

THE VENEREAL DISEASE PROBLEM IN JAPAN

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SYNOPSIS

According to statistical reports, venereal disease case-rates and death-rates have both shown a real decline in Japan in the last decade. However, from a one-day survey of patients in all Japanese medical establishments carried out in 1955, it is estimated that not less than 720 000 new cases of venereal disease occur annually. Moreover, with the coming into force of the new anti-prostitution law, prostitutes (responsible for some 70% of male venereal infections) will become scattered among the general population and consequently more difficult to control and treat; as a result there may even be an increase in the spread of venereal infection.

The authors describe the control methods currently in use in Japan, which may be grouped in two categories—case-finding, and treatment and case-holding—and suggest how these might be strengthened or improved.

Extent of the Problem

For the planning of any venereal disease control programme and for the evaluation of its results it is imperative to have accurate information on the incidence and prevalence of such disease. There are several methods by which the necessary estimations may be made.

The first is estimation of the incidence from the cases reported. As will be seen from Table 1 and Fig. 1, both the number of reported cases and the case-rates for all venereal disease in Japan have shown a real decrease over the 10-year period 1947-56, after an immediate post-war peak in 1948. Syphilis, particularly primary and secondary syphilis, has shown the greatest decline in comparison with the other diseases, while acute gonorrhoea has decreased least.

The number of venereal disease cases in 1956 is shown by sex and age-group in Table 2.

The ratio of the number of cases reported to the number actually occurring is not high, as is indicated by the results of a special survey carried out in 1952 by the Tokyo Metropolitan Department of Health: it was found that only 9.6% of all cases of venereal disease diagnosed by private physicians were reported to the Health Department, although such notification is required by law.

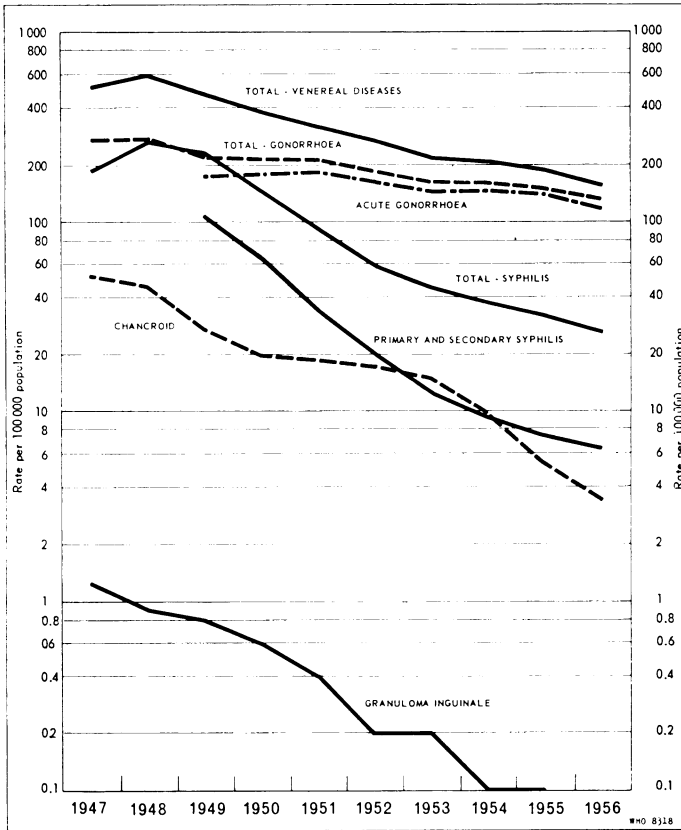
TABLE 1. ANNUAL NUMBER OF REPORTED VENEREAL DISEASE CASES AND VENEREAL DISEASE CASE-RATES (per 100 000 population)

