



## SEXUALLY TRANSMITTED INFECTIONS: A PUBLIC HEALTH PROBLEM THAT COLOMBIA NEEDS TO FACE

This issue of *Revista Colombiana de Obstetricia y Ginecología* includes a policy brief on the World Health Organisation Strategy on Sexually Transmitted Infections 2016-2021. This strategy was developed in compliance with the 2030 Agenda for Sustainable Development agreed upon by the United Nations (UN) member countries with the aim of eradicating poverty, protecting the planet, and ensuring prosperity for all (1). The document also focuses on the steps that Colombia will have to take in order to meet the goals of the strategy.

Consistent with the WHO approach to public health issues, the strategy focuses on three sexually transmitted infections: gonococcal infection, human papilloma virus infection, and syphilis, considering their significant consequences for health and quality of life, that, in the case of Colombia, affects the most vulnerable population.

The document offers a series of recommendations to the countries so that national governments can define policies to guide sustainable actions and facilitate institutional and governance actions that will result in the implementation of interventions that have shown to be safe, effective and economically viable for managing these infections. The aim is to impact the largest number of vulnerable individuals within a framework of respect for human rights, gender equality and equity in health (2). The actions included in the strategy focus on: a) stronger surveillance, follow-up and evaluation of the progress of the program; b) prevention of STIs; c) early diagnosis; d) adequate management of patients and their partners,

and (e) approaches for reaching the most vulnerable populations.

This editorial is intended to describe the current situation regarding policies on STIs in Colombia. We start with a brief review on how this problem has been dealt with in this country since the 1970s, as well as some proposals regarding the role that must be played by some stakeholders of the health sector and other sectors, in order to ensure the successful implementation of this strategy in Colombia.

The very first documented records in the area of sexually transmitted diseases (STDs) date back to 1975, with the creation of the National Health System (NHS). At that time, the Health Ministry was in charge of receiving notifications regarding communicable and non-communicable diseases (3). Public health policy and actions in the country were planned, guided, coordinated, controlled and implemented by the Ministry. In the regions, this role was in the hands of the Regional Health Services. This model resulted in many successes, including the Expanded Immunisation Programme (EIP), but there were also failures, like the malaria eradication programme (4). Although there are reports of syphilis, trichomoniasis, gonococcal infections and genital herpes since 1975, it is not clear how the reports were made. Apparently, cases were reported on the basis of a syndromic diagnosis, considering that there are reports of ulcerative cases and urethral discharge syndromes. These records are available until 2000 (5). At some point during those years, public hospitals offered follow-up consultation for venereal diseases targeted to sexual workers, and

the aim was the detection and treatment of STDs in the event an infection was diagnosed.

STI surveillance and state policy changed as a result of two situations: first, the emergence of the acquired immunodeficiency syndrome (AIDS) in the United States and its identification as a sexually transmitted infection in 1981 (6); and, later, the identification of the human immunodeficiency virus (HIV) as the causal agent of this syndrome (7). The first cases were described in Colombia in 1983 (8), and the rapid spread and high mortality rates associated with this disease led the country to focus its resources on surveillance and treatment of this infection, at the expense of other sexually transmitted infections (9). On the other hand, as a result of Law 100 of 1993, the National Health System was replaced with a Social Security System in Health, leading the Ministry to delegate its promotion and prevention activities in the hands of third-party payers (insurance companies) to which the users then became affiliated under the contributive regime for workers, or under the state-subsidised regime. The Ministry went on to play a key regulatory role, whereby collective public health actions are implemented by the territorial entities under the guidance of the Ministry of Health, and individual actions are implemented by the insurers. The Health Superintendency is in charge of oversight and control. This change brought about the phasing-out of all programmes previously coordinated directly by the Ministry, such as the immunisation, malaria and STI programmes (10). It is worth noting that as a result of the lower vaccination coverage that ensued, the Ministry had to take direct control over immunisation as the only way to ensure the quality of the programme (11).

According to the national fortnightly epidemiological report, all sexually transmitted infections had shown a linear decline up until 2000 (5). This drop could probably be attributed more to the absence of reporting rather than a reduction in the number of cases. In 2004, the surveillance system was placed under the responsibility of the National Health Institute,

and the National Public Health Surveillance System (SIVIGILA) was created (3). A review of the SIVIGILA epidemiological newsletters since 2006 showed that, initially, only congenital syphilis was reported among the sexually transmitted infections (12). By 2014, the Epidemiological Newsletter included surveillance of the following STIs: hepatitis B and C, congenital syphilis, and HIV-AIDS. Gestational syphilis was included as of 2015. Consequently, there is no current surveillance neither of cases of resistant strains of *N. gonorrhoeae*, nor cases of cases of human papilloma virus, *C. trachomatis* or the herpes simplex virus.

Regarding the prevention of STIs, primary prevention actions are taking place for HPV in the form of inclusion of the vaccine in the benefits plan (13). However, vaccination coverage has dropped significantly (14) because of people's fear of potential adverse events (15) and ignorance regarding the importance of this intervention. Secondary prevention of STIs is geared to early diagnosis and treatment of gestational syphilis and HIV in pregnancy, as part of the strategy for the elimination of mother-to-child transmission of syphilis and HIV, a commitment in Colombia since 2011 (16). As part of the early detection of cervical and uterine cancer, the Colombian guidelines include screening for HPV of high risk for cancer (17). Moreover, national guidelines were published for the syndromic management of STIs, including the use of rapid tests at point of care and single doses of treatment for improved adherence (18).

Secondary prevention activities are not being carried out in the form of population screening or through risk or opportunity screening for *N. gonorrhoeae* or *C. trachomatis* infections, just as no early detection and treatment of syphilis are being implemented in vulnerable populations such as men who have sex with men (MSM), sexual workers and homeless people. Not controlling these sources of infection and reinfection will make it very difficult to achieve the goal of elimination of congenital syphilis.

The Ministry of Health should take direct responsibility for developing a policy for the elimination of

STIs similar to how it did with the expanded immunisation programme, considering that insurers (benefit plan managers - BPMs) have not been able to effectively implement individual public health actions in the area of sexually transmitted infections. Examples of this situation include the challenges encountered with the national and subnational evaluation of the strategy for the elimination of mother-to-child transmission of syphilis and HIV in the various territorial entities, in terms of the benefit plan managers' implementation of the individual actions under their responsibility. These include induction of demand for prenatal controls in vulnerable populations; reduction of access barriers such as service fragmentation or contracting issues in order to ensure availability of rapid tests in the care centres; and treatment of partners of the patients with gestational syphilis (19).

On the other hand, resources need to be allocated in order to ensure sustainability of an STIs eradication programme, for example, with funds coming directly from royalties, or implementing oversight and control actions to ensure that BPMs fulfil their obligations. On the other hand, research should be conducted in the academic settings with the support, for example, of funds from the Science and Technology programme, in order to generate new data about other STIs not covered by the strategy. This research could include *C. trachomatis*, *H. ducreyi* or herpes virus prevalence studies in population groups; treponema resistance to macrolides; or prognosis of inflammatory pelvic disease in our women. Scientific societies interested in this area, in particular the Colombian Federation of Obstetrics and Gynaecology, should act as oversight agents to ensure that the organisations in charge of public health in Colombia face the reality of the acquired commitments and plan the necessary actions to reduce the health inequity associated with the disease burden of STIs among the younger and poorer populations, ethnic groups, sexual workers, diverse groups and the most vulnerable populations to the burden of STIs. The involvement of the education and the communication and technology sectors, as well as of the social organisations, is also required if

the goals set forth in the strategy for the elimination of STIs are to be accomplished.

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Editor

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