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REVIEW OF THE STATUS OF THE VENEREAL DISEASE PROBLEM AND CONTROL  
PROGRAMS IN THE AMERICAS

I. IMPORTANCE OF THE PROBLEM \*

The venereal diseases are truly world-wide in occurrence -- but the exact extent of the problem is unknown. Variations in morbidity reporting practices from country to country and, indeed, within countries, make it difficult to compile reliable statistics relating to the incidence and prevalence of the venereal diseases.

In the United States, where a vigorous venereal disease control program has been carried on since 1940, the figures from a recent survey of case reporting by private physicians indicate that only 11 per cent of the cases of infectious syphilis, 38 per cent of the cases of other stages of syphilis, and 11 per cent of the cases of gonorrhoea treated by private physicians during the survey period were reported to the health department.

In spite of the under-reporting problem, Guthe and Hume estimated in 1948 that at least two million cases of new venereally acquired syphilis occurred in the world annually. In terms of prevalence, they estimated that a total of 20 million cases of syphilis existed among persons over 15 years of age throughout the world. There has been a tremendous increase in the world's population since 1948. There have been similar increases in factors affecting the rate of spread of syphilis such as greatly increased mobility and migration, as well as an apparent increase in sexual promiscuity. A recent global survey conducted by the World Health Organization covering 106 countries and areas established the fact that there has been a sustained rising incidence trend of early syphilis in all regions of the world. With

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\* The information contained in the first part of this document has been taken from the paper "Venereal Syphilis and Gonorrhoea in the Americas" prepared by William J. Brown, M.D.; M. Brittain Moore, Jr., M.D.; James F. Donohue; and William F. Schwartz.

these considerations in mind, along with the large degree of under-reporting of treated cases, it is now conservatively estimated that at least three million cases of new venereally acquired syphilis occur throughout the world annually and that the present reservoir of syphilis, that is, prevalence, is at least 30 million cases.

Even more important than the world-wide recrudescence of acquired syphilis is the potential disability and premature mortality that can be expected to occur among persons who do not receive treatment. For example, among the millions of syphilitics throughout the world who will not receive the benefit of diagnosis and adequate treatment, it can be predicted from the Oslo study by Bruusgaard that one in 200 will become blind; one in 50 will become insane because of central nervous system syphilis; one in 25 will become incapacitated with tabes; and one in 15 will become disabled with cardiovascular syphilis. Furthermore, the Tuskegee, Alabama Study indicated that life expectancy is reduced 17 per cent by untreated syphilis and that in 30 per cent of the syphilitic patients examined at autopsy, syphilitic involvement of the cardiovascular or the central nervous system was established as the primary cause of death.

In addition to the disabling factors and premature deaths caused by the late manifestations of the disease, there is tremendous economic loss due to uncontrolled syphilis. Just to consider one factor of the economics of the disease, in the United States alone, there are at the present time 24,000 patients in mental hospitals because of psychoses due to syphilis. This poses a financial burden to the taxpayer of \$49,000,000 per year for their maintenance. In addition, it is estimated that there are 12,200 persons in the United States of America disabled with syphilitic blindness whose maintenance cost the taxpayer \$5,000,000 annually. Unfortunately, corresponding economic data for other countries of the world are not available. Syphilis must take a tremendous toll each year throughout the globe in terms of blindness, insanity, other disabilities, and death.

Gonorrhoea is even more poorly reported than syphilis. The ratio of gonorrhoea to syphilis cases admitted to clinics indicates that about four cases of gonorrhoea occur to one case of syphilis. Applying this ratio to the estimated world-wide incidence of syphilis, it is conservatively estimated that at least 12 million cases of gonorrhoea occur throughout the world each year. Although the late manifestations of gonorrhoea are not as severe and insidious as those due to syphilis, gonorrhoea does cause pelvic inflammatory diseases in females, sterility in both females and males, epididymitis, salpingitis, other serious conditions, and, on occasion, death.

In spite of the widespread occurrence of syphilis throughout the world, present case-finding techniques plus the efficacy of easily applied penicillin therapy provide adequate tools for the control of syphilis throughout the world.

