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UNITED NATIONS CHILDREN'S FUND
Executive Board

SURVEY ON THE NEEDS OF CHILDREN

REPORT BY THE WORLD HEALTH ORGANIZATION

Control of Infectious Disease

CONTENTS

* This addendum is intended to supplement chapter 5 of E/ICEF/415: "Control of infectious disease".

(9p.)

CONTROL OF INFECTIOUS DISEASE

Leprosy

The greatest obstacle to the compilation of adequate statistics on leprosy is the fact that the largest numbers of cases are to be found in those countries where statistical services are only in embryonic form. It has been estimated, however, that this disease may affect between 10 and 12 million people throughout the world. Susceptibility to leprosy is greater in childhood. It was emphasized in 1952 by the WHO Expert Committee on Leprosy[1] in formulating the principles that should govern leprosy campaigns that this disease is a public health problem in the countries where it is endemic. Any measures which raise the standards of public health are therefore likely to help in the control of leprosy, whether directed against specific infections or aimed at improving nutrition, sanitation or housing. Specific leprosy control work must be undertaken by personnel within the general framework of the health administration of a country, and the policy should be determined, not by public fears and prejudices, but by public health principles.

As far as preventive measures are concerned, it has been considered that in many countries separation of children from their leprous parents is not a feasible measure, because of the lack of suitable institutions, the high rate of infant mortality which tends to result, and because there is no justification for compulsory segregation of healthy children in view of the fact that compulsory segregation of the sick parents has already been rejected. The segregation of children of leprous parents in preventoria stigmatizes the children, breaks up family ties and, after many years, causes a very serious problem of social readaptation of the children educated in preventoria. To avoid this stigma, the new laws passed in many countries specify that the children of leprous parents can only be placed in the normal children's homes and not in specific preventoria. It should be emphasized that a more effective measure is the periodic surveillance of the household contact children in order to detect the earliest leprosy lesions and to treat the children in this stage of the disease in which leprosy is very easy to cure in 100 per cent of the cases.

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On the recommendation of the UNICEF/WHO Joint Committee on Health Policy in May 1953, leprosy was included among the diseases for which joint assistance could be provided to countries. UNICEF has contributed drugs, equipment and supplies to the leprosy control programmes; WHO has provided international personnel, and fellowships to the local staff engaged in the campaigns. When the JCHP met in October 1958 to review leprosy control activities, it noted that very satisfactory progress had been made in thirteen projects jointly assisted by UNICEF and WHO, confirming not only the effectiveness of the methods used (methods based essentially on treatment with di-aminodiphenylsulfone) but also the possibility of organizing on a large scale both the detection and systematic recording of new cases and the mass treatment of known cases, so as to ensure regularity and consequently effectiveness of treatment, even in the most remote areas.

Treponematoses

Some fifteen years ago the incidence of treponematoses was at its post-war peak in most parts of the world. It was estimated at the time that there were some 50 million cases of yaws, 20 million cases of venereal syphilis, and possibly a million cases of endemic non-venereal syphilis. These diseases have wide implications for the health of children, brought out by the fact that the endemic rural treponematoses, including yaws and non-venereal syphilis, are usually acquired in childhood and that approximately 50 per cent of a population with a normal structure is made up of children and adolescents, while the adverse effects of congenital syphilis need no stressing.

Recognizing the vast public health problem represented by the treponematoses and the resulting important economic losses in terms of manpower, with the increasing availability of long-acting penicillin preparations (particularly penicillin PAM) in the post-war period many countries turned to the organization of programmes aimed at controlling these diseases: syphilis control on the one hand and mass campaigns against the endemic treponematoses on the other. International assistance has been given to many such programmes since 1948, when the World Health Organization was established and it was officially decided to give a high priority to this work, as well as to campaigns against malaria,

tuberculosis, and other conditions of universal concern which retard social and economic development. WHO has assisted sixty-one countries and territories by providing more than 150 V.D.T. advisers, consultants and experts and by awarding more than 300 fellowships in this field; UNICEF assistance taking the form of equipment and supplies.

