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SOCIAL BIOLOGY AND WELFARE

edited by Sybil Neville-Rolfe
SEX IN SOCIAL LIFE

Mrs. Neville-Rolfe has also contributed to
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for the years 1935, 1936, 1937, 1938–39, 1939–40
(5 vols.)

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Section on THE BIOLOGICAL ASPECTS OF PROSTITUTION

VOL. XII. LIFE AND LEISURE IN LONDON 1930
Section on SEX DELINQUENCY

SOCIAL BIOLOGY AND WELFARE

by

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together with

A HANDBOOK-APPENDIX ON SOCIAL PROBLEMS

edited by

ETHEL GRANT

M.B.E.

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FOREWORD

It is with considerable diffidence that this book has been produced, and it would never have been attempted had not my old friend, Sir Drummond Shiels, urged me to write it, and good friends agreed to read each chapter with a critical eye open for technical errors. My very sincere thanks are due to Professor F. A. E. Crew, F.R.S., for reading "Social Biology" and giving general advice; to Professor A. W. Heath for his guidance in "Values"; to Mr. B. Hendry—"Age Cycle and Sex Behaviour"; to Cyril Bibby—"The Individual"; and to Sir Cyril Burt for his careful survey of the prostitution section.

Special thanks are due to Miss Grant for editing the Handbook Appendix and to those who contributed to it (notably H. B. Grant, Miss Barlow and Miss Cornach); but for present paper shortages it could well have been less compressed. It was with gratitude that the up-to-date figures were received from the Home Office, the Registrar-General, the Scottish Home and Health Departments and the Army Medical Department in spite of pressure of work.

Warm thanks are offered to the national voluntary organizations for the reports so kindly provided.

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AUTOBIOGRAPHICAL NOTES

I HAVE endeavoured in the following pages to crystallize the experience of some forty years in the hope that it may be of some service to those working in the field of social welfare. To read with discrimination requires some knowledge of the background from which the experience has been drawn

Family Records

My maternal grandfather was George Burnett, son of Sir Robert Burnett of Mordon Hall, Surrey, a scion of the ancient Scottish family, the Burnetts of Leys (1446). He married Lucinda Arbouin of Cognac, Bordeaux, and had eight children—four boys and four girls. My mother, Lucinda Marion, was the sixth child and second girl. George Burnett took on the successful distillery founded by Sir Robert Burnett in 1770, but his principal personal interest was in painting. The acceptance of his portraits by the Royal Academy gave him more satisfaction than his business activities.

My paternal grandfather was Captain Charles Burney, R.N., C B.

That our branch of the Burney family sprang from the same stem as Dr. Charles Burney, the musician and his daughter, Fanny Burney, later Madame d'Arblay, is clear on biological grounds from the strong family resemblances shown in the portraits, but the detailed genealogical tree has never been completed. The family tradition of my youth was that the Lieutenant Burney who accompanied Captain Cook on his explorations was our direct ancestor, but this has not been established, and it appears more likely that our branch descended from an uncle of the musician.

My grandfather laid the foundation for the organized training of Naval personnel, and was for many years Captain of the Royal Nautical School, first situated in Jersey, and subsequently moved to Greenwich. He married and had nineteen children of whom two daughters and four sons survived. Their mother, not surprisingly, was an invalid for the latter years of her life. Two sons went into the Navy and two into the Army. The elder was lost in the H.M.S. *Eurydice* at the outset of his career. He was renowned for an astonishing visual memory and was said to be able to

repeat verbatim any page he had read twice. Ernest Burney was Colonel of the Berkshire Regiment and served in the Boer War. Percy de S. Burney was in the gunners and a Brigadier-General in the 1914 world war. Cecil Burney, the eldest of the surviving children, was created a baronet for his war services, and became Admiral of the Fleet, after having served as second-in-command to his lifelong friend, Admiral Sir John (later Viscount) Jellicoe at Jutland, and as Second Sea Lord. His last appointment was a Commander-in-Chief, Portsmouth.

In 1884 Lieutenant Cecil Burney, R.N., at the age of 24, married Lucinda Marion Burnett, aged 22, while qualifying for gunnery at the Royal Naval College, Greenwich. His father was then occupying Queen's House (now the Naval Museum). It was there, on little but a naval lieutenant's pay, my parents lived for the first year of their married life, and I was born in the room in which King Charles was reputed to wander with his head under his arm.

They had three children, Sybil Katherine, Charles Dennistoun (the present Baronet, inventor of the paravane while serving in the Navy during the 1914–18 war), and Violet Hazel (subsequently Mrs. Ballard, for many years Honorary Secretary of the National Council for the Unmarried Mother and her Child). Her husband, Commander Charles Ballard, was lost in H.M.S. *Formidable* in 1914.

Our mother was a woman of outstanding 'all round' ability which was, owing to the restrictive conventions of the time, fortunately for her family, devoted entirely to their welfare. Her artistic bent found expression in many ways—in landscape and flower gardening, in dress designing and embroidery. Her wide knowledge of French and English literature contributed materially to the education of her children.

For my father I have the deepest admiration, and during his life, we were very close friends. When at home he took an active interest in our education. Routines for daily work were carefully drawn for the governess and handed over with the dictum "routine is a good servant, but a bad master."

The traditions and values of the family were naturally drawn from those of the Royal Navy. The demonstration of these in the home and as governing his own actions throughout his children's early years, made deep and lasting impressions.

That the interests of the Service were the first consideration;

whatever responsibilities had been assumed, they must be fulfilled to the utmost, irrespective of personal or family inconvenience.

That the responsible officer took the blame for all errors that affected the welfare of the ship, committed by his subordinates, guiding, correcting, and, if necessary, admonishing them

That while strict discipline was vital to efficiency, if orders from above were in direct conflict with the individual's view of right and wrong, then the higher values must be followed. Duty decreed resignation and, if necessary, a clear statement of the reasons to the wider tribunal of the country. On two occasions in his career, to my knowledge, my father was faced with this type of situation. Fortunately, in both instances, the review of his reasons resulted in the necessary change of policy—in one case, for the protection of the health of those in his charge, in the second, on war strategy.

To my mind, it is the absence of this principle in the Civil Service that results in senior officials continuing to implement policies of which they personally disapprove under the shelter of a claim that "discipline requires an entire abnegation of personal responsibility," ignoring the pertinent fact that it is not sufficient to write a critical minute, that a conviction of right based on knowledge and experience cannot be ignored without loss of personal integrity.

Early years were restless and happy. We had crossed the Atlantic four times before I was six years old. Later my parents quoted, as a deterrent to my marriage with a naval man, that they had moved forty-eight times in twenty years. Yet each temporary quarters had, owing to my mother's home-making genius, been given the atmosphere and quality of 'home.'

Resources of the family were such that only the boy could be sent to school, which accorded with the convention of the time. For five years my sister and I had, as a nursery governess, a Norfolk girl who came to us at the age of 18; a French governess succeeded her when I was 13 and, subsequently, the family went for some months to Poissy in France near French relatives while my father was abroad. Six months in a German family near Hamburg preceded my return home as 'grown-up.' My mother explained that, as it was not possible to provide a university education, she believed the next best was a knowledge, even a colloquial knowledge, of languages. How right she was! Even two languages have been of the greatest assistance, but the

absence of the mind training that a university education provides has been a very real handicap.

Habits of wide reading were formed early. From thirteen onwards the French and English classics had been indicated for daily study, but beyond that one was left free to choose any books that were accessible. Care was taken, however, that the 'undesirable' was not accessible. At the age of 16 a book by Miss Annie Swan opened wide the tragedy of prostitution, and created the determination to 'do something' about it. From then on, interest grew in the biological sciences leavened under my mother's influence by European history and literature, and the daily routine of reading *The Times* aloud.

On return from Germany at 17½ the family were living in Plymouth, the home port of my father's ship. Then followed a few months of misery and pleasure, mainly in the effort to overcome self-consciousness, with hair 'done up' which wouldn't keep tidy, with long dresses, which would get in the way, with a terribly loud laugh for which I was continually being reproved, and with an aggressive manner which shyness accentuated. The pleasures of meeting people, of dances and games and sailing picnics—all the fun of 'coming out.' After a year of pleasant social life and of domestic training in the home the urge to prepare myself for dealing with prostitution made me restless.

I asked to go away to take up some activity which would fit me for what I had planned as my 'life work.' It was kindly and firmly explained that my place was at home for the time being, that I had still much to learn as a woman before I could be much use as a worker. In the meantime, I could study. Also, having had all the trouble of educating me, my parents had looked forward to having a daughter at home, at least for a time. A pleasant year followed—Darwin, Galton, Spencer, Balfour, Morrison, were the background against which one was meeting many people, making some lifelong friendships, and experiencing the stirring of deeper feelings. At 19½ I married Lieut. Arthur Gotto, R.N. a Northern Irishman. My desire to 'do something' about prostitution still remained. It was a problem we discussed and my knowledge was increased through his experience of life. The tragedy of a young friend of his whose ignorance led him to acquire syphilis made a deep impression. After five months in a little furnished house my husband left for the Mediterranean in May, and I went to live with my parents. In September, luggage

was packed and passage taken, and we were to meet in Malta for the winter. The day before departure the news came he had been killed in a coaling accident while the ship was in the Greek Islands (1905).

Shortly afterwards, my 'gunner' uncle went to my father fearing for my reason, because to his question as to what I was going to do I replied: "Study prostitution and venereal disease and try to get rid of them."

My parents, though distressed at the unsuitability (in their view) of the subject for a young girl of 20, tried in every way to smooth my path, hoping it would be but a passing interest.

The first idea, to go to Oxford or Cambridge, was encouraged, but the entrance examination would have required a year's coaching, and inactive study at that time was impossible. Training as a rescue worker could be undertaken at once, and in personal contacts and physical activity, life could be faced.

Madame Ruspini, in those days, sat in a little office, with a blue light over the door at the Piccadilly end of Shaftesbury Avenue. The office was a room in one of the Shelters for 'Fallen' Girls. This kindly and masterful lady was in charge of the rescue work of the London Diocese. Having ascertained this, I gathered my courage and walked in to ask her how to train. Full of kindly sympathy, and with a sense of humour which made her chuckle at the idea of my taking up residence with the group of Anglican Sisters who managed a residential rescue home and took trainees, she made the necessary arrangements. When I had been there a short time I was invited to join the staff over the evening tea to be taught the principles of rescue work. Indignation outran discretion, and instead of meekly learning, I unfortunately attacked the policy of the work—root and branch.

No member of the staff had any knowledge of physiology or of the mechanism of mating and reproduction. A set of emotionally unbalanced girls, mostly in their teens, were steeped in an emotional religious atmosphere of confessions and constant Chapel services. To prevent the exchange of 'unfortunate' experiences, they were forbidden to talk to each other. They were not trained for any gainful occupation.

As a sequel to the news that after two years in the Home they could get a post as a general servant at £24 a year; my question "how much can they earn in prostitution?" was considered a most improper remark. A few days later I was summoned to

Madame Ruspini. The twinkle in her eye belied the severity of her scolding. She considered "outside work would be more suitable," so I was attached to an 'outside' worker in Bethnal Green. A deeply religious unmarried woman of over sixty, who for many years had devoted her whole-time services voluntarily to rescuing unmarried mothers, even to living in the locality. The spirit was willing, but knowledge was absent. An emotionally starved personal life rendered all the 'lurid details' of the sordid cases a source of intense interest and excitement. On one occasion, a meeting with the mistress of a girl said to have been misbehaving with a soldier, approval was given to 'protective' measures that included the secret steaming open of the girl's correspondence by her mistress before she received it, and the acceptance as unquestionable the statement that they "would know for certain if the girl was innocent or not if she missed her period," made me break the silence required of a trainee. "How do you know they didn't use contraceptives?" "What is that?"—explanation—"Oh dear, you married women have the advantage of us."

These experiences, though short, gave me some insight into the scope and method of the rescue work of the early part of the century. In the coming years I did not cease to press for a scientific and objective approach to the problem, and for those employed in social work to be equipped with adequate training that included a thorough grounding in the biological sciences.

The next effort, described in a circular of which a few copies are still extant, was the formation of an "Imperial Society for Promoting Sex Education." The membership was mainly drawn from a circle of personal friends. I well remember being advised to seek the support of the wife of a prominent headmaster who was herself an active social worker. Having been granted an interview and stated the case, I was looked up and down, and asked "How old are you?" Having received "twenty-one" as the reply, the grim statement, "most unsuitable, you'd better go back to school," was so damping I had difficulty in withdrawing in good order. In the future we both laughed over the episode as the lady was for many years a valued member of the Executive of the National Council for Combating V.D.

Bitter opponents often became active supporters a few years later; some even forgetting they had ever disagreed. The initial impact of a new idea appears to create the immediate reflex action of opposition. When reason comes into play, the emo-

tional reaction is overcome, and if the idea accords with common sense and when it ceases to be new it is accepted. One has often been astounded to hear those who violently opposed a proposal warmly advocating it at a later date.)

In 1906, through the courtesy of the Admiralty, I was given a passage in a battleship that was going on her lawful occasions to the Greek island where my husband was buried. The month I spent alone on Cephalonia, under the kindly protection of the British Consul, gave opportunity for thought and planning. (Ignorance seemed to be the barrier, ignorance of man's place in nature, and a strange inhibitory prejudice against applying common sense and common knowledge to personal behaviour in problems related to parenthood, and all matters of sex.) The only chance appeared to be an approach to the subject from a wider, impersonal aspect. (Why did one want to get rid of these terrible diseases—because they injured children. The quality of the child was the vital element in human progress—what did Galton call it? "The right to be well born.")

On my return to England I took a bed-sitting-room in a women's residential club—one large enough to accommodate visitors, and subsequently to use as an office. It was here that the formation of the Eugenics Education Society was planned and launched.

Eugenics and Allied Activities

MR. MONTAGUE CRACKENTHORPE'S book on Eugenics put me on the track of the Sociological Society. Its then Secretary, Dr. J. W. Slaughter, PH.D., and Mr. Crackenthorpe, guided my activities for the next few years. Through Dr. Slaughter's good offices, I not only met those members of the Sociological Society interested in Eugenics, but was able to study the subject under expert direction.

Naturally, an enthusiastic young woman did not inspire the elderly and serious scientists with any confidence, but Sir Francis Galton and Mr. Crackenthorpe both supported the view that no social appreciation of the importance of human heredity would be forthcoming unless public interest in its principles was awakened. They therefore supported the formation of an Educational Society provided its policy was wisely directed. Friends in the journalistic world helped. This publicity for "Eugenics" enabled those interested to draw together. Some two hundred

letters were received after an article in the *Referee* by "Vanoc" (Mr. Arnold White), among the writers was Mrs. (now Lady) Chambers, who with her husband became lifelong friends and colleagues. Lady Chambers became in later years joint hon. secretary with Dr. R. A. Fisher, F.R.S., and a vice-president of the Society. Their home in North Street and the Crackenthorpe's, at 42, Rutland Gate, became the social centres of the new movement. Small funds were raised, and in 1906 an office of one room was opened at 11, York Street, Adelphi, a stone's throw from the offices of the Sociological Society.

Good friends rallied round, several of them thought it unsuitable for a young woman to sit alone in the office, accessible to all, so among themselves arranged that at least one voluntary worker would always be there.

We were admittedly a band of enthusiasts, convinced we could, as a team, succeed in putting the ideas of Eugenics—of individual and community responsibility for the quality of posterity—into the minds of thinking people. At the end of the first year we were a staff of four, three whole-time voluntary workers, and one paid shorthand typist. The volunteers increased to eight and worked continuously until the 1914 war called most of them to other duties.

Six steady years of voluntary effort, during which Lady Chambers, Dr. J. W. Slaughter, and as a stormy petrel Dr. Saleeby, Arnold White of the *Referee* and Knox of the *Morning Post* gave their time, their pens and their goodwill to the cause of popularizing Eugenics. As guides on policy, in addition to Sir Francis Galton as Consultant, and later as Hon. President, were Major Charles Darwin, Mr. Weldon, Dr. David Heron and Miss Ethel Elderton (of the Galton Laboratory staff), Sir Thomas Barlow, Colonel Symonds, R.A.M.C., Mrs. Symonds, Dame Mary Scharlieb, and many others.

The Galton Professor, Dr. Karl Pearson, took the view that the then knowledge of human heredity was too slight for public attention to be drawn to the subject. He feared the possible over-emphasis of uncertain points that might arise from popular propaganda, and was always opposed to Sir Francis Galton's encouragement of the Society. This attitude also made it difficult for Research Fellows to give much of their time to the popular movement, but their help in instructional courses of lectures to those interested and in guiding studies were a vital contribution.

As an ex-Galton Research Fellow Dr. Edgar Schuster was free to work actively for the Society, and was for many years editor of *The Eugenics Review*, and joint hon. secretary of the Society.

Contacts with the Universities drew in the interest of the biologists and offered the privilege of friendship with many of those who have since become distinguished in various branches of Social Biology: Sir Cyril Burt, Professor Frank Crew, Sir Dampier Wettiam, Professor Punnett, Mr. Stockes and Professor Carr-Saunders. The late Professor F. C. S. Schiller was also an active member of the Council for many years.

The first step was agitation for, and promotion of, the legislation advocated by the Royal Commission on the Care and Control of the Feeble Minded. It was the first experience of Parliamentary work and brought to the Society the active support and help of the leaders, such as Dr. Mott and Dr. Tredgold, Dr. Nathan Raw and Dr. Ernest Jones.

The passing of the Mental Deficiency Act of 1913 with the attention it focused on questions of heredity through the debates in the House and the lectures and addresses by the Society and other organizations, gave a practical example of the value of a biological approach to social problems.

During these years too, links were formed with foreign interests. M. Lucien March, Registrar-General of France; Professor Ploetz, of Germany; Dr. Mjoen, of Norway; Professor Starr Jordon and Dr. Kellogg, of the U.S.A.; Professor Gini, Registrar-General of Italy, each promoted interest in the subject in their own countries. The groundwork was prepared for the first International Eugenics Congress which was organized by the Eugenics Education Society in 1912 at the London University, South Kensington.

Mr. A. J. Balfour, then Prime Minister, spoke at the Congress Dinner. The proceedings were fully reported in *The Times*, and were awarded an encouraging 'first leader.' Eugenics as an idea was before the public and was a current interest. Therefore, for me, this marked the turning-point. The time had come to develop in addition the other branch of work for which this was preparatory.

During that summer I joined my parents for two months in Albania, where my father was President of the International Naval Commission, appointed to clear up some of the problems left by the Balkan War of 1912.

There also was Miss Durham who has made interesting con-

tributions to social anthropology, and who revelled in her title of "The uncrowned Queen of Albania." Her store of current and historical local tribal lore was a rich soil to be tilled by the interested.

Within the Eugenics Council came a cleavage of opinion. 'Eugenics' had just attained respectability. It would be fatal to attach Venereal Disease to it—also, it was not strictly a eugenic question, it affected the next generation through congenital infection, therefore was not truly hereditary. On the other hand, until syphilis was recognized as a cause of apparently inherent defect, how could it be seen what proportion of mental defect, insanity, blindness, deafness and sterility were due to this removable cause and what was inherent and truly hereditary? As a compromise, it was agreed that the Council would explore the position, promote enquiry and stimulate action, but for continuing activities in that field a new body should be formed.

The acute difficulty at that time was to awaken public interest. A young lay woman who spoke in public on venereal disease would be labelled a 'crank.' Medical men must be found who would devote themselves to arousing medical and public opinion. I went by appointment to see in turn six prominent medical men who, I was advised, were concerned with V.D. Each one declined to participate in any public ventilation of the subject. I turned for advice to a medical family friend who was a senior member of a hospital consulting staff, and asked him to recommend three or four prominent medical men who would be willing to give papers at medical and sanitary conferences. "My dear, no one who has to earn his living in the Profession will do it. It would be too unpopular The only chance is to find a medical man who has come into a fortune." Two days later I got a line to say: "I have found him; write to Douglas White." I did. Dr. White came to the little attic office in York Street, Adelphi, and I put the V.D. problem before him, as I saw it. He agreed to make the subject one of study and enquiry, and if the conditions were as alleged, he would return in three weeks and give his help. He did return, and from that date started an association in work for many years and a personal friendship that only ended at his death.

Venereal disease figured in the programme of five public health and medical conferences in 1913. By addressing these conferences after the medical speaker, prejudice against a woman speaking on the subject gradually weakened in medical circles. The Royal

Sanitary Institute met in Dublin that year, this increased the difficulties, as the subject was even more taboo in Ireland than in England.

The International Medical Congress met in London in 1913 with Sir Malcolm Morris, the Venereologist, as President. The growing feeling in support of action was crystallized in a resolution from the Congress to the Government, asking for a Royal Commission. A strongly supported letter in the *Morning Post*, which was drafted by Mr. Knox at my desk, was almost the first publicity gained in the lay Press of the country. We realized that the appointment of the Royal Commission, if its work was not reported, would do little to arouse public opinion. Letters to editors asking for publicity on the subject of venereal disease brought sternly negative replies. Newspapers were "for family reading, and such subjects were entirely inappropriate in a paper that was placed on the family breakfast table." Lord Northcliffe was clearly the key. Could he be interested in the national implications of the subject? I asked for and received an appointment, which in fear and trembling I kept. If I could be the instrument for gaining his interest and goodwill sufficiently to open the pages of *The Times* and of the other papers within his sphere of influence, the country would be saved years of delay. Lord Northcliffe kept me discussing the whole problem and the methods by which the support of the Press could be gained, for over two hours.

As President, for that year, of the Association, he was prepared to bring the subject before them, and try to arrange for a deputation of the Royal Commissioners to be received.

To make a long story short—the Sessions of the Royal Commission were fully reported in the Press (thus giving a valuable lead to other countries), and the National Council for Combating Venereal Disease received the great privilege, not only of full reports of its activities, but of the publication of its donation lists, free of charge in *The Times*.

For many years, both Lord Northcliffe and Mr. Geoffry Dawson maintained their interest and publicised both the subject and the Council.

The appointment of the Royal Commission with Dr. White as secretary and of which the members of the Eugenics Society V.D. Committee were members, brought the parting of the ways.

It was one of the greatest disappointments of my life that I was

in hospital with typhoid, contracted *en route* through Italy from Albania, when Lord Morley, then Home Secretary, sent for me, I was told, to ask me to act jointly with Dr. Douglas White.

The Eugenics Society had played a prominent part in opening up the field, and in no way damaged their own position. A new organization was to be formed to 'carry on.' With great generosity, the Society allowed this to come into existence on their premises. The President of the Eugenics Education Society, Major Darwin, became hon. treasurer, Sir Thomas Barlow, the first chairman, I was invited to retain office as hon. secretary of both bodies. The invitations to serve on the National Council for Combating Venereal Disease were in the post when the moratorium was declared at the outbreak of the 1914 war.

During the early stages of the war, other interests supervened for a short time, but it soon became apparent that immediate work in relation to V.D. must be undertaken even before the Royal Commission could report.

The practical aspect of Eugenics also claimed attention. The professional classes, on whom the economic burdens of parenthood became unbearable on the enlistment of the professional breadwinner, led to the formation of the Professional Classes War Relief Council, of which Sir Theodore Chambers and I were joint founders and hon. secretaries.

Mr. Pierpont Morgan generously loaned 13–14, Princes Gate. The top stories became a Maternity Home, in which over four hundred babies were born, attended by a voluntary staff of the leading gynaecologists and of nurse-midwives. The rest of the house became the working centre from which the Council was able to make what was recognized as a useful contribution to the country. Heads of the Public Schools served on the Education Committee under whose aegis two thousand boys and girls were enabled to complete their school life. There was no ENSA, so the "Music in Wartime" Committee managed touring companies. A voluntary staff of ninety regular workers ran the organization, many of them personal friends from naval and eugenic circles.

Sir Theodore Chambers was called in by the then Chancellor of the Exchequer, Mr. McKenna, to assist in launching the War Savings—now the National Savings Movement. In due course I was asked to help in the organization of Savings Committees throughout the country.

Keeping a finger on the National Council for Combating V.D. and a hand on the tiller of the Professional Classes War Relief Council, I transferred with my right hand, Miss Grant, to the offices of the War Savings Committee. There we set up nine hundred committees in nine months. After a short time, as head of my own sub-department, I had the pleasure of working in close contact with Lord Kindersley and Sir Basil Blackett, and was privileged to hear many of the economic problems discussed by the experts of the day.

This period was my first introduction to the Civil Service and even now, after over twenty years, their values are still a mystery. One incident remains in my memory. I was sent for by the Chairman. "I hear, Mrs. Gotto, you have a very efficient staff, and that you've cleared out all the 'duds'?"

Expecting praise, I said, "Yes, the pressure is too great for the inefficient, and I never could suffer fools gladly."

"Well, I'm afraid it won't do," said the Chairman; "the establishment officer has to place them somewhere so you must have your quota."

"But why," I persisted, "if they are no good—why should the country pay for them and suffer from their mistakes?"

Came the reply, "Once they are in the Service they are there permanently, and that's that."

Why? If a man is a failure in the Navy, he fades out, but in the Civil Service—provided he does nothing, and risks no decisions. he is steadily promoted.

When Lord Sydenham, late Chairman of the Royal Commission, applied through the Local Government Board for me to be released by the Treasury, to resume active work with the National Council for Combating Venereal Disease, I willingly went. For my brief and most interesting voluntary work with the War Savings Committee I was honoured by the decoration of O.B.E. in the first list of awards of the newly established Order.

The latter years of the 1914–18 war threw into prominence a long-standing social problem that touches directly on Social Hygiene—the position of the unmarried mother and her child. The conditions then prevailing called aloud for action. It was the custom of Poor Law Institutions to separate mothers from their babies as soon after childbirth as the mother could work. Naturally, the infant mortality rate was a scandal. Affiliation payments were left to the "discretion" of the magistrates, and in Scotland

the average was 2s. 6d. a week! There was no adequate protective legal machinery for mother or child.

Actual cases found in the course of daily work could not be ignored. A few like-thinking enthusiasts joined forces, particularly Mrs. Barnes and Mrs. H. A. L. Fisher. With the support of Sir Charles (Lord) Wakefield, as Lord Mayor of London, a Mansion House meeting was held and the National Council for the Unmarried Mother was formed. Legislation promoted and secured, hostel accommodation modernized and increased by the Salvation Army and religious organizations. Local authorities were approached, and the present good work of the Council begun. From 1918 to 1925 the writer was privileged to be Deputy Chairman of the Executive Committee, and has throughout maintained a live interest in the problem and in the Council's activities.

Soon after my return to the executive work of the N.C.C.V.D.[1] from the War Savings Committee, in March 1917 a long-deferred decision was taken and friends of fifteen years' standing were *quietly married. Mrs. Gotto became the wife of Lieutenant*-Commander Clive Neville-Rolfe, R.N., at that time in a "Q" ship. Our honeymoon was spent as guests of the Commander-in-Chief at Chatham, while my husband was fitting out a new "Q" ship command. The submarine war was then at its height. The coming months were full of anxiety. It was a merciful relief when after sinking an enemy submarine for which he was awarded the D.S.O., my husband was appointed for a few months to less acutely dangerous work, and was within reach and able to see his son a couple of days after his arrival in the world. At the wish of the Council, I retained my former name for official work, but with the world tour in 1920–1921, entailing passports and official documents, it was dropped. It certainly complicates life for a woman not to be able to retain one name throughout, but I have no solution to offer. For many years I was constantly receiving requests for my own address under my former name.

Early Days of the National Council for Combating Venereal Disease

From 1917 to date my main interests, apart from the family, have been within the scope of the objects of the Council. The two years between its formation and the issue of the Report of the

[1] National Council for Combating Venereal Disease. Title changed in 1926 to British Social Hygiene Council.

Royal Commission was devoted to V.D. educational publicity in the fighting forces, facilitated by the Government Service Departments. The enlightenment of groups of civilians in responsible positions, e.g. teachers, clergy, social workers, and local authorities, was undertaken and a group of voluntary speakers toured the country and addressed the troops, among these the names of Sir Thomas Barlow, Mr. E. B. Turner, F.R.C.S., Sir Rickman Godlee, Mrs. Torry, Mrs. Creighton, and Dr. Helen Wilson recall the leaders of an earlier generation.

At the first Annual General Meeting held at the Royal Society of Medicine in June 1916, Sir Thomas Barlow as Chairman of the Provisional Executive Committee reported on the organization built up during the previous fifteen months Special thanks were accorded to Dr. Otto May, first Hon. Medical Secretary. With a total expenditure from voluntary funds of £169, from some £500 received in donations, 1,009 lectures had been given to the forces alone, to audiences estimated at 800,000, while seventy-six lectures or courses were given to civilian groups.

The Royal Commission reported and in 1916 Lord Sydenham, its Chairman, became President and the members of the Royal Commission joined the Executive of the National Council. Dr. Douglas White became joint hon. secretary with the writer.

By the middle of 1918, £15,000 had been raised from voluntary sources, and fifty-four branches of the Council established at home and overseas. Only £3,000 was spent in the year, of which £1,500 was publicity in the Press for the free treatment facilities. The output of voluntary effort was immense, particularly by Sir Malcolm Morris, who with the writer toured the provinces, spoke at the majority of the provincial conferences, stirred public opinion, and gradually broke down much of the opposition.

Questions of V.D. in relation to National Insurance, the winning of the interest of the Friendly Societies, the extension of the medical educational curriculum to include the diagnosis and treatment of V.D., all these were promoted actively, particularly by Dr. Otto May as Hon Medical Secretary.

In fact our joint efforts became so widespread that an historic letter arrived at the office addressed to "Messrs. Otto and Gotto, Southampton Row, London."

Lord Sydenham remained President and guided policy for six years. The Government welcomed the formation of the voluntary

body and gave it benevolent encouragement. In response to its deputation requesting immediate action on the lines recommended in the Report, Mr. Walter Long, then President of the Local Government Board, assured us we "were pressing at an open door," and that free and confidential treatment would be established through the local authorities forthwith.

For Press publicity to be done on an adequate scale, Government help was needed. As an independent voluntary organization, the Council asked the Local Government Board (which became the Ministry of Health, 1919) to provide funds for an extended programme. The first request was for money to pay for Press advertisements of the free facilities, others followed for the cost of literature in adequate quantities to be supplied and films to be produced, for the use of local authorities. It was agreed that if at any time the Council wished to follow a policy in conflict with that of the Ministry, it was to notify the Department. It was made clear this did not extend to constructive criticism of the existing scheme, but was a recognition of the fact that the Council was a free agent in control of its own activities, and could not be expected to advocate any scheme that contravened its principles. From 1918 until 1942 the plan was adopted of submitting to the Ministry of Health an annual programme and estimate of expenditure needed to enable the Council to provide local authorities with the material for publicity. The Public Health Act of 1929 transferred to the local authorities the responsibility of providing the Central Fund on a quota basis. Publicity programmes were either organized by a local authority or the authority provided the funds to employ the services of the National Council. The Council carefully maintained its position as a voluntary organization, and as such, deeply appreciated Government recognition.

The more difficult and interesting field of work was that of gaining the help of scientists and social specialists to consider constructive programmes of education and of social reform in the different fields touched by the V.D. problem. President, Chairman, and Hon. Secretaries all worked actively to recruit those best equippped to help.

A Medical Advisory Board was established on which served the Presidents of the Colleges of Physicians and Surgeons, and representatives of medical and allied societies. They devoted their efforts to securing the extension of all curricula dealing with the

training of the medical and allied professions in relation to the diagnosis, treatment and family implications. It took many years of steady work before all were ensured adequate training in the technical and social aspects of the problem.

On the educational side the help of scientists in the biological field and the educationists, as well as parents, had to be secured. The objective was a change from an attitude of taboo towards sex in home and school to one which would secure the introduction of the teaching of biology in human affairs, including graded sex guidance; carried out with understanding co-operation between the home and educational establishments; a process still far from complete.

War conditions had, as usual, thrown into prominence the activities of the prostitute. It was known she was an agency for the spread of disease, that many were infected, yet few came to the treatment centres. Why? Did the general publicity not reach them? Were they afraid of being detained?

Certain parts of London—as in the recent war—were centres of their activities. Rumour had it that the police connived at a type of quasi segregation, permitting—for a financial consideration—certain girls to use certain beats unmolested, but arresting and bringing before the Courts those who did not make their contribution.

Sir Edward Henry, then Chief Commissioner of the Metropolitan Police, was a member of our Executive. He knew that I proposed making some enquiries in person in the notorious areas early in 1918, so kindly insisted I should carry with me a card, signed by himself, which would ensure me the help of any member of the police force, and also—what might be useful—would confirm my identity if I got into difficulties.

It was not too easy to arrange, as I was at the office all day and had the home, Nanny and small son in London—my husband was serving abroad. However, Nanny and the baby paid a visit to the country, I purchased an auburn wig, took lessons in "make-up" and started on my double life by taking a room in Coram Street, Bloomsbury. In those days it was a well-known centre for the moderately prosperous professional—hardly credible to those who only know it in its present regenerate and respectable guise.

The change of character and appearance from council official to lady-of-the-streets was rather a problem, and eventually a tube staircase or cloakroom seemed to furnish the best cover. My

fellow lodgers were three ladies of easy virtue and the landlady was not lacking in experience. My tale was that I wanted to try London, as business was slow in the North, so was out for help and advice. From the landlady I had much good advice and more garbled information about V.D. than one would have thought possible. A suitable story had to be invented and sustained to cover my absence of accent, and a doctor brother accounted for my knowledge of V.D., as well as a friend who had attended a clinic in Liverpool. So as to be shown round but not to compete with my house-mates for the first few days, I invented suitable excuses and reasons. They were quite open about their earnings, methods, and payments for their beat. As to the latter, money did not actually pass but was left at certain area railings to be found in due course by the right recipient. I was impressed then, as I always am when in personal contact with the "professional," by their kindliness and generosity to each other. A week "in residence" furnished a lot of very useful information.

Quacks were exploiting the girls and crying down the clinics, as also were certain doctors who made a good living from the fees of the women, and I was told of some who offered to a small circle rapid cures for higher payments. I was able to counteract by more accurate information some of the current mis-knowledge, particularly by putting the right literature into the hands of the landladies. This was not given direct, of course, but distributed through the office machinery later. I was convinced the only way of reaching any considerable number of the professionals and clandestines would be through the stage or the film. They could attend as part of the general public. When the Council sponsored *Damaged Lives*, and later the film *The End of the Road*, we saw to it that they were well advertised in these districts.

The police situation then was obviously not healthy, and my report confirmed the findings of the Chief Commissioner's enquiry which, as is well known, led to considerable administrative changes. The police force itself is now well instructed as part of their training in the problem of V.D. and prostitution. The Council have for many years co-operated by providing medical lecturers.

This short experience of actual contact with the business convinced me completely of the anti-social effect of fines as a penalty.

This seems the best place to mention the small first-hand enquiry made among the West End group of financially more

successful professionals some twenty-five years later—during the 1939–45 war. The clear understanding of the V.D. position was in sharp contrast to that of earlier years. My information was picked up through personal contacts made at the little drinking clubs that sprang up during the war all over the West End. We were living at the time near Shepherd Market, which was a popular centre for those whose "war work" was "to amuse the friendless men on leave"—an actual description! I was ostensibly discussing war-work for women. Several were foreign girls married to British husbands who were reverting, during their husband's service, to their earlier occupation. In the small sample (sixteen) the proportion of the physically unfit was high. The reputation for 'laziness' conferred on the type was, in a number of cases, due to impaired physique—not related to V.D. Factory work in two cases had been tried, but old internal troubles returned, in one case ending in hospital. All were intensely patriotic, and as one said: "I must do my fire-watching; it costs me fifteen quid a time, but it is the only other war-work I can do besides making the boys happy." The risks of V.D. they were taking in receiving Service men from abroad were a source of anxiety, and more than one described the precautions they required from clients.

The method of life throws those following it into close association with their colleagues and facilitates the rationalization of their activities as a service to the community, thus enabling them to create within their own group a set of values which screens them psychologically from the sense of social ostracism and condemnation. They believe they are an essential cog in the social machine, rendering a useful service, and withal a lucrative one. Though easy money was the lure, several told of the "young and lonely," or the war weary, who had no funds but were not refused. Even a limited amount of personal contact on a friendly basis clothes sociological concepts with life. We are dealing with individual human beings with personal fears and affections, ideals and aspirations—not objectively based, but none the less potent in shaping the behaviour pattern.

To return to the early days of the Council—each step involved personal contacts with the individuals whose advice and help was needed, and their persuasion to active participation in the Council's endeavour. The membership from home and overseas in the many fields covered was continuously extending.

From the home background came influences and information indicating two lines of development needed.

The contrast between recreation, welfare and medical care provided for the personnel of the Navy, and the absence of any for the members of the Mercantile Marine, was acute in spite of the lip service of admiration accorded to their war services.

The prevalence of V.D in the colonies, and the large amount of disease contracted abroad by the men in our Services. Enquiries from friends resident in, or home on leave from, the colonies supplemented information sent to the officers direct. Approach was made by the Council to Dominion Governments, and Lord Sydenham's former experience as Governor of Bombay and his links with the colonies led to a number of personal contacts with prominent men and women from many parts of the Empire. Overseas branches came into existence from 1917 onwards. To record all that happened even in the years from 1917 to 1927 in the endeavour to secure adequate administrative measures and an enlightened outlook would take undue space. For syphilis and gonorrhoea to be considered as simply and honestly as were tuberculosis or infant mortality in those days seemed a utopian dream. Most educated women did not know of their existence, and neither men nor women could, with personal comfort mention the subject in the presence of the opposite sex.

To speak in public, openly discussing the diseases, was in many cases to put the woman speaker outside the social pale. To quote but one instance, Sir Malcolm Morris and the writer were to address a meeting over which the Chairman of the local County Council was to preside. The leading local medical man who was a member of the National Council was to entertain the speakers at dinner after the meeting. He invited the Chairman of the County Council and drew the reply: "What! meet that abandoned woman socially—never in my life!"

While the late Sir Robert Morant was secretary to the newly established Ministry of Health he took an active part in linking the voluntary with the official efforts. The pros and cons of notification were discussed by him and Ministry officials with our Medical Committee. An effective formula for the suppression of quacks was the outcome of joint discussion, and later there was co-operation between the Council and its branches and the permanent departments concerned, in order to secure effective law-enforcement.

The claims of the Mercantile Marine had been steadily pressed ever since the end of the war, early in 1920 came the first conference with Sir Robert and Sir George Buchanan, the British Representative on the Office Internationale d'Hygiène Publique.

Sir George Buchanan raised the question before the Office Internationale in 1920, and the plans for what eventually became the Brussels Agreement of 1924 were prepared by the Office Internationale, to be finalized in co-operation with the Medical Section of the League of Nations. During this period (1919–20) Lord Sydenham led deputations from the Council to the Ministry of Health, the Shipping Federation and the Joint Maritime Board.

In 1920 no Government department had any information as to treatment or recreation facilities for British seamen in foreign ports. The Council therefore collected and published all particulars, from eighty-eight British Consuls in foreign ports and from the Dominions, India and the Colonies.

Consuls were invited to establish recreational committees and to notify the names and addresses of secretaries for publication in *The Seafarers' Chart to Healthy Manhood.* Clinic and recreation lists were kept up to date, and a wide and regular distribution maintained to Marine offices, ships and all centres frequented by seafarers. A Government grant was given to the Council for printing costs. Later this publication became the basis of the official International Clinic list. Governments participating in the plan of the Brussels Agreement now undertake to issue the list to all their merchant ships.

An amendment to the Merchant Shipping Act was necessary to withdraw V.D. from the category of "misconduct" diseases Fortunately, my husband's family had wide shipping interests, and wise advice as to the general handling of the question was available. With the appropriate introductions I was able to put the case before Mr. Havelock Wilson of the National Seamen's Union, and Sir Norman Hill, the legal adviser to the Shipping Federation, both of whom joined the Council, served on the special committees and conferences and helped to mobilize parliamentary support. Several of the leading members of the London & Liverpool Shipping Federations were contacted socially and informally, and their support gained, not only for the Bill, but for a number of administrative changes, and educational and publicity facilities. The official story is told in Chapter 10.

That venereal diseases and prostitution could only be adequately dealt with on an Imperial and International basis became increasingly clear. The British Red Cross invited the Council to become their agents for international work on V.D., which resulted in Dr. May and I being appointed representatives to the Red Cross V.D. Bureau in Paris, and later to the V.D. Section of the League of Red Cross Societies. From this body subsequently arose the Union Internationale Contre le Péril Vénérien, founded in Brussels in 1923. The League of Red Cross Societies through international conferences at Copenhagen and Oslo promoted, through national voluntary channels, the welfare of the Mercantile Marine. The Council sent delegations to both, on which the V.D. Adviser to the Ministry was attached as Technical Adviser.

Earlier, personal contact in this country with those who became members of the Secretariat of the International Labour Office, led to the first interview at Geneva with M. Albert Thomas. This vital personality warmly welcomed the possibility of ventilating the difficult problem of V.D. among seafarers at the forthcoming Maritime Conference at Genoa, provided it could be done 'unofficially.' When the ground had been prepared by friends of the Council, concurrent approaches at home to the Shipping Federation, the Seamen's Union and the Seafarers' Joint Council were made by deputations led by the President, Lord Gorell, which had far-reaching results.

The Council accepted the invitation to raise the question at Genoa and appointed the Hon. Medical Secretary and the Secretary-General (Dr. Otto May and myself) to address the International Shipping Federation. An unofficial meeting presided over by M. Albert Thomas was held for members of the official Joint Maritime Conference, on June 15th, 1920. The resolutions framed on this occasion stimulated the Brussels Agreement, and became the basis of the International Labour Office "Seamen's Welfare in Ports Recommendation" of 1936.

From that time onwards, M. Albert Thomas remained a warm friend of the Council. An unofficial invitation was received by the writer to discuss with him the points included in the first draft recommendation of the International Agreement on Port Welfare, and a journey to Geneva was made for the purpose. Certain countries where prostitution was regulated wished to recommend this policy for port areas. It was suggested by the writer that as a

social question the advice of the Social Section of the League of Nations should be invited.

Dr. Cavaillon, Secretary-General of the already active Union Internationale Contre le Péril Vénérien, as their representative advised the Social Section of the League, and later was asked also to advise the Maritime Conference, a fortunate aid to the adoption of a progressive and a uniform non-regulationist policy.

During these years there was active parliamentary work, amendments or Private Members' Bills were prepared and promoted; on National Health Insurance—to secure grants to V.D. patients; on separation and maintenance orders—to secure that V.D. in a marriage partner and insistence on intercourse should be recognized as 'cruelty.' The collection and preparation of evidence for various Joint Select Committees or Committees of both Houses, including one on the Criminal Law Amendment Act, to bring ships in harbour within the interpretation of 'brothel' when used for a similar purpose (not included). The Merchant Shipping Amendment Act (1922) to remove the V.D. patient from the operation of the Misconduct Clauses. All this parliamentary activity involved a number of meetings with Members of the House, and gradually a strong body of support arose among Members of Parliament of all parties for the work of the Council, which persisted up to and after the outbreak of the 1939 war.

Overseas Experiences

In 1920 a deputation to Mr. Amery, Secretary of State for the Colonies, urged the need to share recent information relative to V.D. with the colonial governments, and to compare experience with the Dominions.

The Deputation met a sympathetic reception from one who was himself interested in and well-informed on the position. Demobilization, particularly in Africa, had led to a serious spread of disease among the indigenous races.

It was known that in some of the island colonies the diseases were prevalent and modern methods of diagnosis and treatment were not available, except in the Far East, at high cost, from American private practitioners.

The final result after negotiation was that the African position was to be handled by the Colonial Office itself, and officers home on leave would be put in touch with the Council.

The Council were invited to approach the Treasury for a grant to enable travelling commissions to visit the rest of the colonies. The case had to be laid before Mr. Blackett, my former War Savings chief (later Sir Basil Blackett), then one of the Secretaries to the Treasury. Fortunately for the Council, his interest in Empire Development was already keen. Until his accidental death in 1934 we worked as colleagues and friends in the interests of Social Hygiene and Empire Development.

In 1920–21 three Colonial Commissions were dispatched: to the West Indies (Dr. Letitia Fairfield and Dr. Wright), to the Mediterranean (Professor Winifred Cullis and Mr. Kenneth Walker, F.R.C.S.), and to the Far East. On the latter, which included a visit to our colleague organization in the United States and took the Commission over Canada to Japan, Shanghai, Hong Kong, Colombo and Singapore, I was privileged to be the Social Commissioner with Dr. Rupert Hallam, the Leeds Venereologist as Medical Commissioner

It was the first of a series of such tours. Cyprus and India (1927), Egypt and Palestine (1934), Jamaica (1935), Southern Rhodesia and the Union of South Africa (1937), the United States—as the three months' guest of the American Social Hygiene Association (1925), supplemented by investigation visits arranged in connection with international conferences, including those of the International Bureau on the Prevention of Traffic in Women, of the International Council of Women, and committee meetings of the Union Internationale Contre le Péril Vénérien; to Germany on three occasions; to Austria—Gratz and Vienna; Switzerland; to Rome, Madrid, Brussels, Paris, Marseilles, Antwerp, Hamburg, Rotterdam, Gottingen, Bergen, Patras and Athens, Alexandria and Cairo. Visits of several months to Constantinople in a private capacity in 1922 and 1923 when allied troops were in occupation, provided an opportunity for an insight into the prostitution problem under the aegis of both the Allied and the Turkish Health Authorities.

The last pre-war tour in 1937 was as Beit lecturer to Southern Rhodesia, and a visit to our Transvaal Branch in Johannesburg, with a view to promoting co-ordination between the three branches in South Africa as a Union of South Africa Council.

Had one unlimited space, much of interest could be recorded from Colonial and Dominion visits—of the local problems and conditions; of the various methods of handling, or the results of

not handling, the V.D. problems In each case the visits resulted in focusing official and non-official attention on the problems of Social Hygiene. The discussion of local difficulties in the light of general experience resulted in the increase of modern facilities for diagnosis and treatment, and in each, plans for popular enlightenment in forms appropriate to the locality. While conditions in each colony varied, certain points were common to all. In particular, the need for an increased sense of responsibility on the part of British women for the welfare of their fellow-countrymen removed from their home surroundings and often very young—in the Mercantile Marine, in business houses, and in Government service. This is referred to in a later chapter.

From the interchange of visits between the leaders of the American Social Hygiene Association and ourselves, close co-operation developed with our colleague organization, and several valued and lasting friendships were formed among their officers. Colonel Snow, Mr. B. Johnson, Dr. Parker, Professor Exner, Dr. Walter Clarke, and Mrs. Luce, to mention but a few. The American experience was a most valuable part of my education in Social Hygiene in the early days, and the personal discussions between officers of the two organizations led to an alignment of educational policy and close co-operation in endeavour.

From the tours arose a number of subsequent social and educational activities of the Council; this broadening of interests led, in 1926, to the change of name to that now held, the British Social Hygiene Council.

The Colonial Commissions brought personal contacts with many of our Governors, Colonial administrators, technical officers and social workers, whose practical advice and help continued in many cases up to the outbreak of the 1939 war.

The general background has been outlined. What might be a help to others, are a few typical experiences to illustrate different lines of approach to be made to each problem. Indicating that technical knowledge of one question has to be supplemented by a general, even if superficial acquaintance with the legal and administrative position of other social problems and some knowledge of any recent experiments and research in each field. Personal acquaintance with the official and non-official leaders gained through the representative character of the membership of the B.S.H.C. proved of the utmost value in procuring helpful contacts at home for those confronting like problems overseas.

Port Welfare

The Medical and Social Commissioners went after dinner one evening with a local medical man and a young official of the Municipal Council to see that quarter of Shanghai where European seamen ashore were likely to be. In 1920 no seafarers' club or general recreation centre was open, the small mission centre had already been seen. After visiting some not very salubrious places on our way back, we saw a young seaman ahead of us, evidently strange to the place, who shortly turned in to one of the many brothels. The prevalence of V.D. among its inmates was known to the local man. He and the Medical Commissioner were urged, pressed, persuaded and eventually stormed at, to go in and try to fetch the young man out, or at least to warn him. In a few moments they returned with the lad.

We asked him to join our party, and took him with us to have some refreshment. He was a boy of 18 on his first voyage. He pulled out of his pocket and showed us a note that had reached him on board that morning, via a local sampan, something on these lines: "Dear Sailor Man, are you lonely, if so, come and see us, we are having a little party tonight and would like a sailor dancing partner," followed by directions where to find the house. Knowing no one and with no alternative, he went. The doctors later had a talk with him on V.D. and the dangers of prostitution. The commission were spurred on to promote alternative recreation facilities; to devise, with the local administration, machinery to check brothel publicity; methods of preventing boys going to sea with inadequate knowledge; methods of eliminating the brothels, at any rate in the area under the control of the Municipal Council; methods of reaching the branches of the Chinese administration to present the public health aspect from an angle that would appeal. The International Municipal Council, our hosts, and the governing body, were deeply concerned to meet the V.D. menace with suitable methods, and were ready to try to find some effective means of suppressing the brothels as centres of infection. The proposed experiment of a gradual reduction and final abolition was accepted in principle.

The day before the Commission left, we were invited to be present at the initiation of the scheme by a most unexpected method.

A group of Municipal Council members, including the Chinese representative, had advised the Council to issue invitations to all

the brothel-keepers in the town to meet in a large hall. Flanked by the Social Hygiene Commissioners, the Chairman of the Municipal Council sat on the platform with the lottery drum loaned by the Race Course Committee on a stand in front of him. The Chairman opened proceedings followed by the senior Chinese member of Council. It was explained that on grounds of public health the brothels must be closed; that the authorities were providing facilities for modern treatment. That the livelihood of those present would not be withdrawn without warning, so formal notice would be given of the dates of closing. So many would be closed each year. To make it fair, lots would be drawn that afternoon for the section that would close during the current year. Each guest had a marked invitation card and was asked to show it. On a rough estimate one would assess the audience as about three hundred and fifty men and women. The wooden cube numbers of the lottery drum had been brought to the platform and were checked in to correspond with the card numbers, formally shovelled into the green metal cylinder fixed on its three-foot high stand, and the lid closed.

It was announced that as a stranger having no knowledge of the individuals concerned, the Social Commissioner would be asked to draw out (if memory is correct) fifty numbers for the current year's closure. The drum was rapidly rotated, with the noise of a volley of machine-guns, and at the height of its speed *the lid flew open and most of the three hundred and fifty cubes* streamed like hail over the audience! Accident or sabotage? No one knows. Already convulsed with inward mirth at the incongruity of the proceedings, and of the view that might be taken of my participation by some of the more conservative supporters of my Council, the final anti-climax gave a happy release and platform and audience broke into peals of laughter. It was too late that day to renew the procedure—and besides—there were no more numbers. It would have taken ages to collect the original set, most of which had already found their way into the pockets, or rather sleeves, of the audience. An announcement was made that notice would be given of the date of the adjourned meeting.

In 1934 the Commission from the Social Section of the League of Nations visited the Far East and reported that no system of licensed brothels existed in the International Settlement of Shanghai.[1] So the experiment evidently had some lasting result.

[1] *Commission of Enquiry into Traffic in Women in the Far East.* Geneva, 1934. p. 10.

In the general work of the Commissions related to V.D. the provision of diagnosis and treatment for prisoners was part of the regular programme. Commissioners visited the prisons and officials responsible, the man dealing with problems of the male prisoners, a woman with those of the women and girls. A tour of the women's section of the Shanghai prison with a responsible woman interpreter was a depressing experience. There was no woman superintendent, European or Chinese. Accommodation was limited. In fair-sized rooms used as cells, a few old women under long sentences for traffic in drugs, murder, and violence were with young girls serving short terms for slight offences. None had any occupation except the daily cleaning. There was no classification and low-grade mental defectives were scattered among the rest. Eventually, I was escorted to the Governor—to my surprise a young military officer in the early twenties. After a warm welcome he said pathetically: "Can you tell me what they do at home? I'm a soldier and know nothing of criminal administration. I can feed them and keep discipline among the men, but what ought to be done among the women with a restricted revenue and these premises?" Fortunately, home contacts had given one some slight knowledge. The obvious suggestions were made for adequate medical service, for classification, for employment for all the women, and occupational training and elementary education for the young. There was urgent need for some form of discharged prisoners' aid machinery, particularly for the young of both sexes. But the main point was to urge the Municipal Council to provide funds for additional and suitable staff and to give an opportunity to the young Governor to obtain some insight into methods of prison administration at home. Among the resident population efforts were made to promote interest among the Chinese leaders in after-care and of an appreciation of the mental deficiency problem and its social implications. What time allowed was done in both directions and followed up later from London.

The first Imperial Social Hygiene Congress was opened by the Minister of Health at the Wembley Exhibition of 1924. The second in the following year by Mr. Amery while Secretary of State for the Colonies. Thenceforward these Congresses became bi-annual events until 1939. They provided the starting-point of many overseas developments, while the contacts made by the Commissions on tour led to officials of many Departments of most of

the colonies remaining in touch with Headquarters, and attending Conferences and special vacation schools when on leave. The Colonial Office were convinced of the value of these activities and gave practical and financial support. The published proceedings of the Congresses developed into the *Empire Social Hygiene Year Book*,[1] which with the help of both Government Departments and voluntary organizations gave an annual record of international empire and home conditions related to the many branches of social welfare covered by the term Social Hygiene. The success of the policy of inviting overseas visitors to conferences on social questions of Empire-wide interest led to its adoption by other social organizations.

A tribute must be paid here to the helpful co-operation provided by Mr. Harris (now Sir Sydney Harris) and others at the Home Office, in advising officers from the Colonies on juvenile delinquency and allied problems. As British Government delegate to the Social Section of the League of Nations, his views on problems of prostitution and traffic completed in many cases the conversion of those whose interest in the subject had been aroused by the Council's Commissions.

The most delightful memories of all tours date from the three weeks spent in Burma, 1928.

The contrast after the sad faces of the under-nourished peoples of Southern India, to land at Rangoon on a sunny morning under "the Golden Tooth" and to meet the smiling round-faced, well-nourished Burmese, was in itself a pleasure. In each place, bar one, on every tour, the most generous hospitality was accorded to the Commissioners either at Government House or by senior officials.

In Burma my hosts were the Finance Member and Lady Keith, while Dr. David L. Lees was entertained by the Director of Medical Services. It was a strategic as well as a pleasant position, as several of the recommendations of the Commission if accepted would require budgetary provision. Port Welfare and facilities for treatment of the Mercantile Marine, as well as treatment schemes for the general population, made visits to Moulmein, Bassein and Mandalay desirable. The river trip down the Irrawaddy, from Mandalay to Rangoon, and the river passage to Bassein, not only gave one some insight into the life of the country, but took us through the most lovely scenery. It gives

[1] Published Allen & Unwin, 1927–1940.

added poignancy to the grim destruction of recent years, particularly of the fine hospital then under construction in Mandalay and now destroyed.

The brothels, at that time, were pursuing their usual anti-social functions. Under the guidance of the police, accompanied by interpreters and two able British voluntary workers, exhaustive tours were made during the first period of the visit to the different types of huts and houses, catering for the different sections of the community, Europeans, Burmese, and Indians. With the local reports and my own observations, a strong case for abolition was provided. The position was first discussed with several members of the Legislative Council. European and Burmese, in the hope of securing their support when the Commissioners formally presented their report to the Legislative Council. It was surprising to find the Burmese Christian member a strongly convinced regulationist, and still more so when it transpired that his views and arguments were alleged to have come from one of the Christian missions. The immediate move was a request to the appropriate authorities for a round-table conference with representatives of all the British and American missions, and of the educationists—primarily to stimulate the teaching of biology and the giving of sex guidance in the schools, but also to secure their support for an abolitionist policy. The views expressed at that conference by the missionaries made it clear that they were entirely out of touch with recent experience.

They "did not like regulation," but thought it was the best protection for health. Sex teaching was considered 'dangerous.' A qualified biologist could not be found either on the Government or the missions' education staff. Questions asked relating to the local form of Buddhist teaching and its ethical and social values could not be answered by those present, and had to be sought later from the head of the Ramakrishna Mission and the leaders of the Buddhist community. It was this and similar experiences in other places that led on our return home to extensive developments. The whole problem of mission co-operation in social hygiene was raised with the Conference of Missionary Societies and with the Colonial Office. Under the far-seeing guidance of Mr. Amery, and with the active help of the late Mr. Paton and his colleagues on the Standing Council of Missionary Organizations, a series of conferences and vacation schools were held each year, where missionaries, administrators, anthropologists, and

biologists could meet and discuss current social and educational problems. Our colleague organization in the United States being informed of the situation, moved in a similar direction with far-reaching results.

The harvest of experience gained on each of these tours was garnered, analysed, considered and acted on, in the years between the two wars under the direction of the Council's Imperial Committee, on which it had the privilege of the guidance, in some cases as Chairman, over a period of some twenty years, of Sir Gordon Guggisburg, Mr. Amery, Viscount Willingdon, Sir Laurence Guillemard, Sir Edward Grigg, Sir Ronald Storrs and the Earl of Lytton. It was Sir Gordon Guggisburg who applied the experience of the Council's early Vacation Schools to secure a Government course at the University following similar lines for young administrative officers of the Colonial Service. When, on his return from India, Sir Basil Blackett became Hon. Treasurer and later President, he fully and actively supported overseas and international activities. It was these leaders who from their experience knew how to direct the driving force of the voluntary pioneer body, when to raise the pertinent points in Parliament, or at the Social Section of the League, who ensured the admitted success of the work. They were listened to by Ministers and Government Departments. Many were the informal conferences between the biological scientists, the Colonial administrators, home officials and Members of Parliament, that were held either at the President's home, the writer's house, or the Council offices. So much needed to be done if venereal disease and prostitution were to be eliminated—if the time-lag between knowledge and practice in the biological field was to be reduced. In the Colonies the need was particularly acute, for the general development of social welfare and an appreciation of this principle was finally embodied in the Colonial Development Fund Act.

The voluntary organizations can, on occasion, render useful services to their own Government in the international sphere as well as within the Empire. A good example of effective co-operation between the two voluntary social hygiene organizations of the U.S.A. and Great Britain was in promoting special arrangements for the treatment of British and other foreign seamen in the major ports of the U.S.A. Owing to their immigration laws the United States could not ratify the Brussels Agreement. During a visit of the writer to the American Social Hygiene Association a

conference was held at their request with the Government Authorities concerned. The endeavour to find a means of rendering this international service in spite of technical difficulties resulted in the American Government making special arrangements by which foreign merchant seamen could be treated at the Federal Government Marine Hospitals in all ports in which such institutions were established.

Southern Rhodesia, which in 1936 had but recently attained its quasi-Dominion status, can be cited as an example within the Empire. Legislation affecting the indigenous population had to be approved by the home government. The problem of venereal disease was serious and certain new prostitution conditions had arisen in mining areas. A local agitation for compulsory powers of examination and treatment and drastic methods of handling the prostitution difficulty had been proposed. The Council were aware of the position and made representations to the Dominions Office pointing out the unsuitability of the methods suggested. Concurrently with this correspondence the writer was invited to visit Southern Rhodesia as Beit lecturer on social hygiene. The Dominions Office received the new draft legislation for ratification. The writer was asked by the Minister to explain the situation fully and endeavour to secure the support of opinion in Rhodesia for a modification of the proposed measure. As the legislation was almost the first to be submitted for ratification under the new Constitution they were naturally averse to refusing approval, but as it stood its provisions ran counter to British and to international policy Happily a full explanation of the situation to the members of the Rhodesian Government, then fortunate in having Dr. Higgins, a medical man, as Premier, and to the voluntary organizations that had pressed for action, resulted in the substitution of a medical and social programme that embodied the results of recent experience in forms adapted to local conditions.

Personal and Family Notes

Recent years have seen a great change for the better in the status of the social worker. As voluntary social work was usually undertaken by devoted Christian women left in middle life with no home ties and an income that would only meet very modest needs, it was typical that in the rather puritan section to which many of them belonged, self-adornment was regarded as a vanity

of the flesh to be eschewed. The paid workers of voluntary organizations received mere pittances, and what they had was often devoted to their work.

Approaching the problem from a different angle, I felt the worker should be in a position to meet on equal terms those responsible for policy, either in the Governments, educational bodies, the business community, or social organizations. The advocates of reform, particularly if it was unpopular, must first establish that they are normal, common-sense, balanced personalities and not fanatics. Should look, speak and act as anyone would who was in the social circle of those from whom help was sought. With women, particularly, a reasonably smart and tidy appearance removes prejudice that is lurking in the mind of the stranger at the prospect of having to "listen to a frumpish crank on unpleasant subjects." I was confirmed in this view by a snatch of conversation overheard when imprisoned by a crowd behind a door and unseen by the speaker.

The Commission had just arrived in the Colony and were being entertained at a large dinner party.

"My dear, B (her husband) has been dreading this, they will be such awful freaks."

"You needn't worry; it's all right, the woman is well dressed, is smoking, and has taken a cocktail. *She'll* be quite sensible."

What a criterion for sense! However, it is not only the confidence an average appearance gives to those whose help is essential to the attainment of the object in view, but there is the effect on the worker's own self-confidence. People are met in no apologetic spirit but as potential colleagues. This point of view is now generally accepted by the organizations employing trained workers, and the general economic provision is steadily improving; but in the early days a social worker who would enjoy a race meeting, take a cocktail, and dance, was sometimes severely criticized by workers in other fields.

Not appearance alone, but the status of married women helps: however, if young married women are to make their valuable contribution to social welfare in the wider circle of the community, some means must be found of balancing the claims of home and public life.

Had as much been known twenty-five years ago, of the need of the very young child for the mother's personal care, and again during the adolescent years of anxiety and emotional strain, the

years in which the work required the longer absences from home would probably have been spaced somewhat differently.

In those days, I knew the mother would feel the parting from her babies but did not think the babies would miss their mother, provided they were in good hands and under the best conditions. Throughout my service with the Council, the family responsibilities were generously recognized by them, and unpaid leave accorded to enable school holidays to be spent at home. It was not until after the 1914–18 war that I had to make the choice either of giving up public work or taking paid work, to cover the cost of responsible domestic help. In response to Lord Sydenham's request, I agreed to continue, being paid for part-time and volunteering the remainder. Later, when, with many others, my husband left the Navy, I became the whole-time paid servant of the Council, but with the proviso that unpaid leave would be allowed. On three occasions during my service with them I was offered other openings at considerably higher salaries, which, with educational costs to meet, created a difficult position. Social Hygiene was to me a purpose in life—commercial developments were interesting, but held no inspiration. It was, therefore, an immense relief when the officers of the Council decided it would be worth while to enable me to remain with them, at a salary which I estimated would cover the essential home needs, though below the outside offers.

Without the full and generous support of my parents, who opened their home to the children and their nurses during my travels, and of my husband, who was usually in this country when I was abroad, the divergent claims of home and work could not have been adjusted, while the consideration shown by the Council and particularly by the staff has been deeply appreciated. There is perhaps some weight in the late Sir Thomas Barlow's view when he said "the value of an executive officer is increased for the Council by her experience in rearing her own children and leading a happy married life, particularly as the subjects we deal with require the balanced approach of a person with a normal background!"

In my original plan of life was included the endeavour to enter Parliament, but the fates decreed otherwise. Twice I was asked to offer myself for nomination—once by the Conservatives and once as Labour, which indicates an interest greater in subjects than in party.

Twice, Colonial Secretaries pointed out the desirability of a woman member who would specialize on Colonial questions, and I was sorely tempted. Two objections were, however, insurmountable. I already had two whole-time occupations to fit into an eighteen-hour day—Social Hygiene in Great Britain and overseas, and a home with a husband and two children. Most evenings, week-ends and holidays belonged to the home. As an M.P. this time would have to be spent in the House or in the constituency.

To give up the work of the Council would risk accomplishing less for the subject at heart and also the expense then involved would block the education of the children. I recognized too, that almost as much could be done from outside as inside the House, by stimulating the interest of Members of all parties of both Houses; by promoting Private Members' Bills, by providing reliable information for the basis of speeches and questions. Perhaps even more could be done on non-party lines than by a woman member, identified with any one party.

The Future of Health Education

From the early days, when Sir Robert Morant, a personal friend, was Secretary of the Ministry of Health, future developments were freely discussed outside the official setting. We both had a sense of the urgent need for general health education. That after a few years of concentration on enlightening the public on venereal disease, to fill the gap in general health knowledge due to the past taboo, a balanced programme of health education should be the rule. At his request, I prepared plans for a propaganda department of the Ministry, the work of which was to be linked with voluntary effort in order to foster experiment and progress. His tragically sudden death in the middle of a brilliant career delayed this wider development for some twenty years. It has now been launched on very different lines from those then planned. The original scheme, somewhat modified, was submitted to the Parliamentary Secretary of the Ministry, then Mr. (now Lord) Astor about 1920. From 1926 after the change of name the British Social Hygiene Council developed general programmes for health weeks at the request of local authorities and in co-operation with colleague organizations.

With the consent of the Ministry, general Health Exhibitions were organized, as an experiment in 1926, and met with a warm welcome from local authorities. No Government grant was given

for general Health Education, resources were limited to those offered by voluntary organizations and local expenses provided by local authorities. Sir Malcolm Morris, Chairman of the Executive, and I were received in consultation by the Secretary to the Ministry and the officials, to discuss the proposal we had submitted, based on this experience, that the financial basis adopted for V.D. should be extended to cover general Health Education and the co-operation with other voluntary health organizations developed under the aegis of the Ministry.

We next heard a year later that the Ministry had invited the Society of Medical Officers of Health to form a Council of Health Education. The voluntary organizations were represented on a consultative body, but no funds were provided for additional work, and except that the responsibility for Health Exhibitions was handed over by us to the new organization, there was little development for fourteen years.

In 1938 and 1939 the Council drew the attention of the V.D. Department of the Ministry to the large areas left without propaganda owing to the official finance regulations. Eventually the Council voiced its criticism publicly. At the outbreak of war the need for co-ordinated Health Education in the factories became urgent. Schemes were put forward by the Council, but the funds needed were such that the Government decided to take over the responsibility. For the poster publicity alone several hundred thousand pounds would be required. This method of publicity was obviously demanded for our then mobile population, and the Ministry undertook to apply for the necessary funds for an adequate publicity campaign, if the Council would hand over its publicity machinery, with the result as is known to all, that the Government expended some four hundred thousand pounds on posters, and an intensive health educational campaign was carried out.

A negotiating Committee, with a Chairman appointed by the Ministry, arranged the terms of transfer. The Council agreed to leave to the Central Council for Health Education the field of popular education in V.D., and sex education and guidance to school and post-school youth—the programmes which had been financed from official funds. They retained responsibility for the remainder of their activities in the field of Social Hygiene, and should still remain the voluntary body that holds a watching brief for the non-vocal V.D. patient. It was directly concerned with the

social implications of venereal diseases, and maintained its interest in overseas and international pioneer developments, while laying greater emphasis on the social biological aspects of current problems related to the family.

With the principle of general health education rather than continued isolated propaganda on V.D , all were in agreement. The actual treatment meted out to the Council, and particularly to the writer, was unfortunately coloured by antagonism aroused in a section of the Ministry by the persistence with which the V.D. schemes had been criticized in recent years not only in relation to publicity finance, but for their neglect of contact tracing and for not meeting the needs of the infected woman.

After the transfer of official funds, trained personnel and equipment to the Central Council, the financial resources left to the B.S.H.C. were small. I resigned as Secretary-General and undertook to give at least two years full-time voluntary service as Honorary Secretary.

Thirty years have seen three long steps forward on the road which still stretches far ahead before venereal disease and commercial prostitution are negligible problems. Syphilis and gonorrhoea are now recognized as public health problems, of which most have some general knowledge. Sex education is accepted in Great Britain as a necessary part of the general education of youth.

Seamen's welfare is now a government responsibility in the larger maritime countries on a national and an international basis. The problem of prostitution is recognized as in part biological, in part educational and in part sociological. Social Biology is a conception that is gaining support.

Looking back, one is full of gratitude to the friends and colleagues who gave such generous service to the cause of Social Hygiene, who fought the battles of the unpopular subjects of Venereal Disease and Prostitution until they were recognized as urgent sociological problems closely linked with current personal behaviour patterns. Just as in the early years the eugenic setting helped to create the right attitude towards Venereal Disease, so to-day the setting of Social Biology places their social implications in a constructive perspective.

To those who are taking up Social Service to-day a wider opportunity for accomplishment than ever before lies ahead. One warning, however, should be given—Social Service is a service

and demands the wholehearted devotion of its followers. Those who are personally ambitious, who seek 'popularity' or a 'career' should enter politics or commerce. To hope to make a constructive contribution towards the solution of social problems usually involves attacking emotionally rooted prejudices, presenting ugly pictures, which people prefer to leave with their faces to the wall, persisting in your objective to the irritation of authority and leaving to others the reaping of the harvest when the case has been won in principle, because in the struggle the unpopularity that attaches to the troublesome persistence of the problem is transferred to the pioneer. All the same, the personal satisfaction of working for a cause that to you is worth while brings real happiness and satisfaction.

Two events in my working life continue to be sources of pleasure when the opportunities for further service seem less than one's energies demand. That the British pioneer work in the field of Social Hygiene was signally recognized by our American colleagues in awarding me in 1940—as the first non-American and the first woman—the Snow Medal "For Services to Humanity." The letter of appreciation received from H.M. King George V for the Home and Overseas work of the Council on its twenty-first anniversary. This hung framed over my desk until our offices were requisitioned by the Government and I resigned the Hon. Secretaryship and was elected a Vice-President in 1944. Since the death of Dr. Otto May as Chairman in 1946, the Council no longer plays an active part in its former fields.

CHAPTER I

SOCIAL BIOLOGY

ONE of the contributions Western civilization is making to humanity is the scientific knowledge which, if applied, will enable man to provide for himself an environment favourable to social and biological progress. The evidence indicates that by the wise use of such knowledge he can improve the inherent quality of man himself, obtain conscious control over his own health and behaviour, and secure to posterity "the right to be well born."

Social biology is the study and application of the biological sciences directed to the development and conservation of natural resources in the service of the human race, to the improvement of human quality and welfare, and to the clarification of fundamental truth to which man's behaviour must be related.

The trend of the changes that will be accepted as 'progress' will depend on the ethical and spiritual values that attract sufficiently to release the human driving-force of desire for their attainment. If the object of improving his species seems to man worth while, the tools he can use are offered by science.

Social hygiene as a sub-section of social biology is concerned with the application of the biological sciences to the social problems arising out of man's relationship with man.

Increase in our knowledge has been accompanied by an increase in the complexity of the world problems. The period of unrest and upheaval through which Western civilization has been struggling, with the three acute peaks of the 1914–18 war, 1929–32 economic slump, and the recent war and its aftermath, leave the present generation to face the tasks of providing adequate food, employment, health and welfare, of relating population to resources, and of maintaining the biological unit of the family, in a number of changing social structures.

The immense growth in industrial wealth in the nineteenth, and for the first years of the twentieth century, was in no small part due to the yield of the recently cleared virgin soils of the American continent. The increase of population arising from industrial development in Europe and the U.S.A. has raised the standard

of living and increased world food consumption. Yet it is now recognized that practically half mankind suffers from malnutrition and the world to-day is in the grip of food shortages and famines attributable, it appears, as much to the decline in the production capacity of the soil as to international political difficulties. The very increase of food production has already destroyed much of the soil. As G. V. Jacks says: "As a result solely of human mismanagement, the soils upon which men have attempted to found new civilizations are disappearing, washed away by water and blown away by wind. To-day, destruction of the earth's thin living cover is proceeding at a rate and on a scale unparalleled in history, and when that thin cover—the soil—is gone, the fertile regions where it formerly lay will be uninhabitable deserts."[1]

"Over forty million acres of new land in the United States were brought under the plough during the 1914–18 war and the immediate post-war period." To-day much of this "has been eroded beyond repair or has become 'sub-marginal' land to be left for time and nature to restore to fertility." In the Piedmont of Carolina and Georgia some 50,000 farms retired from cultivation between 1920 and 1930. "It has been estimated that not less than 165,000 people have moved from the Great Plains since 1930."

Soil erosion is a problem that is affecting parts of every continent and on its solution depends the possibility of raising the basic standard of nutrition.

Lord Hailey attributes the low population density of Africa to the poverty of the soil, cites erosion as one of the major problems on which all administrations should concentrate, and points out that present soil conditions are largely responsible for the malnutrition so widely prevalent.[2]

Recent researches have disclosed that soil deficiencies directly affect not only health but human fertility. Lack of iron results in conditions of anaemia of varying severity. It is particularly important for pregnant and nursing mothers, and for those suffering from malaria and hookworm, the debilitating diseases. Lack of calcium promotes dental caries, results in imperfect bone formation, and has an adverse effect on general health. The analysis of conditions has shown that "perhaps the deficiency in

[1] *The Rape of the Earth: A World Survey of Soil Erosion*, by G. V. Jacks and R. O. Whyte, pp. 18, 25 and 294. Faber & Faber.

[2] *An African Survey*, by Lord Hailey, p 1636. Oxford University Press.

vitamins of the B_2 complex is the most serious as this not only gives rise in severe cases to serious disease, but causes a variety of skin lesions and affects even mental health. Where this deficiency occurs, mental reactions are slow and intelligence impaired. It also contributes to malnutrition as appetite is absent in those suffering from B_2 vitamin deficiency, even when food is available. In China, the health of the young adolescent and adult is seriously impaired. In 1933–34 Dr. Platt in an enquiry in Shanghai found in 2,000 apprentices 70 per cent showed deficiency damage. Few could work for more than a year.[1]

In the recent survey of nutrition conditions in the West Indies, the view is taken that much of the leg ulceration, so frequent in the West Indies, Africa, and India is the result of malnutrition. Soils, therefore, may limit both personal and social development by inhibiting the expression of the full human potential.

To meet the needs of the still growing world population and also to provide sufficient food to raise the standard of nutrition for the under-nourished presents the biological scientists, the engineers, and the agriculturists with a major world problem of real urgency. The agricultural methods of North-Western Europe are suited to that area, but their introduction elsewhere by the colonizing powers is now seen to have been disastrous.

Nutrition is another problem of social biology which circumstances have at last forced into prominence. The time-lag between the acquisition of knowledge by the scientist and its application to daily life by the family doctor and the administrator was more than the estimated thirty years. In fact the conception of seeking positive health rather than awaiting the development of disease is new to the West, where we pay more highly for curative than preventive measures.

During the last ten years surveys and researches have been undertaken at home and in the Empire, and present conditions perforce give the subject priority, as evidenced by Bretton Woods and other international post-war conferences. The demonstration of the close relationship between output of work and intake of the right kind of food has been given by the fall in the output of the inadequately fed Ruhr mineworkers, and international publicity thereon has served a valuable educational purpose.

The Union of South Africa established a Nutrition Council

[1] *Aspects of National Research*, by B S. Platt, M.Sc., M.B., British Medical Bulletin, vol. 2 (1944), No. 10–11, pp. 204–207.

by law in 1940. An advisory body to the government which is encouraged to co-operative effort with non-official bodies both in research and in the distribution through non-government channels, of local surplus and perishable foods.

Surveys disclosed that of 58,000 European schoolboys throughout the Union 40·3 per cent were found to be under-nourished.

The Bantu survey declared "There is no escaping the conclusion that the percentage incidence of malnutrition and preventable disease among Bantu children is very high."

The problems we have mentioned occur on a world-wide scale, but social biologists are also actively concerned with problems which, while their effect is world-wide, occur in localized areas. The destruction wrought by insect pests such as the locust and the tsetse fly are examples Africa has yet to solve the difficulty o the tsetse fly which over large areas is still an acute danger tc human and livestock; some of the methods earlier in use wen dangerously near promoting soil erosion over the tracts clearec of vegetation to destroy the fly The present plan, tried out in Nigeria and elsewhere, is to move the whole population temporarily from the fly-infested area, and then to attack the conditions that encourage the fly and facilitate its breeding.[1] The experiment made at Anckau included bringing the inhabitants of forty-two hamlets in a tsetse fly area into sixteen villages in a cleared district.

The transfer was carried out, in spite of shortage of funds and staff, during the war years. "The cause of the high incidence of sleeping sickness was the close man–fly contact Innumerable households drew their water and did their washing in tsetse infected streams" Now the streams have been cleared, the returning population will be responsible for keeping them clear. It is anticipated that the tsetse fly will no longer seriously affect the health and economic development of the area.

The Nigerian administration took the opportunity afforded by the move to prepare improved conditions of village life, including housing and sanitation, in readiness for the migrated. This is an outstanding example of combining sociological and medical experience in an experiment in social biology. To use this method, however, for all the infected areas in Africa would be a long and costly process.

[1] "The Anckau Settlement in Nigeria," by T. S. M. Nash, D.SC , Nigeria *Farm and Forest*, vol. 2, pp. 76–82, 1941.

The locusts which have been a scourge to mankind since the dawn of history provide another problem in social biology. Northern Europe being part of the temperate climate belt that is exempt, the man in the street in England usually thinks locusts belong to Palestine and Egypt, and ceased to be a serious menace after the Seven Plagues Unfortunately, famines have been, and still are, caused by locusts in India, China, and elsewhere. In 1930 losses of crops to the value of £1,000,000 were caused by locusts in Morocco In Nigeria, in the same year, 1,000 tons of grain had to be imported to prevent famine, locusts having destroyed the harvest.[1]

An estimate has been made by the Anti-Locust Research Centre of the cost of locusts (and their first cousins—the grasshoppers) for the ten-year period 1924–35. The figures are an admitted underestimate as the armies of voluntary labour needed to limit the depredations of the insects when swarming, have not been included, but represent millions of man hours of work withdrawn from other and gainful occupations.

Also, only forty-nine of the seventy-seven countries affected were included. Even so, "the total was staggering, showing that crops to the value of £83,120,800 went to feed the locusts in ten years. The losses would certainly have been greater if no defensive measures had been taken, but the latter cost another £13,000,000. On the basis of these figures, it was not an exaggeration to estimate the average cost of locusts and grasshoppers to the world at fifteen million pounds per annum."

It is found to be useless to wait until swarms are in existence. The scientists having traced the life history of the locust, declare the way to prevention is to discover and deal with the breeding-grounds. In the meantime modern methods have reduced the destruction of the swarming plagues—flame throwers, poison gases, bacterial diseases, steam rollers, balloon barrages, smoke screens, and even artillery have all been tried. Lately, however, the method of poison belts has come into almost universal use.

The locust question is one that well illustrates the impossibility of effective biological progress on a national and limited scale. Without close international co-operation, expenditure of money and labour are wasted. A swarm of desert locusts has been

[1] *The Locust Plague*, by B. P. Uvarov, D.SC., Entomologist, Anti-Locust Research Centre British Museum, Smithsonian Report, p. 334, 1944. Washington, D.C.

encountered in mid-Atlantic 1,500 miles from Africa en route to South America.

Fortunately, with benevolent encouragement shown by governments, pioneer groups of scientists have gone forward in a combined plan that should within measurable time benefit the seventy-seven nations affected. The International Centre for Anti-Locust Research under the technical direction of Dr. Uvarov, centralizes all information in Great Britain at the request of the First International Locust Conference of 1930. Breeding-grounds are now being sought and anti-locust missions have been welcomed in Arabia and Ethiopia. The four-year invasion, now past its peak, damaged far less agricultural produce than ever before.

Only four typical problems of social biology have been mentioned, as an indication of the effect of such problems on human welfare. Even the major developments due to the application of biological knowledge to animal and plant breeding are not included. A survey of the whole field would need a volume.

The Family, Administration and Social Hygiene

To turn now to social hygiene. What is sought is a yard-stick, the gauge of which is common to all cultures, to measure the advance or recoil in human welfare resulting from social and economic changes, and a set of values agreed by all cultures which would provide a foundation for a general understanding of the implications of progress. The family appears to provide both the yard-stick and the values. It has been stressed that the stability of the family unit is of major importance to the health and welfare of a community. This is recognized in all parts of the world, though the unit accepted as the 'family' varies.

Throughout Western civilization and the majority of the Christian communities the 'family' implies a legally monogamous unit. In tribal communities the family unit is different but is stable within the tribe, while in China and certain other parts it includes (or until recently included) a system of legal concubinage. In practically all, monogamy is required from the woman. Apart from any religious considerations, there appear to be grounds for the belief that monogamy with freedom for the selection of partners is in the line of biological progress for the human race, but that at the moment is not the point under discussion.

As we can recognize even with our present knowledge certain of the vital needs of men and societies, these if clarified would

be some guide in the handling of the detailed problems of social adjustment that daily come before the administrator, the social worker and the responsible citizen.

The outlines of behaviour patterns and the influence of economic and social conditions on family structure often appear more obvious when seen in a different cultural setting. Fuller consideration often confirms their more general application. Embodied in law and convention are customs that have a biological and an environmental bearing that influence family status, examples are indicated by comparative marriage laws and by race mixture problems.

Industrial and economic development as well as the World War have rapidly broken down geographical barriers and brought members of divergent races and cultures under the immediate influence of the Western financial structure and its social and ethical values. The administrator and the business man seldom realize the biological repercussions of their short-term policies to raise revenue or organize industry. The development of the gold and diamond mines of the Rand may serve as an example. These have brought economic stability to the Union of South Africa and have masked the agricultural poverty of the land by providing a generous source of revenue. Not only the Union but Great Britain has benefited from the interest on investments, and the world's gold supply has been increased.

The application of the European conception of employment of labour to mining and industrial developments in a tribal community have resulted in many unexpected consequences. Young males were recruited from surrounding tribes. The response was good because the system of taxation which required money for payment—a commodity that does not figure in the computation of native wealth—led the chiefs of the tribes to send their able-bodied men to the mines to earn the tax money. Over-recruitment followed. Tribes were denuded of males, the absence of husbands and fathers broke the family stability, local agriculture lacked labour and the tribe's subsistence-level fell. Lord Hailey emphasizes the same point in his call to the authorities "to consider the social implications of systems of taxation which may impose unforeseen burdens and have anti-social consequences dislocating native society, owing to the migration of adult males, amounting in some areas to 50 per cent."[1]

[1] *An African Survey*, by Lord Hailey. Oxford University Press.

In Broken Hill in 1940 it was found that of the £67,830 cash wages (about half the real wages) the annual money earnings of the 6,460 of the rural labour force from Northern Rhodesia and Nyasaland, only 10·5 per cent, i.e. about 22s. per man per year was passed on to their rural dependants.[1]

The young men often remain for many years in the Rand and other mines in spite of paper regulations designed to limit their term of absence; 69·9 per cent of the Broken Hill force, for example, has spent two-thirds of their time in the towns. While the regimented life led to a general improvement of the mine workers' physique through good food, the damage was serious to the family. The unmarried were deprived of tribal discipline; the married had no home life. Widespread sex promiscuity obtained with local detribalized women highly infected with venereal disease.

Ten years ago industrial diseases were dealt with in the mine hospitals, social diseases were not. For venereal diseases a special hospital provided a six weeks' course of treatment. In those days a purely palliative measure. The patient's return to the tribe was followed only too often by the infection of his wife. A marked prevalence of congenital syphilis and of gonorrhoeal sterility had caused a serious fall in the live birth-rate.

When the writer went through the Rand mines and mining towns in 1937 and subsequently visited the native reserves, it was clear that unless a change of policy were adopted, an increasingly rapid deterioration and decline of the indigenous populations was inevitable.

There has been a considerable change for the better in the public attitude in recent years. On the social side the question of over-recruitment has been given serious attention by the Union Government, by the European Colonial Administrations and also by the International Labour Office.

The Dutch system of bringing the family to the industry with the worker has much to recommend it from the biological standpoint. The Reports by Major Orde-Browne, Labour Adviser to the Colonial Office,[2] included recommendations which were in process of application at the outbreak of war, some of which, in spite of the difficulties, have already been implemented. The

[1] *The Analysis of Social Change*, by J. and M. Wilson, pp. 17–18. Cambridge University Press. 1945.

[2] West Indies 1939, West Africa 1941, Ceylon, Mauritius and Malaya 1943, East Africa 1946. See Parliamentary Papers and Blue Books.

position disclosed in the African Reports, however, provides a clear illustration of the importance of evaluating financial developments from a biological standpoint.

While these examples have been taken from Africa, the danger from administrative measures that ignore the over-riding importance to the community of protecting family stability is of general application. Even in Great Britain it has taken over a generation to secure family quarters for officers and men serving overseas in the Royal Navy, and then it was from reasons dictated by political popularity, and not by social biology.

Many Government and commercial appointments for young men serving overseas forbid marriage, some for long terms of years, to those who should be encouraged to marry and transmit their qualities, with a result similar in effect on the birth-rate to that of over-recruiting in primitive tribes.

