Epidemiology and control of tuberculosis and sexually transmitted infections in Thyolo District, Malawi

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CHAPTER 7

Behavioural characteristics, prevalence of *Chlamydia trachomatis* and antibiotic susceptibility of *Neisseria gonorrhoeae* in men with urethral discharge in Thyolo, Malawi.

Introduction

Sexually transmitted infections (STIs) are known to facilitate the sexual transmission of HIV (COTTEY & DALLABRITA, 1993), and effective STI case management is known to reduce the incidence of HIV (GROSSKURTH et al., 1995). The HIV national prevalence in Malawi is estimated at 15% (NACP, 2001), and HIV infection rates among patients with STIs range from 53% to 83% (KRISTENSEN, 1990). As part of its STI and HIV control strategy, Malawi adopted the World Health Organization (WHO) recommended syndromic approach to STI care management in 1993. Based on clinical efficacy, in-vitro studies and cost considerations, a combination of gentamicin (240–mg single intramuscular dose) and doxycycline (100 mg twice daily for 7 days) was recommended as the treatment of choice for men presenting with urethral discharge (MOHP, 1993). Although this regimen is meant to cover for Neisseria gonorrhoeae and Chlamydia trachomatis infections (JUULE et al., 1994), the relative prevalence of these pathogens in rural communities in Malawi is not known.

Regular monitoring of antimicrobial susceptibility of N. gonorrhoeae and other STI pathogens is essential as resistance patterns can change rapidly (LIMD, 1990). Because of scarce resources, this is not done in Malawi and there is limited information on the subject.

Control of STIs involves not only providing effective treatment to those that are infected, but should also involve promotion of safer sexual practices during the symptomatic period.

The present study was undertaken in a rural district of Malawi among men presenting with urethral discharge, in order to (a) describe their health-seeking and sexual behaviour, (b) determine the relative contribution of N. gonorrhoeae and C. trachomatis to urethral discharge, and (c) verify the antibiotic susceptibility of N. gonorrhoeae.

Material and Methods

Study population, and data collection

This study was conducted in Thyolo district, a rural region in southern Malawi. Between October 2000 and May 2001, all adult males presenting with urethral discharge to the district STI clinic were invited to participate in this study. After obtaining informed consent, a semi-structured questionnaire was used to gather basic socio-demographic data and information on health-seeking and sexual behaviour. All patients were managed according to national STI guidelines (NACP, 1993).

Prevalence of N. gonorrhoeae and C. trachomatis

Patients were requested to provide a urine specimen at the time of first attendance. Nucleic acid amplification, by ligase chain reaction (LCR) was used to determine the presence of N. gonorrhoeae and C. trachomatis in the urine samples.

Antimicrobial susceptibility testing for N. gonorrhoeae

Swabs were also taken from the anterior urethra at the time of first attendance, smeared on a glass slide for Gram staining and placed directly in a transport medium (Amies media, Oxoid, Basingstone, UK) containing charcoal. The specimens were transported at the end of each day to the laboratory. Plating was done on modified New York City medium (gonococcal selective) containing lincomycin, colistin sulphate, amphotericin-B and trimethoprim lactate. Yeast autolysate was used as a growth supplement and incubation was done in a candle jar for 48 h at 35°C with 5–10% CO2.

N. gonorrhoeae was identified by colony morphology, Gram staining and oxidase testing. Penicillinase-producing strains (PPNG) were detected using beta-lactam paper strips (Oxoid), which show β-lactamase activity.

Antimicrobial susceptibility testing was performed on Muller Hinton agar (Oxoid) supplemented with 5% sheep blood, using the disk diffusion technique. Inhibition zone sizes for N. gonorrhoeae were read according to National Committee for Clinical Laboratory Standards (NCCLS, 1998). The E-Test strip (AB-Biodisk, Solna,
refusal (37%) and having sex with a spouse or having sexual encounters during the symptomatic period and the majority (84%) had not used condoms. The main reported reasons for not using condoms during sex in the symptomatic period was partner refusal (37%), and having sex with a spouse or with someone in a steady relationship (28%) (Table 1).

### Data analysis

The EpInfo software (Centers for Disease Control, Atlanta, GA, USA) was used for data analysis.

### Results

#### Socio-demographic characteristics of the study population

A total of 114 adult male subjects with urethral discharge were enrolled in the study. The median age of the study participants was 27 years (range 16–47, SE 0–6). Most patients (79%) came from rural villages, and were married (57%). The mean educational level of participants was 6.5 years in school. Patients included farmers (29%), unskilled employees (34%), skilled employees (6%), business people (24%) and students (7%).

#### Health-seeking and sexual behaviour

The mean reported time with STI symptoms before presenting at the STI clinic was 27 days; 61% of all subjects reported having taken some form of medication before coming to the clinic. The most frequent single source of medication was traditional healers (43%) (Table 1). Sixty-eight patients (60%) reported having had sexual encounters during the symptomatic period and the majority (84%) had not used condoms. The main reported reasons for not using condoms during sex in the symptomatic period was partner refusal (37%), and having sex with a spouse or with someone in a steady relationship (28%) (Table 1).

