

Where have all the STDs gone?

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Summary

A review of the clinic records of patients attending the UCH Ibadan, Special Treatment Clinic show that the number of patients seen for treatment has been on the decline. In 1979, 914 patients attended the clinic. From then there was a steady increase until a peak in 1987, when 2,610 were seen. After this, a decline began which reached its lowest ebb in 1994, when only 378 patients were seen in 1996, 735 patients attended the clinic. In the men non-specific urethritis was consistently the commonest STDs, its prevalence ranging between 22.8% and 32.0%. It was followed by gonorrhoea, with a prevalence between 9.8% and 21.6%. In the females, candidiasis was diagnosed most often (prevalence was between 17.3% and 34.2%) followed by non-specific vaginitis (10.6% - 27.2%). The factors that have contributed to this decline were identified to be the introduction of fees, social strife, and reduced quality of services offered as a result of the depressed economy. The overall place of STCs in the control of STDs is also discussed.

Keywords: *Sexually transmitted disease, AIDS, HIV, utilization of health care services, gonorrhoea, candidiasis, Nigeria.*

Résumé

Une revue des archives des patients présentée à la clinique de traitement spéciale du Centre Hospitalier Universitaire (UCH) a montré que le nombre de patients qui viennent pour le traitement a sensiblement baissé. En 1979, 914 patients se sont présentés à la clinique. En 1996, 735 patients se sont présentés. Chez les hommes, les urethrites non-spécifiques ont été de manière constante la MST la plus courante et la prévalence se rangeait entre 22.8% et 32.0%. Elle était suivie par la blennorrhagie avec une prévalence qui variait entre 9.88% et 21.6%. Chez les femmes, les candidas avaient été diagnostiquées le plus souvent (prévalence entre 17.3% - 34.2%) suivies des vaginites non-spécifiques (10.6 - 27.2%). Les facteurs qui ont contribué au déclin de la venue des patients ont été identifiés, et sont l'introduction du paiement des traitements, les conflits sociaux, et la réduction de la qualité des services offerts à la suite de la dépression économique. Le rôle des conseils dans le contrôle des maladies sexuellement transmissibles sont aussi discutés.

Introduction

Sexually transmitted diseases (STDs) constitute an important public health problem all over the world [1,2,3]. The problem has been compounded by the newly identified STD: the Acquired Immunodeficiency

Syndrome (AIDS). AIDS is a cause of premature death, and most cases are as a result of sexual transmission [4]. Other STDs cause considerable morbidity, particularly in the reproductive health of women. They can have damaging long-term effects on health such as chronic pain, infertility, ectopic pregnancies, puerperal sepsis, cervical cancer and damaging effects on the foetus and newborn child [5]. Of critical importance is the fact that a significant role is played by STDs in the transmission of HIV; the presence of STDs increase the risk of HIV transmission by a factor of 3 to 5 [4,5].

In Nigeria, STDs are one of the five leading causes of out-patient visits by the adult population [6]. To help control this group of diseases, special venereology clinics were established in different parts of the country. The oldest of these evolved into the Special Treatment Clinic (STC) at the University College Hospital (UCH), Ibadan, which was officially opened in 1975. However, the effectiveness of these services in contributing to the control of STDs depend on their attendance and utilization by patients.

The true incidence of STDs in Nigeria may perhaps never be known, not only because of inadequate reporting, but because of the secrecy that surrounds them. No doubt the social stigma around issues of sexual activity and STDs have a major influence on patterns of presentation at health care services. Thus, there are no reliable data on the national incidence of these diseases [4]. Nevertheless, various studies have been conducted to estimate the disease burden in different parts of Nigeria [7-10]. They show a previous experience of STDs of 24% among healthy populations and patients in rural Ilora in one study [7], while in the other studies, 68 and 74 case incidence per thousand of the population in metropolitan Jos and Maiduguri, respectively [8,9]. A prevalence of 58.4% was obtained among ante-natal clinic clients in Ado-Ekiti [10]. Based on the Federal Ministry of Health, the prevalence of STDs in the country is estimated to be 9.3% [6]. The studies also show that STD patients have many competing and often preferred places for the treatment of their illness than STCs [8,9,11].

With the newer disease, AIDS, studies in different parts of Nigeria show sizeable disease burden in these regards [12-17]. Between 1987 when prevalence studies of HIV infection were carried out and the Federal Government 1993/94 sentinel sites data, the seroprevalence of the disease has shown a rise from 1.0% to 4.5%, a 400% increase [17,18]. Using AIDS as an index of all STDs therefore, there is strong evidence that the occurrence of these diseases are increasing in Nigeria rather than declining.