Laws and the Family

A clear appreciation not only of the biological importance and needs of the family, but also of its sociological variations will be essential to those who have to unravel the threads of the stranded populations of the post-war world. Laws and conventions affecting the institution need analysis from the biological standpoint and measurement with our yard-stick to judge their effect. Even in Western Europe the position varies widely. In some countries the biological conception of parenthood has already received recognition, e.g. in Norway. Every child, legitimate or illegitimate, is legally recognized as having both a father and a mother. If three or four men have placed themselves within the range of potential fatherhood, no one of whom accepts paternity, the law imposes on all four an equal economic share in the cost of maintenance of the child and the State enforces payment.

In Great Britain a man can divest himself of all responsibility for paternity by proving that others could be equally responsible. Even when paternity is acknowledged and the father's financial contribution has been assessed by the Court, the State takes no steps to ensure continuous payment but leaves to the mother, throughout the sixteen years of the child's minority, the often continuous task of finding the man and bringing him to the Courts to enforce payments.

Many measures, too, that are advocated in all good faith to improve conditions may have unexpected reactions. For instance,

the higher standard of general education for both men and women in Norway led to a higher standard of personal adjustment being required by both partners in marriage. It was recognized that marital disharmony was damaging to the personality of both partners, and moreover, the child would suffer. The legal persistence of a union which no longer had any emotional sanction was rejected as unethical. Divorce laws were drastically reformed.

Since 1918, if adequate financial provision is made for the wife, and the entire cost of the children's education provided, divorce can be obtained with little difficulty. The financial safeguards have restricted its use to those able to meet such economic responsibilities.

In a sociological enquiry made in 1938, this legislation, unsupported by any readjustment of conventions or of popular enlightenment on the social and ethical value of the permanent relationship, was found to have reacted in unforeseen ways. Other factors in Scandinavia favour comparatively early marriage. A high sense of parental responsibility leads partners to remain together until the education of the children is completed; but easy divorce has resulted in large numbers of men between the ages of 45 and 65 leaving their wives after sixteen, eighteen, or twenty years to marry a young girl. The legislation to safeguard a woman from having to live with a man for whom she no longer felt any emotional attraction resulted in many women finding that when they had become too old to remake their own lives, they were left to a lonely old age.

The status of the child born outside wedlock has become an acute question not only from the national, but also from the international standpoint for which a solution must be sought, preferably on biological-ethical lines. While the stability of the family is maintained, the welfare of the illegitimate child and the status of the mother must be ensured. Is it in accordance with biological knowledge or ethical principles to place 4 per cent to 5 per cent of infants born annually in Great Britain, under social conditions which result in a far higher death-rate than among legitimate children, and condemn a large proportion of the survivors to subsequent social and emotional maladjustment? To ostracize from social life the small minority among girls who have premarital experience, those who give birth to a child, cannot safeguard the family.

Recent years have seen large numbers of young women forcibly migrated from one part of Europe to another, some with their families, but the majority taken for war work in distant factories During this time a number have become mothers. What is to be their status? What financial provision is to be made for the child? What policy is to be adopted in the interest of the community, the family, the mother, and the child? While the subject is thrown into prominence by post-war conditions it is a continuous problem in every legally monogamous country.

It is hoped that where conditions beyond the control of the individual have governed the circumstances of unmarried maternity, widowhood status will be accorded to the mother to facilitate her return to normal citizenship in her home district.[1] Another tragic consequence of the war in every belligerent country is the large number of orphaned children. Those residing in their own countries who belong to village and peasant communities will doubtless be cared for by relatives. Large numbers, however, have become entirely detached from their home and family background. The provision of an environment in which they can develop into normal balanced individuals, fit to assume the responsibilities of parenthood and citizenship, is one of the greatest tasks with which communities are faced, and its solution will need the wise application of the principles of social biology. Reports submitted in pre-war years to the League of Nations; others from the present international voluntary and official organizations; the evidence provided in this country, together with that derived from researches into the causes of delinquency and prostitution; all throw into prominence the danger to the child of the 'broken home' background. The orphanage and the institution are now recognized as lacking the primary needs of the child. We must clarify what is physically, emotionally, intellectually, and psychologically necessary to the child, then formulate plans for its environment which incorporate these needs—expressed, of course, in forms appropriate to the culture to which the children belong and to which they must be adjusted. The physical type of the child and its traditional values must be ascertained before it can be placed in a suitable 'substitute' home.

Miscegenation and the Family

As *homo sapiens* of whatever colour or type is one species, there is no physiological barrier to cross-breeding between dif-

ferent branches of the human race. This fact has provided the civilized world to-day, and particularly our own country, with a difficult group of social-biological problems.

The administrator and the social worker in the post-war world will be faced with an increase of marriages and unions between members of different races with the attendant difficulties of adjusting the offspring to conditions of life in their country of residence.

Race mixture or miscegenation has been handled very differently by the Dutch, the French, the British, and the Russians. Here again the biological sciences can even now throw some light on the problem, but this is the field in which observation and research are most urgently needed. The experience available from the various lines of approach under different cultures furnishes interesting material.

In the British Empire there is no legal barrier to marriage between members of different ethnic groups, but there are serious social deterrents. These, at present, have a damaging effect on the social adjustment of the offspring. Available information gives no ground for the belief that the health or physique of the offspring of a mixed marriage suffer biologically, but the difference in the traditional inheritance of the two parents provides an unstable emotional background for the child, which cannot adjust itself to the culture of either parent.

The assertion so often made that the offspring of mixed marriages (or unions of parents of divergent race) are characterized by excitability and moral instability would derive from this cause. A change in values and conventions under which the partners of different colour but of the same educational background could live in a society where no social stigma attached to inter-racial marriages, would be unlikely to provide the child with a mixed traditional inheritance or an inferiority complex. This appears to be borne out by the experience of the West Indies. Some of the most intellectually brilliant men and women are descended from African stock. Both the white and coloured population have a general Christian outlook and live in a community, the social customs of which derive from the Christian ethic. There is, therefore, no basic conflict of traditional values.

Higher education and the Western Universities are open to both men and women, there can therefore be a similar background of factual knowledge. Offspring of marriages between the

educated white men or women with coloured partners do not appear to suffer from any disabilities so long as they are in a social environment where their ancestry is not the object of criticism. Acute psychological danger arises at once, however, when such persons enter other communities and are confronted with administrative barriers and social ostracism.

It is claimed that the mixture of Indian and Portuguese—the Goanese—are a more intelligent and industrious type than the members of either parent stock. They are the result of a deliberate policy of intermarriage promoted by the Portuguese invaders of India in the seventeenth century, the children having the status of Portuguese citizens; they have never been at a social disadvantage in their own country. It is certain that to-day on the West Coast of Africa and the borders of the Indian Ocean the Goanese are accorded a high status by the indigenous communities.

The marriages between Chinese and Europeans usually create far less difficulties for their children, probably because the difference in colour is less obvious and the Chinese who come abroad are often a more educated type, usually in skilled or well-paid employment.

It may not be generally recognized that the problem exists on our own doorstep—in most of the large ports terminal to shipping in the African, West Indian and Eastern trade. Recent surveys in Liverpool and Stepney (London) disclose the growing number of young half-caste children whose future prospects in the home labour market and for personal and social adjustment are bad for the boys and deplorable for the girls. In an anthropological survey 14 per cent of the girls were found to be mentally deficient, and in each this defect was proved to be hereditary from the English mother's side.[1]

The life of the Eurasian, West Indian and African half-caste boy and girl in South Wales, Liverpool, Tyneside and other home ports is not easy; none could return to Africa or India in early adult life and re-forge links with their father's family and occupation to which their English educational background has unsuited them, or find a husband or wife brought up in an entirely

[1] *Report of Investigation into Conditions of the Coloured Population in a Stepney Area.* Chairman of Committee, Rev St. John B. Groser, Rector St. George's, Stepney
Report on an Investigation into the Colour Problem in Liverpool and other Ports, by M. E. Fletcher. Issued by the Liverpool Association for the Welfare of Half-caste Children.
(See p. 341.)

different social, ethical, and religious tradition. Yet what are their prospects of marriage and parenthood, or of good employment in this country? We find, in fact, that numbers of the girls drift into sexual promiscuity, some into prostitution. In visiting the commercial brothels round the shores of the Mediterranean and in India, the writer found that many inmates of the better class houses were girls who were offspring of mixed marriages or mixed unions contracted in the world's large seaports. At present, society has no place for these people.

Either the system of employment of British seamen of a different race should, on sociological grounds, be such that the shipping companies were bound to engage them for the round voyage, only discharging them on their return to their homeland or the implications of the present policy, dictated by the political considerations of the freedom of residence inherent in British citizenship, must be recognized and social provision made for giving effect to it. At present the worst possible impression of Western civilization is given to the coloured seamen visiting this country. Practically the only women they meet are of the unsuccessful prostitute type and social cruelty is inflicted on both women and children in the slums of our seaports.

Probably the largest experiment in race mixture now being made is in Russia beyond the Urals. It is reported that social, economic, and administrative preference is being given to the partners of mixed marriages between European Russians and members of the nomadic tribes of Turkestan and Southern Siberia, but so far we have no information of its social and biological consequences.

Whatever may be the result of research and analysis or of the changes these may bring in public opinion in years to come, we have the immediate problem of the present offspring of mixed marriages, forced by circumstances to live at an economic and social disadvantage in an unfriendly and critical community.

It appears that at present the deep divergence in ethical values, religious outlook, social cultures and educational backgrounds render a mixed traditional inheritance inevitable. The result to offspring would therefore be emotional instability, while divergence in social conventions is usually too great for satisfactory adjustment and economic stability.

A mixed traditional inheritance from parents of the same colour, but of divergent cultures, would also be damaging to the child.

The social worker and administrator who will have to deal with this problem, to-day and to-morrow, can therefore only be guided by the biological fact that a child of any race and in any climate requires as the first essential to normal development, emotional security, and an adolescent, a coherent "way of life" supported by agreed values in the home and a recognized right to a place in the community. These are vital to stability of character.

Education and Research

We have dealt with a few of the current problems of Social Biology and Social Hygiene.

The biological aspects of these problems are beginning to be recognized as such. It is a good omen that the United Nations Organization has among its earliest activities established U.N.E.S.C.O. (United Nations Education, Scientific and Cultural Organization) to promote international co-operation.

The British, Dutch and French Governments with their Colonial responsibilities, are focusing the attention of their scientific associations on biological problems and appointing specialists in the separate branches of biology to their Colonial staffs.

In British colonies there has been real advance since the establishment of the Colonial Development Fund, and the recent enquiries into, and reports on, Higher Education in the Colonies, recommending the establishment of a network of universities throughout the Colonial Empire promise a firm foundation for future progress. The general outlook is, however, still towards the short-term policy of meeting an immediate local difficulty usually related to the economic needs of the colony. It is hoped that in the near future a long-term policy of international research and experiment relative to world requirements will secure more attention and support. It is this broader conception of promoting biological research and applying existing biological knowledge to basic human interests and to man himself—not necessarily the immediate economic interest of a limited human group—that is implied by the term social biology.

The Social Sections of the League of Nations and now U.N.O. bring together the representatives of different nations and different cultures. It is clear that similar problems are confronting administrators and social workers of every continent. Social work of the last thirty years has demonstrated the advantage of applying

scientific method to social problems. It is probable that the acuteness of social problems arising from post-war conditions and industrial pressure on the backward races, will provide the most convincing arguments for this development.

Is it too much to hope that those sections of the United Nations Organization entrusted with the responsibility of research will put high on their list of priorities such vital human problems as miscegenation, human fertility, and the methods of securing to the individual conscious direction over his emotional forces? It is vital that the best available brains of this and the next generation should concentrate their abilities in this field.

The young man with scientific training and a bent for original research has, hitherto, been offered adequate remuneration only by the large industrial corporations whose objectives, naturally, are the improvement or discovery of marketable products. Even in the field of preventive medicine research has been starved, while the wider problems of human betterment have hitherto been practically ignored except by certain of the public-spirited American Trusts The Nuffield Foundation has, however, given a lead to social medicine in this country. Hitherto increases in our knowledge of social biology have been mainly a by-product of enquiries initiated with a different and immediate object. Observations and analysis of the results of living under certain conditions or in certain areas, enquiries carried out with a non-biological objective may throw light on a biological question —the borderland between pure hypothesis and proved fact, can be taken into consideration in an intelligent forecast but is not to be confused with knowledge. It is on this borderland it is hoped that research will be encouraged and intelligent observations focused. For this type of research no immediate financial return can be expected. Hence its rarity.

Just as formerly the social and economic prizes were offered to workers in the material sciences, so in the future they must be extended to cover the biological field if lasting benefit is to result and man rendered capable of handling constructively the forces he now controls. The absence of immediate financial return in long-term policies of social biology results, under present values, in few prizes, no social glory and very low salaries. The young men and women from the universities anxious to "make their mark" choose other careers.

Until the biological sciences become part of the general intel-

lectual equipment of the majority, the results of new researches will not be appreciated. Delay will continue before they are applied.

The introduction of physics and chemistry into the schools has produced a generation of young people who can follow this branch of scientific work; wide application to material development has been made possible because not only have the best scientific brains of the last two generations been attracted to this field, but the time-lag between the acquisition of new knowledge and its application to man's needs is now slight

If world-wide measures to foster human welfare are to be effective it is urged that an understanding of the biological sciences should be widely generalised in all cultures.

CHAPTER II

VALUES

ONE of the contributions social biology offers is evidence of the vital necessity of the stable family to human welfare and personal development. The task of the leaders of this generation is to promote objectively grounded values with sufficient appeal to motivate human conduct. The cleavage between the outworn emotionally rooted values and factual knowledge is to-day creating instability of character in many cultures, not least in Western industrial civilization.

As each culture will in turn adapt their social customs in relation to new knowledge should it not be possible to promote now certain objectively based values that will appeal to the educated followers of all religions? On our capacity to do this depends effective international co-operation in the field of human welfare.

What can be done to close the present gap between real values and social practice? The interpretation of the principles embodied in the Christian ethics, as with all living religions, has slowly changed as scientific knowledge has increased. The newer concepts of social biology intellectually accepted, have not yet been integrated with the emotionally rooted values of the major religions.

To answer these questions it must first be understood (*a*) how values arise, (*b*) what values now motivate conduct in each community, and (*c*) where these run counter to objective truth.

Values arising under conditions of factual ignorance, if unchallenged, retain their emotional appeal after discoveries and developments which demonstrate their error have enriched the traditional intellectual inheritance; the old values become the prejudices of those who are too apathetic intellectually and too fearful emotionally to challenge current interpretations.

Man's intellect has been trained for thousands of years, but conduct and behaviour derive from the emotions, and the human emotions are still at the primitive and childish stage. The weakness of character due to behaviour being so often governed by primitive emotional reactions is one of the difficulties of national and of international co-operation.

The recent dawn of scientific knowledge in the psychological field has thrown light on man's emotional nature, giving understanding of the mechanism of integration and of the inter-relationship of the emotional, physiological and intellectual aspects of personality. Such understanding is a necessary first step towards devising methods of promoting change in personal behaviour.

History demonstrates that with the growth of scientific understanding the interpretations of the teachings of the living religions change; though the rate of change in the teaching of the hierarchies is almost imperceptible in a generation, the customs based thereon alter more quickly. With the spread of general education there is a wider background against which the possibilities for human welfare disclosed by the biological sciences can be appreciated. The slow historical forces could now become conscious and directive. The difficulty of the present situation is the varying content of education, divergence in social structures, and the unevenness of the biological potential in man.

The observation of cause and effect, the careful analysis of the experience of mankind, the seeking of truth through science tends more and more to confirm as objective truth the perceptions of intuition. When the approach by the intellect and by the emotions (or by the mind and the spirit) meet and confirm each other, there, for most of us is basic or objectively grounded truth. To many, when the two lines diverge and give different answers it appears either that science may not have perceived all the facts, misinterpreted them or their implications, or the religious hierarchies may have misinterpreted the vision or its recording may have been imperfect.

For man to express the whole force of his personality in the service of his ideal, this must satisfy both the intellectual and the emotional self at whatever degree of development both may be; it can then integrate the personality into one harmonious vehicle of endeavour to attain a worthwhile and desired objective.

There is ample evidence that changes in behaviour pattern are consciously made when certain values make such an appeal. For example, patriotism led many to fight or work for the defence of their country. That they left their families to do so did not mean that love of home was killed by love of country, but that in the emergency love of country and love of home fused and did not create conflict. In those cases, reason and emotion were both satisfied, therefore the whole personality willingly adopted the

changed behaviour pattern, though its pursuit might destroy the home and even life itself.

The fervour with which an individual will embrace an ideal and concentrate the whole force of personality on its pursuit even when the conduct involved is entirely at variance with instinctive behaviour, is exemplified in all races and cultures.

The strongest primitive instinct is acknowledged to be that of self-preservation, yet death has been and is to-day willingly accepted by the individual who is convinced that by giving his own life he can best serve the ideal that to him embodies the supreme values. Think, for instance, of the Christian martyrs, of many members of the fighting forces of all belligerent countries, of the Indian widows committing suttee, of the Samurai committing *hari-kiri*, and of the political fanatic on hunger strike. The values vary, but the reactions of the individual and the behaviour patterns are similar.

The second strongest instinct, that of race preservation embodying the sex life, mating and parenthood, has been in the past as in the present, canalized in certain channels, or entirely denied expression, by different types of individuals in the service of various ideals which express different values. Think of the convinced religious celibates among the Christians, the Hindus and the Buddhists; of the African 'Braves' on probation for full tribal membership; of many of the unmarried women, in cultures where a high value is placed on virginity at marriage, and marriage is delayed long past the age of maturity.

Whether the values motivating conduct have any relation to true and objectively grounded values does not appear to affect the results. Provided they attract the whole personality of the individual the appropriate behaviour pattern is followed willingly and with satisfaction.

Values and fashions that change the behaviour pattern appear to arise first in a small group, and if socially valuable, or in line with desire, tend to spread, the followers forming groups as a protection from criticism. The mechanism by which the new value and behaviour pattern arises applies to both the ephemeral and to the objectively grounded.

Fashions and values both derive their appeal and their motive-power from the same source. If they conflict, fashion being imposed from within the group has usually more effect on behaviour in daily life than the higher values which are abstract

and related to ethics and religion. For example, if the fashion among the local young is to go to the cinema twice a week, the cost of the seat will be met by great personal sacrifice if parental or earned funds are not forthcoming. One of the most frequent excuses given for the petty larceny of the juvenile delinquent is "to get money for the cinema"! Society accepts and teaches the value of honesty, but the emotional desires of the young "to run with the herd" are the major driving-force directing their behaviour.

Another instance was the outbreak of sex promiscuity among groups of young people, ultimately including considerable numbers, during the high emotional tension period of the war. The opinion of the small group of personal contacts—the working colleagues, the schoolmates, the social circle, can exert the strongest emotional pressure.

The young girl, who in fact looks forward to marriage and a home of her own in the future, joins her friend in the competition to see how many men she can attract to the extent of (*a*) standing her a drink; (*b*) kissing her; (*c*) sleeping with her—whatever the standard of the group may be.

Yet the majority of these young girls were animated more by the spirit of emulation and competition—admittedly along the lines rendered easy and attractive by emotional desires—than by a specific sex urge. Fortunately, with the break-up of the group and a return to normal conditions, many of the "wild young girls" of the early war years are now happy wives and proud mothers. While the values of the family were held, pressure of 'fashion' was the stronger influence in behaviour.

The same crowding out of a real value by a passing 'fashion' is seen in the development of 'fashion' in the interest of 'expanding markets.' In Zanzibar, the industry displayed by those who desired to purchase the bicycles, electric bells, and wireless sets imported from the West, beneficially affected the labour output, but did nothing to improve the standard of living, of nutrition or of family health.

Surely, the first practical endeavour should be to relate 'fashion' to basic values, at the same time increasing the opportunities for free general education based on the scientific approach. If the stability of the family and a happy adjustment of personal relationships are accepted as essential, the administrator and the social worker has a yard-stick with which to measure current fashions, as

well as the trend and content of popular education and social legislation. It must be borne in mind, however, that the approach to a 'fashion' for a different age, or culture group, must be by indirect stimulus. It can never be effectively imposed. For unmarried members of the older generation to condemn 'frivolous' and 'lax' behaviour has little or no effect and in many cases only arouses contempt. As an illustration of the indirect approach may be taken the story of a business man who bought a large consignment of gaudy walking-sticks which he found quite unsaleable in his United States home town, in spite of good money spent on advertising. He took a supply of dollars, went to the film producers and persuaded them to allow the hero in the scenario of a film to be shown in Cuba to carry one of the sticks. He then shipped the lot to Cuba and kept them under cover until the film arrived. He sold every walking-stick at a handsome profit before the end of the run.

The impetus to act must derive from the emotional desire of the individual, as with the members of the audiences who desired the walking-sticks. To direct emotional desires into socially advantageous channels, fashion must be called in as an aid, and fashions are set by contemporaries. To promote objectively founded values related to marriage and parenthood, for instance, it is the young themselves who have to create their own fashions.

An experiment made by the writer during the war, and repeated by others, may give some indication of a possible line of approach.

In a war factory centre where the fashion of promiscuity was rife, a course of film-illustrated lectures on "Science and Sex" were held with a final conference in which the audience were to be the speakers on "What Standards of Sex-Behaviour should be Promoted by the Younger Generation." Tickets for men and women under twenty-five were limited. The two hundred seats were filled. The final views expressed were indignation that vital information had been withheld. Freedom for friendships was stressed if marriage partners were to be wisely chosen. The older generation were pilloried for presupposing that intercourse was the necessary ingredient of holidays spent together by a young man and woman. Strictness for both partners within marriage, with recognized but self-limited freedom in the pre-marriage years were the generally accepted outlook

Youth should be given all available biological knowledge, together with an indication of where this confirms inspirational

visions of truth. Each individual must not only think out and relate values to current fashions, but must desire those he accepts sufficiently to readjust his own behaviour.

Facts may be assimilated intellectually, their implications on behaviour may be perceived, accepted and even demonstrated to others, but unless the new knowledge is related to personally desired values, the moment the emotions are aroused, the traditional behaviour pattern triumphs. We all have evidence of this in our daily lives.

We find ourselves rationalizing our intellectually condemned actions in desired directions. A man wants to go racing, but in doing so he is depleting the weekly family budget. He makes a reasoned case to himself to justify following his emotional desire. He will work better for the change, he will win more than he will spend, he will make useful business contacts—in fact, he intends to go, desires to go, and he goes.

Or, take the story of a young Burmese assistant surgeon the writer met up-country. An intellectually brilliant man who was in charge of a district frequented by snakes. He had a record of outstanding work among those who had been victims of poisonous attacks. While the European medical officer was on leave, his own child was bitten by a poisonous snake. Traditional emotional fears overshadowed all the intellectual knowledge—serums were left aside, and sacred water, the magic stone and temple ablution, substituted. Fortunately for the child the senior medical officer returned in time.

The experiment of prohibition in the United States provides an effective demonstration of the futility of imposing by law a practice at variance with the emotional desires of the community.

Is the full acceptance of certain objective values by different religions and cultures possible? Alterations can be made in laws and regulations, but if they involve changes in behaviour, unless these are motivated by the emotional desires of the individual the result on personal conduct is slow or negligible. Hence the difficulty of enforcing international conventions until their objective is desired by all cultures.

Social customs, conventions and traditional values that dictate personal behaviour vary widely even between countries where all accept in principle the ethics of the same religion, where there is a difference in educational background. They vary even more widely between countries of different religions, some of which have

no common background of factual knowledge. Yet, to-day, to live at peace, in health, and in economic security, nothing short of recognition by all mankind that a few fundamental values are common to all can be effective.

As an instance of a common social and educational background making for tolerance and an approximation in social values may be cited the behaviour pattern and social conventions of the Christian and Mohammedan tribes of Northern Albania. When the writer was resident among them some thirty years ago, these were almost identical. The Christian had adopted a variation of the Mohammedan marriage ceremonies, the Mohammedan had adopted conventions protecting the freedom of women; both were exponents of a local tribal and warlike culture. Both lacked any contact with current scientific knowledge, except the travesty of Western values brought back to Albania by those of its sons who had spent some years in the meat-packing yards of Chicago. The formal banquets accorded to the International Commission by each major tribe in turn differed but little in ritual The hand-washing in running water, a Mohammedan practice, had been adopted by the Christian tribes; the wine offered to his guest by the Christian was similar to that offered by the Moslems, and the tradition that a host must eat and drink first of whatever is offered to his guests—for traditional 'security' reasons derived from the distant past—was stronger than any religious inhibition of alcohol. Both were agreed—the family was the centre of tribal organizations, and offences related thereto were subject to equally heavy penalties.

At the opposite end of the educational scale stands the cultured Mohammedan who has studied at the universities of Europe and India, and has assimilated the continually enriched traditional inheritance of the world in all fields of knowledge and intellectual experience. He interprets the teachings of his religious leaders with a very different emphasis from the Albanian peasant or the nomadic Arab.

Owing to the over-riding effect on personal behaviour in daily life of current fashions, group outlook, and the general level of education, no generally applicable account could be given to-day of the behaviour to be expected from a Christian, a Hindu, a Buddhist, or a Moslem, as such. While the practices in the differing geographical and biological backgrounds of the followers of the major religions differ profoundly on certain fundamental values

both spiritual and social, the cultured followers of each religion find much ground for common understanding. There would be many points of unity, for instance, between thinkers such as Rabindranath Tagore, Canon Streeter and Mr. Jinnah. Such men are citizens of the world, holding in common a background of ordered knowledge, an understanding of cause and effect, of the action and interaction between man and his environment. While they would differ on the emphasis they would place on the spiritual essentials of man's personal adjustment to the Infinite, of man's place in time and Eternity, they would agree on a number of social values relating to daily behaviour and practice, and all would place the interests of the family in the centre of their plan of the social structure. The form of the family and its inter-unit relationships would differ widely as would therefore the forms of social and personal behaviour enjoined by convention. As these are the most deep-seated of emotional values, if social changes are to be promoted, particularly if advocated by followers of a different faith, at home, in the Empire or in the international field, it is vital that administrators or others should first understand the values that motivate the conduct of those among whom they work, otherwise they cannot graft the new strain on to the growing plant with any hope that the sap of emotional appeal will activate the new value.

Religious Values

An outstanding human characteristic is the impulse of man to relate himself to a Beyond-self, to attempt to perceive a 'way of life' that will harmonize both thought and feeling, mind and emotion. The capacity to formulate, and to strive towards an ideal, the desire to understand the why, the whence, and the whither of the individual life is recorded in the history of all cultures.

Religious leaders have proclaimed the facets of truth gained through intuition and inspiration. They have been the beacons that have guided man, and have provided the positive philosophies of life that have been a major influence in dictating his behaviour. Each leader has had to present a picture of his vision in words and on a background comprehensible to the people among whom he lived. Every educator knows that to secure the interest and the understanding of a pupil new knowledge and new values must be grafted on to what is already familiar to his listeners.

Crystal jewels of fundamental truth are to-day embedded in an

incrustation of outworn customs and ancient folklore. All major religious organizations formed to present the teaching of the leaders have been initiated by groups of individuals belonging to the earlier cultures and their successors tend to preserve the practices of earlier days, employed by the leaders to illustrate the underlying principles as themselves part of the Truth. For example, because on the shores of the Eastern Mediterranean over 2,000 years ago it was the accepted custom for all women except the prostitutes to cover their heads and faces when they walked abroad, and as St. Paul obviously would not want the women of the early Christian community to be mistaken for those of lax morals, he enjoined that while the covering of the face (the wearing of the *yashmak*) was not necessary for Christians, they should cover their heads when attending to their religious duties. This for centuries was a tenet of the Christian Church, and in many sects still remains. Even in Africa, where little or no clothing is worn and no face or head covering was ever worn by women, Christian converts had to cover their heads to go to Church![1]

A great many of the social practices now in force among some of the Hindus have become identified not only in the minds, but in the hearts, of the Hindus themselves, with the fundamentals of the Hindu religion, while in fact many are due to the persistence of customs originally deriving from historical and social conditions. This applies to the practice of child marriage. In the parts of India over-run by the Mongol invasion, to preserve the girl child from rape or capture, it was essential she should have a male protector before the onset of puberty, to preserve her from the invading hordes. The teachers of the people were the Brahmins, they supported this 'emergency' policy, and continued to press it long after the conditions had altered from which it arose. Within the Hindu community itself, great efforts are now being made to eliminate the practice, as evidenced by the passage of the Sarda Act in 1929 and the amending Act in 1938 which strengthened the powers to enforce it.[2]

The debates in the Legislative Assembly are a demonstration of the contention that emotionally rooted traditions tend to

[1] There is also a psychoanalytic explanation of this related to belief in conception through the ear. (See Ernest Jones, *Essays in Applied Psychoanalysis*, Chapter VIII, p. 261.

[2] Previously an orthodox Hindu father was responsible for arranging the marriage of his daughter before eleven years The Act raises the legal age to eighteen for males and fourteen for females.

preserve values condemned intellectually, and ultimately create a cleavage in personality.

Those religious systems that become static and anchor "Truth" to the conditions of the age in which they are formulated, die out, the gap between factual knowledge and religious teaching steadily increases until the gulf between the emotional ideal and intellectual knowledge creates divergent values, uncertainty of direction and ultimately, if the emotions are deeply engaged, a cleavage in personality.

Religious hierarchies show the characteristics of bureaucracy and monopoly in opposing change. In their case the opposition has been particularly to changes inherent in intellectual advance. They have taken refuge in appeals to primitive emotion and have probably been an important factor in prolonging the emotional childhood of man. Those religions that reinterpret the form and retain the spirit of intuitional inspiration are dynamic and alive.

To call to mind a few of the changes in emphasis and interpretation in Christianity. The Christian ethic asserts the value of the individual personality, the form in which this principle is expressed has been steadily reinterpreted following the growth of factual knowledge and the changes in social and economic life. The essential value of each individual personality now takes a central position in Christian teaching, but has only recently been interpreted as applying socially and legally to women as well as to men. A girl's marriage partner was arbitrarily chosen by her father, usually on economic grounds. The wife remained in law the chattel of her husband and could not even control her own property until quite recent times. Again, it is often forgotten that in a world ignorant of economics, Church dignitaries opposed the abolition of slavery All are customs now recognized as offences against the integrity of personality.

The strongest emotional drive at the moment is behind the endeavour to provide opportunities for higher education for all who can benefit from it, and to guarantee a minimum standard of living that could enable all to attain to the 'good life.'

The emphasis on monogamy has increased progressively. In early centuries even some bishops were polygamous. It was the Diet of Wurms in the eleventh century that imposed monogamy; while the Prussians (practising Christians) only agreed to limit themselves to one wife in the thirteenth century. In the troubled earlier years of this country, child betrothal and even child

marriages obtained, and are recorded as being "blessed by the Church" up to the Middle Ages. The Catholic Church confirmed the principle of the stable marriage and extended its application to all, independent of property considerations, by making marriage an indissoluble sacrament for its members

The sacredness of personality carried with it the implications of *freedom* both personal and spiritual and of equality before the law as well as before God.

The interpretation given to 'freedom' varies from the actual to the purely theoretical While certain sects claim complete independence for each individual to interpret the Gospels, others impose the interpretations of the hierarchy, but all subscribe to the principle that man has the right to spiritual freedom and therefore the responsibility of choosing his own 'way of life'—this in contradistinction to the limitations imposed, for instance, by the caste system of the Hindu It is also true that while equality before the law was acknowledged in principle Europe suffered right through the Middle Ages from the struggle of the lay world to impose such equality on the Churchmen, while to-day the legal equality between those of the West and the primitive races has yet to be fully implemented.

Of the current variations in emphasis and its effect on social customs and ethical values among different branches of the Christian Community, there are many instances. One will suffice: the people of Northern Europe and that part of the population of the United States deriving from them, have in common a vivid consciousness of independent personality, are intolerant of intellectual restrictions, object to the imposition of any collective control of intellectual development, and have a passion for freedom. From this outlook derives the social insistence on individual responsibility for personal conduct. One result is the social value, supported by convention, attaching to a high standard of personal conduct in matters of sex, of public service and of financial integrity. Those forms of Christianity that emphasize the completeness with which a 'sinner' can be 'saved' by a deathbed repentance have done much to weaken the sense of personal responsibility for the consequences of anti-social actions. Even if the sadist repents at the end of a long life, the sufferings of his victims are not reduced thereby. This attitude can be seen to result in a lower standard of personal social conduct, and a lack of appreciation of the inevitability of effect following

cause. Confusion between a mystical conception and objective fact has had anti-social repercussions. In such communities the main requirement of conduct in marriage appears to be that the outward forms necessary for legitimacy of offspring and the inheritance of property should be observed. Ignorance of the effect of personal adjustment or its absence on the personalities of the partners not being understood, little value was attached thereto.

To illustrate the point from the past, in seventeenth-century Italy it was the social custom for the husband's mistress and the wife's paramour to be invited openly to official entertainments and private hospitality. The veniality of extra-marital promiscuity was accepted together with the indissolubility of marriage. Post-marital promiscuity has always been looked at askance in Northern Europe, particularly in the Anglo-Saxon and Scandinavian countries. No claim is made that many in these countries were not lax in sex relations, but it is claimed that the accepted standards when enforced by social customs and social conventions are a useful indication of current values.

Responsibilty for the care of our fellow-citizens derives from the Christian principle of the Brotherhood of Man. It enjoins the care of the weak, of the poor, of the sick and of the young, upon the Christian community. Lip service is accorded to the principle, but it is applied with no appreciation of the basic emotional needs of the young.

Values not adjusted to objective facts become false values and make for anti-social practice. False values may with dangerous ease be so presented to the intellectually ignorant as to satisfy the mind and release the emotional drive towards their realization by the correct technique directed to the wrong objectives—as for example, the distorted eugenics related to the policy of aggression and aggrandisement by Germany.

More has been done to embody in law the lip service given to ethical values than to guide the emotional desires of the individual so as to secure their full and personal acceptance. The conflicts thus created provide some of the major sources of human suffering in civilized communities. For example, monogamous marriage is enjoined by law in many countries, but the most frequent cause of personal misery is maladjustment of personal marital relationships.

Higher wages do not necessarily imply better conditions for the

family and a fuller life; they may equally well result in increased revenues from drink, tobacco, gambling and the cinema, and the purchase of leisure through absenteeism. The personal evaluation of the good life and the desire for its attainment is the first essential.

In Western Europe the emphasis on the economic aspect of life which arose from the rapid industrial development of the last two centuries, has resulted in far more protective legal machinery for property than for person.

While the general penal code has shed the savagery of its punishments for offences in the last two centuries, the penalties for infringement of property rights are still far heavier than those for offences against the person. A man can get fourteen years for fraud and two years for child assault.

The qualifications required of a chartered accountant are far more exacting in relation to accountancy than the qualifications relative to child hygiene, nutrition and psychology, hitherto required of the individual placed in charge of children or adolescents removed from their homes.

It will perhaps give a sense of perspective to recall the numbers of the followers of the major religions in the world. In previous generations their followers were mainly confined to different continents; with every year that passes, the continents and their populations are brought into closer touch with each other and become more interdependent.

THE MAJOR RELIGIONS[1]

Christians (all denominations and sects)	692,400,000
Mohammedans	209,020,000
Hindus	230,150,000
Buddhists	150,180,000
Confucians and Taoists	350,600,000
Animists, etc.	135,650,000
Jews	16,140,000
Shintoists	25,000,000
Unclassified	50,870,000

The non-Christian population is given as 1,167,110,000 while Christians of all sects amount to 692,400,000.

Broadly speaking, the Christian ethic has been the major influence in shaping personal and social values among the Western and

[1] *Whitaker's Almanac*, 1943, p. 448.

Near Eastern nations for 1,500 to 2,000 years. It is submitted that the biological differences and the variation in the level of factual, particularly biological knowledge in the communities accepting Christianity, have perhaps been a major cause of the wide variations in interpretation and practice now obtaining In spite of difference in emphasis, however, the major Christian values are common to all Christians. The brotherhood of man, the sacredness of human personality, have been the foundation on which international progress has rested. Around these have grown a whole network of village, city, national, and international conventions, customs and social agencies.

Hinduism

Hinduism is difficult to define. Mr. Rabindranath Tagore says, "There are no dogma in Hinduism. You may believe in any doctrine you choose, even atheism, without ceasing to be a Hindu." With the intellectual Hindus to-day the Bhagavadgita is more highly prized than the Vedas. The distinctive features of Hinduism appear to be a vivid sense of the unity of the living world, a general belief in Karma and transmigration. The Upanishads give the description of man's need to free himself from the chain of changing forms of life, the aim is release, the methods by which it is obtained may vary, but those recommended are extreme asceticism—the absence of all desire, or great knowledge. Knowledge is believed to be twofold—higher and lower. To those possessing the lower knowledge, the material and living world appears real. To those possessing the higher, all but Brahman-Atma, is Maya illusion.

In India its popular forms have been so overlaid by social and religious practices arising from historical conditions that to-day the conceptions and values of those reinterpreting its teachings—men like Tagore and Gandhi—are ethically and intellectually more akin to those of the modernist Christian than they are to many of the popular Hindu sects of India.

The caste system, which in our minds is identified with Hinduism, we are now told originated after the Vedas were written. The restriction that the sacred books should only be possessed by the three higher castes was part of a social system devised by the Aryans to prevent the mixture of their white race with the indigenous native tribes. The system persists, though its objective has long been a demonstrable failure.

If all life is one and every form in which it is expressed is of equal importance, it is as great or as small a matter theoretically if a human child or mouse dies. Among Hindus it is easier to secure provision for homes for aged sacred cows or shelter for water buffalo, than to secure funds for the care of destitute and abandoned children. The general belief in transmigration and the unity of life inhibits the destruction of life in all forms.

A narrow and severe application of this belief provides barriers to many sanitary and hygienic measures. Fecundity is highly valued and to give opportunity to migrant souls to assume human form is a sacred duty. In spite of this, in the towns in recent years, information on contraception has been eagerly sought and applied. The infant welfare movement, though mainly initiated in non-Hindu circles, is now attracting mothers of all faiths and is being steadily developed.

The educational leaders of each community are trying to popularize the reinterpretation of the teachings of the sacred books in the light of modern knowledge.

The Devadasi, the religious cult of the Temple prostitutes had its prototype in Byzantine Rome, and appears to be the persistence into the present day of a custom widespread in early historical times. In a similar way, the mystical attributes accorded to certain animals is seen to-day in its original primitive setting, in Africa. While not detracting from the emotional appeal of the ideals of Hinduism, these practices will, it is anticipated, pass away with the advance of general literacy and of factual knowledge.

Buddhism

"Buddhism," a later development from Hinduism, Dr. Cave says: "is not a religion as we use the word, as it is not concerned with God or Gods, but was the revelation of a Way of Life by which release from Karma might be won."

Gautama, the Buddha (560-480 B.C.), was a Hindu who found from personal experience the advised methods of reaching spiritual peace through either ascetism or knowledge to be unsatisfactory, and sought a new method His own revelation was to the effect that the middle way should be chosen.

This is the eightfold path: Right belief, Aspiration, Speech, Conduct, Means of Livelihood, Endeavour, Memory and Meditation, through which Nirvana might be attained.

Buddhism became a proselytizing religion whose benefits were

not confined to any race or caste. Interpretation of the original teaching now varies widely, in Japan and China it has been considerably modified by the influence of the pre-existing religious ideals. In India, the emphasis on transmigration, and the burden of Karma, led to a passive and contemplative way of seeking Nirvana. It was an attempt to reform Hinduism which failed in the land of its origin To-day there are but few Buddhists in India. In Japan its adaptation to the biological characteristics of the race led to its interpretation taking a more active and materialistic bent. The teaching encourages the good life by promising a heavenly reward.

A student of the Far East gave this succinct summary: "In China, Buddhism profoundly influenced the Chinese attitude towards Taoism and Confucianism, and the religious background of the Chinese is coloured by the three systems of thought. Buddhism proclaimed the necessity of active love and compassion; Confucianism, the duty of filial piety and reciprocity in all social relations; and Taoism added the thrill of magic and mysticism."

No attempt can be made to summarize accepted social values in China, except to indicate that the widespread and deep sentiments of filial piety, arising from ancestor worship and the high value attached to the contemplative life, provide an attitude of mind diametrically opposed to that engendered by either Bolshevism or Christianity, and its influence on the personal behaviour pattern of the Chinese is profound.

Young China to-day, therefore, is open to forceful pressure to adopt values deriving from three widely separated rays of inspirational Truth. While these converge to the centre, the popular interpretations emphasize entirely different virtues and provide conflicting social customs. The habitual looking to the past inherent in ancestor worship is perhaps one of the strongest barriers to change, and the foundation of the deep-rooted dislike by China of foreign influence, while the contemplative and philosophic attitude to life is said to explain their contempt of war as a method of deciding moral issues.

Take but one example: that the son alone can secure the after-life of the parents by his prayers, has caused little value to be placed on girl children. The pressure of economic stringency added to this has resulted in the persistence of the practice of female infanticide, concubinage and the sale of girl children. These are, deep-rooted and widespread. Here again, inter-

national progress in the social field will be delayed until the assimilation of general knowledge has resulted in a reinterpretation of religious teaching and a reform of traditional social customs

Mohammedanism

Islam is, after Christianity, the most actively proselytizing religion, and is spreading rapidly in tribal Africa. It carried the Koran and the sword over much of the old world. With its emphasis on the one God and one Faith, and in its belligerent method of presentation, it is a long but possible step forward for the primitive animist. It promises a release from the fears of pantheism, magic, and witchcraft, in a less abstract and simpler form than Christianity, and is, therefore, spreading rapidly among the more backward peoples of Africa, as it fits in with but little disturbance of current practices to the local tribal structure.

For Islam, the family is the centre of the social structure, but emphasis is on paternity. The man's sons are considered as the trustees of the future of the family, and in tribal groups—of the tribe.

The convention of demonstrating wealth and social status by a well-filled harem often leads the older and wealthy men to acquire more women than are called upon to minister to their physiological demands; they are the additional domestic servants and retinue that enhance the prestige of the chief and his 'favourite wife.'

Mahomet himself laid down that five wives should be enough for any man and that the wise who valued their peace of mind should limit themselves to one. Their songs and literature extol as the highest delight in sex expression two divergent ideals—the passing passion for the young and beautiful girl and also the enrichment to life of the lasting association and love between a man and a woman.

Any widely known expression in literature of the woman's attitude to life in Mohammedan countries has not been found.

Buddhism and Hinduism belong to the East, are the natural approach for a contemplative race living under climatic conditions where a simple agricultural economy allows the maintenance of life at a malnutritional level, and where for many generations intellectual interests have followed literary and philosophic lines.

The impact of Western scientific knowledge, particularly in the growing industrial centres, is creating in Asia and Africa a

widespread challenge to existing values. By pressure of circumstances the social economy is changing, factual education is spreading. It is impossible to assess at present the effect of the last ten years of war, and of intensive political propaganda from Russia and from the Western Powers. Reinterpretation of many values sanctioned by the religious organizations are likely to be telescoped into decades where, with Christianity, they have been gradual over centuries. The powers science has conferred on man ill-prepared in the West, where material development has been gradual, are being handed complete to millions, with no time—as measured by generations—to relate new knowledge to local social and ethical values in the traditional inheritance. Emotional instability and an absence of binding moral codes must inevitably result.

Take but one example: in China, responsibility for the behaviour of each member of the family extends to the whole clan; each individual being responsible to the group and the group being responsible for all its members. If one member incurred debts, the family was the ultimate guarantor. Strict control was, therefore, maintained over the activities of all relatives. Honesty, commercial integrity, truthfulness, ranked high in the scale of values. The Treaty Ports brought Western commerce and demonstrated Western commercial morality. The limited liability company is reputed to have undermined Chinese commercial integrity in that it removed responsibility from the family and legally limited the liability of the individual for the full personal consequences of his commercial activities.

If it is agreed that a wider recognition of the fundamental values common to all religions can be most easily attained by the spread of a common background of general, particularly biological, knowledge, it is important that this should be promoted through channels unidentified with any religious system, in order to leave each community free to reinterpret the teaching of their own religious leaders. The danger of attaching to Christianity the objective knowledge which has given rise to modern Western civilization appears to be two-fold.

For those who are adjusted to their own religious system, the rejection by them of Christianity involves the rejection also of the education brought by the proselytizing Christian mission.

For those of other cultures who find in the Christian revelation an angle of truth that integrates their personality and resolves

their conflicts, the acceptance of the Christian faith is a truly spiritual experience, a development of personality, and not a channel of social and economic betterment. The 'Rice Christian' of India[1] and the elderly African who 'turns Christian' to disencumber himself of all but one of his elderly wives for whom his tribal rules hold him economically responsible, retain at heart their traditional values The wise who spread the Christian ethic build the new interpretation on the best in the old culture.

Some years ago in India it was the writer's privilege to give a course of lectures to a large body of Hindu teachers on the physiological and psychological development of the adolescent. The span of years between the onset of the first physical signs of puberty and the attainment of physiological and psychological maturity was demonstrated to be a period of from four to six years, the optimum age for parenthood falling between eighteen and twenty-two years of age. The Sarda Act was at that time before the country, and the question of child marriage prominent in the minds of the audience though ignored by the lecturer. At the completion of the course, the chairman and the members of the Teachers' Committee asked for a private conference. A number of pertinent physiological questions were put and answered factually and objectively. At the end, the chairman turned to his colleagues and said: "This is quite clear; we must have misinterpreted the Upanishads."

Values in Conflict

It would appear that three streams of influence determine the values accepted and the behaviour pattern followed by the individual: the biological type to which he belongs; the culture in which he lives; the level of factual knowledge acquired, or received in his traditional inheritance.

If this is reasonable, then we should see the evidence around us. In the ancient civilizations of the East, where the understanding of human personality and the endeavour to interpret the meaning of life by cultured intelligences has been a major human interest for longer than in Europe, Christianity makes little general appeal, it attracts some of those oppressed by or conscious of dissatisfaction with their own circumstances, e.g. the young mothers of a famine area in China where girl infanticide is practised, the 'untouchables' of Hindu India, the pantheists of Africa oppressed

[1] In times of famine, converts were issued with rice by the missions of India.

with fears of the unknown and the haunting of malignant spirits, all find emotional solace and release and a sense of personal protection in a God of Love.

The groups of the younger generation accessible to Christianity are students attending the Christian Mission Colleges. Many of these tend to identify the economic activity of the West, its industrial development and its science with the interpretation of life presented by its religion.

In Turkey the tradition of the past is Mohammedan, and education has of recent years been provided by the State, which at the same time has withdrawn any official support or encouragement of religion. The official practice is monogamy, this at present is more in the legal structure than in individual sex behaviour, as pre-marital and extra-marital association, both selective and non-selective are prevalent.

The absolute control of the Christian Church organization followed the early pattern of absolute secular government. Fearing that factual knowledge would undermine their power, the authoritarian religious organizations have been a standing barrier to free and widespread secular education in science, particularly the biological sciences. Catholic communities in Northern Europe and in the United States, however, adjust themselves when in a minority to the manners, customs, and conventions of the culture in which they live.

For instance, there is no barrier imposed in these countries by the Catholic Church on those of their women members who seek higher education or practice in the professions, while the social opposition to both these customs in Spain and in South America, where the majority are Catholics, has the support of the Catholic Church.

Another variation in emphasis related to the level of education is the attitude to responsible parenthood. Numbers of Catholic women seek advice at the Birth Control Clinics of the U.S.A., where there is also no difference between the followers of different religious sects in those attending lectures on venereal disease. In Eire, on the other hand, no books or information on contraception may even be sent through the post; no publicity on V.D. either by poster, pamphlet, or public meetings is allowed in many parts owing to the opposition of the local representatives of the Catholic Church. It is also in those countries where popular education is not in secular hands that the recognition of the woman's indepen-

dent rights as a human personality still lags, and where selection of her marriage partner and the management of her property is not yet accorded to her.

There is urgent need for clear thinking and for the reinterpretation in the light of knowledge of the fundamental teachings of Christ; for the sloughing off of the accretions from earlier and more ignorant culture patterns that have become identified with its principles and tend to distort them. This now creates a dangerous cleavage between the methods of expressing the values that accepted facts indicate, and the old methods, devised before the knowledge was available. We recoil from the idea of irresponsible and prolific child-bearing on the part of the defective and the inherently sub-normal or abnormal; from a high infant mortality rate; from continuing a fertile marriage with a victim of transmissible insanity or mental defect, or condemning to celibacy or illicit unions the partners of terminated marriages.

It is of great moment that the proposed reintroduction of 'religious teaching' in the schools should take the form of an endeavour to inspire youth to rethink the traditional forms in which spiritual values are expressed; it is hoped authority will not seek to impose dogmas, but will clarify the truth they embody in a form that may go beyond, but would not conflict with, factual knowledge.

The added personal responsibility deriving from the widespread knowledge and practice of contraception and from an increased understanding of heredity have altered personal values, while social customs and much religious teaching remain unchanged. It is now accepted as a higher value to plan for a consciously desired child. To-day, owing to the values they hold, many are sacrificing emotional fulfilment in marriage because they carry some serious hereditary tendency which they feel it is wrong to transmit.

The value to individual development of both the play and the reproductive aspect of sex also calls for a readjustment of ideas. Hitherto, except between marriage partners, both have been combined in a general condemnation, and only the reproductive aspect was considered respectable.

New social customs, new and personally accepted controls are needed for the play aspect of sex to be expressed in personally and socially satisfactory ways. Further, a community seized of the truth of social biology will appreciate the impossibility of realizing

the spiritual and biological values of the 'unique relationship' in marriage, or of maintaining the balance of population in a social structure that defers marriage until years after maturity, and even beyond the optimum reproduction age.

Truly monogamous marriage, the unique relationship between one man and one woman, is recognized as the source from which the fullest individual development and the highest experience of happiness can be attained; it provides the conditions in which fit and happy children can be reared to follow a like path. The mystics maintain that the integration of personality won through a harmonious human partnership is in the line of the mystical and supreme experience of consciousness of the love of God—of atonement with the Infinite.

For two individuals to integrate the intellectual, physical and emotional strands of personality into an harmonious whole the prerequisite is that each strand in both individuals should have the capacity to respond.

If one individual is sub-normal biologically in mental capacity, a mental defective, or has been psychologically damaged and remains emotionally infantile, unable to attain any permanent emotional focus—obviously no equal mutual partnership could be attained.

It is urgent that the current values affecting the family should be related to objective values if Western civilization (apart from misdirected atomic energy) is to persist.

Biology and inspired religion agree on the value of the harmonious and permanent partnership between one man and one woman as an expression of both objective and intuitive values, but as later chapters indicate the social structure and current fashions create serious barriers to their practical application. The question one would ask the religious hierarchies is what leadership are they prepared to give in relating objective values to the interpretation of Christian principles?

For two fully developed individuals to make a free choice of a life partner, demands opportunity for selection based on knowledge. The strong probability is that such knowledge should exclude pre-marital sex intercourse on scientific as well as ethical grounds.

However, there is surely an objective difference between a single pre-marital sex adventure with emotional sanction but without parenthood or a single experience between adolescents

and the persistent promiscuity of an adult? There is as great an objective difference also between a single pre-marital experience and deliberate and persistent extra-marital relations with their danger to family health and harmony At present, the religious organizations appear to consider all as equally serious.

The problem of some form of recognized marriage between the unfit who have been voluntarily sterilized has not yet been faced. Yet it is an obvious corollary to the social recognition that they are unfit for parenthood. Is it just, humane, ethical, or a practical policy to deprive them of a home and a life partner, of an outlet for their affections?

It is recognized that the churches would wish such unions to be legal contracts as they claim that the sub-normal (when recognized as such) could not enter into "the sacrament of marriage." This inability of the sub-normal and the psychologically abnormal to adjust to stable marriage, while recognized as a fact, has not yet been fully assimilated into the cultures and values of even the progressive countries.

It is true that the grounds for divorce have been extended, and the grounds on which marriages can be annulled by the Catholic Church take cognisance of the physical and mental conditions of partners and of potential offspring, but the implications of monogamous marriage have not yet been clarified, and Europe has raised few legal barriers to marriage on biological grounds.

A community is not supporting biological monogamy as a social and ethical value by limiting a man to one legal wife and a woman to one legal husband, and at the same time maintaining values and conventions in the social structure that discredit marital happiness, that encourage promiscuous adventures as the source of relaxation and amusement; that treats sex as the main topic of indecent jest and at the same time as of supreme importance In our own country, where the level of education is reasonably high, the standard is measured by the results in the subsequent money earning capacity of the pupils far more than by their success in attaining a balanced emotional adjustment to life and in their family relationships. Yet economic success is presented as the means to the end of providing a home and family

The Government and business administration offer employment to the young adult of both sexes with the prohibition of marriage attached. The country provides education to its youth but omits

positive teaching on the place of the family in the community and preparation for marriage and parenthood.

These omissions are not deliberate anti-social behaviour, but are due to the absence of constructive effort to relate social practice to fundamental values.

If the development of human personality to its highest potential is the basis of human progress, then the knowledge we have of what influences that development for good or ill must be applied and related to the ideal. We already recognize that a man cannot hit a child on the head and render it imbecile for life and still maintain his position as a free and responsible citizen. Because cause and effect are not immediately visible, we do not, however, recognize our own duty as a community, to protect posterity from a like injury from inherited defect, or from emotional starvation in childhood.

Early marriage, to be encouraged in the interests of the individual, the community and posterity will inevitably have a percentage of failures, as do marriages at all ages. Individuals develop intellectually and emotionally at different ages. Opportunities to rectify mistakes in selection there must be. The forced maintenance of the form of an intimate relationship that has not only ceased to be a partnership but has become a source of active friction, if not due to remediable causes—can only become harmful to parents and offspring alike. The whole weight of value and convention should, however, be on the careful selection of partners, and subsequent failure to adjust, even after the resources of science have been sought, should be recognized as a failure in personality.

A man who fails in business goes before the Bankruptcy Court. Having met his liabilities he can start again, but failure is recognized as such by the community—so it could be with marriage.

Often different and even primitive cultures have appreciated the biological needs of the family more clearly than the West, with its over-emphasis on the economic aspect of life.

While marriage, in all cultures, involves the control in a monogamous union of the sex life of the woman (apart from the seasonal fecundity religious rites of certain tribes), in many, the play aspect of sex is provided for during the post-initiation—pre-marriage period—its limitations being strictly defined by tribal law. The conventions governing this period vary, but in none are the young so devoid of self-imposed control, or of guidance on the basic facts of the implications of mating, marriage and parenthood, so open

to influence of group fashions, as the youth of this and other Western countries, who are kept in ignorance of either the social or biological implications of sex in social life. The cleavage to-day between the ethical values 'accepted' and the group fashions followed by the young is wide, and a serious cause of emotional instability and of social maladjustment.

To sum up—an endeavour has been made to marshal familiar facts to illustrate the continuous change in accepted values and the urgent need to embody in the influences promoting change such factual knowledge as will lead to a challenge to customs arising under conditions of ignorance. If ethical principles can be related to current knowledge there is some hope that objective values will be accepted and embodied in custom.

Some conflict is, of course, inherent in all growth, but the extent and rapidity of the growth of scientific knowledge in the last fifty years in the West, and the increasing force of the impact between different races, religions and social structures throughout the world, have greatly intensified the present strain. There appears a real danger that the emotional instability caused, coupled with the absence of a recognized basic unity of value, will contribute considerably to the difficulties mankind is now facing. It is claimed that some of the strain would be eased by a more rapid dissemination throughout the world of factual knowledge.

International progress depends largely in the recognition by all, of objectively grounded values, particularly those related to the family.

A widespread democratization of science, particularly the biological sciences in their human implications will inevitably lead in the future, as in the past, to a reinterpretation of religious teachings and practices in conformity with factual knowledge and thus increase the common basis for understanding and endeavour.

CHAPTER III

THE INDIVIDUAL

THE absolute values of the philosopher, that are the thought conceptions of the few, remain abstract values. Our concern in analysing the activating forces of human behaviour is with the impact on, and interpretation of, values by the individual. To promote human behaviour patterns which give promise of human betterment we are therefore concerned equally with the essential value and with the individual by whom it must be accepted before there can be any effective reaction. We must recognize what governs the capacity of the individual to accept and give practical expression in daily life to values affecting personal behaviour. To do this, some attempt must be made to understand the potentialities and limitations of the individual.

Any effective policy for raising the standard of health and welfare in a community must start from the individual. If manners and customs prevail that make either for the deterioration of physical quality or for the prevalence of anti-social methods of behaviour, these can only be altered when the cause has been recognized and removed. For instance, while the prevalence of tuberculosis is recognized as due in some cases to inherent constitutional causes that make certain people easier victims of infection, it is recognized that persons with no such predisposition will develop it if exposed to sufficiently bad conditions of air and under-nourishment. Preventative measures require not only a reduction in over-crowding but a change in personal behaviour—to sleeping with open instead of closed windows—not only the social recognition of the need for adequate nourishment but a change in the type of food necessary to provide a balanced diet. For rapid and lasting changes the individual must appreciate the causes of disease and co-operate in their removal. Curative measures alone have as little chance of success in eliminating a 'behaviour' disease as the housewife has of drying her kitchen floor if she mops it up without turning off the tap that has caused the sink to overflow!

The limitation of the capacity of the individual to develop and adapt is the governing factor in human progress or even in the ability of the human race to persist. While variations between

individuals have been obvious throughout the ages, the causes of these variations are only beginning to be understood; man is now conscious that he can control his environment, can apply his intelligence, forethought and energy to devising different environments and values that it is anticipated would lead through biological-social selection to the gradual preponderance of different types of human personality.

The persisting conflict between two ideologies is in essence a conflict in the method by which knowledge can be applied in order to attain an agreed objective. One, relying on outside pressure, violence and force, the other seeking to secure the willing co-operation of the individual in making the necessary changes.

The former method can only be effective so long as the violence is exerted and the pressure maintained; the latter carries within itself the hope of permanent improvement. The clock cannot be put back. Man must take note of what is happening to the human race and endeavour to understand the inter-play of factors that make for social adjustment or chaos, that promote or impair the welfare, happiness and personal development of the individual that he may promote an environment in which the factors beneficial to human progress will operate favourably.

The cynic claims that "human nature does not change." Does he intend to convey that human nature is unchangeable in those aspects it shares in common with all living things?—or does he mean that there is a pattern of behaviour common to all human beings? Or only that each human follows the life cycle through birth, growth, maturity, reproduction, senescence and death? That each individual is provided with the organs common to the species—limbs, senses, muscular, circulatory, digestive and reproductive systems, slightly more complex but deriving from the mammalian world? In common with the whole of the animal kingdom, man has the power to move, to acquire nourishment, mate and reproduce. Surely this is not the connotation of "human nature"? Even these attributes do not make for uniformity, either in appearance or behaviour. Are there not wide differences in the form in which human nature expresses itself?

Consider a Chancellor of the Exchequer presenting his budget to the House of Commons—a clear picture of complex world finance in his mind and a command of language with which to depict it to his fellows. Contrast with that the nude grass-girdled

African pigmy. Both are human, yet appearance, mind content and behaviour pattern have nothing in common.

The basic characters of the mammalian group, plus a capacity for language, for abstract thought and forethought, developed in the one and but dawning in the other is the only *human* distinction. These obviously differ profoundly.

In each individual, physical, mental, and emotional characters are all subject to wide variation. Man may be tall or short, with a good digestion or bad, a black skin or white, he may acquire facts and understand figures without effort, he may have the capacity to compose an oratorio or be tone-deaf; he may be inherently promiscuous or innately monogamous. There is no end to the physical, intellectual, and emotional forms in which "human nature" may be expressed in the individual.

The difference between the human and other animals is a development of the intellectual and emotional equipment which enables man to reason and to appreciate spiritual values—abstract ideas; the capacity to control or direct instinctive behaviour by reason—the capacity to remember and to co-ordinate knowledge, to apply the results of experience. As is to be expected, these characters that are distinctly human, being the more recent evolutionary developments, are more variable than those held in common with the animal kingdom. It is desirable to give to the term "human nature" a clearer meaning. Surely it should designate those attributes which are peculiar to the human and not shared by the animal kingdom? In short, conscious behaviour, understanding, forethought. These are the characters most influenced by agencies under human control—environment, traditional inheritance, and ethical values

What are the factors and influences that go to the make-up of an individual?

1. The inherent and inherited capacities conferred on him at conception by his parents.

2. The physical environment in which he lives from the moment of conception and throughout life, including climate, nutrition, the general physical and emotional surroundings.

3. The traditional inheritance, embodying the family life and pattern of his childhood, the social structure of the community in which he lives, the religious beliefs, ethical values, educational facilities, and the common background of general knowledge of his age and generation.

Hereditary, Environment and Traditional Inheritance vary for each individual in the same country; they differ profoundly in emphasis and content between cultures, though the biological laws which govern their effect on the individual are of universal application. Without some knowledge of the factors that limit the potentialities for individual development, no administrator, educator or social worker can adequately cope with the health, welfare and behaviour problems of any community. The growth of knowledge of the biological sciences during the last thirty years has thrown very considerable light on each of these streams of influence, and yet of all, our knowledge is slight in relation to what is still unknown.

It is therefore urged that an adequate course in human biology should be required of all proposing to work among their fellows. Environment plays so large a part in the potential development of the individual that the assessment of what is basic and inherent can most safely be made through the analysis of the evidence of variations in a single community living under the same general conditions of environment and tradition.

It is not proposed here to cover the ground of the mechanism of human heredity, as this has been done often and well.[1]

The researches that have spanned the years from Darwin and Mendel to the present day disclose a complex and fascinating mechanism, of which the details still claim the attention of the scientists. Many characters are inherited as units, others are linked in pairs or groups. Some are dominant and obvious, others recessive and often masked.

Each individual receives at conception the potential for the development of the limbs, muscles, circulatory, digestive, respiratory, reproductive, motor and endocrine systems, the senses and their mechanisms of interpretation. A wide variation is apparent in these in each generation, some traceable to the family antecedents.

While tallness is inherited as a unit character in some plant species, in the human inheritance, it is very complex, but other characteristics, such as eye-colour, are inherited in a fairly simple manner, and in general brown eyes are dominant to blue. Other characteristics, such as colour blindness and haemophilia (bleeding

[1] For a brief and clear outline, giving information up to 1939, *Heredity, Eugenics and Social Progress*, by H. C. Bibby. Victor Gollancz Ltd., London; and to 1945 *Sex in Social Life*, Section 1, pp. 15–87, "Biology of Sex" by Dr. C. H. Waddington. Allen & Unwin Ltd., London, can be strongly recommended.

discharge) are linked with sex. Thus a haemophilic man usually has children who are apparently normal, but his daughters will, in fact, receive the gene, and although it has no effect on them, transmit it to about one-half of their sons.

The inheritance of mental characteristics is not yet clearly understood, but some important facts are known. Certain hereditary mental defects are recessive; that is, they are carried, but 'masked' by those members of the family who are themselves quite normal. If two such normal but "carrier" persons mate, and produce offspring, some of their children might receive a recessive gene from each parent, and thus be mentally defective. It also seems probable that special characteristics, such as those leading to musical ability, may be inherited in a somewhat similar fashion. Thus, if a marriage occurred between two people not themselves musical, but members of musical families, they could expect a proportion of the offspring to be musical, as this also is a recessive character. Among the members of families showing some mental character that is inherited but recessive, there are a proportion of each generation who do not carry the recessive gene at all. Their offspring, therefore, could not inherit the character—whether it be mental deficiency, a tendency to insanity or musical ability.

For the human, the points of greatest interest are not that the absence or presence of an extra finger joint should be inherited (though the tracing of these characters throws valuable light on the mechanism of inheritance), but whether immunity to certain prevalent diseases is hereditary, to what extent mental and emotional capacities are inherited and what factors determine behaviour? The literature on the subject is now extensive but of variable quality.

Research has covered a wide field, including studies of inheritance in plants, insects, mammals and man—incidentally, they have brought to light the effect of the glandular equipment in linking physical and emotional reactions in animals which by observation and research are also found to apply to man.

The injection of certain glandular stimulants to female rats and dogs increases the parental instinct, the mating instinct, or the herd instinct. The waltzing mice, the dancing rats are well-known examples of 'behaviour' inheritance. The inheritance not only of unit physical and mental characters, good and bad, from the standpoint of the individual and the community, but

also of the quality and development of each hormone and secretion-producing gland which stimulate and co-ordinate the three strands of human personality, are now appreciated as key factors in the inherent and hereditary make-up of the individual.

At conception the new individual is endowed with a potential to development governed by the chromosome content of the parents and by the reactions on each other of the units contained in the two streams of inheritance. To what extent the potential is attained depends on the environment; the form in which the potential is expressed in behaviour depends on the traditional inheritance. For instance, a parental stock may transmit the factors for tallness and a large physique, but malnutrition from infancy to adolescence will check its development. A good example is the small-statured town dwellers who migrated from Britain to New Zealand and whose offspring returned to win our admiration for their physique and good-looks in 1914–18. On the other hand, no amount of good food, educational facilities or wise care can add to the intelligence of the hereditarily mentally defective, or to the build of the inherently small-statured.

In addition to the inheritance of the potential to develop certain physical, intellectual and emotional characters a pattern of development is also inherent. The period from conception to birth varies with each species, but within the species it is practically constant. The ovulation cycle of a woman (whatever her colour) is about twenty-eight days. A human infant requires a nine-month period of gestation irrespective of any environmental factors. While there are still certain primitive cultures which apparently do not connect the act of mating with child-birth, the majority of the human race have built their social structure round the sequence of mating and parenthood.

Recognition that the later periods of human growth and adjustment are equally clearly defined, and just as much a part of the inherent development pattern is more recent.

In children under seven, a pattern of emotional development can be discerned whether they live in Britain, Japan, Argentina, or Fiji. All devise for themselves, or are provided with, similar types of toy. Something to make a noise—rattles from bells, shells or seeds; something to drag—trains for the Western child, a block of wood tied on a string for the Eastern, a calabash on a grass thong in the Tropics. The play of the human child takes the

form suited to its age, whatever its colour, whatever its traditional inheritance.

The foundations of physique and emotional stability are said to be laid between birth and the seventh year. The school years of childhood from 5–11 are the period of quiescent growth and unconscious absorption of the emotional values from the home and from the school.

No systematic popular education has, however, yet brought to all parents or to the administrators of the Social Services that understanding of the emotional make-up of the young child that is vital if its needs are to be met, nor planned the social structure to meet the needs of the adolescent.

It is, therefore, essential to success in handling behaviour problems and social adjustments that workers in this field should have up-to-date knowledge

Adolescence provides both the administrator and the welfare worker with their most difficult problems, because the need for social adjustment is both intensified and complicated by the rapid physical and psychological development of this age. In almost every culture it is during the period (between 15–20) that the responsibility of citizenship is conferred. The physical signs of puberty which appear in the age span of eleven to seventeen (usually a year or two earlier in girls than in boys) mark the beginning of the process. In those races where reliable enquiries have been made, the peak age of onset appears to fall between thirteen and fifteen. The adjustments of adolescence—most of them invisible after the immediate onset of puberty—are not generally recognized as covering a span of from four to six years according to the development and complexity of the traditional inheritance to which the growing personality has to adjust. It is during this period that the different strands of the individual make-up are welded into a mature personality, that environment and the traditional inheritance can make or mar the individual.

The endocrine system, inter-relating the physical and the emotional, adjusts the balance of personality, and completes its complex development. During the adolescent years, a good inheritance can be thwarted, diverted, or developed, or the effect of a bad inheritance mitigated, by measures designed to protect both the individual and the community from its potential dangers.

The physiology and psychology of adolescence must be fully studied and understood if our own and other social structures are

to be adapted to human needs. They have been well and clearly presented by specialists of experience and will not be recapitulated. Suffice it to say that the keynote of this period should be quiet growth, ample physical, intellectual and emotional nourishment and stimulus, with the absence of strain and avoidance of conditions which canalize sex towards physical experience.[1]

It is agreed that heredity involves the transmission of the basic physical structure of the species, of unit characters, of the development pattern, and usually of mental capacity.

So far even our knowledge of obvious hereditary conditions has not yet been applied constructively. Take but one example. Mental characters can be and usually are, inherited. There are some three hundred thousand children and adults in Great Britain whose degree and type of mental deficiency brings those under sixteen within the definition required by the special clauses of the Education Act, and those over sixteen, within the protection of the Mental Deficiency Act.[2] Hitherto administration has been such that a large proportion of these have not received care from society adequate to protect either the individual or posterity. Though all may not be defective from hereditary causes, none are fit for the responsibilities of marriage and parenthood.

The report of the Mental Deficiency Committee stresses the fact that mental deficiency is found in all races and in all social classes but that certain families appear to form a 'social problem' group in that their members contribute a disproportionate number to the defective, the maladjusted and the criminal members of the community.

Confirmatory evidence of the effect of inborn characters on the conduct of the individual comes from Cyril Burt's study of the young delinquent, in which he comes to the conclusion that: "congenital factors have been recorded among delinquents rather more than three times as often as any non-delinquents; and non-congenital factors less than three times as often: 'Hence the share of innate conditions in the production of juvenile delinquency is beyond doubt considerable' . . . At the same time, there still remains a large balance of offenders—between 60 and 65 per cent of the total—whose lawless actions have been precipi-

[1] "Sex in Social Life," Section II, pp. 88–115, *Physiology of Reproduction*, by Professor F. H. A. Marshall. Allen & Unwin Ltd., London.

[2] *Adolescence*, C. M. Fleming. Routledge & Kegan Paul, London, 1948. *Psychology and Adolescence*, Cove Allen & Unwin Ltd., London *Adolescence*, Stanley Hall. Appleton-Century, New York. See Appendix

tated primarily by the difficulties of their environment, or by the events of their own past life."[1]

Among those now suffering from a form of mental deficiency and an absence of moral and social perception are the victims of the terrible disease of *encephalitis lethargica*, and while the individuals are only too often permanently damaged by the acquired disease, it is due to no hereditary cause, and its results in the individual are not transmissible to the offspring.

The recently developed application of knowledge of the measurement of variation in mental capacity has led to the development of its social application through vocational guidance. This should, when current misunderstanding and prejudice is overcome, lead to the better adjustment of the individual to his occupation and environment, thereby contributing materially to individual happiness.

The analysis of individual histories in Sir Francis Galton's *Inheritance of Ability* demonstrates the concentration of ability in the professional classes. While mental deficiency and ability both appear in all branches of society, mental deficiency tends to drag down the family in the economic scale, inherited ability tends to raise it. Therefore higher proportions of the able are found at the top, and of the mentally defective at the bottom of the economic scale.

The development of social structures along lines that will ensure that members of able families obtain educational opportunities for their children, in whatever self-supporting occupation they happen to be, is therefore vital to national health That ability is widespread in healthy and mentally stable families and can be discovered through opportunity for expression, has been demonstrated both in our own war effort and the uprush of scientific and industrial ability experienced in the U.S.S.R. It must, however, be borne in mind that the values held by the community determine the types of character and ability that will be socially selected and established. The range of human variation is so wide that any type valued will be thrown into prominence. Those individuals possessing the desired character are sought after and social conventions grow up which favour their selection. It has still to be discovered what are the factors that at present cause a reduction in the size of family among the socially selected groups. One of the difficulties in any long-term policy of

[1] *The Young Delinquent*, by Cyril Burt, p. 605. University of London Press.

improving human quality is the present tendency to sterilization apparently inherent in success.

There are several reasons for the popular impression that a new type suddenly appears. Some will be 'Sports' or mutations—that is to say, their peculiarity may be due to an accidental condition that affected the mechanism of inheritance, and therefore not apparent in the ancestry though probably transmitted to offspring. As an indication of what is meant—the colour of the flower of the evening primrose changed when the plant was moved to a different climate, but the change persisted when the seeds of the plant were sown in the original home soil.

In some cases the character or ability may have been unexpressed through lack of demand or opportunity, or expressed in a different form. Ancestors of a family now showing high intelligence may have expressed theirs in a simple agricultural environment, while their offspring, with wider opportunities will gain technical, professional or literary prominence. We see an example in the Scottish crofters, who in their fight with the elements in isolated crofts have often needed high intelligence to wrest from the land a bare subsistence for themselves and their families, contributing sons and daughters who have made their mark as leaders in every profession and industry in the Empire. In these cases it is not only inherent ability but also their traditional inheritance which endows them with self-reliant characters and a strong sense of the essential values.

The hard lines of demarcation drawn in the earlier days between heredity and environment are becoming more and more blurred as knowledge increases.

We have seen that the lethargy and disinclination for sustained physical effort displayed by the majority of Africans, formerly considered an inherent characteristic, is now believed to be largely a disease due to malnutrition. With the removal of the burdens of malarial infection and hookworm, coupled with the adoption of a more complete and balanced diet, this lethargy disappears and it is claimed that the healthy, well-fed African's *per capita* output of physical effort compares favourably with that of the European, and his resistance to diseases rises. It is encouraging, too, on the psychological side to find how rapidly the young men of the primitive tribes of Africa can acquire skilled techniques, and assimilate elementary scientific facts.

Western knowledge, associated with Western values, is being

acquired by individuals brought up under tribal conditions, whose families continue to live in accordance with the local traditions and values. This absorption of divergent values inevitably makes for emotional instability in such individuals owing to the rapid changes it involves in their personal adjustments to family and industrial life. The fact remains that the young Kekuyu makes an excellent hospital orderly and in many cases is a technical assistant to an overworked Medical Officer, meticulous in his technique and accurate in his provisional diagnosis. In this field the careful observation of existing experiments is badly needed, but such as have already been made are encouraging. These observations which stray somewhat from the intended summary in broad outline of the existing knowledge of heredity illustrate two points; first that we have a knowledge of the mechanism of heredity and of a number of conditions that are inherited; secondly, that many inherited potentialities are undeveloped and that defects similar in appearance and behaviour-results to those due to heredity, can be acquired from environmental causes. Therefore, in planning legislative and administrative changes a careful analysis must be made as to causes from which derive characters of advantage or disadvantage to the individual and to the community.

Broadly and briefly, what do we know? We have a fairly clear conception of man's biological place in the web of life, of the trends that have governed the development of his bodily structure, of the complex mechanism that links the generations. We know something of the basic requirements of the human at each age stage. Psychology, anthropology and endocrinology have of recent years widely extended our understanding of the emotional nature of man.

The life of the cell can be followed, the story of fertilization has been told. We have still to ascertain what influences, if any, can be consciously and deliberately exerted to direct the mechanism before two parental gametes fuse. The two focus points of present research are: (1) To seek the means to control the sex of offspring; the mechanism of the inheritance of sex has been traced by the scientist, but so far man cannot decide at will the sex of his own child. (2) To establish the dates of highest and lowest fertility for partners in marriage; the ovulation cycle is understood, but what controls the individual variation in ovulation, and therefore governs the time of conception is as yet unknown. The

full understanding of these two points will be an additional step in personal freedom, and to apply such knowledge in relation to basic values will be an additional responsibility for the individual.

We now appreciate that the degrees of influence on the individual of heredity, environment and traditional inheritance are so interdependent and interlocked that no hard-and-fast line of demarcation can be drawn between them.

There still remain, however, the environmental factors inherent in geographical conditions, such as climate, chemical constitution of the soil, nutritional limitation and disease prevalence that materially affect the development of the hereditary potential. While these may be alleviated in the future by the application of science, the actual types of human being in the world to-day are seriously affected by environmental conditions. These are most clearly recognized by the Western observer among primitive communities, as it is more difficult to see objectively the restrictive influences of one's own environment.

In considering the individual from the standpoint of the *administrator, the educator and the welfare worker, it is behaviour* problems that loom largest. A man can defraud or use violence in any culture, whether he is feeding in a Western hotel, or drinking milk as a Hausa of Africa Men and women can be promiscuous in their sex relations, whatever the climate or the menu. The extent to which they do either depends on the content of education—the manners, customs, and values, in fact, on the traditional inheritance. This needs sympathetic understanding before changes in behaviour patterns can be successfully developed.

Many well-known phenomena hitherto quoted as evidence of the "unchangeability of human nature" are now recognized as the expression of primitive unanalysed and undirected emotional impulses. Man is in the main intellectually adult and emotionally childish. The traditional inheritance often embodies customs and practices assessing a low "expectation of conduct" on the emotional level. It accepts as inevitable that the sex life of mankind is outside the control of reason. We are paralysed by the half-truths "self-preservation and reproduction are the strongest primitive instincts" and "if the race is to continue, sex cannot be weakened or suppressed."

The instincts of self-preservation and reproduction provide the motive power of most of human activity, but the form that activity takes varies from age to age, from culture to culture.

Self-preservation in the cave-man was expressed through a club. Apart from war conditions which for a decade have demonstrated the human in the grip of primitive emotions, we had proceeded so far along the road of co-operation as to consider personal violence an offence to be punished by the community.

Within the framework of the nation, self-preservation now expresses itself not with a club, but with a mining drill, a coffee crop or a batch of shares; it has shifted its form of expression from the physical to the economic field.

The whole of civilization has been an attempt to direct the instinct of self-preservation into channels helpful to man and the community. It is only recently that our knowledge of the biological sciences and our better understanding of human personality have led us to realize that sex and the reproductive instinct can also be directed and used for the betterment of the individual and the race. We need, by the application of intelligence, to relate this knowledge to our ideals. The energy that has been directed to training the intellect must now be directed to enabling man to understand and to secure conscious control of the emotions.

The ignorant tradition that the period of adolescence begins and ends with the onset of its physcial signs has been the cause of much social damage and administrative error. Why the tradition grew up that the different branches of the human race should vary in one of its major physical processes of growth and be stable in another, is hard to understand. Nobody questions that the period of gestation is nine months, whether the mother is an Eskimo or an African, a European or an Asiatic. Yet the equally complex adjustments of adolescence which span a period of approximately six years are assumed to be completed on the twelfth, or the fourteenth, or the sixteenth, or the eighteenth, or the twenty-first birthday, according to the legal and social pattern of the different countries.

Fortunately, the interchange of social experience through international organizations and the growth of medical and biological knowledge is leading to some adjustment of the European social structure to the needs of the adolescent. Special food, protection, conditions of work, and a limitation of the degree of legal responsibility, up to the age of at least eighteen, are points appearing in International Labour and Social Conventions and Recommendations. The effective extension of the adolescent period, however, is still incomplete and glaring anomalies remain. A

'man' of 18 is required to give his life to the defence of his country, but is not allowed to manage his property. He is allowed to marry and have children but is not allowed to purchase a house.

To what extent have we recognized in legal practice and in social custom the accepted fact of variation between individuals or of the period of adolescent emotional instability?

Many countries and most colonial dependencies have no legal definitions that accord protection and guardianship to the "mental defective" of any age. The "dull and backward," though a recognized group in the educational system, requiring the provision of Special Schools, which forms the largest class of inmates of voluntary homes and contributes considerable numbers to approved schools under the Home Office, are not subsequently recognized or provided for.

The Child Guidance Clinic is touching the fringe of the problem and acquiring valuable knowledge and experience.

In spite of the more or less homogenous background of values and customs there is in this country considerable maladjustment between the individual and the social structure. This is far more acute, however, in those areas where Western civilization makes impact on primitive cultures.

The child is essentially father to the man, in that the experience of the individual from birth to maturity will very largely govern the extent to which his hereditary potential will develop, and will permanently influence his emotional adjustment. It is agreed that the human characteristic of adaptability enables adults to change their behaviour patterns. The inherent potentialities, given opportunity, can develop throughout life. That new values can, at any age, release the full emotional driving-force in pursuit of an ideal considered worth while is the basis of the work of the minister of religion, the politician and even the advertiser.

Were this not so indeed any hope of human betterment would be vain. It is for the adult and mature to plan and work, to pursue and apply knowledge.

It is the recognition of human variation in capacity and responsibility as a biological factor that needs to be applied constructively to social development, if anything approaching a truly democratic structure is to be created.

For the legislator, the administrator and the worker are ulti-

mately dependent for the success of their plans for social betterment on the capacity of the individual to benefit.

Education is useless to the mental defective; economic opportunity cannot be seized by the under-nourished; hortatory exhortations at variance with tradition or custom are ineffective. The essential to success in any social effort is an understanding of the individual, of his heredity, environment, and traditional inheritance. To this end the introduction into the educational system of biology related to human affairs is vital. The voluntary effort expended to secure this is an example of the slow but effective methods of democracy.

Just as science had to fight the classics and the arts in the last generation to obtain any place in the curriculum, so biology has had to fight all the rest of the interests to obtain even a small place in the sun. It is no easy matter to gain admission to formal education for new knowledge. Before qualified teachers are willing to train in a new subject, ability to teach it must be proved to be a personal asset. Local Education Authorities, as the employers, must be convinced that the subject is necessary. Unfortunately the majority of members of Education Committees are elderly and do not readily accept new ideas. One advantage of democracy, however, is that public opinion can stimulate the perceptions of authority.

The usual answer given ten or fifteen years ago by the Director of Education (usually with Arts degrees) and his Education Committee to the request that biology should be taught, including the human reproductive processes, was:—

(*a*) That the parents would object, and
(*b*) That the teachers knew nothing of the subject and would refuse to teach it.

The position was put to conferences of parents and the dangers to which ignorance exposed their children explained. Unanimous resolutions were passed and referred to the Education Committees asking that biology should be taught in their schools. While a demand was stimulated among parents, continuous pressure was maintained on the educational authorities and the national teaching organizations to secure their co-operation and support urging that sex should not be an isolated subject but a natural part of the general biological approach to life.

A number of vacation schools were held for teachers (by the

British Social Hygiene Council and subsequently extended under the Board of Education) designed to equip them with the knowledge necessary to deal with problems of social hygiene arising in the schools. Such courses were obviously inadequate to enable non-biologists to teach. Biology could not be taught until the curriculum of the teachers' training colleges included the subject. Women's colleges proved the most progressive, and to-day the majority include adequate courses on biology, physiology and psychology, and relate the subject to human affairs. In the early days teachers for these courses were often supplied by the voluntary organizations pending the increase of qualified staff.

Even when it was conceded that the biological sciences should be given an adequate place in formal education, the general attitude in the 1920–30 decade was that school biology could not possibly include an application to human affairs. The inclusion of human reproduction was held up for some years by the opposition of the National Union of Teachers. In 1932 a resolution advocating biological teaching was at last adopted, but it was only in 1943 that full support for sex guidance and the teaching of biology related to human affairs was accorded. During the intervening period opinion in the teaching world had been influenced by general public opinion. The principle is now accepted that during the educational years children should be given both direct guidance on sex matters by the parents and factual knowledge from the biological angle in formal education. In some cases, however, schools still give isolated teaching on 'sex' unrelated to any biological course. This is due to the shortage of teachers qualified in biology and should be rectified by time.

As an indication of the difficulties to be overcome, one may recall a meeting of biology teachers arranged by the Education Committee of the National Union of Teachers in 1927 before which advocates of the teaching of biology relating to human affairs had stated their case. A senior biology teacher rose from the audience and stated in sepulchral tones: "I have been teaching biology for thirty years and have never yet mentioned the word 'sex'."

Tribute must be paid to the pioneer work among Universities, Educational Authorities and organizations, at home and overseas, of the late Professor Sir Arthur Thomson and of Dr. Julian Huxley, who independently and also as representatives of the

British Social Hygiene Council pressed forward the new policy in this country, in India and in Africa.[1]

The formation of an Educational Advisory Board to the British Social Hygiene Council in 1932 brought together, for the first time, the representatives of all branches of education from the University to the Primary School, the examining boards and all organizations of teachers and observers from the Board of Education and the Colonial Office Education Committee. This Board worked actively for fifteen years to promote education in biology related to human affairs.

A tribute must also be paid to the Board of Education for the firm stand it has taken in encouraging experiments and initiative in schools; perhaps because it has been their policy to attach to their Inspectorate those of wide experience, and not to staff it from the members of the regular Civil Service.

[1] Dr. Julian Huxley's *Africa View*.

CHAPTER IV

AGE CYCLE AND BEHAVIOUR PATTERN

INFANCY TO ADOLESCENCE

It is appreciated that many of our social problems are related to sex behaviour and arise from personal and social maladjustments due to faulty education and a time-lag in relating the social structure to biological needs and ethical and religious principles. The social worker and the administrator have to deal daily with the results. It might be of some service to indicate the biological characteristics relating to each age group of which cognisance could well be taken. To what extent can we estimate the basic educational needs of the individual, and what are the divergencies between their needs and the present education influences of home, school, and society?

Each seven-year period requires separate consideration. The first and the third seven years of life are the periods of greatest change, and are those when outside influences can have the deepest and most lasting effect.