### Table 1. Health-seeking and sexual behaviour in adult males with visible urethral discharge (n = 114) (Thyolo, Malawi, 2000/2001)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous medication before coming to clinic</td>
<td>70/114</td>
<td>61</td>
</tr>
<tr>
<td>Modern (ampicillin, co-trimoxazole, etc.)</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>Traditional (herbs, roots, etc.)</td>
<td>30</td>
<td>43</td>
</tr>
<tr>
<td>Both</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>Source of previous medication (n = 70)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public and private clinics</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Drug vendors/public pharmacy</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Traditional healers</td>
<td>30</td>
<td>43</td>
</tr>
<tr>
<td>Several of the above</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Mean duration of urethral symptoms (days)</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Sex during symptomatic period = yes</td>
<td>68/114</td>
<td>60</td>
</tr>
<tr>
<td>With same partner</td>
<td>37</td>
<td>54</td>
</tr>
<tr>
<td>With different partners</td>
<td>31</td>
<td>46</td>
</tr>
<tr>
<td>Condom use during sex in symptomatic period (n = 68)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intermittent/sometimes</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>No condom use</td>
<td>57</td>
<td>84</td>
</tr>
<tr>
<td>Reasons for ‘no condom use’ (n = 57)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex with steady partner or spouse</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>Refusal by partner</td>
<td>21</td>
<td>37</td>
</tr>
<tr>
<td>Condom not available</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Reduces pleasure</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Religious reasons</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

### Discussion

In this study, 61% of all participants presenting at the rural district STI clinic with urethral discharge had first sought care at an alternative source. The search for effective treatment is therefore delayed, and meanwhile the men continue to have sex while symptomatic, the large majority (84%) not using condoms. These different alternative sources of health care could be targeted to improve STI control in the district and reduce delays in effective treatment.

The traditional healer was found to be the most important single source of alternative care in our rural setting as was found in a similar study in an urban setting of Malawi (LULE et al., 1994). In Malawi, traditional healers are generally reputed to be sympathetic, more confidential, and easily accessible. Considering their importance as an alternative care provider, and the potential role they could play in encouraging safer sexual behaviour, it is important to integrate them in control activities and ensure condom availability (to clients) at their sites.
The National Tuberculosis Control Programme in Malawi conducts training sessions with traditional healers from around the country, and encourages early referral of tuberculosis suspects. Training on STIs and HIV infection could be linked with such an existing initiative, and might be one way of also encouraging earlier referral (by healers) for antibiotic treatment.

This study was the first in Malawi that has used a highly sensitive and specific nucleic acid amplification technique (STARY, 1997) to determine the presence of C. trachomatis and N. gonorrhoeae in the urine of men presenting with urethral discharge. Infection with N. gonorrhoeae was confirmed in 80% of urine specimens whereas C. trachomatis was found in only 2% of specimens. In contrast to previous suggestions (TAYLOR-ROBINSON et al., 1995), Chlamydia was not found to be a major pathogen in men presenting with urethral discharge in our rural setting. A similar low prevalence of C. trachomatis was found in Blantyre, an urban town in Malawi, where Chlamydia antigen was found in only 26 (3.4%) of 497 urine specimens tested (LULU et al., 1994). We had not screened for other possible organisms associated with urethral discharge such as Ureaplasma urealyticum, Mycoplasma hominis and Trichomonas vaginalis.

Only 47 isolates from 90 patients positive for N. gonorrhoeae by LCR were available for susceptibility testing. This might be explained by the fact that N. gonorrhoeae is a very fastidious organism and, despite use of a transport medium, undelivered delays did occur between collection of specimens in the district STI clinic and inoculation at the laboratory in Blantyre. Specimens were transported once a day and could have been subjected to the rapid changes in ambient temperature that are characteristic of the region.

We used the E-Test for testing the susceptibility of N. gonorrhoeae to gentamicin and found it easy and practical to use in our developing country laboratory setting. The disc diffusion method, although most widely available and least expensive, is not considered reliable for gentamicin susceptibility testing, and agar dilution assays are quite complicated to perform for routine surveillance (DALY et al., 1997).

None of the antibiotics tested in our study approached the 95% sensitivity recommended for effective ‘blind treatment’ (WHO, 1989). The clinical cure rate for gentamicin treatment of N. gonorrhoeae was 95% in 1993 (LULU et al., 1994) as compared to 92% in 1996 (DALY et al., 1997). Our study, which is the first since 1996 in Malawi, shows that only 85% of N. gonorrhoeae isolates are currently susceptible to gentamicin. Although clinical cure rates might differ from in vitro susceptibility patterns, this finding is of concern since selection of resistant strains may rapidly limit the usefulness of gentamicin for the treatment of N. gonorrhoeae in our setting. There is therefore a need to search for alternative antibiotics for the syndromic treatment of urethral discharge caused by N. gonorrhoeae.

All isolates tested in 1996 (DALY et al., 1997) were fully sensitive to ciprofloxacin, ofloxacin and cefixime. We had not tested susceptibility to ofloxacin and cefixime but found 6% resistance and 26% intermediate susceptibility to ciprofloxacin. This could be due to the rising indiscriminate use of this agent which is now readily available (without prescription) at some public pharmacies. Ciprofloxacin is relatively expensive and ‘cost considerations’ often encourage the use of inadequate, or low dose, regimens that will help increase the selection of strains exhibiting resistance or reduced susceptibility (HANDSFIELD & WHITTINGTON, 1996).

The great majority (96%) of N. gonorrhoeae isolates in the rural district of study were PPNG strains, the majority of which exhibited multi-antimicrobial resistance. Continuing surveillance of antimicrobial susceptibility of N. gonorrhoeae is essential in order to detect emerging resistance, prevent treatment failures and control the spread of resistant strains within the population.

Acknowledgements

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