In order to increase the proportion of people with STDs who seek effective treatment and counselling, programme planners need to know more about the utilization of these services and the common STDs in the

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community. A better understanding of the common STDs would help in developing algorithms for the syndromic management of the different STDs. We therefore decided to study the phenomenon more closely by carrying out this study. The objectives of which are to identify the common STDs managed at the clinic, describe patient attendance and utilization patterns, identify factors that have led to these patterns and use the data generated to discuss the place of STC's in the control of STDs in Nigeria and similar developing countries.

Materials and methods

This is a retrospective study based on the review of case notes of patients seen at the STC of the UCH Ibadan, using a checklist. The information collected included sex, diagnosis and year of presentation.

This record review was done as far back as 1979. For some of the objectives, data was only available from 1989. The dates of introduction of various fees and other societal events that could affect patient utilization of the services were also ascertained. The findings are tabulated and presented below.

Results

Figure 1 shows the total number of patients seen with STDs at the clinic. The onset of decline in patient attendance coincided with the year that patient fees were introduced to the STC in the UCH in 1988/89. Further declines in 1991 also coincided with further fees inclusion. The initial fees were introduced on the basis that free treatment might in fact promote more recklessness in sexual life as the patients would know that treatment would be free. Other overall declines were associated with general social strife in the country, which kept the clinics closed for several weeks, including over three months in 1993, during the political upheaval.

Along with these social changes, the cost of treatment of STDs at the standard clinics (registration, laboratory investigation and drug treatment), has increased tremendously. For example, the cost of treatment of gonorrhoea has gone from virtually free in 1989 to N30 (\$2.5) in 1993 to N700 (\$87) in 1996.

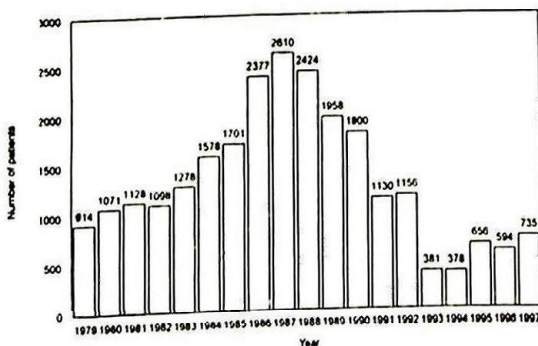


Fig. 1: Number of patients attending the clinic (1979 – 97)

Tables 1 and 2 show the three commonest diseases seen in the male and female patients, respectively, over the years.

Table 1: The common diseases seen in male patients

Year	1st	2nd	3rd
1989	NSU/NGU/PGU 239(22.8%)	Gonorrhea 220(21.0%)	Herpes 47(4.5%)
1990	NSU/NGU/PGU 206(23.7%)	Gonorrhea 188(21.6%)	Tinea cruris 39(4.5%)
1991	NSU/NGU/PGU 150(25.1%)	Gonorrhea 96(16.1%)	Herpes 33(5.5%)
1992	NSU/NGU/PGU 130(22.8%)	Gonorrhea 73(12.8%)	Herpes 35(6.1%)
1993	NSU/NGU/PGU 54(24.2%)	Gonorrhea 22(9.8%)	Tinea cruris 14(5.9%)
1994	NSU/NGU/PGU 61(26.1%)	Gonorrhea 25(10.7%)	Tinea cruris 11(5.9%)
1995	NSU/NGU/PGU 116(32.0%)	Gonorrhea 41(11.3%)	Genital warts 20(5.5%)
1996	NSU/NGU/PGU 91(27.7%)	Gonorrhea 43(13.1%)	Tinea cruris 27(8.3%)
1997	NSU/NGU/PGU 117(33.8%)	Gonorrhea 60(17.3%)	Herpes 24(6.9%)

Table 2: The common diseases seen in female patients

Year	1st	2nd	3rd
1989	Candidiasis 158(17.3%)	NSV/U 141(15.4%)	Gonorrhea 113(12.3%)
1990	Candidiasis 242(26.0%)	NSV/U 146(15.7%)	T. vaginalis 89(9.5%)
1991	Candidiasis 176(32.9%)	NSV/U 72(13.5%)	T. vaginalis 35(6.5%)
1992	Candidiasis 139(30.1%)	NSV/U 49(10.6%)	T. vaginalis 40 (8.7%)
1993	Candidiasis 46(29.1%)	NSV/U 25(15.8%)	Genital Warts 13(8.2%)
1994	Candidiasis 53(34.2%)	NSV/U 21(13.5%)	Genital Warts 14(9.0%)
1995	Candidiasis 98(33.3%)	NSV/U 80(27.2%)	Genital Warts 24(8.2%)
1996	Candidiasis 84(31.7%)	NSV/U 47(17.7%)	T. vaginalis 28(10.6%)
1997	Candidiasis 93(23.9%)	NSV/U 80(20.5%)	T. vaginalis 29(7.4%)