The new life begins at the moment of conception. Heredity has made its contribution and the mother's uterus is as much the child's environment as is its home after birth. For this reason, the mother and the community are responsible that the nine months spent in it should be under good conditions. The placenta acts as a filter to the blood stream that nourishes the child, and this protects it from the majority of variations in the health of the mother, there are, however, certain poisons and viruses that can penetrate and affect the foetus. For this and other reasons connected with the personal health of the mother, skilled ante-natal care is now made available to all expectant mothers in those countries with a well-developed public health service. That the physiological influence of the mother is decisive is known. Whether there is any psychological link between mother and child before birth is at present considered unlikely. There is no reliable evidence that such is the case. The process of birth may be a dangerous experience to the child if the mother is suffering from

certain diseases, one of which is gonorrhoea, as the infant's eyes may become infected.

Infancy

The psychologists are unanimous in attaching the greatest importance to the environment, physical and emotional, during the first years. Physical and emotional security are the desired conditions. The physical needs are recognized and administration endeavours to provide them. The emotional needs have not yet been fully appreciated or met. The infant must sense the mother's affection through bodily contact. Breast feeding is not only important for the infant's digestive processes, but as it involves the infant being held every few hours by the mother to her soft and warm body, that sense of emotional security needed for balanced emotional growth is provided. While science has found substitutes for mother's milk it has only recently recognized that the physical expression of mother-love is equally essential. The infant should be nursed in her arms by the mother or deputy-mother during the bottle feed when this method is inevitable. It is common knowledge that the death-rate of babies is high when from force of circumstances they are deprived of maternal, or deputy maternal, care in the early months of life, even when the feeding is in expert hands. The classic example is the experience of the American medical woman in charge of an orphaned babies' home. In spite of the efforts of the medical and nursing staff, a number of babies that arrived healthy, pined and died. The medical woman then directed that each baby should be tightly wound in a shawl when carried, and should be cuddled by the nurses at feeding-time. In fact, maternal behaviour was reproduced by the hospital staff, with the result that the death-rate among the infants fell to normal.

Emotional insecurity is found to result in self-mistrust in later life and in a sense of insecurity in placing the affections. One can see it as a factor in promiscuous sex behaviour in adult life. In infancy, too, interest in the ego includes interest in and admiration for all parts of the body, including the visible sex organs. Exhibitionism—the "showing off" of the whole self—is natural, particularly to the potential extrovert, and, provided no emotional stress of guilt or fear is imposed by the social tradition, the normal child grows up and adjusts its behaviour to the pattern of the culture in which it lives.

While a baby is born with full physical equipment, not all the complete inter-relationships and interactions between the sense organs, the brain and the body are developed. It has eyes, but for some months these cannot be focused. It can hear, but at first has no sense of the direction of sound. It has the organs of sex, but part of the internal glands and hormones do not function fully, some not until adolescence, others not until mating, while in women others only function during pregnancy and childbirth. In infancy the pubic centres, the lips and the area round the external sex organs are already sensitive and integrated with the endocrine system. The pleasure and satisfaction the infant experiences in sucking at the mother's nipple, or the substitute bottle teat, is obvious and real.

The old-fashioned practice of 'nannies' when they wanted to show off their charges in the drawing-room with a happy smile, was to carry them so that they could tickle their genitalia at the appropriate time. In India, Hindu tradition takes the practice further and baby boys and girls are systematically 'tickled.' That it can connect the idea of pleasure with local stimulation at an early age is a fact. The indications are that it may not only make the normal, temporary childhood experience of masturbation tend to become a persistent habit, but may also give undue prominence in later life to the physical aspect of sex.

In infancy, a shock, fall, a sudden loud noise can, owing to the lack of integration in the psychological defence mechanism that develops later, directly reach the subconscious and be recorded. It can cast a shadow, or rather give a long enduring and sometimes permanent fear, that affects the emotional reactions of the individual throughout life, or until its origin has been discovered and brought to conscious memory. Some psychologists even go so far as to think that a forgotten fall, or fear of a fall, in infancy may in adult life show itself not only as an inability to look down from a height, but if not corrected by character training, where a tendency is observed in the child to shirk independent action, from its vague fears of the unknown, may be expressed, more indirectly, in business or in politics in the inability to take risks and in "playing for safety." Such conditions are also said to have been disclosed as past experiences of those who cannot convert an engagement into marriage. One is often mystified by the 10, 15, and 20 year-long periods of 'courting' that so often are never finalized in marriage.

Of importance to the child, too, is emotional harmony between the parents. Every mother knows that if she loses her temper at nursing time her milk is affected and that the baby either refuses it or has a 'tummy-ache.' Children who are present when their parents argue heatedly, themselves experience an emotional storm. Here, the effect on the subsequent sex adjustment of the child is very real—a conflict is created. The two people who form his world disagree. His world shakes. Nothing is secure.

A recognition of these points will necessitate considerable changes in administration and in our treatment of the infant orphan, the illegitimate, or the neglected child. The information must form part of any educational preparation for marriage. The treatment of the child to whom the community stands in *loco parentis* is of such importance that it claims attention in several later sections.

Up to three or four years the child's needs in sex education are simple and more concerned with emotional atmosphere than factual knowledge. From four to seven, simple facts are usually called for. The object of giving this information in infancy is mainly to avoid the creation of a mystery or the arousing of curiosity. From our knowledge of psychology we know that the creation of a mystery develops curiosity, and that curiosity is a stimulating emotion. We know that the emotions stimulate the endocrine system and react physically, and yet we have made of sex a mystery.

So far as we know, the sum of the biological needs of the child under seven in addition to its physical demands are: a sense of physical and emotional security to be sensed by the child from birth, harmony between the parents, no precocious experience of physical sex, no subconcious suggestion of shock or fear, no taboo on information sought. These, if met, will facilitate a well-adjusted emotional life in the future.

Seven to Fourteen Age Period

Physically, the period of steady growth and adaptation to the environment, the time for childhood's infections, for acquiring conscious habits of self-control, of co-ordination between hand and eye.

Psychologically, a quiet period, except at the latter end when the long span of adolescence brings the dawn of objective intel-

ligence, the awakening of those capacities that make for the integration of the personality, while for some, puberty develops.

Up to eleven or twelve years, the question of sex behaviour has no interest for the average boy or girl. It can be, and often is to-day, stimulated by the imitation of adult behaviour but mainly from a competitive standpoint: "How many boys have looked at you?" Boys develop psychologically some two years later than girls, and few in this country before 14 have any sexual interest in the opposite sex. Each sex is passing through the team and 'best friend' stage, each being attracted to their own sex. The basis of factual knowledge needs to be laid in relation to human sex and reproduction, in this period, when the intelligence is awake, school and its lessons are interesting, and questions to parents unending. The subject, before puberty, is of objective interest only: it should be dealt with from the objective standpoint before it has personal implications. In these years, the co-operation between home and school needs to be close. The lessons of general biology in school will give rise to activities in the home. The weary parent may well look askance at the white mice, the tadpoles, the birds' eggs, and the caterpillars that their offspring bring home with pride and want to keep in their bedroom or the kitchen.

Tolerance is called for, as there is much to be learnt from the study of other living things. Not only the wider lesson that the cycle of life, growth, maturity, reproduction, death, is followed by all, but the inevitability of effect following cause, the effect of food on growth, of care for the expectant mouse or rabbit, of the dawn of family life as seen in the mammals. The valuable opportunity should be taken of pointing out and explaining the differences as well as the similarities between man and the rest of the living world; man's control of his surroundings, his capacity to foresee, his appreciation of values, the emergence of reason and, consequently, of responsibility.

These years enable the foundations of knowledge to be laid on which to build the positive values, relevant when questions of personal adjustment to sex and of sex behaviour will become acute in later adolescence. This period of steady mental and physical growth needs to be peaceful and undisturbed. There is danger to the future as well as the present in overcrowded housing conditions.

Overcrowding to-day is such that very often children have to

sleep in the same room, even in the same bed, as their parents. It should be borne in mind that from two years and upwards the child's subconscious mind can receive impressions, particularly between sleeping and waking, that may have a lasting effect on its attitude to sex in later years. Every effort should be made by the parents to live their own sex life out of hearing of their young children—even if they are thought to be asleep. The results of psycho-analysis have disclosed that the impressions so obtained have given rise to fears of sex that have proved difficult to trace and remove, and that as long as they persisted, happy emotional adjustment could not be attained.

In self-defence every community penalizes incest. To preserve the family, it is essential to remove the members of the family group from the circle of those with whom sex relations are admissible. In this country it is in the years between five and fourteen that the majority of known cases occur. These also derive in a large measure, but not entirely, from conditions of overcrowding.

The numbers brought before the Courts or "known to the police" in Great Britain are but a fraction of the actual cases. The position is difficult, as on the one hand the publicity involved in prosecution harms the innocent child and damages her prospect of subsequent marriage, and on the other, the imprisonment of the offender, who too often is the father, removes the wage-earner. The mother is usually the individual who has to take the initiative in reporting the matter to the police, so it is understandable that the majority of cases go unrecorded. The silence on matters of sex behaviour results in no personal recoil from such a relationship being implanted in the mind of the individual during the formative years; therefore sex attraction tends to operate within the family circle and becomes a tragically disruptive influence. It is a serious criticism of our own civilization that in this respect a lower standard of behaviour is tolerated than among primitive races.

Positive teaching on the family and its implications must form part of general education. During the generation that will elapse before such teaching becomes general and affects behaviour, the social practice of handling incestuous cases needs careful consideration and revision.

The cases fall into a few main categories: (*a*) father–daughter; (*b*) brother–sister; (*c*) uncle–niece. The first are the most difficult to handle if serious psychological damage to the child is to be prevented.

The offenders fall into two categories (*a*) the inherently normal who can, through education and psychological treatment and the removal of conditions of overcrowding that provide undue physical stimulus, be readjusted to life, and are then safe, in due course, to return to their families. (*b*) The inherently abnormal or sub-normal from whom permanent protection for their family is required. At present, a father after perhaps serving a two-year sentence without psychological treatment is free to return to his home and young family. The man sentenced on the evidence of his wife and daughter returns, biologically unchanged and emotionally resentful, to claim the position of head of the house

As is well known, only a small minority of father–daughter cases are actually proceeded against as incest cases owing to the impossibility of obtaining evidence. Many are dealt with as cases of assault, and after a short sentence the offender returns to the family.

The brother–sister offences are sometimes due to abnormality, often to ignorance and bad housing, but in the main they are the result of those social conditions that promote juvenile sex promiscuity among the unrelated. These include ignorance of physical sex, curiosity and the urge to experiment, unbalanced physical and emotional development, and the absence of social customs embodying any expectation of, or aids to, continence. The absence of any positive teaching on family values gives no opportunity for developing a deep-seated recoil from inter-family, sex relationships such as permeate tribal communities.

These offences should be dealt with in a manner to mitigate any permanent damage to normal adjustment to sex in adult life for both of those involved. The aid of the educationist and the psychologist is needed rather than that of the police

While the Departmental Committee on Abortion do not recommend incest *per se* as a cause for the termination of pregnancy, it is pointed out that in any case in which adequate medical reasons are present there would be no question as to the legality of the operation. Minority reports recommend incest as a reason in itself for the termination of pregnancy.[1] Uncle–niece relationships only have biological significance when it is a blood and not a marriage relationship, and then only if the stock is unstable; or sub-normal.

[1] The law has not yet been amended to embody the recommendations of the Report.

The Fourteen to Twenty Age Group

As we have seen in the immediate pre-adolescent stage, attraction to the same sex is normal, but if physical and emotional development do not keep in step during the adolescent period, and if through circumstances emotional development is arrested at the pre-adolescent stage, then serious maladjustment may result. With the normal person, as sexual capacity develops the motivating desires and emotions associated therewith are heterosexual, that is, the attraction is to members of the opposite sex. Friendships, of course, remain from the adolescent period, and are often the greatest enrichments of life, but the normal friendships between men and between women are not linked with physical sex attraction. With the psychological homosexual, the emotional desires do not develop but remain anchored at the homosexual stage, and physical sex expression becomes related to members of the same sex and does not develop to the mature heterosexual stage.

From puberty onwards the capacity to perform the sex act with physiological completeness is present, but it is some years before the psychological and endocrine adjustments of maturity have been attained. For six or seven years during the period of adolescence, therefore, the three strands of personality—physical, emotional, and intellectual may be less completely integrated. The physical sex urges are present, the emotional capacity is developed, but the integration of the intellectual with the physical and emotional is incomplete. The appreciation of the ideal, the social sense, the desire to please are implemented by strong emotional resources, but often not consciously integrated with either the physical or the intellectual self. An adolescent with an emotionally satisfying home background can pass through these years without the changing personality being put to undue strain before stability and balance are attained. From an environment where there is reciprocal love and understanding between the members of the family circle, adventures in dawning heterosexual attraction can follow a harmless course. The play aspect of sex can and should be recognized as part of education for life. The adolescent will be attracted in many directions. The problem to-day is to devise limits acquiesced in by the young themselves which will prevent the period of sex-play including intercourse and the risk of parenthood and thereby damaging or checking the attainment of balanced maturity with its prize of a happy, well-adjusted marriage and satisfying family life.

The adolescent trait of flitting from flower to flower always in the belief that each one will provide the particular kind of honey sought; the constant "falling in love" with a feature or a voice, a *part* of a person, then finding the whole individual is quite different from the lover's dream; or the sudden urge to physical sex relations with an intellectually and emotionally unknown individual either for no recognized reason, or because they had some physical trait of an admired film-star, or because the individual thought boredom and loneliness would vanish in physical union—such are normal phases of adolescent experience. When, however, such transient and unbalanced attractions continue into adult life, and include physical sex relations, an individual of whatever age still continues to behave—emotionally—as an adolescent. Many of those who are promiscuous in their sex behaviour, both in and outside marriage, are of this type.

What do we know at the moment? That from the onset of puberty until psychological and endocrine adjustment are complete and the personality is fully and consciously integrated covers a period of about six years. It is during these years that the intelligence, which reaches its potential for development about fourteen, is at its most assimilative—information, skills, techniques, can then be most readily acquired. Capacity for appreciation, both intellectual and emotional, arises. Objective reasoning becomes possible. Ideals, art and music, have significant appeal, altruism awakes; religion becomes real and personal. In fact, the distinctive human traits flower. Psychologically, the desire to express individuality is shown in revolt from authority, whether of home, or traditional ties of religion or politics. The instability of rapid growth, physically, psychologically, and emotionally, with the gradual integration of the three strands of personality—with often a varying rate of growth of each, make it a time of biological stress and instability. The background against which this turmoil in the individual has to achieve balance, should therefore be purged of extraneous social and emotional stress and strain. Exercise for the emerging faculties, yes; training, yes, but not the expectation of mature behaviour. The more complex the adjustments needed by the culture, the longer the psychological and emotional adolescence may well be. Life in an industrial town of the West is far more exacting than in an African village.

These adjustments, inherent in the change from childhood to maturity, have only one visible obvious and sudden event in each

sex—seminal emission for the boy, menstruation for the girl. It is popularly, and in the opinion of the writer and others, erroneously supposed, that climate affects the age of onset of adolescence. Much more research in this field is needed; what has been done, however, seems to point in the opposite direction. The enquiry made in the early twenties in this country and in India disclosed that the span of age of onset of menstruation in girls in the Calcutta and in the London schools both had a range of from 11 to 17 years with, on the average, a six weeks' earlier onset in Calcutta. If this has significance it is more likely to be psychological than climatic.

An enquiry is needed as to the physical reaction to psychological stimulation in the maturing of the endocrine adjustments. For instance, the Hindu tradition focuses the attention on physical sex from infancy onwards. Phallus worship among young girls plays a large part in their early lives. Family tradition encourages stimulation of the external genitalia among boys. The Hindu mother endeavours to and claims that she succeeds in obtaining an erection of the penis of her infant son. To what extent, if at all, does this hasten the onset of puberty and, if it does, is there any indication that complete maturity is attained in a shorter interval?

In Great Britain the school-leaving age of the bulk of the population has been 14 to 15, and will be 15 to 16 years. Juvenile delinquency, expressing social maladjustment among boys in larceny and property offences, and to a far less extent among girls, often as sex delinquency, has risen steeply in the 14–17 age groups during the war years, but was already high and on the up-grade in the pre-war period. According to the criminal statistics, the indictable offences dealt with under the Children and Young Persons Act (age 8–17) were, in 1935, 15,062; in 1937, 30,733; and in 1945, 42,823.[1]

That the general conditions are largely responsible appears probable because those of the same age group remaining under social care at boarding schools up to the age of 17 or 18 years contribute hardly at all to the volume of recorded delinquency.

Even for them the educational strain remains. Examinations that open the door to the professions and skilled occupations occur in the years of late adolescence. Evidence is considerable that among less phlegmatic races than the British the strain

[1] *Criminal Statistics. England and Wales.* Figures for later years kindly provided by the Home Office.

shows itself in physical and psychological troubles, and though the form of expression is less violent in the Northern races it undoubtedly obtains. When school and university life covers the span of adolescence, the conditions more nearly follow biological needs—regularity, lack of social strain, recreation, and opportunities to meet the opposite sex from a home background under social conventions that are a protection from irresponsible sex expression.

A further indication that sex promiscuity and other delinquencies are stimulated by external strain comes from a comparison between the previous way of life of girls in Approved Schools for offences unconnected with sex behaviour. All are under 17, and before their arrival practically all had experienced casual sex intercourse. Among girls under seventeen following full-time education, whether at residential schools or in a well-adjusted home, this would be a rare occurrence.

In inquiries published by School Medical Officers and others, among boys at public schools either in Britain or Scandinavia, up to the age of 18 very few have had any physical sex relations and their interest therein has hardly developed. In contrast, youths in the same age group thrust into life under adult conditions are often habitually promiscuous. Those who give sex guidance lectures to adolescents have ample evidence from their audiences that contraceptives are freely used. Boys of 18 and 19 are among the V.D. clinic patients, and among those directed to pay affiliation orders.

When social care extends throughout the adolescent period, the physical and psychological adjustments are made before the individual has to meet the personal problems of adult life. When these come, the young adult can make a conscious decision and is not a prey to uncontrolled and uncomprehended physical and emotional urges.

While no suggestion even has yet been made that the social structure should be adapted to provide for the biological needs of the individual up to the attainment of maturity, an attempt has been made to bring home to parents and to the community that they and not the juvenile offender are mainly responsible for their offences and must secure that the minimum amount of permanent social damage is suffered by the young delinquent.

The Children and Young Persons Act, 1933, recognizes "that the problem is not the right of society to be protected from the

disorderly and anti-social child, but the right of the disorderly and anti-social person to be made orderly and useful" Those under seventeen are dealt with by the Juvenile Courts and no Press publicity for the proceedings through which the child may be identified is permitted. The services of doctors and psychiatrists are not specifically provided for under the Act, but most progressive Courts now avail themselves of such expert guidance. This is particularly necessary as effective ameliorative treatment requires the prior recognition of the biological factors involved. Admittedly, financial provision for treatment if required is as yet not available through the Court. It is hoped that in the future it will be recognized as much a public responsibility as is now the provision of the maintenance cost of the delinquent in Borstal or an approved school. However, even to-day change in environment, though not inclusive of medical care, can be arranged and is often helpful. A large number of those on the border-line of mental deficiency, the dull and backward and the abnormal, are among the delinquent. These, without expert help, would remain unrecognized as such. No special social provision has yet been made for them even when recognized, but it is these who, under present conditions, tend to become recidivists. It is for the adolescent that the industrial social structure of the West is most acutely maladjusted. For biological needs to be met and a foundation laid for human progress, this problem must be handled constructively.

The parents of to-day were passing through their school years either before or just after the introduction of the biological sciences into the ordinary school curriculum, when the tradition of teaching these subjects and of relating biological knowledge to the interpretation of religion, of history, of citizenship, of education, and of personal welfare had hardly begun. A general move was made between 1920 and 1940 to press for the raising of the taboo of secrecy which surrounded human sex relationships and reproduction, and to give truthful answers to the child's questions as to its origin and arrival in the world. It was not appreciated until some years later that sex education, to be effective, should be a graded process of information and guidance spanning childhood, adolescence, and maturity, and should include preparation for marriage and parenthood.

The majority of parents to-day have not the biological knowledge to enable them to assess what is transitory and what is

essential in behaviour fashions, or to encourage or check personality traits in their children.

British parents were at a greater disadvantage than those of other progressive countries, as in addition to the advent of biology as a new subject to formal education, there was a local and deeply ingrained taboo on all matters of sex.

The Social Outlook on Sex

At the end of the seventeenth and during the early part of the eighteenth centuries the manners of the time were coarse and crude, sex and its manifestations were a common topic of conversation. While certain sections of the upper strata of the community were lax and casual in their sex behaviour, family life in provincial England appears to have been stable and settled. The Victorians thought to improve standards by creating a taboo on all matters pertaining to sex and reproduction. It was the period when pianos were clothed because legs of any kind were unmentionable in polite conversation, and women had no physical attributes between the neck and the ankle.

The result was that the children raised under this taboo had no accurate information to transmit to their children when they in turn became parents. Ordinary common knowledge of sex and sex behaviour was dropped out of the traditional inheritance for some three generations, and was replaced by 'smut,' superstition, and distorted facts. It is recorded by members of the medical profession that occasionally men sought medical advice months after the marriage ceremony to ascertain how a child could be conceived. It was common for girls to marry with no knowledge of the physical implications of the relationship. The reputation Englishwomen acquired for emotional frigidity in all probability arose from this abnormal attitude to sex. The position has been steadily changing from the beginning of the century. The spread of education, and the growing social and economic independence of women were factors in the situation. The violent agitation for women's participation in politics was embittered and emotionalized largely as a compensation for this abnormal suppression of the recognition of sex as a factor in human development and as a normal attribute of living things.

The girls of the inter-war period were taught in schools staffed mainly by women teachers precluded from marriage by the terms of their employment, or by women who, having during

their own formative years, received a distorted impression of the place of sex in life, were determined to omit its influence from their own lives: their pupils were only too often the victims of over-compensation or suppression. The view of marriage and parenthood unconsciously transmitted was not one of sympathetic encouragement.

The fathers of the inter-war period were, in the main, convinced that some positive guidance in sex behaviour should be given to the young man. The idea of frank and truthful answers to the questions of children under seven was, however, to them rather startling. A moralizing talk to a son of sixteen was what they usually had in mind, but they themselves were in the main entirely ignorant of the physiological and psychological sex equipment, of the stages of development and the needs of the individual. It was a matter of conforming to convention and accepting the moral code. They could not give very effective help except the outstanding guidance of their own example and values. The young parent of to-day with a wider understanding of biological processes meet the educational needs of the infant and young child.

During the last twenty-five years general enlightenment on the opportunities and methods of sex guidance has helped a number of parents, teachers, and youth leaders to equip themselves with the necessary knowledge. Parents' conferences, teachers' vacation schools, youth leaders' courses, were provided by the British Social Hygiene Council and others with the support of many local authorities between 1920 and 1942 until the general policy was accepted, and the Board of Education recommended sex teaching in all schools. Government finance enabled the facilities for teaching the groups of post-school age to be continued and extended through the Central Council for Health Education. It will, unfortunately, be at least another ten years before many of the children now passing through the schools will be in a position to transmit their knowledge of the place of sex in life to their offspring. The facts of sex, its influence on human affairs, and its current values will in due course become part of the general background based on biology taught in the schools and related to behaviour in the home. It will then no longer require special emphasis. The omission of the subject in the past has inevitably isolated it for peculiar treatment during the period of its reintroduction. The manners and customs the younger generation will

adopt depend very largely on their capacity to apply knowledge both ethically and constructively

The present generation of adolescents have been subjected to all the stresses and strains of war. Evacuation removed many from their homes; war production demands resulted in many being "boarded out" or placed in hostels, distant from family and friends. Working under pressure, meeting new points of view, new standards of behaviour with no yard-stick of knowledge, tradition, or training with which to measure them. One instance of the reversal of values is a song constantly on the lips of the girls in the munition factories, of which the refrain is "Roll me over, lay me down and do it again."

Sex intercourse is maintained by many of the young to be a minor not a major experience of life. Now that it is largely divorced from the risk of parenthood, it is looked upon as a purely personal matter without social implications.

Just as the social significance of the kiss has been shed, so, too, many think, the social significance of the sex act is passing. Both are half truths. The "kiss with significance" will always remain part of the prelude of the love cycle, and to a girl will cause profound psychological reactions. It is the kiss of greeting and friendship that is exchanged by men and women to-day that has become accepted behaviour.

So with the sex act. It is common knowledge that young men and women who have had pre-marital experience have subsequently met their partner in marriage and attained a happy and stable relationship. With greater understanding of the full implication of marriage, however, the sex act that is not the expression of the whole personality, body, mind, and spirit in an enduring harmony will be not only unattractive but repellent.

Just as developed personalities to-day recoil from prostitution, so will they in the future consider it an offence against themselves to enter into an incomplete and unsatisfying temporary relationship. The more fully the art of love is understood and the more fully individuals are developed as conscious personalities, the greater the depth attained in the mutual harmonies of the unique relationship.

The tribal seasonal fertility orgies, or the Western sex reactions to the stress of war conditions, only engage the individuals' reactions on the physiological level. Such experiences may and often do check full development. In most cases, however,

when the causative conditions pass, the individual readjusts to life in the group.

No positive guidance has been given to each generation on the personal value of the "unique relationship," nor of the risk of anchoring sex experience at the physiological level, thereby preventing a full integration of personality in marriage.

That the wave of youthful promiscuity has brought serious consequences is obvious The number of illegitimate children of girls under 20 rose steeply during the war, and, the immediate post-war period Syphilis and gonorrhoea increased, and among girls was often undetected and untreated.

That the tradition of the group is the governing factor in the behaviour of the normal individual is evidenced by the wide variation under war conditions. In a Service unit where the tradition of a high standard of sex conduct obtained both among the women and the men of the Service, a very small minority were promiscuous. In a factory where the ages were similar but where the fashion favoured frequent promiscuity, the lavatories were choked with contraceptives, and the song already quoted was the fashion.

The effect of adolescent promiscuity where there is no feeling of guilt, on subsequent adjustment to a stable marriage relationship is unknown. The indications are that the revival of social values, as after the last war, will preclude any permanent harm resulting from a short phase of laxity, provided a sense of responsibility can in the future be attached to sex behaviour and the wartime experiences viewed as exceptional and transitory.

Our task for the future, therefore, is to apply our knowledge that adolescence is a period of instability and should be protected from stress and strain; that marriage on the attainment of maturity should be encouraged; that a high social status should be accorded to the family; and the values and ideals appropriate thereto embodied in our social tradition, and these should be effectively presented and demonstrated to each generation during the formative years.

CHAPTER V

SEX BEHAVIOUR

THE legal regulations and social customs relating to sex behaviour depend on the culture, the current interpretation of the religious teachings, the social structure—tribal, nomadic, agricultural, or industrial—and the level of general education. The sex behaviour of the individual depends on his biological endowment, the social structure in which he lives, and the values which are the motivating influence of his personal life. The personal attitude of the normal individual towards sex is the foundation on which must rest effective laws and social customs

Monogamy, polygamy, and concubinage are the main patterns of sex behaviour adopted by the different cultures. In certain small areas where the geographical and social conditions lead to a large preponderance of males, polyandry obtains. All embody the conventions that govern the position of the family as the central institution of the culture.

Behaviour in relation to all human functions and attributes varies both historically and geographically, but usually these variations in practice embody an underlying uniformity of principle.

In the conventions governing sex behaviour it has already been indicated that some of the primitive cultures approach more nearly the immediate biological needs of the individual, but it appears that the methods adopted of securing the stable family have in some cases checked intellectual and thereby material development. For instance, the Papuan Islanders recognize the difference between the 'play' and the 'reproductive' aspect of sex, and make provision in their culture for both to be expressed.

Unfortunately, without the necessary biological knowledge, the conventions adopted may have had a deteriorating effect on the material and intellectual development of the tribe which is believed to have remained static for some two thousand years. It is, however, still a matter for research before it can be dogmatically stated that extensive physical sex expression during adolescence checks intellectual development, though the general indications that it does are acknowledged.

The Papuan children live in their families until puberty. The tribal lore is ceremonially transmitted, after which the boys live together in one hut at the end of the village, the girls in another at the opposite end. (Independence under supervision.) During these adolescent years the girls and boys are encouraged to "keep company." Changes among the partners are uncriticized. After a certain age they are expected to make the selection of their permanent partner, and once the selection is made it is irrevocable. Quite a number, however, seek and maintain one partner whom they eventually marry with approved tribal rites. The married couple are accorded full membership of the tribe with its privileges and responsibilities. Adultery by either the man or the woman is punished by death. It is of interest that the islanders obviously have a full knowledge of a technique of contraception which must be transmitted with care by the elders of the tribe at the onset of adolescence. Parenthood during the playtime period is practically unknown. When it obtains, it is thought by the anthropologists to be a reason for marriage.

In many of the primitive African cultures the onset of puberty is recognized as the most important stage in development. The initiation of the boy and girl into the sex behaviour pattern of the tribe is a serious matter. In some tribes both the boys and the girls are taken separately by the elder men and women away from the community for some days or even weeks and put through a severe course of training. In order to accentuate parental responsibility some communities have imposed severe surgical operations as part of the initiation. These have been in many cases particularly injurious to women.

Through the impact of Western culture and of the Christian missions, an endeavour has been made for many years to abolish or modify the injurious elements in the initiation rites. That the dawn of maturity should be marked by a serious endeavour to attach a sense of personal responsibility to sex behaviour and to ensure that each generation receives all available knowledge pertinent to the personal and social responsibilities of citizenship is surely a useful custom.

In tribal communities such as the Papuans, where pre-marital sex relations are sanctioned by the tribe for a limited period and are open and guilt free, they do not appear to affect subsequent adjustment in marriage. No provision exists in these tribes for post-marital promiscuity; prostitution is unknown.

In other countries where male pre-marital promiscuity is accepted with mild disapproval, while the female partner is condemned, it is not limited to a brief period of late adolescence, and in some becomes a persistent habit, may delay emotional maturity, and continues or even arises after marriage.

The major objective of the various types of behaviour pattern enjoined by communities seems to be to establish the parenthood of the child and to allocate the responsibility (not necessarily of both parents) for its maintenance and upbringing.

Among Mohammedans, particularly those living under tribal conditions, the priority accorded to the older and wealthy men in the acquisition of wives and the close protection of women leaves the young males without opportunity for early marriage and directs their ambitions and activities into channels from which female society is excluded. The normal psychological development through the homosexual to the heterosexual stage during adolescence is apparently considerably delayed, and owing to conditions frequently becomes related to the physical. Homosexual relations are a recognized and tolerated social custom. In North African towns of mixed population where facilities for commercial prostitution are available while the practice of homosexuality still obtains, it is not so prevalent and the young Mohammedan makes free use of the local brothel. Information as to whether the practice has appeared among the converts to Mohammedanism in West and Central Africa would be interesting. The writer has found no record of it, nor would it be expected where different tribal organizations and values exist, and still retain an influence even among the detribalized.

While mathematics and astronomy have long had a place in the Arabic tradition, the opportunities for the introduction of the biological sciences have been slight, and there is little scientific or factual basis on which to build sex education and guidance. The deep-seated desire for offspring and admiration for physical fitness provide, however, agreed values on which to base the presentation of the case for a pattern of sex behaviour which would be more in line with biological needs and the higher ethical values. An interesting experiment was made by the French health authorities in North Africa. A film with an Arab background presented elementary biological facts of human reproduction and explained the dangers of venereal disease inherent in

prostitution. This was understood and much appreciated by the Arabs both urban and tribal.

Western Europe has long adopted the Christian ethic and legal monogamy, but the social sex behaviour conventions differ in Great Britain and France, in Scandinavia and the Balkans.

In Northern Europe education, outlook, and woman's economic independence materially influence the conventions and customs which embody respect for personality. In these countries to force a distasteful marriage partner on an individual is condemned. The forced retention by law of a marriage when either party has made other ties is recognized as injurious. From the days of the Icelandic and Norse Sagas, tradition has laid emphasis on the romantic aspect of love, high value is therefore attached to individual selection of the partner in marriage, and emotional harmony is accepted as essential to the stability of marriage and the family.

In a country that has lived just as long under the Christian ethic—France—we find the romantic element discounted. The selection of partners lies in the hands of the 'family council,' and their system also is defended on the grounds of family stability. The stabilizing influence being economic rather than affectional. The experience of Russia from the beginning of the century is interesting and may give a pointer as to the biological essentials which man subconsciously seeks. Russia lived under the Christian ethic, including legal monogamy, until 1917; then for a period rejected its principles and conventions with violence in the belief that monogamous marriage was a joint product of capitalism and religion. To-day she is readjusting her culture so as to secure family stability, relating this movement not to the Christian ethic but to the basic human needs as disclosed by science. An illuminating remark made by a refugee White Russian woman (during the revolution) who had been divorced four times and was then living with her fifth husband indicated the attitude of the educated to the importance of the emotional harmony in marriage in pre-revolutionary Russia. In discussing the difference in outlook between the Russian and the British she said, "We think it too crude and degrading for two people who no longer love each other to live together, it is an offence against personality."

In pre-1917 Russia it was reported that an individual remained socially acceptable provided their partner in marriage had not

been legally changed more than five times. It was probably the persistence of this same feeling against legally binding marriage and family responsibilities, as well as the endeavour to break with the economic and religious ideals of the past that was behind the revolt, and led to the experiment of the State withdrawing all legal support from the family as a social unit. Sex relations and sex behaviour were considered an entirely individual personal matter even to the extent of the State assuming the care of all children. It has taken less than a generation, however, for the basic value of the family to be demonstrated and to reassert itself. The deciding factor was said to be the deterioration of morale among the children and the widespread promiscuity and disease among the young adolescents.

While divorce in Russia is still obtainable, it is discouraged, and the need for providing the conditions of social and emotional security necessary to the development of the child's personality are recognized as of equal importance to the development of the personality of the adult. Parents are now expected to rear their own children, and the social structure is being gradually adapted to facilitate and encourage family life and parenthood.

Thus we see these three countries each emphasizing a different value and therefore developing a different pattern of sex behaviour.

Where the West has so far failed is in passing on as part of the traditional inheritance a sense of personal responsibility in the exercise of the sex function and such knowledge of the human sex equipment and its influence on personality as was available.

The subject of sex behaviour has not been considered objectively; even to-day many find this difficult. The Westerner can take an objective view of the sex behaviour pattern adopted by other cultures, influenced by different religions, and can assess their biological advantages and disadvantages. It is a very different matter to take an objective view of conditions in their own country and their own group, and of the motivating influences of their own conduct.

Education was for so many generations in ecclesiastical hands, science had but little place. The first chemists, the necromancers, reputed purveyors of magic and witchcraft, were believed to have sold their souls to the devil. The biological sciences, which were thought to undermine Christianity, have only recently been

recognized as worthy of consideration. For some two generations Darwinism was the centre of religious controversy.

An objective view of sex behaviour has therefore to overcome not only the barrier of apathy and prejudice faced by all new knowledge, but the far higher one raised by a tradition linked to deep-rooted emotional prejudices.

It has been the custom in most Western countries in previous generations for the father to advise his son on the problems of life before he left the parental home. Such advice, so far as sex behaviour was concerned, was usually that excess was to be avoided, and if some adventure became inevitable the partner should be chosen with discretion. A talk from a priest or doctor either supplemented or replaced this helpful paternal homily Girls belonging to the leisure class were presumed before marriage to be under close protection, moving under chaperonage, a custom which still obtains over much of Southern Europe and South America; the advice was often limited in this country to avoiding conversation with strangers, but in the Latin countries it includes a franker discussion of physical sex between mother and daughter. The few young girls who work outside the home and not as domestic servants in another home appear to receive more knowledge as to the physical facts of sex than the British of former generations.

The first real change of attitude arose from the Reports of the Royal Commissions on Venereal Disease (1916–19) in Great Britain and the Scandinavian countries, all stressed the dangers of ignorance on matters of sex among the young and their teachers, as evidenced by the amount of disease contracted through ignorance, among the older adolescents. In Protestant Northern Europe it was the custom of the churches to take the opportunity of confirmation classes to appeal for a high standard of sex morality. Unfortunately, from the biological standpoint this was not a happy solution for several reasons. Until quite recently usually neither the teacher nor the taught had any knowledge of physiology or psychology on which to base guidance or understanding. Therefore the vague discussion of personal sex problems under adolescent conditions of emotional strain which left unexplained to the young the changes taking place within themselves, aroused, without satisfying, a stimulated curiosity. An atmosphere of emotional appeal to a pattern of behaviour whose governing factors were unknown can but increase the

difficulties of the adolescent. The main appeal was based on fear.

This approach resulted in the persistence of the sin-sex-guilt complex and created an additional barrier to an objective outlook. In Catholic communities, as preparation for the first communion usually takes place before adolescence, sex behaviour is a matter for individual guidance in later years through the confessional. Here again the absence of any clear foundation of biological facts on which to build, on the part of the leaders and the led had similar results. Many theological seminaries have, in recent years, added the biological sciences to the curriculum. As the manifestation of sex during adolescence is so often interpreted as a dangerous evil, the sense of sin and guilt is from its onset attached to any physical expression of sex except when directly related to parenthood within marriage. This general appeal to fear had the unexpected repercussion that priests, ministers, and clergy of all denominations, were among those who actively opposed the establishment and advertisement of treatment facilities for venereal disease on the grounds that a knowledge of their curability would remove the lever of fear for obtaining a better standard of sex behaviour. This view was not endorsed by any of the responsible leaders of the Christian denominations, but it has checked the development of healthier customs in the educationally backward countries. Morality based on fear is a danger to the individual and to the community in which he lives.

Believing that the pattern of life advocated was at variance with human nature, the Catholic church has always been tolerant of sexual laxity, and in the view that some form of extra-marital sex expression was inevitable for men has looked leniently on social customs which made provision for it.

In the Mediterranean countries, the prevalence of the tolerated brothel under municipal auspices and the openly kept 'mistress' are an indication of the general attitude. In this setting the Catholic priesthood exerts its influence to encourage early and stable marriages which, in the peasant communities, are the rule rather than the exception, as always among a working agricultural population, but has not actively opposed prostitution.

Priests and doctors are, in most communities, the leaders of public opinion. If a whole branch of knowledge is omitted from general education and from the specialized training provided for

their professions, they are obviously not in a position to lead thought in that field. Being accorded the position of teachers, they subconsciously deprecate and are antagonistic to anything outside their own range of knowledge. Bitter opposition to the introduction of biology related to human affairs, and particularly to the inclusion of factual information on human mating and reproduction has been raised by many of the Churches. Perhaps owing to the presence of a peasant priesthood in such parts of the world as Southern Ireland, Spain, Southern Italy, and the shores of the Levant, opposition has been most bitter from the Roman Catholics. That it is due to confusion of thought on the part of those entirely ignorant of the biological sciences is evidenced by the fact that the leading members of the Roman Catholic communities have participated actively in the endeavour to secure a scientific foundation of factual instruction in physiology and psychology. They stressed, quite rightly, that the province of religion is that of spiritual values, morals, and behaviour, and these can develop best on a secure foundation of fact. As an example of this, in 1918 a popular film on sex education, related also to the campaign on venereal diseases, had been shown widely in Great Britain and the United States of America It was desired to show it in Belgium. The film, therefore, was submitted in the first instance to the Bishop who gave it his warm approval, with this approval it was widely circulated. This same film was banned from Southern Ireland by the local Catholic leaders.

It is the failure of the religious hierarchies to relate their interpretations of the Christian ethic to scientific facts that has created so wide a cleavage between the ethics demanded by current knowledge, and the behaviour often advocated on the grounds of religion. The result is that spiritual values which should have a sufficient appeal to motivate conduct are so widely removed from objective truth that they have no effect. The result can be seen in the rapid shrinkage of the membership of the Churches, particularly among the younger elements in the population. In a pre-war analysis of the situation on the Tyne-side it was disclosed that only 8 per cent of those under 21 were confirmed or maintained contact with the Church. To ensure objective knowledge and effective guidance in sex behaviour we must therefore look to the home and the school.

For twenty-five years an active endeavour has been made to promote biological teaching related to human affairs in the

schools, with the result that in 1944 the Ministry of Education issued instructions that sex education was to be included in the curriculum. The biological equipment of teachers is at present, and must be for some years, very incomplete. While many schools are now able to provide a graded biological course in which human sex takes its rightful place in the general story of living things, others still present human sex in a separate lesson and thus retain the undesirable isolation and emotional setting of the subject.

While opinion in Great Britain now supports that correct factual knowledge on matters of sex and reproduction should be accorded to the rising generation, the border-line between factual education and guidance in sex behaviour is still indistinct. School appears the right place for factual knowledge of science, citizenship, and the social values. Home, the centre from which effective behaviour patterns can derive. Fear is still expressed that biological facts are dangerous meat for the young, and may only encourage more irresponsible behaviour. Arithmetic is taught in class as part of general education, but whether the knowledge acquired is used as a basis for developing engineering skill, of clerking in a bank, or applied to the falsifying of accounts and to fraud, depends on the character of the individual, on the home background, and on the accepted moral standards of his group. Factual knowledge of sex is essential as a foundation for intelligent guidance in sex behaviour, but the type of behaviour adopted will depend on the guidance given in the home and on the morals and customs of the community.

The trend of opinion in this country has been followed elsewhere. In Norway and Sweden the training of teachers in physiology to enable sex and reproduction to be included in the hygiene courses in schools is decreed by law in order that before the age of 16 all young people should have received the necessary instruction.

In Northern Europe the tendency of the past thirty years has been to extend the adolescent period and to give social protection in certain directions until the individual is nearer maturity.

As indicative of the high value placed on property the law gives the minor protection from financial exploitation until 21, which is the age of economic independence.

The more important personal and social experience of marriage is still in process of adjustment. In Northern Europe "the age of

consent" and the age of marriage is at present 16. It was only in 1930 that the law throughout the British Empire was brought into line with the practice of the British Isles. The Statute book still retained the legal marriage age as 12, and this was found to be the social practice in a minority of cases in certain Colonies and Dependencies, including those of the Mediterranean where the social traditions of Southern Europe was followed.

The general trend in the United States of America has been along lines similar to those indicated for the British Commonwealth and the Scandinavian countries. In certain States a programme of biological education, including preparation for citizenship, marriage and family life, is in operation which, so far as is known, is more complete than anywhere in Europe or the Empire

From other countries very little is yet recorded. The general attitude in the South American Republics follows fairly closely the attitude of Southern Europe. Social biology has made far more rapid progress in the British Commonwealth, the United States of America and in the Northern European countries than elsewhere. Educated women with civic rights are in direct contact with the major social problems, and recognize their responsibility for promoting changes when tolerated forms of sex behaviour result in disease and injury to posterity. They have claimed an equal share in the management of their children, taken an active part in promoting educational reforms, and have begun to use the machinery of democracy for implementing their wishes.

Those connected with social hygiene in the United States of America and in the British Commonwealth, being convinced that the major problems of human relationship could only be dealt with adequately in a community which had at their disposal all the available knowledge which affected human behaviour, were anxious to promote an international survey on the place of biology in education and of the type of sex instruction and guidance in matters of sex behaviour given to the young of each country.

An international inquiry was suggested to the Social Questions Committee of the League of Nations in 1927 and the money to cover the cost offered from voluntary sources in the United States of America, which had in the same way financed the inquiry of the Committee of Experts into the Traffic in Women. It was clear from the type of objection raised that the then current

opinion, particularly in the Latin countries, was coloured by the "theology versus science" controversies of the previous century. Any mention of biology relative to man was interpreted as a desire to prove that the members of the Committee were derived from a simian ancestry. There were impassioned speeches protesting against giving currency to the idea amongst the young that they should model their sex behaviour on that of the monkeys, and that such would inevitably be the consequence of teaching the young that biological laws applied to man.

The general spread of knowledge during the last twenty years has affected the attitude of responsible people almost unconsciously, and in all probability a similar proposal put forward in the near future to an international group of educationists would meet a very different reception. As sex behaviour effectively influences population and public health, family stability, racial quality, and personal happiness, it is hoped that U.N.E.S.C.O. will make an early opportunity to revive and review the suggested enquiry.

From the background of past prejudice and ignorance an objective outlook on sex behaviour is emerging. There is growing recognition of the wide inherent variation in human sex, of the seriousness of the psychological maladjustment caused by emotional shock or starvation in childhood, and of the interaction between the individual and his environment. It may be possible by setting out the different types of people into the two major groups of those who can and cannot follow an accepted plan of life, to consider the educational, legal and social measures calculated to promote well-adjusted family life, and to reduce promiscuity.

In relation to a number of behaviour patterns that involve the response of the individual to opportunity—whether sex promiscuity, alcoholism, forms of recreation, or even, the driving of a car—there are those who are inhibited from various causes, those who will always seize opportunity to excess, and the vast majority who follow the fashion of the group with which they are in contact. That such a broad classification applies to sex behaviour is borne out by experience. An attempt will therefore be made to analyse the three following categories:—

1. The inherently promiscuous.
2. The inherently non-promiscuous.
3. The average individual open to influence.

1. *The inherently promiscuous, the sub-normal and the abnormal*
   (*a*) The physiologically over-sexed.
   (*b*) The nymphomaniac and allied types of the psychologically over-sexed, the homosexual and the lesbian.
   (*c*) The psychologically unbalanced and maladjusted. Those who have been emotionally starved in infancy and early years; those that in childhood have been exposed to early sex relations—incest, etc.—adolescents who have early sex experience; those who have been subjected to undue strain of the emotions during the years of immaturity.
   (*d*) The mentally defective, the dull and backward.
   (*e*) Those with glandular maladjustment.

2. *The non-promiscuous: by inclination, circumstances or inherent causes*
   This group includes:—
   (*a*) In a monogamous society those with a fully integrated personality capable of fulfilling their plan of life, which includes those in whom the transition period from childhood to maturity has been lived under conditions of emotional security. The young adult of this type in the Western culture envisages and plans for permanent marriage.
   (*b*) The happily married.
   (*c*) The well-adjusted unmarried, i.e. those who have sublimated their psychological sex life into other satisfying forms of self-expression.
   (*d*) Those who are sex-deficient, psychologically sub-normal or abnormal; those with sexual inhibitions and maladjustments; those who have failed to adjust to their own emotional relationships.

3. *The average man and woman.* Those who may or may not be promiscuous according to circumstances.
   This includes the bulk of the population:—
   (*a*) Adolescents and young unmarried adults with no compelling tendencies. They are open to the influences of: the expectation of conduct by their contemporaries; the sex customs followed by their country; the conditions under which they pass their childhood and adolescence, and the ideals and spiritual values around them embodied in their traditional inheritance and their family and social groups.
   (*b*) The married who are not completely adjusted; the potential maladjusted; and those for whom sex implies mainly physiological satisfaction.

(*c*) The mature unmarried; the married partners separated by occupational and other external circumstances.
(*d*) Those that verge towards either end of the groups of sex abnormality and through environmental or psychological influences could be easily attracted either into the homosexual, lesbian, or promiscuous group.
(*e*) Those who adopt temporarily in youth habits of promiscuity or homosexuality through external influences

In a free community in which each is responsible for his own behaviour and its consequences, a certain level of mental capacity and of emotional stability is the foundation on which all response to law, custom and values must rest. It is useless to expect a nymphomaniac to be a partner in a monogamous marriage, or a mental defective to provide the best conditions for educating and training a family.

The normal individual adapts himself fairly well to the standard of sex behaviour accepted by public opinion, whether this recognizes laxity or control, but the abnormal and sub-normal persist in the behaviour that arises from inherent causes, irrespective of standards and conventions

In Northern Europe and Russia the last decades have brought changes that have affected conventions and standards of the general population of a kind that have thrown into relief those unable to adapt to the changes and thereby facilitated their recognition.

During the educational period the mental defective can be certified and thus protected throughout life, if the administrative facilities are effective and adequate. Otherwise, only those defectives who break the law come under the notice of the authorities, often after much damage to themselves and others. The aim of the future should be to provide diagnostic and treatment facilities that can be voluntarily sought; extension of the Child Guidance and Psychiatric clinics as well as treatment with residence in place of prison sentences for offenders.

For the sexual pervert the attitude of the community should be sympathetic understanding for the victim of a disability coupled with the recognition that youth must be protected from the psychological infection of the homosexual, from the oppression of the inhibited, from the maladjusted and those who have failed in their own family relationships owing to these causes. Their injurious influence in education on the attitude of the young

towards sex and family life has already been noted. Unfortunately educational establishments, institutions for children and young delinquents in many countries have numbered among their staffs those drawn from this group which has accentuated the emotional starvation the institutional system itself engenders The suppressive attitude towards personal sex-development has increased the time-lag in adopting an objective attitude in sex education. It has contributed not a little to the anti-social attitude towards sex and has checked normal emotional development in those under their influence. The lesbian and the homosexual is attracted, often unconsciously to types of occupation that bring them into contact with the young of their own sex, sometimes as a channel of sublimation. While this may be helpful to the affected adult it is not conducive to a healthy outlook on family life being unconsciously absorbed by their young charges.

An interesting confirmation that social work, related to sex problems, attracts these types comes from a report of the Welfare Division of U.N.R.R.A. made by an international body of responsible psychologists dealing with the displaced persons in relation to the treatment of the promiscuous girls and mothers of illegitimate children.

"Experience suggests—it might be wiser to say 'insists'—that it will be useful to issue a warning against the extent to which sexual problems attract individuals unsuited to this field, and lead to inquiries and discussions in which the motives of the would-be helpers and investigators are clearly far from objective. The connection between extreme aggressivity and violent pacifism and that between pathological religiosity and pathological sexuality are fairly well-known examples of this kind of difficulty.

"Although there are many excellent moral welfare organizations, this field of social work is more handicapped than any other by the existence of 'self-selected unsuitables' whose failure to recognize the mixed nature of their own motives is a constant source of surprise to their colleagues.[1]"

Medico-legal formulas are required to implement an objective outlook on sex behaviour; one to enable offenders coming before the Courts or those in social difficulties caused by inherent physiological or psychological conditions to be given residential

[1] *Psychological Problems of Displaced Persons;* Report to the Welfare Division of the European Regional Office of U.N.R.R.A. by an Inter-allied Psychological Study Group June 1945. Quoted by permission.

treatment and kept under guardianship if their condition is not yet amenable to treatment; another to enable the unbalanced adolescent to be temporarily placed under ameliorative care.

A further step is to recognize by law and convention that seriously maladjusted individuals, often impervious to education and public opinion, are not capable of fulfilling the responsibilities of marriage and parenthood.

The largest group whose members continue to be promiscuous is that of the average man and woman who follow the habits and customs of their group and tradition. Towards these should be directed every influence and social reform that can promote a higher standard of sex behaviour and can lend prestige and attractiveness to marriage, the family, and the home.

CHAPTER VI

FAMILY RELATIONSHIPS

To persist, a population must replace itself in each generation. That this replacement is not occurring in the West has aroused anxiety and the causes are being sought.

A full and authoritative analysis of the facts is confidently awaited from the Report of the Royal Commission on Population, now sitting in Great Britain. We will, therefore, only consider here the present social, administrative and educational trends that affect personal relationships within the family; their possible influence on family limitation, and on the attitude of the coming generation towards family life.

The alleged break-up of the family, of which the decline in the birth-rate, the fall in its size and the increase in divorce and separation are cited as evidence, may be indications of changes needed in the social structure to meet objectively based values related to a fuller appreciation of the implications of marriage and of the responsibilities of parenthood.

The general social structure in Great Britain is not widely dissimilar from other Western industrial countries.

To assess the biological effect on the family of the social and economic changes in the Western way of life, it may be helpful to recapitulate briefly the values that appear to be held in common by all mankind:—

Present in all cultures is—

(1) The sense of shared responsibility among the members of the family for the welfare of each of the group which reaches its biological focus-point in the provision of affectional care from infancy to maturity for the children of each generation. In the West this tends to be delegated in part to the community as represented by national and local government.

(2) The affectional tie between the parents varies in depth and duration, but in all, the lasting bond is respected and valued.

(3) The mutual educational influence of brothers and sisters as a vital link in the chain of personal development, and

an important channel for the passing on of the traditional inheritance.

(4) The brother-sister relationship which excludes sex relations gives opportunity for emotional ties and often involves material responsibilities, thus providing an essential training for the young of both sexes in social adjustment.

The relationships between the parents and children vary widely. In many tribal communities, for instance, the father of the children is not responsible for their care and guidance; this is the duty of the mother's brother, although the married partners usually have a joint home. Elaborate provision is made for the transfer to relatives of what is considered the privilege of inheriting the child in the event of the death of those exercising parental authority.

In polygamous cultures, variety in sex experience and also a real marriage and companionship of long duration with one wife, are often practised concurrently. In the setting of a harem, the first or chief wife may provide the unique relationship, though its biological significance has not been recognized, nor has woman yet been accorded the rights and status of an independent personality. Mohammedan communities, and "the Way of Life" in large parts of China, decree that the wife shares with others the sex life of her husband. The members of the harem share the domestic life in common, while in China, where concubinage is recognized, it is more usual among the wealthy, for each woman and her children to have her own quarters. In both cultures, the man is financially responsible for the woman and her offspring.[1]

In the West, extra-marital relationships are prevalent, but in the interest of the monogamous family and its legal status, the economic responsibilities of the man for the woman and her offspring are limited, ineffectively enforced and often ill-defined in law. For biological monogamy to obtain, not only must its advantages be understood and desired, but tradition, education and the social structure will require to be adapted to it.

In the West the social changes of the past century have undoubtedly affected family relationships. The causes of the change may be cited as the alteration from agriculture to industry as the economic basis of society; the increased economic complexity; the wider range of personal experience afforded by education

[1] In parts of tribal Africa that are polygamous, the wives have their own huts and share of land, and are usually responsible for providing the food for their offspring.

and the higher standard of living provided by industrial development; increased mobility; the effective recognition of the equal rights of the woman in the economic and political field; and the segregation in densely populated towns of the majority of the population. Recent economic stresses that often require both parents to work outside the home, and force adolescents to assume certain adult responsibilities—each and all have had an effect on the relationships of family life in Western civilization.

In primitive and agricultural communities, children are an economic and social asset, even a necessity. There are few economic barriers and strong social and psychological advantages in early marriage and prolific parenthood Our problem is not to replace primitive agricultural conditions because in these there are large families, not to withdraw education and independence from women, because large families obtain in communities where women are in ignorance and subjection, but to examine what are the factors in the other cultures which encourage the family.

It is asserted that the employment and higher education of women are important factors in the falling birth-rate. Yet there are reported to be large families now growing up in Russia where 65 per cent of the women between 20 and 45 are working gainfully.

The exhaustive analysis of the Soviet population made under the aegis of the League of Nations, and based on the census returns state that in spite of some 5,000,000 of war losses: "the dynamics of the Soviet population will bring continued population increase in the post-war period, with a large though gradually decreasing population of children, youth and young adults." Nevertheless after evaluating the general position the author indicates that: "the Soviet population may not pass through the trend towards population decrease that is now characteristic of most Western European nations."[1]

Literacy in Soviet Russia rose rapidly between 1926 and 1939. In 1926 only 66·5 per cent men and 37·1 per cent women were literate, by 1939 literacy, it is recorded, had been attained by 90·8 per cent of the men and 72·6 per cent of the women, and the reproductive rate is well above replacement needs even in the cities. In European Russia, one-third of the women marry at 19 or under. In the Caucasus mountains and in the rural parts of the

[1] *The Population of the Soviet Union: History and Prospects*, by Frank Lorimer, pp. 199–201. Published by the League of Nations, 1946.

U.S.S.R. and of the U.S.S.F.R. the reproduction rate is, to Western European standards, fantastic.[1] Whatever the cause of the decline in the West, it does not appear to be attributable either to women's work or to general education, as such It would seem that neither the women working outside the home nor general education need necessarily affect family size or status, but may be expected to influence the relationships of its members and to require certain adaptations of the present industrial pattern.

While the decline in family size has undoubtedly impoverished family relationships, several obvious causes can be removed by social and economic adjustment.

While every effort is rightly being made to raise the general standard of education and prolong school life, that university education can be open to all who can benefit therefrom, there will remain that deep-seated desire of parents, irrespective of their financial resources or social status, to give their child the best education available, and if possible, different from that sought by those they consider on a lower rung of the economic or social ladder. A working parent in a large town will take her children daily to a distant primary school, because the children "are a better class and use clean language." The professional or managerial parent will continue to limit their families to the numbers they can afford to educate at the public schools and universities. Some such system of group insurance as that proposed by Mr. Roy Harrod could be a valuable easement in the present situation.

The general attitude to marriage is an acceptance of the principle of monogamy, and the vast majority of marriages in Britain are entered into with the intention that the partnership should be permanent, but with an appreciation of the ultimate possibility of divorce should failure follow.

Both sexes now demand a higher standard of personal adjustment in marriage, both partners expect a fuller and more complete relationship if they are to forgo their independence. Two intellectually developed individuals will each draw deeper satisfaction from a happy and harmonious marriage which gives an opportunity for a wide range of shared interests, enriched by children, each one planned for and welcomed, than the simpler relation-

[1] Replacement is taken as 500 children under five per thousand women between the ages of twenty and 24. In 1926 for the total European part of Russia there were 844 children under five for this group, while in the rural areas it ranged from 933 to 1,219. Lorimer, *ibid.*

ship between those of more primitive peoples whose demands on each other may be less, but whose range of shared interests is small.

While leaders of thought of every developed culture have recognized in the unique relationship of a permanent partnership life's most satisfying adventure, it is more recently that the scientific and philosophical explanation of this has been developed and portrayed by the thinkers of the West.

There is admittedly a conflict of ideas and of practice in the method of seeking satisfaction in the sex life, the pros and cons of which should be argued out with the older adolescents of each generation. The monogamous union held as the highest form of human relationship by the inspired leaders of all the major religions shows every likelihood of gaining the endorsement of science as the relationship providing for the fullest development of the individual and the best atmosphere for the child.

The two patterns of sex behaviour are: on the one hand the deep and complete relationship between two people rooted in the physical, intellectual and emotional satisfactions of two mature and integrated personalities from which secure foundations the responsibilities of parenthood and citizenship can be undertaken as a natural form of self-expression. On the other, it is claimed that the life of the individual is enriched by a variety of sex relationships with different types. The case for this course is often presented on behalf of the male, but when followed by the female of the species, every social tradition condemns her, unless she seeks variety of sex experience under the cloak of an easy divorce law or keeps the Eleventh Commandment with care.

Psychologists indicate that the urge for variety persisting throughout life is a character pertaining to psychological immaturity, possibly due either to the persistence of the 'play' aspect of sex (see pp. 86, 89, 115) or to the failure to free the emotions from their attachment to the parent of the opposite sex, or the still unsatisfied seeking for the perfect mate, an attitude that belongs to late adolescence. Vandervelt,[1] Ouspensky,[2] Keyserling,[3] and Kenneth Walker[4] have all contributed constructive thought to this problem, and all are convinced that deeper satisfaction and

[1] *Ideal Marriage*, by Vandervelt.
[2] *A New Model of the Universe*, by Ouspensky. Kegan Paul, pp. 514–542.
[3] *The Book of Marriage*, by Keyserling. Jonathan Cape, London.
[4] *Sex in the Twentieth Century*, by K. Walker. Bodley Head.

greater personal development is won through the unique relationship.

Vandervelt stresses the importance of the practice of the art of love, thereby extending the intellectual affinities to the deepest emotional levels. Keyserling explains the importance of 'tensions' within marriage as a contribution to stability. Ouspensky in his emphasis on different sex types outlines the evolution of sex expression by the fully integrated personality as the highest human experience antecedent to the religious ecstasy of the mystic. Kenneth Walker places the new standpoint in perspective to the home culture.

One of the contributory causes of the persistence of the dual standard of morality has doubtless been the canalization of knowledge of the art of love to the courtesan and the withholding of it from the wife. To secure stability and at the same time the necessary freedoms claimed by two developed personalities in a life partnership, this must be based on a fundamental relationship with its roots at the deepest emotional levels of personality.

From such a basic stable relationship, mobile employment, friendships with the opposite sex—which adds so much to the interest and fullness of life—the management, training and guidance of the family, can all be faced with confidence.

For the roots of deep mutual adjustment to grow, it is desirable for the first year at least of married life to be one of undisturbed companionship with an opportunity for the growth of mutual understanding and for starting the home and the family. Yet, to-day, this relationship is constantly damaged by social conditions, while each partner, in conformity with the current trends of custom, feels at liberty to seek his or her own friends without the previous attainment of stability in the marriage relationship, thus bringing danger of disruption.

What of the maladjusted marriage? All are agreed that where there are children their welfare should be the primary consideration. With two emotionally mature and intelligent individuals, the effort will be made to secure that measure of mutual adjustment that will keep a home in being during the childhood and adolescence of offspring.

Divorce, where there are children, apart from any religious considerations, is a serious failure of personality and in the practice of responsible citizenship on the part of one or both partners; but for these failures the community must share the responsibility

as no place has been provided in general education, for positive education on the importance of family life, or in preparation for marriage.

If a high standard of adjustment within marriage is required, some failures are inevitable, but it is still to be proved that the increase in the number of divorces (see pp. 347–351) that have been granted since the Matrimonial Causes Act widened the grounds for divorce, do in fact indicate any increase in broken homes due to marriage maladjustment. An additional divorce is not necessarily an additional broken home. The home may have been broken beforehand, but the cause did not come within the scope of law. The new Act also brought divorce within the financial reach of the majority of the population while previously it had only been obtainable for the well-to-do minority.

The accumulation of cases during the war and post-war period, and the reduction of costs, led to the phenomenal figure of some 50,000 divorces for 1947, but for the future, the annual average is estimated at between 10,000 and 20,000; the average number of marriages being 400,000 per annum—the figure is not alarming. In the inter-war period some 6,000 Separation and Maintenance Orders were granted annually, this number is likely to fall as separation was the only and unsatisfactory solution for those who could not afford divorce.

The emotional tensions of a war unavoidably lead to hasty and unsuitable marriages or marriages immediately followed by enforced separations with no opportunities for adjustment. It is too early yet to know whether the increase in the number of divorces reflects any real increase of failures in marriage, but it appears unlikely.

The trend of public opinion towards the interest of marriage and the family is evidenced by the desire to provide social assistance to those in marital difficulties, to endeavour to prevent the break-up of the home. The appointment and Report of the Denning Committee[1] to enquire into procedure relative to divorce stresses the importance of efforts to reconcile the parties in the early stages of marital disharmony in the interest of the State, the parties themselves and the children. The ultimate development of an official marriage reconciliation service is advocated. A welcome step forward. The experiences of certain magistrates and probation officers, in recent years, have proved

[1] See Appendix, p 350.

how often understanding advice or even medical treatment can remove what had appeared insuperable difficulties in a marriage.

Among psychologically mature individuals it is the marriages based on physical attraction, on intellectual friendship, or on emotional sympathy alone, that are liable to break in the stresses of modern life. In the Victorian Era of large families and few divorces, marriage usually meant a shared and settled home life.

The real reasons for the failure of a marriage are not necessarily those presented to the magistrate with the request for a Maintenance (Separation) Order or to the judge in the Divorce Court.

There are many more cases of extra-marital adventures in a continuing marriage than those used as a ground for divorce in marriages that have failed. The reasons why most marriages fail are, broadly, two, physio-psychological maladjustment between the partners, or a biological defect on the part of one or both partners.

Where physio-psychological adjustment has not been attained the sense of frustration generates the desire to part, and any course legally admissible will be sought, consciously or subconsciously. Or if one or other is biologically handicapped, a complete marriage cannot be achieved or the responsibilities of parenthood fulfilled as these require emotional maturity, stability, and intelligence. It should be borne in mind, however, that the broken marriages are considerably increased by the frequent attempts of the permanently adolescent to attain a satisfactory relationship. It will be recalled how often the individual going through the divorce courts is doing so for the second or third time.

There are to-day probably at least a million individuals that belong to the "dull and backward" type, the psychopathic and the emotionally unstable. It is only to be expected that among them wise selection of the marriage partner and subsequent adjustment would both be less probable, while the tasks of home-keeping and child training are beyond them. Many "broken homes" and the "problem families" derive from this type while many of the persistently delinquent juveniles are handicapped by such parents.

So long as the serious responsibilities of marriage and parenthood are legally undertaken, though without capacity to fulfil them by the sub-normal, abnormal, and maladjusted, so long will the problem family continue to create a tragedy for its members and remain an open sore on the body politic. Dr. Brockington and others directly connected with health administration have

analysed the situation and taken a census of such families in their own areas; all agree in principle that a recognizable group exists. The following description given by the Quaker Pacifist Service Units after a survey of 62 such families, in Manchester, Stepney and Liverpool, presents the picture.

The family income is seldom higher than the allowance of a private soldier's wife, and is often irregular through chronic ill-health of the bread-winner. Payments of all sorts are generally in arrears, but there is excessive expenditure on non-essentials such as alcohol, cinemas, and children's pocket-money. The family is badly housed, and uses the house badly; "sinks and lavatories are choked, windows broken and woodwork used for fire," and eviction notices and Court Orders are common but unheeded. Sleeping arrangements are congested, "4 to 7 in a bed," while "often rooms are left empty while the entire family huddles together in one room for warmth" The house is bare of minimum necessities, "kitchens are without even the traditional sofa and sideboard"; "bedroom furniture, even of the crudest kind, is exceptional and a cot or a pram a rarity." The family live in a great disorder; "one may visit at ten in the morning to find the entire household asleep," or "sitting over the fire in the middle of the morning, the blind half-drawn and the gas just guttering out the last of its pennyworth, children in the underwear they slept in." School attendance is most irregular; children arrive late, ill-clad, lousy, unwashed, and without breakfast; often they are mentally deficient or educationally backward. Parental handling of the children is extremely faulty, leading to delinquency, disobedience, wildness, anxiety, frustration, physical and nervous exhaustion. There are no fixed meals at home, and filth abounds. About half the families lack one parent through death, war-service, desertion, or separation. "Their obtuseness of mind and degenerate habits . . . gain for them their reputation of hopelessness." "Landlords, officials, home visitors, all who have unsatisfactory dealings with them tend to treat them with disrespect."

Often, in spite of such conditions, the unity and affectional links between members of such families are strong; any proposal to the parents to split up the individuals among various institutions, even if it reduced the financial burden, is strongly resented and opposed. A dirty but affectionate mother means more to the child's development than cleanliness in an institution.

Certain authorities are therefore now appointing social workers who try to rehabilitate these families. This is an interesting experiment. Admittedly, an educated public opinion and wise administration would place barriers to parenthood on the part

of those obviously unfit or unable to rear fit children, but where the family already exists, it is surely the responsibility of the community to protect both the children and the neighbourhood from continuing damage.

The social changes, culminating in the active participation of women in war service have removed the difficulties that previously existed for the young of both sexes to meet. The vast majority of young men and women now have a wide range of friends of the opposite sex from whom they can select a marriage partner. This might well facilitate earlier marriage if other conditions were suitable. In 1939 the average marriage age was 26 for women and 29 for men. Socially this covers a decade of physical maturity for men imposing celibacy or promiscuity, and is well above the optimum child-bearing age for women. To make matters worse, barriers are raised to marriage of employees by National and Local Governments, commercial corporations and, before a certain age, even by the Church.

Greater consciousness of the importance of mental and physical health is beginning to affect selection, and the number of those intending marriage who seek a pre-marital medical examination is increasing while the custom of life insurance also tends to accentuate health as a social and economic asset. The general advocacy of pre-marital health examination with a view to establishing this as an accepted custom should, it is believed, precede for a considerable period any attempt to enforce pre-nuptial certificates by law as has been done in thirteen of the United States, Norway, Sweden, Roumania, and several other countries. In Great Britain, such a law would only be effective when it enforced on a small minority a practice already followed voluntarily by the majority

Rigid class distinctions are disappearing with the increasing opportunities for technical and professional education. The woman, on marriage, now legally retains her status as a separate personality, has jurisdiction over her own property, a right to her own earnings, and in marriage with a citizen of a different nationality she seeks to retain her own. The latter point is still a matter for discussion and concern in the International legal organizations.[1]

[1] "The Economic and Social Council of the United Nations Organisation is continuing the study of the problem begun by the League of Nations. In January 1948, during the Conference on the status of women, the resolution presented by the United States was considered. Ref E C.N C 32 and E°615 (stationery office)."

While education and a change in values has led to an increase of independence and in mutual respect of personality between marriage partners, conditions of industrial development have tended to increase the amount of separation imposed by employment.

Considerable numbers are drawn into mobile occupations, the commercial traveller, the seafarer, members of the Services, the staffs of nation and empire-wide enterprises such as the commercial air lines and many others have to leave their wives and families either for long intervals or frequently for short periods. The war and the housing shortage greatly increased the temporarily broken homes. A greater strain is placed on both partners in maintaining stability of relationship. Under those conditions the father, instead of embodying the spirit of discipline in the home, often becomes an exciting visitor, and is not there to enforce discipline or share the daily joys and troubles with his partner.

The form industrial development has taken makes increasing congestion by driving ever-growing numbers into towns The tenement and flat saved space—economic not biological considerations were paramount. Production of goods not families was the motivating influence. This position worsened with war damage and economic checks to reconstruction. For many the idea of 'home' is no longer of a settled place. A congested dormitory and seldom a centre of family life. The young married couples to-day are too often either living with relatives or in furnished rooms where tenancy is conditional on 'no children.' Both situations deny the young couple the primary needs for mutual adjustment and the building of a family, and encourage both instability in the marriage relationships and the small family.

Different types of housing are needed by different age groups, but in an ageing population, those without families of small children have created an effective demand for their own requirements, crowding out the economically weaker minority—the married people with young families. Is it not possible that one of the factors encouraging larger families in pre-industrial times was the elasticity provided to the cottage and the small house by the garden? Though sleeping accommodation was often overcrowded the extra open-air space gave the opportunity for the creation of those individual interests of parents and children which are the essence of home—pets, gardening, the workshop and the extra sitting-room in summer.

That the nostalgia for the garden and the private dwelling is still strong is disclosed by recent inquiries. The housing estate is designed to meet this situation, but at the expense in time and money in long daily journeys to and from work for the bread-winner.

An estate of 3,000 houses was built in 1926. Five hundred of its householders with families were questioned in 1934 as to whether they would prefer to be nearer their work in a tenement, or remain where they were. Eighty-seven per cent preferred to stay.[1]

A sample of 7,023 of the people of Birmingham were interviewed, 92·4 per cent liked gardens, 96·7 per cent preferred houses to flats.

The mass-observation housing survey conducted in six different types of housing development areas mainly around London showed from 68 per cent to 91 per cent preferred small houses or bungalows, while the flat attracted from 1 per cent to 22 per cent. There is no indication, however, whether this inquiry was limited to those with children.

In 1942–43, among the lectures given to young men and women in the Navy, Army and Air Force were a number on the post-war re-planning of Britain. The advantages of both flats with communal services for health, food and recreation, and of the one-family house were enumerated. After the lecture, a vote was taken. About 98 per cent of the men and about 83 per cent of the women preferred the one-family house to the flat.[2]

It is probable that the housing congestion will operate for a decade at least, during this period the rehousing and reconditioning plans should be open to the influence of popular demand.

It is recognized that the general conditions in China are not favourable to child welfare, but the stability of the family is renowned. It may be significant that the most usual form of industrial production is the family workshop. While under present conditions of hygiene and child labour China is not a model for the West, the principle of the parents working under conditions that do not disrupt the family is one that the West might endeavour to adapt.

[1] *Replacing Britain*, by Holdroyd Chambers, edited by G. F. E. Towndron, p. 108. Faber & Faber, London.

[2] *Civic Design of the House*, by A. Whitlock. Faber & Faber, London.

The garden city, with priority in accommodation and local employment for parents with growing families would both demonstrate in practical form the value placed by administration and industry on the family and be a direct encouragement to parenthood. This would apply equally to those factories around which workers' houses with gardens and civic amenities are available. It is not, of course, suggested that an unmarried specialist would be barred from employment, or that skilled workers in industry could only be employed, if married, in factories so situated. But that among candidates of equal efficiency for a post, preference would be given to the man with a family and flats rather than houses offered to those without children.

The advent of the first child is not only apt to be delayed and the size of family unduly limited by adverse housing conditions and separation, but also by economic difficulties involved in the woman having to relinquish paid employment for maternity, thus reducing the joint income at the time when family expenses rise. In certain other countries provision is made to facilitate maternity. Laws enforce that leave with pay must be given during the latter two months or six weeks of pregnancy and for two to three months after childbirth, while in factories and large businesses nurseries are provided where the breast-feeding of the infant can be continued by the working mother. Such provision in this country is still in its infancy.

The Government has tried to meet part of the economic difficulty by providing family allowances, but as at present conceived, they resolve neither the economic nor the biological problems.

No allowance is made for the first child, and the 5s. per week for each subsequent child only aims at covering the cost of additional food. The earning capacity of the mother is not replaced. It is true that a certain number of casually employed women with several children have been able to relinquish such employment and remain at home. It would be interesting to know the total number affected when the information is available. In the main, either the standard of living of the family must be limited to the earnings of the father, or the mother must work outside the home, and either risk neglect of the children or secure alternative care.

The gain in securing the acceptance of the principle of family allowances is appreciated, and, in the present period of economic stress, it is obvious that without other adjustments to the social

structure the economic strain of adequate family allowances would be beyond the financial capacity of the country.

It is desirable, however, that we should have clearly in mind what are the essentials in family life to which the industrial social structure must be adapted if both are to survive.

When husband and wife as parents of young children are engaged in full-time employment outside the home, what chance have they to develop their own relationship and preserve their mutual interests? A husband returns after his day's work to find an equally tired wife who then has to start the home duties of cooking, cleaning and washing, with no leisure for companionship. The child or children may be taken to a nursery school, but the infant hurriedly dressed and fed then left there for the whole of the mother's working day, to be called for, bathed and cared for when she is exhausted, is deprived of that physical and emotional contact with a happy mother through which it obtains its emotional satisfaction.

The need for the work of every man and woman was so great during the war that the Ministers of Health and Education promoted crèches, nurseries and residential schools to free the mothers from parental responsibility and enable them to work in the factories; many of these have now been taken over by the local authorities, or by grant-aided voluntary bodies, and will, it is hoped, be the nucleus of a widespread social service extending to villages and small towns as well as to large cities.

The development of facilities for temporary residential, intermittent and daily care under expert guidance has been rendered necessary and urgent by industrial conditions and changes in family structure and relationships. The nursery school provides the only child with substitute brothers and sisters The small families of the last generation and the employment of women have abolished the leisured unmarried aunt, who previously replaced the mother on any emergency. The relatives with large families to whom the presence of an additional cousin made little difference, no longer exist, and even the "spare bedroom" is scarce. So long as children were in the charge of those within the wider family circle, the same general values obtained. There may be a danger to be recognized and obviated in confronting young children with conflicting values and widely different patterns of social behaviour, such as prescribed by a nursery school, when they are too young to make decisions. Close co-operation between

parents and nursery staff appear to be essential to the emotional stability of the young child.

The residential nursery provides the best solution for the child in a family emergency, such as sickness, the advent of another child or the mother's absence in hospital. It also enables the parents to take an occasional short holiday together. The good residential nursery school can help, but cannot replace the parents. Just as the crèche and day nursery are necessary to changed family conditions, these must be recognized as an adjunct to, and not as a substitute for, the home.

Many a young married woman to-day is on the horns of a dilemma. If she takes whole-time paid work while her children are under five, their physique may benefit at the price of their emotional development. For a mother to work outside the home with safety for the family really requires "a substitute mother in the home" that brings a third into the adult circle and tends to damage the marriage relationship. One solution might be part-time work in industry and the social services for married women, together with an adequate supply of daily domestic help.

The majority of young married women prefer to make the home their occupation, though many who have had the companionship of working colleagues and the amenities of modern industrial welfare activities feel acutely the intellectual isolation often imposed by modern conditions on the housewife. The young married man and woman is urgently needed on the Social Services Committees of local authorities.

Those who are satisfied and happy in their home life are often loath to spare their leisure or to risk the serenity of the home by assuming outside responsibilities which are, therefore, imposed on the elderly and retired who have leisure. Their experience is valuable, but needs leavening by youth. This applies particularly to the voluntary committee work of local government and philanthropic administration. To-day the average age of such committees is often found to be between 65 and 70 years. The active participation of the young and happily married would go far to reduce the time-lag between current knowledge and practice.

Admittedly, the mother of a young family has little surplus energy or time for more than home duties until the children are at school, but whenever possible the marriage partners, the family and the community will benefit by the active participation of the happily married in social administration. Recognition of this will

add prestige and status to the family, while the wider interests will enrich and refresh the friendship between husband and wife.

The administrative adjustment to part-time work will admittedly be complicated, but full-time work, if accepted, tends to damage the young family; if refused it deprives the social services and industry of contributions, not only administratively valuable, but ethically essential to the creation of a right attitude to the family.

The part-time employment of young married people in the social services, education, the care of the homeless child, the domestic courts and in local government would go far to secure the desired change in outlook on marriage. It would indicate that the community recognized that the well-adjusted marriage provided experience which forms the basis of a valuable social contribution. For this to be practicable an adequate substitute domestic service would be needed.

Present trends in education, recreation and town life draw children away from home during the formative years. This has weakened the traditional transmission of essential home skills. The advent of a generation of young women unable to cook, brought it home to both parents and educational authorities as well as husbands that domestic instruction must be included in formal education. Much has already been done and more is projected for the girls in the extended year of school life—the wives and mothers of the future. The proposed equipment of the boys as potential husbands and fathers is less in evidence. Just as in the primitive tribes the youth is taught the household arts, so the more complex needs of civilized homekeeping should be acquired by both sexes during the school years. That the essentials of cooking and infant care are as necessary to the father as to the mother has been proved during recent years, and a man who cannot maintain the efficiency of the water, electricity and gas equipment of his home, do the essential carpentering and maintain the structure and repair of the house is a handicap both to his family and the community.

The idea of homemaking as a central interest of adult life should permeate the school atmosphere to the same extent as does to-day the future economic status attainable by the diligent pupil.

On many grounds it is being advocated that young women as well as young men should contribute a year of national service. It is suggested for serious consideration that the young women

should be recruited on the same basis and in corresponding numbers to the men. They could then work for one year under officers, trained either in child-care, the domestic arts, institutional management, nursing or local administration. The trainees under such guidance would, as future wives and mothers obtain training which would be to their personal advantage, while rendering service at crèches, day nurseries, hospitals, institutions for the handicapped children, for the old people—in fact for all those for whom the community has assumed the responsibility and care. During the latter few months of their service they could act as domestic helps to those selected families who are either acting as foster parents to the homeless children or who were doing part-time public, industrial or social work.

If it is accepted that the most satisfactory families are those where the marriage partners are happy, create family homes, and act as good citizens, then their contribution is required (providing it does not damage their own family life), and opportunities for part-time work must be made available.

Towards the child to whom the community stands *in loco parentis*, the country has a growing sense of responsibility. This was evidenced by the recent ventilation of the subject, including children from bad homes with defective, alcoholic or criminal parents, the orphans and the homeless. These can be brought before the courts and placed under the guardianship of the local authorities. The large philanthropic organizations, such as the Shaftesbury Homes, Dr. Barnardo's, the National Association of Homes and Orphanages, not only act in co-operation with the local authorities, but also cover a wider field and take many who are not eligible for official assistance.

The problem is no small one. The country is responsible for some 124,000 children, deprived for various reasons of parental care. It was, however, only after agitation by individuals and voluntary interest and the tragic demonstration that current conditions could result in serious injury to children, that the Government appointed the Care of Children Committee, which reported in 1946.[1] This presents in authoritative form the deplorable conditions under which many of the homeless children have hitherto been cared for by those responsible.

Physical care of the child up to the level of current knowledge has been provided, but constant change of home, lack of staff

[1] *Report of the Care of Children Committee*, Sept. 1946.

with sufficient leisure for 'mothering,' the frequent absence of the 'father' influence, the lack of substitute family relationships, e.g. brothers and sisters, of social contacts, of that essential need of the child—of belonging to someone—these were seldom recognized. In recent years the policy of boarding-out in a family has been developed, but if the child moves on to a secondary school, away from the home of the foster parents, no provision was made for it to spend the holidays at the only home it knows; just at adolescence the boy or girl is cut off from all stabilizing emotional links.

It is only to be expected that even among the potentially normal children coming under community care, the rate of delinquency and maladjustment in after life is disproportionately high. It is appreciated that among these children are a number with sub-average mental and physical inheritance. To add to this the strain of emotional starvation and the lack of opportunity during the formative years to adjust to social life can but increase the difficulties which will confront the individual as an adolescent and an adult. The recently enacted legislation designed to improve the condition disclosed will depend for its success largely on the selection of suitable personnel and on wise administration.[1]

The Report urges that these children should be provided for in as far as possible by adoption, by boarding out, and only if unfitted for such types of care, should the Institution be utilized.

For the physically and mentally handicapped, institutional care of special kinds is inevitable, but it is hoped that in future substitute parents will form part of the institutional personnel. The recognition of the importance to each child of continuing affectional care from infancy to maturity, must inevitably influence social administration.[1]

The Committee take the view that Institutional life is one of the reasons so few of the children under the care of the Public Assistance Committees proceeded to secondary education, this

"reflects in a serious way a failure to compensate the child deprived of a normal home life; not only because they are not getting the opportunities open to normal children, but because the lack of individual attention and of special teaching and stimulus in the infant and toddler stages may have directly contributed to their failure to reach the necessary standard."

[1] See Children Act, 1948, Appendix, p. 362.

In other words, nobody loved them, there was no one for them to love, so they did not develop.

This report as a whole is a tragic document, and is another indication that goodwill unfortified by knowledge can do serious harm. Moreover, as has been stated, those serving on the responsible Committees are mostly elderly gentlemen of between the ages of 70 and 85 and not young married people with growing families of their own in touch with current knowledge, because these under present conditions have no leisure to fight elections and serve on regular committees Nobody suggests that the local authorities do not wish to do well by the children under their care, and yet the type of care provided has been such as to damage irrevocably large numbers of those passing through their hands. Some seven different authorities have hitherto been responsible for the child from birth to adolescence The residential school and nursery will, of course, be needed for those children temporarily deprived of their own home life, but expected to return to their parents in the near future. We would protest, however, against using the approved school established for the juvenile delinquent as a suitable substitute home, even a temporary one, for the normal, non-delinquent, non-problem child, as is proposed. Although this may be to meet present austerity needs, it is urged that some equally economical but more suitable substitute arrangement be adopted.

It is hoped that in future serious endeavours will be made to find a home in a family for every normal child who is homeless, from the time it leaves its own home until it reaches maturity and forges other emotional ties.

The Report emphasizes that foster parents should not undertake this duty for reward.[1] Surely a community that valued and appreciated good training for home life and the development of stable character in the young citizen would recognize that they were receiving a valuable service. The privilege of bringing up those normal children who are the wards of the community, should only be accorded to the outstandingly good families in each community. 'Good' in this connotation implying a happily married couple that is rearing a happy, healthy family of its own. One would like to see the nomination of such families to a grade of citizenship that carried with it as one of its privileges that of acting as deputy parents on behalf of the community for which services they would receive an adequate reward and domestic help.

[1] The Act provides for payment.

While the Committee have spared no pains to satisfy themselves of the actual conditions under which children of different types are cared for, and have stressed the need for continuity in the home background, one regrets that even more emphasis has not been laid on the importance of the emotional life of the child, and, more specifically, of providing each with substitute parents, nor has this point been made the subject of one of their recommendations.

It is true the recognition of the need of someone to love and be loved by is implicit in many of the criticisms of existing practice, but a clearer emphasis of the point would have been welcomed.

Furthermore, no clear statement has been made as to the importance of substitute fathers and mothers being provided for both girls and boys. While it is stressed that the right type of matron should be available for the boys' homes, there is no mention of a substitute father for the girls, and this influence is essential to the growing girl. As has been indicated in other chapters, the rate of delinquency and maladjustment to-day is high among those who have come from the broken homes and been brought up under the institutional system.

Another cause for regret is that no stress is laid on the desirability of including young married women with children of their own as trained visitors and inspectors. Not only has a good mother first-hand experience of the management of children, but any suggestions and advice given by a mother who, in addition, has the status of a recognized inspector, would carry far more weight with the foster mother than would that of a young unmarried woman, however much theoretical knowledge she may possess.

Such an occupation would also make ideal part-time employment for carefully selected mothers, who would, naturally, have to take a preliminary course of training. The Committee stresses the importance of a university degree and theoretical training, but in the adjustment of personal relationships and in the real understanding of children, practical experience is an essential background to factual knowledge.

The Government accepted the Report and have embodied recommendations in the Children Act, 1948 (see Appendix, p. 562).

Under the old system the young adolescent suffered from the ignorance of those in charge of his welfare as much as the young child.

It has been seen that it is for the mid-adolescent that the social structure has diverged most from biological needs.

