Sexually Transmitted Diseases in Rhodesia

PART II

BY

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Statistics gained from the European population are even less accurate than the African figures. Only eight in-patients were reported as suffering from STD in Government hospitals in 1972 and 10 in 1971[19]. Information from four Salisbury general practitioners was that STD were uncommon, mostly occurring in the promiscuous and often contracted outside the country. Private laboratories reported 640 positive specific treponenal tests (not VDRL) in Europeans during the last five months of 1972[23]. This gives a monthly average of 128 although the statistics must be interpreted with care[23]. Thus, although present in the white population, STD do not appear to have reached the high levels seen in Europe and North America.

The Pattern of Disease in the African Population

Not every sore is syphilis nor every discharge gonorrhoea.

1 995 diagnoses were reported from 1810 patients during the survey (Table I), showing that one in 10 patients had more than one condition. Only 10,6 per cent. of diagnoses made in Salisbury (1 707), and 6,3 per cent. at Triangle (288), were confirmed by laboratory tests. Thus, 90 per cent. of cases are diagnosed clinically, illustrating the need for accurate diagnosis.

1. *"Sores"*

Despite Willcox's plea in 1949, chancroid is still being widely misdiagnosed as syphilis. No chancroid cases were recorded from Triangle although 130 cases of syphilis were reported (11 positive VDRL tests). Doctors A, B, C and D (Table I) presumably see similar patients as all practise within 1 km of each other and charge similar fees. Doctor A reported 24 per cent. syphilis, Doctor B, 32 per cent.; and both recorded three per cent. chancroid. By contrast, Doctors C and D reversed these figures, reporting 46 per cent. and 24 per cent. chancroid respectively, and only reported one case of syphilis between them (Table I). The doctor with a suburban practice did not report a single case of syphilis in 417 patients diagnosing chancroid in 102 patients (24 per cent.). Salisbury's AIDH recorded 59 per cent. chancroid in this survey (Table I) and 41 per cent. in 1972[23].

The confusion between syphilis and chancroid is important since chancroid is insensitive to penicillin, which is the usual treatment for syphilis. Chancroid is described as a disease of the "socially unenlightened and economically unfortunate"[37]. The high rate at AIDH may be explained by the 54 per cent. unemployment rate in this group, previous inadequate treatment (20 per cent. had seen private doctors) and more accurate diagnosis.

Thus, many "sores" may be chancroid rather than syphilis in view of Willcox's findings[14], the rarity of late syphilis[19] and the few cases of syphilis found when patients are fully investigated as at AIDH (Table I).

2. *"Discharges"*

Gonorrhoea was diagnosed in 1 226 patients (61,5 per cent.) during the survey. Not one diagnosis of non-specific urethritis (NSU) was recorded although the condition now exceeds all male cases of gonorrhoea in England (68 139 and 37 833 respectively in 1973)[38]. How many "discharges" are gonococcal in Rhodesia? Cowan thought gonorrhoea was "relatively uncommon" in 1962[5]. Recent figures suggest a high incidence. Of 215 smears submitted by three Salisbury Clinics (February-April, 1974), 125, or 59 per cent., were positive. The prevalence of gonorrhoea and related conditions is also considerable amongst African women (Part I). Research into the microbiology of urethral discharges is needed to find the relative frequencies of gonorrhoea and NSU in

Table I
CLINICAL DIAGNOSIS

	Syphilis	*Gonorrhoea*	*Chancroid*	*Other*	*Total*
SALISBURY					
Clinic 1					
No.	15	74	22	9	120
%	12	62	18	8	
Clinic 2					
No.	6	116	43	20	185
%	3	63	23	11	
Clinic 3					
No.	49	136	48	35	268
%	18	51	18	13	
Clinic 4					
No.	29	75	15	—	119
%	24	63	13		
African Inf. Diseases Hosp.					
No.	4	9	41	15	69
%	6	13	59	22	
Doctor A					
No.	83	242	11	11	347
%	24	70	3	3	
Doctor B					
No.	12	19	1	6	38
%	32	50	3	15	
Doctor C					
No.	1	11	11	1	24
%	4	46	46	4	
Doctor D					
No.	—	30	10	1	41
%	—	73	24	2	
Doctor E (Suburban)					
No.	—	315	102	—	417
%	—	76	24	—	
Doctor F (Township)					
No.	7	60	12	—	79
%	9	76	15	—	
TOTAL	206	1 087	316	98	1 707
%	12	64	19	5	

	Syphilis	*Gonorrhoea*	*Chancroid*	*Other and Non-Specific*	*Total*
Triangle Hospital					
No.	130	139	—	19	288
%	45	48	—		100
GRAND TOTAL					
No.	336	1 226	316	117	1 995
%	16,8	61,5	15,8	5,9	100,0
No. of Patients	1 810: DIAGNOSES PER PATIENT — 1,10				

Rhodesia. This is of epidemiological importance since the postulated infective agents of NSU (e.g., Chlamydia, 4) are insensitive to penicillin.