Discussion and conclusion

All evidences suggest the high prevalence of STDs in the local environment. The build up of the clientele in the Ibadan STC from some 900 in 1979 to over 2500 in 1987 demonstrates this trend properly [6-9, 12-18]. However, the build-up had not stabilised when hospital fees were introduced to the erstwhile non-fee paying service in 1989. This immediately resulted in drop in the attendance at the clinic. Further declines followed the introduction of further fees in the STD services in 1991. The fees were introduced because it was felt that free health service for STDs while people paid for other health care was an implicit encouragement of promiscuity and STDs and more importantly because of the economic difficulties the hospital was facing. Experience however shows that the introduction of fees

must be done cautiously and should be closely monitored to examine its impact on the level of utilization. It may be better to phase in a modest fee over a period of time and attention should be paid to the ability to pay of lower income groups in order not to discourage the use of essential services [5,19,20]. Thus review of existing STD treatment services should be done periodically to ensure that service production is user-friendly.

Further decline in the number of attendants at the clinic in 1993 and 1994 were associated by several interruptions in the services of the clinic due to worker's strike and the prolonged disruption of national services due to the political crises on account of the cancellation of the presidential election results. In addition to these was the persistent shortage of water in the hospital premises which resulted in the closure of the clinic laboratory.

The question which arises with this decline in the utilization of the clinic's services for anybody concerned with STD control is: Where have all the STD clients gone? Experience from other studies [5, 8-11] would suggest that STD patients had never preferred such public services that the STCs provided. They had always preferred services that kept no record of them, in which they do not have to see more than the one person for treatment, where they can negotiate prices and postpone payments, etc. An STD service that is not organised to have many advantages over these preferred alternatives except for the 'suspected' greater expertise of the doctor, is not going to convince more than just a handful of the clients to wait on such health care. It is therefore necessary to improve on the quality of care offered at STCs. This can be done by conducting communication programmes through clinic counselling, videotapes, posters and brochures, and mass media campaigns. STCs should also be more actively involved in outreach programmes for high risk populations such as commercial sex workers and their clients, pregnant women and youths. Also, notifying the sexual partners of STD patients can get people who are asymptomatic and likely to have an STD to come for treatment. Clinics for antenatal care, family planning or treatment for other ailments should be encouraged to screening people for STDs when they present for treatment, after which they may treat or refer to STCs, depending on their facilities. To ensure the quality of the services offered at these clinics and maintain the referral system, the doctors and nurses of these clinics should periodically be exposed to the services offered at STCs. They would also benefit from regular exposure to workshops and training programmes on STDs.

The preferred places of STD treatment where these patients may have gone to include the pharmacist, the patent medicine seller and the herbalists, spiritual healer, friends and relatives [5, 8-11]. The likelihood that these people will treat the STDs properly is very small. However, it is obvious that with many competing needs, there is not way STDs patients can justifiably enjoy free health services any more in any developing country. Moreover, it would seem rather obvious that the argument of such an act as promoting promiscuity and the very same STDs is absolutely plausible. All these point to the need to improve the services of STDs in the direction of a very quick service and cost consideration when treating the patients to make the prescription as low as possible. Also, health workers should be trained to

have a sympathetic and understanding attitude to patients who present for treatment.

The declining utilization of STC services also emphasise the need to train private doctors and health workers at primary and secondary health facilities on sexual health promotion, syndromic case management and partner notification, and perhaps the pharmacist, patent medicine sellers and traditional healers too. In this way, their involvement in STD control will be more useful. The patients that still patronise the public health services should be thoroughly educated against self-treatments and informed about the complications of the diseases.

The delivery of STD clinical services through the primary health care system should be encouraged, as this promotes early recognition and treatment of STD, especially for women who are often asymptomatic maternal and child health and family planning programmes are in a unique position to contribute to reducing STD levels by providing services [19]. Cases that are complicated or chronic should be referred to STCs.

Although some investigators recommend mass treatment because of the large hidden population with asymptomatic and untreated infections, the principal disadvantage of this is the high cost of treating large number of people, some of whom do not require medication [5]. This rules it out as a possible option for many developing countries.

This study also demonstrates the importance of complete documentation of findings and good record keeping as the records on the diagnosis and the different STD were not available between 1979 and 1988, hence the trends during this period could not be reviewed.

However, non-specific urethritis was consistently the commonest diagnosis of the males, followed by gonorrhoea. The prevalence of gonorrhoea appears to be on the decrease. In the females, candidiasis was the commonest diagnosis, considering the disease may not be transmitted only by sexual intercourse, non-specific vaginitis come to light followed by trichomonas vaginalis, genital warts and gonorrhoea in different degrees. Further research along these lines will be useful in identifying the patterns and trends of STDs in Nigeria.

What we need to do now is to improve the quality of services provided at the STCs, improve community awareness on STDs and health seeking behaviours, train other health workers on sexual health and the syndromic management of STDs including when to refer patients. The staff should be more actively involved in outreach programmes to different target groups in the community. The importance of good record keeping is also emphasised.

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