Yaws is mostly confined to the rural areas of the humid belt between the tropics of Cancer and Capricorn. It is a contagious disease of childhood, the early onset of the disease resulting in a variety of disfiguring and disabling manifestations in children and young adults. The WHO Expert Committee on Venereal Infections and Treponematoses which met in 1959[2] stressed that widely accepted epidemiological points important in yaws campaigns are: environmental factors favouring the transmission of the disease include warmth and humidity, scanty clothing, poor personal cleanliness and/or the absence of good soap, and low standards of living; contacts outside the family are more important than familial contacts; the prevalence of latent cases, and the frequency of infectious relapses in latent cases within the first three to five years after infection. On the basis of such epidemiological knowledge, it was recommended by WHO in 1955[3] that when the prevalence of clinically-active yaws is over 10 per cent, total mass treatment be given; that is, all patients with clinically-active yaws should be treated and the remainder of the population protected with half doses of PAM. Where this prevalence is 5 to 10 per cent, in addition to patients, all children under the age of puberty should be given half doses (juvenile mass treatment), and where this prevalence is under 5 per cent, in addition to patients, all household and other obvious contacts should be given half doses (selective mass treatment). These three treatment policies, followed by the recommended policy of periodic surveillance, particularly of all children, in the areas where the mass campaigns have been carried out, have been widely adopted with complete satisfaction.

Fifteen years ago there were estimated to be some 50 million cases of yaws among the 200 million people at risk in tropical areas. By the end of 1958, some 70 million people had been examined for yaws in the initial surveys of mass campaigns assisted by WHO and by UNICEF in Africa, the Americas, South-East Asia, and the Western Pacific regions, and about 90 million people had been examined in resurveys. During these campaigns some 30 million people,

either patients with active yaws or latent cases or contacts, received injections of long-acting penicillin.

The achievement of eradication, which is the objective of all yaws campaigns, will obviously still encounter many problems. These are connected with the consolidation of initial successes, the ultimate integration of the mass campaigns into a strengthened local rural health service, and the retraining of auxiliaries for employment in other preferably broader health activities. These programmes must in turn be related to social and economic development and to improvements in the standard of living.

Endemic syphilis. In many areas of Africa and Asia Minor, syphilis is a contagious disease of childhood, non-venereally acquired. The common denominator in both non-venereal syphilis and yaws is an unfavourable socio-economic state and, consequently, unhygienic living conditions. Under these circumstances, proper cleanliness and personal hygiene are extremely difficult and these diseases flourish among the under-privileged children. Endemic syphilis is transmitted non-venereally among children and adolescents by bodily contact with active lesions, and indirectly by the common use of eating and drinking vessels and other household utensils. Contacts inside the family may in some areas be more important than extra-familial contacts. Studies of the prevalence of endemic syphilis in crowded households with little living space show that there is a considerable likelihood of many members of the family becoming infected.

As in the case of yaws, the keystone of the present-day approach to the control of endemic syphilis is a better understanding of the epidemiology of the disease and the availability of repository penicillin PAM, which has been used with great success in the mass campaigns assisted by WHO and by UNICEF. Bosnia may be cited as an example of a particularly successful campaign of mass treatment, begun with international assistance as early as 1948. No new active case of endemic syphilis has been found for five years, in spite of careful surveillance, in a population of approximately a million people. On the basis of these findings, it is considered that complete eradication has been achieved, representing the first instance of the eradication

of a communicable disease in a large area following a treatment campaign assisted by WHO and by UNICEF.

Venereal syphilis. Where it has been possible to measure trends over a period of time, it has been observed that venereal syphilis remains predominantly an urban disease in "normal times", the majority of early cases occurring in the productive age-groups, with a preponderance among young women, and serious implications for their unborn babies. The disease invades rural areas during times of poverty, war and occupation, and with migrating populations. Following every major war, its prevalence decreases with a return to normal economic and social conditions and with a stabilization of the population. Unstable conditions during and after the Second World war caused a steep rise both in the incidence of symphilis and in the infant mortality due to syphilis, im all countries of Europe and in the United States of America. In Asia and Africa the prevalence of venereal diseases rose.

As early as 1949 the Expert Committee on Maternal and Child Health[4] considered the important effect of venereal disease control programmes on the health of mothers and children and emphasized that demonstration of venereal disease control can show rapid clinical and epidemiological results in early and late syphilis, particularly in terms of babies born alive and in sound health because the mothers have been given adequate treatment. With the assistance of WHO and of UNICEF demonstration and training projects for venereal disease control have been established or strengthened, as a model to be copied later in different areas by local health administrations and to be a training base for medical and auxiliary personnel. Centres of this type have usually been placed in urban areas and supplement mass treatment campaigns against endemic treponematoses in rural areas. In some countries, with special problems of syphilis control, advantage has been taken of the maternal and child health services for case-finding and treatment of children, adolescents, pregnant women and nursing mothers. Findings in WHO-sponsored surveys of the sero-reactor rate in pregnant women suggest that, although in many areas a decline in prevalence of venereal syphilis has resulted from the control programmes which have been carried out, the problem continues to exist. In certain areas case-finding in venereal syphilis carried out through the family

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unit can be considered as a useful public-health technique, provided that the fathers are included as well as expectant mothers and children, so that incomplete epidemiological information and palliative measures are avoided.

