

# Observations on syphilis in Addis Ababa

## 1. General considerations

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**SUMMARY** The socioeconomic picture of Addis Ababa, the capital of Ethiopia, is briefly described and the provision of general medical care is outlined. Control of venereal disease is centred on one clinic. Here two doctors attend to nearly 1000 outpatients daily. It is perhaps not surprising that self-diagnosis and self-medication are common and follow-up attendance is erratic.

### Introduction

Ethiopia is bounded by the Sudan to the west, Kenya to the south, Somalia to the east, and the Red Sea to the north. The population of about 26 million comprises several tribal groups which differ in ethnic origin and culture. The Ethiopian economy is based on agriculture and the principal export is coffee. The capital city, Addis Ababa, lies 9° north of the Equator but as it is situated in the central highlands the climate is temperate. Founded in 1898, it is now the home of about half a million people. It is a sprawling city of stark contrasts. The central commercial area gives an appearance of wealth and prosperity. There are modern multistorey blocks that house banks, insurance offices, and hotels. Some are apartments inhabited by wealthy Ethiopians but, generally, they are rented by foreigners.

The handsome municipality building overlooks the city from the shoulder of a hill. In front stands an obelisk inscribed with the motto of the two-year-old revolution: Ethiopia Tikdem, which points out that the needs of the state take precedence over those of the individual. To the east stands the old imperial palace, its red roofs descending in a long series of terraces. A closer inspection through the guarded gates reveals decaying grandeur. The walls are cracking and the roofs are made of corroded sheets of corrugated iron, the same roofing material that is used on most dwellings in Addis Ababa, but without the benefit of a coat of paint.

Most Ethiopians live in houses made of mud and eucalyptus poles. Their average income is less than \$US 1.7 a day and there is much poverty and destitution. Many orphans and victims of disease or injury beg on the street corners. Malnutrition is all pervading. For example, the mean intake in one rural area was 1400 calories a day (Miller *et al.*, 1976) and kwashiorkor is seen in the young. The age of first marriage is usually at adolescence. Formal religious marriage is uncommon and most marriages are civil or temporary common law arrangements which frequently lapse after a number of years. Then the man takes the property while the wife is given the children—her contribution to the marriage. Apart from work as house servants, which is difficult to get, the only profession left for discarded women is prostitution, which traditionally is respectable in Ethiopia. No slur is attached either to the prostitute or her clients, who openly discuss the merits of the courtesan and her establishment at social gatherings. Older women who become prostitutes often set up beer parlours in their one or, at best, two-roomed houses, advertising the place by standing an inverted tin can on a stick outside the door. Younger girls find work as waitresses in bars or coffee houses where they are available for more personal services.

Assessments of the number of prostitutes in Addis are unreliable but estimates have been made of as many as one in five of the female population (Mayer, 1962).

Prostitutes are supposed to have some sort of certificate of cleanliness from the Venereal Disease Centre; their ranks, however, still provide a large reservoir of the sexually transmitted diseases (Guthe and Willcox, 1954).

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### Aspects of general medical care

There are about 300 doctors in Ethiopia, most of whom work in the towns. Primary care is provided by pharmacists and 'injectors' and although hospital physicians engage in private practice, they see comparatively few patients. Most patients have to pay for hospital care. There is a choice of three price categories, but the poor can obtain a certificate of poverty which may allow them entry to one of the free hospitals—if there is room. There is much self-prescription and doses of antibiotics, which are often inappropriate, are taken by many as a panacea.

The social changes that have taken place during the last two years since the revolution have caused the closure of the only university and medical school and have interrupted the training of qualified people of every kind. Attempts have been made recently to increase the numbers of paramedical 'health officers' and nurses as their numbers are critically short.

### Treponemal diseases

Yaws occurs only in the south-western province of the country, Sidamo. Endemic syphilis has been described in the east (Schauffele, 1961) and there has been an unconfirmed report of pinta, the diagnosis being based on atypical vitiligo and lymphadenopathy (Ferreira-Marques, 1964). Thus it is likely that positive results in serological tests for syphilis on sera from patients in Addis Ababa reflect infection with venereal syphilis.

### Control of venereal disease

There is only one treatment centre functioning under medical supervision in Ethiopia and that is the Ministry of Public Health Venereal Disease Demonstration Centre. There is also a flourishing private practice among Ethiopian physicians. The VD Centre lies on the borders of the eastern 'red light' area of Addis Ababa. Nearby, such names as Moon Bar and Venus Club attract the eye. Consultation and treatment are free and the daily outpatient attendance approaches 1000. Approximately half the patients are 'new'—that is, they have not attended during the previous six months. Although most patients come for treatment of venereal diseases, many have other dermatological conditions. Re-attendance for follow-up is erratic.