The early entry of youth into industry, which often brings economic independence in mid-adolescence, weakens parental authority. So long as the adolescent was dependent on the family, the parents had influence over the ordering of their lives; they could exercise some control and direction over their recreations and their friendships. To-day, when the earnings of girls and boys from 15 to 18 are an essential contribution to the family budget, the parents dare not criticize although they often sense the danger of irresponsible behaviour and undesirable company. The adolescent tends to resent criticism and will move from home to lodge elsewhere, in complete freedom, but with incomplete knowledge and an undeveloped sense of responsibility. A desire for independence is normal and healthy, but its present form is often disastrous. The extension by even one year of the school age will be a real benefit, but the extension of protection, training, and education to cover the full period of biological adolescence would enable many more to attain a mature and integrated personality. With the increased expectation of life now ruling, this would not be a greater proportion of the total span. Their irresponsible sex behaviour is due, it is submitted, to the adverse conditions and the absence of any educational emphasis on the value of the family and the inability of organized religion to relate spiritual with factual truth. The result has produced a behaviour pattern in which the play aspect of sex involves many in casual sex experience before marriage. Such casual experiences are usually intended to be transitory and the endeavour is made to avoid parenthood by the adoption of contraceptive measures. Forty-two per cent of the young women married under twenty years of age are pregnant on marriage, the first child being born less than 8½ months after the ceremony. The illegitimate birth-rate has remained at between 4 per cent and 6 per cent of the legitimate births since the beginning of the century except for the war peak (see Appendix, p. 359). The proportion of abortions due to criminal interference is believed to be rising.[1]

From the figures and from common knowledge it is clear that the social conditions and psychological influences surrounding

[1] In the figures for abortion a number of married women would be included, while in the marriages contracted after pregnancy would be included those who were living together with the intention of marriage on the advent of a child.

young people during the latter years of adolescence are at present conducive to casual sex relations, of which one of the results is a considerable volume of unwanted parenthood. As is indicated elsewhere, a considerable proportion of the unmarried who become pregnant unintentionally are drawn from the biologically under-endowed section of the community. The vast majority of normal young people, though often irresponsible in sex relations before marriage, look forward to permanent marriage with a self-chosen partner.

The Youth Movement[1] is a social endeavour to provide young people with the necessary wider interests under responsible supervision outside the home. The movement has as yet hardly begun to appreciate its unrivalled opportunity for providing education for family life and preparation for marriage. It is upon them that we must at present rely very largely for a readjustment of values.

Their influence can be exerted to promote among the young a sense that the adventure of life may be achieved in the right selection of a marriage partner, in creating a home and rearing a family, and that the family and its interests give economic success its value. That money without personal happiness brings little satisfaction

Furthermore, that in the transitory and unsatisfying adventures of irresponsible promiscuity or in the passing liaison, the future may be jeopardized. Factual information and hortatory exhortation will, however, be ineffective unless the community itself accords status and prestige to the homemakers in its local administration, national legislation and social conventions The principle is accepted, but so far nothing but a few economic easements have been accorded to the family. Surely the efficient parents of a healthy and well-reared family have not only an extra stake in the country, but are qualified to make a greater contribution in the influence of their citizenship than the young boy or girl of one and twenty. One might suggest the adoption of the principle that the number of votes accorded to each person is related to their stakes in the country; that parents of families attaining a certain size and standard should have an additional say in their country's destiny.

The public conscience has been sensitive to the plight of the old people, but contrary to expectations the introduction of retirement pensions does not appear to have weakened family

[1] See Appendix, p. 364

ties. In an ageing population such as ours[1] the position of the older generation in family life is important. In country districts and provincial towns the three-generation family is still closely linked, and according to the recent Nuffield Report on Old People, the grandmother when living with the family, in the vast majority of cases, makes a very material contribution to the domestic work. In the large towns, however, the acute housing difficulties and the mobility of labour materially reduced the proportion of old people living with the family, and the trend may well be towards special provision away from the home. Such provision is already urgently necessary for those old people without families. As a stabilizing influence to the traditional inheritance and as a definite factor in family relationships, it is hoped that where accommodation outside the home is provided this will not be in segregated areas, but in a residential district to enable the younger generation to preserve family ties

The economic provision for old age since 1946 of £1 6s. a week as the basic rate with various additions necessary for special cases, should preclude material want both in the interests of the old and of the young. One of the tragedies of the present situation as disclosed by the report, is the loneliness of numbers of old people requiring medical care, who therefore have to take refuge in public assistance institutions which, owing to their location and the rigidity of their regulations, are often almost inaccessible to their relatives.

In May 1946, of the 400,000 persons of pensionable age in England and Wales, nearly 63,000 were resident in public assistance institutions About an equal number were receiving medical attention as out-relief, but over two-thirds of the pensionable are either living with their families or independently. It is estimated that by 1989 the numbers of the pensionable will have so risen as to equal the numbers of the children under 15 years

To summarize, the shrinkage in family size has undoubtedly had an influence on family relationships. The sense of unity is more circumscribed and more concentrated on the immediate group. The wide range of cousinship claimed, and the large family gatherings are passing, affected by the increased mobility of the population and the long span of housing shortage. The relationship between parents and children ceases much earlier to be economic, but remains affectional. The shrinkage in family size

[1] See Appendix, p 374.

is in part due to a higher sense of parental responsibilities exercised in a social structure that penalizes the parent both economically and socially. Deriving therefrom is the need for domestic help and part-time employment for mothers of young families. There is no evidence of a lack of desire for children where conditions favour family life. The present structure is creating the social problems related to individual maladjustment to sex, social and occupational life by ignoring the biological requirements of child and adolescent development.

In primitive cultures certain factors for stability appear to have been preserved that are tending to disappear in the industrial West. For example, the destitute orphan and the homeless child are not a social problem in tribal Africa, where the wider range of family responsibility ensures to each orphan the affection and care of substitute parents.

Reviewing the war years as a whole, and considering the number of families that were divided through war service, their outstanding characteristic is not the number of marriages that failed, but the extent to which the members of the separated families overcame astounding difficulties to reunite whenever possible. The weight of evidence is that the links of marriage and the family, with all the disadvantages of industrialization and administrative failure, are still strong enough for the individual to be willing to make many sacrifices in order to maintain unity and stability of the family.

CHAPTER VII

PROSTITUTION

PART I

COMMERCIAL ORGANIZATION

In spite of the constant state of adaptation, and unconscious adjustment to advances in the application of science to daily life, in some fields there will be a long period of unchallenged conservatism; in others, a series of apparently entirely unrelated conditions will throw a custom into relief, create a challenge, and give rise to far-reaching changes.

This is the present position in relation to casual promiscuity and commercial prostitution.

This challenge is not due to an increase in moral fervour and is not confined to the culture that recognizes legal monogamy and the canon-law "table of affinities." It is world-wide and due to the spread of general education resulting in the growth, throughout the world, of a background of common knowledge.

The social conventions bearing on the place of sex in life are based on the standards of conduct and the ethical values from which they derive. As the social implications of the contributions made by the biological sciences are appreciated, a demand for changes in the social structure arises.

Sociologists and statesmen belonging to widely different cultures are beginning to recognize that certain principles have to be incorporated in the social customs of all communities where the democratic principle of personal responsibility and freedom is accepted, if the family is to be maintained as the basic social unit.

Among these are included the suppression of traffic in women for purposes of prostitution and the elimination of the vested financial interest in the business. By 1933 sixty-five nations drawn from every continent had declared themselves opposed to, and

prepared to suppress, the traffic in women between one country and another. A number of these governments have also made it illegal, under heavy penalties, for a third party to profit from the sex indulgence of others. This entails the suppression of the brothel and of regulated prostitution France added her name to the list of abolitionist countries in 1946.

There is still a widespread belief among members of the fighting Services and others that prostitution has always existed, that it is inevitable, and that the best protection for the health of all is to regulate it and place the women under medical control, the men serving under discipline being already assured of treatment. This, however, is a fallacy.

While it is not claimed that the abolition of regulated commercial prostitution will of itself abolish the demand for the supply of extra marital sex relations, it will immediately reduce the commercial stimulation of the demand. This is demonstrated by the experience of Russia. Many other educational and social factors that contribute to the demand will require to be changed through the application of long-term policies before the practice dies out completely. It is clear that to give lip service to the principle that prostitution and promiscuity are immoral, as has been done for some two thousand years, has but little effect. Man's reason must be convinced and the social structure adapted to human needs if casual sex relations are no longer to be the subject of a commercial transaction. To de-bunk casual sex relations from their place of priority interest as the leisure occupation of Western culture, a considerable change will be needed in the traditional inheritance transmitted to the rising generation.

That certain policies reduce demand and supply is evidenced by the fall in commercial prostitution witnessed in Great Britain and Scandinavian countries during the two generations preceding the turmoil created by the 1939 war. The writer claims that this is evidence of a rise in the general standard of sex behaviour. Not that fewer men and women to-day experience occasional extra-marital sex adventures, but that such adventures are in the main selective and have some emotional sanction. That there are fewer men attracted by unselective commercial sex relations is, it is claimed, in itself evidence of advance. The danger of prostitution to the individual is that, for the young, it prevents the integration of the physical, emotional and intellectual strands of

personality related to sex and therefore checks development. The youth, whose early experiences of sex are commercial, unselective and physiological with previously unknown prostitutes may become in later life the patron of the brothel as a married man because he has missed the satisfaction of the full marriage relationship in which body, mind and spirit unite and offer full expression to a mature personality. The temporary liaison may be anti-social and irresponsible and a source of unhappiness to two people, but at least it is entered into with emotional and often intellectual as well as physical satisfaction and therefore is one step further towards monogamy and not necessarily a barrier to it. For these reasons it is claimed the passing of prostitution is an advance in sex morals.

Casual sex relations on a cash basis were—under pre-war conditions—steadily declining in number. War and social disturbance, the break-up of families, and the migration of large bodies of young adult men to countries other than their own, naturally led to an immediate and large increase of both demand and supply. In Great Britain the women were mostly of the unorganized and free-lance type of prostitute, and young girls in their 'teens who were promiscuous in their sex relations as often for 'fun' as for cash.

First to define the terms:—

Prostitution is the purchase and sale of the opportunity for unselective sex intercourse. The prostitute is the woman whose known and primary occupation is to provide for the sexual physical demands of any man who is prepared to pay for the service. The demand comes from the man willing to pay anyone available, on the basis that the cash payment relieves him of any further responsibility.

Promiscuity is the practice of extra-marital sex intercourse on a selective basis, usually with some emotional sanction, payment being for services other than physical relations—e.g. as with the Geisha in Japan—or indirectly, as with presents or hospitality, as in Europe. On proof of paternity the man is legally responsible in most countries for any child that may result, but these laws are in the main unenforceable or inadequately enforced.

Kept Women and Concubines.—Extra-marital relationships of semi-permanent duration, where the man is financially responsible for the offspring and, in the case of concubinage, also for the maintenance of the woman for life.

Temporary Liaisons—Extra-marital relationships over a period of time on a selective and non-commercial basis.

The first three types are present to a greater or less degree in most of the old-established cultures.

Syphilis, gonorrhoea and other conditions which, if neglected, will be damaging to the quality of posterity, have increased during the war years and have always been particularly prevalent among the prostitutes. These diseases, as well as tuberculosis which is frequently found in prostitutes, need the willing co-operation of the patient if medical care is to be effective.

During the coming decade, conditions in the countries that have been belligerent will be favourable to those who exploit commercial sex relations. It is recognized that war and its aftermath intensifies those conditions which create both the demand for, and the supply of, commercial sex relations; that the amount of money available and the absence of purchaseable goods greatly increases the effective demand, and that the vested interests in the business of arranging supply and stimulating demand develop rapidly under conditions of social disorganization. Conditions in Southern Europe and the Balkan countries are particularly open to exploitation by the international traffic interests and a great increase in commercial prostitution is inevitable until drastic measures are adopted. The United Nations have already taken steps to call the attention of Member Nations to the dangers of the situation, and to the necessity of enforcing existing conventions aimed at the suppression of traffic. Member Governments of the United Nations are also being canvassed as to the desirability of signing a fresh convention on the lines of the draft prepared by the Social Section of the League designed to penalize the *souteneur*.

By reviewing the pre-war trends and the social and medical results of various experiences we may find guidance as to the lines on which the present emergency can be handled to the benefit of the community and the individual victim.

Historical Notes

A brief historical sketch of the origins of present attitudes and practices in so far as they affect those populations whose behaviour is based on, or influenced by, the Christian ethic, will be useful as a background. However, an analysis of the causes of prostitution cannot rest on historical evidence alone as so many pertinent

facts are omitted from historical records and regulations. Laws are recorded, but there is a lack of detailed pictures of the then current values and beliefs, of the extent of the gap between stated values and their interpretation in daily life, and of the social conventions that obtained in the different social classes. Also, we do not know how much factual knowledge was included in the traditional inheritance and passed down verbally from one generation to another. Yet these are the factors that influence personal behaviour; they are the flesh that clothes the skeleton of law.

What of the attitude of the matrons of Roman Egypt towards the intellectual leadership of Hypatia? Were they proud of the status of a fellow woman or were they behind the fanatical authority that caused her death? What was the social and home reaction of the wives of ancient Greece—more tolerant of human frailty than Imperial Rome—towards Aspasia and her prototypes? Did they consider it an honour for their husbands to be included in their artistic circle? The social position of the courtesan in Greece was one of leadership—was this acknowledged by the wives as well as their husbands? If it was so, it would be no more a reversal of the expected than the attitude of the wives of the Christian community in Southern India who to-day often insist on their husbands providing them with the conditions of purdah as a mark of social eminence.

The historical origins of prostitution give some clue to the confusion in current thought.

In primitive communities, human intercourse is deemed to have a mystical effect on the fertility of Nature. This idea still finds expression in several of the African communities and, in a slightly different form, in Southern India In earliest times in Europe it was embodied in prostitution of a religious character. Herodotus records that every woman was required by law to present herself, once in her life, at the Temple of Mylctta for the worship of the Babylonian Venus by giving herself to the first stranger who threw a coin into her lap. Or, again, he describes the Kadeslito (the Holy Ones), attendants of the goddess Ishtar, who were prostitutes. It is recorded that similar rites attended the worship of Osiris and Aphrodite in the islands of the Eastern Mediterranean and Greece.

In these early days chastity was primarily a male virtue and was reputed to be the means of increasing personal vigour and

bravery. It was also recognized as developing certain mystical and spiritual qualities. The influence of these values gradually resulted in the decline of temple prostitution.[1]

Side by side with this interpretation of the idea of chastity grew the custom, in troubled times, of keeping the women of the community in what was originally, protective seclusion in order to preserve their virginity. The growth in severity of the penalties for adultery imposed on women, and the strengthening of the social structure to protect the family also focused attention on the conduct of the women, and thus quite a different meaning became attached to the word 'chastity.' From an attitude of mind desired by the individual in the interests of his own spiritual and physical development, it became a physical attribute for a woman to be secured mainly by external protective or punitive measures. The confusion of these two lines of thought has resulted to-day in serious psychological problems of sex maladjustment due to conflicting values and a social structure inadequately related to human development.

With the decadence of temple prostitution in the Mediterranean the custom persisted on secular lines but was socially deprecated. Constantine officially abolished the custom of the girls previously dedicated to the temple seeking to earn their marriage portion by prostitution, while in Rome the baths and arches of the Temple were renowned as the meeting-places of the promiscuous. Solon is recorded as having opened the first public brothel, "a purely secular establishment for a purely secular end, with the object of safeguarding the population and of increasing the public revenue "[2]

The brothel was the death-blow to the conception of extra-marital intercourse as an act of religious worship. The State regulated prostitute thenceforward became an object of "public contumely."

From early days there are traces of prostitution along the caravan routes from China to Europe, on the shores of the Mediterranean and in the Babylonian cities. Traces exist in these early days of the two main branches of the business that in modern times are known as the professional prostitute and the individual "kept woman." The traffic in women was then (and continued

[1] *Social Hygiene To-day*, by H. E. Garle, pp. 20–40. Allen & Unwin. *History of Prostitution*, by W. W. Sanger, M D. The Medical Publishing Co., New York.

[2] "Study in Comparative Legislation": *Social Hygiene Year Book*, 1935, by H. E. Garle, p. 551. Allen & Unwin.

until recent years in North Africa and the Middle East) part of the normal slave trade, purchases being made in the open market, at the seaport or caravan station by the prototype of the brothel-keeper and by the agent of the wealthy man.

While the populations of the world were mainly engaged in hunting and agriculture under a strongly organized patriarchal family system both nomadic and settled, the demand for unselective commercial sex relations was in the main limited to those removed from their own background, i.e. the seafarer, the trader, and the cattle and transport drivers.

The different attitudes towards sex held by the Moslems, Hindus, Buddhists, Confucians and Pagans has led to the Middle and Far East developing social structures along somewhat different lines. Where industrial development has separated individuals from their families, as in Egypt, North Africa and the cities of India, commercial prostitution and the brothel system have arisen. Since the Middle Ages, when European seafarers and traders ranged the globe, the brothel or the "known woman" has existed in all the large port towns of Asia In parts, the custom has spread to the interior. Japan, of course, has for long had its own system.

The association between disease, sex abnormality and prostitution has long been known to exist. Certain early hygienic rules are by some attributed to attempts to prevent venereal disease. We have the evidence of the rules of circumcision of the Jews, of the avoidance of intercourse with women during menstruation throughout the Arab community, and of the avoidance of intercourse during pregnancy and often during lactation among many communities, including African pagans, and the rules of ablution and purification before and after intercourse which appear in various teachings.

During the decadent period of Greece, facilities for both prostitution and homosexuality were accepted as part of normal community life.

The conception of the family as the basic social unit was the foundation of early Roman institutions. In early republican times prostitution was practically unknown . . . it was not until the extension of Roman conquest developed the Roman city that it made its appearance to be met, however, not with the smiling acquiescence of the Greeks, but with the austerity of the Roman magistrate. The prostitute was registered with the proctor to whom she paid a tax, and might under

no circumstances secure radiction of the inscription. . . . Until the fall of the Empire of the West prostitution continued to be the subject of severe sumptuary and fiscal enactments.[1]

The early Christians, while demonstrating in a period of lax behaviour the value of chastity to men and women, not only as a discipline but as a means of happiness in marriage, showed kindness and sympathy to the prostitute while condemning the 'sin' of prostitution. This attitude changed when the Church acquired political power. The civil power penalized the 'crime' only in the woman: the administration of the Church, while condemning all sex laxity, was, presumably, influenced by current opinion, and imposed far heavier penances on the woman than on the man.

This dual moral code was (and is) justified by its supporters, strange to say, on biological, not on moral, grounds—because the possible consequences of childbirth made the act more grave for the woman. Will the ecclesiastical interpretation of sex morality now adjust itself to the additional knowledge by which parenthood can be a conscious act and an optional result of intercourse? Will the weight of their condemnation shift to a recognition of the equal responsibility of both partners in irresponsible parenthood? Will a casual act of sex intercourse with no social consequence be looked on as a less serious transgression, but a transgression for which both partners therein are equal offenders?

When the barbarians from the North succeeded the civilized socially-minded Romans, secular and ecclesiastical laws became harsher and even more concentrated on the woman. The Catholic Church condemned all physical experiences of sex as 'lust' and esteemed celibacy as a higher state than matrimony. Alaric introduced a different civil code under which prostitution became a crime with a penalty of three hundred lashes for the prostitute, but nothing for her partner in the act. The Church fell into line with the civil power and condemned adultery and fornication as equally grave offences for a woman.

The degradation of many of the religious orders into centres of licentiousness, the existence of a technically 'celibate' priesthood, many of whom accepted their celibacy as relieving them from any social responsibility for their mistresses or offspring but not as

[1] *Social Hygiene To-day*, by H. E Garle, pp. 25 and 26. Allen & Unwin.

limiting their activities in the field of extra-marital sex adventure, were all factors that confused ethical values in the public mind.

Those who recoiled from such conditions saw in all manifestations of sex the trace of the Devil. Hence the feeling of guilt that for many still attaches to all sex relations, even within marriage. This confusion of thought has seriously warped the development of personality and biased the outlook on the place of sex in the life of the West. The conception of an intellectually and emotionally accepted ideal of chastity in personal life as a method of enrichment of personality and of canalizing within the partnership of marriage the full and integrated experience of sex is entirely different from the forms of sex behaviour imposed by the community through convention and law. An imposed course of conduct and an attitude of mind are entirely different. Those to whom the ideal of chastity appeals inevitably avoid promiscuity because it is unattractive. The undeveloped mind that desires casual physical sex experience and is forcibly denied it, continues to be maladjusted. This connotes not chastity but frustrated prostitution An ideal cannot be imposed by force. As well try to make a street sweeper paint a picture of Titian quality by inflicting the knout. A community can be made to acknowledge and conform to social codes and the majority will see that the recalcitrants are either excluded from community life as incapable, or made to feel the pressure of public condemnation through legal measures, but the adjustment of the emotional life of the individual must be voluntary and come from within. It depends largely on education, on the values absorbed through the family, and on the current expectation of conduct.

It is interesting to note that those countries that to-day have adopted in the schools the objective, scientific approach to human development, placing the sex functions and sex responsibilities of the individual in perspective, are those countries that have shown the most rapid fall in demand for, and supply of, the professional prostitute. It is a form of sex expression from which the more educated and developed, and therefore the more fastidious individual, recoils This does not mean there are necessarily few extra-marital relationships in such communities, but that only those that are selective and have some emotional sanction are attractive to the more developed type of personality.

In Europe, from the downfall of the Roman Empire to the end of the sixteenth century, first the Crusaders and then the existence

of mobile mercenary armies, in addition to the travellers, maintained a demand for commercial sex relations The existence of the recognized brothel became part of the social structure in many of the larger towns.

The grounds on which authority undertook the responsibility of organizing the supply of prostitutes were, as has been said, to protect health and to preserve order and decency.

Henry II in 1161 decreed that in London no brothel-keeper might keep any woman on his premises who was suffering from the 'dangerous disorder of leprosy' (in those days the distinction between syphilis and leprosy was undefined). The same decree limited the woman's customers to one per night—a pleasant contrast to the twenty to twenty-four per night which were averaged in the Malay Street brothels of Singapore in the early twenties of this century.[1]

Prostitution and Administration

We have seen that, historically, the object of authority in endeavouring to regulate prostitution was to secure a standard of order and decency that accorded with the knowledge and the public opinion of the time, and to prevent the spread of disease. It was not until the beginning of the twentieth century that the causative organisms of syphilis and gonorrhoea were discovered and successful methods of treatment devised. The next stage was the recognition of the social and racial damage caused by those diseases, since when their prevention has become a major objective. From the social angle came the endeavour, in the handling of the problem of prostitution, to prevent the exploitation of women. Underlying all measures was the desire of good governments to reduce prostitution and encourage a high standard of public behaviour.

At the end of the last century the effect of the work of Josephine Butler in Great Britain, which secured the repeal of the Contagious Diseases Act in 1886, had brought to public notice the position of those women and girls who were prostitutes, the extent to which they were exploited, their civic defencelessness, and the dependence of their occupation on the financially backed demand for their services. Her presentation of the case was based on moral grounds, and her major plea was for justice to the women. The interest in and appreciation of the position aroused

[1] *Social Hygiene To-day*, by H. E. Garle, p. 31.

by her, directed attention to the serious problem of traffic in women from one country to another. One cannot consider prostitution in relation to administration without bearing in mind that such traffic is mainly a traffic in those girls who have already followed a life of prostitution in their own countries and are, therefore, where regulation exists, outside the network of social agencies created by most European communities to protect young people. From 1889 to 1894 Mr. Alexander Cootc (subsequently Sir Alexander Coote) toured the Chancelleries of Europe —with the benevolent goodwill of the British Government—in an endeavour to secure international action designed to check the traffic. At that time girls were decoyed and kidnapped even in Great Britain, and taken to the brothels of foreign countries where they were entirely friendless and unprotected. The greatest scandal was that young girls unconnected with prostitution in any way were abducted and taken to foreign brothels, while girls from clandestine brothels and, in far greater numbers, from the brothels of regulated countries were induced by fraud and misrepresentation to travel to fictitious openings offered them abroad Once the girl was out of her country of origin the trafficker was safe, as there was no extradition for such offences. The publicity given in all countries to the scandal and to the prevalence of the traffic helped to crystallize opinion.

The system of regulated prostitution persisted in Great Britain until 1886 under the Contagious Diseases Act which was only introduced in 1865 to protect the health of the Army and Navy. It was a measure limited to port and garrison towns.

Although brothel-keeping is illegal in Great Britain, the owners of brothel property, the pimp, the *souteneur* and the brothel-keeper are penalized—brothels still exist in the ports and large cities. They are often known to the police, but without the active co-operation of the citizens the law is often difficult to administer. Also, a number of the more conservative-minded and less well-informed of the local Watch Committees and police forces still hold the view that "as prostitution must go on, it is better to know where it is." A number of those whose actions could bring them within the law, gain immunity by making themselves useful to the police in their knowledge of the habits of criminals and loose characters. There are in the large cities a certain number of luxury establishments that change their locations and are run in the guise of Clubs, Nursing Homes, etc. etc.

On the whole, however, such brothels as remain either from tolerance or from legal difficulties are small; they are rather "lodging-houses" for prostitutes than the Continental type of brothel. The women and girls pay highly for their accommodation, but are in no sense in the power of the keeper. Debts for entertainment and clothes—i.e. professional debts—between a brothel-keeper and a prostitute are not recognized in law as the occupation of brothel-keeper itself is illegal. This is important in the policy of suppression. The difficulty still in Great Britain is the apathy of public opinion. The unwillingness of citizens to complain or lay information that an adjacent house is used as a brothel, or to come forward as witnesses tends to hamper active administration. Everyone nearby will help to catch a thief—few will help to catch a brothel-keeper.

A different form of organization now seems to have developed in certain large towns, particularly London, where groups of business men exploit a number of girls as tenants of single-room flats. These, as the law stands, cannot be proceeded against as brothels, even if known to be used for the purpose, as the legal definition excludes them.[1] How to draw an Act of Parliament that would suppress the use of a flat as a brothel by a single tenant and at the same time leave freedom to the tenancy of the professional woman, and the wife or widow living alone, has, so far, not been solved, but is under continuous consideration.

There is still among those out of touch with recent experience a strong under-current of support for some form of regulation. Therefore, it may be useful to summarize the results of recent sociological and medical investigations that have convinced those in close contact with the subject that any of the known forms of regulating prostitution have failed in their objective. They have proved a barrier to the reduction of the incidence of venereal disease in the general population, and have not been found to contribute to order and decency, to protect the virtuous woman from rape, or to promote the stability of marriage and the family; on the other hand, they have been proved to be the foundation of the traffic in women.

Regulation is applied in various forms—

(1) *The tolerated brothel* may be registered and pay special taxes to the municipality which, in return, provides free medical

[1] See Appendix, p. 400.

inspection to the inmates, as in Spain and Greece, or may be tolerated by the police without official connection with the municipality.

(2) *Segregation* where the municipal authority requires that prostitutes should reside in certain quarters of the town, or, if they do not 'require' it in practice, it becomes a police custom only to leave unmolested brothels or single prostitutes living in certain houses, streets or districts.

(3) *Registration* where, to obtain police protection and to be guaranteed—as it were—by the authorities, a woman must be registered by the police, and must present herself, where and when instructed for medical examination; if and when hospitalized, it is at the charge of the municipality. In most cases registration leaves the woman free to choose her own lodging and exists in countries where the brothel is not tolerated as well as where it is still legal.

(4) "*Etatisme Sanitaire*."—An official sanitary service which has been instituted by several of the countries that have recently abolished the brothel system and penalized third party financial interests in prostitution. It requires the compulsory treatment of venereal disease. It is a step forward from regulation as it does not create a focus for traffic, nor are the women obviously exploited. When it is the sequel to regulation, however, it frequently results in the compulsory treatment for venereal disease being mainly limited to the prostitute group.

The dangers and social disadvantages of the brothel and, to a lesser extent, of the registration systems are.—

(*a*) A group of women are segregated from the community, deprived of the normal social protective influences, and become the market in which the trafficker buys his goods. The main traffic routes are found to run from one brothel-keeping country to another. The brothel and the house of accommodation provide the financial framework of the commercial interests in prostitution. A full account of the business organization of traffic based on the brothel appeared in 1927—the Report of the Experts Committee of the League of Nations.

(*b*) The brothel is the advertising centre; those owning the property support all methods of local advertisement of its services, and stimulate the demand in many and devious ways. Brothel-keeping and drug distribution are often associated. The very existence of a known house or a group of known registered women

is a constant suggestion and advertisement of casual sex relations. If an industrial producer wants to sell his goods, he promotes chain stores, employs salesmen and spends large sums on advertisement. the brothel is the shop, the girls the advertisement; the pimps, taxi men, bell boys, guides, waiters, etc., the salesmen. Official toleration influences the general expectation of conduct and gives a false sense of security from infection. Wherever there are brothels or registered women, there are more clandestine prostitutes or amateurs. Flexner in 1900 estimated the proportion in European regulationist cities as ten clandestine to one registered woman. More recent figures give a higher percentage.

(*c*) The periodical examination of women has proved in practice to be ineffective. To establish whether or not any trace of infection remains from long-standing syphilis or chronic gonorrhoea is a complicated and lengthy proceeding, including in the case of gonorrhoea the making of cultures and in syphilis of provocative treatment, an examination of spinal fluid, etc. The procedure at a municipal clinic is for a number of girls, from twenty to one hundred and fifty in a morning, to receive a cursory local examination, possibly a blood and smear will be taken and examined on the premises, the card stamped and the girl dismissed in as short a time as possible. In one of the 'best' clinics in Northern Europe, attended for a morning by the writer, two medical men passed through one hundred and forty girls in two hours. The medical men themselves acknowledged the procedure as a means of making accurate diagnosis was useless except in acute cases. The girls prepared themselves before examination by disinfectant douches which made any taking of specimens a farce, therefore chronic gonorrhoea could not be recognized. No responsible venereologist would pronounce an individual known to have been exposed to infection as free from disease under a period of at least three days.

(*d*) Regulation, by canalizing the customers, results in a large number of exposures to the risk of infection being directed towards a known highly infected group. From this standpoint it is a purely arithmetical problem. The brothel inmate or registered woman is examined weekly, or often fortnightly. The number of customers received in twenty-four hours varies from six to twenty-four, according to type and conditions—even higher numbers obtain under conditions of war or social disturbances. In one week, therefore, on the lowest computation, a healthy woman infected

by her first customer may be a carrier of the risk of infection to at least forty-one others. If she herself becomes infected, her condition will not be recognized until the next weekly examination. The average 'amateur' does not receive more than one visitor a night, and two in the week is the more usual average.

(*e*) The claim that the provision of facilities for prostitution is necessary to preserve the family as otherwise women and girls would be pestered by the unmarried male is a theoretical argument. Several analyses of customers have disclosed that the most numerous frequenters of the brothel are married men. In the seven areas in the British Empire where brothels have been suppressed during the last fifteen years, no administration records an increase in rape or sex offences.

(*f*) To provide free treatment facilities for the prostitute only, can never eliminate or even reduce disease, and the result of so doing deters all other women from voluntarily seeking treatment: the clandestine prostitute, because if found to be infected she would be forced to register, and the married woman or casually exposed girl because they would be known to have the 'prostitute' disease.

(*g*) The arguments that have proved convincing to the administrators in areas where brothels existed have been those based on the growth of our knowledge and understanding of the etiology of syphilis and gonorrhoea. It is now recognized that the community is best served by bringing all the infected under medical care at the earliest moment after infection.

During the war and post-war period, the medical authorities of the armies who were solely concerned with maintaining the health of the forces and not with the social results of their emergency measures or the general spread of disease in the alien civil population, went so far in some cases as to place the alien service medical officers in charge of the women and girls in the brothels to examine them daily, dismissing those showing signs of infection and replacing them by other candidates who were examined before admission. Some military administrations authorized their military doctors to treat the infected girls if they wished to be treated, but the scarcity of the new drugs and of hospital accommodation in all cases that have come to the writer's knowledge precluded giving the girls the new intensive treatments. Other armies left the infected to rejoin the civil community even where the pre-war civil clinics were closed and drugs were not available.

Even these methods, ethically indefensible, did not prevent every belligerent army showing a high increase of new infections Even the British Army where the figures are said to compare favourably with those of other armies or units where figures were available, showed a steep rise (see page 396).

From the various experiments in social administration made during the last twenty-five years one from the British Empire is selected as its results, when presented to the Social Section of the League of Nations, were a stimulus to reform on similar lines in other countries. Six other areas in the British Empire followed a similar policy, and the results of all seven illustrate the same principles.

In 1920 three Commissions were appointed by the British Social Hygiene Council and financed by the Colonial Office to visit British Crown Colonies to confer with their administrations on matters relating to venereal disease and prostitution. The writer was privileged to be one of the two Commissioners visiting the Far Eastern Colonies. Technical medical questions were in the hands of the Medical Commissioner; the educational and social matters were the responsibility of the woman Commissioner.

The visit to Singapore disclosed a high prevalence of venereal disease both in the civil population and in the units of the British Army and Navy on the station.

Commercial prostitution flourished in all its forms. For the Europeans: better-class brothels, most of the girls being Eurasians, and a large number of independent clandestine women and girls, both Eurasian and of European nationalities. Chinese brothels for the Chinese; a small residue of Japanese brothels (the Japanese prostitutes having been recently recalled by their Government from all foreign establishments); brothels for Malays: queues of intending customers that vied with the London queues for a popular film, were seen every evening in Malay Street.

Many of these establishments were visited; facilities for a full enquiry were courteously given by the Chinese Protectorate, the police and all the official agencies concerned; services of trustworthy interpreters were made available for interviews with all types of men, women and girls involved. With the background of such divergent religious and social values as were presented by the variety of races present in Singapore, the medical and scientific objective approach gave a basis of common interest and, in the main, created a co-operative and informative atmosphere.

The Commission fortunately reached Singapore after visiting Japan, Shanghai, Canton and Hong Kong, in which places they had had the opportunity of discussing the general problems of social hygiene, not only with the British Administration but with the leading Japanese and Chinese officials, medical practitioners, and hospital and public health officials. They had in this way acquired some understanding of the attitude of mind of the members of the different races resident in Singapore which was vital in enabling them to make an approach inoffensive to the members of the different cultures.

The leading British medical practitioners and the local Press were firmly convinced of the value of regulation. Some of the administration, being more in touch with the additions to scientific knowledge and social experience in recent years, were willing to move on progressive lines and exchange the regulation system for a scheme that provided free treatment for venereal disease for all, checked recruitment for the brothels by changes in the immigration law, and gave notice that at a given future date (the Commission suggested three years' notice) brothel-keeping would be made a punishable offence The reason for this was to remove the financial value from brothel property and, by checking the influx of girls, to reduce the numbers who would have to be cared for on the closing of the houses. It would give those financially dependent on the business an opportunity either to leave the place or to find other occupations. These ideas were violently opposed in the Press and in discussion, both during and after the visit of the Commission.

The various developments that arose from the visit of the Commission over the ensuing twenty years will be summarized from the British official reports to the Social Section of the League of Nations which were prepared with the co-operation of the Singapore and Straits Settlements administrations.[1]

Close personal contact was maintained through the bi-annual Imperial Congresses on Social Hygiene which were attended by officials and representatives of non-official interests home on leave, and by visits to Singapore by prominent members of the British Social Hygiene Council. The writer was also honoured by an invitation to serve on the Committees appointed by the Colonial Office in 1925 and 1929.[2]

[1] Committee to report on proposed New Ordinances, 1929.

[2] First Report Advisory Committee on Social Hygiene, 1925. Nos. 15 and 17. C.M.D. 3294 Colonial Office.

Straits Settlements, 1924–29

"Conditions of peculiar difficulty affected the problem of prostitution and venereal disease in Singapore. The large immigrant Chinese and Indian population resulted in a sex ratio of one hundred Chinese males to about forty-seven Chinese females. For Malaya as a whole, the ratio is one hundred Chinese males to about thirty-eight Chinese females. There is a long history of regulation of prostitution, and the abolition of the Contagious Diseases Acts in Great Britain, although followed by the Colonial Government, was not in accordance with local opinion and a system of tolerated brothels persisted.

"The visit of the Social Hygiene Commission led to the appointment by the Legislative Council of a special Medical Committee of Enquiry in 1922. This Committee reported an exceptionally high incidence of venereal disease among the population, particularly among the Chinese section, and recommended that an Ordinance should be adopted increasing the brothel area and improving the arrangements for the medical examination and control of prostitutes.

"The Ordinance was submitted to the Colonial Office for the consideration of an Expert Committee. This Committee reported against the Ordinance and in favour of ample facilities for free treatment and for public enlightenment and various other social measures."

Singapore

A Social Hygiene Board was established under the Medical Department in 1926 and took over the work of the then existent Singapore Branch of the Social Hygiene Council. A special officer was placed in charge of the Social Hygiene Department; money was voted by the Government to finance the establishment and staffing of a number of centres for the free diagnosis and treatment of venereal disease.

From 1926 to 1928 the activities of the Social Hygiene Department steadily increased. By 1928 there were four clinics and four outdoor dispensaries for the free treatment of men; two clinics and two outdoor dispensaries for the treatment of women; and three hospitals at which in-patient accommodation was available. Clinics for out-patient treatment were also held at the hospitals. All examinations and treatment in the women's clinics were carried out by a medical woman.

The number of new cases treated increased from 7,284 in 1926 to 14,016 in 1927, of whom only 1,266 were women.

It should be noted that, under the former system, the only treatment available, in part free and in part at low cost, was that in connection with the brothels. The total number of women in the brothels amounted to approximately one thousand eight hundred, of whom only a small proportion were actually brought under treatment. Therefore, from the public health point of view, the policy of providing facilities for free treatment on a voluntary basis brought a far larger proportion of the general infected population under medical care than the system of compulsory control of the prostitute group alone.

The measures taken to reduce disease in the civil population are reflected in the official Army figures for the troops stationed in Malaya, the majority of whom were in Singapore. These fell from 119·9 per 1,000 gonorrhoea in 1922 to 65·9 in 1926; from 42·4 per 1,000 syphilis in 1922 to 12·1 in 1926. The medical measures aimed at reducing the incidence of the disease in the general population were supported by the policy of the Government with regard to the prevention of traffic in women in that, in 1926, it was made illegal for professional prostitutes to enter the Straits Settlements. At the same time, steps were taken to carry the policy recommended by the Colonial Office Advisory Committee into effect and gradually to reduce the number of tolerated brothels.

Between 1926 and 1928, with the help of the laws prohibiting the immigration of prostitutes, the Chinese Protectorate were able to reduce the number of known brothels from 231 to 176 and the number of inmates from 1,864 to 1,189. It has always been recognized that the practical difficulty of enforcing a policy of the rapid closure of brothels was to provide for the inmates in such a way as to protect the health of the community and the interests of the individual women concerned; it is interesting, therefore, to register an actual case. In the Report of the Secretary for Chinese Affairs it is stated:—

> If this policy is consistently followed during 1928 and 1929, it is probable that by the end of 1929 this class of brothel will have disappeared. The only problem that presents itself is that of the disposal of the inmates when a particular brothel closes. It has, however, been shown that a large number of prostitutes leave their brothels of their own will every year. This fact, combined with the cutting off of the

supply will, in my opinion, do away with any real immediate difficulty as to the disposal of the great majority of prostitutes in these brothels.[1]

The Straits Settlements were visited in 1931 by the League of Nations Committee of Inquiry into Traffic in Women.[1] Notice had been given to all concerned in 1926 that in 1929 brothels would be closed, and subsequent to that date brothel-keeping and the using of brothel property would be penalized. By 1929 only 69 houses and 519 girls remained.

A full account of the measures taken to check the arrival in the port of new inmates during the three years, and the educational and protective measures adopted by the Protectorate to safeguard the girls from exploitation by traffickers and to help them to find other employment when the time of final closure arrived are given in the Report to the League of Nations. At the moment our concern is to put before those who, from their traditional inheritance, have a lingering feeling that the regulation of prostitution is really a good thing and is only opposed by "a lot of old women of both sexes who don't know what they are talking about"

On the effect on 'Order and Decency,' of the closing of the brothels, and the removal of all forms of regulation, the Report states:—

Law and Order

One result of the policy of closing down the licensed brothels has been in a sense unearned increment, a very considerable gain in the peace and good order of the towns of Singapore and Kuala Lumpur . . . the consequent dispersal of prostitutes over a very much wider area than had been the case before has resulted in a great decrease in cases of disorder resulting from these gangs and in cases of extortion and blackmail.

Solicitation

No recorded increase of complaints of annoyance and none reported by the police.[2]

Traffic in Women

A network of preventive and protective measures was established by the Chinese Protectorate which, with the removal of the local 'market' provided by the brothels, resulted in a marked decrease.

[1] Social Hygiene in Singapore and the Straits Settlements 1921–34. Report on Abolition of Licensed Houses, p. 77. League of Nations (221 M 88 1934 IV). Also Questions and Answers re Effect of Abolition Questions and Answers, p. 3 (1933, Nov 25).

[2] The experience of Hong Kong was different, and a temporary increase in street solicitation was met by special measures.

Sex Offences

There is no evidence that the closing of the houses has caused any increase in sex offences.

Public Health

In 1926 the free treatment facilities were extended by the opening of 26 centres for treatment in other towns in the Straits Settlements. The nine already mentioned in Singapore continued to develop under the supervision of a Social Hygiene officer. By 1934, as a sequel to several years of steadily increasing attendances, there was a fall of 2,800 in the new cases of male infections. Large numbers of women from the general population, as well as prostitutes, attended. Before the closure of the brothels the only women treated were inmates of the houses who went under compulsion. Contrary to expectation, those subsequently remaining as clandestine prostitutes stopped attendance for a time, but by 1932 they were gradually returning. The number of clandestines and of married women crept up slowly.

It will be realized that to attract the independent women of the educated populations of the West to treatment centres has been a major difficulty, even to approximate the numbers of women from a largely illiterate and racially mixed population of an Eastern port is an indication that the right approach can be effective in very divergent settings.

The general policy advocated and subsequently adopted in Singapore was also promoted by Social Hygiene Commissions and adapted to local conditions in six other places within the Empire, in the port cities of Bombay and Madras, the Federated and Unfederated Malay States, in Cyprus, Gibraltar, and Hong Kong. In each, conditions varied, in some, the steps were gradual and slow, but in all the same general results followed.

Unfortunately with changes in administration, personnel and the war which broke the links with the Home organization, there has been a partial retrogression in some of the Colonies.

To mention one other enquiry in relation to public health. The French Ministry of Health have for many years been advocating the penalization of the third party interest and the consequent suppression of the brothel (see Appendix).[1] To convince some of the legislators who feared this policy would lead to an increase in venereal disease, an endeavour was made in 1927 to assess on a population basis, the comparative number of new infections of syphilis in Paris and in London. In London, brothels

[1] Efforts of the Ministère de la Santé Publique were crowned with success and abolitionist legislation reached the Statute Book in 1946.

were illegal and venereal diseases were treated free of charge on a voluntary and confidential basis.

As the British representative on the Union Internationale the writer was asked by the French representative, Director of the Social Hygiene Section of the Ministère de la Santé Publique, to collaborate in the enquiry and to prepare the report. The British authorities of the London County Council and of the Ministry of Health courteously gave the fullest co-operation. In both Paris and London the new infections among those presenting themselves at the treatment centres infected with syphilis during the year 1928 were recorded and, for London, an estimate was made of those cases treated by private practitioners, based on the drugs applied for under the V.D. Scheme. This was acknowledged to be rather an over-estimate The population of Paris was taken as 4,000,000; that of Greater London as 8,000,000. In 1926 there were seen for the first time in the V.D. clinics of Greater London 5,270 cases of syphilis. A special investigation was made to ascertain how many of these new cases were recent infections. The enquiry disclosed that about 40 per cent had contracted the disease within the last twelve months, i.e. were, in fact, new cases. Therefore in 5,270 cases 2,108 would be new infections. In addition it was estimated that practitioners saw patients amounting to not more than one-third of those attending the clinics. On a generous estimate this gave a total of 2,800 new infections of syphilis for 1926. The same proportions of new cases of recent infections applied to the population of Paris would give an incidence of 1,400 new infections in the year.

In Paris, treatment was given at the Vernes Institute and its branches, at various dispensaries, at three large general hospitals, and by private practitioners As the result of a special investigation it was found that new infections formed 60 per cent of the new cases, and the Vernes Institute alone handled 13,171 new cases, of which new infections were estimated as responsible for 7,902. Since this figure for the Vernes Institute alone greatly exceeds the total for Greater London, it appears reasonable to conclude that the system of regulating prostitution in Paris had not proved an efficient method of reducing the incidence of disease.

We claim, therefore, that the objects for which regulation was instituted are not attained thereby; that it does not accord with current medical and social knowledge; and that apart from any

consideration of Western sex morality and the Christian ethic it is a barrier to human welfare.

The Prevention of Commercial Prostitution

It must not be imagined that the legal suppression of third-party commercial interests will by itself eliminate traffic in women, commercial prostitution and venereal disease. If actively enforced such measures take away the artificial stimulation of the demand. It must be realized that when capital is invested, dividends are expected, and in France alone the capital invested in brothel property and personnel is said to be greater than the capital in the brewing industry in Great Britain. When it ceases to be of interest to anyone to increase the demand, the volume of promiscuity will fall to the varying degree of initiative of each individual. The recording of public condemnation embodied in legislation, opens the way to constructive measures which there is reason to hope may be effective.

In a country where the population is highly infected, it is urgently necessary to attract the infected to medical care. The pace at which the disease is spread, even in a highly infected community, will slow down with the suppression of the brothel, but those already infected need to be treated. The closure of the brothel removes the easy market, but so long as any country has a commercial organization the trafficker will still try to recruit individuals.

CHAPTER VII

PROSTITUTION

PART II

PROSTITUTE AND CUSTOMER

Demand and Supply

In Part I prostitution was considered from the administrative and legal standpoint under the definition of "an unselective commercial sex relationship." Attention must now be turned to the individual and more biological aspect to ascertain whether any particular physiological and psychological types of men and women follow the practice of sex promiscuity, whether any particular features in the home or personal environment are common to the promiscuous.

Even in social structures that include facilities for prostitution and therefore expect men to be promiscuous there is wide variation in personal behaviour. All citizens of regulationist countries do not visit brothels or keep mistresses. All men in Abolitionist countries do not seek the "pick-up girl" or the casual partner for a week-end. In both communities many women and girls have casual sex relations in which no cash transaction occurs.

The questions that need answers based on facts are whether certain physiological and psychological conditions impel to frequent and promiscuous sex relations. Whether certain conditions of the early environment of an individual promote such behaviour. Whether, if either of these conditions are shown to be the cause of promiscuity, they can be cured, if biological, or reduced, if social. What is the effect of promiscuity on the individual's personal development and adjustment to life? Are there any facts as to the type of men and the type of women who create the demand for and supply of the prostitute? If the causes of this behaviour pattern are recognizable and are of a biological type they will not be limited to the relatively small technically defined 'prostitute' group. One would expect to find individuals showing the

biological and physiological characters that may cause promiscuity scattered throughout the various strata of society. If the tendency to transitory and unselective sex relations is (*a*) due to the persistence of a juvenile condition into maturity, or (*b*) due to an inherent physiological, psychological, or mental condition, then prostitution is only an intensified precipitate of a widespread, but not universal, form of sex behaviour. Also, if the years of adolescence unfit the individual to face a particular kind of strain during those years, and social conditions place them under that strain, the results are predictable. Fortunately, as the personality of the adolescent is still in process of development, is open to influence, and resilient, it is usually possible in suitable environmental conditions for balanced maturity to be attained even after damaging sex experiences.

The frequency with which the same couples, or one partner of a marriage, go through the divorce court in those countries where such facilities are offered, while the bulk of the community maintain a settled family life, supports the view that promiscuity is frequently due to a need of adjustment by the individual to the culture pattern of his community. Those people, in the United States and in Great Britain, have been until recently largely from the leisured and moneyed classes because their condition obtains publicity when they come before the Courts; also divorce was, until recently, a costly business. But, from whatever cause, it demonstrates that continuous promiscuous behaviour on the part of the individual is more likely to be correlated with biological than with economic conditions in a community that discourages prostitution.

In a previous chapter we have classified into groups the inherently promiscuous, the non-promiscuous and the average individual.

During periods of war and social disorganization a number of normal persons who are under acute emotional stress seek escape in sex relations. The larger 'average' group adopts the "fashion of promiscuity" but, given a reversion to normal conditions within a reasonable time, the majority of the young reassume their pre-war standard of behaviour.

Apart from war conditions, there is considerable ground for the opinion that the financial demand for the prostitute has fallen in the Northern European countries. Better education, freer association between the sexes of the same social groups, a higher sense of

fastidiousness and self-respect has shifted the demand from the economic to the selective and emotional field, and limited it much more to the adolescent personality type or to those undergoing abnormal emotional strain.

It has already been indicated that the sex life of the individual follows observed lines of physiological and psychological development; that certain characteristics belong to each stage of normal development.

The maladjusted marriage is probably the most general cause of intermittent promiscuity. The married man is the usual protector of the kept woman and in Western Europe the most frequent customer of the brothel. It is not "sex starvation" that is the main cause of promiscuity in a settled population, but emotional maladjustment, often due to the emotionally adolescent stage of development of the promiscuous partner. The married woman from the suburbs who "picks up" for adventure in London, or has a room in an accommodation hotel in Paris, is of the same type.

Sex behaviour, however, is not entirely dependent on the variation of personality; it is largely conditioned by the expectation of conduct within the social group. In an agricultural village where each inhabitant is known to all and the standard of family life is high, the few lapses into extra-marital intercourse are usually limited to the mentally sub-normal, to experiences under conditions of excitement—away from the village during visits to large towns—or to those employed away from home, i.e. under conditions where the individual is outside the range of the local circle whose opinion is valued.

To take a few examples—in the United States social conditions are fluid. A number of its citizens came, at no distant generation, from peasant stock of the Balkans, from the shores of the Mediterranean, and Great Britain, Northern and Central Europe. Through formal education a common "American tradition" is imposed on widely varying home backgrounds. This, of itself, creates conflicting values for the rising generation. One attitude to sex behaviour in the school and another in the home. Freedom, in the individual sex life, rightly recognized as part of the greater freedom; but positive guidance and training in the personal responsibilities involved in freedom are no more and no less prevalent in the United States of America than in Northern Europe.

Some years ago a delegation from the Council of Christian Churches came to Europe to ascertain how the problem of the illegitimate child of the high school student was being handled. Fortunately, the number of cases in this country were too minute to create a problem. Its existence in the U.S.A. was evidence that for some the strain of co-education during the adolescent years was too great. It would be interesting to know if the adolescent parents were among those without a secure emotional background in the home.

The average person adapts to the pattern of behaviour expected by those among whom they live and by whom they wish to be valued and admired. After the 1914–18 war, for example, "petting parties" were the vogue in the U.S.A., and the "Bright Young Things" of London Society vied with each other in the varieties of their sex adventures; week-ends where wives and husbands were exchanged, and the unmarried 'initiated' were well known. Promiscuity of a non-commercial, and almost unselective, kind was prevalent. A certain proportion of marriages were broken, a certain number of separations were continuous. But, in the main, the promiscuity was temporary and among the young. Many of them were later known to be happily married parents, but with a strong desire to protect their own daughters from similar experiences

Naturally, this phase of fashion threw into prominence the nymphomaniacs and the "gay Lotharios" who enjoyed a short period of exotic popularity. Physical sex was glorified as the primary means of 'self-expression,' and a popular misconception of Freud's teaching led many to think that 'repression,' which the psychologists use as the unconscious consignment of an experience into the subconscious, meant the conscious repression of a recognized desire—an entirely different matter. The one is the known cause of many forms of physical and psychological ills; the other is the practice of self-discipline essential to all forms of social life. Those who lived through these early inter-war years in contact with individuals of the group will confirm this analysis, while others will find it reflected in the fiction of the time.

Social workers among the wives of men serving overseas know well the rapidity with which sex laxity in behaviour would spread in groups. A fashion in behaviour—whether of austerity or of laxity, whether of temperance or of alcoholic excess—affects a far larger number of a group than those with any direct tendency

to, or those with an innate repulsion from, the form of behaviour in question.

For example, if the table of venereal disease Army infections on page 396 is referred to, it will be seen that the changes in social life of the Army between 1886 to 1936 show a greater influence on the reduction in these diseases, which are largely contracted by promiscuous behaviour, than the adoption of the modern methods of diagnosis and treatment. The latter would reduce the duration of the disease and, therefore, the infective period, but would not affect the volume of exposures to the risk of infection, which is a matter of personal behaviour.

During the last war, an R.A.M.C. colonel stationed in one of the Colonies kept careful records of the men under his care. In the early days there was a disturbingly high incidence of venereal disease in the regiment, few recreation facilities for the men, and a highly infected local population. The volume of exposures was large. Over three years, prophylactic treatment, health education, improved living conditions and recreation facilities were all provided, and a sense of responsibility promoted. In his final report the M.O. gave the fall in infections and stated that, roughly, just under one-third of the men never exposed themselves to infection even during the early days when it was the 'fashion' to do so with frequency and regularity. Just over one-third continued to expose themselves regularly, even after all protective measures had been adopted. The fall came from the large middle group who were open to the influences of education, of social surroundings and of fashion.

To turn now to enquiries and researches in recent years that may throw light on the general conditions that create a demand for promiscuity, and possibly help to answer the question as to whether there are any recognizable predisposing causes affecting the sex behaviour of certain individuals. As all men and women are not promiscuous, why are some persistently so, and some for short periods of their lives?

In 1944 an enquiry was made in England by two R.A.M.C. psychiatrists into the history of 200 Army venereal disease patients against a Control Group of 86 impetigo patients. The latter, being fortuitously infected by 'itch' irrespective of their conduct were taken as an average sample of the Army population.[1] This

[1] *Some Psychological Aspects of Sexual Promiscuity* Summary of an investigation by Major E. D. Willkow, R.A.M.C., and Captain J. Cowan, R.A.M.C.

enquiry is an indication that further research in this field is desirable. Though there is an obvious weakness in that the investigators are dependent on the veracity of the men in acknowledging promiscuity (particularly in the Central Group) for the accuracy of their results. However, it opens a suggestive field in which further investigation may have considerable significance.

A marked difference in type was disclosed between the two groups:

	Impetigo 86 men	*V.D.* 200 men
Immature personality types	19%	59%
Border-line types	19%	30%
Mature personality	62%	11%

The authors stated: "These figures were obtained by what were clinical judgments. The findings of the Control group were consistent with previous investigations in which the present and other observers employed similar methods in random or psychologically neutral groups of men. The statistical significance of the figures alone supports the impression, widespread among specialists in the subject, that V.D. patients are not a random sample of the Army population."

In the case histories given, a number of those in the 'immature' personality group had a previous history in civil life of delinquency and petty larceny and were deeply attached to their mothers. Of the two groups, 52 per cent of the V.D. patients and 46·6 per cent of the Control group were married men.

"Out of the married men in the Control group, only one had been unfaithful, and that on a single occasion."

"Out of 105 married men in the V.D. group, in 52 there had been promiscuous acts before the act which led to V.D."

Of the Control group, 63 per cent were non-promiscuous. Of the V.D. group, the habitually promiscuous were 38·5 per cent; occasionally promiscuous 29·5 per cent and promiscuous since joining the Army 32 per cent. For this last, the comparative figure in the Control group was 16 per cent.

It would be illuminating when full information as to units and areas can be published, to know if the 'fashion' of sex laxity was noticeably prevalent in the groups who were "promiscuous since joining the Army," or whether they were a random sample from a number of units and areas.

One further quotation is pertinent. "The habitually promiscuous were to a large extent poor bargains from the Army's point of view. Immature in personality and incapable of adequate loyalty, they were unlikely ever to become efficient soldiers. On the other hand, among the V.D. patients there were some men of high personal morale and efficiency. . . . In most cases these men were of relatively mature personality and the situations or events which had led to promiscuity were proportionately severe" . . . and "would certainly have produced severe emotional disturbance in most people."

Among the cases quoted is a man returning on embarkation leave to find his wife, to whom he was devoted, committing adultery. Another, where, under great provocation, a hot-tempered but keen soldier used abusive language to his corporal and was given a detention sentence and sent from his commando to an infantry unit. He drowned his sorrows in drink and picked up a woman in the 'pub.'

The authors summarize the impressions gained from their investigations as follows:

"(*a*) Physiological needs—the 'human nature' theory does not exist in true promiscuity.

"(*b*) True promiscuity has an active or chronic neurotic motivation. There is not the slightest evidence for the view which attractively links up health, virility and promiscuity.

"(*c*) Promiscuity, like drunkenness and absenteeism, is a matter of morale rather than morals. Ethical judgment of neurotic problems has not proved helpful in the past."

Some indirect evidence that an unbalanced psychological type tends to be promiscuous is furnished by the survey of "Venereal Disease Anxiety Among Soldiers" made by the medical staff of the U.S.A. Army's 121st General Hospital in Germany serving as a redeployment and replacement centre through which passed men needing psychological treatment before their return home. "Thirty per cent of the total neuro-psychiatric patients, including outpatients, and 50 per cent of the Urological Clinic patients" suffered from "venereal disease anxiety." Approximately one-half of them had been treated for V.D. within the preceding year but none presented any infection at the time of their visit.

The enquiries that have been made relative to supply—as to the causes of women being promiscuous and/or becoming prostitutes are far more numerous and detailed than those relating to

the demand. It is only of recent years that the biological approach to behaviour problems has influenced the sociological outlook. A considerable amount of research on male promiscuity, confidential at the time of writing, may be published in the belligerent countries within the next few years.

Individual inquiries into the causes of persistent absenteeism, persistent maladjustment to industrial occupations, and persistent delinquency disclose much the same personality characteristics as shown by the persistently promiscuous. The combination of any of these conditions with persistent promiscuity is statistically recorded among the women and girls where this behaviour has been disclosed, and not infrequently mentioned also in case records of youths and men. For instance, among the girls (ages 14–18 juveniles) in Home Office Approved Schools who are sent for other than sex offences, a large proportion had already experienced sex intercourse It is a field where investigation is urgently needed.

The most recent widespread enquiry into the antecedents of prostitutes was that promoted by the Social Section of the League of Nations between 1936–38.[1]

A questionnaire, prepared by the Committee, was sent to fifteen Governments and six voluntary associations. Each were asked to fill in the answers for 50 or more prostitutes who should be, if possible, adult women and nationals of their country. Replies were received describing 2,659 women in twenty countries. Included in this figure is Dr. Tange Kempe's Report on 530 prostitutes in Copenhagen, which has particular value as coming from a single trained investigator. It was forwarded by the Danish Government as their reply:

> From 1931 to 1935 the 530 women who had been questioned by the morality police were given a medico-psychiatric examination, particular attention being paid to their inherited traits. Only 29·4% were mentally normal and without defective intelligence.[2]

Of the 50 from the U.S.A., the psychiatrist making the investigation found 17 of superior or normal intelligence, and 33 ranging from dull to imbecile.

In Rumania, Uruguay, India, and Norway the majority are

[1] *League of Nations Inquiry into Measures of Rehabilitation of Prostitutes* (Part I). *Prostitutes—Their Early Lives* Geneva C. 218. M. 120. 1938 IV.

[2] *Prostitution*, by Tange Kempe, pp 142 and 143. William Heinemann, London. 1936.

classified as mentally normal. It must be borne in mind, however, that except for the two cases mentioned, the case sheets were filled in by many different people—often on a brief police interview; that the accepted standard of "mental deficiency" varies from country to country and the psychiatric classifications are only used by the trained investigator. The reports published by the League must not be confused one with another, on those points dependent on individual interpretation, but as a factual foundation they provide a broad outline.

One-third of the women were, or had been, married—a slightly higher proportion in Belgium, the United Kingdom, Canada, and Denmark. A number had married very young and taken to the life after marriage had failed them—in some cases, evidently, because they failed in all their social relationships: in others, because it left a woman, untrained for lucrative skilled work, with children to support, in a country where commercial sex relations were a tolerated custom

Home conditions were recorded and are important, as throwing light on the prevalence or the reverse of inherent and hereditary causes. The view expressed is that "on the whole judgment and experience support the theory that particular inherited and acquired characteristics form one, at any rate, of the reasons for prostitution, and that therefore heredity and upbringing must play their part."

Obviously, detailed family histories are not available from this enquiry, only general information of the material and moral background of childhood.

"Usually only a small minority suffered from extreme poverty." Apart from Dr. Kempe's report, the average of "very poor homes" was 9 per cent. Most came from working-class families. (It must be borne in mind that such form the majority of all the populations of the reporting countries.) "Of the women examined by Dr. Kempe, two-thirds were the daughters of unskilled or skilled labourers" (p. 29). "The remainder, with few exceptions, came from the lower middle classes." It is pointed out that in many countries after the last war, the sudden change for the worse in the economic position of this group may be a factor in the larger proportion shown among the prostitutes than Flexner found in his survey in 1910.

A very large proportion of the women were not brought up by their parents, or by only one parent.

Far more striking than the number of homes whose influence was unquestionably bad is the number which seem to have been defective, unsuitable, or unhappy.

In nine countries, including Great Britain and France, 7 per cent was the average number of illegitimate women In Flexner's enquiry (1910) the number of prostitutes who were illegitimate was far higher. During or after the 1914–18 war most of the Western countries improved the legal and social position of the unmarried mother and her child. One of the beneficial effects of the change seems to be that the incidence of the illegitimate in prostitution is very little higher than their incidence in the general population.

Considering as a whole the family and background conditions disclosed by the individual life histories,

About a third of the women appear to have good homes and have been brought up by both parents, and about half spent their childhood in unfavourable circumstances. This was due in part to poverty and ill-treatment, more often to unhappiness and wrong handling.

Few of the women had any professional or skilled occupational training, therefore were of low earning capacity, more than half of them drifted or were placed into some form of low-grade domestic service. This is the worst form of employment for the dull and backward, or the neurotic, as the continuous and intimate relationships it requires is beyond their capacity for adjustment. Just as the types concerned experience maladjustment in their own homes, so that peculiarity engenders maladjustment in the employer's home. Also, low-grade domestic service is a lonely life, lived often in bad conditions of accommodation, food and wages. It requires strength of character if a reasonable recreational circle is to be created and good working conditions secured. Even for a normal and intelligent girl it is shown to be a dangerous occupation. A factory worker or a shop girl may live at home, but domestic servants, who often begin work at 16, go to live with strangers, often in a strange district, where their actions are unknown to their family and friends. They are in constant association with people whose standard of living is more luxurious than their own. They have no fixed working hours and they are often at a loss how and where to spend their spare time. (P. 42.)

The usual idea that poverty is the major cause of women becoming prostitutes is therefore not borne out by any enquiries.

In 1933, in order to provide information called for by the Social Questions Section of the League of Nations, the International

(Voluntary) Bureau for the Prevention of Traffic in Women, mobilized their resources through the national committees in each country in order to ascertain what effect, if any, the economic slump in Europe and the U S A. had had on commercial prostitution. Had sudden poverty driven a large number of girls to become prostitutes? Had the *proxenet* become more active?

The time given was too short to carry out long-term researches, but each committee presented a report on the current situation in their own country. The writer had the honour to be joint *rapporteur* for the subject to the International Conference on Traffic in Women at Berlin in 1936. The position as there disclosed may be summarized as follows:

(1) There was no evidence that poverty was in itself the cause of prostitution. There was evidence that an unstable social background in juxtaposition with a demand supported by wealth will attract women and girls to prostitution.

(2) There was no indication of increased activity on the part of the trafficker except in Germany and Uruguay.

(3) Nowhere had the economic stringency and abnormal unemployment led to an increase in the numbers of those women living from professional prostitution. Several countries reported a reduction in their number owing to the shrinkage of the financial value of the demand.

(4) There had been no increase in the new cases of venereal disease, on the contrary the majority of the countries concerned notified a reduction in the new cases of syphilis.

This would indicate that not only was there no increase in the number of professional prostitutes but also that there was no increase in the numbers of clandestines or amateurs who in regulationist countries receive a large number of clients providing direct evidence of the bearing of the economic demand on the volume of commercial promiscuity.

(5) Several countries drew attention to the numbers of the psychologically and physiologically abnormal and sub-normal women and girls who become professional prostitutes or were found among the amateurs and clandestines.

The importance of "the Broken Home" as a factor in conducing to promiscuity or prostitution has been repeatedly mentioned. A recent enquiry made by Dr. Ray Wilbur, under the aegis of the Public Health Department of San Francisco in 1944, finds:

that of the 1,402 women, 794 (56·7 per cent) came from broken homes, a broken home or an unhappy home background being defined as any breaking up of the solidarity of the home by (1) death of one or both parents when the child was 18 years of age or under; (2) divorce or separation of the parents; (3) removal of the child from home, i.e. placed in boarding-school, work home, foster home, et cetera; and (4) illegitimate child of mother

Strikingly similar findings of Doctor Rachlin show 52 per cent of 249 women studied at the Midwestern Medical Center in St. Louis, Missouri, came from broken homes.

According to the expectancy curve, 50 per cent of a normal population falls within the limits of the normal mental level (91 to 110 I.Q.); in our population only 32 per cent of the total cases fell within the normal range. This figure is 18 per cent below the normal expectancy. The *incidence* of border-line defectives in our group was 21·3 per cent above the *expectancy* in the normal population.[1]

A considerable number of medical and psychological analyses have been made of the prostitute. In Germany, in France, in the U.S.A., and in Great Britain, men eminent in psychology and medicine have carefully examined a number of registered prostitutes and brothel inmates in regulationist countries, and prostitutes coming before the courts for indictable offences in non-regulation countries. One and all find a high proportion of the abnormal and sub-normal among them.[2]

Sir Cyril Burt's enquiry into the home and family background of a group of London girls "engaged in sexual misconduct for mercenary motives" disclosed that one in three of the girls had comfortable homes to which they could have returned, while "of all the factors making for sex delinquency in girls, an over-sexed constitution is at once the commonest and the most direct."[3]

An outstanding feature in many cases was the fact that, at any rate about the time of adolescence, the girl appeared over-developed either physically or sexually, or in both respects together. Sometimes puberty had been premature, and still more frequently the outward manifestations of these sexual changes emerged precociously, so that in her whole form and figure the girl, while still at school, looked an over-sexed type.[4]

[1] Pamphlet: "Promiscuity as a Factor in the Spread of Venereal Disease," by Richard A. Koch, M.D., and Ray Lyman Wilbur, M.D.

[2] "Causes of Sex Delinquency in Girls," by Cyril Burt. *Health and Empire*, vol. 1, No. 4, p. 251.

[3] *A Biological Aspect of Prostitution*, by S. N. Rolfe.

[4] *A Social Problem Group?* by C. B. Blacher, p. 101. Oxford University Press. 1937.

The intelligence and educational attainments analyses showed

Mentally defective, 12·4 per cent.
Dull mental ratio, 70–85. 27·4 per cent.
Backward educational ratio, 70–85. 53·2 per cent.
Verbalist type, 14·2 per cent.[1]

In studying the family histories "the most striking fact is the prevalence of sexual irregularities among the parents and other relatives of the girl. A large percentage of the girls themselves were illegitimate, and in numerous instances there was frequent sexual misconduct on the part of the girl's father or mother."

In the pedigrees of socially dependent families traced by E. J. Lidbetter,

An oversexed or psychopathic tendency shows itself in some cases through four or five generations. The variety of ways in which delinquency such as illegitimacy and prostitution is shown by the women of some of these families suggests an inherited mental and emotional instability.[2]

That the mentally sub-normal, particularly if in a bad social environment, tend to be promiscuous is also shown by the histories of women who have been certified as mentally defective and placed under care after being for several years in the community without protection. The Medical Officer of one of the London County Council Institutions analysed the histories of 101 women who had been certified and placed in his institution because they were particularly troublesome cases.

7 had been professional prostitutes
27 had been promiscuous in their sex habits
21 had given birth to 31 illegitimate children
10 had acquired V.D.
2 give histories of incest.

In 149 girls arrested for committing or offering to commit prostitution who came before the Women's Day Court, New York City, Dr. Greta Scott on psychiatric examination found

18·8 Normal (Terman intelligence tests)
24·8 Dull
30·9 Border-line
25·5 Defective.

[1] "Causes of Sex Delinquency in Girls," by Cyril Burt. *Health and Empire*, vol. 1, No. 4, p. 251.
[2] *Heredity and the Social Problem Group*, by E. J. Lidbetter, p. 101. Arnold. 1931.

Dr. Kurt Schneider (1926), Cologne, in a thorough examination and study of 70 prostitutes on the Municipal Register found only 15 stable and normal. Sichel found 43 normal out of 152 and Bonhoeffer 32 per cent without psychological abnormalities in his group of 190.

Briefly, the evidence presented from various enquiries made in both regulationist and non-regulationist countries indicates that the girl with a subnormal intelligence or an unbalanced personality tends to drift into the lower ranks of prostitution or promiscuity.

Poverty is one of the many contributory factors, as is also the over-sexed temperament, but far less significant than the "broken home." Poverty becomes an important factor when it is a sudden change in status and background for the individual, e.g. White Russian women fled to China in 1917—where, in a strange land with no occupational training, they adopted prostitution as the only available means of earning a living.

Where the manners and customs of the time expect men to be promiscuous and women to be 'chaste,' they provide for the majority of women to be protected and prevent them from mixing freely with the opposite sex before marriage; considerable post-marital laxity is tolerated among men and women provided it is discreet. This has remained to this day in those countries that deny facilities for divorce. These are the places where brothels still remain and where there are the largest number of clandestines. The financial backing to the demand is high. With this type of community, the economic openings for women are few and none can compete with the scale of pay commanded by the successful clandestine prostitute, or offer prizes to compete with the ease and luxury of the mistress of the wealthy man. In normal times it is only the failures, the friendless, and the inefficient that reach the brothel, the municipal register, or the street-walker level.

In wartime, the conditions that lead to promiscuity among normal men and women are intensified—large numbers of ignorant adolescents are separated from their home background, local public opinion and family surroundings, and live under conditions of strain. Wages are high; opportunities for spending are limited.

In present-day conditions, of post-war stress situations, the adolescents (14–20) of all belligerent countries have been, and will be, during the period of social readjustment, subjected to stresses and strains of a nature that would break many of the mature, while the young adult in the early twenties has probably

borne the major strains of war, in the air, under the water, and in the commandos Many of these were actually fighting in the later, adolescent years, separated from home backgrounds, pressed to extreme physical endurance and often living in a foreign land, with sex relationships as almost the sole recreation. It is not surprising that large numbers of young people became lax in their sex behaviour, but it is a matter of pride in character, in the strength of family feeling, and the capacity of youth to ride the storm that so many have come through undamaged.

Many men and girls, if in a group where promiscuity is the fashion, are occasionally promiscuous, as a cash transaction, for payment in kind, or "for fun." One of the features of the British war experience was the youth of the girls, a number of them between 14 and 16—a time when they should be under care and guidance, not evacuated from danger zones among strangers and working in factories These girls, who damaged themselves and the community, were as much war casualties as those contracting malaria on war service. The war placed them under conditions known to be physically and psychologically dangerous to the adolescent, and the protective measures—youth centres and clubs —mere palliatives inadequate for all, though of immense service to many.

The high financial backing for the demand also attracted a number of women who had in earlier years passed through a promiscuous phase and left it on marriage, to return to their former occupation while their husbands were serving in the Forces. Such women, often of foreign origin, were earning from £60 to £80 a week in meeting the demand created by members of the Home and even more of the Allied Forces The desire of all from overseas to spend their leave periods in London intensified the problem.

Before the war the abolitionist countries of Northern Europe by the rising economic security of women, the higher standard of education, the wider choice and greater social and economic prizes for services in the skilled occupations and professions offered a degree of competition to prostitution which was killing it as a profession. The new orientation, however, brought a different anti-social form of demand and supply. In a number of industrial and commercial undertakings, occupational and professional, promotion is now frequently dependent on the woman being willing to meet the physical demands of her occupational

or business 'chief.' Prostitution? Not in the old form—it is partially selective, and not for cash payment. While the demand would come from the 'promiscuous' man, the supply would be drawn from the normal woman. One case was brought to the writer's notice of the foreman of a particular shift in an aircraft factory who was known to have infected three girls with venereal disease, and to be the father of two illegitimate children. But as his abilities in stimulating production were high, his services to the factory war effort were considered essential.

The outline of the picture differs in those countries that for years have penalized third-party profits in prostitution from that in regulationist countries. Where prostitution is a recognized profession it is to be expected that more normal women would follow it and the proportion of abnormal and sub-normal would be lower, while in abolitionist countries it would be a more temporary phase of behaviour for the normal and only the permanent or continuous occupation of those with some inherent tendency or psychological condition. One would expect to find more of these, therefore, among the known professionals or continuously promiscuous.

This is borne out by a long-term enquiry spanning over ten years in Germany, then a "regulationist" country. Dr. Schneider in 1914 published an analysis on the psychological and physiological conditions and the social background of 70 of the women on the Cologne Register of prostitutes. Ten years later Dr. von der Heyde, Police Welfare Officer of Cologne, was able to follow up 62 of the 70 women. Nineteen only had remained registered prostitutes, of whom 4 were of normal intelligence and 2 had died; 43 had left regulation control, of whom 32 were married and living with their husbands; 5 were living in illicit relationships; 1 was widowed and living with her husband's mother; 1 was supporting herself; 4 had died; over three-quarters had been three years or less on the Register. As Schneider summarized his experience:

> The majority of women, who for a time engage in prostitution, do revert to ordinary social life.[1]

A picture of conditions in London in 1930 is given as part of a survey made under the aegis of the School of Economics, London University.

[1] "Studien über persönlichkeit und Schicksal ein geschriebener Prostituierte," by Kurt Schneider, quoted by the writer in *Biological Aspects of Prostitution*, pp. 103–109.

The voluntary rescue and prevention agencies, who deal mainly with the unmarried mother and the young delinquent girl, are primarily concerned with the prevention of the drift of such girls into serious delinquency Their endeavour is to prevent the young and unruly from coming before the Courts, and to return the delinquent girl to the community as a normal citizen. During the period 1900–1930, the growing appreciation of the need for an objective and scientific approach is shown by the increase (from 17 to 132) in the number of trained (outside) workers employed—some with psychological training. The total number of whole-time workers employed by voluntary organizations on preventive work had risen from 195 to 485 in the thirty years.

The object of the survey was to ascertain the type of girl requiring help, the result of such help as had been given on the girl's future, and the changes in the workers' approach to the problem.

The generous co-operation of all concerned was given the writer and her staff in collecting facts, figures, and opinions.[1]

The sources of delinquency are confirmed by three enquiries: that of Sir Cyril Burt in 1926; the Holloway enquiry of 1930; and the opinion of the matrons and superintendents of the homes and shelters of the voluntary organizations. All indicate a large proportion were drawn from those in domestic service. Burt and the voluntary organizations emphasize the prevalence of mental and psychological sub- and abnormality, while the Holloway offenders disclose a high rate of recidivism. The "broken home" is the background of 69 per cent of Burt's cases, and is given as the most frequent contributory cause by the voluntary organizations, coupled with "lack of discipline and moral training." Domestic service under pre-war conditions heads the list of "dangerous occupations" for girls, for two reasons. The demand for domestic help is so great that an ever-present opening is offered in which the 'dull' and 'backward' can be self-supporting. Therefore, more than the average in the general community are found among the lower grades of domestic service. The form which domestic service took up to the war exposed the girl to greater temptation and difficulty than almost any other occupation.

In 1930, out of the 5,715 women and girls dealt with by the

[1] Full Report included in *Life and Leisure*, The New Survey of London Life and Labour, vol. 9, Sex Delinquency Section, pp. 287–345.

voluntary agencies, 2,738 were unmarried, expectant or nursing mothers. The three types of accommodation were: Homes, taking girls for 6 months and over; Refuges, for 3 weeks to 6 months; and Shelters, for under 3 weeks. The accommodation was usually arranged for classified cases, i.e. for V.D., maternity, the mentally dull and backward. The professional prostitute comes very rarely. In homes accommodating 1,533 women and girls, the ages ranged from fourteen to fifty-three with the average nineteen years. The time in residence had fallen, except in certain types of cases, from the two-year period required in 1900 to about six months, mainly to cover the period of lactation for the unmarried mother.

A certain number of girls passing through these establishments were found to be certifiably mentally deficient, and the staffs of two refuges containing eighty girls estimated that 13 per cent were dull and backward and 10 per cent illegitimate.

The most reliable figures were those provided by the trained 'outside' workers, those entrusted with the task of after-care and of dealing with cases in the girls' own homes

Particulars were provided of 1,955 cases, of which 1,129 were unmarried mothers, dealt with in 1930 by twenty of these workers:

279 had venereal disease,
85 were classed as mentally defective,
102 were classed as dull and backward,
8 were classed as abnormal.

A special enquiry was made into the future of the girls for three years after leaving the institution or the immediate care of the worker. A difference in the policy of 'after-care' between different agencies resulted in a large number being lost sight of; while the Salvation Army and others set a high value on maintaining the friendships and contacts, others feel it is better for the girl to leave aside all traces of her social error once she re-enters the community. The 979 "lost sight of" would, of course, have made some contribution to each category.

After-care of girls passing through London Preventive and Rescue Agencies in 1930:

Remained prostitutes	46
Had another illegitimate child	260
Married	488
Returned to friends	1,389
Were self-supporting or had intermittent employment	3,091
Lost sight of	979

While it is difficult to make adequate researches as to the mental and psychological capacity of the persistently promiscuous in this country, there are broad indications that Continental estimates are not unique. There is ground for believing that the bulk of prostitutes follow that occupation for a short time only, and that promiscuity is a phase of maladjusted adolescence

The proportion of recidivism in cases coming before the Courts is high. While the volume of such offences has fallen, the recidivism among the smaller group is striking. To take London only, in 1930 prostitution offences were 9 per cent of the 13,679 women convicted for all types of offence, i.e. 1,295. Taking previous convictions into account, the actual individuals involved would have been at most 546, as 748 had been convicted once or more *during the year*. In 1930 the total cases for all offences was 3,161, of whom 184 were for prostitution offences, involving 85 individuals.

An enquiry made by the Metropolitan Police into the subsequent history of first offenders in prostitution offences in 1927 disclosed that of the 318 first offenders in 1927, 181 were never reconvicted during the next five years While 47 were convicted 5 or more times, 137 once more. The bulk of these (98) recidivists ranged from 21 to 30 years, and formed 53 per cent of the total of that age group, while there were considerably fewer among the younger age group.

This appears to confirm the contention that a minority of the less well-endowed biologically persist in promiscuous behaviour, while the potentially normal, who have been the victims of a bad emotional training in early youth, can with social help revert to normal life. That the main casualties occur during the span of adolescence, i.e. between the ages of 14–21.

The remainder arise from a traditional inheritance, still fairly widespread in Europe, of convention and belief that promiscuity is an inherent characteristic of the human male and 'chastity' an 'inherent' virtue in the female. Hence the variation in the volume of extra-marital intercourse in the different communities and in the social structure.

CHAPTER VII

PROSTITUTION

PART III

REHABILITATION

Social Readjustments and Constructive Measures

Recent and Pending Legislation

While quite a number of adjustments will be necessary to enable the individual and the community to benefit by the additions to our biological knowledge, there were two measures before Parliament in 1938 and 1939 which did not reach the Statute Book owing to the imminence of war. Had they done so, some, at least, of the scandals of wartime promiscuity could have been avoided.

In the Criminal Justice Bill, 1938,[1] the existence of the physiologically and psychologically irresponsible individual was recognized and some provision made for their offences to be considered in relation to their inherent condition.

In the Bill to amend the Laws relating to Order and Decency in Public Places (see Appendix, p. 403), cognisance was taken of the change in the type of solicitation and of promiscuity.

The existing legislation under which solicitation in public places can be dealt with is both unsatisfactory from the administrative standpoint and inapplicable to current social customs. Clauses from a Vagrancy Act of 1824, from a Town Police Clauses Act of 1847, and in London, from a Metropolitan Police Act of 1839, supplemented by various local bye-laws (see Appendix, pp. 402–403) are not applicable; there have been too many changes in social conventions in the 100 years intervening for these laws to be related effectively to present conditions. Hence the present difficulties faced by the police when confronted with undesirable behaviour in public places.

The continuation on the Statute Book of legislation using the

[1] Re-introduced and enacted in 1948.

term "common prostitute" at present precludes the British Government from ratifying the International Convention of 1933, which extended protection from traffic to *all* women and girls, whether prostitutes or not, because the British legal definition of "common prostitute" is too restricted to cover those to be protected.

Solicitation is a complex matter. The personnel involved and the methods used vary with changes in the social structure. Where commercial sex relations are a legal crime, incitement to crime can be a legal offence. Where prostitution is regulated by authority, solicitation on the part of the clandestine becomes competition of the freelance with big business; the authorities being interested in the latter therefore try to suppress the former. Normally in regulationist countries solicitation is firmly suppressed in certain districts and flourishes in others in discreet forms known to the local personnel and advertised to the visitors. To the travelled, one has but to recall the numerous visiting cards delivered in the hotel room of the newcomer to a New York hotel or the frequent telephone calls from "pretty ladies" put through to the visitor: the bell-boy and the 'phone replace the personal approach in a "public place." There is more rather than less solicitation in regulationist countries as there are more clandestine prostitutes, but the form it takes depends on the venality of the police force and on social custom. In the abolitionist countries, the offence of solicitation rests on different grounds. In the words of the late Sir Walter Greaves Lord, "We have always in this country set our minds against making things which are infractions of the moral law and which do not come up against the definite limit of the criminal law, crimes . . . at the same time there are conditions under which those habits which are connected with immorality may come into general conflict with the law, and therefore it is necessary that there should be some special provision." . . . "In connection with solicitation there is no offence of which the law can take cognisance unless the solicitation is of such a nature as to cause a nuisance in a public thoroughfare and to cause annoyance to other persons in their use of that thoroughfare";[1] the offence punished is not the incitement to immorality but interference with other persons' free use of the highway. The other approach is the use of "insulting words or behaviour," and here, too, the offence is the interference

[1] "Solicitation and the Public Weal," by Sir Walter Greaves Lord, K.C. Social Hygiene Congress, 1927. Congress Report, p. 250.

with the free and orderly use of the highway by other people who happen to be on the highway at the time.

Under present conditions the limitation of 'solicitation' to an offence committed by a particular type of person, i e. a "common prostitute" had four major disadvantages. It was not just. To charge a "common prostitute" with solicitation was to pre-judge the case. Again to quote Sir Walter Greaves Lord: "It is exactly like, in regard to a thief, starting to prove that a man has broken into a house by citing a long series of convictions for housebreaking; then proving that he was found outside the premises, the windows of which had been broken or the entrance to which had been effected by somebody opening the window or using a skeleton key . . . the view of lawyers has always been that a man or woman should be dealt with upon the facts of the particular case and not upon any inherent probability that the person accused is the person likely to have committed the offence."

The second objection is that the form of solicitation has changed in a century. Drunkenness and disorderly conduct was prevalent in the 1830's, but is very rare to-day, and it requires a great stretch of the meaning of words to interpret as 'annoyance' or "disorderly conduct" the wink of an eye, the lift of an eyebrow, or the low-spoken "Evening, dearie" that is the present form of 'solicitation.' The free and independent life led by women and girls to-day leads to their frequenting streets and public places at all times on their lawful occasions.

Solicitation of women by men causes individual women and girls a considerable amount of annoyance, but does not come within the law at all. In pre-war days, in all large towns it was a common practice for the young men in cars to draw up by the pavement and pick up 'for a lift' a girl returning from work. Unpleasant sex crimes, including rape and murder, were the occasional consequences. The more usual was a visit to a country pub or hotel for a meal and subsequent open-air promiscuity, with or without cash payment, usually without. If the girl refused, she was often left by the roadside miles from home to find her own way back.

The cinema is now a 'public place' where solicitation is probably about equal by men of women, and by women of men.

Girls—often quite young girls—importune persistently in the streets and on stations, but until they have been warned that they will be regarded as "common prostitutes" and are ultimately

charged as such, they cannot be dealt with under the present law. It is recognized as not in accordance with public welfare to brand a number of young girls between 16 and 18 as "public prostitutes," and they are therefore usually dealt with under the Juvenile Offenders Act under a clause that provides protection to those in "moral danger" or as a First Offender under the First Offenders Act and either placed on probation or bound over.

Under the present law the only penalties are fines and short prison sentences, both of which are anti-social in their effects. A fine only forces the commercially promiscuous girl to earn the money by increased activity in her occupation, and the short sentence throws her into contact with older, undesirable characters who can exploit her youth when both return to the community.

The fourth disadvantage is that there is a varying standard of behaviour tolerated in different areas, and varying penalties meted out for the same offence. The differing local Police Acts and bye-laws and the attitude adopted by the magistrates in different parts of the country in the interpretation of laws inapplicable to present conditions creates confusion.

