Editorial

PROBLEMS OF VENEREAL INFECTIONS IN LATIN AMERICA AND THE CARIBBEAN AND MEANS OF FIGHTING THEM[1]

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Campaigns against sexually transmitted diseases (STD) in Latin America and the Caribbean encounter a number of special conditions. This article describes some of those conditions and points out the rising interest that PAHO's Member Governments have recently shown in STD control.

Introduction

The object of this brief discourse is not to present the most recent statistical data on sexually transmitted diseases that are available from Latin America and the Caribbean.[2] Rather, it seeks to contrast the problem of sexually transmitted diseases in Latin America and the Caribbean with the global picture and with the situation in developed countries; to indicate circumstances in Latin America and the Caribbean which provide opportunities for improved STD prevention, treatment, and control programs; and to draw attention to several significant developments which bear upon the exploitation of these opportunities.

In considering Latin America and the Caribbean, it is important to recall that development is relative; in international terms the Americas are considered comparatively developed. Only one member country of PAHO, for example, meets the UN criteria for a "least developed country."

Furthermore, development has been defined in terms of a country being able to generate valid and useful statistical data. This a subsidiary reason for not projecting data from within the region. Comparison of syphilis or gonorrhea rates is not possible from one country to another. Because of rapid improvement in health systems, trends within the same country over a defined period may also be influenced by a variety of factors. Ironically, increasing reports of STD from a country, upon investigation, are found to be a manifestation of the extension of health coverage to larger populations, improved surveillance, or strengthened public health laboratory structure more often than they are found to indicate a real increase in disease. In this

[1] From a paper presented at the International Symposium on Sexually Transmitted Diseases held at Montreal, Canada, on 31 October 1977. Also appearing in Spanish in the *Boletín de la Oficina Sanitaria Panamericana*, 1978.

[2] All of the Americas except Canada and the United States.

vein, grouping of countries into subregions (such as Northern, Middle, and South America) provides a more reliable indication of trends than country-by-country analysis.

STD Prevalences

With the preceding reservations, it is worthwhile to review some major features of sexually transmitted diseases in Latin America and the Caribbean. Much of this information is based upon the periodic surveys of national STD programs conducted by the Pan American Health Organization. Thanks to major public health programs in the 1950's and 1960's, nonvenereal treponematoses (yaws and pinta) have been eradicated from most endemic areas. Isolated foci, however, still smolder in Haiti, along the Pacific border between Colombia and Ecuador, and on some Caribbean islands (notably Trinidad and Dominica). Surinam has also recently advised us of an apparent resurgence of yaws.

The "minor" venereal diseases (e.g., chancroid, lymphogranuloma venereum, and granuloma inguinale) are gradually declining throughout the region without specific control programs. There are no accurate figures on nonspecific urethritis or herpesvirus hominis.

As shown in Table 1, reported cases of syphilis (all causes) have declined in Middle America[3] at about the same proportional rate as in Northern America. By contrast, the rate of reported syphilis has remained rather stable in South America.

[3]Central America, Mexico, Panama, and the countries and territories of the Caribbean.

Table 1. Total reported cases of syphilis (all stages) and case rate per 100,000 population in the three Regions* of the Americas, 1960-1974.

Year	Northern America		Middle America		South America	
	Cases	Rate	Cases	Rate	Cases	Rate
1960	124,184	62.7	63,102	94.1	48,578	38.0
1961	126,979	63.1	62,023	91.5	34,170	56.9
1962	128,682	62.9	54,302	77.9	36,117	59.1
1963	126,945	61.2	52,495	73.3	35,232	56.5
1964	117,097	55.6	55,295	74.1	36,513	62.8
1965	115,280	54.0	52,672	68.3	41,227	59.9
1966	107,198	49.6	41,814	55.0	42,849	61.1
1967	104,966	48.1	36,849	47.0	45,616	66.2
1968	98,533	44.8	44,945	53.0	26,050	45.1
1969	94,580	42.5	42,749	50.1	41,032	57.1
1970	93,926	41.7	42,645	47.6	40,239	53.8
1971	98,520	43.2	45,987	49.5	46,012	55.5
1972	94,238	40.9	48,651	50.8	55,423	64.3
1973	91,726	39.3	47,502	48.0	41,623	55.3
1974	87,577	37.4	48,124	50.5	38,396	59.5

Source: Brubaker and Rao, APHA, 1976.

