PROSTITUTION AND VENEREAL DISEASE SOCIAL CONSIDERATIONS OF PROSTITUTION*

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In an earlier paper (Willcox, 1960) it was shown that prostitutes in Asia are heavily infected with venereal disease, and in a second paper (Willcox, 1961) the proportion of venereal disease in the general population which was caught from prostitutes in a number of Asian countries is contrasted with the situation in France, the United Kingdom, and the United States of America. In Asia most venereal infections are contracted from prostitutes whereas in the other countries listed, this is not so, the professional prostitute having been largely replaced by the "good-time girl".

In the present paper various social factors relating to prostitution are considered.

Kinsey, Pomeroy, and Martin (1948) noted that the world's literature contained hundreds of volumes attempting to assay the social significance of prostitution: "For an activity which contributes no more than it does to the sexual outlet of the American male population, it is amazing that it should have been given such widespread consideration".

Prostitution is but one of several means by which the venereal diseases are spread. Freed (1953) indicated that the incidence of these diseases varied inversely to the proportion of married persons in the population, and directly with the proportion of young adults in a community, the degree of disparity of the sex ratio, racial heterogeneity (especially where racial heterogeneity and socio-economic differentiation are synonymous terms), economic stratification, illiteracy, horizontal social mobility, urbanization, prostitution, and social disorganization of the population, such as may be caused by war.

Prostitution is obviously therefore only one factor in the spread of venereal diseases, and its

elimination, although it may reduce their incidence, will certainly not lead to their complete disappearance.

THE ITINERANT MALE

The bulk of venereal disease is contracted and transmitted by the itinerant male and the promiscuous static female. The itinerant male may be a seaman or a soldier in a land far from home, or a native on a temporary visit to the capital or some other city. These persons, by the nature of their temporary domicile, are more likely to consort with prostitutes than with other women, and prostitutes are mainly to be found just in the areas in which itinerants abound.

Seamen.—Numerous authors, including Gudmundsson (1956), Häro and Pättälä (1954), Willcox (1954), Hermans (1954), and many others, have stressed the relatively high incidence of venereal diseases in seamen. They featured prominently in a series of 878 cases of venereal disease reported by Tottie (1949) in Sweden. Almost half had been infected by prostitutes, and the seamen comprised 40 per cent. of all cases thus infected.

In Oslo in 1954-1955 about 15 per cent. of all reported cases of venereal disease were in seamen (Gjessing, 1956). Finnish sailors have a gonorrhoea incidence of 74 per 1,000 per annum, a figure almost identical with that for sea-going personnel in the U.S. Navy (1954). How they acquire the infection depends on the social pattern of the country visited. Stuart and Joyce (1954), in an analysis of 4,364 sex contacts of 2,426 American seamen in ports throughout the world (80.5 per cent. had gonorrhoea), noted that 52.2 per cent. of the contacts in the United States were of the "pick-up no fee" type, which was also the dominant type in Europe. In most other areas, however, more than 50 per cent. of the contacts were house prostitutes.

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Figures concerning the source of venereal infections in United States Navy personnel in 1951* show that, of 36,343 venereal infections incurred throughout the world, 58·8 per cent. were contracted from prostitutes. The percentages by areas were 50·5 for U.S. overseas territories and possessions, 88 per cent. elsewhere in the Americas, 43·5 per cent. for Europe, and 87·1 per cent. for the Far East. The lowest percentage (9·1) was for the British Isles—which was even lower than the 11·9 per cent. for the continental United States.

Itinerants in England and Wales.—Using the 1951 Census as a basis (General Register Office, 1952), it was estimated that, of the working population of 16,018,700 males aged 15 and over in England and Wales as a whole, 2,152,800 (13·4 per cent.) were in occupations classified as itinerant. The importance of the male itinerant in the spread of venereal disease was well brought out by the gonorrhoea study of the British Co-operative Clinical Group (1956). When the male gonorrhoea patients in itinerant occupations (including seamen, commercial travellers, showmen and actors, tourists, soldiers, etc.) were compared with those in static occupations (professional men, clerks, shop assistants, artisans, labourers, domestics, etc.), 33·9 per cent. of patients were found to be itinerants as against 13·4 per cent. in the population as a whole.