Over-riding all these special points are two factors. Firstly, many of the delinquents are sick or abnormal and need medical or psychiatric treatment, supervision and social care. Non-recognition of this by the law only promotes recidivism. Secondly, the change in social habits under which the "professional prostitute" before the war was rapidly declining in numbers, and the main volume of promiscuity practised by those of "normal physique and intelligence" was an amusement of a considerable number of young women for a short time rather than the regular profession of a few. Such young women solicit and importune openly and are "annoying," but the definition "common prostitute" does not fit them.

The result of ventilating this position led the Government to appoint a Departmental Committee on Street Offences in December 1926, which reported in October 1928 (see Appendix, p. 402).

A certain amount of controversy arose between the social organizations interested. The police forces of the country were loath to lose certain local powers, and some did not like the new definition. It was not a subject that would win any political popularity at the time and no Government Bill was introduced. It was not until 1938, after questions in the House and deputations

to Ministers as a sequel to the ventilation of the subject by the Societies concerned—the British Social Hygiene Council and the Association for Moral and Social Hygiene in the forefront—that a Private Member, Mr. Turton, presented his Bill (see p. 403).

Had the new Bill become an Act before the war, much of the soreness and ill-feeling between our allies and ourselves over the state of the streets and public places of London and some of the provincial towns would have been avoided. Unfortunately all representations made during the war on the need for legislation were unheeded by the Government in the stress of major anxieties.

The Criminal Justice Bill, which recognized the need for an alternative to prison sentences in cases of offences due to mental causes, contained a far-reaching and beneficent reform It embodied the results of experience and research in both social biology and administration Introduced as a Government measure, it was under consideration by a Standing Committee in 1939. The objective, scientific approach to the fundamental predisposing causes of certain types of behaviour, and the need for the administration to secure their diagnosis and treatment is of recent development. The British Social Hygiene Council, working through a committee of scientists and social workers, considered the Bill in detail in consultation with their then Honorary Parliamentary Secretary, Mr. R. H. Turton, M.P., who gained acceptance for several far-reaching amendments.

Under the 'mental' cases for whom care and treatment were to be provided, it was desired to include all forms of treatment, mental, medical, physiological, and psychiatric. Dr. Dennis Carroll, President of the Institute for the Scientific Treatment of Delinquency, and the writer prepared a memorandum for the British Social Hygiene Council, which was sent to members of the Standing Committee "on the need for a definition of the word 'mental' to include cases of crime arising from glandular and other physical causes, kinks in character and errors of upbringing, etc." The Home Secretary agreed to a wider definition. The Criminal Justice Act passed eventually in 1948 includes a wide definition of the mental and physical causes to be taken into consideration.

In future, therefore, the abnormal and sub-normal can be constructively handled when they come before the Courts. A great reduction in recidivism will certainly follow, while from the broader standpoint of social welfare, curative treatment and/or

social protection should reduce the numbers of the unhappily maladjusted and their victims.

Traffic in Women. Protective Measures

So long as there is a business organization providing for commercial sex relations in any country, protective measures are required for the women and girls of other countries to prevent their entanglement in the network for the recruitment of victims.

The general level of education in this country to-day is such that the majority of women and girls know that the prostitution business of the Continent, South America, and Asia does recruit in other countries and that employment abroad cannot be accepted without careful enquiry. The present risk is for women and girls who take a *bona fide* job abroad and, at its termination, or on an unexpected change in the employer's circumstances, find themselves stranded without friends or resources in a foreign country. The advice should always be given to any woman going abroad alone to visit the British Consulate immediately on arrival and, if possible, to deposit there sufficient money for her return fare.

The traffickers themselves have long recognized that Northern Europe is not a good recruiting-ground. The position for the girls of this country as well as the Scandinavian countries only becomes dangerous when they take employment abroad, as efforts are then made to recruit them. Safeguards are necessary and will, it is hoped, be continued and strengthened during the coming years.

In Great Britain, since 1929, all employment abroad of girls under eighteen must not only be approved by an official employment agency, but must have the direct consent of the parents. The local authorities issue bye-laws governing the activities of employment agencies which are confirmed by the Home Office. Agencies are registered and inspected, and no theatrical, variety, or concert agent "may book any person to appear in any theatre, music hall, or other similar place or in any cinema film production abroad," "unless he is in possession of written information obtained from a responsible person or society testifying the satisfactory nature of the proposed employment and the *bona fides* of the proposed employer." The attention of all local authorities has been called to the importance of the enactment and enforcement of similar bye-laws, and no visa is issued until these regulations have been complied with. Similar protective measures have been in force since 1913 for children under fourteen.

It was found that under the guise of cabaret troupes and theatrical parties British girls were decoyed abroad and, on arrival, discovered the employment included the duties of acting as a prostitute to the clients or customers. This obtained particularly in the Balkans, North Africa, and South America. English artistes in the Balkan countries found themselves looked upon as prostitutes and required to attend for medical examination when they believed themselves to be employed as professional artistes. Even after the safeguards had been imposed in this country, it was found that a *bona fide* theatrical manager might take out his caste to fulfil an approved booking, but if and when it did not pay and the caste was stranded, the foreign trafficker would appear with the offer of a well-paid theatrical or cabaret job in South America. It was to check this development that, in the late twenties, the co-operation of the British Consuls was sought. This machinery will, it is hoped, be implemented as soon as possible.

It is important during the coming years that every woman or girl before leaving the country for employment abroad should be warned not to accept other employment in another foreign country without reporting to the British Consul. Before the war plans were in hand under which all British Consuls were to be requested to make the necessary enquiries on behalf of British women, and it is urged that on the revival of full travel facilities this recommendation will be implemented.

In the pre-war years, while there were still a certain number of British girls drifting into difficulties in South America, the writer only met two British girls in all the brothels visited on the shores of the Mediterranean and in the Far East. France at that time contributed by far the largest number of European prostitutes seen.

The whole problem of the employment of artists abroad was raised before the Social Section of the League of Nations between 1930 and 1932, a full report on the subject being made by the British Delegate to the Traffic in Women and Children Committee in February 1931. The matter was subsequently referred to the International Labour Office. They took the view, however, that the numbers involved, according to their enquiries, only amounted to some three thousand, and therefore any special international convention or regulation would not be appropriate, but that the matter should be dealt with on general lines. It is hoped that the questions inherent in migrant labour under post-

war conditions relating to woman and girls will be reviewed by the appropriate committees of the United Nations and the International Labour Office in the near future.

Another difficulty that arose after the 1914–18 war was the desire to adopt British girl children by Belgian and other Continental residents. Voluntary agencies in this country became suspicious, and enquiries were made on the Continent as to the past business and social connections of the adopting parents. Among them were found some whose circumstances were most suspicious. There was ground for believing that some, at least, of the "generous gestures" were inspired by hope of future gains through the exploiting of the girls a few years later in the prostitution market. This led to a strengthening of the regulations governing adoption in this country and precluding the acceptance as adopters, except under stringent safeguards, of persons living abroad.

This country suffered somewhat from the active endeavours to improve the position in France. In the inter-war years there were six Bills introduced in the Senate to suppress brothel-keeping, though none reached the Statute Book until 1946. After the strong report of the Senate Committee presided over by the prominent syphilologist, Dr. Queyrat, recommending their suppression in the interests of public health, this country suffered an influx of French prostitutes. Any who claimed public assistance within six months of their entry into the country could be, and were, returned to their country of origin. A number, however, took a drastic step to secure British residence and citizenship by marrying a British subject. The usual charge was £5 to £10 paid by the woman to the man for going through the marriage ceremony and furnishing her with the certificate which entitled her to British citizenship. A number of those prostitutes who were so much in evidence in the West End of London and in the large provincial towns during the Second World War belonged to this category. The Aliens Act is actively administered, but up to 1939 there were still ways and means of circumventing it

Owing to the move to abolish regulation in many countries and the need that would arise of dealing with the women and girls employed, methods for the rehabilitation of the professional prostitute and methods of checking the young girl entering the ranks of commercial prostitution were the subject of study by the League of Nations from 1934 to 1938. Enquiries were carried out

and three publications issued under the aegis of the Advisory Committee on Social Questions (formerly the Committee on Traffic in Women and Children).[1]

These enquiries disclosed that the religious and philanthropic agencies in most countries as well as official administration concentrated attention principally on the prevention of the drift to prostitution by the young, but little was done for the professional prostitute. The problem had proved beyond the power of the benevolent and well intentioned. For those biologically conditioned, a scientific approach was essential. For those living in communities where convention and tradition accepted the custom, the financial prizes offered to the successful prostitute (not the brothel inmate) soared high above those offered by any other openings for women, and required no experience and lengthy period of training. Moreover, those inspired to seek the 'rescue' of the prostitute were convinced of the personal guilt of the woman and required of her a long term of repentance and penance before she was permitted to re-enter society, and then on a low rung of the economic ladder. Only the few who could turn whole-heartedly to the Christian way of life as enjoined by the branch of the Church concerned with her personal redemption, were able to adjust themselves to being 'rescued.'

There have been, however, three successful experiments. While all approached the problem from different angles they had certain characteristics in common. Two with and one without objective psychological knowledge, but all embodying the psychological need of raising the self-respect of the individual, offering her desired and obvious rewards for successful endeavour, and opening the door to a career in which she could win social prestige and permanently shed any contact with, or reminder of, her past.

The Dominican Order of Bethany founded on the ideas of the redemption of sin, and the imitation of Christ has, in the past one hundred years, been successful though the numbers concerned are small.

Those recruited to the Order from social delinquents are either ex-convicts or prostitutes. They wear dress indistinguishable from others in the Order of the same rank throughout novitiate, Little Sister, and Sister. There is no barrier from their past to their becoming a Mother Superior should they prove personally fitted

[1] Social Services and Venereal Disease, 1938; Methods of Rehabilitation of Adult Prostitutes, 1939; Prevention of Prostitution, 1943.

for the responsibility. If they do not wish to adopt the religious vocation the Order undertakes their after-care in other occupations for which they have trained them. No one but the Mother Superior knows their past. There is no separation within the House between the rehabilitants and the rehabilitated "Bethany is a daring attempt to carry to its logical conclusion the Christian conception that the repentant sinner may aspire to a higher level than the innocent."[1]

The Russian Prophylacteria

These institutions passed all trainees through a period of medical and psychiatric observation, withdrawing those inherently incapable of benefiting from specialized training. The women accepted covered all those who were misfits to the Bolshevist scheme, and while many were prostitutes there were other types as well whose occupation had been abolished or who had never been self-supporting. Those capable of skilled work were trained and allotted to it. Reports in the war years indicated that some of the leading women among the shock troops in industry now in high and responsible positions, entered industrial life through the Prophylacteria. It is not suggested that the actual administrative methods or the treatment meted out to the unfit can be followed by different cultures. The principle, however, can be adapted to suit the general structure of any community.

The V.D. Clinic

The social service of the venereal disease clinic has been the third successful approach to the rehabilitation of the professional prostitute. Here also each woman is treated as a patient, irrespective of her social background. If mentally or psychologically unfit, as well as infected, her V.D. treatment brings her in contact with those who can recognize her condition and place those who are mentally defective under care. Each patient is given social assistance suited to her needs by the trained social service worker or almoner. With the patient's consent, every social agency that can help may be called upon.

Training can be provided, removal from bad surroundings arranged, employment secured. The records published both by the League and by clinic workers prove the value of this line of approach, and the need for its development. For the

[1] Methods of Rehabilitation of Adult Prostitutes, p. 56.

abnormal woman, treatment or social protection; for the normal, respect, encouragement, economic opportunity, and social recognition as a valued citizen.

The post-war situation of the displaced persons in Europe provides a somewhat new set of conditions, in that a number of women and girls who but for war would have married in their home surroundings and led the natural life of their community, were marched out of their homes, transported across Europe, and forced to work in alien lands subject to sex exploitation of every kind. The problem of their rehabilitation is no easy one. The experience of a group of psychologists working among these women and girls on behalf of U.N.R.R.A. will be valuable to all studying the question and is therefore quoted.

Psychiatric studies further show that in the case of people who have been unwillingly seduced, or raped, the main problem which arises is not the relative superficial and transient emotional disturbance—the assault on social status—but the deeper and usually unrecognized problem of guilt and shame in the individual. In other words, however unreasonable it sounds, the problem is to persuade or help the victims of such assaults *to forgive themselves* in relation to the very real but quite unreasonable sense of guilt which they possess over the incidents concerned It is important to stress that although it is sometimes held that promiscuity must be approached by the imposition of prohibitions and the attempt to develop a rigid external morality, experience shows that this approach offers little hope of success. Most of us are probably a good deal more moral than we think or fear; and whether it is over the taking of life or the breaking of sexual taboos in an attempt to evade despair, there is a prolonged process of self-reproach which presents the real problem of help and treatment.

In approaching women, therefore, who have been leading what would be commonly called an 'immoral,' but which would be better described as a 'demoralized' life, it will be important to be aware beforehand of the existence of a deep sense of guilt in these people, whatever their superficial attitude or behaviour may appear to be like at first glance. (The overlap between 'chronic' prostitution, mental defect and psychosis should, however, be borne in mind.) Secondly, it is particularly important to approach them neither in an aggressively cheerful manner which will appear to them as not beyond suspicion of collusion in salacity; nor on the other hand in a moralistic frame of mind which will be to them a guarantee of inability to understand In the simpler example of the man who in despair turns to alcohol it is obviously important that his rehabilitation should not be attempted either by a fellow drunkard or by a violent teetotaller; of

the two the fellow drunkard has the better chance of exerting influence. The best results, however, are obtained by those who are able to see, beyond the symptoms of alcoholism, to the reality of the emotional problem which lies behind it. Similarly with demoralized people, the slow development of rapport and the provision of an opportunity for some core of affectionate human relationship will be the first step towards helping these people to begin to forgive themselves and to regain self-respect.

It is possible that in trying to achieve a return to previous social status, or, in the case of younger people, to build up ideals and attitudes suitable to an adult, many women expatriates will wish to evade the intensification of guilt likely to result from return to their home environment. The next best thing will be to return to their own country, so to speak, incognito. This impulse can be clearly seen in repatriated prisoners of war, in some of whom there exists a homologous problem of unrecognized guilt albeit from a different source. They too desperately want to get home, but in some instances find it extremely difficult to tolerate the emotional tensions generated by a return to their own family and their own community. Those women who so desire it should, therefore, be given any available opportunity to return to their own country, away from their own home, and to take up work which will enable a self-respecting frame of mind to be achieved before facing the inevitable tensions of meeting their own families.

The case of the younger people, it has been said, presents a more difficult problem, and in their case it will be wise to arrange for social contact with young people of their own, and the opposite sex, and with groups of young people in whom effective attitudes and customs are already developed in relation to sexual relationships. This is a problem for youth leaders, and for carefully selected members even among those.[1]

There will be a hard core of older professional women for whom nothing in the way of psychiatric treatment can be effective and who are beyond training for new occupations. For these it would be a sound economic, hygienic, and social investment for the authorities to bind them over to good behaviour as a condition of allowing them a maintenance grant—a pension, in other words, dependent on good behaviour. They are the casualties of human ignorance. Having acquired a deeper understanding of the causes that called the profession into existence, the community, being committed to its abolition, should pension the members of a

[1] *Psychological Problems of Displaced Persons.* A Report prepared for the Welfare Division of the European Regional Office of U.N.R.R.A. by an Inter-Allied Psychological Study Group. June 1945. Quoted by permission.

profession no longer desired and which changes are making redundant.

So far, we have noted the legislation pending and needed in this country to enable the community to deal with the changes in manners, behaviour, and values that have occurred during recent generations. A few laws, that register and confirm changes in sex behaviour already apparent, are, however, quite inadequate as the sole measure for guiding sex behaviour into channels conducive to social health and embodying standards related to science and ethics.

The recognition and social protection of the mentally subnormal, the psychopath, and the maladjustment is a step forward, which, however, only covers a part of the problem.

Those social changes required to remove commercial prostitution and persistent promiscuity as tolerated practices are such as touch the whole community and affect other problems as well which earlier chapters endeavoured to define.

The 'rescue' training home of the Victorian era is, happily, gone. The whole idea of taking from among the many irresponsible young those who have become obvious in their sex delinquency through maternity and labelling them as unmarried mothers where they are otherwise normal citizens is repugnant to the modern scientific outlook. Already cases among the normal are mainly dealt with by the outside worker without publicity. The homes and hostels for the unmarried mothers are mainly used by the inherently "dull and backward," who are unable to face the turmoil of industrial life unaided; they play a very necessary and useful role in the community. None would welcome more than those responsible, some adequate provision for the maintenance and training of those girls when they leave the homes. For the moment each case of unmarried and irresponsible parenthood needing social help, whether youth or girl, man or woman, should be considered by a trained individual, first to ascertain whether there is any biological cause on either side for the conduct, and, if so, to devise measures which will check recurrence. The fact must be faced, however, that at present the provision of psychiatric treatment for all maladjusted cases is not a practical possibility. The application of our knowledge in this field is still in its infancy and nowhere is encouragement and experiment likely to be more useful than in methods of psychological re-education and adjustment. For those who are passing through the adolescent unstable

stage, a congenial interest in life, pursued under supervision and with opportunity for promotion and self-establishment are needed —for this purpose, while home conditions should be carefully selected, the educational and training opportunities should not be limited to sex delinquents. The misfits in industry, in commerce, and in formal education, have often the same characteristics as the sexually maladjusted. The Russian Prophylacteria made no distinction between the different kinds of social misfits, but concentrated on training all the trainable for the occupations for which they were best fitted. One would like to see training centres where the students were under medical and psychological supervision, but whose training was similar to that provided for all post-school entries in skilled occupations in industry and commerce, to which all social and industrial misfits would be sent as a first step with a six-months' "condition of residence." This would give an opportunity for classification, observation, and training, which, for the biologically normal, should enable them to assume the responsibility of citizenship and would leave the untrainable residue to be handled to the best of our medical resources.

Conclusions

From the ground covered so far by our observations we may summarize the position as follows.

Commercial prostitution resulting in traffic in women is recognized by the majority of cultures as anti-social, but until this recognition has been translated into action, preventive and protective measures to check exploitation are an immediate and urgent necessity.

Where the social structure provides a reasonable standard of general education, economic opportunity and independence, to both sexes and has abolished regulated prostitution and provided safeguards from the major social stresses of widowhood, unemployment, and unmarried maternity, there was before the war a steep fall in the demand for, and supply of, professional prostitutes.

In countries where prostitution is still the field of financial exploitation, the expectation of a low standard of sex conduct leads to a large demand for, and supply of, clandestine and professional prostitutes.

The brothel and regulation has been proved to damage the health of the individual and the community; it has not prevented

the spread of venereal disease or secured a higher standard of order and decency than in countries where they have been suppressed.

That conditions of social disorganization are those conducive to an increase of supply and demand for casual sex relations has been obvious in the large increase in all war-affected countries, but this should prove transitory if wisely handled.

In the educated abolitionist countries the persistent demand for casual commercial sex relations comes from those brought up in the old traditional inheritance, the psychologically immature, and the sub-normal. A number of those who continue to be persistently promiscuous are in need of medical and psychiatric care and need permanent or temporary social guardianship. For this to be administratively practicable, a legal-medical definition of the *biological-psychological condition is an urgent need. We appre*ciate, however, that a national and free psychiatric service of a high grade is not at present practicable, but experiments should be encouraged.

To reduce casual irresponsible sex relations among the biologically 'normal' the social structure must be adapted to remove the conditions from which they arise, e.g. barriers to early marriage, adolescent strain, emotional starvation in infancy and childhood.

As sex behaviour is a matter of personal values a long-term policy in education needs to embody a healthy attitude of mind to sex and accord the family a high position.

Methods of rehabilitation for the prostitute and the persistently promiscuous need development on lines that promote self-respect and self-confidence. (1) Each to be treated as an individual not in segregated groups with others whose maladjustment to society has also taken the form of commercialized sex behaviour. (2) Social misfits to be given opportunities for training in the first instance at a residential school under medical control where they are sent by the courts or can be introduced by a recognized organization or hospital. No entrant accepted for less than six months. (3) The older, untrainable, recidivist prostitute to be pensioned on a confidential condition of residence and good behaviour.

CHAPTER VIII

VENEREAL DISEASES

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PART I

MEDICAL

Syphilis and Gonorrhoea

THE venereal diseases are no new problem, medically or socially, although to many the recent wartime publicity campaign has been the first indication of the extent and importance of this group of infections. The venereal diseases are legally defined in the Public Health (Venereal Diseases) Regulations of 1916 and in the Venereal Diseases Act of 1917 as *syphilis*, *soft sore*, and *gonorrhoea:* other conditions, resulting from promiscuity or transmissible by sexual intercourse—many of them of a less serious nature—cannot correctly be designated as 'venereal.' Syphilis, gonorrhoea, and chancroid (soft sore) form an ever-potentially dangerous group of diseases, capable of rapid dissemination, and followed in the absence of adequate treatment by individual disability, economic liability upon the community, and by sterility, or by physical or mental impoverishment of subsequent generations. No other group of diseases is responsible for so much human tragedy.

Syphilis is the most important of the venereal diseases: it is caused by a small spiral or corkscrew-shaped organism, the *Spirochaete pallida* (*Treponema pallidum*), which can penetrate even intact skin or mucous membrane, causing first a local sore at the point of entry, then generalizing rapidly throughout the body with liability to manifestations of the disease in any organ at any later period of life.

Infection may be acquired or congenital. Acquired infection results usually from sexual intercourse, less commonly, perversions, with an infected person: accidental contagion is rare, but may be conveyed by imperfectly cleansed eating or drinking-utensils on which infective secretion from mouth lesions has recently been deposited, by the common use of toilet requisites, by tattooing needles, etc. Such cases are very infrequent since the spirochaetes die off rapidly as the infected material dries. The transmission of infection by kissing may occur: in one case, a young man, suffering from infective syphilitic mouth lesions, attended a party at which kissing games were played and was responsible for the oral infection of six girls, and, through one of these, of another youth.

The course of untreated acquired syphilis can be divided into:

(1) The early, or acute, stage, occurring within the first year (or two years) from the date of infection, and including the incubation period, the primary sore, and the secondary rash.

(2) The late stages, including all manifestations occurring more than two years after infection.

(See Appendix, page 383, for full description and methods.)

The schemes of treatment fall into one of three main groups: (1) routine long-term treatment with arsenicals and bismuth, (2) intensive arseno-bismuth therapy, and (3) penicillin, not invariably combined with arseno-bismuth injections. Routine, long-term treatment, although the standard method up to ten years ago is now seldom used except when patients can attend for treatment only once weekly. It comprised four or five "unit courses," each course consisting of ten injections of neoarsphenamine and of bismuth at weekly intervals, and spaced by rest intervals of four weeks, i.e. a total of forty to fifty injections over a period of twelve to fifteen months. The outward signs of the disease vanished after the first or second injections, and it was often difficult to convince the patient that this long series of injections

was essential for cure. Default before completion of treatment was common, and many of those who defaulted suffered infective relapse, or, not infrequently, precociously developed manifestations of late syphilis. While this routine treatment was nearly 100 per cent curative, when completed, the default rate of from 20 to 30 per cent, and the smaller number of cases in which treatment had to be interrupted or mitigated because of intolerance to the drugs employed brought the average cure rate, proved by consistently negative clinical and laboratory findings over a period of at least two years, to a very much lower figure. This emphasized the need for more compressed treatment, and for less toxic medicaments.

Intensive treatment.—The introduction of a less toxic arsenical drug, arsphenoxide, made short-term treatment possible. Experimental observations with arsphenoxide indicated that, with the appropriate dosage for the weight of the individual, early syphilis could be cured by twenty or thirty injections in a time period varying from twenty to thirty days up to not longer than seven weeks. For the twenty or thirty-day courses, the patient had to enter hospital, as special dietary and other precautions were required. The seven weeks' course was applicable to ambulant patients.

The application of intensive treatment of early syphilis was greatly widened by the exigencies of the war period—the necessity to conserve man-power, and the necessity for completing treatment in the case of seamen and other itinerants who could not otherwise receive adequate treatment. A rapid appraisal of the results over a sufficiently large number of cases so treated showed the cure rate to be very comparable with that of the routine long-term schemes.

Penicillin was, soon after its discovery, shown to possess anti-spirochaetal properties, and when used in the treatment of early syphilis rapidly caused healing of the primary sore, disappearance of the secondary rash, and the serological tests, if positive originally, became reversed to negative. The original dosage employed was shown to be too small by relapses of the infection: a more definite guide was afforded by experimental observations suggesting that the curative dose of penicillin for early syphilis in humans approximated ten million Oxford units. A second observation showed that a synergic action existed between penicillin and the arsenicals. The modern trend of treatment is, therefore, to give the dosage of ten million units of penicillin in a period of fifteen days, and to

combine with this one "unit course" of ten injections of neo-arsphenamine and bismuth, or one of the intensive courses.

While the immediate results of combined penicillin-arseno-bismuth therapy are promising, the end-results cannot be evaluated fully for a number of years, and periodical observation over a minimum period of two years is necessary to make certain that the infection is eradicated.

The serious manifestations of late syphilis coming on as they do many years after the original infection, frequently strike during the fourth or fifth decades of life—at the time at which the individual's working capacity is at the greatest, and his economic liabilities to his wife and growing family are most heavy. Thus the tragedy of late syphilis does not invariably remain a personal one. Because of the length of time from the primary infection, syphilis may not be considered as the possible cause of the symptoms until irreparable damage has been done. The earlier treatment is commenced, the better the outlook: the syphilitic degenerative process can be arrested, but full restoration to physical fitness and earning capacity depends on the degree of tissue destruction before the recognition of the disease. Destroyed tissues cannot be replaced, and only too often, despite treatment, there remains some deterioration of the mental or physical capacity. The same drugs are used in late syphilis as in early infections: the dosage may require modification because of the patient's age or physical condition, and the course of administration has frequently to be very prolonged. In late syphilis of the nervous system, fever therapy by malaria innoculation, or by special fever cabinets, in which body temperatures of 105–106·7° F. can be maintained for periods of twelve hours, has revolutionized the outlook, and restored to a useful life many whose condition would otherwise have been hopeless.

Congenital or Pre-natal Syphilis.—Infection with syphilis, occurring in the pregnant woman, or in women of childbearing age, may lead to tragic interruptions of the pregnancy, and death or infection of the offspring. In recently acquired untreated maternal syphilis there is the tragic history of a sequence of early miscarriages, still-births at full term, living syphilitic children, and finally healthy children may result. In late maternal syphilis, the chance of infection of the child depends on the flaring up of a residual focus of infection, a transient blood-stream infection, and spirochaetes reaching the foetus through the placenta or after-birth.

Infection of the unborn child occurs usually about the fifth month of pregnancy: in syphilis, acquired by the mother late in pregnancy, the child may escape intra-uterine infection, only to develop a primary sore after birth, the infection being acquired during the process of birth.

The tragedy of congenital syphilis is the greater because it is so entirely preventable: the detection of maternal syphilis early in pregnancy and the application of treatment invariably result in the birth of a healthy infant. Even if the infection is not detected until the fifth month or later, treatment will ensure a healthy child in possibly 50 per cent of cases.

The detection—or exclusion—of syphilis in pregnancy depends in many cases on the carrying out of routine serological tests. Where there are signs suggestive of syphilis, the diagnosis is easily reached. On the other hand, the course of recently acquired syphilis is very often modified by pregnancy: the primary sore heals rapidly: the secondary rashes are absent or highly transient: there are no constitutional symptoms In such cases, and in the cases of later asyptomatic infection, blood serum tests are the only available guide. Fears have often been expressed that the occurrence of "false positive" reactions might lead to the erroneous diagnosis of syphilis in numbers of cases. False positive tests are infrequent in well-conducted laboratory tests, and the knowledge that they may occur leads to the most thorough investigation and full confirmation of the diagnosis before any treatment is commenced.

The suggestion, often made, that women would resent the 'insult' of being subjected to a routine blood test has not been borne out in practice. Expertly carried out the test is painless, and the reassurance that there is no hidden blood disease is welcomed. The wartime course of early syphilis has made routine testing in pregnancy even more urgent.

Gonorrhoea is a disease caused by the *gonococcus*, a kidney-bean shaped organism, the site of infection being the mucous membrane of the male, or female, genito-urinary tract. Infection is almost invariably by sexual intercourse: accidental genital infection of the male is almost unknown; women may rarely become infected by contaminated lavatory seats, or towels, etc., but such cases are so rare that for all practical purposes the risk of accidental infection in adults may be discounted. In female children, below the age of puberty, a sexual infection may occur (gonococcal vulva

vaginitis) and spread rapidly, while in both sexes the eyes may be infected during the process of birth giving rise to a gonococcal ophthalmia (*ophthalmia neonatorum*).

An incubation period varying from four to fourteen days—occasionally as long as six or eight weeks—elapses before the occurrence of symptoms and signs. Some degree of discomfort on, and increased frequency of urination are noted, and a genital discharge is complained of. This is at first thin and watery, but rapidly becomes purulent.

It will be appreciated that the possibilities of untreated gonorrhoea can spell disaster for the individual: this is the more so, since gonorrhoea can occur in either sex with minimal symptoms, no suspicion of infection arising until the onset of some complication. Before the introduction of the sulphonamide group of drugs, cure of gonorrhoea could only be achieved by protracted local treatment, complications were common and epididymitis, with associated prostato-vesicular changes, occurred in 8 to 10 per cent of male infections, salpingitis in from 1 to 3 per cent of female infections, and arthritis in from ½ to 2 per cent.

Diagnosis.—The symptoms and signs of gonorrhoea—dysuria, and discharge—may be caused by a large variety of other conditions, and some of them infective, and following sexual exposure. Proof of a gonococcal infection can therefore only be made by the demonstration of the gonococcus in the discharge or other morbid secretions.

This should invariably be done before any treatment is instituted: several tests may have to be made before the organism is isolated in smears or cultures, and even small doses of the modern curative drugs render bacteriological confirmation of the diagnosis impossible.

Gonorrhoea is rapidly cured by the sulphonamide group of drugs, and even more quickly by penicillin After a single injection of half a million units of penicillin, the discharge ceases in from six to twenty hours, the symptoms are relieved, and the gonococcus can no longer be demonstrated. The vast majority of cases are cured by this single injection, thus averting the risks of any of the serious complications: in a small number of instances delayed response to penicillin or relapse may necessitate further administration. To make certain of cure, however, it is necessary that tests should be taken at intervals over a period of six months.

The possibility of dual infection with syphilis must also be

excluded by repeated blood tests during this period: the dosage of penicillin curative for gonorrhoea will not cure syphilis but does greatly lengthen the incubation period and may modify the early signs of the disease, hence serological tests are essential

Gonococcal vulvo-vaginitis has been mentioned as affecting girls below the age of puberty. Infection could spread rapidly—by means of sponges, towels, bed-clothes, etc., and cause epidemics in nurseries, crèches, or where children lead a communal life. Fortunately the condition is rapidly curable by penicillin.

Perhaps one of the most tragic sequels of unrecognized or untreated gonorrhoea in the female is infection of the infant's eyes during the process of birth, ophthalmia neonatorum. This in the past was a frequent cause of blindness—accounting for from 25 to 40 per cent of all inmates of blind asylums. Ophthalmia neonatorum is not invariably due to the gonococcus, although this organism causes the most serious cases Since 1914 it has been notifiable, ensuring prompt and efficient treatment and leading to a very marked reduction in the damage to sight. The real prevention of gonococcal ophthalmia lies in the detection and adequate treatment of the maternal infection, but as there are many practical difficulties, e.g. asymptomatic gonorrhoea, or patients not being seen until labour has commenced, etc., preventive measures are invariably applied to the child's eyes—usually drops of silver nitrate or other antiseptic.

Thus, while it may truthfully be said that since the advent of the sulphonamides and penicillin, gonorrhoea has lost much of its former terror, yet, if the disease is untreated or neglected, the same train of complications can ensue as in the past. The premium is on early diagnosis, adequate treatment, and complete tests of cure.

CHAPTER VIII

VENEREAL DISEASES

PART II

ADMINISTRATIVE: GREAT BRITAIN

Incidence of the Venereal Diseases—Before the passage of the 1916 and 1917 enactments, and the subsequent establishment of V.D. clinics, no accurate knowledge was available of the incidence of syphilis, gonorrhoea, or chancroid in the country. The Royal Commission (1912–14) which reported in 1916, emphasized this point, but concluded from the evidence given that not less than 10 per cent of the community were infected with acquired or congenital syphilis and that a much larger percentage were afflicted with gonorrhoea. The Commission recommended that facilities for free treatment of these infections should be made available. This recommendation led to the passage of the 1916 and 1917 Acts which empowered the local authorities to establish public clinics for free treatment, under conditions of secrecy and privacy. Other important provisions were, the suppression, under penalty, of treatment of venereal diseases by quacks; payment of travelling expenses of indigent patients to permit them to attend for treatment: free issue of certain drugs to approved medical practitioners for use in their own practices; public enlightenment by means of lectures, printed information, etc.

It is from the official annual returns of these public clinics to the Ministry of Health that our information as to the incidence of infection is drawn: it is believed that in the inter-war period 1919–39 approximately 85 per cent of all civilian cases of V.D. attended the special treatment centres. The incidence of syphilis has shown a progressive decline, in 1919, 42,134 cases were recorded, in 1920, 42,806, in 1925, 22,588, in 1930, 23,120, in 1935, 19,335, and in 1940, 16,379. It is true that these figures are somewhat raised by including a number of multiple recordings of individuals who have attended at a number of clinics, and of returned defaulters.

This progressive decrease to 1940 affected all forms of syphilis —early, late, and congenital in males and females:—

	Total syphilis		Early syphilis		Rate per 10,000 of population	Congenital under 1 year
	Male	Female	Male	Female		
1931	11,285	6,827	6,421	2,863	2·28	339
1935	8,596	5,565	4,226	1,745	1 47	251
1940	7,093	4,605	4,029	1,582	1·36	217
1942	8,529	6,542	5,470	3,576	2·19	245
1944	7,667	8,251	4,384	4,934	2·26	346

Thus the decrease, although slow, was satisfactory until the outbreak of the war since when there has been a rapid extension.

The incidence of chancroid or soft sore in males shows a decrease from 1,048 in 1925 to 628 in 1944; in women there has been a fairly constant small number—under thirty per annum.

When we consider the clinic incidence of gonorrhoea, we find a different picture. In 1919, 38,499 cases attended the clinics; in 1920, 40,284 cases. In 1922 the figure had fallen to 29,477, but by 1930 had risen again to 45,001 cases. In 1938, 41,759 cases were recorded, in 1940, 31,438, in 1942, 32,938 and in 1944, 35,554 cases.

The failure to obtain a fall in the incidence of gonorrhoea parallel to that occurring in syphilis was due, in great part, to the lack of a drug capable of rapidly controlling the infective stage. Since 1935, the availability of such a drug, in the sulphonamides, has led to the private treatment of increasing numbers of gonococcal infections and has made the true incidence difficult to estimate.

The clinic figures show a decrease in male, and an increase in female, infection:—

Year	Males	Females
1937	29,250	7,787
1939	24,811	6,489
1941	20,572	7,314
1942	17,956	8,413
1944	16,629	10,646

The possible number of cases, calculated by the application of the gonorrhoea-syphilis incidence-ratio in service patients in this country, whose infections are all accurately recorded, shows a very marked increase—estimates approximately 33,000 male infections in this country including Service infection, and 25,000 female infections.

The Control of the Venereal Diseases.—The persistence of the venereal diseases amongst the community is due principally to two factors; firstly, the uninvestigated, untreated human reservoir of infection —those individuals who from apathy, ignorance, or the triviality of their symptoms do not seek skilled medical advice, and secondly, those individuals who default before treatment has been completed, and who are still infective or are liable to suffer infective relapse. Venereal diseases are an "all-human" problem, the reservoir of infection is human, the transmitters of infection are human, and the patients are human. We cannot blame non-human agencies, as we can in many other diseases of Public Health concern, for example water, milk, mosquito, in relation to typhoid, tuberculosis, or malaria

Default from treatment occurs in from 20 to 30 thirty per cent of cases and may result from many causes—ignorance or indifference towards the disease, rapid relief of symptoms, and inadequate explanation as to the necessity for complete treatment, tactlessness of Medical Officer or other clinic personnel: unsuitable clinic premises, hours, or the fear of the moral stigma attached to anyone known to attend a V.D. department, etc.—the reasons are legion.

On the whole, the V.D. clinicians were content with the gradual decrease in recent infections: little serious attempt was made to influence the attendance of suspected sources of infection, except through the co-operation and endeavour of the patient. There were few social workers to attempt to trace these sources and influence them to attend. Default was tackled, by letter, and in some cases by personal follow-up by almoners or Health Visitors.

Such was the position to 1938. Syphilis continued to decrease: we had drugs to control rapidly gonorrhoea and chancroid, and could anticipate a future decrease parallel to that achieved in syphilis. Nevertheless, failure to attack the reservoir of infection directly had resulted in a slower decrease in infections than could otherwise have been achieved.

The venereal diseases are well described as camp followers of

war, and the partial mobilization of 1938 saw marked local increases in the incidence of syphilis and gonorrhoea, pointing to what was likely to happen generally in the event of war. This forecast was fully borne out, in 1939 and the following war years. The unsettlement of life inseparable from war conditions—mobilization, evacuation, forced migration of labour, loss of the stabilizing influence of home or family background, emotional tension—were all conducive to a great increase in sexual promiscuity and consequent transmission of disease, while the black-out, fear of air raids, difficulties in travel, all proved obstacles to seeking treatment.

The increase in venereal diseases was greater in the areas of the active seaports than in the inland towns, the average percentage increase in syphilis from 1939 being:

	Percentage increase		
	1942	1943	1944
Ports { Males . .	134·9	107 3	71·4
Ports { Females . .	290	365·1	433·5
Inland towns, Males . .	25·8	31·5	14·4
	97·3	150	220 7

In the ports a significant percentage of infections was imported and of the merchant seamen attending the clinics from 30 to 60 per cent were foreign nationals.

The measures adopted to deal with the situation were:—

(1) *Increase of Treatment Facilities.*—The increase in number of infections, the alteration in their geographical distribution, and difficulties in travel led to the establishment of an additional forty-one new treatment centres in England and Wales, and from 1940 (Circular 2226, Dec. 17, 1940) to the provision of a "practitioner service," the practitioners having had special instruction or experience in taking specimens for diagnosis of venereal diseases and in the application of treatment, to supply the needs of rural areas.

The service was supervised by the County Venereal Diseases Medical Officer. It has proved of more limited value than was originally anticipated.

(2) *Regulation 33B: Contact Tracing: Default Control.*—Until 1942, when Regulation 33B was introduced, no powers existed to compel suspected sources of infection to attend for investigation and treatment. Under this regulation a reputed source of two or more infections can be required by the Medical Officer of Health to attend for investigation and, if necessary, treatment until certified by a venereal diseases specialist to be no longer suffering from the disease in a communicable form.

The maximum penalty for non-compliance was a fine of £100, or three months' imprisonment, or both, while similar legal penalties were prescribed for malicious notification.

It was realized that this regulation could only be effective against a relatively small number of sources of infection: e.g. those responsible for multiple infection of troops, or other localized communities, but it had great publicity value in focusing attention on the problem of venereal diseases.

The Local Authorities were encouraged to undertake the confidential follow-up of those in respect of whom only one notification had been received; contact tracing had begun; social workers were employed by a number of the larger authorities to carry out not only the work in relation to the 33B notifications, but to interrogate all infected new patients as to the source of their infection, to obtain, if possible, adequate identifying particulars, to locate and persuade the individual, by a health-education approach, voluntarily to attend for investigation. If the contact was infected, the same process was gone through and the chain of infection followed up.

From the interrogations, certain information became available. Prostitutes were found to be responsible for a small percentage—less than 10 per cent—of infections in the country, although in some regions, e.g. the West End of London and dock areas, they constituted a major factor. The majority of infections were transmitted by *young good-time girls*—sexually irresponsible, unrestrained by moral or ethical considerations. The rapidity of their "friendships" and casual promiscuity made tracing a difficult task: their outlook on life and general irresponsibility made them highly default-prone. They were often mentally sub-normal and enquiries into their occupations record showed a series of rejections from firms. For such cases, hospitalization and intensive treatment offered the best chance of cure. Ideally, social reclamation should be attempted—by psychological and psychiatric examination,

vocational aptitude testing, occupational therapy, and a period in a residential rehabilitation training home: their venereal disease infection can only be regarded as a symptom of their social maladjustment.

Since its institution, contact tracing and the follow-up by the same personnel of defaulting patients have proved their value in the control of the venereal diseases.

For the rising generation, a long-term progressive policy of education in personal and public health is essential, and is being put into effect. In the past, too often the adolescent has entered the world ignorant of the facts of life, the responsibilities of sex, and of the pitfalls awaiting, only to undergo a rapid and crude education from workmates. Sex is given an undesirable prominence, and promiscuity accepted as a matter of course. It is a matter of wonder that under these conditions so few go wrong. How different the outlook of the adolescent protected by accurate knowledge, and imbued with high ideals! The sequence of gradual approach—sex education approached from a biological point of view, factual instruction being given before puberty, before there is any emotional bias, and also before any chance arises to acquire secretive, and often distorted, information from undesirable sources.

The ethical aspects are best dealt with about, or after, the age of puberty; personal, social, and family implications being explained and the attempt made to inspire a high idealism. With this teaching, venereal disease is alluded to in its proper perspective in relation to sex and its problems, and to public health, and is not, as at the moment, so often over-emphasized as a medical problem only.

The ideal for which we are striving, the abolition of venereal diseases, will not be achieved by any one means but only by judicious consideration and application of all available measures; of these the long-term educational policy is likely to be the most ultimately fruitful.

CHAPTER IX

HEALTH AND BEHAVIOUR

PART I

SOCIAL IMPLICATIONS IN GREAT BRITAIN

In considering problems of Welfare from the standpoint of Social Biology, it is clear that one of the main objectives of law, custom and convention should be to promote a population of good inherent quality and to maintain it under conditions that enable the greatest number to develop their optimum in health and ability. Hitherto, the attention of the community has been focused mainly on the cure of disease in the individual. As scientific understanding increased it was obvious that much disease arose from conditions beyond the control of the individual and that their removal needed collective action, local, national—and in some cases international.

In practically all countries some form of Health Service exists and is now directed to the prevention of disease. A good water supply, an efficient system of sanitation, the destruction of the breeding-grounds of disease-carrying insects are major preventive measures. To check typhus, typhoid, diphtheria, malaria, sleeping-sickness and a number of other conditions require environmental changes. Cholera, smallpox, yellow fever, bubonic, and other plagues that in earlier and more ignorant days claimed victims by the hundred thousand are now the subject of International Sanitary Conventions, with the object of preventing their spreading from one country to another. This has developed on voluntary lines to include the concentration of resources in fighting an outbreak in one country by all others able to assist.

There still remain many and serious scourges for which no effective preventive or curative measures have yet been found, and which take either a cyclical or a continuous toll of human health and life. As a plague, the pneumonic influenza of 1918–20

which claimed more lives than the preceding war, may be cited; while among the others cancer, diabetes, infantile paralysis and encephalitis lethargica may be mentioned. For these, such general ameliorative measures as have already been discovered are applied, and where infection is suspected, though the actual form thereof is as yet undiscovered, efforts to limit the number of victims are made through the application by the authorities of general principles, such as the isolation of the patient and of contacts. These and many others are problems still to be solved by research.

Nutrition, noise, artificial light as factors in resistance to disease or as affecting the physiology and psychology of the individual are recognized, but their effect on the human organism is still incompletely understood.

While the etiology of tuberculosis, syphilis and gonorrhoea is known, the social structure, social customs and personal behaviour have all to be adapted if the causative conditions of infection are to be removed The same applies to hookworm, malaria and other diseases in tropical countries. In a closely-knit industrial organization, with its network of labour and insurance regulations, the mobility of some workers and the inherent physical disabilities of others make the necessary adjustments a complex and difficult matter.

That they are being made in the wake of knowledge can be seen by the man in the street. What has been attained in relation to tuberculosis is summarized on pages 383–388. For the moment it will suffice to call to mind the successful adaptation of industry to the needs of its victim in the Papworth experiment, now being repeated in other countries. The provision of early diagnosis, free medical care, sanatoria, and food priorities for T.B. patients, together with a general policy directly related to the interests of the family and the community, as well as the individual, is steadily improving the position. The passing of spitting as a personal habit is an example of change in behaviour following knowledge. Forceful propaganda and measures to prevent it developed through the educational influences of the school years, backed by legal penalties, was soon supported by an enlightened public opinion, and has, in twenty years, abolished the habit. Cleanliness of transport, public-houses and pavements secured in less than a generation is a hopeful indication of what understanding co-operation between scientist and public can accomplish.

Tuberculosis, however, still remains a serious burden, and a problem for study and research as well of administrative and social endeavour.

The elimination of syphilis and gonorrhoea should be a more hopeful task, as the inherent predisposition to develop the disease when exposed to the risk of infection as in tuberculosis does not appear to be recognizable. There may be in some, however, a predisposition to the behaviour likely to expose the individual to the risk of infection.

Public health administration in relation to what have been termed "venereal diseases" varies in relation to the community background. In Europe this has historically deep emotional roots.

These two diseases occupy a unique position. They still retain in many countries some of the atmosphere of the tradition that all disease was a punishment inflicted by evil spirits, by a special deity, or in Christian times, was a punishment for sin, or an inscrutable "Act of God."

It is only in recent years that Northern Europe has broken with this tradition, and it still lingers in the rural districts of backward countries in regard to leprosy, insanity, and mental deficiency.

Syphilis and gonorrhoea have been labelled "venereal" diseases, thus permanently attaching to them the stigma of being directly derived in each case from anti-social sex behaviour.

This additional burden has been reflected in the social condemnation meted out to the sufferer throughout historical times.

Public opinion has already changed considerably, owing to the spread of information as to their prevalence, origin and methods of treatment, aided by the challenge to values and conventions offered by acute problems thrown into prominence by two world wars. A sketch of the relation of the hospital to venereal disease in the different countries indicates considerable variation in the extent to which the new point of view is finding effective expression. Hospital administration is selected as it provides a useful bridge between popular and medical opinion.

As disease has been closely allied in men's minds to the supernatural and as bearing directly on the relationship between God and Man—medicine, the study of disease, the care of the sick has from earliest times been closely related to religious institutions. Before the Christian era medical schools were attached to the Temples of Saturn. We hear of the medical books of Hermes

being preserved under the care of the priesthood at the shrines. In India we find in 260 B.C. that Asoka founded the hospitals of Hindustan. In the Far East, institutions for the care of the sick were initiated by, and under the direct supervision of the Buddhists and later the Mahommedans. It was under Constantine that the Christian communities organized provision for the sick; and we have records of the Nosocomia that were initiated by the Christian Churches in Alexandria, Rome and elsewhere. From then throughout the Middle Ages the connection between the monastery and the hospice has been close.

For example, St. Bartholomew's Hospital was founded in 1123 as a Nosokomeion or Home of Refuge.

The hospice at first was a place of refuge and of hospitality for the traveller, for the poor, the distressed, and the diseased. Some Religious Orders devoted themselves particularly to the care of the sick.

The spirit which inspired them was that of Christian charity and was in no way related to the preservation of the public health. It was the soul rather than the body that was the focus of interest. The actual disease, therefore, would not be a reason for refusing help, but the help given would be spiritual rather than medical. Traces of this feeling were evident until recently in this country and still remain in Southern Europe and also, it is reported, in South America, in the Rescue Homes and Penitentiaries that accept all, but too often provide no adequate medical treatment for those "sinners and penitents" suffering from syphilis or gonorrhoea.

It was not until the eighteenth century that civic authority began to assume any general responsibility for the sick. (Before 1710 there were no general hospitals in twenty-three of the counties in Great Britain.)[1]

An exception must be made of leprosy, which there is some ground for believing was often confused with late manifestations of syphilis. The regulations enforcing the isolation of lepers were operative from very early days in the East, and later, throughout Europe.

Although little or nothing was known of methods of infection or treatment it is clear a connection existed in the popular mind between prostitution and disease. In 1430 public regulations were made in London to prevent the admission into houses of prosti-

[1] *Encyclopaedia Britannica.*

tution of persons attacked by a disease which appears from the description to have been a form of syphilis

Admittedly the exact date of the introduction of syphilis to Europe is still a matter of controversy.[1]

In France there was an ordinance in 1497 of the Parliament of Paris exiling from the city all suffering from syphilis who were able to travel and appointing agents to pay to each victim 4 *sols parisis* for their journey, a refuge or hospital being provided at public expense for those unable to travel. Indications exist of its recognition and prevalence at about the same time in Spain and Italy.

In 1497 James IV of Scotland issued a Proclamation banishing the infected from Edinburgh and ordering them to retire to the sands of Leith, undertaking that they should be provided with boats and furnished with food, but instructing that they should remain there "until God provyde for thair health."

The medical men of that day and even later were averse to treating these diseases, probably owing to lack of existing knowledge, as syphilis was for long looked upon as incurable.

The prevalence of gonorrhoea in these times may be presumed, but apparently it was not so closely related either in the medical or the public mind with moral laxity as was syphilis and, therefore, was probably merged in the general sickness and ill-health of the community.

The lack of any specific knowledge of syphilis as such, however, is indicated by the definition of the scope of the small hospital set up in Paris in 1535 to deal with those suffering from "Syphilis, St. Vitus' Dance, epilepsy and the itch." That the demand for hospital accommodation in those days far exceeded the supply is graphically disclosed by the account, appalling to us, that is given of this hospital. It was soon so full that several patients shared the same bed! The majority, if not all, appear to have been men who eventually rebelled owing to the lack of food and accommodation and forced an entry into the general hospital, the Hôtel-Dieu.

The conditions at the end of the seventeenth century in the Salpétrière and the Bicêtre almost beggar description.[2] Eight women slept in a bed and such was the congestion that among

[1] *History of Prostitution*, by W. W. Sanger. The Medical Publishing Co., New York.
[2] Op. cit., p. 134.

those waiting their turn for treatment, sleep was only possible in gangs, one group having the bed from 7 p.m. to 1 a.m. another claiming it from 1 a.m. to 8 a.m. The hospital imposed a rule that none could claim admission until a full year had elapsed since their application This did something to reduce congestion, as many died before their turn for medical attendance came.

In 1614 a hospital for syphilitic males was opened. As far as one can trace there was then no provision for women other than that given by the religious communities on the basis of general distress. The regulations of this hospital express an attitude of mind which is in contrast to that of to-day when people are encouraged to come for treatment and to remain under medical care until cured. Our early precursors in the public health field ordained that all patients should be soundly whipped on entering and on leaving the hospital as a punishment for having contracted disease. In spite of this the hospitals remained overcrowded. The Managers eventually protested, declaring naively that this practice deterred patients from seeking treatment! The practice did not, however, cease until twenty-five years after the protest.

Since 1828 the Municipal Authority of Paris has endeavoured to provide medical care for recognized prostitutes.[1]

In Great Britain in Henry VIII's reign there were six Lazarets open on the outskirts of London which accepted syphilitic patients, but the Lock Hospital founded in 1747 and the Magdalen Hospital for the Rescue of Women and Girls founded in 1758 were the earliest institutions for the medical treatment of syphilis and gonorrhoea in Great Britain. This does not mean that a considerable number of syphilitic persons were not treated at the general hospitals.

Then, as now in the more backward countries, there were two points of view: on the one hand, those who would care for the sinner and looked on the disease as a punishment for sins, and, therefore, founded special hospitals where the moral welfare of the patient was the primary consideration; and on the other, the more enlightened medical men and members of the governing bodies of some of the hospitals who gave such assistance as was possible to all sick persons.

The idea held by many representatives of the Churches that

[1] *History of Prostitution*, by W. W. Sanger, p. 34 The Medical Publishing Co., New York.

venereal disease is a personal punishment inflicted by the Deity on prostitutes and their customers still obtains in Christian communities where the standard of education is low and the hold of the peasant priesthood is firm Only in 1937 special efforts had to be made by the medical and other intelligent leaders of the Roman Catholic hierarchy in Rome to convince a branch of one of the religious orders in one of the British Colonies that infected Catholic prostitutes rescued and brought under the care of the Order should be allowed to attend the local V.D. clinic or to receive treatment in the convent from the V.D. specialist.

The community assumed some responsibility for Public Health from the eighteenth century onwards and with every increase in knowledge the scope of Public Health was extended. Theoretically no case could be turned away from a public institution maintained from public funds by the State or Municipality. In Great Britain, however, the only properly equipped institutions for the sick were the voluntary hospitals.

At the end of the eighteenth century legal provision was made for the destitute among whom were included many of the sick. Poor Law Infirmaries were instituted all over the country. The position of the syphilitic patient up to the present century was most distressing. Even in the general hospitals and infirmaries (not under Poor Law management) as late as the twentieth century there were regulations that no venereal disease patients be admitted either as in- or out-patients. The rules of the Hereford Infirmary contained a special exception: "Unless (as very pitiable cases may occur) at the desire of physicians and surgeons."[1]

In the early days of the present century it was usual to find in the chronic sick wards of Poor Law Institutions cases of tertiary syphilis housed in the same wards as other diseases and receiving no specific treatment for their condition. This situation still obtained in certain Colonies into the 1939 war and may not yet have been entirely eliminated.

A step in development was the provision in most countries of special hospitals for professional and clandestine prostitutes, some are still administered as prisons. As efficient medical institutions that have made valuable contributions to scientific knowledge society must be grateful to them, but these specialized hospitals belong to an earlier social condition and even as a method of rehabilitation are at variance with the modern outlook.

[1] Report of the General Infirmary, Hereford, 1936. Rule 37.

Commercial prostitutes are now known to be numerically but a small proportion of the women who contract venereal disease. Speaking broadly, in the countries where private hospitals exist they tend to devote their attention to the temporarily sick and to direct their care to the individual. In practically every country the care of infectious and contagious disease and the care of the insane, and to an increasing extent of the mentally defective, is undertaken by the State.

In 1916 when the British Government scheme for offering free treatment for venereal disease to the whole population was introduced, the Governing Bodies of Voluntary Hospitals were asked to give facilities for the establishment of the free treatment centres to be housed on the hospital premises but financed from public funds.

The Charters or regulations of many of these hospitals contained clauses prohibiting the admission of patients suffering from venereal disease and many refused at first to co-operate in the scheme.

On one occasion, when a Hospital Committee stated it would be impossible to admit such "loathsome" diseases and that the nurses would refuse to care for them, Sir Malcolm Morris, accompanied by some of the medical staff, the matron, and the Governors, made a tour of the hospital and established the fact that a large proportion of the beds were then occupied by patients suffering from the sequelae of untreated syphilis and gonorrhoea. The clinic was shortly opened and is still doing good work.

In Denmark and in Belgium, private hospitals and institutions are nearly all dependent on religious bodies. In Norway the greater part of them belong to the Norwegian Red Cross and Catholic and Protestant congregations. In Spain the hospitals are mainly under the control of the Catholic Church. In France there are a number of beds for the sick under the care of the religious orders. These Orders also provide a large proportion of the nursing service required for the public hospitals.

The former attitude of the Nursing Services towards these diseases has been an important factor in reform. The absence of any mention of them in the nursing training courses, and the prevalence of both fear of infection and abhorrence of the diseases led the nursing staffs and matrons of a number of voluntary institutions to protest against the acceptance of the infected as patients. In practically every country where nurses are given a

recognized professional training the curricula now include some education and sometimes training in the care of these diseases. The nurse can and often does play an active and most valuable part in the enlightenment of the public.

In the West the public health and personal curative aspects have both been influenced by the fact that infection is usually acquired by adults through sex intercourse, which in the public mind is associated with prostitution and extra-marital adventure. Ignorance veiled their prevalence among married women, and congenital syphilis among children in its varied forms was seldom recognized as such.

The designation 'venereal' crystalizes the confusion of thought, of values and of convention belonging to the historical past. Some recognize the barrier this nomenclature creates to the attainment of the medical administrator's objective of securing their recognition as public health problems and their administration on public health lines. Twenty years ago, to indicate "venereal disease," such terms as "The Great Scourge," "The Social Evil" were used for syphilis and gonorrhoea—mere words that could not appear in the Press or be mentioned in public; in fact, only between members of the medical fraternity. As the enlightenment of the public coincided with the development of and publicity for treatment facilities the historically ancient expression "venereal disease" has become entrenched in European languages. In these days when infectious and contagious diseases have to be considered in relation to world populations, it is a harmful anachronism. A discreet allusion to the pleasures of Venus may have been appropriate among classical scholars of the past; it has no meaning for the Arab of North Africa or the Cantonese of Southern China. It simply labels the diseases as different from others and checks their natural incorporation into general health measures. Moreover, syphilis and gonorrhoea are so different in their etiology, in their sequelae, and their treatment, that to continue the myth of their identity is unscientific as well as administratively embarrassing.

We do not designate malaria and sleeping sickness under the generic term of "Marsh-Mosquitoitis," nor do we combine silicosis and tuberculosis as Bad Working Condition-diseases. Many other ailments derive from bad working conditions and many other ailments are contracted through persistent sex-promiscuity—yet these are not labelled 'venereal.'

A strong resolution recommending that the term 'venereal' should be dropped from all official medical communications and its general use discouraged, was passed in 1936 by the V.D. Committee of the International Hospitals Association and widely circulated.

When the true position of the prevalence and consequences of syphilis and gonorrhoea in all sections of the community was disclosed by the Royal Commission in 1915, by Government enquiries in several countries, and by war, popular knowledge of the place of sex in life in Great Britain was at a minimum. The agitation against traffic in women and commercial prostitution, started by Josephine Butler (see page 172), had created a sensitive social conscience which rightly condemned any measures that could either encourage prostitution or be interpreted as so doing. This attitude was most fully developed in Great Britain, Holland and Denmark.

During the 1915–20 period a great effort was made by all countries where a national Public Health Service was in existence, to make available the newly-discovered methods of accurate diagnosis. The present position is fully described by Dr. McLachlan in Chapter VIII.

That the new methods of diagnosis and treatment of syphilis and gonorrhoea were first given general currency in the fighting forces resulted in the medical men of the belligerent countries who had served with the forces being those most conversant with the modern technique. Their experience was derived from applying their knowledge to men under discipline. This attitude, in Great Britain particularly, delayed the development of the scheme to suit the more varied needs of a civil population. Even where the Public Health Service was already developed it has not been fully recognized that a successful scheme of treatment must meet the needs of the family at all ages. Great Britain was at a disadvantage in comparison to the Scandinavian countries as the diagnosis and treatment of syphilis and gonorrhoea (and normal sex psychology) did not form an integral part of medical training. Only in 1930 was failure to pass in "venereal disease" made a reason for failing the candidate, and then only in some hospitals. This resulted in the diagnosis and treatment of the population being canalized into the hands of a relatively small group of specialists who could obtain very little technically efficient co-operation from their colleagues in public institutions, other

specialist branches of hospitals or in private practice. It has delayed effective co-ordination both in curative and preventive measures between the different medical services. Cases of congenital syphilis are even to-day by no means always recognized as such and referred for syphilitic treatment by the eye hospitals. It is not yet a matter of national routine for all institutions and It is not yet a matter of national routine for medical practitioners in all institutions and in private practices seeing maternity cases to make a routine diagnostic test for syphilis. As late as 1927 the Venereal Disease Adviser to the Ministry estimated there were 16,000 infected expectant mothers each year, a minority of whom at that time received adequate treatment. The total number of women attending the Venereal Disease Centres for the first time in 1927 was 7,553. Even to-day the Local Authorities can be counted on the fingers of one hand in which an efficient confidential co-ordination exists between the V.D. and the School Medical services. And yet a pioneer of the early twenties who held the two posts of Venereal Disease and School Medical Officer undertook a survey of the school children in the town, with the result that over three hundred were found to be the offspring of venereally infected parents—all were tested and a large number were in need of treatment for congenital syphilis. As Dr. McLachlan points out, while the treatment of the expectant mother during the latter five months of pregnancy can almost certainly ensure the birth of a healthy infant, if a child's treatment is only begun after the age of five years it may be ameliorative but is seldom curative.

The French Medical Service in the early twenties was still in process of development, but during recent years, under the energetic guidance of Dr. Cavaillon and his colleagues, the Infant Welfare, Venereal Disease, and School Medical Services have developed close co-ordination. From the start the Infant Welfare Service of France has participated actively in the campaign against venereal disease and the V.D. centres have made use of the *Service Visiteurs* in following up defaulters from treatment and contacts with infected patients, preserving secrecy and persuading the individual to seek medical care.

In the Scandinavian countries the better technical equipment of the medical fraternity has disclosed itself in the widespread detection and treatment of the congenital child. In all countries providing it, happily, the treatment of the adult has led to a

steady reduction in the deaths of infants under one year from syphilis. The British figure for 1945 being 0·15 per 1,000 live births (see Appendix for table, p. 394).

In Holland, Denmark and the Scandinavian countries, thanks to the initiative of a millionaire philanthropist, Mr. Weylander, schemes have been developed for the combined treatment and education of the congenitally syphilitic child in the Weylander Homes.

The position of the congenitally infected varies much from country to country. While it is recognized by all that the best preventive of congenital syphilis is the ante-natal treatment of the expectant mother, in no country in the early days was provision for this complete. In all, there were—and still are—numbers of children and adolescents with the stigmata of congenital syphilis. While the treatment is long and complete cure is rare, the ameliorative results were claimed to be well worth effort and expenditure.

The system of providing large orphanages for the illegitimate, abandoned or destitute children by popular philanthropy has persisted up to the present times, but is passing. The charitable and religious background of many of these institutions in all countries has not led them to follow and benefit by the progress of medical science. While in some cases blood tests are taken before an infant is admitted, and the syphilitic sent elsewhere, there are few where a routine test is taken on all inmates and cases of inherent tuberculosis or congenital syphilis sought out and systematically treated, or where eye and ear conditions developing in adolescence are recognized as the stigmata of congenital syphilis and treated as such. In this country, while some local authorities provide for adequate diagnosis and treatment of children passing through the hands of their Public Assistance Departments, many do not. Some, even yet, are unwilling to incur the expense.

The general trend away from the institutional care of the child and the increased powers of medical inspection of all children under non-parental care should prove beneficial, but in many countries and particularly in Colonial Dependencies, the congenital child is seldom recognized or provided for.

The pioneer work of France during the last twenty-five years has given noticeable leadership to the Southern European countries and also materially influenced the South American republics.

As a regulationist country (until 1946), free treatment, at first, was limited to the municipal clinics provided for the registered prostitutes.

From the early nineteen-twenties onwards, under Dr. Cavaillon, of the Social Hygiene Section of the Ministère de la Santé Publique, free clinics for the public were opened in the hospitals, the range of the municipal clinics extended, and in addition as a non-official enterprise, the Vernes Institute at Paris won world-wide fame. The high incidence of disease was disclosed as due largely to Regulation, and much medical opinion favoured abolition.

Syphilis and gonorrhoea—particularly syphilis—often obtain in communities where prostitution in the Western sense is unknown, and where the only social stigma that attaches to it is that common to all disease—the individual becomes a burden on the community. Again, in the East, the social conditions and the ignorance are such that these diseases are very prevalent among the married women and the children for whom no modern treatment is available; or where it is available, it is not under conditions the women are allowed by their men to accept. Treatment is only sought by the small minority who do not distrust 'Western medicine.' In such communities any facilities limited only to the relatively small prostitute group or to the men, will not materially affect conditions.

For syphilis and gonorrhoea to be eliminated from any community requires a careful analysis of the family structure, the labour conditions, the morals, social conventions and values on which the behaviour pattern of the individual are based; an understanding of the medical needs of curative treatment; and a scheme of education and treatment that integrates the two.

The social implications of these two diseases cannot be appreciated without a general understanding of the medical position; therefore, the information in Dr. Eric McLachlan's preceding chapter must be correlated with the social conditions.

In Great Britain, the Victorian veil of silence that so long covered all open allusion to matters of sex, made it essential to stress the confidential nature of treatment and to maintain a continuous programme of popular enlightenment. Emotionally rooted prejudice made it more difficult to secure the attendance of women for treatment at clinics. While a stigma still attaches to the diseases in the Scandinavian countries, the better under-

standing and education of the population has led to a recognition of its serious repercussions on individual and racial health, and this view overshadows the idea that infection is definite evidence of moral laxity. While in no non-regulationist country do the new cases among women seeking treatment equal those of the new cases among men, in the Scandinavian countries the published figures show a proportion of between two and three men to every woman while the general figures in Great Britain range between four and five men to every woman. It is true that a close analysis of "new cases" into "recent infections" in 1927 indicated that among the latter the number was reduced to 2½ men to every woman. We have no comparable figures of this particular study for any of the Scandinavian countries. While no country has solved the problem of bringing all its infected women, particularly those with gonorrhoea, under early medical care, there is reason to believe that the gap between actual infections and those under treatment is smaller in Sweden than in Great Britain.

In an enlightened population where consequences of neglect are feared more than possible publicity, those who expose themselves to the risk of infection do tend to seek medical advice. The numbers attending before disease has developed, or for other conditions that the individual personally attributes to the result of promiscuity, can therefore be taken as a measure of public enlightenment and of confidence in the free treatment available.

Where Great Britain has failed in an otherwise successful policy is in the estimate of the effect the social attitude towards all matters of sex would have on relation to the participation of women in the venereal diseases treatment scheme. During the 1916–26 period few of the adults had acquired positive teaching in relation to personal health or an objective outlook on sex as part of their education and traditional inheritance. Both were available for that generation in Scandinavia. Special cognizance should have been taken of it when planning the facilities for treatment in the early post-war years. It did not suffice only to stress that the treatment was confidential. When, after the first ten years, it was clear that seafarers and workers were deterred from hospitalization by the administration of Sickness Insurance through many Approved Societies, and that the women attending fell below the estimated number infected, the scheme should have been revised.

There are still social discouragements. People will not seek

treatment at once if they risk dismissal from their employment or if, when hospitalized, they are forced to lose several days pay, or, when attending a distant centre they have to lose a day's work. For such, it is not *free* treatment Again, where the social stigma is still strong, and secrecy lapses, fellow workers may refuse to continue on the same bench or in the same work-room with a man or woman known to be under treatment The confidential character of the treatment facilities offered must still be carefully maintained for a transition period, possibly of a generation—pending a new attitude being developed in the younger people and the attainment by them in the future of administrative posts

Where social conditions so clearly affect medical results, constant vigilance is needed. Even where, on paper, arrangements are made to maintain secrecy, these are only too often ignored in practice, and if no remedial action is taken by the National Supervising Authority, they persist. For instance, fares of patients are authorized to the treatment centres when such visits entail travelling. In more than one area personal application had to be made by the patient to the Local Authority, not at the clinic. As soon as it became known that an official would visit the residence of the patient to ascertain if it was necessary to pay the fares from public funds, few applications were made and the number of women from the environs attending clinics in such areas were small.

In the areas of understanding authorities the officer in charge administers a travelling fund and gives cash payments.

All Insurance and Maintenance allowances payable for ordinary sickness must apply unquestioned to these two diseases. The economic aspect of V.D. hospitalization for the seafarer and his family also need attention

For women especially, if the time interval between infection and treatment is to be reduced, a careful study of their conditions and attitude must be made and the treatment offered in a form suitable to each community It must be remembered that the symptoms of the diseases are much less obvious in women, and that those of gonorrhoea are to the lay person indistinguishable from a similar discharge arising from many other causes. The patient cannot diagnose herself and would not willingly first seek advice at a V.D. Clinic. To reduce the stigma caused by attaching to the disease the idea of sex-promiscuity, and at the same time to maintain the support of public opinion for a high standard of

sex behaviour, the general gynaecological condition should be the focus of publicity in connection with treatment facilities. If administration and publicity cease to relate treatment to moral obliquity, the association will gradually die out. Married women, war-strained adolescents and children are not devotees of Venus!

In a careful analysis of those attending a group of clinics in the Midlands in 1937 it was found that although the non-venereal figures were high, the number of unmarried girls who came on their own initiative was minute. Nearly all who were attending had previously reached the hands of a welfare agency for other reasons. The majority of patients were married women, liaison partners, and just a few of the older persistently promiscuous. The young potential wife and mother who has had one early lapse in conduct has not yet been acceptably provided for. The recent infections of men and women attending seven clinics in 1944–47 showed a grave discrepancy between the sexes, particularly for gonorrhoea, e.g. 293 men to 52 women, 162 men to 41 women, 90 men to 19 women.

The ante-natal centre can attract the young married women, and it is but a matter of staffing and administration to see that routine tests disclose all the infected, thus their treatment can be assured. For the single woman on whom the stigma weighs most heavily and to whom ante-natal provision can no more be used without loss of character than a V.D. Clinic, the most hopeful and attractive provision would seem to be in a form that can be related by her and her own group to menstrual difficulties or gynaecological ailments. The former are common among women, an important factor in personal health and in relation to future marriage and maternity.

An easier way of bringing all potential women patients under care would be to stress the importance to the individual, to the family, and to posterity, of all gynaecological conditions being considered seriously and immediate advice thereon sought at an 'Ailments of Women Clinic.'

An expectation of conduct can easily be developed based on accepted emotional values which would lead to the desired behaviour pattern. The line of teaching would be that on any unfamiliar symptoms appearing, medical advice should at once be sought. Any good results would be short-lived, however, if on diagnosis those found to need treatment for syphilis or

gonorrhoea were in any way segregated or labelled as such by administrative measures recognizable by patients or their friends.

It is vital to success that such clinics should include on their staffs an experienced gynaecologist and a venereologist, and one should be a woman.

Difficulties have in the past been raised in hospital administration by insistence on the isolation of all V.D. cases. Yet in the V.D. hospitals of the Services (1914–18) thousands of cases of gonorrhoea and syphilis were nursed in the same wards without any cross-infections. The late David Lees limited to a very small group those conditions that could not, in Western Europe, be dealt with in a general ward. Such administrative differentiation against the V.D. patient tends to retain the stigma, to concealment and to the avoidance of treatment, behaviour which derives from the emotions rather than science.

The Union Internationale Contre le Péril Vénérien serves as a valuable channel for the interchange of experience derived from differing administrative methods. Certain hospitals in this country had attained beneficial results from appointing almoners to the V.D. Clinics to check defaulting in attendances for treatment. In 1927 this was reported to the Union. The French treatment scheme was then being extended. A Service Visiteuse was made an integral part of the organization of the treatment centre. In spite of continuous representations from the voluntary body to the authorities in Great Britain to benefit by its own experience and do likewise no progress resulted. In 1939 there were only five V.D. Almoners outside London, as the cost was not allowed as part of the V.D. scheme. It was only in 1942 and 1943 that regular financial provision was made first for almoners, and later for social workers and health visitors, whose duties included the confidential following-up of contacts to persuade them to visit the clinic or to continue treatment. After years of opposition from the V.D. Department of the Ministry of Health, social service is at long last part of the treatment scheme.

From the emergency period of 1938, the danger in this country of having no provision for liaison between the civilian and service V.D. administrations had been stressed by the non-official organization. France, through its Service Visiteuse and with a better understanding of the social implications of the problem by those in authority, was able to develop rapidly an effective co-ordinated

scheme. The forceful representation based on the successful experiments with their own personnel made by Dominion Medical Officers in this country, forced action, but at first on ineffective and limited lines open to considerable social criticism. Defence Regulation 33B as a war measure was hastily passed.[1]

The voluntary organization pressed on Members of Parliament the urgency of contact tracing for all on confidential and voluntary lines. During the debates on 33B this was pressed for and gained.

The majority of the men at the peak ages of risk were in the fighting services and under discipline; the vast majority of infected males were, therefore, under medical care. All Service men infected were closely questioned as to the source of infection and when adequate information was forthcoming it was transmitted to the civil medical officer of the appropriate area. This again resulted in the majority of those notified being women. The numbers examined and treated under the Regulation up to 1946 were 9 men to 880 women. Concurrently, the Ministry of Health advised the appointment to Clinic staffs of almoners, social workers or health visitors for contact tracing, and authorized the cost. This latter method of informal persuasive action brought in 308 men and 7,199 women contacts for examination over the same period.

Quite apart from notification of single cases of infection reported to the Medical Officer, which enabled the social worker from the Clinic or the health visitor to seek out and persuade them to attend the clinic voluntarily for diagnosis and if necessary treatment, there are a large number of contacts who are persuaded by the patient under treatment to attend. In the seven large Clinics an interesting analysis was made of the various ways of handling such contact. It was found that a combination of persuasion by the social worker and by the patient give the best results.

The first object of a health administration in diseases where the individuals themselves are often unaware of their condition during the infective and curable early stages, must be to ascertain who are the infected before the treatment which renders them non-infective can be applied. The earlier treatment is begun, the more readily curable is the condition. The initiative of seeking medical advice can only be taken by the individual or be enforced in disciplined groups. Even in the fighting services no com-

[1] See Chapter VIII.

pletely satisfactory scheme has yet been devised; all still must rely on the individual themselves "reporting sick" and endeavour to secure that as far as possible such reporting shall be complete. Those who fail to do so and subsequently develop the disease in an obvious condition are penalized, often by measures that injure the innocent family rather than the offender.

Health education has for this reason been an important aspect of the V.D. programme of every country. The points emphasized and the angle of presentation have varied to suit different traditions and values, though perhaps not sufficiently. The advent of the internationally distributed film is a case in point. Documentary films confined to the scientific facts, presented in simple form with no social background, are of value for popular education in all branches of Social Biology, particularly in relation to health and agriculture. When, however, dramatic stories illustrate the social implication of behaviour diseases, the appeal must be within the framework of the values, conventions and customs of the audience. Films illustrating the need for changes in the British behaviour-pattern do not ring true in France or America, still less in tribal Africa.

In the mid-twenties a plan was prepared by the writer, considered but unfortunately not adopted owing to the then lack of financial support for educational films, by which simple scientific films—particularly those dealing with human and agricultural biology—would be prepared but the social implication of the facts should be illustrated with different examples or stories on local backgrounds. In this way a body of varied teaching material suited to the different parts of the Empire would gradually be built up. The need remains in principle, and it may well be developed in the coming years.

An adequate supply of suitable material for adult education is vital if an early change in behaviour is to be possible. Even if not yet applicable in all areas it would be valuable in the majority. Recent experiments in rural India are reported to have been encouraging.

It is difficult for those in charge of popular education to gauge the results. Living among the informed, continually giving out information and distributing material, it is easy to imagine a greater reaction on the part of the public than obtains. Every Western country with an active Social Hygiene policy has developed propaganda. The United States, British, French and

Belgian voluntary organizations have produced and sponsored films, issued between them millions of pamphlets, leaflets, and posters. Broadcasting is a more recent channel used for the first time in Great Britain to publicize V.D. by the Chief Medical Officer of the Ministry of Health in 1942, but Canada and the U.S.A. have for long had access to this medium.

Denmark has made a valuable contribution to our knowledge of the effect of propaganda. After an intensive campaign carried out by the League Nationale Belge Contre le Péril Vénérien with the support of the Government the results were tested by the Belgian Gallup Institute. One would not expect these to be very different in any country that provides compulsory education and has an extensive newspaper reading and film-going public. The poll was taken in 1944 designed to test the level of popular information on V.D. The enquiries directed to equal numbers in three groups, the workers, lower middle, and leisured and professional. Ages were also classified in three groups—18 to 25, 25 to 45, 45 to 65 years. There was only 10 per cent less knowledge among the workers, and this was mainly due to the almost complete ignorance of the agricultural labourer in rural areas. There was no significant difference between the lower middle and the professional and leisured classes. The real difference was between the town and the country dweller. The best informed were in the lowest age group and those with a bias against the subject among the oldest section. Three-quarters of the population had acquired their information from lectures or conversations, only 3 per cent had acquired it at school, and 2 per cent had received specific instruction from their parents. The two latter points depend, of course, on the school curriculum which varies in each community, and the family outlook on sex which also differs widely. That Denmark is ready for an educational step forward is shown by 90 per cent of the population being in favour of young people between 14 and 15 receiving information at school from a doctor. It is the varying impressions made by the different forms of publicity that interests all engaged in Health Education. Eighty-five per cent had noticed that there had been a propaganda campaign—50 per cent from the newspapers, 20 per cent from posters, 17 per cent from the radio. The film, pamphlet and lecturer had played but a small role:—

SUMMARY OF GALLUP POLL

Samples covered 1,230 women and 1,180 men, of whom—

50 per cent did not know that a person could have either disease without being aware of it,
75 per cent did not know the symptoms of gonorrhoea,
94 per cent did not know the length of the incubation period,
39 per cent did not know the diseases were infectious before the symptoms were obvious,
40 per cent did not know of their possible grave results,
80 per cent did not know medical advice was necessary,
27 per cent did not know treatment was available,
65 per cent did not know where to go for treatment,
62 per cent did not know there were preventive measures,
83 per cent knew nothing of chemical prophylaxis
50 per cent did not know there was a risk of infecting others through sex relations,
84 per cent knew nothing of modern remedies for gonorrhoea,
15 per cent did not know children could be born infected.

To focus emotional drive behind the factual knowledge a new "expectation of conduct" must be generated in the groups, a different 'value' demonstrated in administration, and reforms made in the social structure to encourage the behaviour desired. Such changes are needed in all countries, but it is not practicable to make concrete suggestions here applicable to the varied cultures. Suffice it to say that whenever the population are under direct guidance or subjection, the goodwill and effective co-operation of the individual recognized and accepted as responsible for directing their behaviour should be actively engaged. The Catholic priest in Ireland, Southern Italy and elsewhere, the Chief of the Arab or African tribe, the Mohammedan or Hindu husband—yes, even yet in many parts of Europe the husband—if the wife is to seek and continue treatment, all have to encourage her to do so.

In such areas an entirely female staff at the Centre is always desirable and often essential. It is to be remembered that it is not only the objection of the father or husband to a man seeing and treating his women-folk, but in a culture where none but the men of the immediate family of the women are seen, her reaction may be resentment of a strange male, particularly in such circumstances. The 'Doctor' in other cultures also has different attributes accorded by public opinion.

The problem of reducing V.D. in primitive communities is linked so closely with changes in behaviour pattern that it may be useful to recall to mind the steps by which the behaviour pattern in primitive tribes has been changed in order to reduce hookworm. This debilitating disease, widely prevalent in most primitive communities, arises from a small worm generated from human excreta entering the skin of the sole of the foot and penetrating to the intestine. The obvious preventive measure is the wearing of effective foot covering, and the practice of elementary sanitation. This requires explanatory propaganda to a primitive community in which no conception of a relationship between personal habits and disease has hitherto existed; the training of primitive communities in the principles of sanitation; the provision of designs for primitive tribal middens foolproof in construction and maintenance, and the technical planning of the type of ditching and disinfecting suited to the area in question has to be decided on and designed by the Western sanitary experts. Plans then have to be adapted after lengthy consultations with the chiefs and the medicine men in regard to their appearance and location so as not to offend any susceptibilities or taboos. In certain communities provision for the women and for the man had to be widely separated. In others this was not only unnecessary but misunderstood. Careful and detailed explanatory propaganda had to be undertaken by the representatives of the Western administration to the chiefs and the elders of the tribe, whose advice was taken as to the angle of presentation to be adopted in general popular propaganda While the sanitary principles in both plans and propaganda have remained constant the details have varied considerably in the tea gardens of Assam, in the native compounds of Southern Rhodesia and in the different parts of tribal Africa.

The pioneer work of the Rockefeller Institute in sending out its well-equipped experimental teams to different parts of the world to handle this problem and the subsequent experience of the different medical officers of health have provided information that can well be adapted and applied in the handling of all the behaviour disease policies.

In many groups the film and poster was ruled out because the idea of magnification could not be clarified to the primitive mind. The film was useless as it could not be interpreted Exhibit, demonstration and descriptive addresses in their own language

were in the early days the only effective approach To-day in those areas where the primitive people have been in longer contact with the West, means of visual education can be and are being widely used One interesting point emerged from these experiments in propaganda—the period of effective memory appears to be about three years. The habits of cleanliness advocated and enforced by the chiefs secured full support for half this period. The number of backsliders grew steadily during the second eighteen months, but all again adopted the necessary behaviour pattern on the repetition of the propaganda at the end of three years.

CHAPTER IX

HEALTH AND BEHAVIOUR

PART II

INTERNATIONAL ASPECT

PARTICULARLY in the field of human relationships international action is fraught with difficulty, even with concrete and measurable facts, such as the maintenance of the Plimsoll Line,[1] the international enforcement of which has done so much to increase the safety of mariners, effective enforcement in certain countries is not easy. Considerable success has also attended the enforcement of international sanitary regulations, designed to check the spread of plague and epidemics. Here, however, unless the public are aware of the dangers no fear of neglect motivates national action. When we come to the enforcement of international Conventions that require national action on matters of which many of the population are ignorant, and other communities find the methods advised to implement the internationally agreed principle (to which all are prepared to give benevolent support) can only be carried out by detailed local action at variance with local tradition, a Convention tends to be ineffective. Even to check the spread of bubonic plague, which involves the destruction of rats on the incoming ships by the Port Authorities, is a difficult policy to enforce for a Hindu, to whom all forms of life are sacred. In Bombay in early days the rats from the ships were taken ashore alive in sacks and freed in the city until non-Hindus were employed by the Port Authorities. The Hindus employed knew nothing of Western medicine or of the ways by which disease is spread, but it was deeply ingrained in them that it was wrong to kill.

As has already been emphasized, international co-operation is inevitably limited to co-operation between those communities

[1] The Plimsoll Line is the indication on the hull of a ship of the security water-line. The cargo must be limited so as to maintain this line above water.

sharing agreed values. Even with the goodwill of the experts in each country international conventions are always limited in their operation by the amount of support they receive from general public opinion; it is for this reason international progress is limited and slow. These considerations arise in connection with the working of the conventions on the prevention of Traffic in Women (see p. 404, Appendix). Although the Convention of 1904 embodied the principle of the repatriation of prostitutes, the machinery under which this could be effectively implemented was still a question of acute discussion in 1939 In this field an international voluntary organization exists to focus the attention of national governments and international bodies on the problem, and to bring to their attention those international undertakings that are not being effectively carried out. The International Bureau for the Suppression of Traffic in Women and Children co-ordinates the work of national committees; it is they who were promoting the plan for the repatriation of foreign prostitutes that was submitted to and considered by the Social Section of the League of Nations. It was also urged that measures to prevent the entry of prostitutes into different countries could be improved. This would help not only to protect the victims of traffic, but also assist each nation to trace and suppress the trafficker. Repatriation requires well-organized co-operation from each country, and local arrangements that will guarantee the reception, maintenance, and the future of the repatriated victims, but in many of the countries from which they are drawn, particularly in the Far East, such local organization does not exist. The Bandoeng Conference arranged by the Social Section of the League of Nations in 1937 marked a great step forward in the attitude of the Asiatic countries. As the post-war situation in the East is likely to provide conditions for many years, under which the exploitation of the Eastern woman is to be feared and anticipated, it is hoped that active measures to revive interest in this problem will be taken under official international aegis as soon as practicable.

It is a hopeful indication that the United Nations have already agreed to stimulate its members to implement the three existing Conventions (1910, 1921, and 1933) and is now consulting its members on the subject of a fourth Convention designed to penalize the *souteneur*. This had already been prepared by the Social Section of the League of Nations and was to have been

presented for signature by member states in 1940 had the war not intervened. That it will be actively enforced by the Western countries can be anticipated, if adequate national publicity promotes the necessary local interest. In those countries where regulation still obtains and the *souteneur* and brothel-keeper have a recognized trade and the vested interests are large, an interchange of women and girls from one branch of a business to others situated in different countries will be hard to detect when the administrative personnel in those countries see little in the traffic—if the women appear well treated—that conflicts with their traditional values Effective public opinion alive to the facts must be aroused in each country, not only among the officials but among the men and women of the general population. It is for this reason that a framework of agreed values based on the health and welfare of the family is vital to progress. The attitude of a country cannot safely be judged by the laws on its Statute Book; the true measure is in the method and effectiveness of the administration of the laws. Several South American Republics have fiercely suppressive laws on prostitution and for the notification and treatment of syphilis and gonorrhoea. The indication of the real position, however, is in the proportion of medical practitioners who notify their cases, the extent to which drugs and treatment facilities are provided, in the number of women other than prostitutes under treatment, and the extent to which the prostitute is still recognized as a class apart in local administration. The reaction of those countries in which only the medical specialists, sociologists and some politicians had been convinced of the rightness of the modern policy and secured legislation on those lines—was to revert to old methods when the post-war increase of venereal disease became known. This is understandable, as the advantages of treating the whole population through venereal medical facilities instead of trying to control prostitutes, had taken no roots in the popular consciousness. In the countries that have now reverted to Regulation, the new policy had but recently been introduced, had not been fully established, and had not had time to win public confidence.

