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Global epidemiology of yaws: a systematic review

Oriol Mitjà, Michael Marks, Diby J P Konan, Gilbert Ayelo, Camila Gonzalez-Beiras, Bernard Boua, Wendy Hountou, Yiragima Kobara, Earnest N Tabah, Agana Nsiire, Darnas Obvola, Fasiah Taleo, Rita Djupuri, Zhang Zaixing, Jürg Utzinger, Lasse S Vestergaard, Quique Bassat, Kingsley Asiedu

Summary

Background To achieve yaws eradication, the use of the new WHO strategy of initial mass treatment with azithromycin and surveillance twice a year needs to be extended everywhere the disease occurs. However, the geographic scope of the disease is unknown. We aimed to synthesise published and unpublished work to update the reported number of people with yaws at national and subnational levels and to estimate at-risk populations.

Methods We searched PubMed and WHO databases to identify published data for prevalence of active and latent yaws from Jan 1, 1990, to Dec 31, 2014. We also searched for ongoing or recently completed unpublished studies from the WHO yaws surveillance network. We estimated yaws prevalence (and 95% CIs). We collected yaws incidence data from official national surveillance programmes at the first administrative level from Jan 1, 2010, to Dec 31, 2013, and we used total population data at the second administrative level to estimate the size of at-risk populations.

Findings We identified 103 records, of which 23 published articles describing 27 studies and four unpublished studies met the inclusion criteria. Prevalence of active disease ranged from 0·31% to 14·54% in yaws-endemic areas, and prevalence of latent yaws ranged from 2·45% to 31·05%. During 2010–13, 256 343 yaws cases were reported to WHO from 13 endemic countries, all of which are low-income and middle-income countries. 215 308 (84%) of 256 343 cases reported to WHO were from three countries—Papua New Guinea, Solomon Islands, and Ghana. We estimated that, in 2012, over 89 million people were living in yaws-endemic districts.

Interpretation Papua New Guinea, Solomon Islands, and Ghana should be the focus of initial efforts at implementing the WHO yaws eradication strategy. Community-based mapping and active surveillance must accompany the implementation of yaws eradication activities.

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Introduction Yaws is a neglected tropical disease caused by Treponema pallidum subspecies pertenue. This bacterium causes a chronic relapsing non-veneraeal treponematosis, characterised by highly contagious primary and secondary cutaneous lesions and non-contagious tertiary destructive lesions of the bones. The infection can become latent at any time, with only serological evidence of infection, and relapses can occur for up to 5–10 years. The ratio of clinically apparent to latent cases has been estimated to be as high as 1:6.1 In 2012, WHO launched a new initiative to eradicate yaws by 2020.2 Undertaking surveys and mapping the disease at a community level and immediately treating the entire endemic community with single-dose azithromycin is recommended.3 The efficacy of this approach has been shown in a study of mass treatment in Papua New Guinea.4 A key principle inherent in an eradication campaign is the need to intervene everywhere the disease occurs. However, the present geographic extent of yaws is incompletely known, because yaws is not a notifiable disease in many affected countries. To guide the WHO eradication programme, a better knowledge of yaws epidemiology is needed. Data that can be used to identify the burden of yaws in a community include the prevalence of active infectious yaws (ie, ulcers or papilloma), which shows the intensity of yaws transmission, and the prevalence of latent yaws (ie, seropositivity in healthy individuals), which shows the extent of latent or hidden infection in the community. Clinical surveys for active yaws lesions can be done without any sophisticated laboratory test through interviews and physical examinations, whereas serological tests measuring yaws antibody (treponemal and non-treponemal) are needed for surveys of latent disease.3 Another important source of information is national routine surveillance data, which allow estimation of the incidence of yaws at country and regional levels; countries report the number of cases at the first administrative level.

In this study, we undertook a systematic review of published and unpublished work to improve our understanding of the global distribution of yaws and to contribute to the global yaws eradication campaign.

