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Sexually transmitted diseases in Surinam

Observations and thoughts

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Introduction

Surinam, a tropical country, is geographically located in the north-eastern part of South America and bordered by Guiana, French Guiana, Brasil, and the Atlantic Ocean (see Figure). The country became a republic on 25 November 1975 after 300 years of colonisation by the Netherlands. Surinam is sparsely populated with 400 000 inhabitants, approximately 60% of whom live in the capital Paramaribo and its surrounding areas. The remainder of the population is concentrated in the coastal plain and fewer than 10% live in the interior. About 130 000 people of Surinamese origin live in Holland. Most of them moved there shortly before Surinam gained independence and there is close contact between them and their home country.

Surinam, apart from the Amerindians, are descendants of voluntary and involuntary immigrants. However, Surinam is distinct in having a more heterogeneous population, originating from Africa, Asia (Indonesia, India, and China), and Europe. These groups practise several religions including Hinduism, Islam, various Christian denominations, and Animism. Although there is substantial cultural intermingling and assimilation, most ethnic groups have retained features of their original culture. In relation to this, one can find differences in the distribution of diseases in the various ethnic groups.

The economy of Surinam is based primarily on the production and export of bauxite, alumina hydroxide, alumina, and timber (plywood) together with agricultural products (rice and bananas).

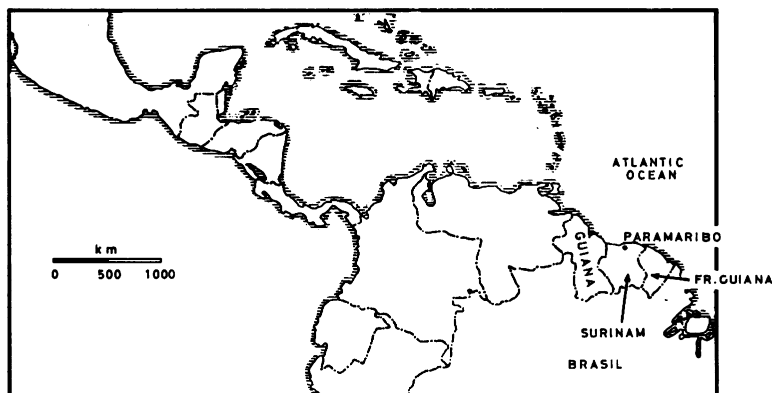

Figure *Geographical position of Surinam.*

Historically and sociologically, Surinam has a closer relationship with countries of the Caribbean area than with Latin American countries. As in other countries in the Americas the inhabitants of

For almost a century the country has been self-sufficient in general medical practitioners trained at the local medical school founded in 1882. Recently, this medical school was incorporated as a faculty of the University of Surinam, which was founded in 1968. Medical specialists are educated abroad, mainly in the Netherlands. Unlike many developing nations, the physician to population ratio in Surinam

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is good, with one doctor for every 2000 inhabitants. Medical research, which is partially done in conjunction with foreign universities and international institutions, is developing. Most research is focused on tropical infectious and parasitic diseases of high morbidity—such as schistosomiasis, filariasis, leprosy, and treponemal diseases.

Control of STD

Sexually transmitted disease (STD) comes under the jurisdiction of the Ministry of Health, and its control is implemented by the dermatological service. This service was founded in 1971 by Dr Paul Niemel, a dermatovenereologist, who is currently the director. There is an outpatient department in Paramaribo, and rural areas have consultation services and special campaigns. Before 1971 any patient suffering from STD, leprosy, or a dermatological disorder had to visit one of three different medical departments. These departments are now integrated into one service. It is therefore more difficult for patients to be identified by laymen as suffering from specific diseases and there is less stigma.

Control of STD and leprosy has been helped by the fact that patients are treated free of charge in the outpatient department. However, many patients with STD prefer to consult physicians in private practice. Although in theory reporting is compulsory, doctors are reluctant to report cases; therefore, the statistics are unreliable. Self medication is often practised by the patients.

Incidence of STD

Clinical observations suggest there has been a gradual increase in the number of patients with STD in Surinam during the last 15 years although the actual number visiting the dermatological service outpatient department with STD has remained stable during the last four years that records have been kept. Data on the five classical venereal diseases indicate that gonorrhoea, early infectious syphilis, and donovanosis are much more common than lymphogranuloma venereum and chancroid. Donovanosis is diagnosed more often than it was a decade ago. This is attributed to cases in people who moved from the interior to Paramaribo. Contrary to western European countries and North America, non-specific urethritis is diagnosed less frequently than gonorrhoea.