Belligerents and neutrals alike report an increase in both diseases in their civil population. Those countries formerly occupied by enemy armies report the most serious conditions, and in Poland and the Balkan States the situation worsened until recently

by a scarcity of venereologists and of drugs[1]. In Poland the medical profession suffered such heavy casualties that the number remaining is inadequate to meet the needs of the general practitioner or of the health services. In the Balkan States also a severe shortage of drugs and medicaments adds to the difficulties. Help in kind and in some cases in specialist medical personnel has been provided through international channels.

The reaction of various countries towards the situation has reflected their general attitude. Roumania had become an abolitionist country in 1930, but the new policy was not understood by the public and the new treatment facilities and publicity were not fully developed. The five-fold increase in new cases at the Bucharest Clinic and an estimate from responsible medical sources that one million out of the eighteen million population were infected led to drastic action in 1945–46. The country reverted to the old policy in an intensified form. Lacking drugs, technical personnel and propaganda facilities regulations (on paper) made treatment compulsory, revived the regulation of prostitution under active police control and required a number of women employed in various occupations, including florists, domestic servants, hotel waitresses and hairdressers to be periodically examined for venereal disease. In addition pre-marital health certificates have been introduced.

Bulgaria reported a steady rise in infections up to 1945 when the tide turned and the numbers began to fall. The Popular Front introduced measures of control in 1945, including contact tracing and compulsory treatment with heavy penalties on patient and doctor alike for non-compliance. All domestic servants were compelled to have a health certificate recording freedom from V.D., tuberculosis, and trachoma. Twelve new clinics have been opened and all soldiers examined for V.D. and other infectious diseases on demobilization are hospitalized if infected. In the north a Labour Camp for the 're-education' of prostitutes was opened.

Those countries that had been abolitionist long enough before the war to prove its advantages, have met the situation by increased treatment facilities and intensified propaganda.

During the last twenty-five years there have been a number of administrative measures which have been hotly discussed by advocates and opponents. The Union Internationale has rendered a valuable service in providing an opportunity for all to pool

[1] The N.N.R.A. and the World Health Organizations have now given material assistance.

experience and interchange ideas. Many of the controversies have now been resolved and the agreed principle embodied in an internationally accepted resolution. On some points where the differences arose from a variation in culture pattern, representatives agreed to adopt the means best suited to their own population for obtaining the common objective. This has been the case with the notification of syphilis and gonorrhoea. Those countries that have adopted it are likely to retain it. It appears unlikely that others with a well-developed scheme on different lines will find it worth while to change.

Unless notification is adopted with the sole object of attaining a statistical record, and not as a basis for retaining the patient under treatment, the use of this administrative measure depends on the nature of the disease to which it applies, the ease with which it can be diagnosed by the general practitioner, the level of general and health education, and the adequacy of special treatment facilities. Its application to syphilis and gonorrhoea has been a subject of long-standing controversy partly because it is at variance with the tradition of certain countries and partly because the advantages that are obvious for many diseases are not easily secured in relation to these, in an industrialized community. Notification is an administrative asset for diseases which are easily recognized and run a definite course during which the patient needs conditions of hospitalization or isolation, is cured in a few weeks and able to resume family and wage-earning commitments, as is the case with smallpox, scarlet fever, measles, etc.

Syphilis and gonorrhoea have both been made notifiable in some countries, in others syphilis alone.

There is considerable variation in the laws. They may be roughly divided into two groups.—

(*a*) Those countries such as Germany, Sweden, Poland, Roumania and Hungary where the enactment of legislation rendering brothel-keeping illegal was replaced by laws making the treatment of venereal disease compulsory and the diseases notifiable.

(*b*) Those countries, such as Canada, Denmark and Australia where registered prostitution had long ago been abolished and the measure was entirely a matter of medical administration and operated to apply to the infected of either sex.

The writer had the opportunity of studying the administration and results and was accorded the privilege of full facilities for so doing by the Health Authorities of Canada, by the late Dr. Marcus, V.D.

Adviser to the Swedish Government, by the M.O.H of Hamburg, and many other officials and administrators of the V.D. organizations.

The various methods adopted are included in the outline of world legislation on venereal disease issued by Dr. Cavaillon under the aegis of the Union Internationale in 1930 and brought up to date in 1948

In the first group the Public Health measure was administered as neo-regulation, and during the war a form of regulation was revived. The former morals police were in some towns attached to the Venereal Disease Department to implement the V.D. control. It proved difficult, under this system, to bring all sections of the population under medical care. Women who had previously been registered as prostitutes were still warned by the police as 'known' infected persons. The social barriers that deter the married and the occasionally promiscuous girl from seeking treatment still remained, while the known prostitutes were forced to seek treatment, the law was seldom enforced against infected men.

In one foreign port, for example, the new cases coming under treatment at the Municipal Centre for one month in 1927 were 262 men and 1,024 women (excluding seafarers). Men were asked to give the source of infection, the women were then sought out and if they did not attend for examination were subsequently fetched by plain clothes police. In six months only two men had been followed up.

Notification was limited in practice to the seafarer, the prostitute and the indigent.

In Canada and Australia where brothel-keeping had never been recognized[1] and where the growth of public health measures gradually brought syphilis and gonorrhoea within the scope of the public health service, notification is administered impartially for both sexes and is unrelated to any particular social group. Medical reasons alone govern administration.

The social services attached to the Government centres in Toronto, for example, are ample and well staffed. The policy of attraction is coupled with that of compulsion and the latter powers are only used in cases of absolute necessity. This was also the practice in Sweden. Contacts are sought by personal investigation

[1] Excluding Montreal and Quebec.

from the treatment centre and a widespread educational campaign has been an integral part of the free medical treatment scheme for years.

A comparison of the results obtained at the principal centres in London (without notification) and in Toronto (with notification) showed that in London people were brought under treatment slightly earlier and the defaulters were persuaded to continue treatment in slightly larger proportions.[1]

At the instigation of the British Social Hygiene Council a commission of technical experts visited Scandinavia on behalf of the Ministry of Health to study the system and reported to the Ministry in 1938 that there was no substantial difference in results obtained under the British and under the Scandinavian systems. While Scandinavian figures were slightly better than the British, this was attributable to causes other than notification.

Through the Union Internationale contact has been maintained by the writer over many years with those directly concerned in initiating and working the Northern European V.D. Scheme. The late Dr. Marcus, Dr. Sundquist of Sweden, the late Dr. Soren Hansen, the Norwegian representative, Dr. Veldheuysen of Holland; Dr. Hermans of Rotterdam, and other leading venereologists of Northern Europe were and are valued friends. Under the aegis of the Union, visits had been paid to their countries on more than one occasion between 1923 and 1938.

The following summary is based on experience gained over the period of thirty years since the introduction of popular enlightenment and modern treatment. All five Northern European countries, Canada[1] and Great Britain have attained very similar results; some with and some without notification and ultimate compulsory powers. In the deaths of infants under one year from syphilis they have all shown a steep fall: in Great Britain the rate per 1,000 live births was 0·15 in 1946. In the hygiene and treatment of the congenitally infected child and adolescent Great Britain was less successful than some owing to the inadequacy of its provision for ante-natal diagnosis and treatment, the lack of diagnostic knowledge on the part of the medical profession, and the frequent absence of administrative co-ordination. Until the rapid increase arising from war conditions which is already returning in this and some other countries to the pre-war level, all secured a fall in new

[1] The French Canadian Provinces of Montreal and Quebec at that time were Regulationist and were omitted from the study.

infections and serious sequelae of syphilis, and almost eliminated by effective prophylactic measures infantile blindness due to ophthalmia neonatorum.

Where notification has been adopted by an efficient Public Health Service in communities long freed from regulated prostitution, it has not affected the volume of promiscuity, but neither has it brought the anticipated advantages It tends to limit the time spent by the infected person under observation and treatment to legal requirements which cover only the infectious period, with the result that fewer remain until the completion of cure. Where the outlook of doctors and staff is not primarily to attract persons to the centres there is a danger that reliance will be placed on the legal power alone to secure continuity. In some the personnel at the centre do not appear to spend the time in education or show that sympathy to patients which is so essential where observation is needed over a long period. Where the policy of 'attraction' and of gaining the co-operation of the patient is followed and the legal powers only used after all other efforts fail the results are good. All countries adopting notification report large numbers of patients who give false addresses and are untraceable, a difficulty which appears less under the voluntary contact tracing system. There is also in most of them a large discrepancy between the total of active general practitioners and those who notify their infected patients or defaulters.

Notification is expensive to administer and the reductions obtained in the prevalence of disease in the Scandinavian countries and in the Dominions differ very slightly from those in countries with a similar health administration such as Holland and Great Britain; also as has been said, these slight differences appear to be attributable to other causes. On balance, therefore, it would appear that there are other measures of more vital importance to which available funds could more usefully be devoted.

Continuity of treatment appears to be more effectively reached through the good trained social worker, health visitor or almoner who is concerned with the personal and social adjustment of the individual patient—man or woman. Notification does not touch the main public health problem—the time gap between infection and treatment during which the individual can pass on disease to others. In this connection it is important that in all countries the mentally deficient should be certified and placed under

guardianship, as in bad company they are open to sex exploitation and are too irresponsible to seek treatment.

From the scientific standpoint the most complete system of confidential notification is that initiated by Dr. Madsen at the Serum Institute, Copenhagen. To him practitioners sent records of every case of syphilis, these were classified on a family basis, reinfections and congenital infections recorded. It provided an accurate yard-stick with which to measure the incidence of the disease and the efficiency of treatment Such a system would, however, only be effective for a small and relatively stable population.

In the period between the two wars when the different countries were establishing treatment schemes suited to their own backgrounds, among the subjects of controversy was one that is still raised in relation to primitive communities; whether the Government in providing facilities for treatment should undertake the expense of treating the individual until cured or whether their responsibilities were limited to checking immediate infection. Belgium, for a period, gave up the provision of free treatment for gonorrhoea and limited official provision for syphilis to that of a short course of disinfecting treatment. The same policy was also adopted by the administering powers in certain dependencies and has been again raised in relation to post-war difficulties. Fortunately the fallacy of the position, even from the strictly public health standpoint, was clearly demonstrated and technical opinion may now be said to be unanimous in requiring that treatment facilities provided be planned on lines that have the cure of the individual as the objective.

Another was in relation to the prominence to be given to chemical prophylaxis in the campaign against venereal disease.

A comparison of the figures (when they are comparable) from countries where a population knows of chemical disinfection and makes use of protective measures, and those countries that are averse to it and create barriers to popular publicity on the subject showed a similar fall in new cases before the war. Its general use supported by persistent propaganda in all the fighting forces during the war did not prevent their experiencing a rapid and extensive increase in infections.

The suppression of the quack and the charlatan has been an important factor in the West in securing effective treatment for

the civil population. The very peculiarity of the position which syphilis and gonorrhoea have occupied in the public mind for so many generations surrounds them with the atmosphere of mystery and magic. The network of emotional sentiments that adhere to them, even after knowledge has been acquired, make the exploitation of the sufferer a lucrative field for the charlatan. In Great Britain and in the Northern European countries they were legally penalized soon after the introduction of free treatment. In Germany and in France the promoters of the suppressive legislation had a severe tussle with what proved to be an extensive vested interest, but both countries were eventually successful. On other continents the position is far more difficult. In the West, the practice of medicine is based on science and in each country a standard of qualification is required before a licence to practise is accorded. While differing in standard all medical degrees are related to the same body of scientific knowledge.

In Asia, not so—Chinese medicine is age old. Many herb decoctions and animal extracts used in their pharmacopœan lore enriched our own, but for many of the ills of man, the successful discoveries applied in the West are ignored and mistrusted.

In China "Western medicine" is always in competition with Chinese medicine. The practitioners of Chinese medicine have their own organization, professional rules and regulations different from, though as strict as, in the West. The Government hospital in Hong Kong up till quite recent times played "Oranges and Lemons" with incoming Chinese patients, asking them at the door whether they would choose Eastern or Western medicine and directed them according to their choice to the Eastern or Western branch of the hospital. A profound change has, however, already overtaken the Chinese attitude to Western medicine, through the influence of the Chinese students at the Medical School of the Universities of Pekin, Hong Kong and the Universities of the U.S.A. These young scientists are the apostles of Western medicine in all parts of China, and it is anticipated that both their number and their influence will develop rapidly. Up to date, however, the general Chinese public, except in port towns and in Pekin have had very little opportunity for benefiting from the modern methods of handling syphilis and gonorrhoea even were they willing to do so.

The type of administration that is likely to prove effective in securing their wide application can only, with any hope of

success, be formulated by the Chinese medical fraternity and their social leaders.

The extensive organization of the Ayurvedic system of Indian medicine is well known. Owing to the long contact with medical administration in British India, confidence in Western medicine has grown and in the towns and ports large numbers now benefit from the medical services of the hospitals, public health service and the medical missions. Numbers of Indian doctors have qualified in the universities of India and Europe and are slowly carrying medical science to all parts of the sub-continent. In Africa, the same acute competition exists between the indigenous systems of medicine, mainly based on witchcraft supported by herb concoctions and drugs, without the knowledge of anatomy enjoyed by the older Chinese and Indian systems. It is a strong competitor with Western methods. The medicine man of African tradition also holds considerable sway in the West Indies.

It is clear that in none of these cultures can any legislation similar to the European laws making treatment illegal by other than fully qualified practitioners of scientific medicine be considered for some time to come. So long as emotionally rooted values still attach to any historically entrenched indigenous system and have not been reinterpreted and confidence in scientific medicine attained, so long will suppressive legislation be inoperative, even if on the Statute Book.

To return to the problem of syphilis and gonorrhoea in primitive communities, there appear to be traces of syphilis in primitive Africa, particularly on the routes followed by the trade with ancient Egypt, the Arab slave-trade routes and the area of the early Portuguese Settlements. There is reason to believe that it was unknown among the Bushman and South African Abantu prior to the advent of Arabs and Asiatics.[1] Up to the nineteenth century it was absent or very uncommon among the Zulus, Pondos, Temibus, Fingoes and a number of other warrior tribes, notwithstanding certain customs involving very promiscuous sex relations. The Zulus dealt most severely, usually by a death penalty, with the individual importing any infection or contagious disorder.

During the present century, however, it has developed into

[1] V.D as Affecting South African Natives, by Lt.-Col. Pargett-Adams, M.O. British Bechuanaland Protectorate. Imperial Social Hygiene Congress Proceedings, 1925, p. 183.

a major problem over a wide area under the administration of European countries, particularly since the demobilization and the distribution after the 1914–18 war of native personnel from the services, ports, mines and other areas of recruited labour.

Sequelae affecting the nervous system, so distressing in Europe, are seen nowhere in Africa and are almost absent in China, a condition now largely attributed to the prevalence of malaria. The outstanding damage in Africa is the sterility caused by both diseases to male and female. So serious did this become among the Buganda people that the tribe was actually dying out, the birth-rate being lower than the death-rate. With full Government support an intensive effort was made to secure to them modern methods of V.D. treatment. The Medical Director, Major Keene, and Dr. Webb planned a campaign to provide first the immediate short-term treatment to check infection which was followed by facilities for treatment until cure.

The four-hundred-bed Mulago Hospital formed the base from which radiated subsidiary centres covering the whole area. The British Medical staff was increased to enable a District Medical Officer to be in charge of each subsidiary centre. To secure the confidence of the infected and their attendance at the centres, steps similar to those adopted for the hookworm campaign were followed.

It was found that the Africans themselves could be trained to carry out subsidiary services under medical direction. The full co-operation of the chiefs of the tribes was obtained and they themselves assumed the responsibility for securing attendance of all for diagnosis and the continuity of treatment of the infected members of the tribe. Within a few years the normal birth-rate was re-established.

The intensive health education initiated in those early days has provided a foundation of interest on which it has been possible to develop close co-operation with health policies in other fields and has reacted also on agricultural developments and general education. In Uganda, the proportion of girls to boys in the schools is high.

With reference to what has already been said as to the dearth of medical and subsidiary medical personnel in Africa, it is impossible to contemplate intensive facilities provided in a limited area to meet an emergency being made available in less than a generation to the whole population of primitive Africa. In present

circumstances the most satisfactory method seen by the writer of spreading the services of the limited experienced personnel over a wide area was that which also embodied the principle of bringing the family as a unit to village huts round the well-staffed base hospital (to be supported as soon as practicable by several mobile clinic vans). In the reserves of Southern Rhodesia, syphilis and gonorrhoea had been disseminated by returning mine workers and other industrially employed Africans. The villages were widely scattered with few track roads and no transport. Simple hospital buildings and quarters for nurses and a medical staff were erected in the centres of the area A large area around the hospital was laid out in lines of African village huts; the chiefs were responsible for building and keeping in repair so many huts for their own villagers. Patients who came to the hospital with their families were treated as out-patients and remained in residence, catering for themselves on rations drawn from a hospital store and paid for, until their treatment was completed. For cases of syphilis this method had the immense advantage of automatically bringing the women and children under medical care. There was no differentiation in the popular mind between these or any other diseases. When treatment was completed and the family returned to the village the Chief was responsible for seeing that all members of his tribe whose ailment required further supervision or tests of cure were sent down to the hospital as instructed by the Medical Officer. In these conditions a form of notification of all diseases is obviously essential.

The circumstances are entirely different, however, in the large seaports and industrial centres. The detribalized African has assimilated something of the European attitude towards these diseases. Many sections of the European communities in Africa have in the past agitated for compulsory examination and treatment of the African. Fortunately a better understanding today of the essential needs has led to greater emphasis on the provision of adequate medical facilities for the African in the town. These were winning confidence and the latest records show a growing number of voluntary attendances. The problem has not been solved of securing continuity of treatment, but the difficulties of the situation will be much reduced when the drugs necessary for the latest short-term treatment can be made available.

The reports on the recruitment of labour organization in East and West Africa disclosed the prevalence of syphilis and gonor-

rhoea as well as other diseases among the mobile young adult males. Much has already been done and more is planned to prevent over-recruiting and to provide medical and welfare supervision for those on the main routes between their tribes, and the mines, ports or industrial centres—including food, lodgings, and medical facilities. The responsibility of the employing authority or industry for the feeding, social welfare and medical care of the recruited tribal labourer during his term of employment is a subject of increasing legislation. The I.L.O. had the whole matter under review in the immediate pre-war years.

The special needs of the Western mobile worker have not yet been fully recognized. The traveller removed by conditions of labour from his home background, and housed in strange and often uncomfortable conditions, is in receipt of wages which become the objective of commercial interests in the industrial or port area. This leads to the exploitation of the worker in his leisure time often in ways detrimental to his health and well-being.

A recent enquiry from the United States emphasizes the point.

"In the Serologic examination of 14,354 new employees of a San Francisco war industry which represent, in the large, a transient population, or at least a population which did not have its roots deeply established in a communal environment, we found 1,590 (11·1 per cent) to have a positive serology; 685 (6 per cent) Whites and 905 (30·6 per cent) Negroes. These statistics again illustrate the high incidence of syphilis among the relatively promiscuous transient. On the other hand, examination of 3,610 workers from the same industry before the introduction of large masses of migratory workers showed 214 (5·9 per cent) to have a positive serology; 108 (3·7 per cent) Whites and 106 (15·5 per cent) Negroes; thus again is illustrated the lower incidence of syphilis in the resident, less promiscuous class of our population. Further analysis shows the low incidence of positive serology in our own more stable population."[1]

Welfare of the Mercantile Marine

The seafarer throughout the world is another example, so obvious that his needs are now being provided for by inter-

[1] Excerpt from "Promiscuity as a Factor in the Spread of Venereal Disease," by Richard A. Koch, M.D., and Ray Lyman Wilbur, M.D *Journal of Social Hygiene*, vol. 30. December 1944. American Social Hygiene Association Incorporated, New York.

national action. In the highly organized countries, members of the Mercantile Marine by their occupation are excluded from benefits of health insurance and other social services and amenities available to home residents. In most maritime countries special provision for him has on paper been made for many years. Ships carrying over a certain number of passengers and crew (Great Britain, 300) are bound to provide a Medical Officer.[1]

Masters of all ships of whatever size are by law supplied with a medicine chest and official instructions for emergency treatment. The employers are responsible for providing hospital accommodation where necessary, for the members of their crew injured or seriously sick in foreign ports and to defray the cost of their passage home. It became necessary to devise methods of making available to seafarers the benefits of the modern methods of diagnosis and treatment of venereal disease, to enlighten them on the situation and endeavour to secure their co-operation in the necessary changes in behaviour pattern to reduce infection and encourage treatment, and above all to secure an improvement in the social conditions in the dock areas.

Progress depended on international action. Two lines of development were necessary, medical and social. A combination of voluntary and official effort resulted in an International Convention known as The Brussels Agreement which was entered into in 1924 by the major maritime countries with the exception of the U.S.A. (owing to their immigration regulations) and Russia. The signatories undertook to provide free treatment facilities for all seafarers at their major ports.

The International Red Cross Society and the British Social Hygiene Council from 1917 onwards pleaded the cause of the seafarer with activity and persistence. Voluntary organizations in the other countries joined and a representative Ports Commission was formed in 1926 by the Union Internationale Contre le Péril Vénérien. Under the aegis of the International Red Cross Society, conferences representative of medical, shipping and seafaring interests were promoted by the Union Internationale and met in several of the maritime countries of Northern Europe. The first maritime conference under the International Labour Office met in Genoa in 1920. At this session the seafarer's need for social welfare facilities at home and foreign

[1] "Reports of the Labour Adviser of the British Government," Major Orde Brown, 1944–46.

ports was recognized by the reference of the problem to the International Labour Office. During the years 1923 to 1936 there was close co-operation between the maritime section of the International Labour Office and the voluntary bodies. The I.L.O. made surveys and published and circulated to all maritime member Governments a report and draft recommendation for consideration.

Public opinion was perhaps earlier and more generally aroused in the British Empire as the premier seafaring power. The main objective of the pioneer movement, which was advised and supported by the National Union of Seamen and the Shipping Federation, was to secure the establishment of voluntary Port Welfare Committees at each of the major ports on which seafaring organizations, the shipping interests, the local authorities, the Consuls of foreign maritime powers, as well as the voluntary organizations (in Great Britain largely represented by the Seamen's Missions) should be represented. The establishment of committees of this type was promoted in British and Colonial ports and in India by the British Social Hygiene Council. It was recognized that if the British Government was to press at the International Labour Office Maritime Conferences for such committees to be established in all countries by international agreement, it would be desirable that some experience should be gained through a preliminary experiment, and this indeed proved effective. The British Council for the Welfare of the Mercantile Marine came into existence to promote welfare and recreation in home and overseas ports. While the voluntary committees established in British ports had no financial resources, the exploration of the position and the recognition of needs provided a programme of action that could be and was put into operation when the International recommendation on "Seamen's Welfare in Ports" was adopted at the twenty-first session of the International Labour Conference in 1936, and ratified by the Government in 1938.[1]

That international progress must ultimately depend on current standards and on public opinion in each country is well demonstrated in connection with the Brussels Agreement. A seaman hospitalized in a foreign port is to be fed on the best scales accorded to the hospital-using-citizens of the country. The entirely different types of food and scales of diet provided for hospital patients in London, Oslo, Patras (Greece), and Bari (Southern

[1] Appendix, p. 344.

Italy) is such that the seamen from Northern European countries complained bitterly of the fare provided, and in all probability the Greek seamen suffer similar discomforts in northern hospitals. Also, the interpretation given to the undertaking to provide "free treatment" for the seafarer has proved to require close international supervision if it is to be effective. In too many cases where free treatment clinics were not provided for the local population, the letter of the agreement is obeyed by the medical man appointed by the authorities being present on duty at the port for one hour in the day. The hour chosen in one instance being that at which the tide precluded the attendance of any seaman from a ship in the port. A notice was fixed to the clinic door advising seafarers when they did arrive that the Medical Officer would treat them at his private surgery of which the address was given and at which also the seaman found he was charged full fees! In several other ports it was found that while a seafarers' clinic would be shown to the visiting committee of the Union Internationale, no information that such a centre existed was furnished to the visiting seafarer. In one port the clinic was hidden in a back street with no indication of its existence, and even the Medical Officer of the port had to obtain detailed instructions by telephone from his own office as to where it was to be found in order to show it to the International Committee. It was, in fact, in the upper storey of the building before which stood the telephone booth he was using.

The Union Internationale, through visits of its members and the holding of its sessions in many countries, has done much to stimulate the effective running of the Seafarers' Service.

During the period 1932–34 the numbers of seamen treated at port clinics in eight maritime countries amounted to 15,420, of whom 7,555 were foreigners.[1]

Much good work was done by the scientists through the Medical Section of the League of Nations to secure agreed courses of treatment, and the various Governments arranged for the issue to patients of an international card so that a seaman starting treatment in London could present his card to the Treatment Centre at Lisbon or Marseilles and the Medical Officer would be able to continue the course.

The Brussels Agreement is, it is hoped, but a pointer as to the

[1] *Social Hygiene in the Mercantile Marine*—the Brussels Agreement, a Survey of Action taken from 1920 to 1934, p. 24, by S Neville-Rolfe. Published by the British Social Hygiene Council, Tavistock House, London.

type of health service that should be available for all major conditions that cannot be treated on board ship, but its development will require constant interchange of opinion between the technical personnel of the different countries and a constantly circulating team of individuals representing seafaring and social interests and a specialist of international reputation in each disease, to develop and maintain the service on technically efficient lines both acceptable and accessible to the seafarer. During the war the conditions for seafarers in belligerent maritime countries altered For ten years the adjustments in the scheme that experience has shown were needed, could not be made. The lapse of time, coupled with the serious rise in the incidence of disease, makes the service provided for seafarers equally necessary to all the internationally mobile.

The seafarer was admittedly the most outstanding claimant for international co-operation to secure his health and welfare. There are, however, increasing numbers of mobile men and women whose occupations or recreations entail frequent passage from one country to another. As each country develops methods of protecting its own nationals from syphilis and gonorrhoea it becomes increasingly evident that co-operative measures to extend that protection, irrespective of political frontiers, are essential. Disease is unconscious of geography. Sweden had already called attention before the war to the fact that the majority of her own cases of syphilis arose in the ports. The contact tracing system which is proving so effective cannot at present reach the infected, hitherto retained under treatment, if they go to another country. Every country wishes to prevent such persons spreading disease and would be willing, did they know of their existence, to continue their treatment.

Responsibility for the supervision of the Agreement has been taken over by the World Health Organization[1] (see p. 343–347).

From the standpoint of population stability and national health, constructive measures should be planned in the interests of social biology to secure possible conditions of family life to the large numbers of specially selected fit and able men who follow the seafarer's calling and are to-day handicapped in their home

[1] In 1947 and 1948 the Union Internationale urged that priority should be given by them to the revision and extension of the Brussels Agreement. The World Health Organization has already (1948) placed V D. among the three priorities and appointed a Committee to study a wider Agreement to replace that referring only to seafarers and to include all mobile workers.

and family relationships. The development by the Port Welfare Committees in Great Britain, of accommodation for husbands and wives at some of the official seafarers' clubs is a welcome move in the right direction. A useful social experiment was made in New York where trained welfare workers were available on the Marine Institute premises to assist the men in making advance contact with their families before the ship arrived, of assisting them in a number of their social adjustments and doing something to mitigate the hardships imposed by the uncertainty of their movements. In all probability a Social Service Department for the use of the members of the larger seafarers' clubs and hostels in each port will develop in response to need. The proposal was put before the Seamen's Welfare Committee in its early days by the writer, and has doubtless had consideration.

From France, too, comes the demand for a fuller recognition of the seafarer as a family man in the development of welfare services.

The type of organization which includes seafarers on each port committee and on the central Seamen's Welfare Board will enable him to voice his own needs. Any general move to improve the status of the family and to facilitate its solidarity, in the general population, will inevitably be reflected in the provision made for special groups. With the seafarer, however, much still remains to be done before the special disadvantages inherent in his calling have, as far as practicable, been overcome.

During the war years the welfare provision for foreign seamen in British ports, though supported and assisted by the Port Welfare Committees, rested on the shoulders of their own Nationals resident in the ports. Medical practitioners were provided by each maritime country to care for the health of their own nationals (including V.D. treatment) where these used the port in large numbers. War conditions facilitated this in that all seamen of different nationalities were attached to labour pools in certain of the larger ports. Revision of welfare arrangements on a more international basis will probably be found necessary to meet peace-time requirements.

Great steps forward have been made since 1939 in the improvement of conditions for Colonial seamen in British ports, and something has been done since the appointment of the Indian Welfare Officer on the staff of the High Commissioner for India to improve conditions for Indian seamen.

Empire and international machinery is in process of growth and the policy for its development is in the hands of its beneficiaries, so the future is promising. Action from a different angle is now needed for further progress.

Treatment and propaganda have brought about a fall in new cases through bringing more of the infected under medical care at an early stage, and by reducing the period of infectivity; but for a few years before the war those countries that had already carried out this policy for some years had ceased to record any very material reduction in new infections. So long as social custom tolerates and personal habits include promiscuous sex behaviour in communities where the disease exists, it cannot be much further reduced by treatment and propaganda alone.

Even in those countries that have pursued the abolitionist policy for many years, the annual new infections during recent years have remained fairly constant though at a lower figure than in countries where commercial prostitution is regulated or tolerated.

This is confirmed by war and post-war experience in the fighting services. Continual propaganda and the best facilities for treatment obtained, but the volume of new infection followed the usual course of war experience and reached a high figure in all the armies from which accurate information is available. The primary factor is clearly the social conditions existing in the different areas in which the units were stationed. In the Middle East, however, to avoid possible trouble in a Mohammedan community, the European troops were stationed whenever possible at a distance from the local civil population centres, which explains the lower incidence.

The figures in the British Army were quoted by Lord Moran in the House of Lords on June 3, 1947.[1] These are reported to be lower than those of other occupying countries. For the troops stationed in Japan the incidence figure of one Power was reported as 50 per cent of the total strength. The figure for the British Force in September 1946 was 228 per 1,000.

V.D. cases per 1,000 British troops by Commands—September 1946 (over a period of twelve months):—

Home	33
Germany	185
Austria and Italy ..	168
Burma and Malay ..	141
Middle East	31

[1] House of Lords Debate, *Hansard*, June 3, 1947, p. 53.

It is clear from this situation that the effect of propaganda and treatment is limited by the individual pattern of sex behaviour, and the prevalence of disease in the general population.

The coming years hold promise of growing efficiency of International efforts to maintain world health, but the behaviour diseases are the group in which results will be most difficult of attainment. Success here will depend not only on the acceptance of scientific medical and chemical factual knowledge and their technical application to agreed standards throughout the world, but also on the growth of a common ethic and on the acceptance of biological facts and their application to the varying social structures and the development of a sense of personal responsibility in behaviour affecting personal and social health.

CHAPTER X

SOCIAL WORK IN THE COLONIAL EMPIRE

THOSE Western countries that have assumed responsibility for the development of large areas inhabited by populations of cultures different from their own have been groping for, and experimenting with, methods by which their richer store of scientific knowledge can be shared with their Colonial populations, in order that these may benefit personally and socially. It is now recognized that a higher standard of living throughout the world will benefit all.

Until the early years of this century, Colonial possessions were considered either as strategic points or as areas to be developed by the administering power on behalf of their home industry and trade. With the increased knowledge and appreciation of what is essential to human development, of the interdependence of the industrial world economy of to-day, and of the responsibilities of Western civilization towards the backward peoples, a salutary change has taken place in thoughtful opinion. The evils inherent in rapid de-tribalization are evident in the industrial centres and the seaports of Africa. On ethical grounds it is now seen that new knowledge must be presented with an understanding of the traditions of the culture on which it is to be grafted in order that the accepted values, where these are common to all cultures, may be expressed in different ways, rather than denied. On economic grounds, it is to the interest of world welfare that health and efficiency should improve, endemic disease be suppressed, latent intelligence developed, and the standard of living raised. The individuals in healthy, educated populations can make their full contribution to world economy, and with a higher standard of living will in turn absorb more of the goods and services available. Above all, a wide acceptance of basic ethical values is the essential foundation to stable social and international relationships.

Each colonizing nation has approached the problem somewhat differently, and it is hoped the pre-war opportunities for the interchange of experience will be fostered in the future by the United Nations organizations. France, Holland, Belgium and the U.S.A. have each brought to their own Colonial possessions a somewhat

different conception of their responsibilities towards the indigenous populations, and have carried into their overseas administration certain characteristics of their own social philosophy.

It would lead us too far to discuss the different trends and their results, therefore, we propose to confine ourselves to British Welfare Work overseas, bearing in mind, however, that a common policy in the main lines of approach to social questions is vital to success, particularly in those parts of the world where the areas administered by different Western countries adjoin.

The Colonies, Protectorates and Mandated Territories of the British Empire comprise representatives of nearly every branch of the human race, and every type of culture. From the Mediterranean Colonies, with their populations drawn from Southern Europe and the Levant, to the Papuan Islander, recently studied by the anthropologists on behalf of Australia; from the West Indies, with a white and coloured population that for several generations has had a common background of Christianity, to the vast territories of East and West Africa, with their many primitive religions and complex tribal structures; from the tribes of the hinterland of Borneo—hardly in contact, until the recent war, with the West—to the sophisticated mixed populations of Hong Kong and Singapore: all are to be found.

In Great Britain the voluntary agency has a long history and has won a well-established position. It has acted as the pioneer in almost every field of social progress. When the community is convinced by the results demonstrated that the limited voluntary service should be available to all, the Government take over. For a transition period, the voluntary agency may be recognized by the Government, receive financial grants, or undertake certain duties for official authority. Many branches of social welfare that have already become part of the Government administration at home, or are in a transition period of "recognition," are now being developed under the Colonial Governments. It is to be hoped that in the present enthusiasm for placing everything in the hands of the ubiquitous Civil Service, opportunity will still be accorded to voluntary pioneer efforts arising from the people themselves, or developed in their interests by non-official bodies.

The different branches of social work in Western countries are well established. The welfare worker at home finds a network of interlocking and interdependent organizations supporting the interest for which he or she is responsible. The Probation Officer

can call on the co-operation of his colleagues in the youth movement and at the Child Guidance Clinic; the C.O.S. or the local authority can help to find suitable foster parents or lodgings. The Children's Country Holiday Fund or charitable foundations can assist in providing a change of surroundings. The Almoner can call on many official and voluntary agencies to meet the social needs of her patients. In most of the Colonies none of these agencies exist. The Welfare Officer will often have to work in a philanthropic void. There may be no local machinery for detecting or providing for the mentally sub-normal; there may be no Remand Homes for juveniles, no Approved Schools, no Public Assistance, no voluntary agencies, and, moreover, in many parts the home policy would not be appropriate.

The methods of protective care, preventive agencies, and social education need to be devised on lines suited to the traditions and outlook of the local community It is for this reason that those charged with the responsible task of Welfare in different or more backward communities need a wide general knowledge of the principles of human welfare based on social biological understanding rather than specialized qualifications in any of the limited fields demanded by the social structure of the West.

Several examples may be cited of the dangers of superimposing on a different community methods of handling social difficulties suited to Northern Europe. Take for instance the problem of extricating girls from a life of prostitution. Kindly and efficient women trained in rescue work in this country may apply their previous experience with disastrous results. The policy in Great Britain is to return the young girl, if possible, to her own home when the worker has ascertained that the parents, knowing the bitter experience of the girl, are willing to welcome her back. The same procedure was attempted with a Mohammedan girl rescued from a brothel in a North African port town. The worker communicated with the chief of the tribe to which the girl belonged; he indicated his desire that she should be returned; she was returned; it is known she was publicly flogged; she was untraceable a month later. The tradition of the tribe decreed that such conduct carried the death penalty.

To take a less tragic but equally anti-social example seen in the East in 1920. (The conditions were subsequently changed.) The British administration gave legal protection to girls brought

before the courts, who were victims of traffic in women, or were in moral danger, or had been subjected to physical ill-treatment. A philanthropic organization governed by a committee of responsible members of the Eastern community managed the Home for the care of these girls, under the aegis of the Colonial Administration. The inmates of the Institution had a wide age range, many of them on the occasion of the writer's visit had been resident for some years. None of the girls had homes to which they could return. The object of the governing body should of course have been to equip the girls to return to community life, either trained to be self-supporting in some occupation provided by the administering power, or to return to the normal life of a woman in the East, of marriage and home-making. In fact, the girls had one set of English lesson books in use for all ages, and were at that time busily engaged in learning in English that "William the Conqueror reigned in 1066." Enquiries brought to light the fact that the older girls (found sitting on their beds in a basement dormitory playing with a rouge-pot and mascara) had no occupation nor opportunity for recreation, had never played any games, had never been outside the building except into a small yard surrounded by a high wall which the sun could never enter. Their only break in the dreary days was a fortnightly lunch for the male members of the governing body which they were allowed to assist in serving. They had no future except to be selected by the more wealthy members of the governing body as concubines, either for themselves or their sons.

To provide suitable care for girls of a different race and to equip them to be self-supporting in a community that has no paid occupations for women other than those related to the pleasure or recreation of men is no easy task. It is claimed, however, that an understanding of the physical and psychological needs of the child and the adolescent would have provided a very different type of care, and that a Welfare Officer with a background of Social Biology would have planned a training for life in the Chinese community and related the type of care and protection to the future social background. It would have led to the maintenance of those links with the local community necessary to enable the girls to be trained in the type of domestic arts most useful to them as wives and thus provide the opportunity of reverting to normal citizenship. That this could be done with very considerable success was demonstrated by the Po Leung Kuk in Singapore which dealt

with the same type of girl. The British Protector of Chinese enlisted the aid of educated Chinese women in the management of the institution and embodied in its policy the latest scientific knowledge then available. The Po Leung Kuk of Singapore had the status equal to that of a select residential school in this country, the pupils as wards of the Administration were sought after as wives because of their high standard of domestic education, which included home hygiene and infant welfare, and those trained in it proved themselves effective citizens in later years.

One of the differences between social work in the Colonies and at home is the unfortunate tradition that the British residents overseas are "birds of passage" and therefore have no responsibility towards the local community among whom they live. In some colonies in the pre-war years it was even asserted by the wives, when the plea was made to them to participate in local social work, that the Administration looked askance at any such endeavours, that the wife who "worked among the natives" jeopardized the promotion of her husband. This attitude it is hoped belongs now to the past.

In several Colonies the British community had before 1939 developed Social Welfare for the European population and for seafarers; in some, where an outstanding woman has given leadership, pioneer and voluntary infant clinics and maternity care for the indigenous were initiated and are now supported by the Government. The Girl Guide and Club Movement in Nairobi, stimulated by Lady Elinor Cole, and in India the infant welfare work of Lady Cowasjee Jehangar, have won wide recognition.[1]

The absence of understanding of indigenous problems on the part of the educated European women will often add to the difficulties of the social worker. The cleavage that not infrequently exists between the women of the Mission community and the women associated with the Administration also tends to retard development. The point was raised at Imperial Social Hygiene Conferences and representations made to the Colonial Office, suggesting that the encouragement of a financial grant should be given to wives who passed as proficient in one of the local languages. It is believed that wives are now encouraged to partici-

[1] During the war the Girl Guides doubled their numbers in Nigeria, and trebled them in Northern Rhodesia. The Boy Scouts of the Gold Coast, where they receive a proficiency badge for teaching an illiterate to read, rose from 9,185 in 1944 to 12,293 in 1945.

pate in the social development of the Colony in which their husbands are serving. If so, the training courses in overseas citizenship started before the war should be revived.

The experience of Cyprus is a welcome exception to the lack of interest usually taken by residents in Social Welfare. Some years ago one of the leading Cypriotes came to England to acquaint himself with modern methods of dealing with various social problems, among them venereal disease and juvenile delinquency. At his instigation, the Social Hygiene Commission, about to visit India, were invited by the Colonial Government to visit Cyprus *en route*.

Without recounting the recent history of the island, sufficient to say there is both a Christian and Mohammedan tradition. The Education Department of the Administration at that time was in its infancy. During the last twenty years the major problems then disclosed have been dealt with on constructive lines, but at that time the need for the application of biological knowledge to social work was acute.

The local vendetta tradition, the use of the dangerous sharp-bladed pick-axe-like hoe as the main agricultural implement, and constant quarrels relating to goats and irrigation resulted in 127 boys and young men, between the ages of fourteen and thirty, being at that time in prison for murder, in a population of 347,000.[1]

It was recognized by the Administration that the death penalty for adolescents pursuing the normal local tradition was inappropriate. The usual sentences were imprisonment for from two to seven years, but the educational opportunity of these years was entirely unused. This was one among the many crucial needs for which the visit of the Commission formed the starting-point for future development. To-day, of course, the juvenile offenders of Cyprus are brought under the direction and guidance of the Education Department, as at home.

The investigation carried out by the Social Commissioner disclosed that a number of young girls, from twelve years upwards, were in the local brothels. It transpired that it was the custom for the villagers to send their girl children—for a financial consideration, or in payment of a debt—or because of poverty, to a family in the town. The family "adopted" the child and she became a domestic slave. One child of nine was the only "domestic servant" of a family of four, and it was asserted this was no isolated case.

[1] 1931 census.

At adolescence the "adopted girl" would often become pregnant with the child of the master of the house, or the young son. In many cases she was then turned out of the house, and so drifted to one of the local brothels. The Church and the Effcalf—the Mohammedan body—each made some charitable provision for destitute children, and for the unmarried mother, but the general practice was tolerated. The Eastern attitude to women as the "chattel" of her family and therefore to be bought or sold was part of the local tradition. An active policy of social betterment under the guidance of the Governor, Sir Ronald Storrs and Lady Storrs, supported by progressive Cypriote opinion was immediately initiated. A representative Social Hygiene Council was formed, which brought together the leading residents, the local authorities, and the Administration, a Government Welfare Officer was appointed, who acted as Hon. Secretary to the Council. Within a short time drastic changes had been made. Voluntary agencies were formed to co-operate with the Government in suppressing child labour, in promoting the new Adoption Law and in supervising young girls working away from their homes.

For several years courses of lectures and vacation schools on social biology were held for teachers This was urgent as the local tradition maintained that the attainment of manhood depended on sex experience.

Social Welfare in Cyprus has made great strides in the last few years and is now well to the fore in development. From the above examples it is clear that an understanding of functional anthropology is vital to social work overseas, and is not limited in its usefulness to those whose sphere of work is to be the primitive tribes of Africa.

In the West Indies, the Colonial Development Fund has recently enabled real progress in the social field to be promoted. It was known by those in this country concerned with colonial welfare that our responsibilities for these dependent communities could not continue to be neglected. The reports of the various Commissions and enquiries all painted the same black picture, with the result that even during the war a special appropriation was made, through the Colonial Development Fund, to provide for an amelioration of conditions. The wealth this country had derived for over a century from these fertile islands had contributed little in taxation to the local revenues and had been

spent at home. The resident community had benefited hardly at all

In 1935–36 a Commission to Jamaica on Social Hygiene, and on Education in the Biological Sciences, provided an insight into these conditions. There were two significant omissions. In a colony which had produced vast wealth there were no endowment funds for scholarships or philanthropic purposes. There was no sense of obligation to the community or inclination to be concerned with social welfare on the part of the resident, educated, white women. None of the schools which educated the off-spring of the well-to-do permanent residents gave any attention to citizenship, sociology or the biological sciences. With one outstanding exception there was no individual qualified in the Social Sciences to give leadership in the social development of the island Children, aged, destitute and diseased were all housed, unclassified, in the primitive premises provided by the local equivalent of the Public Assistance Board. The absence of any Teachers' Training College, or any provision for the training of teachers, had left in operation a system of pupil-teacher training which preserved the methods of elementary education in force in this country about a hundred years ago. Fortunately, one of the first steps taken by the West Indies Development Commission has been to arrange for the training of teachers, to plan a university for the West Indies, and to provide scholarships to enable suitable local men and women to seek an adequate training in social welfare in this country or elsewhere.

A set of problems, unique to the West Indies, arises from the influence exerted by the original African folk-lore and tradition still current among many of the coloured community. It is held that no adequate measures to counteract the fears and the present anti-social practices will be found without the help of the anthropologist. Even the language, which is English, has the cadence and lilt of West Africa. Christian and African religious rites are often inextricably mixed, the lore of the African medicine man vies with the treatment of the Western qualified doctor. There is a vast field in the West Indies for constructive social work, planned from a background which takes cognisance of the biological sciences, and, for preference, undertaken by residents of the islands, coloured and white. Happily this is the general policy of the Colonial Office. While knowledge and experience are made available from Great Britain, the actual work of social welfare is

to be carried out by those belonging to each community. For them, training is now available. We would stress the need to include therein a grounding of social biology and social hygiene.

The first forward step in welfare in the Colonies was the passing of the Colonial Development and Welfare Act. The late Sir Basil Blackett and the writer had the privilege of serving on the preliminary Advisory Committee where the principle was accepted that a percentage of all grants for development should be directed to the social services and welfare in the Colonies. Up to that time no funds other than the revenue of the Colony was available for administration. The economically depressed Colonies, where such services were most needed, had therefore the least chance of developing them. Since 1940 a wide programme of social welfare has been in operation, fully supported by the British Government (see pp. 338–341). In principle it is linked with the economic development of the Colony and has in view the development of citizenship to the point that the ultimate responsibility of self-government can in due course be assured

"The success of self-government," it was said in 1943 by the Secretary of State, "does not depend only on the capacity of the leaders to lead, but also on the ability of the community to respond."[1]

This new outlook by the Colonial Office gives great promise for the future.

"In 1945 alone, 25 full-time European social welfare officers were appointed in the Colonial Empire. They operate in most of the West Indies, in seven African Colonies, in Gibraltar, Cyprus, Malta, Palestine. They are assisted by officers locally recruited. Trinidad has eight European officers, with 20 juniors raised in the Island operating under them. Courses of training are run in Britain at the London School of Economics, where, since 1943, 80 students have graduated from 21 Colonies, and in Jamaica, Trinidad, Sierra Leone, Kenya and Uganda. The opportunity of acquiring experience in welfare organizations in the United Kingdom has been arranged for officials home on leave and for Colonials visiting this country; at least 100 people have so far taken advantage of it."[2]

The impact of Western civilization on Africa and Australasia occurs through various groups with divergent interests; the mining and agricultural concession holders, and the industrial

[1] "Social Welfare Organization in the Colonies," by J. D. Krivine *The Crown Colonist*, August 1947.

[2] *Ibid.*

"Colonists" on the one hand, and the Administration and the Christian Missions on the other. In the past the Administration had been limited to securing law and order, sanitary conditions and communications under which the Western interests could be developed, and in raising sufficient revenue to cover the maintenance of the Administration and its skeleton services, from industry and the indigenous population. During this period the early efforts to help the local population came from the Missions and was provided by voluntary funds.

Under this system only the more highly developed colonies such as Malta and Cyprus, Hong Kong and the West Indies, could attempt to provide for general education; nor was there sufficient effective demand for Western medicine to enable private practitioners to earn a livelihood. Elsewhere, medical services are therefore mainly limited to the small personnel of a Government Public Health Service.

The influences most directly affecting the emotional life of the individual comes first through the Christian Missions, thus presenting a new interpretation of life and a new set of values. In some areas their methods have been forcefully criticized by the scientists, in others, they have rendered outstanding service. Bernard Deacon, writing from the New Hebrides in 1927, criticized their activities as traders with the indigenous population and ends by saying, "Make them citizens, not half-baked expounders of the history of the Jews, about which they care nothing."[1]

In a few instances, widely educated and observant Mission leaders first made themselves conversant with the social values embodied in the local manners and customs before they required their converts to abandon them as a preliminary to their admission to Christianity. In the tribal communities under their influence, such local customs as were designed to secure the stability of the family, responsibility for tribal order, and obedience to tribal law, were by patient endeavour and understanding education gradually changed in form, while the essential values were shown to be common both to the Christian and the local way of life.

The initiation ceremonies (see p. 125) are primarily designed to attach a sense of responsibility to sex behaviour though often physically damaging to the girls. As one of the successful adaptations of the local ceremony of initiation of the Bantu may be cited

[1] *Malekula*, p. xxv. Routledge & Sons. 1934.

the experiment devised and carried out by Dr. Margai the African Medical Officer of Sierra Leone.

. . . an ancient initiation period for girls of marriageable age has been turned to educative account. Eight hundred and forty girls, in addition to a large number of married women who attended the course voluntarily, spent eight weeks in 17 camps in 1945, as against 600 in six camps in 1944. They learnt hygiene and needlework, sang and danced, made their beds off the ground, and kept their shimbecks scrupulously tidy. . .

While polygamy for the future would be discouraged, a man by turning Christian was not justified in abandoning wives to whom his protection and support were pledged.

Such an attitude was by no means general in the early days of Mission work. In too many cases the form appeared more important than the fundamental Christian ethic, the acute conflict between different sets of spiritual values and social practices created emotional instability for the child reared in the Mission school as well as for the adult convert.

The local family structure was condemned and the tribal disciplines discounted without the power of providing the individual with substitutes sufficiently compelling to enable him to adjust, emotionally or socially, to an entirely different set of values

The obvious additional harm arising from interdenominational friction has been recognized, and the establishment of effective co-ordination at home for the combined work of all Christian churches in Africa has much improved the position in recent years.

The first efforts in providing medical help and education of children were made by the Missions. Therefore, Western factual knowledge still tends to be confused in the local mind with a new religion and with the condemnation of the local way of life.

Education, fortunately for social and biological progress, has now become the responsibility of the Administration, and both Government schools and Mission schools are working to their utmost in the endeavour to equip the African with basic factual knowledge to fit him to take his place in the world's social structure. With self-government in view, training in citizenship becomes of vital importance Julian Huxley, in his pre-war educational tour of Africa, did much to stimulate the appreciation

of biology, not only in relation to education, but in general Colonial development.

The recent report of the Commission on Higher Education in West Africa[1] presents a picture of the present position and maps out lines of possible progress. The Secondary Schools which provide the source from which must come the University graduates, are insufficient in numbers, lacking in qualified teachers, and attended by far more boys than girls.

The total number of teachers is, at present, far below the needs of the future.

The Commission were "deeply concerned about the backwardness of women's education, especially since all improvements in the homes and in the bringing up of children will be delayed until a great drive is made to educate the women and girls."[2]

Southern Nigeria, 1 girl to 8 boys.
Northern Nigeria, 1 girl to 16 boys.
Gold Coast, 1 girl to 8 boys.
Sierra Leone, 2 girls to 5 boys.
Gambia (Bathurst only), 2 girls to 3 boys.

Furthermore, the educated men will need educated wives if harmonious marriage adjustments are to be made and if children are to have emotional stability in the home. An educated father, with an objective scientific outlook on life, and a mother, still a prey to primitive fears and superstitions, will surround the child with just those conflicting emotional values that give many Eurasians their present psychological characteristics. Unfortunately the preponderance of "Arts graduates" in the Colonial Administration and the rarity of the scientist, particularly the biologist, in the Mission Service has resulted in the curriculum of the secondary schools being some forty years behind those of Great Britain, "yet . . . if agriculture, local industry and health services are to be rapidly developed in West Africa, it is essential that the school should encourage an increased appreciation of science and scientific methods." In each of the dependencies efforts are being made to extend the teaching of science, but "in general it is only in the Government schools that science teaching is reasonably good."[3] There is no biologist on the staff of the higher education establishments belonging to the missionary organization that

[1] Cmd 6655, p. 27, para. 34.
[2] *Ibid.*, p 28, para. 38.
[3] *Ibid*, p 24, paras. 23 and 24.

had won a warm place in the hearts of the West African, and has trained five-sixths of the African graduate staff of the secondary schools of Freetown and practically all the African graduate teachers in the Nigerian secondary schools [1] The European teachers are unpaid missionaries. The College is linked with Durham University which also has no biologist on its staff. Yet the major problems of West Africa are those affecting the adjustment of the individual to a rapidly changing social structure and of the development of the environment in the service of the local and the world population—all biological problems.

There are four million children in British West Africa between the ages of six and fourteen. Even in classes of forty, 75,000 teachers are required for primary education. To provide it within the next twenty-five years will require the training of 3,000 teachers each year. The present output is about one-twentieth of this.[2]

In Great Britain, there is one medical man to one thousand of the population, in pre-war West Africa there was one to 60,000: 5,000 doctors are needed to provide one for every 6,000 of the population. The Commission reported there were perhaps half a dozen registered dentists to serve some 27,000,000. The need for higher education facilities in West Africa is indeed urgent.

The four primary objectives laid down in the 1944 declaration of Colonial Office policy embody a wide view. The extension of schooling for children aiming at universal facilities; the spread of literacy among adults; the mass education of the community and the effective co-ordination of education and welfare. Unfortunately it will be some considerable time before primary education is officially controlled and universal in Africa. To take one example, from the area covered by Nyasaland, Northern Rhodesia and Tanganyika. "Taking the children of school age as 23 per cent of the population, the proportion of children in schools of any sort is 26 per cent, of whom only 7 per cent are in Government or aided schools."[3]

The assumption by the Government of the West African colonies of responsibility for higher education, and the training of teachers up to university standard to staff local secondary schools will be a great step forward. The vision is there; the way is long. It is well to remember that the university colleges of Africa at

[1] Cmd. 6655, p. 51, para. 97.

[2] The figures drawn from reports covering the period 1937–42, indicating the African children in schools.

[3] *Social Change*, by G. and M. Wilson, p. 10. Cambridge University Press. 1945.

which the teachers are to be trained are at present only the recommendations of Government Commissions. With no unexpected barriers, it must be several years before the first African teachers holding degrees from African universities are available to teach in African secondary schools. These coming years are those during which close co-operation in social welfare between this country and the African dependencies will be vital to the future.

Adult education is most important. Under the stimulus of government welfare work, social organizations for adults could be available to everyone and can be a valuable educational medium. They are a Western custom and not indigenous to tribal organizations. The Mothers' Union of Uganda has now over 300 branches and a membership of 6,600, who will presumably be drawn from those educated in Christian Mission Schools. Can a correspondingly useful medium to adult education be devised for non-Christians? An adapted form of Women's Institute perhaps—these already exist in Sierra Leone and Trinidad. Adult education both in India and Africa has been most successful when organized on the village basis. In Africa the language difficulty limits the use of the wireless and the films. There is no *lingua franca*, either English or Swahili have to be learned. New knowledge conveyed in an acquired and unfamiliar language has two major disadvantages. With the adult, the interest of the individual has first to be aroused sufficiently to induce him to learn the language—with the inevitable delay of time—and the new knowledge being associated with a strange language does not so readily become part of the intellectual background. It tends to be kept in a different compartment of the mind from the tribal traditional inheritance, and therefore does not become readily associated with deep-seated emotional values. Facts learned in a strange language are not so easily recognized as being in conflict with existing beliefs and practice. The demonstration method is, therefore, of particular value—in nutrition, in agriculture and in health, for adult education. That this does not only apply to the backward races is shown by the experience of the War Agricultural Committees through the influence the farming demonstrations have had in modernizing agricultural practice in this country.

In the West, with a well-established and complex social structure, welfare work has a recognized place. In those colonies,

where the indigenous population is of an entirely different culture, with a far simpler social organization, welfare, in the Western sense, is a foreign idea still to be grafted on to, and cultivated from the local conditions. To be a stabilizing influence the policy needs to be in accord with those manners and customs of the population that make for family stability and personal responsibility. In localities where the Christian ethic, accepted by the Administration, is at wide variance with the local religious outlook, it is suggested that ethical values should be presented from a background of factual knowledge and that this presentation should, wherever possible, be made to the parents as well as to the children; the object is to obtain a gradual reinterpretation of the local values on the basis of fact and reason, rather than to force the issue of an emotional conflict in the individual, and also to remove the present confusion in the primitive mind that a knowledge of science cannot be acquired without conversion to Christianity. In the interests of the child it is undesirable to force the pace of the conflict between the standards of home and of school. The strongest emotional tie of a child is the home, an emotional impetus is essential as a basis of conduct, and if an emotional cleavage between two different standards is developed in the formative years, the result will be an emotionally unstable adult.

Except where the local values are in direct conflict with Western principles, it is desirable to obtain the necessary change of emphasis indirectly by popular education, designed to lead naturally to the reinterpretation of values. The danger to be avoided in the future is the removal of one set of values before another can be assimilated from those who are unable to relate Western concepts to their own experience and understanding, or to their own emotional sanctions.

Practical Work

The populations of the Dependencies among whom welfare work is developing may be roughly divided into three main groups.—

1. Those where the Christian ethic is the basis of values and the social structure therefore may appropriately follow the lines of development in Great Britain. This covers the Mediterranean Colonies, and the self-governing Dominion of Malta, the West Indies, and certain small islands.

2. Those where Eastern values and cultures, embodying

powerful religious organizations emphasizing different ethical values, are well established—this covers Asia, North Africa, and the Middle East.

3. Those where Western culture and the Christian ethic or Mohammedanism are being superimposed on primitive tribal or recently de-tribalized communities. Those who express their emotion through religions closely attached to nature, where society is built on tribal law, witchcraft, and fears of the unexplained. This covers East and West Africa, the Rhodesias, Melanesia and Polynesia.

Against these three different geographical and racial backgrounds there are certain groups found in all for whom welfare activities are needed.

1. The resident British and European population, administrators, technicians, merchants, industrialists, missionaries, visitors, and temporary residents, members of the Mercantile Marine, and of the Defence Forces, tourists and commercial travellers.

2. The indigenous population.

3. The racially mixed community.

The British, either permanently or intermittently resident in Colonial Dependencies, face many similar social situations in all parts of the Empire overseas. Voluntary agencies in this country have already done excellent pioneer work; as, for example, the Y.M.C.A. and Y.W.C.A. with their hostels and recreation facilities for young European men and women employed in the local administration and industries.

Many of the leading firms have themselves initiated welfare activities for their own staffs, but the ground is by no means completely covered.

The senior members of the Administration are themselves well catered for and have facilities for family life; but unmarried junior employees in public, commercial, engineering and other undertakings, junior officers and apprentices in visiting ships, are often badly provided for, and therefore tend to increase local social problems. In the past, the absence of social amenities and the discouragement of marriage among young Europeans stationed abroad has contributed to the growth of the mixed race community, which is an increasingly difficult problem in many Colonies, and to the persistence in this country of the sequelae of syphilis due to neglect of treatment, and in later years of uncounted cross-marital infections and congenital conditions.

The provision for recreation, residence and welfare of this group varies widely in the different Colonies. The welfare provision for the officers and men of the Mercantile Marine developed in recent years will, it is hoped, reduce the exploitation of the seafarer—bad liquor, drugs, gambling and prostitution were pressed on his attention with the inevitable consequences of crime, violence, and disease. A real responsibility rests on the shoulders of every British woman resident—even temporarily in a Dependency. By her daily life among a different community she embodies to them the Western tradition and values. Also, as a partially leisured individual, on her rests the responsibility for promoting pioneer social efforts, and where her help is desired, for assisting in the building up of the official services. On the British woman, too, rests the responsibility of securing good social conditions for the young men and women of her own race working in the Colony. In earlier years it was often the convention that no junior employee ever visited at the home of his seniors, and for months a young man might never meet or speak to a fellow countrywoman. It is hoped these days are past and that the women of a colony now assure that between them no young unmarried man or woman or grass widower will be left without some home he can frequent informally, and regard as a "home from home."

Apart from young residents, those most in need of friendly and informal hospitality are the young apprentices and junior officers of the Mercantile Marine.

Where no Port Welfare Committee has yet been set up, it is urged that this should be done. (See p. 344.) While organized games and recreation facilities for officers and men are needed and welcomed, the personal friendliness and simple hospitality, of expeditions to local sights, of an insight into British home life, and a chance to play with the children, is what is most deeply appreciated Neither officers nor men want or would accept 'charity,' all are willing to cover their share of expenses in expeditions and amusements, but the companionship of women of their own kind is always welcome, and is their greatest safeguard from exploitation by the undesirable. Often, the limited local recreation facilities—golf courses, tennis, sailing clubs, etc., exclude juniors and Mercantile Marine officers from temporary or permanent membership. If the women of the colony will consider existing arrangements from the standpoint of their own

sons or young brothers visiting the place in their absence, and develop arrangements that provide what they would wish for the young members of their own families, the need will be met. None are more generous and hospitable than the overseas resident, but in pre-war years the circle that benefited was often limited to resident and senior personal friends.

Home traditions are carried overseas, and often, too, the social prejudices and narrow conventions. The women who have studied and have eschewed social life and become missionaries, often at home move in a different social circle from the girls who become the wives of administrative officers, or of members of the business community. No link is ready-made in colonial life to draw the teaching and medical staff of the Mission into the general social circle. Those who know the local community best are, therefore, out of touch with those who could bring a wider and secular interest to some of their problems. The more tolerant attitude of the modern mission worker enables her to enter with pleasure and personal benefit into the social life of the British community, but too often the old tradition of mutual mistrust persists and no opportunity is accorded her. A closer liaison between the resident women and those in the Missions would be not only beneficial to both, but also to the social welfare of the community.

To turn now to the welfare problems of the indigenous in the three groups of colonies, each with their different backgrounds.

Colonial Dependencies with a Christian Background

In the Mediterranean colonies, the West Indies and a number of small islands—those with the Christian background where the type of development is in line with the home social structure—education, infant and child welfare, the care of the mentally afflicted, are now responsibilities accepted by the community. The problems of the sub-normal and the abnormal are still on the border-line of progressive experiment in the non-official field and have hitherto been encouraged and often assisted financially by the Government. The after-care of the criminal, social developments linking psychiatry and physiology with the Administration engaged in handling the social misfit, were developing hopefully in the pre-war years. Probation, domestic courts, approved schools, discharged prisoners' aid, are all current lines of social welfare. The position of the adolescent has been a matter of concern; that the young have to be guided and assisted up to the years of maturity

to adjust themselves to the complexities of Western civilization has long been recognized. The result has been the development of youth movements of all kinds and the growth of social, legal and administrative protection for the adolescent.

The Social Hygiene Commission visited Jamaica in 1935 and 1936 while the Colonial Development and Welfare Act was in preparation. After the outbreak of war, the Development and Welfare Commission for the West Indies was appointed and dispatched. In the meantime, in 1937 an interesting development was initiated, "Jamaica Welfare Ltd." was founded and has since developed as Barbados Welfare and Trinidad Welfare. Funds were derived from ½d. cess on a bunch of bananas.

"Since 1940 its main interest has been "Better Village" campaigns, which concentrated on the erection of community centres (it has set up 31 village associations), and on the encouragement of local co-operative activities. In 1943 it received a grant of £165,000 from C D. and W.W. Its recent campaign for better nutrition, under a "3-F" slogan, "Food for Family Fitness," has been of a value that far exceeded expectation.

Jamaica Welfare operates through a variety of "pioneer" clubs, both for adults and for adolescents, through the famed 4-H organization which, subsidized by Government to the sum of £55,000, by March 1946 have spread through the West Indies, and whose membership has risen in Jamaica alone from 5,172 in 1943 to 8,218 in 1945. The Bahamas have a flourishing branch of the Red Cross Links, a movement started in the Gold Coast which directs its school student members to community service."[1]

The interpretation of Christianity given in local practice is often very much coloured by the folk-lore, traditions and early customs of the population. Some anthropological knowledge of that part of Africa from which a considerable amount of the West Indian population originally derived is needed by those concerned with education and social welfare. Strangers might be misled by an illegitimate birth-rate of about 80 per cent into thinking that the women are necessarily all immoral. A large proportion of the matings are permanent, but the economic and social status of the woman living with a man, but unmarried, is believed locally to be better than that of her orthodox sister. The man, knowing he has no legal hold on the woman, will support her and her family,

[1] "Social Welfare Organization in the Colonies," by J. D. Kitwine. *The Crown Colonist*' August 1947

whereas he will abandon his wife. It is not uncommon in Barbados and Jamaica for the marriage of the grandparents to be celebrated by a large and enthusiastic family.

In these communities, the outstanding social question to-day is the development of measures for the education, recreation and training of the adolescents. Leaders for youth movements, both from the West Indies and from the Mediterranean colonies, are urgently needed, and these should be well equipped with knowledge of the psychology and physiology of adolescence, including the place of sex in life. Understanding of the local background, social values, and the biological sciences will enable them to develop in the young a greater sense of responsibility for marriage, parenthood and citizenship

Wherever possible it is urged that candidates for such training should be drawn from the resident population and given an insight into the various types of Youth Movements now operating at home and in other parts of the Empire, as a preparation for work in their own field.

One aspect that has been very forcefully brought home, when visiting colonies and dependencies of every type, is the influence exerted on local public opinion by the attitude towards social problems adopted by the leading British women in the community, both those employed professionally by the Government or by home voluntary agencies, and the wives of officials and all connected with the administration. Progress would be materially hastened if as well as the men being informed on official policies, every woman going to reside overseas were encouraged to undertake a special course of lectures and reading; to bring her up to date on the present methods advocated for handling the major social problems. If the wife of a high official strongly advocates the maintenance of the brothel system or of opening large orphanages, both practices may be largely supported by uninformed opinions, if no leading resident in the colony has any knowledge of recent experience in these fields, salutary reform and progress may be very much delayed.

If the local magistrate belongs to the "spare the rod and spoil the child" school, or fails to recognize the abnormal and subnormal when they come before the courts, little advantage is likely to be taken of the more successful methods of dealing with unruly youth. The practice in all colonies of employing European trained nursing sisters and matrons in the hospitals has been of

great advantage in the building of the allied medical services overseas. However, as until recently the training of the nursing sister did not include any course in general social welfare, the advice of the matron on social problems as a member of the Governor's Advisory Council was all too often limited by a superficial knowledge she had acquired in early years at home of the methods of dealing with social problems quite outside her range of experience and professional skill.

In one place the writer found the matron of the leading hospital, who exerted great influence on Government and voluntary committees, to be so ignorant of the family and social implications of syphilis and gonorrhoea, and so prejudiced in her attitude that the subject was entirely omitted from the nurses' curriculum, and no case, male or female, if she knew it, was admitted to hospital. It had been impossible for the medical administration to open even an out-patients' clinic.

Dependencies and Mandatory Territories with a largely Mohammedan Background

The second group, comprising the Sudan, Palestine (pre 1948), Aden and North Africa have mainly the Mohammedan background. As quite a number of British welfare workers are also working with or near Mohammedan communities outside the colonial empire it has been considered useful to deal with certain points in some detail. In Mohammedan lands the differences in social and particularly sex behaviour are coloured almost more by the level of general education and the social structure than by the tenets of religion. In the tribal communities the plurality of wives is usually limited to the elders of the tribe. Owing to the shortage of women, many young men cannot marry until the middle or late twenties, and then only have one wife.

Except in the Turkish Empire, Mohammedan areas have not of their own initiative provided compulsory education for girls and boys. Entrance to the universities is limited to the male. Wherever womanhood is in subjection strict protective conventions for their sex behaviour are found. Traditional sex knowledge is transmitted to the young, it is not subject to taboo, nor is a feeling of guilt attached to sex relationships, but the "knowledge" transmitted is usually not of scientific accuracy. There are, of course, large Mohammedan populations living under the administration of Western countries. Here, both boys and girls share in the general

education provided, whether by the French, the British or the Dutch. The change in the status of woman in these areas and the rejection of much of the social protection as "old fashioned" has resulted in the conventions of sex behaviour approximating those of the administering power. The danger-points to-day are the meeting-places between the tribes and the commercial trading centres, and in the districts where general education has recently been introduced. Certain practical points for work in such areas may be worth noting. Factual knowledge related to sex is urgently needed on grounds of both health and family stability. Venereal disease is widely prevalent in North Africa and parts of the Middle East, and its ravages are already causing anxiety to responsible Mohammedan leaders. Sex education can be approached most effectively from the angle of personal health and of fertility. The fact that both syphilis and gonorrhoea are a frequent cause of sterility in both men and women is of vital interest. The goodwill and co-operation of men must be obtained before the woman would be allowed to seek medical treatment. The married woman is seldom permitted, nor is she willing, to take treatment from a medical man. An entirely female staff is desirable at ante-natal and at ailments of women clinics, and at any centres that aim at attracting women, all should include facilities for the diagnosis and treatment of syphilis and gonorrhoea. The Arab communities in Palestine were evidence of this. Before the British administration added medical women to the public health staff, the Arab women would walk miles to seek the advice of the only medical woman in private practice. Propaganda on syphilis and gonorrhoea without the provision of facilities for treatment suited to the locality only develops increased anxiety among the women when they believe they are victims of the disease. When discussing behaviour problems, either with responsible groups of adults or in public with adults or adolescents, it is desirable to give a short and simple general outline of the physiology of human reproduction as the traditional teaching includes much folk-lore which adversely affects habits and behaviour. The education of children must ultimately depend on the attitude of the parent, therefore a clear picture of some biological accuracy is vital both for this purpose and to promote reinterpretation of the accepted behaviour pattern. The scientific reasons for avoiding promiscuity and the social damage caused by prostitution can then be clearly appreciated. It must be borne in mind that discussions of all social behaviour questions

among the Mohammedan community would be far more effective in the hands of a Mohammedan leader. Also, except in the Westernized communities, the speakers must be of the same sex as the audience, whether or not they have medical degrees Numbers of Moslem children and adolescents are likely to be under international care away from their parents. For these provision should be made to explain the implications of the adolescent changes to the boys and to the girls separately.

The practice of homosexuality as already mentioned is common among many groups of Mohammedans and is not an offence against their moral standards. It has probably arisen and become tolerated, particularly in the more isolated communities, owing to the delayed marriage age and the complete absence of women in the social life of the young male.

The social biologist approach recognizes it as an undue persistence along anti-social lines of a normal stage of adolescence. It would be undesirable to attach a feeling of personal guilt to the practice, but rather to explain the potential personal damage involved and to urge a change in the social structure that would facilitate early marriage. The optimum physiological age of marriage is from nineteen to twenty-three. In the interests of tribal and racial health this knowledge can be stressed. For those who have to supervise the welfare of the young of both sexes from adolescence onwards the policy followed must of course depend on the level of general education and of the social background of the young people.

In Palestine, in India, and in parts of North Africa where the Western outlook on recreation has influenced the young who come within the educational scheme, team games for both boys and girls are popular, but otherwise the traditional leisure occupations are entirely different. The mixing of the sexes in social gatherings for the first time at adolescence is likely to put an undue strain on both. Dancing in Mohammedan countries is closely associated with the prostitute, and in many districts no respectable girl sees unveiled any but the men of her immediate family. Where the *yashmak* has recently been discarded, this traditional and deeply ingrained pattern of sex behaviour must be borne in mind by the administrator and the social worker. To turn to specific cases. When girls are detached from their homes, either by war conditions or by the wiles of the trafficker, great care must be taken and the worker in person or through responsible channels must

ascertain the views of the family before returning the girl, possibly with an illegitimate child, to her home. As already mentioned, neglect of such a precaution may be disastrous to the girl. There is also evidence of girls returning after such experiences, being used as the local prostitute. It is suggested for consideration that if it transpires that considerable numbers of women and girls (particularly probable in North Africa), have been drawn into prostitution or promiscuity during the war years, the leading men and women of the Mohammedan communities in the towns should be invited to form a practical plan for the return of such girls to normal life with the prospect of marriage and parenthood.

The risks to health inherent in their experience will probably make medical and even psychological treatment a necessary preliminary.

The Far East with the Hindu and Buddhist Background

A considerable number of university trained Chinese men and women are already devising welfare plans suited to their people. The majority have taken degrees in the United States and maintain links with the social activities of America rather than of Britain. The sphere of the well-financed American Mission is the East, but more in China, Burma and Japan than in the British areas, though they are well represented there also.

One of the social difficulties of the Far Eastern colonies is the disproportion of the sexes in the large ports and industrial centres. Pre-war policy in Singapore, by encouraging family migration, was gradually improving the position, but any racial balance of the sexes in the mixed population was still distant. Here British forms of social welfare are alien in conception to the local community, particularly in relation to the recreation of the adolescent. On the other hand, the probation system and the care and training of the delinquent obtain local support and participation. Education in sex behaviour must be a scientific interpretation of local values presented by an educated member of the race concerned, or failing that, a scientific presentation by a European on the broad ethical lines common to all the higher religions. The danger of any institutional provision for the young is in the neglect of close liaison with the local community, and the provision for employment and marriage within their own community for the youth and girl on leaving European care. Close association of members of the community to which the inmates

belong, in the management of the institution is able to provide an effective safeguard. The experience of the Chinese medical women in Shanghai and of the Chinese social workers at the clinics in Singapore, to cite only two, were successful welfare activities in which Western experience was grafted on Chinese values and customs. It points the way to the desirability of training suitable Chinese, Tamil, and Malay individuals in the scientific approach to the problems of human welfare and then to support their activities through the consultative co-operation of the biologist and sociologist with Western experience.

Tribal Africa, Polynesia and the Pacific

The tribal organization in the African colonies, protectorates, and mandated territories, renders the outside specialist agencies in social welfare a 'foreign conception' belonging only to the 'Government.' The conceptions on which it is based are not indigenous and are often at variance with both the social structure and its ethical principles. For example, the care of the orphan is the responsibility of the remaining members of the family, and if there are none, then of the tribe. To permit a child to be reared by strangers would in their view be wrong. It means that plans for the care of the children of the detribalized in the ports and industrial centres will have to be devised which will accord with the inherent sense of family values, and provide such children with surroundings of emotional and economic stability, under conditions that will enable them to live among their own people in adult life.

In Africa too, even among the detribalized of the ports and mining centres, a form of youth care, different from the home type, will be needed The family structure needs emphasis, the tribal hierarchy needs understanding. Some experiments of collecting all youths from the same tribe under the guiding leadership of a young hereditary chief were reported as most successful.

If local customs and beliefs are not known to the social worker, the value of much good effort may be lost. In one place an Infant Welfare Centre was started, which at first was held in the open, and well attended. In due course a hut was built with the necessary simple fitments. From that day the attendance dwindled and almost faded away. Unwittingly wood for the doorstep was used which was locally endowed with the property of causing sterility if a woman trod on it!

To devise new lines of social welfare suitable to a community motivated by different ethical values, different social customs and with very little of the factual knowledge that is the normal background of the European, requires a sound knowledge of fundamental biological principles, and a sympathetic imagination in presenting new proposals.

It is hoped that for tribal communities, exploratory teams of an anthropologist, a social biologist, and an indigenous leader will be invited to study and report on the type of social welfare that would be constructive and acceptable. The ten-year gap before higher education makes its contribution of trained local personnel, makes it probable that the British personnel may have a temporary but helpful role to play.

Selection and Training of Welfare Personnel

The valuable note provided by the Department of Welfare at the Colonial Office contains the current factual information (pp. 358–371). Men and women are both needed, for posts under voluntary organizations, for those towards the cost of which the Government gives grants and for Government appointments.

In selecting individuals certain attributes of personality apparently essential to success should be looked for. An untrained individual with intelligence, a wide personal experience of life, and a general knowledge of many branches of social work in Western countries, can make a valuable contribution to social welfare in the backward communities. Even more important than academic knowledge is a balanced personality and satisfactory emotional adjustments in personal relationships. In all but the advanced Western countries, where women have attained civic status and liberty of action, it is an advantage for the social worker to be a married woman who has borne children.

A small but important point. Even if in early days the worker cannot speak the language, it is wise to be able to follow it sufficiently to know if the interpreter is transmitting information correctly, or alternatively to go through an address carefully beforehand and make certain the subject-matter is thoroughly understood by him.

Few men or women working in the social field, whether as teacher, nurse or technical scientist, do not find themselves linked up with the welfare work of the Colony. The teacher is in contact with the parents; the Matron and European sisters of the hospitals

and sanatoria have the responsibility of training the women and girls as nurses and midwives. To the professional technique is immediately added an attitude of mind towards health and disease, towards cleanliness and standards of behaviour. It is important that this leadership should be wisely exercised, that the best in the European tradition is stressed. For the local trained women to use their knowledge in the service of their people they themselves must be emotionally adjusted. The family and psychological aspects of the various locally prevalent diseases must be appreciated. It would be a help to progress if every trained nurse going overseas were first given a practical and theoretical course in social biology and welfare, as well as some insight into the local customs and beliefs of the area in which she is to work. A beginning here has already been made with the full co-operation of the British Nursing Association.

In 1927 a One-Year Diploma Course on Social Biology was instituted, at the instigation of the British Social Hygiene Council, at Aberystwyth College, University of Wales, to meet the needs of various Governments in India for trained personnel in welfare work, particularly in social hygiene. The course was made known by the Colonial Office throughout the Colonial Empire, but at that time there was no Colonial Development Fund from which scholarships could be obtained, and Colonies were themselves unable to make the necessary financial provision.

It would be useful if the grounding given by the present courses at the London School of Economics (see p. 340) for selected candidates from the Colonies, which include social biology, was supplemented by a short tour of social organizations in this country and in Scandinavia. We may anticipate, however, that in the near future a team of forward-looking welfare workers, whose influence on colonial development should be rapid and effective, will be available.

CHAPTER XI

CURRENT PROBLEMS OF SOCIAL HYGIENE

HITHERTO, aspects of social hygiene that are well defined, on which national and international policies are in operation, have been under objective review. There are in addition the results of research and experiment in the sociological and biological fields that have disclosed situations that can be constructively handled if biological knowledge is applied.

The increased powers scientific discoveries place in the hands of man may, wisely and responsibly used, add to human happiness and welfare. If not related to objective values they may equally well give rise to serious abuses and result in grave deterioration in personal character and social health. As with atomic power, which can destroy man or serve him, biological knowledge wrongly used can destroy humanity, wisely directed it can prevent much suffering and vastly increase human welfare.

One new apple plucked from the tree of knowledge is the ability consciously to co-operate with nature in the control of human reproduction. Certain methods of sterilization could enable the sterilized to live a normal sex life without the risk of transmitting inherited disease and defect. The recognition of many of the causes and the development of techniques of ameliorative treatment for sub-fertility and sterility is now changing childless marriages into happy families and for some of the incurably infertile help can be derived from artificial insemination.

This increase in knowledge is met by the usual human reaction to the new—fear and opposition. The deep-rooted emotions surrounding personal sex behaviour and family relationships are at present proving a barrier to an objective approach. The possibility of a large-scale abuse of knowledge by the unscrupulous, as where sterilization was used as a weapon in racial war in Germany, stimulates fear. To the scientist, however, working among the people who would benefit, the possibility of applying this knowledge to increasing human welfare and personal happiness is an inspiring ideal. Public confidence would increase if the scientist and the sociologist would formulate the values which should guide application. The welfare of the family is an accepted

basic value. The principles on which policy and practice should be based are therefore that reproduction should be controlled to serve the interests of the family and posterity. This principle applied to many of the offenders in child assault and incest cases would secure that when biological reasons beyond the control of the individual caused the offence, scientific treatment and/or social guardianship should replace the short prison sentence.

The popularization of the use of relatively effective contraceptive methods has given to those with sufficient intelligence (if fertile—the ability to plan the size of the family), a long step towards personal, social and economic freedom. Some attribute the decline in population and in family size primarily to this practice. While it has undoubtedly reduced the numbers of births in the family, a larger proportion of those born now survive. There are other influences affecting the size of the family—perhaps some more potent. It is claimed that the governing factor in the size of the family is the desire to have or to avoid having children. The desire is the motivating force, the means vary. The fear of an unwanted conception is a strong emotional driving-force to action which has been operative since earliest times.

The degree of efficiency achieved by the practices handed down by tradition, through the family, through 'wise women,' 'witch doctors,' 'medicine men' and other repositories of lore have varied with the level of general knowledge. Abortion ante-dated contraception. To-day, as science has clarified the physiological processes of reproduction, the technique of contraception will inevitably become increasingly effective and foolproof until practically every birth by a person of normal intelligence may within measurable time be conscious and deliberate; either by the difficult method of accurate observation of the 'safe period' which varies with each individual (the only method approved by certain forms of Christian teaching) or by easily obtainable chemical means.

This will make other factors governing the desire for children of increasing importance. The reaction to social barriers to parenthood could then be rapid and definite.

Already public opinion in educated communities is expecting the individual to exercise conscious responsibility for parenthood. The fertile fit who avoid it are criticized as are also administrations that do not protect posterity from known hereditary defects. In several European and American states certain here-

ditary diseases, insanity and mental deficiency, are barriers to legal marriage, and is a policy supported by the Christian churches of the countries concerned.

In much of the 'population propaganda' now current, the religious and political views of the propagandist largely influence the emphasis placed on the different factors. It is anticipated that an objective analysis of the causes coupled with biologically constructive measures related to ethical principles will be embodied in the findings of the Royal Commission on Population.

The facile explanation that the fall in the birth-rate is mainly due to the irresponsible use of contraception in those countries that have not tried to suppress the popularization of such knowledge or of the supply of the required facilities, is found to be incomplete. A factor, it may certainly be, but the decrease in conceptions from this cause must be considered in relation to the lives of infants, children, and young mothers saved by the spacing of births within marriage by the same methods. It is disclosed by the figures that the Northern European Protestant countries, where knowledge and facilities are available, have not had a more rapid fall during the last generation than have those Roman Catholic countries where the knowledge is considered 'sinful' and the dissemination of facilities for its application strictly suppressed. On the other hand, the latter countries had a higher birth-rate in 1912 (see p. 352).

In 1912 the live birth-rate in England and Wales was 24. In Italy 34·4. In Spain 31·7. In 1941 England and Wales showed a live birth-rate of 13·9—a fall of 11·9. While Italy with a 1941 figure of 20·8 showed a fall of 14.

Is it significant that those countries with the higher birth-rate in 1912 are also the less highly urbanized?

The suppression of information and facilities for contraception, even if it were practicable, would not rectify the position. Not only would this be an impossible task, but it would also remove a valuable agency in human progress. The more responsible the individual parent, the greater the desire that children should be born under the best conditions. The responsibility is recognized and to an increasing extent is used constructively, not to avoid but to space the arrival of children.

Economic and social pressure on parenthood has stimulated efforts to regulate family size either by contraceptive or abortive methods, particularly in the industrial areas where conditions of

family life are difficult. Where contraceptive information is inaccessible the rate of induced abortions appears to be higher.

In Great Britain, France and the Soviet Union responsible reports on abortion have appeared. The term 'abortion' in both the British and French Reports covers:—

(*a*) Spontaneous and natural abortion.
(*b*) Therapeutic or medically induced abortion by a qualified practitioner in the interests of the life and health of the mother.
(*c*) Criminal abortion, caused by deliberate interference with the course of pregnancy without the required circumstances of justification in No. 2.

The French Report stresses the impossibility of separating voluntary from involuntary cases under the first category, particularly in the early months, and cites a number of cases of personally induced abortions in the later months, that involve no third person and cannot be classified as 'criminal,' but are certainly the result of behaviour followed by the mother in the hope of securing a miscarriage.

The estimates as to the prevalence of abortion in the different countries, owing to the differences in records, in the interpretation of the term, and the different methods of collecting statistics, makes any comparison misleading.

Contrary to the general opinion, Dr. le Roy says that married women with no children or one child seek abortion more frequently than the unmarried women.[1] This is at variance with experience in this country. Here the childless couples are those most frequently seeking medical advice on the attainment of fertility and it is believed that few healthy young married couples are willingly childless.

In Great Britain where the barriers to accurate knowledge of contraceptive measures are steadily falling, the Interdepartmental Committee (1939) estimated the number of abortions of all types as between 110,000 and 150,000 per annum. They had before them medical evidence that from 16 to 20 per cent of all pregnancies end in abortion.

Relatively few are 'therapeutic,' therefore "it follows that almost all abortions are spontaneous or criminal, estimates of their respective proportions vary widely."[2] After considering the available evidence the impression of the Committee is that perhaps

[1] Department Committee Report on Abortion, 1939, p. 363 [2] *Ibid.*, p. 10.

40 per cent of the abortions in this country may be due to 'illegal interference' which is believed to be an increase on the past, but if all types of abortions are included together "the frequency of abortion has not appreciably increased in recent years"[1] and spontaneous abortions still constitute the majority that occur.

"If a death from criminal abortion is regarded as a death from a puerperal cause," about "one in every six women who die from puerperal causes dies directly as the result of having aborted,"[2] but treating the available figures with some reserve it is estimated that taking induced and spontaneous abortions together, for the six years previous to the issue of the Report the average risk of mortality attaching to abortion would appear to be roughly between 0·3 and 0·4 per cent.[3]

The British law against abortion as it stands is clearly not in accord with public opinion as it is freely disregarded among women of all types and classes. The motives for seeking a termination of pregnancy are mainly economic, but also include considerations of health, fear of confinement and other personal and social reasons. "Purely selfish motives predominate in only a small minority of cases.[4]

The points of controversy in the Committee were on the value of notification to the police by doctors of cases coming under their care after abortion had been sought and on the notification to the health authorities of all pregnancies. The majority favoured notification by doctors of previously aborted cases with the consent of the patient, but a general notification of all pregnancies it is considered would have but little influence. The need to clarify the legal position of the doctor who terminates a pregnancy to save the life or preserve the health of the mother is recognized. As a safeguard a second medical opinion and notification to the health authorities within forty-eight hours are recommended as compulsory clauses in a new act. That abortion is frequently sought because knowledge of or facilities for contraceptive measures have not been available is recognized, and within the present framework which limits information to "every married woman to whose health pregnancy would be detrimental" it is recommended that local authorities should be invited to make

[1] Department Committee Report on Abortion, 1939, p. 12.
[2] *L'avortement Fleau National*, by le Docteur J. E. Roy. Editors Jouve & Cie, Paris. 1943.
[3] Department Committee Report on Abortion, p. 18. [4] *Ibid.*, p. 40.

both available. A minority report is submitted Mrs. Dorothy Thurtle recommends a wider dissemination of accurate information on contraception and the legalizing of abortion on economic and social grounds. Nine of the fourteen members, while signing the report, make reservations on the different points of controversy.