Notes

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Barcelona Institute for Global Health, Barcelona Centre for International Health Research, Hospital Clinic, University of Barcelona, Barcelona, Spain (O Mitjà PhD);
C Gonzalez-Beiras BSc,
Q Bassat PhD); Liïhr Medical Centre-International SOS, Newcrest Mining, Lihir Island, Papua New Guinea (O Mitjà);
Department of Clinical Research, London School of Hygiene and Tropical Medicine, London, UK (M Marks MD); Hospital for Tropical Diseases, University College London Hospitals NHS Trust, London, UK (M Marks); Laboratoire Biostatistique et d’Informatique Médicale, Université Félix Houphouët-Boigny, Abidjan, Côte d’Ivoire (D J P Konan MD); Centre de Dépistage et de Traitement de l’Ulcère de Buruli d’Allada, Cotonou, Benin (G Ayelo MD); Programme National de Lutte contre les Maladies Tropicales Négligées, Ministère de la Santé Publique, de la Populations et de la Lutte contre le SIDA, Bangui, Central African Republic (B Boua MPH); Disease Control Branch, National Department of Health, Port Moresby, Papua New Guinea (W Hountou MD); Programme National de Lutte contre l’Ulcère de Buruli et la Lèpre, Lomé, Togo (Y Kobara MD); National Leprosy, Burundi Ulcer, Yaws and Leishmaniasis Control Programme, Ministry of Public Health, Yaoundé, Cameroon (E N Tabah MD); Ghana Health Service, Public Health Division, Accra, Ghana (A Nsouë PhD); Programme National de Lutte contre l’Ulcère de Buruli, Ministère de la Santé Publique, Brazzaville, Congo (D Obvala MD); Neglected Tropical Diseases Program, Newcrest Mining, Lihir Island, Papua New Guinea; Liïhr Medical Centre-International SOS, Newcrest Mining, Lihir Island, Papua New Guinea;
Fasiah Taleo, Rita Djupuri, Zhang Zaixing, Jürg Utzinger, Lasse S Vestergaard, Quique Bassat, Kingsley Asiedu

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Articles
understanding of yaws epidemiology stratified by country, and to provide an update on the number of people with active yaws to estimate at-risk populations in endemic countries.

**Methods**

**Search strategy and selection criteria**

We did a systematic review to identify all relevant studies that examined yaws prevalence and incidence. We searched PubMed and WHO databases for (“yaws” OR “treponematosis” AND “prevalence” OR “incidence”) OR (“yaws” AND [each individual previous and current yaws-endemic country]). We consulted the Department for the Control of Neglected Tropical Diseases at WHO regarding previous and present yaws-endemic countries.\(^6\) We limited the search to studies published between Jan 1, 1990, and Dec 31, 2014. This period covers studies published since the last systematic review of yaws epidemiology, which was published in 1992.\(^7\) No language restrictions were set for searches. We hand-searched the reference lists of all recovered documents for additional references. We also searched for ongoing or recently completed but unpublished studies from the WHO yaws surveillance network.

We included studies if they investigated active or latent yaws prevalence or incidence. Studies on active yaws had to meet the surveillance case definition provided by WHO: a person with a history of residence in an affected area who presents with signs of clinically active yaws, consisting of chronic skin ulcers, multiple papillomata, squamous macules, bone or joint lesions, or plantar hyperkeratosis. For latent yaws seroprevalence studies, we deemed serological test rapid plasma reagin titres of at least 1:2 and venereal disease research laboratory titres of at least 1:2 as acceptable evidence of untreated latent infection. Use of the treponemal test (\(T\) pallidum haemagglutination assay, \(T\) pallidum particle agglutination assay, and the fluorescent treponemal antibody absorption) alone was not sufficient evidence of latent infection because people who have had yaws at any time will test positive for life, even after successful treatment.

**Procedures**

We calculated the number of people with active disease at the first administrative level (eg, province, region, and prefecture) between Jan 1, 2010, and Dec 31, 2013. First, whenever possible, we obtained the country estimates of yaws cases at the first administrative level from the latest national reporting figures provided to WHO.\(^4\) Second, for countries for which no recent data were available, we contacted yaws control programme managers to request official national routine surveillance data. To estimate the maximum population at risk of yaws, we made calculations at the second administrative level (eg, district, department, and regency). We contacted yaws control programme managers to request data on the proportion of second-administrative level regions that reported yaws cases in 2012. We summed the population living in endemic districts using the 2012 reported populations.