Year	Total		Syphilis		Gonorrhoea		Chancroid		Granuloma inguinale	
	cases	case-rate	cases	case-rate	cases	case-rate	cases	case-rate	cases	case-rate
1947	402 734	515.6	148 191	189.7	212 784	272.4	40 836	52.3	923	1.2
1948	473 822	592.3	216 617	270.8	219 745	274.7	36 753	45.9	707	0.9
1949	386 990	473.1	185 785	227.1	178 901	218.7	21 669	26.5	635	0.8
1950	316 044	379.9	121 461	146.0	178 273	214.3	15 820	19.0	490	0.6
1951	271 024	320.5	77 044	91.1	177 774	210.2	15 903	18.8	303	0.4
1952	224 315	261.3	50 528	58.9	158 670	184.8	14 909	17.4	208	0.2
1953	191 856	220.5	38 721	44.5	140 458	161.4	12 514	14.4	163	0.2
1954	184 115	208.5	33 829	38.3	141 416	160.2	8 745	9.9	125	0.1
1955	167 950	188.1	28 673	32.1	134 571	150.7	4 636	5.2	70	0.1
1956	144 273	159.9	24 323	26.9	116 842	129.5	3 068	3.4	40	0.0

Another method for estimating the extent of the problem is the one-day survey of patients of all kinds in medical establishments throughout Japan, which is conducted annually by the Ministry of Health and Welfare. The total number of venereal disease patients treated in hospitals and clinics on Wednesday, 13 June 1955, was 25 800, of which 2100 were new cases. Using this information to estimate the total extent of venereal disease in 1955, on the assumption that there was little day-to-day variation in the occurrence of cases over the year, a total of not less than 720 000 new cases

annually is reached; and the total man-days lost for treatment of venereal disease during 1955 may be calculated at 8.8 million.

FIG. 1. ANNUAL VENEREAL DISEASE CASE-RATES IN JAPAN (per 100 000 population)



A third basis for estimation is the results of mass examinations or mass blood-testing for syphilis in various occupational groups. Fig. 2 shows the case-rates or seropositivity rates for a number of population groups between 1948 and 1956.

The annual figures of mortality from venereal disease as compiled by the office of vital statistics are presented in Tables 3 and 4 and in Fig. 3. It will be seen that, so far as infant mortality is concerned, the appreciable decrease has occurred in the most recent years.

TABLE 2. NUMBER OF VENEREAL DISEASE CASES BY AGE-GROUPS AND SEX (1953)

Age-group (years)	Total	Male	Female
Total	14 294	2 722	11 572
Under 4	24	11	13
5-9	36	14	22
10-14	24	8	16
15-19	1 424	199	1 225
20-24	6 720	950	5 770
25-29	3 577	641	2 936
30-34	1 226	258	968
35-39	484	163	321
40-44	227	117	110
45-49	182	124	58
50-54	135	96	39
55-59	90	59	31
60-64	58	44	14
65-69	38	21	17
70-74	20	12	8
75-79	5	4	1
80-84	1	—	1
Over 85	1	—	1
Unknown	22	1	21

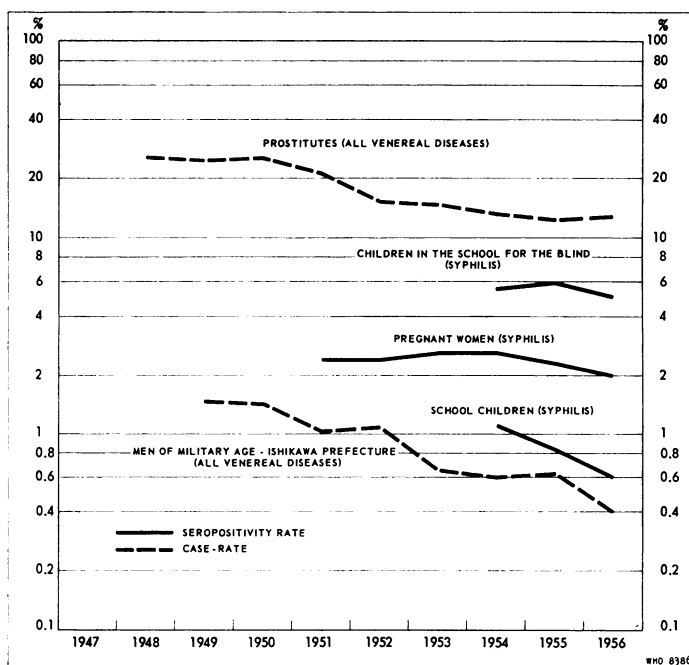
TABLE 3. ANNUAL NUMBER OF DEATHS AND DEATH-RATES FROM VENEREAL DISEASE (per 100 000 population)

