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Venereal diseases in Bangladesh

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Bangladesh is one of the few countries of the world where recent increases in the incidence of venereal disease have been principally determined by poverty and war-time conditions. Other factors have also been at work. The population has doubled since the second world war and is now 75 million, a density of 1,300 per square mile, one of the highest in the world. At present 46 per cent. of the population is under 15 years of age. Population movements have involved large numbers. Between March and December, 1971, civil disturbance resulted in the emigration of some 10 million people to neighbouring India. This was accompanied by the internal migration of a further 16 million. The war lasted two weeks in December, 1971, and this was followed by the return of migrants to their homes between then and the end of February, 1972.

Only 15 per cent. of the population live in the cities, principally Dacca, Chittagong, and Chalna, which together account for about 3 million. There is a tendency for people, especially unattached males, to move from rural areas to the cities in search of work and education. Although the practice of strict purdah is declining and women are emerging in the professions and elsewhere, for the most part they lead dependant lives. Family influences prevail in the area of sexual attitudes and behaviour, but as always demands for general freedom are accompanied by similar demands for sexual freedom. It is not surprising, therefore, that there is evidence of freer sexual expression amongst some young people in Bangladesh.

Size of the V.D. problem

Considerable difficulty was experienced in trying to determine the incidence of infection. Data for recent years was available from only five of the ten public clinics in the country.

Table I shows the number of recorded cases of infectious syphilis. No data were obtainable regarding late, latent or congenital syphilis, but clinicians were agreed that these had declined over the last decade. Antenatal blood testing, once widely practised, has been becoming rarer. Blood donations were tested for syphilis only in Dacca.

At the last yaws survey, done in 1959 in the hill tracts near the Burmese border, the seropositivity rate was 1·15 per cent.

Table II shows the incidence of gonorrhoea. The trend is similar to that of infectious syphilis and suggests that infection rates have increased upwards of 100 per cent. over a 2-year period, at least in the areas of the cities concerned.

No detailed reports of the incidence of non-gonococcal urethritis (NGU) are available, but where the condition is differentiated from gonorrhoea the ratio of gonorrhoea to NGU is 5·5:1.

Venereologists, gynaecologists, and general practitioners all report an increase in the incidence of vaginal discharge as a condition requiring treatment. No detailed figures or diagnostic information is available.

Chancroid, lymphogranuloma venereum, and granuloma inguinale are stated to be rare or unknown.

The incidence of genital warts, genital herpes, and molluscum contagiosum is unchanged in recent years in the only department keeping a diagnostic register.

No such data referring to venereal or other sexually-transmissible diseases are available from the rural health centres, but all workers contacted in these and in country hospitals were agreed that vaginal and urethral discharges were commoner complaints than in 1970.

Scabies is widely viewed as epidemic throughout the country, its incidence being said to have doubled between early 1971 and late 1972.

Three of the most experienced doctors in the field of venereology were agreed that between 80 and 85 per cent. of all venereal disease in Bangladesh was treated by private practitioners and that the percentage was higher in the villages than in the towns. It is estimated that in the towns two out of three

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TABLE I *Recorded cases of early syphilis in Bangladesh*, 1962-1972

Year	*Dacca Medical College Hospital*	*Mitford Hospital, Dacca*	*Skin and Social Hygiene Centre, Chittagong*	*Chittagong Medical College Hospital*	*Venereal-Disease Clinic, Sadat Hospital, Khulna*	*Total*
1962	641	1,293	231	—	—	—
1963	695	2,568	910	—	—	—
1964	459	4,541	290	—	340	—
1965	718	7,539	252	—	497	—
1966	984	4,004	261	176	390	5,815
1967	626	3,477	298	241	680	5,322
1968	761	1,329	253	262	745	3,350
1969	258	753	396	447	921	2,775
1970	654	766	342	1,094	892	3,748
1971	400	511	170	1,545	157[c]	2,783
1972		1,179[a]	243[b]	2,974[b]	900[d]	5,296

[a]Period 1 January–18 October, 1972
[b]Period 1 January–25 October, 1972
[c]Period 1 January–25 March, 1971
[d]Period 25 March–31 October, 1972

TABLE II *Recorded cases of gonorrhoea in Bangladesh*, 1962-72

Year	*Dacca Medical College Hospital*	*Mitford Hospital, Dacca*	*Skin and Social Hygiene Centre, Chittagong*	*Chittagong Medical College Hospital*	*Venereal-Disease Clinic, Sadat Hospital, Khulna*	*Total*
1962	1,126	1,059	228	—	—	—
1963	895	1,713	570	—	—	—
1964	911	2,401	454	—	512	—
1965	946	1,435	92	—	750	—
1966	1,068	3,409	52	603	662	5,794
1967	991	2,813	96	654	845	5,399
1968	987	1,292	47	532	1,270	4,128
1969	724	785	82	506	1,164	3,261
1970	1,208	776	52	1,251	1,385	4,672
1971	941	598	67	1,656	217[c]	3,479
1972		2,221[a]	140[b]	3,048[b]	1,250[d]	6,659

[a]Period 1 January–18 October, 1972
[b]Period 1 January–25 October, 1972
[c]Period 1 January–25 March, 1971
[d]Period 25 March–31 October, 1972

infected patients are seen by orthodox physicians and that the remainder are seen by quacks or pharmacists or indulge in self-medication. It is estimated that for every patient treated at a clinic for syphilis at least one other is seen and treated elsewhere; for gonorrhoea this ratio is 1:5 or 6. The incidence of infection in the armed forces is said to be considerably higher than amongst civilians. Together with available figures these estimates give morbidity rates for 1972 of 175 per 100,000 population for syphilis and 700 per 100,000 for gonorrhoea.