**Statistical analysis**

For all qualifying studies, we extracted data on study country, sample size, diagnostic test used, number of people with latent or active yaws, and age range. We undertook descriptive analyses of the extracted data. Prevalence estimates are presented for each study with 95% CIs on the basis of binomial distribution. We did not undertake quantitative meta-analyses because the studies we identified did not sample populations at...
random and hence the estimates are not representative for a broader geographical area. All statistical analyses were done using Stata version 13.1.

**Role of the funding source**
There was no funding source for this study. The corresponding author had full access to all the data in the

<table>
<thead>
<tr>
<th>Year of study</th>
<th>Country</th>
<th>Location</th>
<th>Schoolchildren or community survey</th>
<th>Case ascertainment</th>
<th>Cases (sample size)</th>
<th>Prevalence, % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Cameroon</td>
<td>Lomié, Zoubalot, Messok</td>
<td>Community</td>
<td>Clinical</td>
<td>97 (1075)</td>
<td>9.02 (7.38–10.90)</td>
</tr>
<tr>
<td>1990</td>
<td>Central African Republic</td>
<td>Lobaye</td>
<td>School children</td>
<td>VDRL and TPHA</td>
<td>12 (213)</td>
<td>5.63 (2.94–9.63)</td>
</tr>
<tr>
<td>2012</td>
<td>Republic of Congo</td>
<td>Bétou, Ebyellé</td>
<td>Community</td>
<td>RDT</td>
<td>183 (6215)</td>
<td>2.94 (2.54–3.40)</td>
</tr>
<tr>
<td>2004</td>
<td>Côte d’Ivoire</td>
<td>Adopé</td>
<td>Community</td>
<td>RPR</td>
<td>11 (2182)</td>
<td>0.50 (0.25–0.90)</td>
</tr>
<tr>
<td>2005</td>
<td>Democratic Republic of the Congo</td>
<td>Wasolo</td>
<td>Community</td>
<td>RPR and TPHA</td>
<td>56 (1176)</td>
<td>4.76 (3.62–6.14)</td>
</tr>
<tr>
<td>2011</td>
<td>Ghana</td>
<td>Volta Region</td>
<td>School children</td>
<td>ND</td>
<td>3159 (125 364)</td>
<td>2.52 (2.43–2.61)</td>
</tr>
<tr>
<td>1998</td>
<td>Nigera</td>
<td>Garhida</td>
<td>Community</td>
<td>Clinical</td>
<td>64 (1523)</td>
<td>4.20 (3.25–5.33)</td>
</tr>
<tr>
<td>2012</td>
<td>Benin</td>
<td>Tofo, Z6, Ailada</td>
<td>School children</td>
<td>RPR</td>
<td>22 (900)</td>
<td>2.44 (1.54–3.68)</td>
</tr>
<tr>
<td>1990</td>