As to gonorrhoea, the incidence of which has also been steadily increasing throughout the world, there have been some breakthroughs in gonorrhoea research which will make the diagnosis of gonorrhoea in the female much easier and more certain than in the past. Such progress offers hope for the eventual control of this venereal disease.

#### IMPORTANCE OF THE PROBLEM IN THE AMERICAS

Venereal syphilis continues to be an important communicable disease problem in all regions of the Americas. While yaws occurs mainly in the Caribbean Islands and some countries in South America, and pinta occurs in Mexico and some South American Countries, venereal syphilis is widespread throughout all three regions. Syphilis consistently ranks among the top ten notifiable diseases for American countries (Table 1).

There has been an increasing trend in the incidence of early syphilis in the Americas since 1957 (Table 2). In 1962 reported cases of all stages of syphilis per 100,000 population were 77 and 64, respectively, in Middle and Northern America as compared to 48 in South America (Table 3). Reported cases in Northern America have increased slightly. This upward trend may be due to intensified case-finding activities in the region. On the other hand, the number of reported cases of syphilis has decreased slightly in Middle and South America. This downward trend is difficult to evaluate because of lack of reports from several countries for one or more years.

Gonorrhoea also consistently ranks among the top ten notifiable disease for American countries. There has been an upward trend in reported cases of gonorrhoea in all three regions (Table 4). In 1962 reported cases per 100,000 population were 151, 140, and 111 respectively in South, Northern, and Middle America. The gonorrhoea rates are approximately three, two, and one and one-half times the syphilis rates respectively in South, Northern, and Middle America.

The other venereal diseases --chancroid, lymphogranuloma venereum, and granuloma inguinale-- are reported from all three regions of the Americas, although the numbers are not sizeable. Of some significance is the chancroid rate for South America which is approximately one-half the syphilis rate (Table 5).

#### II. GENERAL CONSIDERATIONS

The recrudescence of venereal diseases is world-wide. Nevertheless the syphilis morbidity per hundred thousand population in Middle America declined between 1959 and 1962 from 98.7 to 77.3 and in South America from 52.5 to 47.8. There are good reasons for believing that this decline is more apparent than real. Because of factors such as the spontaneous disappearance of the objective manifestations of primary syphilis, self-medication, treatment by healers and professional workers

other than physicians, treatments by physicians and institutions that do not report cases, etc. our knowledge of the extent of the problem is incomplete. The customs of the population and the reserve which surrounds the disease are other reasons why official services register only a meager proportion of venereal diseases patients. Improvements in diagnosis, notification, and registration of cases should lead to a gradual rise in the venereal disease rate.

The importance of venereal diseases as a public health problem and their impact on society make it necessary to organize or intensify national programs for the control of these diseases. These programs must be conducted in the light of the new concepts of venereal disease control and new techniques for case-finding and case-investigation and for diagnosis, specially the diagnosis of syphilis.

Venereal diseases must be regarded as only one of the communicable diseases for whose control national health services are responsible. Venereal disease control programs must be long-term and conducted without interruption, since past experience shows that the value of isolated campaigns is ephemeral.

New case-finding methods based primarily on the epidemiological investigation of patients and suspects, of their contacts, and of persons in the social milieu where patients and suspects are likely to be found have proved to be valuable whenever employed by experts who investigate carefully, prudently and discreetly. This necessarily implies thorough preliminary training of personnel.

The new laboratory techniques developed in recent years for the diagnosis of venereal diseases are both sensitive and specific. The diagnosis of syphilis have benefitted enormously from these new techniques.

Mention should also be made of the treatment of all the venereal diseases which has now been put on a systematic basis.

It must be emphasized that correct application is essential and that the patient must not be regarded as cured until the pertinent tests give satisfactory results.

Health education, which is an important factor in all health activities, is fundamental in venereal disease control programs. The health education part of venereal disease control programs has three basic aims:

- a) To provide a better knowledge of venereal diseases, their dangers, and their prevention.
- b) To induce the patient, or suspect, to seek treatment from a physician or medical institution. To induce the patient or suspect to notify the venereal disease control agency of possible sources of infection and of the persons exposed to the risk of infection so they can be treated.
- c) To obtain the cooperation of medical practitioners and medical institutions in undertaking coordinated activities for the control of venereal diseases. Notification of patients is a preliminary step in this direction.