There is no public health education about sexually transmitted disease, other than a few small framed photographs in the VD Centre. Contact tracing is left entirely to the voluntary co-operation of individual patients. The Centre is staffed by a Russian-trained Egyptian doctor and a woman dermatologist

from Poland. There are also several nurses and dressers who perform most of the routine clerical duties, and two to four health officers who have had three years' general training similar to that given to nurses, followed by specialist training in the subject.

The patients assemble at daybreak and queue on rows of benches under corrugated iron roofs. They are marshalled by uniformed *Sabanyas*, or guards, who abound in all public establishments. The various rooms are marked by coloured lights to help the largely illiterate patients. An additional problem is that they do not all speak Amharic, the official Ethiopian language. New patients are called in batches and after registering their name, age, sex, occupation, and area of residence they pass into the blood-drawing room, where lay staff or dressers take blood with vacutainers. The needles are mostly disposable; the glass tubes are washed, sterilised, and re-evacuated. Blood samples are passed through a window to the adjacent laboratory, where slide Venereal Disease Research Laboratory (VDRL) and tube Meinicke tests are performed.

Patients are segregated according to sex. The men see the doctor or a health officer, who cursorily examines the affected parts. Self-diagnosis is common, at least within the trio of syphilis, chancroid, and gonorrhoea. Non-specific urethritis is never diagnosed as such, but resistant cases of 'gonorrhoea' are usually sent to genitourinary surgeons at other hospitals. Urethral smears, when taken, are sent to the laboratory for Gram staining.

The side of the clinic for women is less rushed, partly because there are fewer patients—two females to three males—but also because the division of labour is more efficient. Patients with genital lesions enter screened cubicles where a bevy of nurses and dressers examine them. They take introital smears for Gram stains or darkfield examination, make a diagnosis, and then send the patient for appropriate treatment. If uncertainties arise, the doctor may be called on for her opinion. She is usually occupied seeing patients with dermatological problems, often with the next three or four patients in the queue as interested onlookers. The commonest problems are ectoparasitic infestations, cutaneous pyoderms (especially in children), abnormalities of pigmentation, acne, eczema, and tropical forms of lichen planus. Herpes zoster is seen in children and generalised scabies is not uncommon.

Before they receive treatment, patients are advised on the nature of their condition. The importance of notifying contacts and of re-attendance are stressed and they are usually asked to return after three days for the results of the serological tests.

The drugs supplied free are sulphonamide tablets, sulphur ointment, and PAM. Treatment regimens

used in the clinic are as follows:

Syphilis	PAM 1·2 megaunits intramuscularly, four times at 3-day intervals. Women usually receive six injections.
Gonorrhoea	PAM 2·4 megaunits once.
Other conditions	Sulphonamide tablets 250 mg three times daily for 18 days.

Occasionally, the doctor may provide a patient with a drug obtained as a sample; otherwise patients are given prescriptions for drugs which are bought at pharmacies. If they cannot afford the expense, then it is just unfortunate.

Ethiopia is undergoing a period of profound social upheaval. The resources of medical personnel and supplies which were already extended, are being further taxed by the war in the northern provinces.

The prospects for the establishment of an organised health care programme appear poor at the present time.

#### References

- Ferreira-Marques, J. (1964). Contribution à l'étude des maladies vénériennes et cutanées à Addis Ababa. *Dermatologia Tropica*, 3, 139-151.
- Guthe, T., and Willcox, R. R. (1954). Treponematoses: A world problem. *Chronicle of the World Health Organisation*, 8, 37-114.
- Mayer, H. (1962). *Memorandum: Prostitution and Venereal Disease in Addis Ababa*. Ministry of Public Health: Ethiopia.
- Miller, D. S., Baker, J., Bowden, M., Evans, E., Holt, J., McKeag, R. J., Meinertzhagen, I., Mumford, P. M., Oddy, D. J., Rivers, J. P., Sevenhuysen, G., Stock, M. J., Watts, M., Kebede, A., Wolde-Gabriel, Y., and Wolde-Gabriel, Z. (1976). The Ethiopia applied nutrition project. *Proceedings of the Royal Society of London (B)* 194, 23-48.
- Schäuffele, F. (1961). *An Epidemiological Survey with Clino-mobil in Ogaden District*. Ministry of Public Health: Ethiopia.