In France where the dissemination of contraceptive information is discouraged, the numbers of voluntary and induced abortions appear to be much higher. The French Obstetrical Society in 1909 estimated that one-third of the conceptions ended in abortion. J. Bertillieu in an enquiry in 1911 undertaken through 500 medical practitioners in four departments found that criminal abortion was responsible for 9·75 per cent of all cases of voluntary sterility.

In recent years more attention has been focused on the question, more records have been taken. The hospital returns quoted from different areas in France show a steady rise. Responsible medical authorities give estimates ranging from 400,000 to 1,000,000 a year. The figures of some towns are quoted showing the abortions as higher than the live births.

Le Roy in 1943, after assessing all available evidence, is of the opinion that the higher figure is nearest the truth.

The Roman Catholic outlook of the investigators somewhat confuses the scientific approach with the emotional sense of 'sin' attaching to the subject. Many results which sociologists in other countries refer to different causes, are here considered as inherent in the termination of pregnancy, though the degree of wrong doing has hitherto been graded by the term of the pregnancy. Abortion is considered a less moral offence if it precedes the fourth month and the quickening. This, quite apart from the more serious physiological conditions involved for the mother at the later stage. From the demographic standpoint, the effect on the population is the same at whatever stage the potential new live birth disappears.

Dr. Le Roy quotes as the three views usually taken in France on the causes and the methods of checking deliberate abortion: That it is purely a matter for religion and morals. That it is a purely economic problem to be met by adjustments of taxation and financial allowances to fertile families. That however much preaching and economic assistance is provided the population will not be increased thereby. People do not want children because they are a trouble, and when necessary they will seek

the abortionist. In the view of the French Report the suppression of abortion can only be achieved by police action and suppressive legislation. It is held that each argument has some, but that none contains the whole, truth. The report is designed to demonstrate that religion, economic assistance and suppressive measures can all contribute to the reduction of abortion.

In the Soviet Union in 1920 abortion was made available, under hospital conditions, to any woman who desired to terminate her pregnancy within the first three months. The facilities were very extensively used. From subsequent medical enquiry into the results of this policy, it was reported that many had been terminated at later stages in pregnancy. This medical investigation led to legislative changes, it disclosed that while the maternal death-rate from abortion conducted by qualified doctors under hospital conditions was minute, the subsequent results on the general and psychological health of a large number of the women appeared to be serious. In 1936 the decree was rescinded and replaced by one which it is understood is still in force. This prohibits the induction of abortion except when it is necessary to preserve the health or life of the mother, or when serious parental disease is likely to be inherited. All such operations must be performed in hospital. Penalties are attached to the Doctor who contravenes these regulations and three years imprisonment is imposed on the unqualified abortionist. The women also receive a reprimand and a fine of 300 roubles if the offence is repeated.

Fear of childbirth was cited before the British Departmental Committee on Abortion as one of the causes given for avoiding further addition to the family. It is matter of common knowledge that after one painful experience a number of women are anxious to avoid a repetition. In the country the much-needed reform of the maternity service is being undertaken under the acutely difficult post-war economic and building conditions. While efforts are made to hospitalize all cases where labour difficulties are anticipated, the majority of deliveries still take place with a registered midwife in attendance, at the home of the patient. The deterrent factor could be largely removed could some means be devised which would enable all women to have the solace of an adequate anaesthetic. The need for this to be administered by a medical practitioner renders it difficult as a routine measure, except in an institution, but the scandal of the

inadequate provision of effective anaesthetics for women in labour still obtains even in the maternity wards of many hospitals as well as outside. The position was recently reported to be far better in the U.S.A. and Canada than in this country. There are admittedly technical difficulties to be overcome, but the greatest appears to be the general attitude that in normal labour a deep anaesthetic is unnecessary and adds to the expense by requiring the attendance of one qualified to administer such an anaesthetic.

The Report of the Departmental Committee on Maternal Mortality and Morbidity issued in 1930 brought home to all concerned the deficiencies of the services related to ante-natal and maternity care. Those of its recommendations for which no new legislation was required have already been implemented. The changes now in process under the National Health Services Act, which co-ordinates these services under the larger authorities, are planned to embody considerable improvements. As at present arranged, the administration of the services is in no sense a check to the first birth, but the conditions then experienced are undoubtedly a factor in reducing family size.

There has been, during the war years, partly owing to overcrowding and partly to a better understanding of the medical needs of childbirth, a swing over to institutional accommodation. There is a widespread impression that those being delivered in hospital, particularly those of the lower income groups who cannot contemplate the services of a nurse and a private practitioner, will be delivered by a doctor and will have the benefit of an anaesthetic. In many cases the experience of their first delivery disabuses them of both these ideas.

An enquiry into the conditions of childbirth in Great Britain has recently been undertaken by a joint committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee in order that the information may be considered by the Royal Commission on Population.[1]

With the co-operation of 424 of the 458 Maternity and Child Welfare Authorities in England, Wales and Scotland, an enquiry was made through the Health Visitors which involved the interviewing, eight weeks after the birth, of every mother that had been delivered of a baby within the week March 3–9, 1946. The estimated birth registrations for that period were 16,695, of which

[1] A preliminary report is issued in Volume 1, No. 1 of *Population Studies*, June 1947. Chairman: Professor James Young. Secretary: Dr. D. V. Glass.

1,279 fell within the areas of the non-co-operating authorities. Direct contact was made with 13,687 mothers. The enquiry was divided into two sections: 7,287 were interviewed in relation to their personal experiences of medical services, ante-natal, delivery, and post-natal; 6,400 were asked for information as to the cost involved. The replies were classified under groups based on the peace-time occupation of the father:—

1. Professional and salaried workers.
2. Black-coated wage-earners.
3. Manual workers.
4. Agricultural workers.
5. Men in other occupations.
6. Unmarried mothers.

In family order 39·8 per cent were first children; 43·8 per cent second or third; and 16·4 per cent fourth or higher. The second or third children were more frequent in the higher income groups, but the fourth or higher numbers show the widest variation, ranging from 5·9 per cent among professional and salaried workers to 18·8 per cent among manual workers and 27·3 per cent among agricultural workers. The mean age of the mothers ranged from 26 to 28 in all groups excepting the unmarried mothers where it dropped to 22.

Ante-natal supervision had been received through local authorities or the general practitioner services by 58 per cent of the combined groups (this differs considerably from the Ministry of Health figure of 76 per cent. This is attributed to the ambiguity of the official questionnaire which has resulted in multiple attendances at clinics being given in some cases instead of individuals).

The classification of the circumstances of confinement disclosed that 46·7 per cent of all mothers were delivered in their own homes. The proportion in each group varied from 23·4 per cent among the professional and salaried workers to 51·3 per cent and 57·2 per cent among the manual and agricultural workers respectively. In the professional group domiciliary delivery usually takes place under the direction of a medical practitioner who can, therefore, give an anaesthetic. Those undertaken through the local authority services are in the charge of a qualified midwife, the doctor or specialist only being called in cases of emergency (about 3 per cent) Taking all occupational groups and all circumstances of delivery, 39·7 per cent of mothers had either an anaesthetic or an analgesic. A qualified medical practioner had, up to June 1946, to be responsible for the giving of an anaesthetic or analgesic. Of the professional and salaried workers 46·4 per cent of cases

are attended by medical practitioners and can therefore receive an anaesthetic while of the remainder of the groups only 15 to 29 per cent have a medical practitioner in attendance. These conditions in future are, however, likely to improve because "the Central Midwives Board has decided to make training in administration of analgesia compulsory for all pupil midwives entering Part II Training Schools after July 1, 1946 Section 3 of the regulations of the Board has been amended so that analgesia may now be "administered by a midwife provided that one other person, being any person acceptable to the patient, who in the opinion of the midwife is suitable for the purpose, is present at the time of administration in addition to the midwife in charge of the case."

A disclosure of the enquiry surprising to many people is the large number of women in booked beds in hospitals who are not delivered by doctors and receive no anaesthetic. Only 19·2 per cent of such cases are delivered by a medical practitioner, 51·5 per cent being taken by a midwife and 28·8 per cent by students. "It is clear that confinement in hospital does not carry with it a greater likelihood of being delivered by a doctor than does confinement at home. Taking the domiciliary confinements of the 3,407 mothers in the combined groups 18·10 per cent were delivered by medical practitioners.

In nursing homes, naturally, the proportion of medical deliveries is highest. These institutions also retain their patients, in all but 10 per cent of cases for the complete lying-in period of fourteen days, while hospitals tend to discharge them on the eleventh day, partly owing to pressure of accommodation, but, as is pointed out in the survey, it is the hospital patient who, on return to her home, immediately undertakes domestic duties.

Post-natal examination is by no means generalized at present. Those who have either been delivered in hospital or by a private practitioner tend more frequently to seek post-natal examination than those delivered at nursing homes or in their own homes. Figures indicate that 39 per cent are hospital patients, 28 per cent from nursing homes, and 17 per cent those delivered in their own homes. Other factors are the accessibility of the post-natal centre and the difficulty of a mother with several children attending.

With regard to the second section of the enquiry, expenditure on child-bearing, the Survey indicates that quite apart from the

subsequent maintenance of the child, the expenditure associated with the birth of a baby is a financial burden which for many families is likely to be a deterrent to parenthood. The total average expenditure within each group for the first child is given as £57 for the professional and salaried workers, £44·4 for the black-coated wage-earner, £35·6 for the manual worker, £31·6 for the agricultural worker and £47·5 for fathers in other occupations. The average for all married mothers being £39·5. There is a considerable fall in each group in the cost of the second and subsequent children. In the detailed allocation of the costs it is clear that the cost of medical services is lower for all but the professional and salaried worker groups than the cost of clothing and equipment. "The lower social groups spend in actual figures less than the prosperous. However, in proportion to total income, the working-class family is almost certainly paying much more." In the majority of cases this must mean that the family budget "can only be balanced by borrowing or drawing on savings."

"The various forms of assistance to mothers, such as maternity grants and pre-natal allowances for service-men's wives, go only a little way towards reimbursing this expenditure. The major outlay, especially in the poorer groups, is made in buying essential clothes and equipment rather than in paying medical and institutional fees." The group coming within £800–£1,200 a year income range are not within the sphere of the general hospital ward, and are required to pay high fees for nursing home and specialist services.

If it is desired to give prestige and status to the family the administration should by its actions make it clear to each married couple that they are benevolently concerned to ease the path of maternity with all the aids of science and by social encouragement.

An increase of births in Great Britain in the post-war period and the proportionately high rate even during the war, proves that the potential fertility rate is higher than the actual birth-rate fecundity. At the same time, the family-planning clinics and medical practitioners report an increasing number of clients who wish to but cannot conceive a child, and others having one child, are unable to achieve more. There are therefore purely biological as well as social factors involved in the reduction in family size. The only child is apt to become a problem child. It would be wiser to treat the sub-fertility of the parents and facilitate the

advent of brothers and sisters than to rely on the nursery school as an adequate substitute.

During recent years the problem of sub-fertility and sterility has been the subject of serious study and experiment by a group of medical practitioners and bio-chemists. The decline in the birth-rate when it is due to married couples having no children or only one child appears to have been too readily attributed by public opinion to voluntary factors, and social efforts have been devoted almost entirely to easing the economic situation for parents. While this may have some influence on the size of the family that fertile couples may rear, it cannot affect sterility or the only child family when these are due to biological causes.

Those writers who have the widest experience of this important subject are unanimous in submitting high estimates of the frequency with which involuntary infertility is to be found in every section of the community. As Kenneth Walker says: "Highly civilized man is but a poor breeder." Dickenson is of the opinion that one out of every six married couples living in the United States are either sub-fertile or else completely sterile, whilst Meaker estimates the ratio of sub-fertile to fertile couples to be as one to nine. A recent German writer calculates that one hundred and fifty thousand births were lost annually to the old Reich through involuntary sterility, a figure which is below that given by some other German statisticians.

Dr. Mary Barton, speaking from the wide experience of the team of scientists working in this field in Great Britain, which has handled several thousand cases, expressed the opinion that about 10 per cent of marriages in this country are sterile. In about 60 per cent of these cases the male partner is affected, in about 3 per cent he is hopelessly sterile.

Sterility or sub-fertility may occur in both man and woman, and is not the characteristic of the members of any particular social strata and is due to a number of different causes. It is estimated "that in about one-fifth of all childless unions the husband is so infertile as to make it extremely improbable that his wife will ever conceive." "In about two-thirds of childless unions the condition of the husband is such as to reduce in various degrees the likelihood of his wife conceiving."

Recent American writers have estimated that about 200,000 couples in the U.S.A. are childless on account of the poor fertility of the husband. In some cases while either could be fertile with

a different partner, each suffers from a type of sub-fertility which intensifies the other and this results in a childless marriage.

Well co-ordinated teamwork already gives promise of effective ameliorative measures, but as the causes of the glandular or other deficiencies are as yet unknown, preventive measures must await further research. Temperature, chemical influences and nutritional conditions have all been indicated as possible causative factors—that industrial workers in certain processes show a high infertility rate has already been reported. This is a field of current research. Whether or not the condition is in fact increasing, or whether the higher standard of health education results in more of those who desire but cannot have children seeking medical advice is a question still to be answered. What is clear is that those who desire children should be socially good parents, and in those cases where sterility cannot be cured, such couples could well be encouraged to form a family by adoption and thus benefit both homeless children and the community, or those who wish, could seek the aid of the specialist for artificial insemination.

This process involves the use of fertile semen for fertilizing the wife whose husband is unable to do so.

"Artificial insemination," as defined by the experts, "is the deposition of semen in the vagina, the cervical canal or the uterus by instruments," "as a method of bringing about pregnancy unattained or unattainable by sexual union."

At present there are three processes in use to meet the three stages of marital infertility. (*a*) Semen already deposited by the husband, but either because the sperms are insufficient in number or lacking in vitality and cannot penetrate to the operative area, they are taken by the doctor from the vagina by a syringe and are passed on to the cervical canal (neck of the womb). (*b*) In the case of an impotent husband semen is produced by him and the same technique followed without sexual union as this is unattainable. (*c*) The semen is provided by a donor personally unknown to the patient and transmitted instrumentally to the female passage by the doctor.

The percentage of successes that have attended the technique is high. Up to date, it has been used more frequently in the U.S.A., where some 5,000 successful cases are reported to have been recorded; in Great Britain the specialist group already mentioned have reported some 300 cases.

For the scientist to create a bridge between husband and wife

and accord them the satisfaction of a desired family can only be an advantage to the community, and is recognized as such, except by those religious hierarchies who consider the production of semen by masturbation by the husband is wrong.

The fertilization of the wife with the semen of an unknown donor is so new an idea that at present it creates opposition in many quarters.

Those who seek the intervention of the medical specialist to enable them to have a child through a donor are in the vast majority married couples who deeply desire children and are fit and suitable persons to rear a family. As an example an actual case may be quoted:

The husband of the writer of the following letter was a young airman. After about two years—they were married at the beginning of war—during part of which time they were separated, he was brought down in an air crash and his genital apparatus was completely smashed up. The couple came to me for attention and I arranged donation. The letter says: "This is to tell you how very much my husband and I appreciate the wonderful help and kindness which you have given us and we hope you will be able to give us some help again. . . . We are both thrilled about the coming event and my husband says he finds it hard to believe that it is not his own child. He seems as excited as I am about it, for you have solved what seemed to be a hopeless situation and what would have resulted in an unhappy, childless marriage. Please do not hesitate to use this letter should it be necessary . . ."[1]

From a recent address by Dr. Mary Barton.

The safeguards that have been imposed by some specialists to obviate possible undesirable social or biological consequences are: Never to intervene without a written request to do so from both husband and wife which is kept as a strictly confidential document, to be destroyed on the death of the doctor. Only to accept as donors married men with children who render this service with the knowledge and consent of their wives, only those of good character and abilities, of good physique and of good stock being selected. To co-operate in securing the happiness of complete strangers in itself is a presumption of good citizenship.

Some specialists who are working in this field, from their

[1] *Artificial Human Insemination*—Report of a Conference held under the auspices of the Public Morality Council. Chapter VI by Dr. Mary Barton, pp. 46–47. Heinemann.

experience of known cases, testify that many marriages have been stabilized and continue as well-adjusted family units enriched by children attained by this method (A.I.D.—Artificial insemination by donor). The interesting point is made by more than one practitioner that the husband tends to forget there has been any outside technical intervention and looks on the resultant child as his own; thus his paternal desires are fully satisfied.

The process must be kept entirely secret and remain unknown except to the doctor and the parents. The husband asked for the child, which is born as a member of the family. This principle is already frequently acted upon when a husband accepts as part of his own family the child of his wife by another man. Though there may be gossip, it is nobody's business to question the status of such a child. It has been asserted that either the husband or the wife will, in the future, resent the origin of the child which will be a cause for the disruption of the family. Experience gives no evidence of this.

It is claimed that this practice will raise serious legal difficulties *in the inheritance of property. This argument seems inapplicable* to the biological and social position. The child, before conception, is accepted by the putative father, and it is the biological child of his legal and accepted wife with whom he is living. The personal and private arrangement as to the method of fertilization—provided there is no legal barrier to the technique—is not the concern of any third party. The child is born as a member of the family—its position established by the request of the father before conception; surely, much more secure than in the many cases that have existed to common knowledge in the past, and still obtain, where a child of a condoned adultery of the wife inherits lands and titles

As social welfare is enhanced by enabling good citizens who desire a family to obtain one, there seems no possible reason for third parties to call on the law to intervene. The only suggestion so far is that the individual who would benefit by the continued childlessness of the parents would have a grievance if science righted their disability! The objection on ethical grounds that the child never knows his true origin has more substance, but it is in the interests of the continued stability and security of the child that the relationship between it and the parents, who have planned for and desired its advent, should be undisturbed. The biological offspring of one and the desired and intellectual

offspring of both, it will lack no more than any child where heredity is a throwback to a distant ancestor, unlike the father in appearance and temperament—a matter of frequent occurrence in the ordinary family From the standpoint of the community an increase in the number of stable families is an advantage.

For those interested in the official position of the Catholic Church the following may be quoted:—

> Vermeersch, perhaps the greatest moral theologian of our time, held that any artificial insemination of wife by husband is lawful provided that the semen be not wrongly obtained. The manner in which the semen is obtained is a matter of great moment to Catholic theologians. I think it is impossible for anybody to appreciate the Catholic viewpoint on this subject who does not understand the horror in which the Catholic is taught to hold mortal sin. . . . A husband is, therefore, not allowed to practise masturbation in order to provide semen. The contrary opinion is recorded in *Ballerini Opus Morale*, Volume I, No. 1304, and *Bernardi Praxis Confessarii*, Volume I, No. 1009, which admits the lawfulness of solitary pollution for the purpose of insemination, since there is no frustration of nature, but that view is not held to-day by any recognized author.[1]

A number of wild and imaginative forecasts have been made as to the results which would follow the general acceptance of the principle of artificial insemination and of the great powers it confers on the medical profession. As they themselves point out the surgeon is already trusted with the power of life and death over the patient on the operating table; with the well safeguarded powers of certifying persons as insane or mentally defective. One of the reasons anaesthetics were opposed was that 'once unconscious anything might happen to the patient' These fears appear to be only the usual human reaction to the unknown. Suggestions that a woman might produce a Chinese or a Negro infant because the doctor had a perverted sense of humour is merely postulating that an uncertified lunatic was still in practice. A medical practitioner might suddenly become a homicidal maniac, but that does not deter the public from placing their health and even their lives in the hands of the medical profession and is no serious argument. It may be accepted that, under careful safeguards, this new knowledge will be wisely used in the service of mankind.

[1] *Artificial Human Insemination*—Report of a conference held under the auspices of the Public Morality Council. Chapter V, Theological, by the Rev. J. C. Heenan, D.D. Heinemann.

There is the further question as to whether by this means, single women and widows should be enabled to bear children. Taking as our test the family and its stability, the biological needs of the child and its welfare, the answer would be in the negative in the present social structure. The child needs both parents, deliberately to increase the number who have but one can only be anti-social. The only child becomes the problem child. The adoption of two or more children is the obvious solution for the well-adjusted single woman.

In a previous chapter we have stressed the need for some solution to the difficulty of offering a reasonable way of life to those who are unfit for full marriage or for parenthood. The mentally defective, the seriously "dull and backward" and the abnormal who are nevertheless fit, with supervision, to live in communities.

The possibility of sterilization as a prelude to a form of legal marriage would appear to merit serious consideration.

The intervention of the war prevented any action being taken on the report of the Departmental Committee on Sterilization, but it is to be anticipated that the question will be revived in the near future. The shock of the example of the misuse of the power during the war, undoubtedly created a barrier to immediate action, but the problem the committee considered still remains. The publication of the report of the Mental Deficiency (Wood) Committee in 1929 drew attention to the magnitude of the problem of the mental defective, and while voluntary sterilization in the interests of the individual and eugenics would not be limited to the mental defective, but would protect posterity from other transmissible defects and diseases, the large number involved and the obvious burden cast on the community for their care and maintenance, focused public interest on this aspect of the problem.

The Wood Committee recommended that institutional provision should be made for 100,000 of the 300,000 estimated mental defectives. That these institutions should, where possible, be used for stabilizing and training mental defectives to live in the community under guardianship and supervision. This idea of using the institution as a training centre and base for mental defectives was first adopted in the U.S.A.[1] This would mean that the majority of mental defectives would be living at large in the

[1] *Social Control of the Mental Defective*, by Dr. Stanley Randle, chap. 12.

community, many of those of high grade being economically self-supporting. Sterilization will not reduce the need for social care and supervision, nor will it have an immediate or material influence on the numbers of the mentally defective, but as has previously been stressed, whether or not the particular type of mental deficiency is hereditary the mental defective is unable to fulfil the responsibilities of parenthood.

It is clearly impossible adequately to safeguard from sexual exploitation the certified mental defective at large in the community, even with the legal proviso that sex relations with a mental defective is a punishable offence. It is feared by some that there is an added risk of sex exploitation if untraceable by pregnancy. It is surely a false argument to claim the right to risk the welfare of posterity to facilitate social administration.

The whole policy of leaving the certified mental defective at large in the community, even under guardianship, seems fraught with danger. When the very small proportion of incest cases coming before the Courts is recollected, and the casualness of sex relations in certain groups is borne in mind, there is much more than commercial prostitution from which the sub-normal need protection.

In a few special cases doubtless some could be placed in kindly and safe homes, but the risk is there.

The Colony system would appear to provide the most satisfactory solution both for the handicapped and for the community. With self-supporting agricultural activities and home industries, with no barrier to legal and stable unions, the sterilized sub-normal could lead free and varied lives to their fullest capacity.

It is not that the mental defective is sexually aggressive—this seldom arises—but they are easily influenced by their associates. The passage of the Mental Deficiency Act in 1913 resulted in the removal by certification of 116 prostitutes from the London streets alone.

While voluntary sterilization is advocated it is not for the purpose of reducing communal responsibility, but in the interests of the individual and of posterity. Although sterilization would in no way minimize the institutional provision or guardianship needed, it would safeguard posterity and allow for greater freedom without social ill effects. A Private Member's Bill was introduced in 1930 under the ten minutes rule, but did not get beyond the Second reading. Public interest, however, was aroused and in

response to a deputation supported by the associations representing the local authorities and mental hospitals the Minister of Health in 1932 appointed a Departmental Committee on Sterilization (see p. 383 for recommendations). A joint committee representative of the major interested organizations publicized its Report when issued and were reviving public support when all social interests had to be laid aside owing to the war.

Experience provided by the U.S.A. has proved valuable. In this country, it is proposed that the operation of sterilization should be a voluntary act, those too defective to express their view to be represented by parents or guardians. In the States, after an initial difficulty between the States and the Federal authorities as to the legality of earlier State Acts in relation to the Constitution, there are now 27 States with effective sterilization laws. Up to 1933 some 16,000 persons had been sterilized in State institutions and this figure excludes cases operated on outside.[1] The social contribution to be made by voluntary legal sterilization is that it will offer a freer life to some 200,000 mentally defective persons, without the danger of their incurring parenthood, and will free the responsible but hereditarily affected from the fear of transmitting the defect. It is another instance where the application of the biological sciences can be used in the service of man.

A problem in which suffering can be ameliorated by the constructive action indicated by biological knowledge is in the early diagnosis and withdrawal from the community, either temporarily or permanently, of the abnormal man who makes a persistent practice of committing sexual assaults on little girls or small boys. The voluntary organizations have been urging action for nearly twenty-five years. So far, the result of their efforts has been one Departmental Committee in 1924, a number of deputations, the last of which was in 1936, various circulars from the Home Office to Clerks to the Justices for the guidance of magistrates, presenting the administrative changes recommended by the Report, but no legislation. The Press continues to report cases of child assault.

The passage of the Criminal Justice Act, 1948, will enable such cases to be handled constructively. As in other fields, the delays in adjusting outworn laws to existing conditions during the pre-war years has intensified the evils during the war and post-war period.

Sexual intercourse with a girl under 16 carries a maximum

penalty of two years' imprisonment. There is a vast difference in such an act if the girl has attained puberty, especially if she is a consenting party, and the same act committed against a little girl between three and ten years old. While an abnormal man *may* be responsible for some of the cases in the older group, the majority of these are due to irresponsible behaviour between young people; but it can be safely presumed that only the gravely maladjusted would assault little girls under five years old. Owing to the absence of corroborative evidence "in a material particular," particularly in cases of children too young to take an oath, even when these are known to the police to have involved the more serious offence, the charge in court has to be reduced to one of 'indecent assault' in order that a conviction, even with a short sentence, may be obtained. The nature of the offence in these cases practically precludes corroborative evidence.

One of the worst features of the situation is the number of offences committed by one individual. The following case reported by the Committee is worth quoting. It demonstrates the anti-social situation in which a serious offence, indicative of abnormality, can be repeated without any effective preventive measures to protect other children. It also indicates the relatively small social effort and expenditure involved in extending protective control to the apparently few abnormal persons concerned.

Record of a case quoted by Sexual Offences Committee:—

March 27, 1922—Indecent assault on girl of five years. Withdrawn.
March 27, 1922—Indecent assault on girl of seven years. Acquitted.
June 27, 1923—Indecent assault on girl of three years. Acquitted.
July 9, 1923—Indecent assault on girl of six years. Dismissed.
November 19, 1923—Indecent assault on girl of three-and-a-half years. Acquitted
June 24, 1924—Indecent assault on girl of four years. Twelve months' hard labour.

It is probable that, with such a record of alleged offences and on different children, one at least of the previous acquittals may have been due to a lack of corroboration of the evidence of a child of tender years, and yet the man was legally entitled to go free until at last the assault was committed in circumstances which furnished corroboration.

For this reason, after the report of the Departmental Committee in 1934, the Home Office advised that any young child who could tell a consecutive story should be allowed to take the oath. It has been estimated, that the number of cases that come

before the Courts in any form are about one-twentieth of the actual offences. Even those "known to the police" but not brought to Court have in recent years been double the number of the Court cases. Between 1926 and 1930 there were between 60 and 65 cases for "defilement of girls" under 13 proceeded against and between 70 and 90 cases in addition known to the police In 1945 the figures were 50 and 114 respectively. The numbers of those of thirteen and under sixteen were 223 "known" and 165 "proceeded against" in 1926; in 1945 these had risen to 320 and 308 respectively (for Table, see p. 408). Cases of assaults on young boys brought to Court were 125 in 1926 and 252 in 1945. Multiply these figures even by ten, instead of the estimated twenty, and the number of children seriously injured either physically or psychologically or both, demands action.

There is a further offence, of which only a small percentage of the cases ever come before the Courts, which shocks and terrifies children. In the case histories of the prostitute, the problem girl and the promiscuous, it is not seldom cited as the starting-point of their own preoccupation with and maladjustment towards sex. Abnormal men obtain sexual pleasure from exposing their genitalia to children and young women.

Some of the worst child murders have been committed by men whose incipient insanity was first expressed through this type of behaviour. Here again, administrative action could be effectively preventative. Three cases were quoted in the Committee's Report.

(*a*) Over a period of eighteen years ten convictions for exposure, on the eleventh the man was certified as insane, previous sentences had ranged from twenty-one days to twelve months.

(*b*) Over a period of eighteen years thirteen convictions for indecent exposure, previous sentences from fourteen days to twelve months. If still alive, the offender is presumably still at large.

(*c*) Over a period of thirty-five years, sixteen convictions, the last being for gross indecency with a male person after which he was certified as a mental defective.

A further case reported in the Press in 1932: the local police, after his ninth conviction in thirteen years for indecent exposure, reported the man had been before the Court one hundred and thirty times, mainly for being drunk and disorderly, his first conviction for indecent exposure was at the age of 16 and at 56 he is still at large after his last three months' sentence.

The Home Office have pointed out to magistrates that they have power to call in and pay for the services of an alienist, in cases where they suspect an abnormal mental or psychological condition and has advised them to do so. At present, however, there are no institutions to which offenders can be sent for medical care and control, even if, as is hoped, their maintenance costs be met from public funds under the Criminal Justice Act. The punitive régime of prison and repeated short sentences are useless both to the offender and the community. What is recommended by the Committee and by the non-official bodies interested is an indeterminate sentence for recidivists to a medical and protective institution, not conducted on punitive lines. The results of treatment to be frequently reviewed, liberty to be accorded after cure or, if the condition is incurable, the protection to continue. So far the authorities have not ascertained the estimated amount of accommodation that would be needed to deal with the non-certifiable, but sexually abnormal, who commit offences.

From the standpoint of creating a healthy public opinion and to raise a deterrent barrier to irresponsible sex behaviour by the biologically normal, it is suggested that all who commit sex offences against young persons should be medically and psychologically examined after conviction and before sentence. This would label such offences in the public mind as abnormal and would encourage their avoidance by the normal youth. It must be borne in mind that times of scarcity and strain, such as war and post-war eras, create a host of irresponsible and potentially criminal persons among the young, who in more stable and better ordered times would have just sufficient self-control to remain reasonably good members of society.

There is need here for further popular education if legislation and institutional provision are to be wisely and actively administered

Do present social customs and current values select for social recognition and prestige those who contribute to human welfare? Do they favour an environment that encourages the full potential development of each individual? Biological progress and sense of civic responsibility both depend on human quality.

The money value attached by public opinion to the contribution each can make in meeting current popular demands is at present the measure of "success." In Western civilization we are

faced with the Gilbertian situation that the highest incomes to-day are accorded by the public to those who can make them laugh and relax—the humorists and film stars—those who can organize monopolistic systems of distributing mass-produced goods, the chain stores, those who have the commercial acumen to exploit new inventions.

Scientific progress, originality, socially helpful activities, experiments in the promotion of human welfare, have no monetary value and can in the majority of cases only be initiated by those whose means of subsistence is drawn from other sources.

Within each social or professional group the conflict of values is presented—among others to the medical profession between curative and preventive medicine.

The first duty of the citizens is to maintain their families, provide education and professional training for their children so that these in turn should be self-supporting. They are trained to devote themselves to the *cure* of disease. Much disease can be prevented. The prevention of disease in a community that paid only for cure would mean inability on the part of the doctor to fulfil his duties as a citizen if time and energy were devoted to eliminating his source of income.

Even when an endeavour is made to make medical care available to all without financial barriers, there is acute danger, as at present under the Medical Services Act, that the administrative methods adopted will emphasize still more the curative aspect. Practitioners overburdened with patients can only deal with urgent cases and can have little time for early diagnosis and preventive treatment.

An environment of bureacracy and monopoly does not encourage initiative and the full development of the individual.

In some democracies the State is the largest monopoly organization, as now in Great Britain, which makes it vital to the maintenance of human quality that the traditions, methods of selection and terms of employment should be such as to encourage personal development, initiative, and responsibility.

It is characteristic of monopolies that they become sterilized in administration and standardized in production. Changes in any large organization are expensive and are not undertaken unless forced by competition in the commercial, or by political pressure in the administrative field. Competition is anathema to both the commercial monopoly and the State, who expect those

employed to adjust their personality to the pattern of the machine; suppression not only checks development, but in so doing provides the soil on which flourishes the seed of the personal 'power complex.' Even more dangerous to true democracy, the company, or the State, impersonal entities, assume responsibilities for the consequences of their policies and claim the abrogation of the moral sense of its employees.

Traditions that were suitable to a small and select group of civil servants envisaged by Pepys, whose main responsibility some three hundred years ago was to secure the honest administration of public funds, are no longer suited to-day to a service that administers a wide range of social services throughout this country and the Colonial dependencies. In early days the essential quality in a civil servant was honesty, and security of employment is an acknowledged encouragement thereto. To-day, when the public expects and receives honest administration of its public funds (except for certain serious war and post-war lapses, which are severely condemned when known), the country seems to be paying an unusually high price in hampering restrictions for this quality. The Service has had to be enlarged by numerous technical experts, but these are always subservient to the administrative branch.

Central and local governments could demonstrate through those services for which they are directly responsible the principles of social biology that make for human welfare and inherent quality. Early marriage can be encouraged, the family can be accorded status, privilege, and prestige.

As the State may be the employer of increasing numbers, it is of biological importance that the 'values' embodied in its traditions should be related to biological and ethical worth. At present it is a serious drain on the intellectual wealth of the country. The cream of the university graduates are taken in each year to be subjected to a system of intellectual sterilization that in a few years deprives them of the power of initiative and withdraws a serious proportion of potential ability from proving itself effectively. Promotion and decorations are gained in the main by passive routine. Any initiative shown by the individual during his career, that may have been 'troublesome' to his seniors, leads to a black mark, and may, in competition with those who have no such distinction and where all are 'honest and diligent' just tip the scales to his disfavour. The adage 'If you never make a

mistake you'll never make anything else either'—which is the pioneer's motto, is replaced by 'Decide nothing and you can't make a mistake'—the creed of the civil servant. No civil servant once accepted can be discharged except for a serious offence against the law or at his own request. There is no fair and graceful way in general use of shelving the honest inefficient, nor is there any equivalent of the Court Martial and Court of Inquiry of the Services to fix responsibility for mistakes. It should be possible to devise methods which will ensure the full potential contribution of each individual being used in the country's service without any reduction of integrity. The major alteration that could give reliance and promote initiative would appear to be to open the Service to older men and women with wider experience of the rough and tumble of life in the world, particularly those with overseas experience of administrative service concerned with the Commonwealth—or, alternatively, to give the young entrants overseas experience, not as civil servants, before they have administrative powers over peoples of other cultures. Provide a bridge for the experienced technician to enter the administrative branch. In opening departments for the administration of new services, to staff them with men and women of previous experience in the subject to be administered—not as advisers but as administrators. Equal pay for women and the removal of barriers to marriage are already accepted in principle and await action.

These are but a few of the current problems of social hygiene on which policy is still in process of formation. As a dynamic subject, it should claim and will need the interest not only of scientists but of the administrator and social worker, the sociologist, the thinker, the statesman, and the voter. A democratic government throws on the shoulders of its citizens the responsibility of learning, thinking, and acting. His attention is claimed for these questions as a prelude to action.

Pioneer Activities in the Modern State

History is at the moment writing itself so rapidly that it is difficult for inherently conservative mankind to assimilate the many changing factors that are affecting personal and social adjustment, or to place them in perspective against the vista of the past. Man, therefore, finds it hard to clarify the outline of his forecast of the shape of the social structure of the future to

which he should devote his energies or to see to what type of human effort he should attach social value.

The totalitarian states frankly admitted world improvement was beyond their capacity and limited their projected world-order to one that would benefit their own nationals at the expense of the rest of mankind. To that end the organization of the super-State. The rest of the thinking world rejected this philosophy on broad ethical principles and also, because they would be utilized and exploited for the aggrandizement of the self-selected and limited group.

"Personal freedom" and "the good life for all" is the avowed objective of the democracies, but its implications in relation to an industrial and international economy are undefined because not clearly visualized.

Political policies at variance with biological facts and a dawning of new economic perceptions are confusing the issues. The writer makes no claim to suggest a solution, but would submit that in the "trial and error" period that appears to lie ahead such "trials" as are made should take cognizance of biological, economic and historical knowledge. An appreciation of inherent human characters, the conditions of their encouragement or repression and the social consequences thereof, are essential to the development of intelligent and balanced human beings.

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SOCIAL WORK, TRAININGS AND OPPORTUNITIES

GREAT BRITAIN

by U. M. CORMACK
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The new interest in social work as a career, the new demand for trained social workers in an extended and more varied system of social service, statutory and voluntary, is one of the legacies of the war period. Whether it was that the wartime transfer and migration of urban populations accustomed to more developed social service than normal country dwellers and demanding help in readjustment to strange environments, introduced social workers to the hitherto almost untrodden ways of the local authorities and voluntary organizations of the country at large; whether the post-Beveridge discussions on social security stimulated both administrators and the general public to set before themselves somewhat higher standards in the actual administration of the social services; whether the success of the trained social workers called to the rescue in many unfamiliar wartime situations and improvised arrangements, such as evacuation hostels, cut once and for all the association, in the public mind, of the social worker with "charity" or "rescue" exclusively; whatever the cause, or combination of causes, it has now, in fact, become generally recognized that even the best designed social services will fail of their effect if not administered by suitable well-trained personnel, and that social work experience and training is—to say the least—a desirable qualification not only in established social service but in many new fields related to it.

Hitherto, in Great Britain, the development of professional social work has been to some extent confused by a false opposition between the virtues of the voluntary amateur, those trained on the job only, and the academically trained man. Social services in Great Britain have usually originated in the private initiative of some person of outstanding vision and sympathy who has formed a voluntary association to develop the service and prove its worth to the statutory authorities—who may then adopt it. Such people often belong to other professions, or occupations, and are led to their final career by way of voluntary work in clubs, settlements, committees and so on. The false opposition has been to a great extent resolved. It is recognized, not least by the professional worker and the experienced trainer, that it would be disastrous to exclude this type of worker and close this way

of entry. What is wanted is the combination of the three types, which may be achieved by more skilled selection, more scientific instruction and supervision of practical work, more practical application of academic theory; and it is in this direction that modern social work training is developing. The scope for voluntary social work, then, is undiminished, running parallel to the scope for the professional worker, and voluntary social work remains the best field from which to select candidates for training for professional work. The obstacle to this ideal selection is, unfortunately, the lack of adequate funds—apart from the training grants for ex-Service people, and such schemes of training allowances as that of the Home Office for the training of Probation officers—to finance the training of the maturer worker who has given evidence of vocation.

One consequence, however, of the confusion in the idea of professional social work as a career is the variety of the stages of professional development among the occupations in which social workers are employed. Miss Younghusband[1] distinguishes eight classes of occupation:

1. Those with a clearly defined training and a strong professional body, in which the unqualified are only to a decreasing extent employed; for example, almoning, moral welfare, house-property management, psychiatric social work (in child guidance clinics, mental hospitals and observation wards, in children's agencies, in regional mental health work, in research, in training).

2. Those where a training or trainings exist, but the employment of the untrained is still common; for example, personnel management, community centre or settlement work, mental deficiency work (the statutory supervision of defectives in their own homes, or when boarded-out, their after-care, employment and placement in foster-homes, etc.).

3. Those where there is no recognized professional training in general use but where social workers with a basic qualification may be employed and taught on the job; for example, family casework,[2] community organization (e.g. Councils of Social Service), most forms of child care (including work in approved schools, remand homes and orphanages, school after-care, Invalid Children's Aid Association and the new posts of Children's Officers to the new Children's Committees), and a miscellaneous number of voluntary societies for giving help in cases of individual hardship (e.g the Joint Emergency Help Committees of the British Red Cross and Order of St. John, or the Friends of the Poor, etc).

[1] Eileen Younghusband: Report on the Employment and Training of Social Workers, 1947, pp. 3–4. Additions have been made to the examples cited by Miss Younghusband.

[2] A National Association of Family Casework has now been formed.

4. Those where hitherto workers have learned the job by doing it, but now increasingly the trained social worker is being found of greater value; for example, inspectors of boarded-out children, and adoption officers, the Ministry of Pensions Children's Officers (a war-time provision), some workers for the physically and mentally handicapped, Juvenile Employment Bureau Officers, and the new Children's Officers.

5. Those where social workers and those trained in other fields are alike employed and each need some of the other's skills; for example, the youth service will probably be recruited from among teachers and social workers equally; teachers and nurses contribute to the staffing of many homes and institutions, voluntary and statutory, for destitute and handicapped children; health visitors now are largely recruited from the nursing profession.

6. "Those where a leaven of trained social workers is desirable, but where it would be utopian to suggest that the majority of those employed should receive more than in-training"; for example, school attendance officers, Assistance Board and Labour Exchange personnel (particularly on the juvenile and disablement rehabilitation side), prison officers, local government welfare and information officers, and other departments of the Civil Service where recruitment must normally be at 17–19, with a smaller late entrance at 22–24.

7. Those where social workers happen to be employed and find their previous experience useful, although they cannot always claim any more for it than their colleagues, formerly doctors, teachers, administrators, could claim for theirs; for example, posts in the prison service, the factory inspectorate, the Ministry of Health welfare inspectorate, etc.

8. Those in which special trainings of varying length exist, but a social science course may be regarded as a useful additional qualification; for example, some forms of church work, the probation service, the women police, the home teachers of the blind, N.S.P.C.C. inspectors.

The foregoing classification gives some idea of the widening scope of trained social work. It is by no means exhaustive; it makes no reference to such new developments as Marriage Guidance, Family Service Units, Old People's Welfare Committees; and it cannot indicate the increase in scope for social workers resulting in child care from the Curtis report, in education and health from the new legislation, and, generally, in statutory social service from the greater attention paid to the individual in social security schemes. It omits reference, also, to the probability of greater opportunities for research, training and university work in all the social sciences.

In choosing such a career a few main guiding lines among the diversity of possibilities can be discerned. To begin with, a candidate

should have, actually or potentially, suitable personal qualities. Social work can be divided into casework, group work, or community work; but its fundamental activity is compensating individuals, by one of these three methods, for some inequality in their adjustment to their environment. The maladjustment may be in the individual himself, as with a psychotic patient, or in the environment, as with most delinquent children, or in both, as with some problem families. The field of inequality may be in housing, in health, in morals, in mental health, in industry, in recreation, in information, in education, in training, in social responsibility. It follows that the social worker, apart from special interest in some particular field, housing or industry, for example, must be capable of understanding and dealing properly with individuals, and of understanding and modifying—as far as is practicable—environments. The capacity is partly innate, partly to be acquired and cultivated by a training which is both theoretical and practical.

The training possibilities then are (1) to enter the Civil Service or the local government service at 17–19, and hope for promotion into one of the social service departments, taking meanwhile such in-training as is available and some evening or correspondence courses in suitable subjects; (2) to take a degree at a university and try for entry to the Junior Administrative grade of the Civil Service at 22–24; (3) to take a degree at a university, preferably in a sociological subject, and to follow this either by a shortened one-year social science certificate or diploma, or by supplementary vocational training—in property-management, for example—or by both, the minimum total length of training then amounting to a little over four years; (4) to take a two-year social science course at one of the 20 university schools or departments of social science, with or without the supplementary vocational training, which varies in length from the almoner's minimum extra 13 months, the youth leader's 6–12 months, the probation officer's 3–6 months, the personnel manager's 1–2 months; (5) to train for some quite different but relevant profession, teaching, nursing, medicine, the law, etc., or to get work in industry or commerce, keeping in touch with social work by voluntary service and transferring as occasion arises.

It is on the whole advisable, however, not to be limited by too early specialization; the social science course is the academic basis for all social work, as family case-work experience is the practical basis. Specialization can then be guided by personal preference and the state of demand at the moment.

The greater number of entrants do, in fact, take the social science course followed by vocational training. But the tragedy of the present situation is that although the number of vacancies in the university schools has almost doubled to meet the increased demand—in the

three pre-war years the average was 540,[1] now it is over 1,000—yet the vacancies in the practical training agencies are less than a third of the university places. The bottleneck is a serious threat to adequate training, efforts to remove which are likely to be the next development in social work training. The annual intake in the main branches of social work are estimated by Miss Younghusband[2] as follows:

	Places a year
Almoners	100
Caseworkers (including family casework)	35
Children's care workers	25–50
Colonial Social Welfare (including colonial students)	15–25
Community Centre Wardens	20–30
Home Teachers of the Blind	10
Mental Deficiency Visitors	10–25
Moral Welfare Workers	20
Personnel Managers	50
Probation Officers	20–30
Psychiatric Social Workers	60–75
Women Housing Managers (with social science qualification)	10
Youth leaders	75
Miscellaneous	15–25
	465–560

For details of length and cost of training, salaries, facilities and comparative analysis of different types of work, reference should be made to Miss Younghusband's comprehensive report and to the Ministry of Labour pamphlets, *Careers for Men and Women* series. For further discussion of the subject in general, reference should also be made to Dr. Leubuscher's Nuffield College pamphlet and to Miss Macadam's *The Social Servant in the Making.*

[1] *Training for Social Work*, by Dr. C Leubuscher. 1946 [2] Pp. 21–22

TRAINING AND OPPORTUNITIES FOR SOCIAL WORK OVERSEAS

Contributed by Social Welfare Department, Colonial Office

Maternity and Child Welfare.—In the Colonies, as at home, this is primarily the concern of the Medical Departments, who provide in addition hospitalization, training of midwives, ante- and post-natal clinics.

At the same time many colonial territories, for example Jamaica, have flourishing voluntary associations which provide clinics which are distinct from hospital clinics. It is the aim of Social Welfare Officers to increase the staff of voluntary helpers where these are needed, and to add simple instructions on homemaking wherever this is possible. In some territories women Health Visitors are provided who themselves carry out home visits.

As education is in many Colonies far from universal, nursery school activities are limited in the main to areas where working mothers call for them. (Under Malayan Labour Laws crèches are provided in plantations above a certain minimum size.) There is a Nursery School Association in Trinidad, and one or two trainees from Jamaica, and a few from West Africa are receiving training in the United Kingdom as nursery nurses.

Milk for school children comes under the head of child welfare. It is provided, for example, in Bahamas and Bermuda, and there are school meals in Grenada and Trinidad.

As regards handicapped children, a campaign has been started for the prevention of blindness and care of children's eyesight. Neither for blind nor deaf children are facilities comprehensive, but the question is under consideration.

Probation and Juvenile Offenders.—Interest in juvenile delinquency, and the increase during the war of young prisoners in Colonial prisons, were factors contributing to the constitution in 1943 of the Colonial Social Welfare Advisory Committee, one of whose standing sub-committees, known as the Treatment of Offenders, keeps the subject under review.

In 1940 and 1941 a draft model Probation Ordinance was issued to Colonies: by 1943 there were trained Probation Officers in one colony (Palestine) only. By September 1947 twenty Colonies had provided for the employment of Probation Officers with Home Office training and experience. The extent of local training is shown by the total number of probation officers employed—between sixty and seventy. Ceylon,

Trinidad and Kenya have been active in training staff locally: other Colonies, for example, Gold Coast, Mauritius and Nigeria, have sent local recruits to the United Kingdom for training. A number of local magistrates visit Children's Courts and Remand Homes here, when on leave, and compare their own procedure. The Nigerian Children's Ordinance (1943) is regarded as specially interesting. This colony has provided a Boys' Hostel in Lagos and a School Boys' Camp.

One or more Approved Schools are in existence in twenty-eight colonies; in some cases European headmasters are sent out; in others colonial candidates come home for training—for example, from Cyprus.

The need for age-grading is becoming recognized, and Borstal Institutions for older lads are being set up, for instance in the Gold Coast, Kenya and Malayan Union.

After-care is provided where possible, but the sparsity figure of colonial population creates difficulties.

Youth Organizations in the Colonies.—Probation Officers are the first to recognize the value of youth organizations and sometimes are themselves organizers, for example, of Scouts (as in Sierra Leone). The wartime concentration of boys at ports, particularly in West Africa and West Indies, has stressed the value not only of probation but of preventive measures such as Youth Clubs. Youth work is therefore prominent in the activities developed in these two regions although it exists, of course, elsewhere.

There are Youth Councils in Trinidad, Jamaica and Gold Coast; and two special Youth Organizers in Trinidad. Special emphasis is laid on youth work in Jamaica, and British Guiana, and in Jamaica, Trinidad and Lagos Missionary Societies have themselves appointed organizers for club work. The Y.W.C.A. is active in Lagos, Jamaica and Trinidad. The last colony also ran courses for play centre leaders. The Save the Children Fund set up play centres in Jamaica, and they are a feature of Government activities in Lagos.

In the Far East Boys' Clubs were of interest before the war: in Singapore a specialist officer is now responsible for them.

Trinidad and Bermuda look to club work and organized sport to combat hooliganism. Organized sport is a feature of social welfare development in East Africa. Scouts and Guides exist in most Colonies (in Malaya before the war they numbered 14,000) and frequently receive Government assistance. Most Scoutmasters are colonial in origin. The Junior Red Cross is popular, notably in Bahamas, Gold Coast and Kenya and encourages indigenous activities. The Boys' Brigade is popular in Nigeria and Nyasaland. Northern Rhodesian Pathfinders represent the grafting of Scout technique on local tribal organizations. Young Farmers' Clubs exist in East and West Africa,

and in Fiji, in the West Indian colonies the Four H. Movement, with similar aims, but of American origin, is preferred.

Welfare Organizations for Men and Women.—In some instances, youth has been the primary concern of social welfare; but two other problems, one general and one particular, have focused attention upon adults. The first has been the need for an improved standard of living, which called for increased earnings and more attention to food values and to homemaking; the second the return, particularly to Africa, of the ex-service man. To the former circumstance, more than anything else, is due the co-operatives and clubs of the West Indies with their food production drives and training in handicrafts; and to the latter the community or social welfare centres of East and West Africa.

Tanganyika has a chain of modest but well-built welfare centres; Kenya has its centres or information rooms, and Uganda a series of clubs, many centred round the vocational training centres for ex-service men. To most, women are admitted, often at their own hours, though they attend concerts and social events with the men, but the organization is primarily for men. In Kenya the women's activities are at present rather less extensive than the men's, for whom literary training, athletics, group discussions, occasional lectures, reading-room facilities and some films are provided.

Uganda likes women's clubs (it has long been a stronghold of the Mothers' Union). The officers are African, and African women are beginning to lead activities in Kenya and Tanganyika at the centres. (The principle of training wives alongside husbands is accepted in Kenya and Uganda and Nyasaland.)

Northern Rhodesia has its own Federation of Women's Institutes, and so has Trinidad. In Nigeria an eight days' conference was held in August 1947 to discuss the Women's Institute movement. Here too there are several Women's Social Welfare Committees of African origin. Sierra Leone has developed an interesting scheme of training for prospective mothers in a small section of the Protectorate; follow-up activities have produced various clubs on the Women's Institute pattern.

The handicraft training in the West Indies is increasing in skill and finish. Training courses are providing teachers for an ever-widening area. Training in the wider activities included under homemaking is also contemplated.

In Fiji certainly, and to a less degree in other Western Pacific territories, for example Tonga, Women's Committees exist to deal with such problems as child care.

Training for Welfare Work in the Colonies.—With a view to producing for welfare schemes local supervisors of professional standing, the Colonial Office in 1943 secured the co-operation of the London School of Economics in setting up a special course for colonial students which

conferred upon the successful a social science certificate, concentrated upon colonial problems and provided specially selected practical work. The sixth session of this course opened in the autumn of 1947 Approximately 120 students in all have enrolled of whom over 100 have returned to their colonies to take up social work. Other students have taken elsewhere shorter and sometimes less academic courses.

In the West Indies, Professor T. S. Simey (Liverpool), when acting as Social Welfare Adviser to the Comptroller for Development and Welfare, started his first training course (a pre-professional course of six months' duration) in Jamaica in 1943. The sixth West Indian course (June to December, 1948) enrolled in all over 125 students. Many of these hold junior welfare posts in the West Indies; a few have qualified for professional training in the United Kingdom. This course is likely to be absorbed ultimately in the University College for the West Indies.

By way of shorter courses there have been, to quote a few instances apart from youth work courses, courses for handwork, for casework, and an annual course for prison workers in Trinidad. Both Kenya and Uganda have held *ad hoc* courses for 100 male welfare officers destined for centres or demonstration teams

A special feature in the United Kingdom has been the provision of visits of observation, short courses, or brief training on the apprenticeship basis for visitors, both European and Colonial. Since 1944, 300 persons have received longer or shorter periods of such training

European Welfare Officers have by hypothesis relevant experience and at least the younger offer theoretical training. Their preparation for the Colonies has been in background training or extension of experience.

REPORT ON AN INVESTIGATION INTO THE COLOUR PROBLEM IN LIVERPOOL AND OTHER PORTS, 1930

by M. E. FLETCHER

With a Foreword by PROFESSOR P. M. ROXBY

Page 6 (*Introduction*).—At an early stage it became apparent that no serious problem was presented by the Anglo-Chinese community or the Lascar seamen, and attention was concentrated on the Anglo-Negroid population in Liverpool. The Report demonstrates that, as a whole, this community is living under deplorable conditions and

that in particular the prospects of the great majority of the Anglo-Negroid girls, from the time that they leave school, are almost hopeless. . . . No question of race prejudices or discrimination is involved, but the conclusion is clear that the present conditions under which coloured seamen from the West Coast of Africa enter Liverpool constitute a real social menace and are detrimental to the best interests of Blacks and Whites alike.

The Summary and Conclusions of the Report follow in full (pp. 38–39):—

Summary

The men from the West Coast of Africa expect to find employment on the ships trading between their country and our own.

Finding residence in England attractive, they tend to settle here, and as many of them have British passports it is impossible to prevent them from doing so.

The problem of the half-caste child is a serious one, and it appears to be growing in most of our seaport towns.

The coloured families have a low standard of life, morally and economically. It is practically impossible for half-caste children to be absorbed into our industrial life, and this leads to grave moral results, particularly in the case of the girls.

The white women themselves mostly regret their marriage with a coloured man and their general standard of life is usually permanently lowered.

Conclusions

The Committee has given very careful consideration to a number of suggestions which have been put forward for the satisfactory solution of the problems discussed in this report. These problems fall under two heads:—

(1) Those presented by conditions under which it is possible for coloured men to gain easy access to this country, thus helping to swell the number of contacts of an undesirable nature which are being made.

(2) Those presented by the coloured population already in existence in our ports.

With regard to (1) it has been suggested that the obvious solution of the problem is to replace all coloured firemen by white on all British ships coming to this country.

The difficulties connected with this solution are twofold:—

(*a*) The shipowners say that they would be unable to find white men who could work in the heat of the stokeholds on the West Coast of Africa.

We understand, however, that the German shipping lines trading with the West Coast of Africa employ only white firemen, and we are told most emphatically by the National Union of Seamen that white firemen can, and do, take ships to all parts of the world.

(*b*) The second and more insuperable difficulty is connected with the probable political reactions resultant from the prohibition of the employment of coloured men.

While fully aware of these difficulties, the Committee agrees that this is the only real solution. Nevertheless, two further suggestions have been made which would to some extent minimize the problem, and these should undoubtedly be given consideration.

(A) The signing on of the men on the West Coast of Africa so that they would be obliged to make the "round trip" and would receive no pay in this country.
(B) The exercise of greater discrimination in the issuing of British passports.

With regard to (2) the problems involved are questions of adjustment with the ordinary white population of the ports. It is apparent from this report that these coloured families present a special problem both from a moral and an economic point of view. The question of the employment of half-caste juveniles, especially of the girls, should be a subject for official enquiry.

The fact that these families are influenced but little by the existing social organizations indicates the necessity for a separate and special provision for them.

In discussing this point the Committee is of the opinion that a special Welfare Worker should be appointed whose duty it would be to discover and develop an adequate social organization.

WELFARE OF THE MERCANTILE MARINE

International bodies concerned are:—

(*a*) The International Labour Organization.—The welfare of merchant seafarers is one of the questions studied by the Maritime Service of the International Labour Office, which is assisted and advised in all matters of maritime labour by a standing committee, the Joint Maritime Commission. This Commission was set up by decision of

the Governing Body of the Office in 1920 and originally consisted of twelve members. It has since been twice enlarged, and by decision of the Governing Body in September 1946 it now has twenty-six members: twelve shipowners and twelve seafarers appointed by the International Labour Conference, and two members representing the Governing Body. The Chairman of the Governing Body is *ex-officio* Chairman of the Commission.

(*b*) World Health Organization.—This organization was established as the result of an International Health Conference, convened by the Social and Economic Council of United Nations in July 1946. An Interim Commission acted until September 1948, when the organization itself came into being A Protocol was also accepted at this conference and subsequently ratified, whereunder the duties and functions of the Office Internationale d'Hygiene Publique are to be performed by the World Health Organization. Another important development is the adoption by the W.H.O. of a joint programme with the International Labour Organization for improvement of the hygiene of seafarers by the establishment of a joint expert committee.

(*c*) Standing Committee for the Health and Welfare of Merchant Seamen of the League of Red Cross Societies.—This Committee was established at a conference held in 1926, its duties being to arrange for expert investigation of facilities for the medical treatment of seamen and welfare conditions on board and in port. The League is responsible for the Red Cross medical handbook for seamen.

(*d*) Union Internationale Contre le Péril Vénérien.—The Union, established in 1926, has set up a special committee under the title of Ports Commission to deal with questions affecting the mercantile marine.

The Brussels Agreement.—This international Agreement, signed at Brussels, 1924, was implemented by the Office Internationale d'Hygiène Publique. The high contracting parties undertook to establish and maintain in each of their principal sea or river ports free services for the treatment of venereal disease open to all merchant seamen or watermen without distinction of nationality. The Agreement is now the responsibility of the World Health Organization which has decided that its provisions shall be incorporated in international health regulations for the control of the spread of V.D.: these are under consideration by the Expert Committee on V.D.

Seamen's Welfare in Ports Recommendation, 1936.—At the Twenty-first (Maritime) Session of the International Labour Conference, held October 1936, the Seamen's Welfare in Ports Recommendation was adopted. This Recommendation laid down certain principles and methods for the consideration of Governments for the promotion of the welfare of both national and foreign seamen in ports. The recommendation was divided into seven parts, dealing with general organi-

zation; regulation; health; accommodation and recreation; savings and remittance of wages; information for seamen; and equality of treatment for all nationals.

At its Twelfth Session, June 1942, the Joint Maritime Commission adopted a resolution urging all States Members to give effect to the Recommendation.

At the Twenty-eighth (Maritime) Session of the Conference, June 1946, the following resolution was adopted:—

Resolution Concerning Seamen's Welfare in Ports

Whereas it is considered desirable to promote seamen's welfare in the ports of all seafaring countries, and for this purpose especially to take advantage of the experience made by the organs which have been working in this field during the war,

This Conference requests the Governing Body of the International Labour Office—

(1) To investigate the effect of the Recommendation concerning seamen's welfare in ports, adopted by the International Labour Conference at its Twenty-first (Maritime) Session in Geneva, 1936, and for such purpose to ask all Governments to report what they have done or intend to do towards improving the conditions for seamen when visiting ports;
(2) To consider the question of promoting seamen's welfare in ports on the basis of international reciprocal co-operation.

At its Fourteenth Session, December 1947, the Joint Maritime Commission, after considering the replies received from Governments on the above, adopted a resolution requesting the Governing Body—

(1) To instruct the Office to pursue its study of seafarers' welfare both in port and on board ship and to make concrete proposals to the next session of the Joint Maritime Commission for concerted national and international action to promote the welfare of seafarers, with special reference to

    (*a*) co-ordination of hotel, club-room, sports and other welfare facilities in ports, more particularly where those are at present lacking;
    (*b*) co-ordination of library, film, radio and other recreational and educational facilities on board ship.

(2) To instruct the Office, in co-operation with the World Health Organization and other competent bodies, to resume its

study of means for the prevention of venereal and other social diseases among seafarers and of the social and medical aspects of the treatment of such diseases, with special reference to adequate medical treatment and facilities for hospitalization both on board ship and on shore.

Health of Seamen Afloat.—The Joint Maritime Commission at its Twelfth Session in 1942 called the attention of Governments to the following matter, considered of special importance.—

Medical research services should be organized as soon as practicable for the scientific investigation of questions relating to the promotion and maintenance of the health of seamen afloat.

Great Britain ratified the Brussels Agreement, and accepted in 1938 the Seamen's Welfare in Ports Recommendation. After a survey of existing conditions in the principal ports a Seamen's Welfare Board was set up in October 1940, composed of representatives of the organizations of shipowners, officers and men and of the Government Departments concerned—Labour and National Service, Transport and the Admiralty, together with persons having experience of the work of the voluntary organizations, and a medical expert. Its functions are to advise the Minister on all questions concerning the welfare of British, Allied and other seamen in British ports and of the crews of British ships in overseas ports.

Port Welfare Committees have been established in the principal ports, together with Seamen's Welfare Officers who are full-time officers of the Ministry of Labour and National Service. They act as secretaries to the Committees, and have a special responsibility to ensure the provision of adequate accommodation and recreational facilities for seafarers in their respective areas.

In November 1943 the Ministers of Labour and National Service and War Transport set up a Committee with the following terms of reference:—

"Having regard to the Government's acceptance of the Recommendation of the International Labour Conference concerning the promotion of seamen's welfare in ports, to consider the activities and functions respectively of the Government, the Shipping Industry and the Voluntary Organizations in the establishment and maintenance of hotels, hostels, clubs, recreational facilities and other amenities for Merchant Seamen in ports in Great Britain, and in that connection to consider in consultation with the Voluntary Organizations primarily concerned with Merchant Seamen, their appeals for funds not only for welfare but for benevolent and

samaritan purposes whether for expenditure in Great Britain or elsewhere, and to submit recommendations."

The Committee reported a year later.[1] Among their recommendations was the following:—

"Subject to their practicability in particular local circumstances, we wish to make the following recommendations:—

(1) We endorse the policy, adopted as a general principle by the Seamen's Welfare Board, that in every port where the need for a club is shown there should be at least one where beer can be obtained by merchant seamen in decent surroundings.
(2) We believe that, wherever reasonably practicable, a merchant seaman should be able to take his wife or female relative or friend into the clubs.
(3) Provision should be made in ports for accommodation for married couples so that wives can stay with their husbands when the latter are unable to get home between voyages.
(4) Separate residential and recreational facilities should be provided as far as possible for the 'under-twenties.'"

MARRIAGE, SEPARATION, AND DIVORCE

by H. B. GRANT
Barrister-at-Law

Marriage according to English law is "the voluntary union for life of one man with one woman to the exclusion of all others." It may be contracted either (*a*) within the Church of England, or (*b*) outside the Church of England either according to the rites of any other religious denomination provided it recognizes only monogamous marriages, or purely as a civil ceremony in a register office. To be legally valid:—

1. Neither party must be under sixteen years of age.
2. The parties must not be within the prohibited degrees of relationship.
3. The marriage must not be bigamous.
4. Both parties must be mentally capable of marriage (i.e. able to understand the nature and significance of the marriage contract).

[1] *Seamen's Welfare in Ports*. H.M. Stationery Office. Price 6d.

5. The marriage must be celebrated with real consent by both parties.
6. The marriage must be contracted in accordance with the necessary formalities

Some 400,000 marriages are contracted annually in England and Wales. Their success and happiness is of the highest importance, not only to the parties concerned, but to the whole community. The prevalence of divorce is therefore a matter of general concern and anxiety.

About 50,000 decrees of divorce were granted in the year 1947. This staggering figure is exceptionally high, and to some extent explained by the accumulation of poor person's and Service applications for divorce, in many cases several years old, and the adverse effect of the war upon married life. But even if this year's total is only a passing phenomenon an annual average of 10,000–20,000 divorces must be expected in the future.

The grounds for divorce are:—

1. Adultery.
2. Desertion for at least three years.
3. Cruelty.
4. Incurable insanity and consequent detention for five years.
5. Rape, sodomy, or bestiality by the husband.

A marriage cannot be dissolved for the first three years except by special leave of the Divorce Court. Such leave may be given upon proof either that the petitioner has suffered "exceptional hardship" or that the respondent has been guilty of "exceptional depravity." In 1946 the period of six months which formerly had to elapse between "decree nisi" and "decree absolute" was reduced to six weeks, so that nowadays it takes three to six months from the commencement of an "undefended" divorce suit until its determination by a "decree absolute."

Only the Divorce Division of the High Court has jurisdiction to grant decrees of divorce or of judicial separation (on the same grounds as a divorce) or of nullity. The effect of a decree of nullity is, generally speaking, to wipe out the marriage as if it had never been contracted, with the important exception that children born before the date of the decree remain legitimate.

A marriage may be annulled on the grounds that:—

1. One of the parties is impotent.
2. The marriage has not been consummated owing to the wilful refusal by one of the parties

3. One of the parties, unknown to the other, was at the time of the marriage mentally defective or subject to recurrent fits of insanity or epilepsy.
4. One of the parties, unknown to the other, was at the time of marriage suffering from venereal disease in a communicable form.
5. The wife was at the time of the marriage pregnant by another man, unknown to the husband.

Grounds 3–5 cease to be available after one year of marriage.

Magistrates' courts are the appropriate tribunal for the making of separation and maintenance orders. The distinction between the two orders is purely technical. In practice the existence of either implies that husband and wife live apart, and that the husband is liable to pay his wife by order of the Court a weekly sum of money, not exceeding £2 in respect of herself and 10s in respect of each child under sixteen years. The enforcement of payments which are owing is the responsibility of the wife and not of the Court. If the wife proves to the Court that her husband is financially able to comply with the order but that he wilfully refuses to pay or work he may be committed to prison. In actual fact many husbands succeed in evading their obligations under maintenance orders, and the social distress that centres around these orders is considerable; 6,000 orders were made in 1936, but this number is likely to have doubled since then.

Matrimonial cases in magistrates' courts are heard by a special panel of justices. Not more than three, of whom one should be a woman, may deal with any one case. The public are not permitted to be in court during the trial, and reporters are restricted in what they may report in the Press. The parties need, therefore, not fear any undue publicity. The proceedings are generally more informal than an ordinary trial. All these and other peculiar features regarding the matrimonial jurisdiction of magistrates' courts were laid down by the Summary Procedure (Domestic Proceedings) Act, 1937 Magistrates' courts also have at their disposal probation officers for the purpose of reconciliation, investigation of home conditions, child welfare, and general consultation and advice. Probation officers have proved themselves an unqualified success.

The applicant for a separation order is invariably the wife. She may be granted an order if her husband:—

1. Has been convicted of an aggravated assault upon her.
2. Insists on sexual intercourse while knowing that he is suffering from venereal disease.
3. Compels her to submit to prostitution.

4. Is a habitual drunkard.
5. Has committed adultery.
6. Has been guilty of persistent cruelty to her or her infant children.
7. Has wilfully neglected to provide reasonable maintenance for her and her children.
8. Has deserted her.

The trend of future developments is foreshadowed in the Denning Report (Cmd. 6881, 6945 and 7029). The report is the outcome of the appointment of a committee under the chairmanship of Mr. Justice Denning, in June 1946, "to examine the present system governing the administration of the law of divorce and nullity of marriage in England and Wales" . . to consider what procedural reform ought to be introduced in the general interests of litigants . . . and in particular whether any machinery should be made available for the purpose of "attempting a reconciliation between the parties."

The proposals of the Committee regarding procedural matters are mainly technical, and aim at speeding up the process of divorce and at lowering the costs of a divorce suit. This part of the report has been largely accepted. The Committee's suggestions on the subject of reconciliation are of more general interest, and are based on the conclusion that "the reconciliation of estranged parties to marriages is of the utmost importance to the State as well as to the parties and their children." The Committee accepted the evidence given by experienced social workers that the prospects of reconciliation are much more favourable in the early stages of marital disharmony than in the late stages, particularly so where there are children. They applaud the work done by all social agencies that concern themselves with marriage problems and recommend that the State shall assist them financially, such assistance in time to lead to a proper marriage welfare service sponsored by the State but not a State institution.

Under the heading "Reconciliation" the report further recommends the appointment of "Court Welfare Officers" to be attached to the Divorce Court in the same way as probation officers are attached to magistrates' courts, and with similar functions. This recommendation has proved much more controversial (House of Lords debate, March 27, 1947), and the Government, while in full agreement with the Committee about the desirability of reconciliation and the fundamental importance of the preservation of the marriage tie, have no immediate intention of implementing this proposal.

MARRIAGE RATE, ENGLAND AND WALES

Persons Married per 1,000 *Population of all Ages*

1925	15·2	1945	18·7
1935	17·2	1946	18·1

1947 .. . 18·6 (provisional)

DISSOLUTION AND ANNULMENT OF MARRIAGE, ENGLAND AND WALES

Year	Dissolution	Annulment	Total
1925	2,563	42	2,605
1935	3,942	127	4,069
1945	15,221	413	15,634
1946	17,054	610	17,664

TREND OF POPULATION

ESTIMATED POPULATION OF THE WORLD BY CONTINENTS, 1939*

	Population Millions	Distribution Per cent
Asia (excluding U S S.R.) ..	1,154	53·2
Europe (including U.S.S.R.) ..	575	26·5
America and Oceania .. .	284	13·1
Africa	157	7·2
World	2,170	100·0

The population of Asia is rather more than one-half the population of the world.

The population of Europe is rather more than one-quarter the population of the world.

The population of America, including Canada, Australia and New Zealand, is one-half that of Europe and nearly double that of Africa.

* D. Caradog Jones, Conference on Problems of Population, organized by the British Social Hygiene Council, April 1944.

COMPARATIVE BIRTH-RATES, PRINCIPAL BRITISH AND FOREIGN COUNTRIES, 1912–1941*

(*Living born per* 1,000 *Population*)

	England and Wales	N Ireland and Eire		France	Germany
1912	24·0	23·1		19·1	28 3†
1922	20·4	23·3	19·5	19·3	23·0
1932	15·3	20·1	19·1	17·3	15·1
1941	13·9	20·9	19·0	13 1	18·6

	Italy	Norway	Netherlands	Spain
1912	34·4	25·3	28 1	31·7
1922	30·8	23·3	26·1	30·5
1932	23 8	16·0	22·0	28·3
1941	20·8	15·7	20 3	19·5

* The Registrar-General's *Statistical Review of England and Wales*, 1941.
† Pre-war areas.

DENSITY OF POPULATION IN VARIOUS PARTS OF AFRICA*

	Per square mile
Union of South Africa generally	20·3
Transkei (most favoured native area)	58·1
Southern Rhodesia generally	8·6
Uganda	39·0
Tanganyika	14·3
Belgian Congo	12·1
Northern Nigeria	40·1
Southern Nigeria	96·9
French West Africa (excluding lightly populated Sudan Province)	8·9
Comparisons:—	
British India general	200·0
Indo-China	81·5
Java	817·5
European Predominantly Agricultural Countries:—	
France	197·0
Hungary	249·2
Yugoslavia	156·4

* *An African Survey*, by Lord Hailey, p. 2. Oxford University Press.

MATERNITY AND CHILD WELFARE

ENGLAND AND WALES[1]

The maternity and child welfare services provided under the Maternity and Child Welfare Act, 1918, and transferred to the Public Health Act, 1936 and the Public Health (London) Act, 1936, are developed by the National Health Service Act, 1946, which came into force July 1948. These services are administered centrally by the Ministry of Health, and locally by the Councils of the administrative counties and county boroughs. It is the function of these Authorities to provide free of charge maternity and child welfare clinics, midwives, health visitors and district nurses They will also see that their services are closely integrated with the hospital service.

The activities of the local authorities are supplemented by those of voluntary organizations working in co-operation with, and, in many cases, receiving grants of money from them. Each of these local organizations is concerned with some special branch of the work.

Specially trained doctors, nurses and midwives are in attendance at the ante- and post-natal clinics held at maternity and child welfare centres; whilst health visitors, working from these centres, call on homes in the district to give advice and help.

Ante-Natal Care.—Any woman who believes she is pregnant should go to her family doctor, to her local midwife or to the Welfare Centre. Any of these will put her in touch with other services she may need. Behind them are the whole range of hospital and specialist service. On receiving her certificate of pregnancy the expectant mother should visit the Food Office to obtain the extra milk, foods, welfare foods and clothing coupons for which she is eligible under the Government's priority scheme. In 1947 the number of women who attended ante-natal clinics or received ante-natal care by G.P. arrangement was 715,095.[2]

Confinement.—An expectant mother who is having her baby at home can now have without charge the services either of a General Practitioner Obstetrician or her own family doctor if she prefers it and he is willing to undertake her case. The doctor who undertakes her case will carry out certain ante- and post-natal examinations and attend her confinement if he thinks it advisable. The remainder of the ante-natal care is provided by the midwife, in conjunction, in many cases, with the maternity and child welfare centre. The midwife will attend the confinement and lying-in period so every expectant mother should book a midwife as well as a doctor. Confinement in hospital will be available for mothers in cases of medical complication, and priority is

[1] With acknowledgment to the National Association of Maternity and Child Welfare Centres and for the Prevention of Infant Mortality.

[2] Provisional figures, Ministry of Health

given where home conditions are unsuitable and for first babies. Applications for hospital admission will be made through the doctor, or, where admission is required because of unsuitable home conditions, through the Medical Officer of Health.

If the mother decides to have the baby in her own home and needs someone to do the housework and shopping, if there is a local "Home Helps" scheme the Public Health Department will arrange with the midwife for someone to come daily. The mother will be asked to pay what she can afford.

Post-Natal Care.—In many areas post-natal clinics are established for the examination of mothers after confinement, in addition to which post-natal examinations are frequently combined with work at ante-natal clinics.

Health Visitors.—After the confinement the Health Visitor from the Welfare Centre begins her regular visits. They are state registered nurses with general hospital or children's hospital training, and they must hold a certificate of at least Part I of the midwifery training in addition to the health visitor's certificate. They give specialized advice on breast feeding and the care of the baby and on the nurture and management of children up to five years of age. The figures for 1947 show that visits were paid to over 90 per cent of the country's babies in their first year

Welfare Centres.—Many mothers bring their infants regularly. The children are weighed and records are kept of their progress. They are examined by the doctors, and dental, orthopaedic, ophthalmic and sun-light treatment is available at many. In 1947, some 70 per cent of the children born attended clinics before they were a year old. At December 31, 1947, there were open 4,388 centres[1].

Maternity Benefit.—Under the National Health Insurance Act, 1946, subject to certain conditions as to payment of contributions, a mother receives a maternity grant of £4 for each baby born, paid on either her own insurance or her husband's. In addition she can receive (1) if employed or self-employed a maternity allowance of 36s. a week for thirteen weeks if she gives up her paid work during that period; or, if not eligible for maternity allowance an attendance allowance of 20s. a week for four weeks after the baby is born. Claim forms are obtained from the Ministry of National Insurance.

Day Nurseries and other Nursery Provision.—In May 1941 the Government decided to set up day nurseries for the children, aged one month to five years, of mothers engaged in war work. The peak number of 1,550 had by March 1946 fallen to about 1,300 owing to the easing of the demand. The Government policy announced in Circular No. 221/45, December 1945, is to discourage mothers of children under two going out to work; to make provision for children between

[1] Provisional figures, Ministry of Health.

two and five in nursery schools and nursery classes, and to regard day nurseries and daily guardians as supplements to meet the needs of children whose mothers are obliged to work or whose home conditions are unsatisfactory. The great majority of the wartime nurseries in existence March 1946, have continued either as day nurseries, nursery schools or nursery classes. On December 31, 1947, there were 908 day nurseries in England and Wales with places for 43,405 children from 0–5 years old. They are administered by the Local Health Authorities and will continue so long as the need exists as part of the services under the National Health Service Act with the aid of the 50 per cent grant from the Exchequer.

To aid the export drive the Government has encouraged Local Authorities and mill owners in the cotton and wool industry to establish more nurseries to enable trained married women with young children to return to these industries. In the cotton areas Local Health Authorities have in hand about fifty schemes for new nurseries to accommodate about 2,000 children. There are also 62 mill nurseries open and about 45 more are in prospect. When all are in operation the total number of children cared for will be over 3,000. Local Authorities in the wool areas also have schemes for the establishment of more nurseries.

Young children are particularly susceptible to infectious disease. To ensure proper standards of staff and premises the Government have passed the Nurseries and Child Minders Regulation Act which provides for the registration and supervision of factory and private nurseries, and also of persons who, in their own homes, look after children under five for reward. The Local Health Authorities are responsible for the administration of the Act.

Dental Care.—The National Health Service Act places a specific duty on Local Health Authorities to make arrangements for the dental care of expectant and nursing mothers and young children securing for them a priority service of dental examination and, where necessary, treatment.

Vaccination against Smallpox and Immunization against Diphtheria.—Compulsory vaccination against smallpox did not achieve even a 50 per cent vaccination of babies born, whereas diphtheria immunization which is on a voluntary basis, accompanied by intensive education has achieved a remarkable success (cases have fallen from 50,797 in 1941 to 10,465 in 1947). The National Health Service Act therefore repealed the Vaccination Acts and the Local Health Authorities now have the responsibility of providing a service for smallpox vaccination and diphtheria immunization. The family doctor in the Health Service will take part in these services.

Training for nursery nurses.—A new system of training has been adopted whereby students undertake a two-year course (*a*) in practical

work in nurseries and (*b*) further education in vocational and general subjects, enabling them to sit for the examination for the certificate of the National Nursery Examination Board, established early in 1946. Successful girls are then qualified to take the post of nursery nurse in a day or residential nursery, or of nursery assistant (Class 1) in a nursery school or nursery class or to work in private households.

Maternal Mortality*

Deaths and rates per 1,000 live and stillbirths ascribed to—

(*a*) Pregnancy and childbearing, excluding abortion.
(*b*) Abortion (including criminal).

Year	Pregnancy and childbearing		Abortion	
	No. of deaths	Rate per 1,000 births	No. of deaths	Rate per 1,000 births
1931	2,258	3·43	448	0·68
1935	2,126	3·41	464	0·74
1945	1,028	1·47	234	0·33
1946	1,048	1·24	157	0·19

Infant Mortality Rate*

Deaths per 1,000 *Related Live Births*

1926	69·8	1945	46·0
1935	57·0	1946	42·9
1947	41·3†		

* Report of the Ministry of Health for the year ended March 31, 1947.
† Provisional figures Ministry of Health.

Scotland

From the Department of Health

Under the National Health Service (Scotland) Act, 1947, medical care by a general practitioner is available to mothers of young children as for others, through the general medical services and any necessary specialist and hospital treatment through the hospital organization. But provision is made in the Act for these facilities to be supplemented by arrangements made by local health authorities (County Councils

and Town Councils of large burghs) to meet the special need of mothers and young children.

Section 22 of the Act places on local health authorities the duty of making arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who are not attending a school under the management of an Education Authority and who have not attained, or are deemed under Section 33 of the Education (Scotland) Act, 1946, not to have attained, the age of five years. Section 23 (2) of the Act requires authorities to make adequate arrangements for the provision to women who are to be confined in their own homes and who apply for the service, the services of certified midwives before and during childbirth and from time to time thereafter during a period not less than the lying-in period. Other functions of local health authorities under the Act include the provision of health visiting, home nursing and domestic help services and these are available for mothers and young children as well as for others.

Local health authorities exercise their functions through their Medical Officer of Health who is assisted by a staff of Medical Officers of Health, Health Visitors, Midwives, etc. Except in thinly populated areas clinics are organized by the authorities for the supervision of expectant and nursing mothers and young children: where the provision of clinics cannot be justified reliance has to be placed on the health visiting and other domiciliary services.

Authorities are required to submit to the Secretary of State for approval their proposals for discharging their functions under the Act of 1947.

ILLEGITIMACY

Contribution by the National Council for the Unmarried Mother and Her Child (Inc.)

In England and Wales and Northern Ireland the mother of an illegitimate child is responsible for maintaining her child and, as a rule, its custody. The mother, or a local authority to which the child is chargeable, may take action in a Court of Law against the alleged father to secure a declaration of paternity and a contribution towards confinement expenses and maintenance of the child; the weekly maximum payment is twenty shillings. In Scotland the law is somewhat wider; the father as well as the mother has a direct obligation towards the child's maintenance, though the possibility of his obligation being enforced upon the father depends on the establishment of

paternity. There is no minimum nor maximum amount fixed by law for which the father is liable, the Court fixes the amount according to the individual circumstances.

Legitimation by the subsequent marriage of the parents to each other is permitted in England and Wales, Scotland and Northern Ireland, provided that no legal bar to marriage existed at the time of the child's birth, and satisfactory evidence of paternity can be given. The provisions of the Legitimacy Act, 1926, extend only to England and Wales, except in regard to paragraphs one and two of Clause Nine dealing with inheritance, which are extended to Scotland. After re-registration has been effected, a certificate of birth may be obtained which will not show that the parents were unmarried at the time of the birth and will not disclose the facts of the original registration. The Registration of Births (Scotland) Act, 1934, brings Scotland into line with England and Wales and Northern Ireland regarding the re-registration of a legitimated child and the issue of a new birth certificate.

Adoption of Children Acts have been passed for England and Wales, Scotland and Northern Ireland. Application for an adoption order is open only to a person or married couple resident and domiciled within the respective areas to which the Acts apply, and the child concerned must be a British subject. The Adoption of Children (Regulation) Act, 1939 (Commencement) Order, 1943, regulates the making of arrangements by adoption societies and other persons in connection with the adoption of children, and provides for the supervision of adopted children by welfare authorities in certain cases; restricts the making of payments for adoption of children and the publishing of advertisements in reference to adoption. This Act amends section two of the Adoption of Children Act, 1926, and section two of the Adoption of Children (Scotland) Act, 1930, but it is not extended to Northern Ireland.

In considering the problems of the unmarried mother and her child, the main trend of modern thought is to seek means by which separation of mother and child may be avoided and the child given a fair chance in life. The provision of special maternity homes and hostels where attention is paid to the natural feeding of the infant and to training in mothercraft is an important factor in the movement. In England and Wales the powers conferred on local authorities by the Maternity and Child Welfare Act, 1918, were transferred to the Public Health (London) Act, 1936, and the Public Health Act, 1936, and the Local Government Act, 1929, and are now incorporated in the National Health Service Act, 1946. These were applicable equally to married and unmarried mothers and to legitimate and illegitimate children. When the 1918 Act was passed, attention was drawn by the Local Government Board to the special needs of children who "lack the

support of a father," and to the advisability of keeping the mother and child together in such cases, especially during infancy. State grants became available towards the support of voluntary homes for expectant and nursing mothers and children up to five years of age. In 1943 the Ministry of Health published a circular No. 2866 addressed to Welfare Authorities (England) and to the London County Council, on the care of illegitimate children, urging that adequate provision should be made. In 1945 the Department of Health for Scotland published a similar circular on the care of illegitimate children and their mothers. The National Assistance Board as well as maternity and child welfare Committees may pay for the maintenance of individual mothers and children in voluntary homes as an alternative to their admission to public hospitals and institutions.

The National Insurance Act, 1946, is universally applicable, and an unmarried mother, if insured, is entitled to maternity grant, maternity allowance or attendance allowance and sickness benefit.

A particular problem which has been emphasized by war conditions is that of the unmarried mother who has a child by a member of Allied or Dominion forces. When such a man has returned to his own country there is no means, except through voluntary effort, of obtaining payment for the child, even though an affiliation order may have been secured while the man was in England. The National Council for the Unmarried Mother and her Child hopes that some reciprocal arrangement may be made between the various countries concerned to remedy this position.

LIVE BIRTHS*

Year	Total	Legitimate	Illegitimate	Illegitimate percentage of all births
		England and Wales		
1925	710,582	681,686	28,896	4·07
1935	598,756	573,651	25,105	4·19
1945	685,273	621,209	64,064	9·35
1946	820,268	766,560	53,708	6·55
		Scotland		
1925	104,137	97,306	6,831	6·55
1935	87,928	82,151	5,777	6·57
1945	86,932	79,478	7,454	8 6
1946	104,413	97,509	6,904	6 6

* Statistical Reviews of the Registrars-General for England and Wales and for Scotland.

