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Sexually transmitted diseases

Casual sexual intercourse with multiple individuals seems to be the accepted life style of many Malawian men and their consenting female partners. The intensity of this activity is obvious from the large number of young women employed as bar-girls (functionally prostitutes) and the equally numerous unregistered prostitutes who frequent hotel lounges, bars, night clubs and off-licence shops (bottle stores) in our urban and periurban centres.

The price paid for such a life style is the high incidence of sexually transmitted diseases (STD) seen in our hospital out-patient departments and private surgeries. Though no statistical data are available to quantify the extent of STD in Malawi, clinical impression is that of a high incidence of gonorrhoea, syphilis, chancroid, lymphogranuloma venereum (locally best known as "mabomb") and herpes genitalis. Chronic complications especially in women are seen in the many surgically removed chronic tubo-ovarian abscesses and the many blocked tubes on hysterosalpingography during investigations for infertility. More recently we are seeing cases of AIDS.

The management of sexually transmitted diseases presents several problems in Malawi. Clinical diagnosis is often very poor due to the limited knowledge of many front-line health workers about the differential diagnosis of the listed conditions. The crowded out-patient cubicles do not allow for the privacy required for the examination of a patient's genitalia in suspected STD. Consequently a hurriedly taken history is followed by a prescription for a course of procaine penicillin. Laboratory back-up for the diagnosis of STD is often lacking, especially at the district hospital level and in nearly all private surgeries. Where facilities are available, such as at Queen Elizabeth Central Hospital, in Blantyre, and Kamuzu Central Hospital, Lilongwe, they are often inadequate and improperly utilised. At Q.E.C.H. for example, there has been no request for dark-ground microscopy of specimens from patients suspected of and being treated as cases of primary syphilis during the last three and a half years, whilst the VDRL test is excessively

requested. The latter is due to mistaken belief that effective treatment of syphilis soon results in a negative serological test for the disease (VDRL), so that follow up tests are done too soon and repeated too frequently without regard for the VDRL titre reading.

The treatment of STD is also problematic. The selection of an appropriate antibiotic should be based on the clinical diagnosis made, backed up by appropriate laboratory tests. In the light of the comments above this is unlikely to be the case in many out-patient departments in the country. The treatment of gonorrhoea for example, has remained unchanged for the last ten years; a single dose of 16cc procaine penicillin, i.m., preceded by 1gm probenicid - this despite reports of high incidence of penicillin resistant gonococci from neighbouring countries. The 72% of beta-lactamase producing gonococ-

ci reported in the small study from Q.E.C.H. (page 31) should not come as a surprise. It points to a need for a larger study, to define the problem of penicillin resistance; to compare the small district towns with the larger urban centres; and to lay down recommendations for the treatment of gonorrhoea, if not the whole range of STD. The problem of tracing and treatment of contacts of patients presenting with STD, at present completely neglected, needs to be tackled, and some solutions found.

Above all members of the Medical Association of Malawi and the STD Committee at the Ministry of Health should take an active role to educate the community about the problems of sexually transmitted diseases and the need for a more responsible attitude towards sexual relationships.

Editor

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