A NOTE ON SYPHILIS IN INDIA WITH REFERENCE TO SUITABLE, PRACTICAL MEASURES FOR ITS CONTROL

Note submitted by the Government of India

SYPHILIS IN INDIA

There are no accurate statistics of morbidity and mortality due to syphilis in this country but the available and existing data on the prevalence of syphilis based upon the attendance of patients in clinics and hospitals and limited surveys of groups of population show that syphilis next to malaria and tuberculosis, is a major public health problem. From the point of view of control a more comprehensive view of treponemal disease is indicated because of the fact that the disease is prevalent in the Indian Union in three forms:

1. Venereal Syphilis
2. Non-venereal endemic or sporadic syphilis, and
3. Yaws

Venereal Syphilis is mostly prevalent in urban areas - cities, towns, seaports and large pilgrim centres, while non-venereal and endemic syphilis seems to be prevalent among the hill folks inhabiting the vast area of the country extending from Kashmir to Assam. The third pattern of treponemal diseases, yaws is reported to be endemic in Assam, certain contiguous areas of the States of Madras, Orissa, Uttar Pradesh, Hyderabad and also Travancore and Cochin.

From the information available in Madras V.D. clinics, it would appear that yaws is also prevalent in sporadic form among isolated rural populations in many of the districts in the State. It is surmised that the prevalent rate of syphilis among the urban population is round about 5 to 10 per cent while the prevalent rate of syphilis among the hill folks may vary from 10 to 50 per cent. The prevalence of yaws in the endemic areas mentioned above is also reported to be high.
In order to tackle the considerable reservoir of infections among the population the general public health principles and certain public health techniques applicable to communicable diseases, should be applied in the control of syphilis. An accurate idea of the extent and magnitude of the syphilis problem in the various States of the country is a desideratum. It can only be obtained by insisting on a system of uniform reporting of cases as attached per proforma recommended by the Central Government. Before discussing the public health techniques which may be usefully employed in the control of syphilis it is of primary importance that VD control should be placed under the Director of Health Services. At present in some of the major States the VD clinics continue to be under the Director of Medical Services and not even a nucleus of a control organization exists except in West Bengal. It is suggested that each State should have a Division of Communicable Diseases in the Health Directorate with a requisite staff, and an organizational set up for the control of major communicable diseases such as malaria, tuberculosis and syphilis. If resources permit and the magnitude of the problem requires it, a separate control officer with the necessary staff in the higher levels of administration may be necessary for each of these diseases. The Officer in charge of VD should combine in himself public health experience and a wide clinical knowledge of venereal diseases. It should be the function of the officer to plan the campaign dealing with the various aspects of control.

In the case of syphilis which is a disease of intimate contacts only two of the four principles of communicable diseases control can be applied in a long range programme effectively:

A. A numerical reduction in the total number of exposures to the infection within a given period of time.

B. Treatment of the discovered and undiscovered infections in the community.

A. Reduction in the frequency of exposures is affected by decreasing sexual promiscuity which in its turn will be controlled by:

1. Law enforcement measures for the suppression of prostitution and other forms of irregular sex behaviour.
2. Educational propaganda among the public by the various modern methods.

3. Personal prophylaxis whether pre or post-exposure and whether by mechanical, chemical or antibiotic means though theoretically sound is difficult of application among the civilian populations and hence it is not to be recommended as one of the techniques of control. The only exception where it is possible to apply prophylaxis effectively is in the Defence Services of the country.

A study of the squalid and unhygienic conditions in which syphilis is acquired by the uneducated, under-privileged, and poorer sections of the population has convinced me that a bar of soap will be the cheapest and at the same time an efficient prophylactic against infection.

B. Treatment

With the introduction of Penicillin in the therapy of syphilis, we have the strongest weapon at our disposal for the control of syphilis. If properly planned and carefully carried out the treatment of the infected persons will reduce the quantum of the infectious reservoirs.

The following measures are necessary for the control of syphilis by treatment:

1. Establishment of public clinics with adequate laboratory facilities.

2. Adequate supply of penicillin.

3. Case-finding procedures to bring the great volume of undiscovered infections for examination and treatment. Of the several methods of case-finding procedures contact investigation gives the best opportunity for discovering early infectious syphilis and bringing those affected for treatment.

4. Mass blood-testing programme is another method of case-finding but its prohibitive cost is not commensurate with the results achieved. Further the diagnostic value of mass serological screening is vitiated by the occurrence of an appreciable percentage of biologically false positive reactions. But serological screening of particular groups of the population is useful and necessary as in the case of expectant mothers.

As regards the large and undetermined reservoir of endemic syphilis and yaws in the backward hill and rural populations in the various parts of the country from Kashmir to Assam and Assam to Travancore-Cochin, a long term integrated health service should be introduced gradually to tackle simultaneously the several health problems of the area such as environmental sanitation, control of malaria, tuberculosis, syphilis, etc. For this purpose para-medical personnel should be recruited and trained and utilized in large numbers.
To summarize the most effective and economical measures over a long-term control programme of syphilis in India:

1. Establishment of a Division of VD Control or Communicable disease control Centre in every State under the Director of Health Services.

2. Establishment of public clinics in adequate numbers in cities, municipalities, pilgrim centres and sea-ports with laboratories for the rapid diagnosis and treatment of syphilis.

3. Adequate supply of penicillin.

4. Training and employment of social workers, Public Health nurses and health visitors for investigating the epidemiology of the infected cases and to trace and to bring to treatment all the undiscovered infections.

5. A continuous educational propaganda will help to focus public attention and sensitize the public conscience on the health hazards of syphilis in the population. Provision of facilities for diagnosis and treatment is likely to be of little avail unless the public are continuously made aware of the dangers of syphilis and the ease with which it can be cured with Penicillin.

6. Training of doctors and other personnel in well established VD clinics.

7. Mobilization of the private practitioners in the control scheme by affording them free diagnostic facilities.

8. The reporting of syphilis should be obligatory on the part of all medical institutions, state-aided or private and also by private medical practitioners.

ROLE OF THE CENTRAL GOVERNMENT IN THE CONTROL PROGRAMME

A separate division of VD control as part of the Central Health Organization should be set up. Such a Central Organization

(1) can assist and co-ordinate the control schemes in the States.

(2) helps to establish and enforce optimum standards of laboratory procedures and treatment schedules relating to syphilis.

(3) acts in an advisory capacity on educational, legal and social aspects of VD control.

(4) promotes research through a system of grants in aid to the States and in the event of a grave national emergency such as a war to take power to prevent the spread of venereal diseases.
I.  **SYPHILIS**

1.  Congenital syphilis
2.  Early syphilis
3.  Primary syphilis
4.  Secondary syphilis
5.  Late syphilis
   (a) Neuro-syphilis
   (b) Cardiovascular
   (c) Gumma
   (d) Other
6.  Latent syphilis
7.  Other

II.  **GONOCOCCAL INFECTION**

8.  Genito-urinary: Acute or unspecified
9.  Genito-urinary: Chronic
10. Of joints
11. Of eye
12. Of other sites
13. Late effects

III.  Chancroid

IV.  Lymphogranuloma venereum

V.  Granuloma inguinale, venereal

VI.  Other venereal diseases

1.  Here cases should have no clinical manifestation of syphilis but blood should be positive with spinal fluid negative.
2.  This title includes early latent and latent.

Fresh cases mean such cases who have not been treated before for venereal disease in any other hospital or dispensary.

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