However, as pointed out by the WHO Expert Committee in Venereal Infections and Treponematoses which met in 1959, a recent recrudescence in syphilis has been noted in many countries, where it remains a public health problem. Further intensified efforts will therefore be required both in developed and developing countries.

Trachoma

Trachoma, which has been described as "the disease of poverty and overcrowding", affects an estimated total of 400 million people and is still the greatest single world cause of partial or complete loss of sight. The degree of blindness produced varies in different endemic areas. In general, the higher the prevalence of the disease, the earlier the age of onset, and in communities where it is highly endemic it is almost always contracted in infancy.

Eye diseases were mentioned as one of the four main problems of child health in the Eastern Mediterranean Region by the participants in the Seminar on Maternal and Child Health in the Eastern Mediterranean Region[5] held in Cairo in 1957. Environmental factors such as unsatisfactory standards of living and of hygiene favour the transmission of the disease. The many problems involved were discussed during the Conference on Trachoma[6] sponsored by the World Health Organization Regional Offices for the Eastern Mediterranean and for Europe in collaboration with the Government of Tunisia in October 1959. This was the second conference planned on a zonal basis with participants from a group of countries in the majority of which disease patterns, the environmental background and other problems, are roughly comparable. In many areas, and particularly those in which trachoma was highly prevalent and associated with seasonal epidemic conjunctivitis, the evidence was that the principal source of infection lay in the pre-school age group. There is a relationship between trachoma and bacterial infections. For example, the widespread and regularly occurring seasonal epidemic and acute conjunctivities in North Africa and the Middle East aggravates the trachoma, aids its transmission and adds to its complications. There is circumstantial evidence

that the virus of trachoma is frequently transmitted along with the infective secretions of bacterial conjunctivitis and that, in those areas, the common fly is one of the most important agents in spreading both diseases.

On the recommendation of the UNICEF/WHO Joint Committee on Health Policy to include trachoma in the joint work of the two organizations, trachoma control programmes have been carried out to which WHO has provided international personnel; UNICEF assistance taking the form of drugs, vehicles, laboratory equipment, health education materials and other supplies. The programmes were started on the basis of mass treatment methods recommended in 1952 by the WHO Expert Committee on Trachoma.[7] In addition, much national work has already started in countries other than those where the projects have been carried out. In most of the trachoma control projects now in operation local application of antibiotics is the treatment method of choice. Where the prevalence of trachoma is above a critical level from 50 to 70 per cent, varying according to local conditions and resources, it is considered preferable to treat whole population groups (for example, entire communities or all school children) rather than to attempt to exclude those who are free from the disease.

Experience in a large number of trachoma control projects throughout the world has proved that the results of mass treatment campaigns depend largely upon environmental background. Under the worst conditions of poverty, overcrowding and squalor it has not been possible with present-day treatment methods to make any substantial reduction in the incidence of trachoma. Hundreds of thousands of cases have been cured and a high proportion saved from the disastrous end-results of the disease, but new cases continue to appear in almost equal numbers. In such areas, and until improvements in living conditions, hygiene and health education can be introduced and further comprehensive research work has been undertaken, as has been started in Taiwan, treatment programmes will continue to have a very necessary but limited role.

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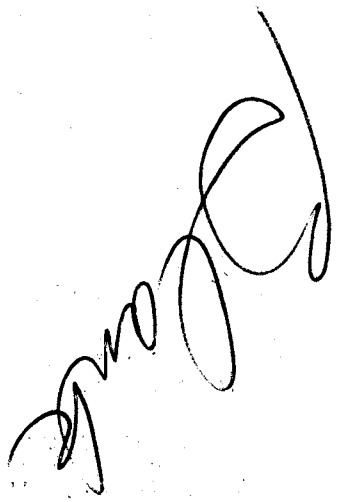

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