As in many other countries in the world the problems of under reporting are widespread and serious. The trends, however, are unmistakable.

The nature of the problem

In the almost complete absence of case notes the following are informed guesses:

AGE

Between 60 and 70 per cent. of all infections in public clinics occur in the 15 to 24-year-olds.

SEX

The male:female ratio of infected persons attending public clinics is 4·5:1.

MARITAL STATUS

70 per cent. of infected males claim to be single. The figure for single females is everywhere less than 1 per cent.

ETHNIC GROUPS (per cent.)

Population	*General*	*Clinic*
Muslim	85	80
Hindu	10	15
All others	5	5

SOURCES OF INFECTION

90 per cent. of infected males claim to have been infected by a prostitute. Nearly all infected females other than prostitutes are secondary contacts of infected males, *i.e.* wives of infected husbands. Homosexuals are said to be few in number.

Students form a growing number and proportion of the sexually infected, particularly in the private sector. A small but growing number of students, both male and female, claim to have been infected by other students.

The ports of Chittagong and Chalna are expected to handle over 60 million tons of goods in 1972. This means a minimum of 72,000 stop-over nights by seafarers. When war damage is completely cleared, these figures are expected to increase substantially. Only Chittagong has facilities for the treatment of infected seamen and the service offered is of good quality. Nevertheless there has been a noted drift of seamen to the care of private doctors designated by the shipping agents. In contrast to findings elsewhere in the world, for example in Singapore, there is no record of the radio-telephone link with ships being used for calls concerning venereal disease.

'Red light' districts are recognized in the cities, large towns, and ports of Bangladesh but only in Khulna were prostitutes found to be registered. This registration was carried out jointly by a male social worker in the V.D. clinic in co-operation with the local police. Some 1,300 young women, mostly aged 18 to 25 years, were on the register. It was noted that a substantial percentage of the males attending the Khulna clinic were police personnel. There was evidence in the capital, Dacca, that brothel type prostitution was on the decline. It is being replaced by the operation of a freer, clandestine type of prostitution. These girls and women are generally free agents and are called 'gay girls'. They are said to cause between one-third and two-thirds of the infections attributed to prostitutes.

In spite of efforts to encourage prostitutes to attend public clinics, most of them seek the advice of quacks. The only exception is Khulna where many do attend regularly at the local public clinic. Some 80 per cent. are said to be infected. About 5 per cent. of prostitutes use oral contraceptives. This is the same figure as that given for all Bangladesh women.

No arrangements exist for the rescue and rehabilitation of prostitutes. However, a unique and remarkably successful attempt has recently been made to forestall recruitment to their ranks. The National Board of Bangladesh Womens' Rehabilitation Programme, with branches all over the country, has done much to help rehabilitate single women abandoned by their families when they became pregnant during migration and war. In the past such women have formed the bulk of recruits to prostitution. It is to be hoped that, inspired by its recent successes, the National Board will turn its endeavours to long existing problems.

The facilities for the care of the venereally infected, as for the sick generally in Bangladesh, are very poor. Recommendations have been made which one hopes will help those charged with V.D. control to deploy their modest resources to the best advantage of this young nation (Morton, 1972).

Summary

The social structure of Bangladesh and how that structure has functioned in recent times are outlined. Particular attention is given to population growth, density, and movement, and to the increased freedom of women. One-third of the population moved their place of abode during the civil and military upheaval of 1971-72.

The problems of V.D. reporting in Bangladesh are widespread and serious. The incidence trends, however, are unmistakeable, both infectious syphilis and gonorrhoea having doubled in the course of 2 years. The morbidity rates for 1972 are estimated to be 175 per 100,000 population for infectious syphilis and 700 per 100,000 population for gonorrhoea.

Special mention is made of students, seafarers, and prostitutes. It is noted that Bangladesh is one of only a few countries where recent increases in venereal diseases have been mainly due to poverty and war-time conditions.

I am indebted to the World Health Organization for the opportunity to undertake this short-term consultancy and to my counterpart Dr. Samuel Azam, whose cheerfulness, enthusiasm, and good companionship made the work a pleasure.

Reference

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Les maladies vénériennes au Bangladesh

SOMMAIRE

On expose la structure sociale du Bangladesh et comment cette structure a fonctionné dans les temps récents. Une attention particulière est portée à l'accroissement de la population, sa densité, ses déplacements, et à l'augmentation de liberté des femmes. Un tiers de la population a changé de lieu de résidence pendant les bouleversements civils et militaires de 1971-1972.

Les problèmes de la déclaration des maladies vénériennes au Bangladesh sont généralisés et sérieux. Cependant, la tendance de la morbidité ne peut échapper, la syphilis aussi bien que la gonococcie ayant doublé au cours de ces deux années. Les taux de morbidité pour 1972 sont estimés à 175 pour 100.000 habitants pour la syphilis infectieuse et 700 pour 100.000 pour la gonococcie.

On mentionne spécialement les étudiants, les marins et les prostituées. Il est noté que le Bangladesh est l'un des rares pays ou les augmentations récentes des maladies vénériennes ont été dues principalement à la pauvreté et aux conditions de guerre.