The proportion of itinerant males was highest in the ports and in London than in the inland cities and rural areas, and this distribution coincided with the distribution of prostitutes (Table I).

TABLE I
OCCUPATION OF MALE GONORRHOEA PATIENTS,
UNITED KINGDOM, 1954
(British Co-operative Clinical Group, 1956)

Area	Seaports and London	Inland Cities and Rural Areas	Total
Total Cases	4,927	1,077	6,004
Itinerants	1,848	189	2,037
Per cent. Itinerants	37·5	17·6	33·9
Per cent. Infections by Prostitutes	38·4	15·7	35·7
Per cent. Infections by Unpaid Casual Acquaintances	39·3	57·8	41·5

Seamen accounted for 1,278 of the 6,004 male cases (21·3 per cent.). Nicol (1956), analysing the British material further, found that prostitutes were

responsible for no less than 68 per cent. of the seamen's infections, but for only 32 per cent. of infections in men in other occupations.

Immigrants.—Of the total of 6,004 male patients, only 3,752 (62·5 per cent.) were natives of the United Kingdom. 1,003 patients (37·5 per cent.) were white immigrants (878 from Europe), 878 were Negro immigrants (mainly from West Africa and the West Indies) who in recent years have been coming to Britain in increasing numbers, and 371 were immigrants from other areas.

In the United States agricultural migrants have recently been shown to be important potential disseminators of venereal disease (Shepard and Page, 1954).

THE STATIC FEMALE

In the gonorrhoea study of the British Co-operative Clinical Group (1956) only 0·5 per cent. of female gonorrhoea patients were itinerants, whereas, according to the 1951 Census, 1 per cent. of the female working population aged 15 years and over were employed in occupations classified as itinerant. Of the male patients only 62·5 per cent. were natives of the United Kingdom, but for the females the proportion was 91·2 per cent.

Prostitutes (in spite of the so-called "white-slave traffic"—or possibly partly because of its suppression) are recruited without difficulty from the natives of the country concerned (Table II, opposite).

There are, of course, some exceptions. In the Lebanon (Table II) there are reported to be many prostitutes from neighbouring Syria and Israel, all but one of the non-Lebanese listed being from one of these two countries. Pereira (1956) stated that most of the prostitutes in the brothels of Laos were not native-born but came from Vietnam or Cambodia, and that of some 290 clandestine prostitutes in the three principal towns approximately 130 came from Siam, Cambodia, or Saigon.

By and large, however, these figures indicate that any large-scale "traffic in women and children" has been virtually stopped and that principal responsibility for women in brothels rests with each particular country.

ECONOMIC AND POLITICAL FACTORS

That both the prevalence of venereal diseases and prostitution are geared to socio-economic conditions has been indicated by many writers (*e.g.* Guthe and

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TABLE II
COUNTRY OF ORIGIN OF PROSTITUTES

Country	Year	Type of Prostitute	Source	Total	Foreigners	Nationals	Per cent. Nationals
Austria	1948-50	Brothels	UN, 1952	78	4	74	96.0
	1951	Vienna: supervised	UN, 1952	568	29	539	94.9
Egypt	1948-49	Brothels	UN, 1952	961	42	919	95.6
France	1946	Brothels	UN, 1948	4,840	19	4,821	99.6
Greece	1950	Brothels and clandestine ..	UN, 1952	984	—	984	100.0
India	1948-50	Delhi: brothels	UN, 1953	549	19	530	96.5
	1948-50	Hyderabad: clandestine ..	UN, 1953	350	—	350	100.0
Iraq	1948-50	Brothels	UN, 1953	622	—	622	100.0
Lebanon	1948-50	Brothels	UN, 1953	551	241	301	54.6
Malaya	1955	"Coffee shops"	Holmes, 1955	45	3	42	93.3
Philippines	1950	Vagrants	Lozano, 1951	1,028	6	1,022	99.4
Portugal	1947-48	"Furnished rooms" ..	UN, 1950	1,505	42	1,463	97.2
Turkey	1947-48	Brothels and registered ..	UN, 1950	2,239	—	2,239	100.0
United Kingdom ..	1954	Clandestine	Nicol, 1956	215	39	176	81.8
Italy	1947-48	Brothels	UN, 1952	4,000	"Almost all" Italians.		
Union of South Africa	—	Unauthorized brothels ..	UN, 1952	"Mostly" European and Coloured women of South African nationality.			
Trinidad and Tobago	—	—	UN, 1952	"Practically all" native-born.			