Positive results to serological tests for treponemal diseases are common. Among 2395 adult outpatients seen between 1 January and 1 September 1977, a total number of 685 (30%) had a reactive VDRL (Venereal Disease Research Laboratory) test. These patients were from urban and rural areas. Further analysis with treponemal tests indicates that biological false positive VDRL reactors are rare. The blood transfusion service shows that many people in Surinam have been exposed to treponemal infection as about 5% of the aspirant donors (mostly urban dwellers) have a reactive VDRL test.

A recent study in the central northern part of the country revealed that out of 2971 people 13·3% reacted positively to the VDRL test (treponemal tests were also positive). For clinical and epidemiological reasons, the reactive VDRL tests were attributed to yaws. It is interesting to note that classical symptoms of yaws were not seen; the cases were either mild or entirely asymptomatic (attenuated treponematosis). In the interior we detected a much higher seropositive ratio. For instance of 408 people examined in one village half showed a reactive VDRL test. Moreover cases of yaws in the interior are generally of the classical type, in contrast to the attenuated cases in the central-northern region.

The data indicate that a substantial part of the Surinamese population has been exposed to treponemal infections. Clinical syphilis is regularly diagnosed in the urban area; cases of yaws from the rural areas are less common. Pinta has not been identified.

Prostitution

The influx of relatively large amounts of money, including revenues from the bauxite industry and development aid, probably contributes to the recent increase in prostitution. Because of economic progress, more sailors, technicians, and businessmen, mostly unattached, visit Surinam for short periods and form a flourishing clientele for the prostitutes. These women can be categorised as indigenous or migratory; the latter constitutes a fast growing group and their number is now estimated to be 300. They originate from the Caribbean islands and South America, and travel from country to country within this part of the world, which indicates a pattern of regionalisation of their profession (regional prostitution). Moreover, there is indication of a transatlantic movement of these prostitutes to European countries and back to the Americas (transatlantic prostitution).

The government has no clear policy on prostitution. By establishing reasonable rapport with the prostitutes and hotel managers and others concerned, some control has been instituted and prostitutes are examined voluntarily every two weeks and a presumptive treatment is administered.

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In the interest of public health it is important to know to what extent the migratory prostitutes import and export STD and help in the spread of disease. However, since they are examined neither when entering the country nor when leaving, no quantitative assessment can be made on the extent of disease transmission across borders. We interviewed 273 men with gonorrhoea between January and September 1977 to obtain information on the source of the disease. Migratory and indigenous prostitutes were the sources in 12% and 17% of cases respectively; the remaining 71% indicated other types of contacts. The figures suggest that prostitutes as well as the general population may be a significant reservoir of disease. However, insufficient data limit the conclusions that can be drawn.

A high percentage of positive results to serological tests for syphilis was found in the migratory prostitutes. Out of 135 prostitutes examined between January and September 1977, 41% of them showed a reactive VDRL and/or rapid plasma reagin (RPR) card test. Treponemal tests gave positive results in most VDRL and RPR reactive cases. VDRL titres were generally low and clinical treponemal disease was not identified. The positive serological results can be related to venereal syphilis as well as to non-venereal treponematoses.

Comment

In spite of the small amount of detailed data presented on sexually transmitted diseases in Surinam, a general impression can be ascertained.

The similarity in social structure and culture makes it probable that there is a close similarity between the STD pattern in Surinam and that in other Caribbean countries.

European doctors may encounter medical problems in people originating from Surinam but living in Holland that are alien. For example, positive results to serological tests for syphilis in Surinamese expatriates may be caused by previous yaws infection. It is obvious that the movement of people between Europe and the Caribbean area can introduce unexpected pathogens and diseases in either region.

International prostitution, a phenomenon which has so far received insufficient attention, transmits diseases across borders. The extent of the problem, however, is largely unknown. If a booklet, such as the one used by sailors, were introduced which gives coded information on diagnosis, laboratory results, and treatment, a contribution might be made to our knowledge and control of STD internationally.

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