<td>Central African Republic</td>
<td>Lobaye</td>
<td>School children</td>
<td>VDRL and TPHA</td>
<td>42 (213)</td>
<td>19.72 (14.60–25.70)</td>
</tr>
<tr>
<td>1988</td>
<td>Papua New Guinea</td>
<td>Karkar Island</td>
<td>School children</td>
<td>VDRL, FTA-Abs, and TPHA</td>
<td>26 (632)</td>
<td>4.11 (2.70–5.97)</td>
</tr>
<tr>
<td>2001</td>
<td>Papua New Guinea</td>
<td>Port Moreby-NCD</td>
<td>School children</td>
<td>VDRL and TPHA</td>
<td>32 (217)</td>
<td>14.54 (10.22–19.81)</td>
</tr>
<tr>
<td>1989</td>
<td>Vanuatu</td>
<td>Tanna Island</td>
<td>Community</td>
<td>VDRL</td>
<td>464 (20 200)</td>
<td>2.30 (2.09–2.52)</td>
</tr>
<tr>
<td>2008</td>
<td>Vanuatu</td>
<td>Tanna Island</td>
<td>Community</td>
<td>VDRL and TPHA</td>
<td>95 (306)</td>
<td>31.05 (25.90–36.56)</td>
</tr>
<tr>
<td>2010</td>
<td>Wallis and Futuna</td>
<td>Wallis and Futuna</td>
<td>Community</td>
<td>RPR and TPHA</td>
<td>27 (264)</td>
<td>10.23 (6.85–14.53)</td>
</tr>
<tr>
<td>1988</td>
<td>Indonesia</td>
<td>Sumatra</td>
<td>School children</td>
<td>VDRL, TPHA, FTA-Abs, TmpA EIA, and WB</td>
<td>114 (37 000)</td>
<td>0.31 (0.25–0.37)</td>
</tr>
<tr>
<td>2007</td>
<td>Timor-Leste</td>
<td>Oecuss, Bobonaro, Cova Lima, Atauro Island</td>
<td>Community</td>
<td>Clinical</td>
<td>6 (1535)</td>
<td>0.39 (0.14–0.85)</td>
</tr>
<tr>
<td>2005</td>
<td>India</td>
<td>Ten states</td>
<td>School children</td>
<td>RPR and TPHA</td>
<td>0 (38)</td>
<td>0.00 (0.00–0.00)</td>
</tr>
<tr>
<td>1993</td>
<td>Ecuador</td>
<td>Santiago basin</td>
<td>Community</td>
<td>VDRL and TPHA</td>
<td>16 (1118)</td>
<td>1.43 (0.82–2.31)</td>
</tr>
<tr>
<td>1998</td>
<td>Ecuador</td>
<td>Santiago basin</td>
<td>Community</td>
<td>VDRL and TPHA</td>
<td>0 (1926)</td>
<td>0.00 (0.00–0.19)</td>
</tr>
<tr>
<td>2000</td>
<td>Guyana</td>
<td>Bartica</td>
<td>School children</td>
<td>MHA-TP</td>
<td>52 (1020)</td>
<td>5.10 (3.83–6.63)</td>
</tr>
<tr>
<td>1993</td>
<td>Ecuador</td>
<td>Santiago basin</td>
<td>Community</td>
<td>VDRL and TPHA</td>
<td>52 (1118)</td>
<td>4.74 (3.57–6.16)</td>
</tr>
<tr>
<td>1993</td>
<td>Ecuador</td>
<td>Santiago basin</td>
<td>Community</td>
<td>VDRL and TPHA</td>
<td>68 (1926)</td>
<td>3.53 (2.75–4.45)</td>
</tr>
</tbody>
</table>