*Regional totals do not necessarily include data for all the countries in the region, or for the same countries in each of the years cited.

Gonorrhea presents a different pattern. Gorrhea rates have increased dramatically since 1960 in Northern America, while the rates in both Middle and South America have remained comparatively stationary (see Table 2).

Table 2. Total reported cases of gonococcal infections and case rate per 100,000 population in the three Regions* of the Americas, 1960-1974.

Year	Northern America		Middle America		South America	
	Cases	Rate	Cases	Rate	Cases	Rate
1960	274,741	138.8	72,041	115.4	87,416	78.7
1961	280,672	139.4	69,607	107.6	87,691	148.9
1962	281,514	137.7	77,829	117.3	84,643	159.4
1963	297,838	143.5	100,092	139.3	91,784	147.9
1964	321,516	152.6	84,490	113.8	81,857	140.8
1965	345,229	161.7	80,730	110.6	76,514	126.9
1966	373,375	172.8	82,366	108.7	76,664	125.2
1967	427,409	195.7	77,518	105.3	89,843	150.3
1968	487,299	221.4	96,179	113.8	91,240	133.7
1969	562,291	252.7	99,540	117.1	94,985	152.5
1970	632,121	280.7	101,680	113.9	93,217	143.3
1971	705,190	309.5	93,949	101.6	94,799	129.8
1972	809,463	351.7	103,754	108.4	103,501	136.1
1973	888,590	382.9	111,198	112.3	113,137	128.4
1974	951,050	406.6	97,870	102.7	103,411	132.6

Source: Brubaker and Rao, APHA, 1976.

*Regional totals do not necessarily include data for all the countries in the region, or for the same countries in each of the years cited.

STD Control Programs

Results of the PAHO surveys also demonstrate that most responding countries have a formally recognized national venereal disease control program. Of those ministries which report an organized venereal disease control program, however, only half include it as a separate item in the budget. It is also the rule for Latin American and Caribbean countries to have statutes for reporting venereal diseases to health authorities. Legal regulation of prostitution, with heavy emphasis on STD control in this population, persists in certain countries. Critical epidemiologic studies have not been done to determine the relative importance of prostitutes in the overall transmission of these diseases.

Some specific comments on syphilis and gonorrhea control programs will, I think, highlight the intermediate stage of development of most Latin American and Caribbean programs. Syphilis serologic screening is common, with emphasis on prenatal testing of mothers; premarital serologies are rarely required. Interviewing of syphilis case contacts is an accepted concept; but in actual practice it is confined to the large urban centers. As a result of a very successful technical assistance program 15 years ago, every

country utilizes a non-treponemal STS test for screening and diagnostic purposes. Almost without exception this is the VDRL. One remarkable feature of the VDRL testing is that the internal and external proficiency testing continues to this date. In many countries the VDRL is the only public health laboratory examination in which this is practiced. Slightly less than half the countries have treponemal tests available.

With regard to gonorrhea, treatment of the disease is an essential feature of every national program. The emphasis, however, is on clinical treatment of symptomatic cases (usually males); epidemiologic tracing of contacts is rarely employed. For economic reasons, or because of poor laboratory facilities, routine culture is rarely practiced. If laboratory studies are done, they generally use a Gram stain technique.

Free treatment in public clinics is a universal feature. It should also be pointed out that antibiotics for the treatment of venereal diseases are available without prescription in a majority of Latin American countries.

