Germany, or Sweden. Rather than being confined to barber shops and public washrooms, they were observed out on the streets of most cities visited.

### Sweden

The National Bacteriological Laboratory in Stockholm is conducting research on the improvement of *Neisseria* transport media. This research is seeking to increase the reliability of the culture method for diagnosing gonorrhoea, and also to reduce the number of cultures required to establish freedom from infection.

Several hospital outpatient clinics are actively involved in the clinical and microbiological aspects of sexually transmitted diseases. These include the Southern Hospital and Danderyds Hospital in Stockholm and the University Hospital in Uppsala.

### Some Implications for Canada

The VD situation in Canada obviously differs from that in the United States. Nevertheless, there are probably enough similarities to make the following excerpt from the 1973 Annual Report of the Chief Medical Officer<sup>4</sup> of England's Department of Health and Social Security worth noting:

"WHO has now published (WHO/VDT/73.386) the report of the International Travelling Seminar on Venereal Disease in the United States<sup>5</sup> in which two British consultants participated. This report indicates that the rising trends in incidence of both syphilis and gonorrhoea in the U.S.A. have been caused by medical, social and behavioral factors operating in modern society which are likely to lead to a further increase in prevalence there and in other countries throughout the world. It also states that epidemiologic and other methods have

failed to control the spread of these diseases. There is an urgent need in the U.S.A. for physicians with special training in STD to be in charge of clinics and responsible for undergraduate and postgraduate education in the subject. This situation emphasizes the foresight of those who have developed venereal disease services in the United Kingdom over the last half-century."

It is the author's opinion that Canada has much to learn from the European approach to VD control—perhaps most of all from the British System, which is admired even in Denmark and Sweden. However, since the effectiveness of the British system is attributable in part to the method by which general practitioners are reimbursed for their services, simple transplantation to the Canadian scene is not possible.

On the other hand, it might be feasible to select from among the best features of the English and other European programs and apply them to Canada as the situation permits. A brief list of such features is as follows:

- Statistical reporting in place of individual reporting;
- Physical location of clinics in hospitals;
- Establishment of clinics in smaller cities as well as in large ones;
- Extension of clinic activities to include management of all sexually transmitted diseases;
- More serious attention to investigation and epidemiologic control of non-specific genital infections;
- Special training in venereology for physicians in charge of clinics;
- Training and increased use of public health nurses and social workers in contact tracing;
- Increased use of public health nurses for health education of high-risk groups;
- Compulsory sex education in schools;
- Increased use of vending machines for sale of condoms;
- Legislation to facilitate examination and treatment of minors without parental consent.

<sup>4</sup>H. Yellowlees. *On the State of Public Health*. London, Her Majesty's Stationery Office, 1974.

<sup>5</sup>Published in PAHO Scientific Publication No. 280, 1974.

## SUMMARY

Venereal disease programs tend to differ a good deal from one country to the next. Even in a limited geographic region such as Western Europe, pronounced variations exist in the major areas of activity—case reporting, contact tracing, treatment services, and health education. The present report reviews VD programs in England, West Germany, Denmark, and Sweden as of 1975 and compares them to the program in Canada, the author's home country.

In England, which boasts an especially successful program, most cases are treated at public clinics. Physicians generally refer patients to these clinics, clinic locations are well-advertised, clinics are staffed or supervised by specialists in venereology, and all treatment is free. Contacts are identified through interviews at the clinic, but most of the contact notification is done by the patients themselves.

In West Germany, private general practitioners and dermatologists treat nearly all VD patients. The law requires all physicians treating contagious venereal disease cases to report such cases to the district health office without mentioning the patient's name or address. Physicians are also asked to obtain as much information as possible about contacts, so as to provide a basis for contact tracing.

In Denmark, venereal disease patients are treated, according to their preference, by general practitioners, by specialists in dermatology and venereology, or at public clinics.

Contact tracing is done by social workers on the basis of clinic patient interviews and contact information provided by private physicians. Contacts failing to heed a request to appear for an examination can be ordered and then forcibly compelled to do so.

In Sweden, VD cases are treated by private physicians, hospital outpatient clinics, and district medical officers. As in Denmark, interviewers at public clinics and individual physicians are responsible for providing contact information. Contacts failing to appear at a clinic after being first requested and then ordered to do so may be apprehended by the police.

Various features of these programs could help to provide a useful critique of Canadian efforts to combat venereal disease. To cite one example, each of these European countries is careful to avoid placing the patient's name and address on official reports; but in most Canadian provinces this reporting information is required.

Of the four programs studied, the English may well have the most to offer. Nevertheless, much of this program's effectiveness depends on a special feature of the English health system that is not readily transferrable to Canada. This point suggests that the most feasible approach to seeking improvements for Canada might be to select the best features of the four programs and then apply them to Canada as the situation permits.