FTA-Abs=fluorescent treponemal antibody-absorption. MHA-TP=microhaemagglutination assay–Treponema pallidum. NCD=National Capital District. ND=not documented. RDT=rapid diagnostic test. RPR=rapid plasma reagin. TmpA EIA=enzyme immunoassay with TmpA antigen. TPHA=T pallidum haemagglutination. VDRL=Venereal Disease Research Laboratory. WB=western blot with T pallidum subspecies pallidum as antigen.

Table 1: Characteristics and outcomes of the 24 included studies of active and latent yaws prevalence
study and had final responsibility for the decision to submit for publication.

Results
Our systematic review identified 103 records, from which we identified 23 eligible published articles9–31 that described 27 studies that met our inclusion criteria (figure 1). We included data from an additional four studies identified from other sources (personal communications with country managers and yaws experts: Tabah EN, personal communication; Boua B, personal communication; Nsiire A, personal communication; Ayelo G, personal communication). The included studies covered 18 countries. Three of these countries—Guyana, Nigeria, and Wallis and Futuna—were classified by WHO as previously endemic countries with unknown status in 2012. Two countries—Ecuador and India—were reported to have eliminated yaws.29,31 The remaining 13 countries were classified as known endemic countries in 2012.6

Among the 31 studies, 16 reported data on active yaws prevalence (table 1; Tabah EN, personal communication; Boua B, personal communication; Nsiire A, personal communication).9,10,13,14,16,18–21,24,28–30 Patients with suspected yaws skin lesions were further tested with syphilis serology, except in four studies in which diagnosis was made on the basis of clinical criteria only (Tabah EN, personal communication; Boua B, personal communication).16,19 After excluding one study from Ecuador30 in 1998 in which no clinical cases were detected, prevalence of active yaws lesions ranged from 0·31% in Sumatra, Indonesia,18 to 14·54% around the city of Port Moresby, Papua New Guinea.21 High prevalence rates were also noted in surveys done in tropical forests in Central Africa that were inhabited by indigenous populations (ie, Pygmies), including 9·03%...
in Cameroon (Tabah EN, personal communication), 11·34% in the Central African Republic (Boua B, personal communication), 4·77% in the Democratic Republic of the Congo,9 and 2·95% in the Republic of Congo.10

Overall, eight studies reported data on the prevalence of latent yaws (table 1; Ayelo G, personal communication).7,25–29 After excluding one study from India11 in which no seropositive cases were detected, prevalence of reactive serology ranged from 2·45% in Benin (Ayelo G, personal communication) to 31·05% in Tanna Island, Vanuatu.26 Seroprevalence estimates were high in all three studies from the western Pacific region.25–27 Other studies reporting high seroprevalence were done in Lobaye, Central African Republic (19–72%).9 In Ecuador, after the implementation of a yaws surveillance and treatment programme, serological surveys done in 1998 showed a low prevalence of reactive serology (3·54%).29 and a survey in India in 2005 reported no sero-reactors among 3821 children younger than 5 years.31

Table 2 summarises health-facility-based incidence studies that used passive case finding.11,12,15,17,21–23 In the study in Nigeria, the results for skin diseases were found in the province of Nusa Tenggara Timur, where also very highly endemic. In Indonesia, most cases were found in the province of Nusa Tenggara Timur, where also very highly endemic (1000–4999 cases). The Western province of Bougainville is also very highly endemic. In Indonesia, most cases were reported during the 4-year period. No recent surveillance data have been reported from Timor-Leste, but the country is regarded as endemic according to WHO.

<table>
<thead>
<tr>
<th>Population of country</th>
<th>Health districts reporting yaws (n/N [%])</th>
<th>Population living in endemic districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benin</td>
<td>3·645 619 (3·5 %)</td>
<td>Minimum 632 488. Total not known</td>
</tr>
<tr>
<td>Cameroon</td>
<td>22·128 420 (22·2 %)</td>
<td>2·360 944</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>4 600 125 (4·7 %)</td>
<td>Minimum 43 845. Total not known</td>
</tr>
<tr>
<td>Republic of Congo</td>
<td>4 001 831 (4·7 %)</td>
<td>Minimum 155 553</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>23 261 022 (25·4 %)</td>
<td>18 000 000</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>7 550 000 (7·5 %)</td>
<td>Not known</td>
</tr>
<tr>
<td>Ghana</td>
<td>24 658 823 (26·3 %)</td>
<td>23 178 000</td>
</tr>
<tr>
<td>Togo</td>
<td>19 151 155 (21·3 %)</td>
<td>545 729</td>
</tr>
<tr>
<td><strong>Western Pacific</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>7 146 240 (7·7 %)</td>
<td>6 201 393</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>5 158 700 (5·4 %)</td>
<td>5 158 700</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>234 023 (2·5 %)</td>
<td>234 023</td>
</tr>
<tr>
<td><strong>Southeast Asia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>241 692 190 (24·7 %)</td>
<td>34 588 881</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>120 1500 (12·5 %)</td>
<td>120 1500</td>
</tr>
</tbody>
</table>

ND—no data. *From 2012, except Ghana (2013) and Vanuatu and Indonesia (2009). †Accurate data were only available for two districts. The prevalence of yaws in the remaining 32 districts was not known. §District-level data were not available to allow an accurate calculation of the population at risk.