Year	Total		Syphilis		Gonorrhoea		Chancroid		Granuloma inguinale	
	deaths	death-rate	deaths	death-rate	deaths	death-rate	deaths	death-rate	deaths	death-rate
1947	4 529	5.8	4 444	5.7	46	0.1	2	0.0	37	0.0
1948	4 409	5.5	4 356	5.4	32	0.0	1	0.0	20	0.0
1949	5 558	6.8	5 501	6.7	51	0.1	1	0.0	5	0.0
1950	5 208	6.3	5 176	6.2	29	0.0	2	0.0	1	0.0
1951	4 660	5.5	4 630	5.5	27	0.0	1	0.0	2	0.0
1952	4 276	5.0	4 265	5.0	10	0.0	0	—	1	0.0
1953	3 708	4.3	3 632	4.2	16	0.0	0	—	0	—
1954	3 408	3.9	3 394	3.8	13	0.0	0	—	1	0.0
1955	2 899	3.2	2 882	3.2	14	0.0	2	0.0	1	0.0
1956	2 750	3.0	2 750	3.0	0	—	0	—	0	—

TABLE 4. ANNUAL INFANT DEATHS AND INFANT DEATH-RATES DUE TO SYPHILIS (per 1000 livebirths)

Year	Deaths	Death-rates
1947	1 016	0.37
1948	1 142	0.42
1949	1 146	0.42
1950	854	0.37
1951	481	0.22
1952	298	0.15
1953	205	0.11
1954	126	0.07
1955	94	0.05
1956	73	0.04

FIG. 2. VENEREAL DISEASE CASE-RATES AND SEROPOSITIVITY RATES AMONG VARIOUS POPULATION GROUPS IN JAPAN



Control Methods

Control of venereal disease in Japan is carried out under the Venereal Disease Control Law of 1948. The chief control measures are as follows:

1. Case-finding:

- (a) case-reporting by private physicians
- (b) contact-tracing
- (c) prenatal and premarital examination
- (d) mass blood-testing
- (e) venereal disease consultation service
- (f) compulsory examination of prostitutes

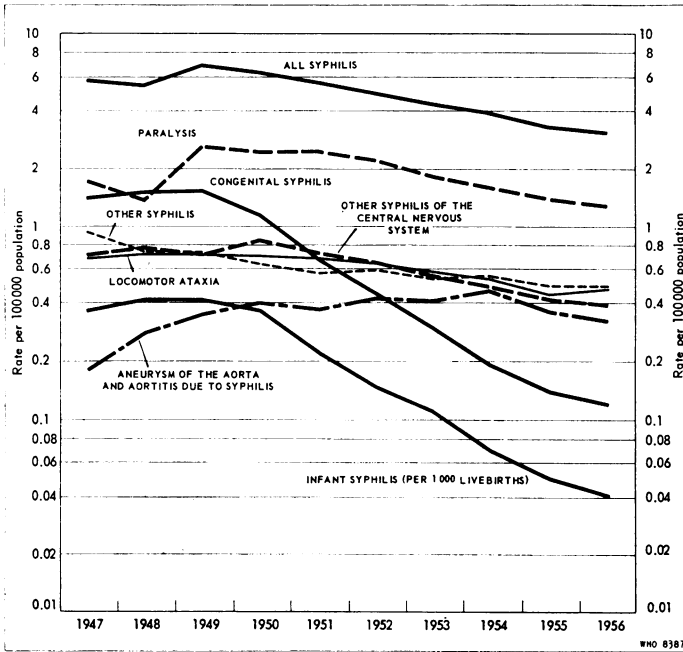
2. Treatment and case-holding:

- (a) establishment of medical facilities
- (b) home-visiting by nurses
- (c) free treatment for the lower income groups
- (d) compulsory treatment of prostitutes

3. Health education

4. Clinical and laboratory research

FIG. 3. ANNUAL DEATH-RATES FROM SYPHILIS IN JAPAN (per 100 000 population)



Case-finding

Case-reporting by private physicians. Any physician diagnosing a case of venereal disease is required by law to report the name, address and age of the patient, and any information concerning the patient's contacts, to the governor of the prefecture through the director of the health centre concerned. However, as mentioned earlier, the number of such cases actually reported is very low.