3. *"Other" Sexually Transmitted Diseases*

Willcox found that the so-called tropical venereal diseases were present but uncommon in S. Rhodesia in 1949[14]. A similar position was found in 1974 (Table I), the most common "other" condition being venereal warts. Nyovera is now rare in Rhodesia and unlikely to cause confusion in diagnosis nor in serology. Nyovera is now regarded as endemic syphilis and not yaws as was widely believed[10]. (Willcox, 1951[39]; Murray, 1957[7]; Schofield, 1972[32].)

SOCIAL FACTORS OF STD IN THE AFRICAN POPULATION

The questionnaire survey in early 1974 provided most of the following information. Unfortunately a control group was not possible.

1. *Dermographic*

Rhodesia's African population has a high proportion of adolescents and young adults, a

group forming the most sexually-active in any population[32]. Forty-nine per cent. of African adults, defined here as 15 years and over, living in Rhodesia are aged 15 - 29 years[40]. Consistent with other countries[1], the group most frequently presenting for treatment was aged 20 - 24 years. Twenty-nine per cent. of clinic patients and 30,6 per cent. of "private" patients were in this group in contrast to population figures of Highfield, 20,2 per cent.[41], Salisbury 17,8 per cent. [19a], and Rhodesia 15,7 per cent[40].

Few patients with STD aged 15 - 19 presented for treatment, only eight per cent. overall, compared to 15,6 per cent. in South Africa [40] and 19,8 per cent. of syphilis cases in U.S.A.[1]. This may represent a lower prevalence in the 15 - 19 group in Salisbury or that younger, unemployed patients cannot afford private or clinic treatment. AIDH figures suggest the latter explanation as 54 per cent. of 56 patients were unemployed and 59 per cent. were 15 - 24 compared with 38 per cent. (271/714) in the clinics and private surgeries.

2. *Population Imbalance*

The survey showed that 87 per cent. of 1 527 cases of STD treated in Salisbury were men, giving a male:female ratio of 6,7:1 (8,8:1 in Triangle). The overall sex imbalance in Salisbury in 1969 was 2,4 to 1, which is even more marked in the 15 - 19 age group[19a]. There is an influx of work-seeking males with an efflux of females to rural areas for "instruction in traditional roles and sexual security"[41]. To further aggravate the male:female imbalance, a large number of "single" males (24 000 in 1971) are concentrated in Salisbury hostels (community development, Salisbury Municipality).

3. *Marital Status*

Similar patterns were seen in patients at Salisbury clinics and private surgeries. Forty-four to 65 per cent. were single or previously married in contrast to 78 per cent. in the younger patients at AIDH. 82,3 per cent. of 567 Salisbury men were effectively "single" as their wives lived more than 25 miles outside Salisbury. However, nearly 18 per cent. of married men treated were living with their wives in Salisbury. This may reflect the degree of extra-marital intercourse, put at 22 per cent. in Symington's survey[26].

The "single" status of urban men, usually through separation from their wives by labour migration, is considered a major factor throughout Africa in the high prevalence of STD[14, 26, 42, 43, 44].

4. *Employment*

Patients attending AIDH, where treatment is free, had a high unemployment rate, 54 per cent., compared to 14 per cent. amongst 532 "private" patients. 81 per cent. of patients with STD, seen at four African clinics in European areas, were domestic servants. They appear to be a high risk group, since wives, unless also employed, are not allowed to live with their husbands on the employers' property and European suburbs are some distance from African townships. Subsequently, female domestic servants have a ready market for prostitution as in South Africa[42a].

5. *Contacts*

Salisbury patients gave an overall incidence of 80 per cent. of infections (270/337) contracted from prostitutes (i.e., money was paid for last intercourse). Willcox (1949) obtained a similar figure which is amongst the highest recorded universally[3a].

6. *Repeated Infections*

The overall Salisbury figure for one or more previous infections was 45 per cent. (289/647). In Triangle only 17 per cent. (32/193) had *not* had STD before. Thus there is a high incidence of re-infection or persistence of infection as many patients do not return to complete courses of treatment. 21 per cent. of 365 Salisbury patients had recently been treated elsewhere; private doctors, clinics and *nganga*. Only AIDH patients used *nganga* treatments to any degree (25 per cent. of 56).