*Table 3: Estimates of at-risk populations living in districts judged to be endemic (second administrative level, 2012)*
Figure 3: Cumulative number of yaws cases by subnational regions in the WHO Africa region

Figure 4: Cumulative number of yaws cases by subnational regions in the WHO southeast Asia and western Pacific regions
Discussion

Our data show that about 65 000 yaws cases per year occurred in 13 endemic countries and that in at least 19 countries the incidence of yaws is unknown; thus, there has been limited progress since the last systematic review on yaws epidemiology in 1992 (85 000 yaws cases in 33 endemic countries). In 1953, Hackett estimated there were 50–150 million cases of yaws in 90 countries. A substantial decrease in the prevalence of yaws was brought about by the implementation of mass treatment campaigns and subsequent surveillance activities in the 1950s and 1960s. In many countries, yaws control and surveillance activities stopped after 1970, with a subsequent resurgence of yaws, particularly in parts of west and central Africa and in southeast Asia. Little activity to control the infection has been undertaken since 1990. The scarcity of political will, inadequate funding, and weaknesses in primary health-care systems in affected countries have been the biggest obstacles to the reduction of the burden of yaws in the past two decades.

The methods proposed for assessing yaws burden have not changed substantially since 1953; however, unlike in the previous review by Hackett, who sent a questionnaire to all countries in Africa and carefully analysed the replies, or in the review by Meheus and Antal, who compiled original data from country reports submitted to WHO, we also extracted and synthesised a large amount of data from published studies, and complemented this with data from grey literature.

An important finding of our work is that almost 85% of all infections occurred in three countries—Ghana, Democratic Republic of the Congo, and Indonesia. The results of individual studies in these countries, which showed high prevalence and incidence rates, are consistent with integrated surveillance data. An overall low number of cases have been reported in national surveillance programmes in other countries in central Africa. However, we have shown that focal indigenous populations (ie, Pygmies) in the Central African Republic, Cameroon, Republic of Congo, and Democratic Republic of the Congo are affected by yaws, with prevalence of active disease ranging between 3% and 11% (Boua B, personal communication). The main risk factor for these groups, as for in other settings in which yaws is highly endemic, is the scarcity of access to health care and poor personal hygiene.

Among the 13 known endemic countries, we estimated that a maximum of about 89 million people were living in yaws-endemic areas. In view of the focal nature of the disease, the size of the population at risk, in particular in Ghana, Côte d’Ivoire, and Indonesia, is uncertain. This global estimate of at-risk individuals would probably be revised down if community-based surveys were used to guide the implementation of mass treatment.

The major limitation of our study is the weakness of routinely reported data. Yaws is not a notifiable disease and the use of national routine surveillance data is likely to result in an underestimation of the real number of cases because yaws predominantly occurs in rural communities with poor access to health facilities, whereas available data are primarily from health facilities. The limited reliability of clinical diagnoses of yaws and the recognition that other organisms can cause clinically similar skin lesions in yaws-endemic countries causes problems for clinical case reporting. The weakness of reported data shows the limitations of the present data and supports the need for surveys as per the WHO strategy.

We did not undertake a meta-analysis for several reasons. First, the studies that we included were primarily implemented in settings where yaws is endemic and no random sampling from a general population was done. Hence, the prevalence estimates are not representative of a given district, province, or an entire country. Second, the number of studies from each WHO region was limited. Third, the inclusion and diagnostic criteria varied markedly between studies, with both children and adults and both clinical and serological definitions of yaws included. These factors make direct comparison of the survey findings difficult.

The results of this systematic review contribute to the epidemiological knowledge needed to guide the preliminary estimation of resources that are necessary for a successful eradication programme. The inability of several countries to undertake more active surveillance and surveys is a major obstacle to achieving the WHO 2020 eradication target. The weaknesses of routinely reported data shows the need to establish a strict and sensitive surveillance system similar to other eradication programmes (eg, for Guinea worm and poliovirus) in a way that enables regionalisation of cases to make the decision about which communities need mass treatment and other control interventions.

Contributors

OM, MM, and KA had the original idea for the study. DJPK, GA, BB, WH, YK, ENT, AN, DO, FT, RD, and ZZ were involved in data gathering and analysis. OM, MM, and CG-B wrote the first draft of the report, with revisions and input from JU, LSV, QB, and KA. All authors contributed to revisions and approved the final version.

Declaration of interests

We declare no competing interests.

Acknowledgments

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References

Articles