Hume, 1948). Prostitutes in Iraq "all belong to the necessitous classes of society" who have lost male economic support (United Nations Organization, 1950, 1953). In the Lebanon "many prostitutes are compelled by poverty and need to sell themselves in order to live" (UNO, 1953). With the improvement of social conditions (*e.g.* of unemployment, poverty, and hunger) prostitution tends to wane (*e.g.*, in Czechoslovakia: UNO, 1952).

Prostitution flourished in the economic confusion of post-war Japan (UNO, 1952), after the partition of India (UNO, 1953), and during and after the Korean conflict (Graham, 1952).

Campbell (1946) and Lees (1946) writing of Italy, Curtis (1947) and Campbell (1946) writing of Germany, and Prebble (1946) writing of India, have all given eloquent testimony to the widespread prostitution to be found in war areas. Prebble described an interesting example of inverted prostitution among the Khasi women in the hills near Shillong, Assam, who were heavily infected with venereal disease. Desiring to become pregnant through intercourse with Europeans, they themselves offered monetary inducement to the troops stationed in the district.

SUPPLY AND DEMAND

The Committee on Social Affairs of the League of

Nations (1938) considered that: "The primary causes must always be the demand for prostitutes—however created—and the public toleration of prostitution, both dependent on current philosophy, and on morality, habit, tradition, education, and the structure of society".

Figures quoted by the Association for Moral and Social Hygiene (1955) give an interesting example of the operation of the law of supply and demand from London. The annual number of charges for street solicitation in the Metropolitan Police District in the years 1935-1949 varied from 1,526 to 5,445—the peak occurring in 1949 when 1,268 women were involved. In 1951 (the year of the Festival of Britain) the number soared to 9,683, and in 1953 (Coronation year—which also attracted many visitors to the capital) 9,584 charges were made. Wailes (1945) noted an increase of prostitution in London during the war because of the presence of large numbers of troops, particularly American soldiers, with money to spend.

However, as Flexner (1919) and others have pointed out, the demand can be artificially boosted by the advertisement of the prostitute herself and by official endorsement by regulation. The efforts of social reformers have rightly been first aimed at reducing the demand created by the mere existence of prostitution itself.

THE PROSTITUANT

That more attention should be paid to the male component of prostitution, the prostitute, has been the plea of many writers (*e.g.* Hijmans, 1953). Prostitution supplies a demand: if there were no prostitutes there would be no prostitutes. "It is certain that there can be found far more men seeking for sexual pleasure than women soliciting gain" (Association for Moral and Social Hygiene, 1955).

Sutherland (1950) stated that more information was required concerning the prostitute, for "unless something is done to re-educate or re-habilitate a venereal disease patient, it is very likely that upon his return to the community he will revert to his former way of life, become re-infected, and in due course return for treatment". The patient who has repeated attacks of venereal infection has frequently been used as a starting point of studies of the prostitute (*e.g.* Anderson, 1954). The emotional immaturity of promiscuous persons has often been stressed (*e.g.* Pincock, 1947).

French (1955), quoting James (1951), listed five types of men who comprise the demand:

- (1) Young men and students in the experimental stage of development;
- (2) Men sexually isolated, whether for a short or long time, such as soldiers and commercial travellers;
- (3) Vicious persons;
- (4) Married men with frigid or invalid wives;
- (5) Men who have defective love objects, *e.g.* amongst others the pimp and the ponce.