The organization of a system of data registration must be the starting point for the organization of venereal disease control programs. In addition, precise objectives must be defined, a time-table of operations must be drawn up, and provision must be made for periodic evaluation. The Pan American Health Organization, recognizing the importance of venereal diseases as a health problem in the Region of the Americas, will provide Governments with all possible technical assistance, subject only to budgetary limitations.

In order to provide an opportunity for an exchange of opinions and to unify thinking about venereal diseases and about what the countries of the Region can do in this regard, a Pan American Seminar on the Control of the Venereal Diseases will be held in 1965 in the United States of America, with the collaboration of the United States Public Health Service. It is hoped that this international meeting will be the starting point of concerted action by the countries of the Region for the control of venereal diseases.

Enclosures: Tables 1, 2, 3, 4, and 5.

TABLE 1

RANK OF REPORTED CASES OF CERTAIN NOTIFIABLE DISEASES  
IN SELECTED COUNTRIES OF SOUTH AMERICA, 1961

Rank "1" represents the largest number of reported cases

<u>Disease</u>	<u>Argentina</u>	<u>Bolivia</u>	<u>Brazil</u>	<u>Chile</u>	<u>Colombia</u>	<u>Ecuador</u>	<u>Paraguay</u>	<u>Peru</u>	<u>Uruguay</u>	<u>Venezuela</u>
Amebiasis			*	10	1	**	*	9		4
Ankylostomiasis		*	*	**	4	*	1	7		3
Anthrax		*	*			*			10	
Diphtheria	9		7	6		5			9	
Dysentery, bacillary, other and unspecified	4				9	**	5	3		2
Gonococcal infection	6	7	*	8	3	*	*	6	7	6
Hepatitis, infectious	10	*	*		**	*			*	**
Influenza	1	2	3	2	2	*	2	1	1	1
Leprosy		10	4			*	9			
Malaria	8	3	1		6	1	4			10
Measles	5	8	8	1	5	*	8	5	2	5
Meningococcal infections						*				
Paratyphoid fever	*		*	*	*	9	*	*		*
Plague		9				7				
Poliomyelitis, acute			10	9		8				
Rabies		*				10				
Scarlet fever				5		*			6	
Smallpox			9			4				
Syphilis	7	5	*	4		*	3	10	8	7
Tetanus						*	10			
Trachoma		*	*		**	*				
Tuberculosis, all forms	3	1	2	**	8	2	6	2	3	8
Typhoid fever		6	5	3	10	3		8	5	
Typhus, louse-borne						6				
Whooping cough	2	4	6	7	7	*	7	4	4	9
Yaws		*	*	**		*	*			

\* No Data Available

\*\* Not Notifiable

TABLE 1 (Continued)

RANK OF REPORTED CASES OF CERTAIN NOTIFIABLE DISEASES  
IN SELECTED COUNTRIES OF MIDDLE AMERICA, 1961

Rank "1" represents the largest number of reported cases

<u>Disease</u>	<u>Costa Rica</u>	<u>Cuba</u>	<u>Dominican Republic</u>	<u>El Salvador</u>	<u>Guatemala</u>	<u>Haiti</u>	<u>Honduras</u>	<u>Jamaica</u>	<u>Mexico</u>	<u>Nicaragua</u>	<u>Panama</u>
Amebiasis	4		*	*	*	8	*		4	*	8
Ankylostomiasis	9	*	2	3	*		*	7	5	*	2
Anthrax		**							*	*	
Diphtheria		2								10	
Dysentery, bacillary, other and unspecified	5	*	3	*	2	10	1	6		*	5
Gonococcal infection	2	10	*	7	6	3	4	1	7	4	6
Hepatitis, infectious		8	*		**		*	8		*	*
Influenza	1	3	1	2	1	2	2	3	1	2	4
Leprosy							10			*	
Malaria	3	4	4	1	3	1	3		9	1	1
Measles	6		7	6	7	7	7		3	*	9
Meningococcal infections	*		*		*						
Paratyphoid fever						*				8	
Plague											
Poliomyelitis, acute		9			10					9	
Rabies										*	
Scarlet fever										*	
Smallpox											
Syphilis	8	7	5	4	8	4	6	2	6	3	10
Tetanus		6	*	10		9	*			*	
Trachoma		*	8	*	*		*			*	
Tuberculosis, all forms	10	1	9	5	4	5	8	5	8	5	3
Typhoid fever		5	10	9	9		9	10	10	7	
Typhus, louse-borne											
Whooping cough	7		6	8	5	6	5	9	2	6	7
Yaws		*			**			4	*	*	