7. *The Cost of STD*

The large number of patients treated annually (Part I) must cause considerable expense to the individual and to official health services. Willcox[14] and this survey showed that 80 per cent. of infected men paid for their last intercourse. The frequency of intercourse in bachelors was 2,8 times per date with an interval of two to nine days between dates[26]. Willcox (1949) found 51,5 per cent. of 400 African men paid 2s. 6d. (25c) for their last intercourse[14]. In 1974, 12,5 per cent. of 281 Salisbury clinic patients did not pay for the last intercourse, 2,1 per cent. paid up to 25c, 52,7 per cent. paid 26 - 50c, 0,7 per cent. 51 - 76c, and 28,4 per cent. paid over 76c (3,6 per cent. unspecified). The two peaks at 50c and $1 are the standard prices for "short time" and "all night" respectively[45]. Triangle men paid more for intercourse, 49,7 per cent. of 173 paid more than 76c.

These are large amounts, considering that domestic servants and agricultural labourers are the two largest and lowest paid employed

groups in Rhodesia[46]. The majority of 474 Salisbury men (55 per cent.) and 173 Triangle employees (64 per cent.) were married although only 23 per cent. and 13 per cent. respectively, lived with their families. Thus much of their low salaries must be spent on prostitution, leaving negligible amounts to support their rural families.

8. *Urbanisation and Changing Attitudes*

Urbanisation accelerates the breakdown of traditional sexual morals[42a] such as: separation for marriage and the Shona custom of *kuenda Kurukuva* whereby a girl is inspected regularly before marriage to ensure her virginity (Gelfand[47]). Also "the attitude of the young towards extra-marital activity has resulted in an increase in venereal disease, particularly in young African girls"[22].

9. *Large Numbers of Female Carriers*

In Salisbury only one woman is treated for STD for every six or seven men (this survey). Prostitutes in other African countries have high infection rates (e.g., 51 per cent. gonorrhoea in Rwanda[48], 32 per cent. in Kenya[44]) and the position is probably similar in Rhodesia.

10. *Socio-cultural Deprivation, Alcohol and Promiscuity*

Discrimination, poverty, poor housing, lack of education and opportunity all contribute to the heavy drinking in Salisbury townships with its associated marriage breakdowns, immorality and prostitution[49, 50].

Conclusions

The world-wide upsurge in sexually transmitted diseases has not left Rhodesia untouched. The "scandalous" nature of these diseases and their low mortality, despite a considerable morbidity, mitigate against arousing much interest in their control and prevention. However, this survey, involving 1 810 patients and 1 412 interviews, has revealed disturbing information. Although health authorities treat many cases annually (64 659 attendances at local authority clinics in 1972)[20] the majority of infected Africans seek private treatment (estimated at 88 per cent. in Salisbury during early 1974). Prevalence of STD in Salisbury may well be as high as found in Symington's survey[26]. On the Triangle Sugar Estates, the annual incidence of infected African men was estimated at 20 per cent. from the number treated between March and May, 1974.

Only one woman was treated for every 6,6 men in Salisbury and 8,8 men in Triangle. In Salisbury, 80 per cent. of male infections were contracted from prostitutes. Clinical misdiagnosis, partial treatment and patients' attitudes are major factors in the spread of STD in Rhodesia.

There is no short-term solution to the specific factors affecting Rhodesia's two main population groups. In the African community there are immense problems: urbanisation, promiscuity, disruption of traditional morals, labour migration, socio-cultural deprivation, alcohol abuse, poverty, inadequate housing and health services, coupled with widespread ignorance. The most cost-effective control measure is probably "an aggressive and positive health education programme aimed at all sectors of the population, including school children"[22]. The control and prevention of sexually transmitted diseases are a "responsibility we must not shirk from a false sense of modesty or a mistaken view that there is no problem in this field"[22].

Summary

This review and accompanying survey of 1 810 African patients has indicated a high prevalence of sexually transmitted diseases in the Rhodesia African population. Accurate statistics are not possible as most patients are treated privately. Laboratory tests were used in only 10 per cent. of 1 995 diagnoses, chancroid (soft sore) was confused with syphilis and gonorrhoea recorded in 61,5 per cent. (1 226 diagnoses). One woman was treated for every 6,6 men in Salisbury and 8,8 men in Triangle. In Salisbury, 80 per cent. of male infections were contracted from prostitutes. The majority of Salisbury and Triangle patients (54 per cent. and 83 per cent.) had been treated for previous infections. Any control measures will be hampered by important social factors such as urbanisation, breakdown of traditional morals, labour migration, poverty, poor housing, alcohol abuse and widespread ignorance.

Sexually transmitted diseases were shown to be an important, but neglected, social and medical problem in Rhodesia.

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