Kinsey and others (1948) considered that men resort to prostitutes because they have insufficient sexual outlets in other directions, or because prostitution provides types of activity not so readily available elsewhere. Others do so because of a physical deformity such that only a prostitute will have intercourse with them. Others because they can pay for sexual relations and forget other responsibilities. Others because (taking the long-term view) it is cheaper to have intercourse with a prostitute than to court a girl for a long period.

There has thus in recent years been a welcome tendency for the other side of the prostitutional coin to be investigated. For example, Wyness (1953), describing VD social work in British Columbia, divided venereal disease patients into five groups:

- (1) Capable of taking responsibility for himself, functioning adequately in his life situation. Infection acquired as an episode out of character with behaviour pattern.

- (2) Capable of taking responsibility for himself, but needing help in defining this. He lacks knowledge about venereal disease and about sex behaviour in general.

- (3) Manifesting real conflict in some area of his life. His promiscuous behaviour is symptomatic of this stress. The pressure may be external, because of the life situation in which he finds himself, or may occur within the personality structure of the individual.

- (4) Functioning in all his personal relationships on a causal level, his sexual behaviour following the same pattern. His roots are shallow and he does not want or is incapable to assume personal responsibilities. His goal in life is ill-defined, but he is not in conflict about himself or his situation.

- (5) Incapable of ordering his own life, his promiscuous behaviour being part of his way of living. He exists on the fringe of crime, and authority is his natural enemy.

Of 660 persons with venereal disease, 104 belonged to Group I, 163 to Group II, 148 to Group III, 208 to Group IV, and 37 to Group V. The relatively small proportion in Group V is probably due to the fact that many were involved in criminal charges and attended the gaol clinic rather than that discussed by the author. Whether such an approach will be productive, however, remains to be seen.

Wittkower (1948) studied the psychological aspects of military patients with venereal disease and concluded that there was "no magic formula to prevent the development of promiscuous propensities. As a long-term policy this is a matter of child guidance, sex education, and mental hygiene in general".

Moreover, the approach to the prostitute can promise only partial success. While attention is being directed more and more to the prostitute and the official attitude to prostitutes in almost all parts of the world has hardened, a new factor has emerged, that of the "good-time girl". She provides a greater problem than ever the prostitute did, for she has a far wider field of operations.

That the "good-time girl" is usually morally a prostitute has already been indicated, but few would dare to draw the line between the prostitute and normal woman-kind. The accurate focusing of the margin between the delinquent teenage girl and the normal spirited young woman is an ever-present difficulty to parents. The key to the problem of venereal disease is promiscuity, not whether money is or is not exchanged for intercourse. Successful

campaigns against promiscuity are infinitely more difficult to undertake than are those against prostitution.

THE RISK OF THE PROSTITUTE TO THE INDIVIDUAL

Lentino (1955), writing of brothels in Italy, re-affirmed the inadequacy of the attempted medical control of prostitutes, and stated that although the girls were examined every other day, 80 per cent. of all cases of venereal disease in American soldiers stationed in the district were contracted in houses of prostitution. He did not, however, state the individual risk per exposure, or the percentage of men for whom the brothel was the regular sexual outlet.

It must not be thought that intercourse with a prostitute in a brothel necessarily carries a high risk of infection. Campbell (1946) indicated that brothels with good medical control and ablution facilities gave rise to little venereal disease in war-time Algiers. Bettley (1949) described the experience of three brothels subject to medical control in an unspecified European country in war-time, where there were 277,482 users in 8 months. Of these, 248,593 (89 per cent.) used preventive ablution in a room set aside for the purpose, and during this period only 87 men contracted venereal disease and blamed the brothel as the source of infection. The incidence per 1,000 brothel-users who took prophylactic treatment was calculated as 0.31 per 1,000, but for those not taking treatment it was 0.723 per thousand. There was little difference in these groups regarding the incidence of gonorrhoea (0.08 and 0.09 per 1,000 respectively), but syphilis was more than four times as likely in those who used no preventive treatment.