\* No Data Available

\*\* Not Notifiable

TABLE 1 (Continued)

RANK OF REPORTED CASES OF CERTAIN NOTIFIABLE DISEASES  
IN SELECTED COUNTRIES OF NORTHERN AMERICA, 1961

Rank "1" represents the largest number of reported cases

<u>Disease</u>	<u>Canada</u>	<u>United States</u>
Amebiasis		10
Ankylostomiasis	**	**
Anthrax		
Diphtheria		
Dysentery, bacillary, other and unspecified	6	7
Gonococcal infection	1	3
Hepatitis, infectious	3	5
Influenza	**	**
Leprosy		
Malaria		
Measles	**	1
Meningococcal infections	10	
Paratyphoid fever	*	9
Plague		
Poliomyelitis, acute	9	
Rabies		
Scarlet fever	2	2
Smallpox		
Syphilis	7	4
Tetanus		
Trachoma	**	
Tuberculosis, all forms	4	6
Typhoid fever	8	
Typhus, louse-borne		
Whooping cough	5	8
Yaws	**	*

\* No Data Available

\*\* Not Notifiable



TABLE 2  
EARLY SYPHILIS CASES PER 100,000 POPULATION  
OVER 15 YEARS OF AGE IN THE AMERICAS

<u>Year</u>	<u>Case Rate</u>
1950	46.3
1951	33.8
1952	23.9
1953	23.2
1954	17.0
1955	12.0
1956	11.9
1957	11.7
1958	12.8
1959	14.1
1960	17.0

Source: Guthe, Thorstein, Measure of Treponematoses Problem in the World, Proceedings of World Forum on Syphilis and Other Treponematoses, Washington, D. C., September 4-8, 1962.

TABLE 3  
 REPORTED CASES OF SYPHILIS WITH RATES PER 100,000 POPULATION  
 IN THE THREE REGIONS OF THE AMERICAS, 1959-1962

<u>Year</u>	<u>Northern</u>		<u>Middle</u>		<u>South</u>	
	Number	Rate	Number	Rate	Number	Rate
1959	122956	63.2	63530	98.7	35586*	52.5
1960	124184	62.8	63102	95.0	36468*	52.6
1961	126979	63.1	62049	89.7	34170	48.6
1962	128682	63.9	54146	77.3	33968	47.8

\* Excluding Brazil - no data for 1961 and 1962.

TABLE 4  
 REPORTED CASES OF GONORRHEA WITH RATES PER 100,000 POPULATION  
 IN THE THREE REGIONS OF THE AMERICAS, 1959-1962

<u>Year</u>	<u>Northern</u>		<u>Middle</u>		<u>South</u>	
	Number	Rate	Number	Rate	Number	Rate
1959	255175	131.1	75238	116.9	71040*	104.9
1960	274741	138.9	69466	104.5	75849*	109.5
1961	280675	139.4	69607	100.7	87691	124.6
1962	281514	139.8	77827	111.1	75258**	150.7

\* Excluding Brazil - no data for 1961 and 1962.

\*\* Excluding Argentina - no data for 1962.

TABLE 5

REPORTED CASES OF CHANCROID WITH RATES PER 100,000 POPULATION  
IN THE THREE REGIONS OF THE AMERICAS, 1959-1960

<u>Year</u>	<u>Northern</u>		<u>Middle</u>		<u>South</u>	
	Number	Rate	Number	Rate	Number	Rate
1959	1545	0.8	6836	10.6	21073	31.1
1960	1683	0.9	8595	12.9	13784*	24.3

\* Excluding Paraguay and Peru - no data for 1960.