Special Features Affecting STD Programs

Opportunities for improved prevention, treatment, and control of sexually transmitted diseases in Latin America and the Caribbean have their basis in the region's relative economic affluence compared to Africa and Asia. I would like to mention three features in particular:

Social Security Institutions

The first of these applies to Latin America and the *Seguro Social* (Social Security) institutions which exist in various forms in most countries. When the PAHO Directing Council met in Washington in September 1977 the topic for the accompanying Technical Discussions was the role that the *Seguro Social* could play in the provision of primary health care services. While individuals eligible for care, by definition, must be workers or their dependents, in the more developed countries workers and dependents represent a sizable portion of the total population. The *Seguro Social* concept also minimizes the negative psychological features of attending a public clinic. At the present time, STD services are delivered in an *ad hoc* fashion. There is growing interest, however, in the utilization of the *Seguro Social* as the "backbone" of national venereal disease programs. Costa Rica, to cite one example, has transferred the responsibility for clinical management of patients with venereal diseases to the *Seguro Social*, while case contact tracing, laboratory diagnosis, and overall responsibility for the program remains with the Ministry of Health. Cuba is another country in the Hemisphere, though perhaps a unique one, where strategies have been developed for venereal disease control.

The Health Infrastructure and Primary Health Coverage

A second feature of Latin America and the Caribbean is the existence of a comparatively developed health infrastructure in urban areas combined

with a strong commitment by the Member Countries of PAHO to extend primary health coverage in rural areas. Excellent opportunities exist to incorporate STD treatment, investigation, reporting, and community education into the services provided through primary health care. Before this can be done, however, considerable preparation will be necessary. Thus there is an important need for epidemiologic studies on venereal diseases in the countries, particularly on the dynamics of transmission and the population at risk. Preliminary data indicate, for example, that ophthalmia neonatorum is extremely prevalent in countries which have looked into the extent of this problem. Norms and guidelines which can be implemented by a health auxiliary also need to be developed and field-tested, and operational research should be supported in order to develop strategies for active case detection, contact tracing, and community education in preventing venereal infection.

The Caribbean Islands

A third significant feature relates to special epidemiologic and geographic conditions. The Caribbean islands, particularly the smaller ones, contain "closed" populations served by health systems that provide complete coverage of primary services with heavy reliance on nurses and public health inspectors rather than medically qualified practitioners. These circumstances provide a ready-made workshop for the epidemiologist seeking to develop strategies that can reduce (and possibly eliminate) the transmission of syphilis and gonorrhea. In this regard, the cost-effectiveness of various approaches will be of particular interest.

Conclusions

In closing, I would like to highlight several positive developments which involve the Pan American Health Organization's program of technical cooperation in Latin America and the Caribbean.

I should add, parenthetically, that PAHO can only respond to requests from governments, and that these developments indicate growing interest by ministries of health in the sexually transmitted diseases. To stimulate such interest, since 1973 we have supported a series of Area Seminars on Sexually Transmitted Diseases. Most recently, PAHO/WHO collaborated with the Brazilian Chapter of the International Union against Venereal Diseases and Treponematoses and the Ministry of Health of Brazil in sponsoring the First Latin American Symposium on Sexually Transmitted Diseases. This meeting was held at Goiás, Brazil, on 3-6 October 1977.

One indicator of rising interest in STD has been the increased attendance at the Annual International Course on the Venereal Diseases in Santiago, Chile. The increased numbers of international participants supported by PAHO fellowships or national funds has been most gratifying.

Another important development has been the recruitment of a PAHO epidemiologist in venereal diseases on Jamaica for a two-year period to assist the Ministry of Health and staff members from the University of the West

Indies in the development of a national STD program. (In Kingston the approach will be to seek the management of venereal diseases in a clinic setting directed at general social problems. The team will also work with the Saint Andrews County Pilot Health Project on incorporating STD management into the primary health care system.) This two-year assignment grew out of the first request to PAHO from any Middle or South American government for assistance of this nature. If successful, it promises to open up a new area for technical assistance provided by the Organization.

SUMMARY

Rather than providing a comprehensive overview of the sexually transmitted disease (STD) picture in the Americas, this presentation contrasts the STD problem in Latin America and the Caribbean with the situation in both less developed and more developed regions of the world. It also points out three areas of opportunity for improving preventive and curative STD services, specifically: (1) more effective utilization of social security institutions in Latin America, (2) incorporation of STD services into primary health care programs, and (*3*) development of pilot projects in the smaller Caribbean territories.

It is noted, in addition, that the more developed countries of the region are showing increased interest in sexually transmitted diseases. Among other things, the recruitment of a PAHO epidemiologist in venereal diseases on Jamaica—to assist in the development of a national STD program—opens up a new area for PAHO technical assistance which, if successful, may be extended elsewhere.