DEATHS OF INFANTS UNDER ONE YEAR OF AGE

Year	Deaths per 1,000 of the total live births	Deaths per 1,000 legitimately born	Deaths per 1,000 illegitimately born
	England and Wales		
1925	75	72	136
*1935	57	56	90
1945	46	44	65
	Scotland		
1936	82	80	120
1945	56	53	88
1946	54	51	89

* From 1931 onwards Deaths per 1·000 related live births.

ABORTION

REPORT OF THE INTER-DEPARTMENTAL COMMITTEE, MINISTRY OF HEALTH AND HOME OFFICE. Appointed 1937. Reported 1939. Chairman: W. NORMAN BIRKETT, K.C. Fourteen members, including five women. Published by H.M. Stationery Office. Price 2s. 6d.

The Committee recommended repeal of Sections 58 and 59 of the Offences Against the Person Act, 1861, and replacement by an Act to cover new legislation and to bring all statutory provision *re* abortion within one Act.

Pars. 8 (i) Citizens should co-operate with the police in the enforcement of the law. Doctors should act upon the recommendation of the Royal College of Physicians and urge patients who have had criminal abortion to consent to having the matter reported to the police.

(ii) Magistrates should be authorized to issue search warrants to enable the police to search any house or other place suspected of being used in connection with offences under the law, and remove any articles of material evidence.

(iii) The words "any poison or other noxious thing" in Section 58 and 59 should be replaced by "any substance whatever."

(iv) A circular should be issued by the Home Office to Coroners calling their attention to the importance, when investigating death following abortion, to satisfy themselves that there has not been criminal interference.

Para. 9 (i). That certain drugs and medicaments be included in the Fourth Schedule to the Poisons Rules, and be sold only upon a prescription of a doctor, dentist or veterinary surgeon.

(ii) That advertisement of abortifacient drugs be suppressed by legislation on the lines of the relevant provision in the Medicines and Surgical Appliances (Advertisement) Bill of 1936.

(iii) That all members of medical and allied professions should emphasize the ineffectiveness and danger to health of such advertised remedies.

Para. 11. That the retail sale of sticks of slippery elm be prohibited.

Para. 12. That the Ministry of Health should suggest to local authorities that contraceptive advice be more widely disseminated by them within the framework of the present law.

Para. 13 The present law puts medical practitioners in an ill-defined position and should "be amended to make it unmistakably clear that a medical practitioner is acting legally, when in good faith he procures the abortion of a pregnant woman in circumstances which satisfy him that continuance of the pregnancy is likely to endanger her life or seriously to impair her health."

Safeguards suggested to prevent criminal abortion: except in urgent cases a second opinion, based upon a personal examination to be obtained (this would give statutory authority to the present common practice): notification of induced abortions signed by both doctors to the Medical Officer of Health of the Local Supervising Authority under the Midwives Act, within forty-eight hours.

Para. 14. The Committee is strongly opposed to any relaxation of the law designed to make social, economic and personal reasons a justification for the induction of abortion.

Para. 15. The Committee would welcome legislation for the termination of pregnancy resulting from rape, but does not support proposals that the induction of abortion should be specifically permitted in cases of girls under sixteen who have become pregnant, or in cases due to incest or when it is thought that the child may acquire a hereditary disease. "In any of these cases in which adequate medical reasons were present, however, there would be no question as to the legality of the induction of abortion."

Paras. 16 and 17. Summarize the reasons for not recommending notification of all abortions to some authority, and point out that compulsory notification of pregnancy would not affect the problem.

Paras. 18, 19 and 20. Recommend social and economic assistance to parents; better provision for childbirth; need for popular education

through doctors and social workers on the dangers of abortion, and reassurance as to the process of childbirth.

Paras. 21, 22 and 23. Local authorities should ensure that the facilities for ante-natal advice, treatment and institutional accommodation and facilities for skilled professional attention in cases of abortion are adequate. Facilities for carrying out pregnancy diagnosis tests should be made more generally available. A sufficient number of midwives should be available to attend cases of abortion which need skilful nursing.

Reservations on certain aspects were made by members of the Committee, and a Minority Report was presented by Mrs. Dorothy Thurtle.

CHILDREN ACT, 1948

Summary of Sections

The Act makes further provision for the care or welfare up to the age of eighteen, and in certain cases, for further periods, of boys and girls when they are without parents or have been lost or abandoned by, or are living away from their parents or when their parents are unfit or unable to take care of them, and in certain other circumstances.

Part I. It is the duty of Local Authorities to provide for orphans, deserted children, etc., appearing to be under the age of seventeen in their area, and to act as a fit person under the Children and Young Persons Act, 1933. They may assume parental rights by resolution.

Part II. The Authority must afford the child opportunity for the proper development of his character and abilities. They must provide accommodation and maintenance either by boarding-out or in a Home, which may be a voluntary one provided that facilities are given for the child to secure a religious upbringing appropriate to the persuasion to which he belongs. Instructions are given as to the type of Home according to the age of the child, and in some cases the length of stay. The Secretary of State may require a Local Authority to provide, equip and maintain homes either within or without their area for the accommodation of children in their care: the home shall include separate accommodation for the temporary reception of children with, in particular, facilities for observation of their physical and mental condition. The Secretary of State may make regulations for the conduct of the home, and also for the welfare of children boarded out by the Local Authority. With the consent of the Secretary of State the Local Authority may arrange for the emigration of a child. They may also

provide hostels for persons who are over compulsory school age but are not yet twenty-one, and who are or have at any time after ceasing to be of compulsory school age been in the care of a Local Authority, for their accommodation near where they may be employed, seeking employment or in receipt of education or training. Financial assistance may be given towards the expenses of maintenance, education or training of persons aged eighteen to twenty-one.

Part III. Contributions to Local Authorities authorized under the Children and Young Persons Act, 1933, and the Children and Young Persons (Scotland) Act, 1937, are extended to cover Section One of this Act. Parents are liable to make contributions in respect of a child up to the age of sixteen. A person who has attained the age of sixteen and is engaged in remunerative full-time work shall be liable to make contributions in respect of himself. A Local Authority who is caring for an illegitimate child may on certain conditions apply for an affiliation order if one has not been made, or for an affiliation order to be revived.

Part IV. After the end of 1948 no voluntary home shall be carried on, under penalty of a fine, unless registered by the Secretary of State. This registration may be cancelled if the Secretary of State considers the conduct of the home is unsatisfactory and the Local Authority may be asked to receive the children into their care. Regulations may be made by the Secretary of State as to the conduct of voluntary homes and as to the emigration of children therefrom.

Part V. The child life protection provisions now in force for those under nine who are maintained apart from their parents for reward, or who have been adopted, are now extended to include all such children up to the age of eighteen.

Part VI. The competent Local Authorities for the purposes of the Act are in England and Wales the Councils of Counties and County Boroughs and the London County Council; in Scotland the Councils of Counties and large Burghs. Each Local Authority, unless exempted by the Secretary of State, must appoint a Committee for the purposes of their functions, which in its turn may appoint sub-committees on which must serve at least one member of the Local Authority. A sub-committee may be appointed by the Children's Committees of two or more Authorities; each Authority having at least one member on the sub-committee. The Local Authority shall also appoint, in consultation with the Secretary of State a full-time officer to be known as the Children's Officer, with adequate staff. Local Authorities exercise their functions under the Secretary of State who shall nominate suitable individuals to serve on an Advisory Council on Child Care to advise him on matters connected with the discharge of his duties. He will appoint a Chairman and Secretary and is authorized to defray travelling, subsistence and other expenses. There will be a separate Council

for Scotland appointed by the Secretary of State for Scotland. The Secretary of State is also authorized to make grants to persons towards fees and expenses of training for employment under the Act, to bodies providing such courses; to voluntary organizations for improving premises or the equipment of voluntary homes. Grants are made to Local Authorities not exceeding 50 per cent of their expenditure for the purposes of the discharge of their functions other than expenses incurred as managers of an approved school, or in respect of children sent to an approved school or in respect of remand homes.

Part VII. Miscellaneous clauses, e.g. family allowances are not payable in respect of children where the rights and powers of the parents are vested in the Local Authority except for any period when the Local Authority allows the child to stay under the control of a parent, guardian, relative or friend. The places are listed into which Inspectors under the Acts appointed by the Secretary of State are allowed to enter to inspect the place and children therein. Local Authorities may be authorized by the Minister of Health or the Secretary of State for Scotland to purchase compulsorily any land for the purposes of any of their functions under the Act.

YOUTH ORGANIZATIONS

There are approximately 4,200,000 young people between the ages of 14 and 20 in the general population. A rough estimate of the numbers attached to some form of youth organization is one-third.

Twenty-two of the large youth organizations are members of the Standing Conference of National Juvenile Organizations, which was established in 1936 as a means of consultation on matters of common concern. In all there is a tendency for membership to increase.

Members of the Standing Conference are:—

The Boys' Brigade, Abbey House, Westminster, London, S.W.1.
Boy Scouts Association, 25, Buckingham Palace Road, London, S.W.1.
British Red Cross Society, Youth and Junior Departments, 15, Grosvenor Crescent, London, S.W.1.
Catholic Young Men's Society, C.Y.M.S. Office, Metropolitan Cathedral Buildings, 152, Brownlow Hill, Liverpool, 3.
The Church Lads' Brigade, 58, Gloucester Place, London, W.1.
Co-operative Youth Movement, Stanford Hall, Loughborough, Leicestershire.

The Girls' Friendly Society, Townsend House, Greycoat Place, London, S.W.1.
Girl Guides Association, 17–19, Buckingham Palace Road, London, S.W.1.
The Girls' Guildry, 212, Bath Street, Glasgow, C.2.
The Girls' Life Brigade, 8, Upper Belgrave Street, London, S.W.1.
The Grail, Field End House, Eastcote, Middlesex.
The Methodist Association of Youth Clubs, 2, Ludgate Circus House, London, E.C.4.
National Association of Boys' Clubs, 17, Bedford Square, London, W.C.1.
The National Association of Girls' Clubs and Mixed Clubs, 39, Devonshire Street, London, W.1.
The National Association of Training Corps for Girls, Alfred House, 24, Cromwell Place, South Kensington, S.W.7.
The National Federation of Young Farmers' Clubs, 55, Gower Street, London, W.C.1.
St. John Ambulance Brigade Cadets, 8, Grosvenor Crescent, London, S.W.1.
The Salvation Army (Youth Organizations), 1293–5, London Road, Norbury, London, S.W.16.
The Welsh League of Youth, Swyddfa'r Urdd, Aberystwyth.
Young Christian Workers, 106, Clapham Road, London, S.W.9.
Young Men's Christian Association, 112, Great Russell Street, London, W.C.1.
Young Women's Christian Association, Central Buildings, Great Russell Street, London, W.C.1.

JUVENILE DELINQUENCY

Juvenile delinquency comes within the jurisdiction of the Home Office and is dealt with in the Children's Department.

Prior to 1847 a child who came within reach of the law was dealt with in the same way as an adult. Then an Act was passed giving justices power to try children under 14 in the Summary Courts for simple larceny: this power was extended by the Act of 1879. The Children Act of 1908 provided that juveniles should have different treatment in Court from adults. The Guardianship of Infants Act, 1925, laid down the principle developed in the Children and Young Persons Act, 1933, that the paramount consideration of the Court was to be the welfare of the child. The Children and Young Persons Act, 1938, enlarged still further the powers of the Juvenile Courts.

Courts of Summary Jurisdiction which hear charges against children or young persons, are known as Juvenile Courts, and in whatever place sitting are deemed to be Petty Sessional Courts. Outside Metropolitan areas a panel of specially selected Justices has to be formed in every Petty Sessional Division. Under the rules the panel holds periodical meetings to discuss questions connected with the work of the Juvenile Court and to arrange the rota of Justices and each Juvenile Court must be constituted of not more than three Justices from the panel, and shall include one man, and so far as practicable, one woman. In Metropolitan Police Court areas each of the six Juvenile Courts is to be constituted either (*a*) of a Metropolitan police magistrate nominated by the Secretary of State to act as Chairman and two Justices of the Peace for the County of London, selected from a panel of Justices nominated from time to time by the Secretary of State, or (*b*) of three such Justices of the Peace, one of whom is nominated by the Secretary of State to act as a Chairman of Juvenile Courts, and of the members of the Juvenile Court one at least shall be a man and one at least a woman.

Juvenile Courts are to sit as often as may be necessary, either in a different building or room from that in which sittings of other Courts are held or on different days. No person may be present except (*a*) members and officers of the Court, (*b*) parties to the case before the Court, their solicitors and counsel, witnesses, and other persons directly concerned in the case, (*c*) *bona fide* representatives of newspapers or news agencies, (*d*) such other persons as the Court may authorize to be present. Unless the Secretary of State or the Court give dispensation no particulars calculated to lead to the identification of the child or young person concerned in the proceedings may be published in the Press.

The words "conviction and sentence" are not permitted to be used in connection with children and young persons dealt with summarily.[1]

All persons apparently under the age of seventeen are to be dealt with in a Juvenile Court but an Adult Court has jurisdiction to hear a charge if:—

(1) A juvenile is charged jointly with a person over seventeen.
(2) A juvenile is charged with an offence and an adult is charged with aiding and abetting.
(3) A juvenile is brought before an adult Court ignorant of his age.

No child under the age of eight can be guilty of any offence.

A child (i.e. under the age of fourteen) shall not be ordered to be imprisoned or be sent to penal servitude for any offence.

[1] For further details relating to the summary trial of children and young persons reference should be made to the Third Schedule of the Children and Young Persons Act, 1933, and to the Summary Jurisdiction Act, 1879

A young person (i.e. fourteen to seventeen) shall not be sent to penal servitude for any offence and shall not be imprisoned for any offence unless the Court certifies he is of so unruly a character that he cannot be detained in a Remand Home or of so depraved a character that he is not a fit person to be so detained.

Sentence of death shall not be pronounced or recorded against a person who was under the age of eighteen years at the time of committing the offence, but in lieu thereof the Court shall sentence him to be detained during His Majesty's pleasure in such place and under such conditions as the Secretary of State may direct.

The arrangements for dealing with those charged with offences and those in need of protection are closely assimilated. The new powers given to the Court by the 1933 Act provide for those who are not under proper guardianship, who are falling into bad association, or who are exposed to moral danger or are beyond control. It provides also for the victim of sexual offences and for those of the same household as the victims; for those of the same household who have been convicted of sexual offences against juveniles; for children found wandering or begging, and indeed for every class of case where protection may be needed.

The powers of the Court to deal with juvenile offenders are:—

To make an order under the Probation of Offenders Act.
To commit to the care of a "fit person."
To make an order for detention in an approved school.
To order the offender to pay a fine, damages or costs.
To order the parent to do this in place of an offender.
To order the parent to find surety for his good behaviour.
To commit him to a remand home for a month's detention.
To commit him to prison under a special certificate, if he is too unruly or depraved to be detained in a remand home.

In addition Juvenile Courts may decide that a charge against a young person between sixteen and seventeen is proved and send the case to Sessions with a view to a Borstal sentence, and such cases may go to prison for the waiting period.

When the Court has satisfied itself that a juvenile is in need of protection, it can:—

(1) Order him to be sent to an approved school.
(2) Commit him to the care of a "fit person," whether a relative or not, who is willing to undertake his charge.
(3) Commit him to the care of the Local Authority as a "fit person."
(4) Order his parent or guardian to enter into a recognizance to exercise his guardianship.

(5) Without making any other order, or in addition to committing to the care of a "fit person," or ordering the parent to exercise proper guardianship, make an order placing him under the supervision of a Probation Office or otherwise, for any period up to three years.

The Act of 1938 gives additional powers in cases of refractory children, and in case of non-compliance with school attendance orders.

The Local Authorities are required to provide remand homes for their areas; the homes are under the inspection of the Secretary of State, who in addition may make rules as to the classification, treatment, employment and control of children and young persons detained in custody there. Children and young persons who escape may be apprehended without warrant and brought back.

Approved schools, known formerly as Reformatory and Industrial Schools, were started on an entirely voluntary basis. Later, under the Reformatory Schools Act of 1854 and Industrial Schools Acts of 1854 (Scotland) and 1857 (England) they were brought under State certification and inspection, while remaining under voluntary management, the Courts being empowered to send delinquents to them. In 1876 the School Boards were given power to establish day industrial schools.

The present position, as defined in the Children and Young Persons Act, 1933, is that no child under the age of ten is sent to an approved school unless it is impossible to make suitable provision otherwise. Pupils may not be licensed within a year of the commencement of an order without the consent of the Secretary of State, except from special short-term schools. Orders are for three years or until the age of fifteen years and four months if this is longer, and if an order is made after sixteen it will expire at nineteen.

The Secretary of State may classify schools according to age, religion, character of the education given, or geographical position.

The broad classification by age for boys' schools is as follows:

Juniors for those under thirteen on admission.
Intermediate for those of thirteen and under fifteen.
Senior, for those from fifteen to seventeen.

For girls:

Junior up to fifteen years.
Senior, fifteen and under seventeen.

The re-classification of junior schools as primary and secondary is in progress.

A new development was the opening in 1943 of a classifying school at Aycliffe, near Darlington, to which the Courts in Northumberland,

Juvenile Delinquency: Numbers Found Guilty in Magistrate's Courts

	1944			1945			1946		
	Total	M	F	Total	M	F	Total	M	F
Indictable offences	40,121	36,727	3,394	42,823	39,601	3,222	36,356	33,539	2,817
Non-indictable offences	27,515	25,238	2,277	30,117	27,872	2,245	25,267	23,505	1,762
Disposal:									
Dismissed	18,435	17,114	1,321	21,271	19,837	1,434	17,483	16,351	1,132
Recognizance without probation order	3,670	3,386	284	3,897	3,627	270	2,613	2,434	179
Recognizance with probation order	19,715	17,743	1,972	19,495	17,776	1,719	16,539	15,066	1,473
Committal to Approved School	4,027	3,623	404	3,888	3,541	347	3,551	3,305	246
Care of fit person	222	117	45	222	174	48	255	214	41
Committed to custody in Remand Home	468	459	9	525	512	13	518	508	10
Fine	20,252	18,736	1,516	22,769	21,290	1,479	20,002	18,574	1,428
Whipping	31	31	—	21	21	—	9	9	—
Sent to institution for defectives	113	102	11	115	97	18	79	73	6
Otherwise disposed of	703	594	109	737	598	139	574	510	64

Yorkshire and Durham have been asked to commit direct. Normally a boy stays at Aycliffe for classifying for about two or three months and is then transferred to the most suitable of the other schools in the three counties. Two classifying schools for girls were opened in 1944 and further classifying schools will be opened in the near future.

Young persons who escape from an approved school may be apprehended without warrant and brought before a Court of Summary Jurisdiction, which may order him or her, if under sixteen years of age, to be sent back and his period of detention increased by a period not exceeding six months, or if over sixteen, either have his period of detention so increased or be sent to a Borstal Institution for two years.

The first experiment for the complete separation of young prisoners from adults in order to give them specialized training was made in 1902 at the Borstal Prison near Rochester. The experiment was followed by the Prevention of Crime Act, 1908, which authorized the establishment of Borstal Institutions for the training of offenders between sixteen and twenty-one (now twenty-three) who "by reason of criminal habits or tendencies or associations with persons of bad character" appear to be in need of such discipline. Additional powers were given to Courts of Summary Jurisdiction by the Criminal Justice Act of 1914. Borstal training lasts for a minimum of two and a maximum of three years. In either case a year's supervision follows the expiration of the terms. A licence can, however, be granted any time after six months to a lad and after three months to a girl, and this licence covers the year under supervision as well as the unexpired part of the sentence. The licence may be revoked at any time for a fresh offence or unsatisfactory conduct. There are now seven Borstal Institutions of which one is for girls.

Every inmate of a Borstal Institution is licensed to the care of the Borstal Association, which then becomes responsible for his supervision during the currency of the licence. It makes arrangements for his future well in advance of his discharge.

Note.—As it will be some little time before many of the provisions of the Criminal Justice Act, 1948, become operative, only those which came into force by September 13, 1948, have been noted.

PROBATION

Probation comes within the jurisdiction of the Home Office, where a special Probation Branch has been set up. A Probation Advisory Committee has been constituted and a Training Board formed. The selection of officers is made by Committees composed of members of the Training Board supplemented by members of the Advisory Committee. Age for entrants to the service is 23–40, and from December 1,

1946, a revised scale for salaries came into force. Men, £305 at age 23, rising by varying annual increments to £570; women, £290 at age 23, rising by varying annual increments to £460.

The Probation of Offenders Act, 1907, with its amendments, is the statute under which the system of probation is at present administered in England and Wales. Scotland has separate legislation which follows very closely the provisions of the English statutes. The Act of 1925 required that the services of one or more probation officers should be available for every Petty Sessional Court. There are 1,026 Petty Sessional Divisions in England and Wales, most of which, by statutory powers given to them, have now become combined Probation Areas. At October 1947 the number of probation officers was 1,041, of whom 798 were full-time (534 men, 264 women), 23 temporary (8 men, 15 women), and 220 part-time (94 men, 126 women).

THE PROBATION SERVICE

by S. C. F. FARMER

Chairman, National Association of Probation Officers

For some years before the war the Probation Service in Great Britain was developing rapidly. A considerable impetus to this development had been given by the report of the Committee on Social Services in Courts of Summary Jurisdiction, published in 1935, and by the legislation which either imposed new duties upon the probation officers or gave official recognition to those which they had in fact already been undertaking.

There was increasing use by the Courts of probation as a method of treatment of offenders, whether juvenile or adult; the use of probation officers to supervise children and young persons brought before the Juvenile Courts as "in need of care or protection" or "beyond control" and made the subject of Supervision Orders (analogous to Probation Orders in the case of delinquents) under the Children and Young Persons Acts of 1933 and 1938. More use was being made of probation officers in undertaking social enquiries and reporting to the Courts upon the circumstances and background of offenders and children and young persons otherwise before the Courts, so as to provide information to assist the Court in deciding on the correct disposal of a case. The Summary Procedure (Domestic Proceedings) Act of 1937 gave statutory recognition to the employment of probation officers as conciliators in matrimonial cases (duties which

had in fact for many years formed a large part of the work of the service), and in addition made certain provisions for their help in investigating the means of the parties to enable the Court to make a fair apportionment in the event of a maintenance order. There was also the Money Payments Act, 1935, with its provision for supervision of persons adjudged to pay sums of money by a Court of Summary Jurisdiction.

Parallel with this tendency to widen the functions of the Probation Service were measures to develop the service itself. The Home Office training scheme was supplying an increasing proportion of the new entrants to the service, and there were continued efforts to improve methods of selection and to raise the standard of technical qualifications of probation officers without losing sight of the essential personal qualities.

The original system of individual appointments of probation officers by single Courts had largely given place to the organization of such Courts into "combined areas" and large single areas, in which the work of a number of officers can be co-ordinated, often under the guidance of Principal or Senior Probation Officers. One effect of this was the appointment of a far greater proportion of full-time instead of part-time probation officers.

The war, of course, brought its own problems, but the development of the Probation Service continued in spite of the inevitable limitations. It is hardly necessary to enlarge upon the increase in juvenile delinquency—which was in some part offset by a reduction in the number of adults on probation. This and the great increase in the number of 'domestic' cases caused by the disruption of home and social life imposed heavy new burdens on the service. These were not by any means accounted for by cases coming before the Courts. A great deal of work was undertaken in the direction of giving voluntary advice, supervision and help with children (evacuees and others) who were giving difficulty or were in difficulties without having come before the Courts. Similarly, the probation officer's help as a conciliator in matrimonial disputes continued to be sought in a very large proportion of cases which never became the subject of proceedings before the Courts. In this connection special reference should be made to the co-operation of the Probation Service with the Army Welfare Authorities in assisting with the domestic problems of men and women in the forces.

The post-war picture is one of further changes in the work to be done, as well as the hope of new developments in the methods of doing it and in legal and administrative machinery. As might have been expected, the numbers of juvenile delinquents are showing a decline, and according to some observers there are hopes of a stabilization, if not yet a substantial reduction, in the number of matrimonial

problems. On the other hand, the need is recognized for still further improvement of the services rendered in the existing fields, together with some extension to other kindred fields of service. An example of this is the need, expressed by the Denning Committee, for a Court Welfare Service in the Divorce Courts, which have no means for offering help in conciliation such as is enjoyed by the Magistrates' Courts dealing with domestic proceedings. In relation to probation work itself, the implementation of the Criminal Justice Act, 1948, should facilitate improvements in the use of probation and such forms of treatment as can be used in combination with it (as well as enlarging the other resources available to the Courts for the reformation or restraint of offenders). The Act explicitly recognizes the need for ensuring that adequate information about the offender, his background, circumstances and potentialities can be considered by the Court, which may thereby be assisted in selecting the most suitable sentence or treatment for him.

The duties of a probation officer have not all been mentioned above, nor can their limits be too closely defined Whatever developments occur, affecting the position of the probation officer as the Court's officer charged with the care of persons placed on probation, as its source of information on the personal and social problems coming before it, as 'conciliator' in those marriage and family troubles so intimately bound up with many of the other problems, it may be hoped that in future, as in the past, full scope will be given to the conception of the probation officer as a social worker attached to the Court, available to give personal help as opportunity offers to all whose troubles have brought them within the purview of the Court.

OLD PEOPLE

OLD PEOPLE. Report of a Survey Committee on the Problems of Ageing and the Care of Old People. Appointed by the Trustees of the Nuffield Foundation. Chairman: MR. B. SEEBOHM ROWNTREE. Reported October 1946. Published by the Oxford University Press. Price 3s. 6d.

The Committee state that unless the able-bodied among the old people continue to work after they reach pensionable age the burden of maintaining the aged may become so great as to result in a lowering of the national standard of living. It is estimated that by 1989 the number of persons of pensionable age will equal the number of children, while, by the same year, the number of persons of working age will be approximately three million less.

POPULATION OF ENGLAND AND WALES BY THREE MAIN GROUPS AT QUINQUENNIAL INTERVALS*

(*Thousands*)

Year	Age under 15		Working age, men 15–64, women 15–59		Pensionable age, men 65 and over, women 60 and over		Total population
	Number	Per cent	Number	Per cent	Number	Per cent	Number
1944	8,671	(20·5)	28,382	(66·9)	5,396	(12·6)	42,449
1949	8,967	(20·8)	28,266	(65·7)	5,795	(13·5)	43,028
1954	9,086	(21·0)	28,080	(64·9)	6,143	(14·1)	43,309
1959	8,892	(20·5)	27,962	(64·6)	6,466	(14·9)	43,320
1964	8,440	(19 6)	27,894	(64·6)	6,811	(15·8)	43,145
1969	8,162	(19·0)	27,387	(63·9)	7,335	(17·1)	42,884
1974	8,081	(19·0)	26,692	(62·7)	7,804	(18 3)	42,577
1979	8,087	(19·2)	26,150	(62·0)	7,902	(18·8)	42,139
1984	8,043	(19·4)	25,547	(61·5)	7,944	(19·1)	41,534
1989	7,886	(19·3)	25,071	(61·5)	7,848	(19·2)	40,805
1994	7,679	(19·2)	24,872	(62·0)	7,504	(18·8)	40,055

* These figures are based on three assumptions:

Mortality.—That this falls gradually from the England and Wales 1938–39 rates to rates equal to the best recorded before 1941 in New Zealand, the latter assumed to be in operation from 1969 to 2004.

Fertility.—That the fertility of married and unmarried women at each age remains constant throughout the period at rates equal to those recorded for married and unmarried women respectively in England and Wales on the average of 1938 and 1939.

Marriage.—That the marriage rates of women at various ages remain constant at 1938 levels from 1944 onwards.

The Committee suggested that when the national house-building programme is completed about 5 per cent of all houses should be suited to, and available for, the aged; that it would be a useful sphere of activity for any organization with funds at its disposal to undertake the repair and modernization of almshouses on a nation-wide scale; that an *ad hoc* body should be appointed by the Government to undertake a comprehensive review of all endowed charities which exist for the benefit of old people; that sufficient homes, each for thirty or thirty-five residents, should be provided by local authorities and voluntary agencies to accommodate substantially all the old people now living in institutions, and those seeking accommodation; that in the homes some rooms should be better fitted and let at higher prices to those who have some private means but cannot afford to pay the normal fees of a nursing home; that better provision should be made for the care of the long-term sick; that a centre should be opened in which the best methods of caring for different categories of aged persons

could be sought for and demonstrated, and training given to those wishing to specialize in the care of the aged; that the number of clubs, particularly for old men, should be greatly increased; that, seeing the high therapeutic value of occupation in delaying the development of the effects of ageing, employers who now insist on a compulsory retiring age of 65 or under should reconsider the matter; that there is need for systematic enquiry into all matters affecting the aged; that consideration should be given to setting up a new central body to study changing conditions and needs, to undertake or stimulate research, to advise on and where necessary to co-ordinate and support the activities of local authorities and voluntary organizations; that the Foundation should discuss with the various organizations possible extension of their work (paras. 259–279).

The Medical Sub-Committee (Chairman, Dr T. S. Parkes), appointed to consider directions in which research into the process of ageing might be conducted, classified the main problems, and recommended that the work should be carried out through research units, the establishment of fellowships, the provision of grants, with a co-ordinating body, rather than any attempt at centralization (pp. 107–109).

In July 1947 the Nuffield Foundation announced that, with the co-operation of the Lord Mayor of London's National Air-Raid Distress Fund, it was sponsoring a National Corporation for the Care of Old People, and had undertaken to provide £500,000 in the early years. The Lord Mayor's Fund earmarked a substantial sum for the help of old people who had suffered distress from air raids. The governing body represents both bodies equally, and there is an expert advisory council to suggest policy, recommend activities and examine applications. The Corporation, incorporated on August 1, 1947, works through local authorities and national voluntary bodies, and is not able to assist individuals direct. Office address is 9, Mecklenburgh Square, London, W.C.1.

BLIND PERSONS

(Prepared by the National Institute for the Blind)

GREAT BRITAIN

Under the National Assistance Act, 1948, the welfare of the blind has been integrated with the general scheme for the welfare of all handicapped persons. The provision of financial aid to those whose needs are not covered by national insurance is no longer the duty of

Local Authorities as it was under the Blind Persons Act, 1920, now repealed. It is administered directly by the National Assistance Board through its local offices. The scale of relief for a blind person is 15s. a week more than that for sighted applicants in view of the extra expenses incurred by blind people. The Old Age Pension for which blind people become eligible at the age of 40 remains.

Local Authorities still have responsibility for registration and general welfare of the blind. They carry out their functions either directly through their Welfare Committees or by delegation to voluntary associations registered with them. Local education authorities are responsible for the education of children of school age and in general for their training up to the age of 21. Thereafter training and employment are the responsibility of the Ministry of Labour under the Disabled Persons Employment Act, 1944.

Certain special concessions are made to the blind. There are special postal rates for Braille literature, and, in some areas, blind persons accompanied by a guide pay one fare for two passengers. Free wireless licences are granted and owners of guide dogs are exempt from buying a dog licence.

Local voluntary associations supplement the work of local authorities by the provision of recreational and other amenities. National voluntary bodies provide facilities which could not economically be provided by local action. The National Institute for the Blind publishes Braille literature of all kinds, maintains Sunshine Nursery Schools for children up to the age of 7 and other special schools and homes, including rehabilitation Homes of Recovery for the newly-blind. Its School of Physiotherapy trains an increasing number of blind students and its employment section is rapidly expanding its work of placing blind men and women in unsheltered industry. The National Library for the Blind loans books in Braille to readers in Great Britain and overseas, while the "British Wireless for the Blind Fund" provides free wireless sets to those unable to afford them. St. Dunstan's cares exclusively for men and women blinded on war service.

Considerable developments have taken place in the field of prevention in the last few years. A Department of Ophthalmology has been established in the University of Oxford, a Chair of Ophthalmology at the Royal Eye Hospital in London, and a Research Centre at Birmingham.

The increase in the number of registered blind persons is indicative of more effective registration rather than of an increase in the incidence of blindness. The total number of registered blind over 70 has, however, increased, but as the proportion of old persons in the population is increasing, a corresponding rise in the number of elderly blind is to be expected.

There has been a steady decline in the number of cases in which

REGISTER OF THE BLIND, ENGLAND AND WALES

Year	0–1	1–5	5–16	16–21	21–40	40–50	50–70	Over 70	Unknown	All ages
1927	258		2,554	1,670	7,636	5,331	17,232	11,958	183	46,822
1936	10	196	1,855	1,391	8,146	6,983	26,455	22,369	129	67,534
1947	12	176	1,338	1,062	7,395	6,705	26,340	32,852	124	76,004

blindness occurred in infancy. Since notification of ophthalmia neonatorum became compulsory in 1915, the incidence of blindness as a result of this disease has markedly decreased In 1921, 49·2 per cent of the babies in the National Institute for the Blind's Sunshine Homes owed their loss of sight to this disease· by 1943 the figure had dropped to 11 per cent. Infant blindness due to other infective causes has also greatly decreased, largely owing to the improved technique of therapy.

SCOTLAND

The number of certified blind as at April 1, 1948, was 8,632, *classified under the following age groups:*

	0–2	3–4	5–15	16–17	18–29	30–39	40–49	50–69	70 & over	Total
Male ·	4	7	69	17	240	353	536	1,698	1,451	4,375
Female	2	5	70	16	150	237	413	1,475	1,889	4,257
	6	12	139	33	390	590	949	3,173	3,340	8,632

This figure shows a slight but progressive decline in the total number of blind people in the last few years.

THE CARE OF THE DEAF

by G. W. LILBURN

Secretary, The National Institute for the Deaf

Until 1948, no legislation specifically applied to the deaf except the Education Acts of 1893 to 1937. Under the Education Act of 1944 the deaf receive similar benefits but are classed under the heading of handicapped children. The position of parents anxious for the education of their child from the age of two years is somewhat strengthened and the school-leaving age can be extended from 16 to 19 years. The

obligation of local education authorities remains, in that it is the duty of local authorities to provide suitable education for children who are too deaf to be taught in a class of hearing children in an elementary school. Under the new Act, all schools will provide secondary education for suitable children from the age of eleven years, and all deaf persons will be eligible to share in the County Colleges Scheme.

The welfare of the born deaf after school age is still the concern of some 60 local voluntary societies, variously termed associations, missions, institutions, etc. These voluntary societies provide, as far as their limited means permit, for the spiritual, social and industrial needs of the born deaf. Under the Disabled Persons (Employment) Act of 1944 provision is made for the placing of all employable deaf persons in employment for which they have the training and qualifications and for the training of deaf persons in other suitable employment. The local societies, whose officers have a wide experience of this work, are co-operating with the Ministry of Labour and National Service in carrying out this provision. The deaf are eligible for training in the Ministry's training centres, but no special provisions of this kind exist for the deaf.

The needs of the partially deaf and hard-of-hearing, for whom no special provisions exist apart from the special educational facilities referred to above, have been met to some extent by the provision, where possible, with the co-operation of hospitals, local authorities, and individuals, of deafness clinics, lip-reading classes and leagues and social clubs. In many parts of the British Isles it is now possible for a deafened person to attend a deafness clinic, receive medical advice on his deafness, a test of hearing and advice on and prescription of a suitable hearing-aid. Local authorities and bodies have set up classes in lip-reading under qualified teachers where possible and leagues and clubs for social purposes are springing up all over the country.

All these local organizations are co-operating with and being assisted by the National Institute for the Deaf either directly or through their own particular national bodies.

Under the new National Health Services Act, which came into operation in July 1948, the deaf and hard of hearing are entitled to exactly the same benefits as everyone else. In addition, those who can benefit by the use of a hearing-aid will get the extra advantage of one of these instruments supplied free, with free maintenance and service. The deaf are entitled to all the general provisions of the free medical service and any specialist advice and treatment which their disability needs. Under the National Assistance and National Insurance Acts the deaf will benefit in the same way as hearing people, but under the National Assistance Act the local authorities have power to provide or assist in the provision of the services now being afforded on a voluntary basis for the deaf and hard-of-hearing.

MENTAL ILLNESS

ENGLAND AND WALES

(From the National Association for Mental Health)

The term "lunatic" is by statute obsolete (Mental Treatment Act, 1930, and Criminal Justice Act, 1948). The expressions "person of unsound mind" and "mental illness" are commonly used. Mental patients are classed as follows:

(1) Certified patients—under the provisions of the Lunacy Act, 1890, and Amending Acts. Two medical certificates, a petition and the order of a judicial authority are required for the certification of a private patient. In the case of a rate-aided patient, one medical certificate, a statement of particulars, and a Justice's order are required.

(2) Uncertified—under the terms of the Mental Treatment Act, 1930:

   (*a*) Voluntary—received on their own written application.

   (*b*) Temporary—received on medical recommendations, one of which must be given by a doctor specially approved by the Board of Control to make such recommendation and at relatives' request.

All three classes are treated in county, borough, and registered mental hospitals, licensed houses, and single care, whilst the voluntary and temporary classes are also receivable in "approved" hospitals and homes. If the patient has sufficient income, treatment may be paid for out of his own estate, and in some cases on the appointment of a receiver.

The class of "rate-aided patients" ceased to exist when the National Health Service Act (1946) came into operation in July 1948 as the Act provides for the free treatment of patients suffering from mental as well as physical illness, in mental hospitals under the regional hospital boards. These boards will also be responsible for the provision and maintenance of mental treatment clinics.

Section 28 of the Act gives power to local health authorities to provide community and after-care for persons suffering from mental as well as physical illness. They are also required to appoint officers to take initial proceedings in providing care and treatment for mental patients.

Scotland

The legal requirements for admission into Royal Mental Asylums and District Asylums are:

(*a*) A petition to the Sheriff of the County by the responsible relative or guardian in the case of private patients, or by the Director of Public Assistance of the parish for other patients.
(*b*) A statement of particulars signed by the petitioner.
(*c*) Two medical certificates of insanity.
(*d*) A judicial order made by the Sheriff of the county

Patients whose mental condition is not such as to make certification imperative may be admitted to asylums as voluntary boarders after making a written application to, and obtaining the consent of, the Commissioners of the General Board of Control, Edinburgh.

Patients suffering from unconfirmed mental malady may be received for a period of six months in private houses upon a medical statement without certification.

A system of boarding-out in farms and private houses of chronic and harmless patients is prevalent in Scotland. Nearly all have been under institutional care. They are mostly able to look after themselves and often give considerable assistance to their guardians. Patients are subject to regular visitation by the Commissioners of the Board of Control, Public Assistance Officers, lay and medical members of local authorities.

Provision has been made in most of the large cities for treatment in special wards of parish hospitals of patients suffering from symptoms of mild or incipient mental disorder, without certification, for a period of six months.

Number of Notified Persons Under Treatment

At January 1st	England and Wales	Scotland
1925	131,551	18,349
1935	152,089	19,685
1945	127,285	18,144
1946	127,386	17,986
1947	146,444	17,745

MENTAL DEFECTIVES

ENGLAND AND WALES

(Prepared by the National Association for Mental Health)

Mental defectives are defined in the Mental Deficiency Acts, 1913–27, under four headings: Idiots, Imbeciles, Feeble-minded, and Moral Defectives.

In accordance with the provisions of the National Health Service Act, 1946, the Mental Deficiency Acts will be administered centrally by the Ministry of Health (Mental Health Services Division), with the board of Control acting in a quasi-judicial capacity. Local authorities under the Act are the newly appointed Health Committees of County and County Borough Councils who will usually establish a Mental Health Services sub-committee. As the provision of certified institutions will become the responsibility of Regional Hospital Boards, the duties of local authorities in regard to mental deficiency are limited to the following:

(1) The ascertainment of all those defectives who, in addition to being certifiable within the definitions of the Acts, are either neglected or whose parents wish them to be trained; or who are notified by the Local Education Authority as being ineducable or in need of care and supervision after leaving school; or who have been found guilty of any criminal offence; or, in the case of defective women who have given birth to illegitimate children whilst in a Public Assistance Institution.
(2) The provision of suitable supervision of defectives in their own homes, and the taking of steps to secure their removal to institutional care or guardianship when necessary.
(3) The provision of training (e.g in an Occupation Centre) or occupation for defectives not in institutions.

Defectives may be dealt with by being
(*a*) placed under the supervision of social workers in their own homes, or, if this control is not adequate,
(*b*) placed under orders and sent to institutions or boarded out under guardianship.

An order is made by a justice of the peace, on a petition presented by the local authority, accompanied by two medical certificates.

Orders are made in the first place for one year; renewed for a further year; after that at intervals of five years Defectives under Order can be compulsorily-detained. If an Order lapses, or is not

renewed, the defective is discharged. Defectives may be discharged at any moment by the Commissioners of the Board of Control.

The total number of mental defectives known to local authorities on January 1, 1947, was 133,967, of which 4,209 were children notified by Local Education Authorities. These figures give a ratio of 2·46 per thousand population which is considerably less than that given by the Wood Committee, i.e. 4·52 per thousand. This discrepancy is to be explained by failure in many areas to ascertain the full number of mental defectives.

Under the Education Act, 1944, mentally defective children leaving *any* school can now be reported by Education Authorities to Mental Deficiency Authorities, and thus a limitation which in the past has so greatly hampered the working of the Mental Deficiency Acts no longer exists

The total number of defectives under some form of statutory care on January 1, 1947, was 101,805. Of these 53,361 were in Institutions.

SCOTLAND

(Prepared by the Scottish Office)

Generally similar provisions are in force in Scotland under the Mental Deficiency and Lunacy (Scotland) Act, 1913. The central authority under the Act is the General Board of Control for Scotland, and the local authorities are now the County Councils and Town Councils of large burghs. The Act provides for ascertainment of Defectives, the provision of Institutions, and payment for Defectives under guardianship, by the Local Authorities. Defectives may, upon certification by two medical practitioners, one of whom must be "approved" for the purpose, be placed in an Institution or under guardianship, either by the parent or guardian or by the Local Authority, with consent of the parent or guardian, or by order of the Sheriff. Defectives may be discharged at any time by the Board.

NUMBER OF MENTALLY DEFECTIVE PERSONS NOTIFIED UNDER THE MENTAL DEFICIENCY ACT, 1913

At January 1st	England and Wales	Scotland
1925	32,141	2,452
1935	82,740	4,275
1945	99,507	5,966
1946	99,767	6,022
1947	102,073	6,036

REPORT OF THE DEPARTMENTAL COMMITTEE ON STERILIZATION

Appointed by the Board of Control with the approval of the Minister of Health. Chairman: Mr. L. G. BROCK, C.B. Reported December 1933. Published by H.M. Stationery Office. Price 2s.

The principal recommendations of the Committee were

"(i) Subject to the safeguards proposed, voluntary sterilization should be legalized in the case of:

(*a*) A person who is mentally defective or who has suffered from mental disorder (paras. 70 and 71);
(*b*) A person who suffers from, or is believed to be a carrier of, a grave physical disability which has been shown to be transmissible (para. 72); and
(*c*) A person who is believed to be likely to transmit mental disorder or defect (paras. 73 and 74).

(ii) Before sterilization is sanctioned in the case of a mental defective, care should be taken to test his or her fitness for community care (para. 65).

(iii) Mental defectives who have been sterilized should receive the supervision which their mental condition requires (para. 59).

(iv) The operation of sterilization should only be performed under the written authorization of the Minister of Health."

The procedure to be applied was indicated by the Committee.

Other recommendations dealt with the type of operation; protection for doctors; and the cost in the case of persons unable to pay in full.

TUBERCULOSIS

ENGLAND AND WALES[1]

Powers for the treatment of tuberculous patients and after-care were based on the Public Health Act, 1936, clauses 171 and 173, which laid on county and county borough councils the duty of making adequate arrangements for treatment at or in dispensaries, sanatoria,

[1] With acknowledgment to the National Association for the Prevention of Tuberculosis.

and other institutions approved by the Minister. In addition a county council or local authority could make such arrangements as they thought desirable for the treatment of tuberculosis and for the after-care of persons who have suffered from it.

Sections 219–23 of the Public Health (London) Act, 1936, formerly regulated the position as regards arrangements for treatment and after-care of the tuberculous in London.

Under the National Health Service Act, 1946, the great majority of of tuberculosis hospitals and sanatoria pass under the control of the Minister of Health and will be administered by fourteen Regional Hospital Boards. Dispensaries remain under the control of local health authorities. Under Section 28 and the Consequential Amendments in the Tenth Schedule relating to the Public Health Act, 1936, and the powers of local health authorities, arrangements will be made by these authorities for the prevention of illness, care and after-care of persons suffering from illness or mental defection, and the authorities may contribute to any voluntary organization formed for this purpose. Care work for the first time, therefore, becomes a statutory obligation.

The main features of the national scheme are still those based on the findings of a Departmental Committee, 1912–14:—

(1) *The Tuberculous Dispensary.*—To act as a receiving house and centre for diagnosis; a clearing house and centre for observation; a centre for curative treatment, for examination of 'contacts' and for care and after-care; an information bureau and educational centre.

(2) *The Sanatorium.*—For prolonged treatment in which, in addition to medical and surgical procedures, rest, open air and light figure prominently.

(3) *The Tuberculosis Hospital.*—For those whose disease is in a more advanced stage.

(4) *The Open-Air School.*—For delicate children and those from households in which there is an active case of the disease.

(5) *The Working Colony.*—For patients requiring prolonged treatment and yet capable of useful work.

(6) *The Village Settlement.*—An institution where various industries are run by tuberculous persons under medical supervision. The workers live with their families in the village.

(7) *The Care Committee.*—Tries to combat the social consequences of the disease. There are now over 200 throughout the country, of which 151 are affiliated to the national organization, the National Association for the Prevention of Tuberculosis. Though the number is increasing, there are never enough to deal with the volume of care work needed

Notification.—When tuberculosis is discovered, the patient is notified to the Medical Officer of Health. The proportion of notified cases

awaiting treatment in hospital or sanatoria has never been greater than to-day. They number 7,000 to 8,000, and the waiting lists are from three to twelve months long. Shortages of nursing and domestic staff have resulted in some 4,000 beds being closed down. Care in the home is therefore of primary importance.

Mass Radiography.—It is too early to estimate the advantage of this aid to diagnosis, but it is undoubtedly of value. Some thirty-three units are now operating in the British Isles, and the number examined represents two million of the population Out of every 100 presumably healthy people examined, seven or eight may have to return for a large-size X-ray film and clinical examination; of these less than one will probably be found to have pulmonary tuberculosis.

Treatment Allowances (formerly Ministry of Health Allowances Scheme 266/T).—This scheme has now been replaced by the National Assistance Allowances by regulations made by the Ministry of National Insurance under Section 5 of the National Assistance Act which enables tuberculous persons in need and those who have suffered a loss of income in order to undergo treatment for tuberculosis of the respiratory system to claim National Assistance Allowances. These are payable through the Post Office, the necessary form being completed by patients at the Chest Clinic and forwarded to the Area Officers of the National Assistance Board with any necessary special recommendations. The allowances are to facilitate treatment and a return to work; it is now for the first time possible to say that practically every tuberculous person if in need can be assisted.

Rehabilitation Schemes.—Sufferers from pulmonary tuberculosis form a substantial proportion of the total disabled population. The Disabled Persons' Employment Act, 1944, gives advantages in schemes of training and resettlement in employment to anyone who has suffered by injury or disablement from birth or accident. A tuberculous person is disabled within the meaning of the Act. There were in August 1948 about 40,000 tuberculous patients who had voluntarily registered from a total of approximately 900,000 registered disabled. The Ministry's officers can now go into institutions and advise patients about registration and future employment, and there is a new follow-up scheme for keeping in touch with disabled persons in collaboration with the doctors.

Under Section 28 of the National Health Services Act it is the function of Local Health Authorities "to assist tuberculous persons in their resettlement in suitable employment and their welfare." It is hoped that these Authorities and others interested in the welfare of the tuberculous, e.g voluntary Case Committees will plan home industries and other welfare facilities and employment schemes for the more severely handicapped, particularly as the factories set up by the Disabled Persons Corporation cannot cover all needs of the homebound.

Sheltered Employment.—The six village settlements in England and Wales—e g. Papworth—make a valuable contribution, but far more sheltered employment in industry generally is needed. The Disabled Persons' Corporation was set up in 1945 to provide this, not only through existing organizations but by building new factories. The target was over fifty factories by the spring of 1946, but shortages of building material and labour have brought the programme down to a very slow rate; it is feared that not more than two or three, each employing 200 or 300, are being devoted to tuberculous patients.

Waiting periods for training schemes are much too long, and rapid extension of these facilities is required.

Psychological Factors.—It is now recognized that psychological factors are of great importance in the national health. A survey into the psychology of tuberculosis is being conducted by the N.A.P.T. The personality and aptitude tests tried out in the Services are being extended to industry. Careful analyses are being made, not only to fit the man to the job, but also to fit the job to the man, whatever his disablement.

Environmental Factors.—No one has yet estimated how far the lack of nutrition, housing and hygiene contributes to the breakdown which is the prelude to the onset of tuberculosis. In view of the number of new cases coming into the dispensaries annually, approximately 10,000, great improvements in these directions are called for.

New Drugs.—Recently much talk has been heard of the expectation of new drugs and living moulds, e.g. penicillin, to exterminate the bacillus, but even if the discovery should be imminent experts know that the well-tried methods of treatment based on rest, fresh air and nutrition will have to continue for many years to come.

Plans are being made by the Ministry of Health to manufacture B.C.G. in this country for vaccination against tuberculosis, but in the meantime supplies are being imported from France and Scandinavia. For the moment B.C.G. is most useful in giving additional clinical control with infants and young children, school leavers and adolescents, nurses and medical students and adults who are specially liable to tuberculous infection such as a daughter who is home-nursing a tuberculous mother.

SCOTLAND

(From the Department of Health)

The clinical treatment of persons suffering from tuberculosis is undertaken by Regional Hospital Boards as part of their responsibilities for hospital and specialist services under the National Health Service (Scotland) Act, 1947.

ENGLAND AND WALES: FORMAL NOTIFICATIONS OF TUBERCULOSIS AND DEATHS FROM TUBERCULOSIS NOT NOTIFIED BEFORE DEATH, EXCLUDING TRANSFERS BETWEEN AREAS AND DUPLICATE NOTIFICATIONS

	Formal notifications			Deaths of tuberculous persons not notified before death
	Males	Females	Persons	Persons
1925	40,024	35,204	75,228	Not available
1935	28,117	23,953	52,970	3,572
1943	30,121	24,221	54,342	3,780
1945	29,124	22,986	52,110	3,603
1946	29,003	22,286	51,289	3,580

SCOTLAND: NEW CASES OF TUBERCULOSIS

	Pulmonary	Non-pulmonary	All forms
1925	6,616	5,106	11,722
1935	4,939	2,951	7,890
1945	7,316	2,342	9,658
1946	7,627	2,086	9,713
1947	7,984	2,133	10,117

Responsibility for the preventive and environmental aspects of the disease is placed on local health authorities by the Act. Under Section 27 they are given wide powers to make arrangements for the prevention of illness and the care and after-care of persons suffering from illness including tuberculosis.

To achieve co-ordination of the treatment and preventive services for tuberculosis, authorities will have arrangements with the Regional

Hospital Boards whereby the specialists in the hospitals will advise them on the operation of their tuberculosis service.

Tuberculosis in both respiratory and non-respiratory form is a notifiable disease in terms of the Public Health (Infectious Disease) Regulations (Scotland), 1932.

ENGLAND AND WALES: DEATHS FROM TUBERCULOSIS, INCLUDING NON-CIVILIAN

	Respiratory			Other forms		
	Males	Females	Persons	Males	Females	Persons
1931	16,136	12,604	28,740	3,285	2,934	6,219
1935	13,602	10,238	23,840	2,516	2,133	4,649
1945	12,077	7,936	20,013	2,072	1,870	3,942
1946	11,753	7,612	19,365	1,827	1,655	3,482

SCOTLAND: DEATHS FROM TUBERCULOSIS

	Respiratory	Other forms
1925	3,734	1,656
1935	2,812	834
1945	2,932	871
1946	3,231	753
1947	3,389	707

VENEREAL DISEASE

By A. E. W. McLACHLAN, M.B., F.R.S.

Early Syphilis—The Primary Sore.—Having gained entrance to the body, the spirochaetes multiply, and, after an incubation period of about three weeks, a painless local sore—the primary sore, chancre, or hard chancre of syphilis—arises as the result of the reaction of the tissues to the multiplying organism and the poisons it produces. The sore is at first small and inconspicuous, but in the course of a week or ten days develops into a definite ulcer with hardened edges, accompanied by painless enlargement of the glands of the groin. In the male the genital (penile) sore is obvious, but in women the common site of

infection is internal on the neck of the womb where the chancre may not be recognized unless special examination is made. In both sexes the sore may be extremely small and transient, and so may escape detection, or because of its spontaneous healing and painlessness may be regarded as trivial and due to some other cause. In those cases in which syphilis has been contracted apart from sexual exposure the chancre is found on other sites—on the finger of the surgeon or midwife, on the lip or tonsil where infection has been acquired by kissing, or from some contaminated eating or drinking utensil. The lymph glands draining the infected area become enlarged.

The chancre and enlargement of the regional lymph glands are the first stage of syphilis—the primary stage. In the absence of treatment, the chancre may heal spontaneously in a few weeks, leading to a sense of false security. Despite this local healing the spirochaetes continue to multiply, invade the blood-stream, and are carried to every part of the body. This early generalization of the infection constitutes the *secondary stage*, the symptoms and signs of which may vary greatly in severity and duration; the patient may complain of severe headache, or pains in the joints, fever, lassitude, nausea, etc., but not infrequently secondary syphilis is symptomless and manifested only by eruptions on the skin and mucous membranes, generalized enlargement of the lymph glands of the body and falling out of the hair. The skin rashes are painless, and may pass unnoticed, may imitate any known skin disease, may last only a few hours or may persistently recur over a period of months. The mucous membranes, e.g. of the throat and mouth, are frequently involved, the resulting moist ulcers exuding myriads of spirochaetes, being of the most highly infective character.

Although symptoms referable to the internal organs, eyes, etc., are rare at this time, yet it is during the secondary stage that the seeds of the late killing or crippling manifestations of syphilis are sown. Early syphilis is therefore important for two reasons—it is the phase during which the majority of infections are transmitted, it is also the phase in which adequate treatment is most certainly curative, preventing the spread of infection to others and the late manifestations in the individual.

The Diagnosis and Treatment of Early Syphilis.—The occurrence of a genital sore a week or two after sexual exposure should suggest the possibility of syphilis to the individual and to his doctor. The earlier, however, the sore is seen the less typical it is, and the more difficult it is to be certain of the diagnosis unless the special tests are made. These are examination of the exudate of the sore for the *spirochaete pallida* and the testing of the blood serum by the Wassermann reaction, or other special test, e.g. the Kahn. The microscopic demonstration of the causal organism of syphilis is certain proof, and it is possible to confirm the diagnosis by this means earlier than by serological

tests. These do not become positive for some six to eight weeks after infection. In the secondary stage, syphilis is the great imitator, and the secondary rash may mimic closely any of the common skin diseases; the ulcers on the mucous membranes of the mouth or genitalia are painless and like the skin rash give rise to no symptoms. Unless a constantly high index of suspicion as to the possibility of the occurrence of syphilis is maintained, and this possibility confirmed or excluded by serological tests, which are invariably positive in the secondary stage, there is the risk of cases continuing untreated and spreading infection.

Confirmation of the diagnosis of early syphilis by one or both of the pathological tests should invariably precede treatment, the objects of which are twofold, first to render the infective lesions non-contagious in the shortest period of time, and, secondly, the complete eradication of the infection. There is adequate evidence to show that thorough treatment will cure early syphilis, but that, on the other hand, insufficient treatment in this stage predisposes to the serious manifestations of late syphilis.

Various schemes of treatment are available to suit the needs of different patients; these all insist on an adequate dosage of drugs over an adequate time period, while the recent introduction of penicillin has added a drug of the highest value to those already available.

Late Manifestations of Syphilis.—In the absence of treatment, the secondary stage of syphilis runs its course in from three to nine months and all manifestations of the disease disappear. This does not, however, mean cure. In syphilis, as with any other infection, there is a contest between the invading organisms and the defence-mechanism of the body. If the infecting organism wins, death results. In syphilis, death seldom occurs now during the stage of early generalization, although it did formerly; the immunity forces of the body reduce the numbers of spirochaetes and eliminate them from many of the organs and tissues of the body, thus arresting the symptoms and signs of the disease. But all the spirochaetes have not been killed off—a state of equilibrium has been reached—and the numbers of spirochaetes remaining in the body are confined to residual foci or 'nests' in the brain, spinal cord, in the heart or aorta, in the liver, bone-marrow, or other tissue.

A period without symptoms ensues, varying in length from a few months up to fifty years or more. Yet so long as living spirochaetes persist in the body, and despite the absence of symptoms, there is every probability of slowly progressive insidious damage to the internal organs in which there are residual foci of spirochaetes, and of recurrent generalization of the infection following disturbance of the tissue-spirochaete equilibrium, leading to involvement of further organs, and sooner or later to the clinical manifestations of late or tertiary syphilis.

These fall naturally into one of three main groups, according to the structures principally attacked:—

(1) Skin, bone, muscle, joint, tendon lesions.
(2) Heart, aorta, and other blood-vessel lesions.
(3) Nervous system lesions

The first group presents lesions which are 'benign,' although characterized, for example, in the skin, by slowly progressive deforming ulcerations, or in the bones by chronic painful inflammation, leading to marked thickening.

In the second group, the degenerative process of late syphilis is best seen in its effect on the aorta, the great blood-vessel leading from the heart. The effect of syphilis is to lead to the progressive destruction of the elastic and muscular coats of the aorta and to their replacement by scar or fibrous tissue. The weakening thus caused leads to a progressive dilatation of the walls of the aorta, forming what is termed an aneurism. This dilatation, bulge, or aneurism gradually increases in size and presses on nerves or other vital structures, giving rise to severe pain. Finally, rupture and sudden death ensue. If this degenerative process affects the brain or spinal cord, important nerve centres or connections are destroyed, leading in the case of the brain to general paralysis of the insane, and in the case of the spinal cord to tabes dorsalis or locomotor ataxy. In general paresis the first symptoms are frequently vague and indefinite—headache, sleeplessness, inability to concentrate, then loss of memory, serious errors of judgment, deterioration of personal habits, delusions of grandeur, and progressive mental impairment, terminating in insanity. In tabes dorsalis, progressive degeneration of the spinal cord leads to a progressive loss of muscular control, ending in complete paralysis, accompanied by severe neuritic pains, and not infrequently by blindness from involvement of the optic nerve. There are no mental changes.

Apart from those showing frank signs of late syphilis, there is a group, comprising some 30 per cent of all cases, in which the disease remains asymptomatic. The benign group of lesions affect approximately a third of all cases, while cardio-vascular and nervous system manifestations each occur in from 10 to 15 per cent. In contrast to early syphilis, the late manifestations are virtually non-contagious, and after the fifth year it is rare for infection to be communicated by sexual congress or to the child in the womb.

Congenital or Pre-Natal Syphilis.—The child born infected with syphilis is frequently wasted and marasmic, has a wizened 'old-man' facies, and shows muco-cutaneous eruptions similar to those of secondary acquired syphilis. The mucous membrane of the nose is often affected, giving rise to snuffles—snoring nasal breathing; involvement of the growing ends of the long bones, osteochondritis,

may lead to paralysis of one or more limbs within a few weeks of birth; syphilitic meningitis may give rise to convulsions, or to later hydrocephalus, or mental enfeeblement.

On the other hand, the infected child may show no signs at birth, or even for a number of years; in such cases the signs correspond to the late or tertiary period. Benign manifestations affect the skin and bones; a painless synovitis affecting typically the knee joint (Clutton's joint) and responding well to treatment is not uncommon. From the age of five onwards the eyes may be affected by iritis or keratitis. In the latter the cornea, the clear window of the eye, becomes inflamed and cloudy. If untreated, interstitial keratitis may run its course in a few months, leaving an undamaged cornea, more commonly, however, there is left some degree of opacity and scarring, causing impairment or, more rarely, complete loss of vision Juvenile general paralysis or locomotor ataxy may occur from the age of ten upwards. And, as in acquired infection, a number of cases are asymptomatic, show no detectable signs, but are found to have positive serological reactions.

The diagnosis is based on the signs and symptoms, the results of the blood test, and the result of the examination of the mother. Treatment follows the same lines as for infection in the adult, the dosage of drugs being modified to suit the age and weight of the infant.

Soft Sore or Chancroid is the least serious of the venereal diseases, and is caused by Ducrey's bacillus, a short, rod-shaped organism. After an incubation period varying from one to five days, rapidly progressive, usually multiple, genital ulcerations occur. The lymph glands of the groin become enlarged and acutely tender (Bubo); suppuration occurs, and the resulting abscess ruptures through the skin, giving rise to an intractable ulcer. Infrequently a rapidly spreading phagedenic gangrene supervenes, leading to rapid and wide destruction of the tissues involved.

Before the introduction of the sulphonamide group of drugs, chancroid could be healed only by frequently applied antiseptic dressings; the bubo and groin ulceration might take months to heal, being a very definite cause of invalidism. Now chancroidal sores heal within a few days of sulphonamide treatment; bubo and phagedena are prevented.

Chancroid is of importance in that it may occur as a dual infection with syphilis, and these cases must therefore be kept under surveillance for at least three months to exclude the possibility of an incubating syphilitic infection.

Gonorrhoea.—In the male the mucous membrane of the urethra or water-pipe is involved; here the infection involves the many small mucous glands and may penetrate deeply below the surface, giving rise to sub-mucosal infiltrations which may later give rise to stricture formation. The gonococci travel backwards along the urethra towards the bladder and involve the prostate gland at the neck of the bladder

and the seminal vesicles (sperm sacs), giving rise to acute inflammation or abscess formation. This is frequently followed by sterility from blockage of the ejaculatory duct through which the sperms pass into the urethra. Sterility may also follow the acutely painful extension of infection from the seminal vesicles along the vasa deferentia or the sperm ducts to the epididymis and testicle. Less commonly, extension occurs towards the upper urinary tract, involving the bladder, the ureters, or the kidneys, and giving rise to acute or chronic febrile illness.

In women the sites of infection are the urethra and the cervix or neck of the womb. From this latter situation infection can pass upwards through the womb and involves the Fallopian or uterine tubes—the ducts through which the ova pass from the ovary to the uterus. The acutely painful abdominal illness which ensues (salpingitis) may necessitate urgent surgical intervention and commonly results in sterility from permanent blockage of the tubes, or in chronic pelvic infection and ill-health.

In both sexes the gonococcus may get into the blood-stream and cause infection of other structures of the body. Most commonly the joints are involved (gonococcal arthritis) or the eyes (iritis) Gonococcal arthritis may involve one or more of the large joints, giving rise at first to acutely painful swelling and later to deformity or contractures leading to chronic pain, limitation of movement and incapacity.

VENEREAL DISEASE: STATISTICS

ENGLAND AND WALES

TABLE A*

NUMBER OF CASES (IN ALL STAGES) DEALT WITH FOR THE FIRST TIME AT ANY CENTRE, EXCLUDING CASES TRANSFERRED FROM CENTRE TO CENTRE AND THOSE THAT RETURNED WITH THE SAME INFECTION *AFTER BEING STRUCK OFF THE BOOKS IN PREVIOUS YEARS*

Year	Syphilis		Soft Chancre		Gonorrhoea		Total V.D	
	Men	Women	Men	Women	Men	Women	Men	Women
1925	11,782	7,385	1,048	27	24,398	6,120	37,228	13,532
1931	11,285	6,827	1,042	20	29,310	7,697	41,637	14,454
1935	8,596	5,565	1,011	16	27,506	7,732	37,113	13,313
1945	18,134	8,508	589	29	21,280	11,603	30,003	20,140
1946	13,803	10,075	994	34	36,912	10,431	51,709	20,540
1947	11,699	8,438	776	27	29,647	7,019	42,122	15,484

* Report of the Ministry of Health for the year ended March 31, 1946. Ministry of Health for 1946 and 1947 figures.

TABLE B*

CASES OF ACQUIRED SYPHILIS IN TABLE A WITH INFECTIONS OF LESS THAN ONE YEAR

Year	Number		Per cent of Table A cases	
	Male	Female	Male	Female
1931	6,421	2,683	56·9	39·3
1935	4,226	1,745	49·2	31 4
1945	5,214	5,527	64·1	64·9
1946	10,705	6,970	77·6	69 2
1947	8,750	5,416	74·8	64·2

TABLE C*

CASES OF CONGENITAL SYPHILIS DEALT WITH FOR THE FIRST TIME AT THE TREATMENT CENTRES

Year	Under 1 year	1 and under 5 years	5 and under 15 years	15 years and over	Totals
1931	339	204	974	922	2,439
1935	251	165	671	944	2,031
1945	326	83	210	736	1,355
1946	363	103	215	701	1,382
1947	343	120	214	676	1,353

TABLE D*

DEATH-RATES PER 1,000 LIVE BIRTHS OF INFANTS UNDER ONE YEAR CERTIFIED AS DUE TO CONGENITAL SYPHILIS

Year	Rate	Year	Rate
1925	0·82	1935	0·26
1931	0·45	1945	0·15
		1946	0·15

* Report of the Ministry of Health for the year ended March 31, 1946. Ministry of Health for 1946 and 1947 figures.

TABLE E*

DEATHS FROM GENERAL PARALYSIS OF THE INSANE, TABES DORSALIS, AND ANEURISM OF THE AORTA (INCLUDING NON-CIVILIAN)

	General paralysis of the insane		Tabes dorsalis		Aneurism of aorta	
	Males	Females	Males	Females	Males	Females
1931–35†	734	217	442	99	715	240
1945	326	133	221	53	592	261
1946	322	127	178	54	668	292

* Report of the Ministry of Health, March 31, 1946 and Ministry of Health for 1946 figures.

† Annual Averages. Deaths during this period have been corrected to the classification in use from 1940 onwards.

SCOTLAND*

SUMMARY OF NEW CASES TREATED AT V.D. TREATMENT CENTRES

Year ended	Syphilis		Chancroid		Gonorrhœa		V D other than S.C G		Total V D.	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
15 5 25	2,181	1,877	298	1	4,477	1,234	173	335	7,129	3,447
1935	1,562	1,197	177	—	4,343	1,376	1,267	653	7,349	3,226
1945	1,312	1,317	85	12	3,131	1,444	2,085	665	6,613	3,438
1946	2,250	1,663	202	11	5,475	1,369	3,253	1,051	11,180	4,094
1947	1,934	1,343	120	13	4,230	981	2,592	816	8,866	3,153

DEATHS FROM GENERAL PARALYSIS OF THE INSANE*

1925	191	1945	61
1935	100	1946	56

* Department of Health for Scotland.

INCIDENCE OF VENEREAL DISEASE IN THE BRITISH ARMY*

Annual Rates per 1,000 *of the Strength*

	1937	1938
United Kingdom	12·8	11·7
Egypt, Cyprus and Khartoum	44·2	43 8
India	40·4	45 0

	1946
United Kingdom	32·8
British Army of the Rhine	158·6
Central Mediterranean Force	139·8
Middle East Force	30·6
South-East Asia Land Forces	144·0

Note.—Statistics for the Royal Navy and the Royal Air Force are not yet available.

* Army Medical Department.

INCIDENCE OF VENEREAL DISEASES PER 1,000 PER ANNUM AMONG TROOPS IN THE UNITED KINGDOM FROM 1882*

	Admissions to Hospital per 1,000 of Force
Contagious Diseases Acts in force.	
1882	246·0
Contagious Diseases Acts suspended.	
1883	260 0
1885	275·4
Contagious Diseases Acts abolished.	
1886	267·1
1905	90·5
Modern methods of treatment introduced	
1913	50·9
1925	22·3
Recreation facilities extended.	
Improved post-war living conditions in the Army	
1934	9·8
1936	10·2

* Annual Reports on the Health of the Army.

TREATMENT OF VENEREAL DISEASES, 1930

Defaulters

	Total defaulters	Per cent of defaulters to new cases or cases notified	Returned for treatment	Untraced by reason of wrong address or no address	Total remained in default or refused to return for treatment (including untraced)	Per cent of defaulters resuming treatment	Per cent remaining in default
New South Wales*	774	14·81	400	351	374	51·68	48·32
Queensland†	316	7·3	202	72	114	63·92	36·08
Edinburgh†	801	20	649	97	152	81	19

* Annual Report of the Director General of Public Health, New South Wales.
† Annual Report of the Commissioner of Public Health, Queensland.
† Annual Report of the Public Health Department of the City of Edinburgh.

UNION INTERNATIONAL CONTRE LE PÉRIL VÉNÉRIEN

Sixty-eight member countries representative of Governments and national organizations. Address: Institut Alfred Fournier, 25, Boulevard St. Jacques, Paris XIV.

The following resolutions adopted by the Assembly are of special importance; the text of others can be obtained on application to the Secretary.

Resolution on Prostitution, October 1926.

That medical treatment of those suffering from venereal infection is one of the principal means for the suppression of syphilis and the reduction of other venereal diseases.

That regulation of prostitution has not at any time and in any country helped to limit the damage caused by venereal infections; that, further, it is contrary to all justice and all ideas of social morality.

Recommends:

(1) The suppression of the regulation of prostitution
(2) The application of medical measures embracing the whole population (men, women and children) and conceived in the widest sense with due regard to the principle of individual liberty.

(3) That Governments should take measures against the social causes which provoke and maintain prostitution.

(4) That by means of extensive propaganda the entire population should be made aware of the existence of the venereal peril, and that every individual suffering from venereal disease should receive, when necessary, such gratuitous treatment as his condition requires.

(5) The adoption of measures in conformity with the customs and manners of each country, designed to bring about the suppression of:

(*a*) Solicitation (on the public streets, in places accessible to the public, etc.).

(*b*) Instigation to immorality, particularly to the corruption of the young of either sex, by all methods, even those indirectly obscene (films, advertisements, etc.).

(*c*) Any act of enticing, leading astray or inducing to immorality any person, irrespective of age or sex, in order to satisfy the passions of others, or forcing such persons to deliver themselves into prostitution.

(*d*) All persons who cause it to be known, while concealing the nature of their offer in equivocal language, that they practice prostitution or facilitate its practice by others (notices, announcements, advertisements, special paragraphs inserted in newspapers and periodicals, prospectuses, pamphlets and circulars, exhibition of posters, placards, or inscriptions in any places accessible to the public).

(*e*) The possibility of all advertisements in favour of medicines, designed for the cure of venereal diseases, and made by means of notices and circulars or in lay newspapers, and in general of all publicity of a non-medical character.

(6) That a special appeal should be made to the medical profession asking for their complete and whole-hearted co-operation in giving advice and warning to those of their patients suffering from venereal disease. In particular it would be of great service if the doctors distributed a warning circular enlightening those venereally diseased of the gravity of their condition, their infectivity, the precautions they should take, and as to the provision made by the community with the object of helping them.

Resolution on the Treatment of Syphilis, August 1930.

The Union . . . invites all Governments, public authorities and anti-venereal associations to ask the medical profession to take its

stand, in the duty which every doctor, specialist or not, owes to syphilitic patients, on the following four cardinal rules:

(1) First and above all, if the patient is contagious, to reduce his period of contagiousness to a minimum by immediate and intensive treatment.

(2) Second, to try to prevent the reappearance of contagious lesions by a sufficiently active and prolonged treatment.

(3) Thirdly, to try to prevent all possibility of congenital transmission of syphilis to the offspring The Union in regard to this insists especially that the fight against congenital syphilis should be carried on—

  (*a*) By a systematic tracking, including inquiries in the family as well as clinical and serological examinations.

  (*b*) By treatment not only of children known to be congenital syphilitics, but by sufficiently regular and prolonged treatment of the parents before procreation, and of the mother during pregnancy.

(4) Fourthly, in the last place and as far as at all possible, to protect the patient against the future personal consequences of his syphilis in such a manner as to secure the definite disappearance of the treponemae from the infected organism.

The Union Internationale insists on the fact that these fundamental principles carry as their corollary the necessity for every doctor to enquire in each case into the source of infection of the individual examined and into those of which the individual has been or could have been the origin, so as to be able to institute the necessary treatment as soon as possible. Obviously these investigations must be made with the greatest discretion and tact.

The Union draws the special attention of Governments, public authorities and anti-venereal associations to the necessity of practising doctors being trained in syphilology from the point of view of prophylaxis as well as of diagnosis and treatment according to the exigencies of medical science and practice.

It considers that for the success of a common enterprise the practitioner taking part in the social attack against syphilis should have the support and guidance of medical specialists and of the anti-venereal organizations.

The Union, in fact, believes that only a complete programme of attack can give real and lasting results.

Resolution on Treatment, Voluntary and Obligatory, of 1933.

The Union Internationale, renewing its resolution of 1926 on the general principles of prevention and treatment of venereal diseases, from the point of view of prostitution:

Considering that the results obtained by the two systems at present in use in abolitionist countries—i.e. voluntary and obligatory treatment of venereal disease—have so far been judged to be equally satisfactory by the different countries which have adopted them, and from which has been obtained the information serving as a basis for the present resolution:

Affirms that it is for the different nations to choose and to put into operation whichever of these solutions (or any other solution of a like kind) is best adapted to their mentality and their national customs.

It considers necessary that nations adopting the systems of obligatory treatment:

(1) Should use compulsion only against those persons of either sex who are infective, it being understood that, in some cases, it is advisable to put into operation preventive measures;
(2) Should consider compulsory measures as a local (national) addition to the general policy of educative propaganda and of free and voluntary treatment, which should still remain the real basis of the anti-venereal disease campaign;
(3) Should normally apply compulsory measures only through the public health authorities assisted by specially trained social workers. Where police intervention becomes necessary, sanitary questions should be dealt with by the ordinary judicial machinery and only questions of public order should be dealt with by the police constable.

PROSTITUTION AND TRAFFIC IN WOMEN

Since 1866 Great Britain, in dealing with the problem of prostitution, has discarded all aspects of official regulation.

Exploitation for Purposes of Vice.—Under English law the keeping of a brothel is indictable as a common nuisance. A brothel is the same thing as a bawdy house, a term which in its legal acceptation applies to a place resorted to by persons of both sexes for the purpose of prostitution (Singleton *v.* Ellis). It is immaterial whether indecent or disorderly conduct is or is not perceptible from the outside (*Stephen's Digest Criminal Law*, p. 110) A room which is occupied by one woman who receives a number of men, but is not used by other women is not a brothel (Singleton *v.* Ellis), and a house let out in separate apartments to women, each of whom receives a number of men, is not a brothel if the owner does not live in the house, or exercise any control over it (Reg. *v.* Stannard (1863) 33, L.J.M.C. 61). Where, however, the owner's agent (a porter) was shown to have lived in and exercised control over a house composed of self-contained flats, several of which

were to his knowledge used for receiving men indiscriminately, the premises as a whole were held to be a brothel, and the porter was convicted for being wilfully a party to this use of the house (Durose *v.* Wilson (1907) 96 L.T. 645.

The Criminal Law Amendment Act of 1885 (as amended by the succeeding Acts of 1912 and 1922) provides that any person convicted of brothel-keeping or of allowing his premises to be used as a brothel shall be liable on conviction. "(1) to a fine not exceeding £100 or to imprisonment with or without hard labour for a term not exceeding three months; and (2) on a second or subsequent conviction to a fine not exceeding £250 or to imprisonment with or without hard labour for a term not exceeding six months; or in any such case to both fine and imprisonment."

NUMBER OF PERSONS DEALT WITH FOR BROTHEL-KEEPING

Year	England and Wales (cases tried on indictment as well as those tried summarily)	Scotland (disposed of summarily)
1926	324	41
1935	223	26
1945	843	50
1946	255	23
1947	Not available	16

The offence of procuration for immoral purposes is dealt with severely under English law. The Criminal Law Amendment Act, 1885 (48 and 49 Vict., Ch. 69), as amended in 1912, provides that any person who procures or attempts to procure any girl or woman under twenty-one years of age, not being a common prostitute, for immoral purposes either within or without the Queen's Dominions, or who makes use of threats or intimidation, false pretences or false representations, or drugs with intent to stupefy with the same intent, shall be guilty of a misdemeanour, and being convicted thereof shall be liable at the discretion of the Court to be imprisoned for any term not exceeding two years with or without hard labour.

Great Britain is one of the signatories to the International Convention for the Suppression of the Traffic in Women of full age, October 1933, under which the age limit of twenty-one is abolished in connection with traffic between one country and another. The question as to how far amending legislation may be necessary has not yet been decided.

Any person who allows a child or young person between the ages of four and sixteen to reside in or frequent a brothel is liable to a fine not exceeding £25 or, alternatively, imprisonment for any term not exceeding six months (Children and Young Persons Act, 1933, Section 2).

Any person who, having the charge of a girl under sixteen, causes or encourages the seduction, unlawful carnal knowledge or prostitution, or the commission of an indecent assault upon her, is liable to a term of imprisonment not exceeding two years (Children and Young Persons Act, 1933, Section 3).

NUMBER OF PERSONS DEALT WITH FOR PROCURATION

Year	England and Wales (proceeded against)	Scotland
1939	19	121
1942	25	100
1945	21	128
1946	15	118
1947	Not available	149

Souteneurs.—The number of persons dealt with in recent years for this offence has fallen from an annual average of 479 in 1910–14 to 234 in 1937; 189 in 1945, and 312 in 1946 (England and Wales).

Reduction of Prostitution.—Under English law neither prostitution nor solicitation for immoral purposes constitutes any offence under common law, but by statutory law certain offences have been created arising from the manner in which prostitution or solicitation is carried on. For instance, prostitutes may be prosecuted for behaving in a riotous or indecent way in the public streets or public highways (Vagrancy Act, 1824), or for loitering and importuning passengers for the purpose of prostitution in any street to the obstruction or annoyance of the residents or passengers (Town Police Clauses Act, 1847). Difficulties have arisen from time to time in the enforcement of these provisions and enquiries have been held with a view to the alteration of the law. The most recent enquiry was made by the Street Offences Committee whose report was issued in 1928. The main recommendations of the Committee were:

(1) That the existing general and local legislation in England and Scotland relating to solicitation between the sexes be repealed.

(2) That there be substituted a simple enactment of general application constituting it an offence for any person of either sex to importune a person of the opposite sex for immoral purposes in any street or public place.
(3) That the expression "importune" be defined as referring to acts of molestation by offensive words or behaviour.
(4) That it be made an offence for any person to frequent any street or public place for the purpose of prostitution or solicitation so as to constitute a nuisance, but that the evidence of one or more persons aggrieved be essential to a prosecution.

No parliamentary action was taken on these recommendations until July 1938, when a "Bill to Amend the Laws relating to Order and Decency in Public Places" was presented by Mr. R. H. Turton. The Bill does away with the term "common prostitute" and makes it an offence for any person to behave in an indecent manner or to molest, obstruct or importune any other person in any street or public place. Similarly, any person loitering in or frequenting any street or public place to the obstruction, danger, or annoyance of the residents shall be guilty of an offence. No person shall be taken into custody for any offence under this section except upon complaint by or on behalf of the party aggrieved. The Bill was brought in under the ten minutes rule, but made no progress. The Home Secretary felt the subject was an important one, but that no time could be spared by the Government for its discussion during the Session.

There is no record of the number of prostitutes carrying on their employment in Great Britain, but the numbers dealt with in Court since 1910 show a large decrease.

Year	England and Wales	Scotland
1910–1914 (annual Average)	10,682	2,077
1925–29	3,130	418
1935	3,303	286
1945	2,117	254
1946	4,423	141
1947	Not available	105

INTERNATIONAL CONVENTIONS ON TRAFFIC IN WOMEN AND CHILDREN

International Agreement Signed at Paris, May 18, 1904

By this Agreement the High Contracting Parties pledged themselves to take certain administrative measures, including the appointment of central authorities charged with the consideration of all information relative to the procuring of women and girls for immoral purposes abroad.

International Convention of May 4, 1910

By this Convention it was agreed that, within specified limits, the procuration of women and girls should be made punishable by the laws of each country and offences should be vigorously prosecuted.

International Convention of September, 1921

This Convention amplified and strengthened the obligations contained in the former Conventions.

International Convention of October, 1933

This Convention removed the age-limit of twenty-one, thus making the procuration for immoral purposes in a foreign country of a woman, whether of age or not, and even with her own consent, a punishable offence.

INTERNATIONAL CONVENTIONS OF 1921 AND 1933*

a. Signifies that the Convention applies to colonies, overseas possessions, protectorates or territories under the sovereignty or authority of a State signing or acceding to the International Convention of 1921 which has adhered on their behalf as provided under Article XIV of that Convention.
r. Indicates ratification or definite accession
s. Indicates signature or accession not yet perfected by ratification.

Country	International Convention of 1921 for the suppression of the traffic in women and children	International Convention of 1933 for the suppression of the traffic in women of full age
Afghanistan	r	r
Union of South Africa	r	r
Albania	r	s
Argentine Republic	s	—
Australia (including Papua, Norfolk Island, New Guinea and Nauru)	r	r
Belgium	r	r
Brazil	r	r
Great Britain and Northern Ireland	r	s
Bahamas	a	The signature given on behalf of the United Kingdom is also binding upon all parts of the British Empire which are not separate members of the League of Nations
Barbados	a	
Basutoland	—	
Bechuanaland	—	
Bermuda	—	
Burma	a	
Ceylon	a	
Cyprus	a	
Falkland Islands	a	
Fiji	a	
Gambia	a	
Gibraltar	a	
Gilbert and Ellice Islands	a	
Gold Coast	a	
British Guiana	a	
British Honduras	a	
Hong-Kong	a	
Jamaica	a	
Kenya	a	
Leeward Islands	a	

* League of Nations, Advisory Committee on Social Questions, Summary of Annual Reports for 1942–43; Traffic in Women and Children. C.65.M.65 1944. IV.

Country	International Convention of 1921 for the suppression of the traffic in women and children	International Convention of 1933 for the suppression of the traffic in women of full age
Great Britain and Northern Ireland—*continued*		
Federated Malay States ..	—	
Unfederated Malay States.	—	
Malta	a	
Mauritius	a	
Newfoundland .. .	—	
Nigeria	—	
Nyasaland	a	
Palestine	a	
Northern Rhodesia ..	a	
Southern Rhodesia .	a	
St. Helena	—	
Sarawak	a	
Seychelles	a	
Sierra Leone .. .	a	
British Solomon Islands ..	a	
Somaliland	-	
Straits Settlements	a	
Swaziland	-	
Tanganyika	a	
Transjordan . .	a	
Trinidad and Tobago ..	a	
Uganda	a	
Windward Islands ..	a	
Zanzibar	a	
Bulgaria	r	r
Canada	r	—
Chile	r	r
China	r	s
Colombia	r	—
Costa Rica	s	—
Cuba	r	r
Czechoslovakia	r	r
Danzig	r	s
Denmark	r	—
Egypt	r	—
Estonia	r	—
Finland	r	r
France	r	s
Syria and Lebanon.. ..	r	—

Country	International Convention of 1921 for the suppression of the traffic in women and children	International Convention of 1933 for the suppression of the traffic in women of full age
Germany	r	s
Greece	1	r
Hungary	r	r
India	1	—
Iran	r	r
Iraq	r	—
Ireland	r	r
Italy	r	—
Italian Colonies	r	—
Japan	r	—
Latvia	r	r
Lithuania	r	s
Luxemburg	r	—
Mexico	r	r
Monaco	r	s
Netherlands (including Netherlands Indies, Surinam, Curaçao)	r	r
New Zealand	r	—
Nicaragua	r	r
Norway	r	r
Panama	s	s
Peru	s	—
Poland	r	r
Portugal	r	r
Roumania	r	r
Spain	r	s
Sudan	r	1
Sweden	r	r
Switzerland	r	r
Thailand	r	—
Turkey	r	r
Union of Soviet Socialist Republics	—	—
United States of America	—	—
Uruguay	r	—
Yugoslavia	r	s

Note.—Up-to-date information on the position is not available. No notice has therefore been taken of political changes since 1942–43.

SEXUAL OFFENCES AGAINST YOUNG CHILDREN*

A. Number of offences known to police.
B Persons proceeded against in magistrates' courts; defilement of girls.
Persons dealt with at magistrates' courts; indecent assaults.

	1939		1940		1942		1943		1944		1945		1946	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B
Defilement of girls:														
Under 13	101	55	65	43	117	69	108	55	109	52	114	50	109	53
Under 16	526	336	433	233	651	349	700	303	767	291	320	308	684	328
Attempts to commit unnatural offences:														
Indecent assaults on males under 16 by persons under 17 .	—	48	—	40	—	45	—	58	—	51	—	58	—	46
Indecent assaults on males under 16 by persons over 17 ..	—	233	—	221	—	224	—	308	—	264	—	290	—	287
Indecent assaults on females under 16 by persons under 17 ..	—	406	—	397	—	428	—	507	—	507	—	541	—	395
Indecent assaults on females under 16 by persons over 17 ..	—	775	—	629	—	694	—	769	—	789	—	822	—	955

* Home Office Statistical Branch.

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