Contact-tracing. This has become a part of the venereal disease control programme in Japan since the end of the Second World War. The results of such work in 1955 are shown in Table 5. The efficiency of contact-tracing—measured by the number of contacts brought to treatment divided by the number of patients reported and multiplied by 100%—is only 2.5%, a very low figure compared with the USA, for example.

In order to determine why so low a figure was obtained, each entry in Table 5 should be analysed. First of all, it should be stated that the number of contacts named is only one-third of the total number of patients reported, whereas ideally at least one contact should, of course, be named for each patient.

TABLE 5. RESULTS OF CONTACT-TRACING FOR VENEREAL DISEASE (1955)

(1) Number of patients reported	167 950
(2) Number of contacts named	48 890
(3) Number of contacts found	17 930
(4) Number of contacts brought to examination	14 358
(5) Number of contacts diagnosed as infected with venereal disease on examination	5 251
(6) Number of contacts brought to treatment	4 127
(7) Percentage of contacts found = $\frac{(3)}{(2)} \times 100\%$	36.7 %
(8) Percentage of contacts examined = $\frac{(4)}{(2)} \times 100\%$	29.4 %
(9) Contact-patient index = $\frac{(3)}{(1)}$	0.17 %
(10) Epidemiological index $\frac{(5)}{(2)}$	0.11 %
(11) Brought-to-treatment index $\frac{(6)}{(2)}$	0.09 %
(12) Efficiency of contact-tracing = $\frac{(6)}{(1)} \times 100\%$	2.5 %

It should also be pointed out that under the present system in Japan the interviews with patients to obtain the necessary information for contact-tracing are conducted, not by the contact-tracer, but by the private physician. The main job of the contact-tracer is to visit the contact's home, using the information provided by the physician, to interview the person concerned and to try to persuade him or her to report for examination and treatment.

For the improvement of contact-tracing in the future one of the most important measures will be to institute a new system whereby the contact-tracer will also interview each patient in order to obtain the fullest possible information about contacts.

The assignment of contact-tracers with a good personality and their proper and scientific training are, of course, also of importance.

Prenatal and premarital examination. In 1956, some 800 000 women, or about half the expectant mothers in the country, received prenatal

veneral disease examinations. The number of persons undergoing pre-marital examinations, on the other hand, is not so high, although such examinations are required under the Venereal Disease Control Law.

Veneral disease consultation service and mass blood-testing. There are 780 health centres all over the country which are responsible for conducting the venereal disease consultation service and for mass blood-testing. The figures for the number of cases examined in these centres in 1956 are given in Table 6.

TABLE 6. VENEREAL DISEASE CONSULTATION SERVICE AND MASS BLOOD-TESTING IN HEALTH CENTRES (1956)

Venereal disease consultation service		Mass blood-testing	
population group	number of persons examined	population group	number of persons examined
Pregnant women	321 968	Schoolchildren	37 624
Lying-in women	3 251	Children in schools for the blind	1 766
Infants	532	Industrial workers	80 623
Pre-school children	983	Members of juvenile associations	45 344
Prostitutes	116 266	Seamen	672
Others	184 119	People in welfare institutions	1 231
		Workers in restaurants, cafés, bars, hotels	130 138
		Other groups	117 865
Total	627 119	Total	415 233

Control of venereal disease among prostitutes. As prostitutes are the source of some 70% of venereal infections in men in Japan, venereal disease control measures for these women are considered of the greatest importance. Prostitutes are therefore encouraged to submit to medical examination in the venereal disease hospitals and clinics; if they disregard such encouragement, they are subjected to compulsory examination.

With the coming into force of the anti-prostitution law in April 1958, the organized prostitutes are gradually scattering and being absorbed into the general population. It is feared that they will become a serious clandestine source of infection and will cause an increased spread of disease.

It is therefore necessary to expand the measures for controlling venereal disease in the general population and thus to meet the increased risk represented by the scattered prostitutes.

Treatment and case-holding

Establishment of treatment facilities. Each of the 780 health centres in Japan has a venereal disease clinic attached to it. In addition to these, there are 48 separate venereal disease clinics and 30 venereal disease hospitals. All these establishments are responsible to the departments of health of the prefectures, and approximately 150 000 cases of venereal disease were treated by them in 1956.

They provide free treatment for those unable to pay, the cost being borne by the prefectural department of health, subsidized by the national government to the extent of one-half. However, only 16% of all venereal disease patients receive free treatment; and if this percentage is to be increased it will be necessary for the national government to cover all the expenses involved, as occurs in certain other countries.

Home-visiting by nurses. Nurses in the health centres made more than 60 000 home visits to venereal disease patients in 1956.

Health education

Health education on the prevention of venereal disease has been provided for three major groups: (a) professional groups working in venereal disease control, (b) the population as a whole, and (c) leaders of various groups, such as schools, women's organizations and juvenile associations.

Particular emphasis in the health education programme has been placed on the importance of prenatal and premarital examinations for women, and on teaching the younger generation the nature of venereal disease, the means of prevention and the necessity for early diagnosis and complete treatment.

Central and local organization for venereal disease control

In conclusion, a brief summary of the organization of control may be of value. The Ministry of Health and Welfare is responsible for the planning of venereal disease control programmes at the national level and for supervision of and technical assistance to the prefectural departments of health. There are also two institutes of the Ministry which have functions to perform in this field. One is the National Institute of Health, in charge of setting up standards for serological tests for syphilis; the other is the Institute of Public Health, responsible for training venereal disease control workers.

The department of health of each prefecture is, in turn, responsible for planning control programmes at the prefectural level and for supervision of and technical assistance in control activities and clinical procedures at the health centres and the venereal disease hospitals and clinics.

At the local level, the responsibility lies with the health centre, which carries out such control measures as contact-tracing, health education, etc., and provides clinical service to the patient and a laboratory service for the private physician bringing in specimens for examination.

RÉSUMÉ

Les taux de morbidité et de mortalité par maladies vénériennes se sont abaissés notablement au Japon, au cours des années 1947-56, surtout ceux qui concernent la syphilis primaire et secondaire; la gonorrhée décroît plus lentement. Toutefois, d'après le dénombrement des cas, effectué en un jour donné de 1955 dans tous les établissements médicaux du Japon, on évaluait à 720 000 le nombre annuel des cas nouveaux et à 8,8 millions le nombre de jours de travail perdus par traitement des maladies vénériennes.

La lutte contre ce groupe de maladies est régie par la loi de 1948. Elle comporte la déclaration des cas par les médecins privés, le dépistage des contacts, l'examen prénatal et prénuptial, l'examen hématologique systématique, les services de consultation, l'examen obligatoire des prostituées; la mise à disposition de facilités de traitement, la visite des malades à domicile par des infirmières, le traitement gratuit des malades à ressources modestes, le traitement obligatoire des prostituées; l'éducation du public; les recherches cliniques et en laboratoire. Les consultations et les examens hématologiques systématiques sont effectués dans 780 centres, répartis dans le pays.

On peut craindre qu'avec l'entrée en vigueur de la nouvelle loi sur la prostitution, en avril 1958, les prostituées — qui étaient considérées comme étant à l'origine de 70% environ des cas — désormais disséminées dans la population, deviennent des sources d'infection difficiles à repérer. Il est donc d'autant plus nécessaire de renforcer les mesures de dépistage au sein de la population, afin de prévenir une expansion des maladies vénériennes dans le pays.