In the Far East, where prostitutes as a whole are highly infected and precautions other than washing are seldom employed, the average individual may expose himself frequently with prostitutes without contracting venereal disease.

Ram (1950), writing of Singapore, where three-quarters of the prostitutes were infected with venereal disease, interviewed 194 male V.D. patients. Of these 19.5 per cent. exposed themselves on the average once a month, 29 per cent. twice a month, and 20.5 per cent. more than twice a month. Of 154 single men only 3 per cent. were infected after the first exposure and 15 per cent. in under ten exposures. Up to 100 exposures were achieved with impunity by 33 per cent. and up to forty exposures by 60 per cent. The average number of exposures before infection was 102.

It is evident that, for every individual who is so unfortunate as to contract venereal disease, a great

many others apparently escape. A few of these, of course, are infected with syphilis without knowing it.

ALCOHOL, PROSTITUTION, AND VENEREAL DISEASE

The association of alcohol and venereal diseases has often been noted (*e.g.* in Ethiopia by Guthe (1949) and in Sweden by Tottie, 1950).

Tottie (1949) concluded from his series that, where cash payment was given, alcohol played the greatest role; prostitutes obviously seek their clientèle among persons under the influence of alcohol, when moral inhibitions are less valid and the fear of venereal infection disappears.

Wittkower and Cowan (1944), quoted by Dicks (1953), noted that 29.5 per cent. of 200 military men with venereal disease were heavy drinkers, 68.0 per cent. were moderate drinkers, and only 2.5 per cent. were teetotallers. Of 86 "controls" on the other hand, 2 per cent. were heavy drinkers, 91 per cent. were moderate drinkers, and 7 per cent. were teetotallers: 49 per cent. of the patients with venereal disease admitted intoxication at the time of infection and 7 per cent. were totally drunk.

Johns (1945) noted the association between alcohol and venereal disease on Tyneside in England; she postulated that for women the association of drink and sexual indulgence may be due to the relaxation of moral judgment, or else to the fact that the promiscuity provides the drink or the money to buy it.

In the gonorrhea study of the British Co-operative Clinical Group (1956), 76.7 per cent. of 2,254 male patients, but only 24.8 per cent. of 286 female patients, admitted drinking alcohol before intercourse. There is no doubt that the majority of male patients with venereal disease have taken alcohol before intercourse; this very fact leads to a smaller likelihood of taking any precautions, so that there is a greater possibility of infection in promiscuous drinkers than in promiscuous non-drinkers.

Ryan (1955) questioned 172 American enlisted men after 5 days in a modern Asian city. 70 per cent. had had intercourse. 88 per cent. had taken alcohol, but only 57 per cent. of the contacts were made after drinking, and 80 per cent. said that they would have had sexual intercourse whether they had been drinking or not. This is a significant observation. On the other hand the selling of alcohol in most countries does more or less directly encourage prostitution. Prostitution is used to encourage the sale of alcohol by the employment of girls, "waitresses", hostesses, singers, and the like in bars, restaurants, and night clubs. The truth probably is that men are less inhibited in seeking their sexual pleasures when

under the influence of alcohol; some even take it deliberately for this reason. Where alcohol is sold prostitutes tend to congregate to satisfy the demand.

SUMMARY AND CONCLUSIONS

- (1) That the prostitute is but one factor in the spread of venereal disease is indicated. The prostitute, especially the itinerant male, is equally important. Evidence is given to show that itinerant males are more prone to venereal disease than non-itinerants, and that they frequently contract such diseases from prostitutes.
- (2) The itinerant male usually contracts his disease from the static female. Figures are presented which indicate that over 90 per cent. of the inmates of brothels in many countries of the world are staffed by the nationals of the country in which the brothels are situated. The tendency is noted for more studies to be undertaken of the prostitute as opposed to the prostitute.
- (3) Prostitution flourishes in situations of political and economic confusion and obeys the law of "supply and demand".
- (4) The risk of an individual contracting venereal disease from a prostitute is considered. Some of the data presented indicate that the risk is lower than might be expected.
- (5) The role of alcohol in the spread of venereal disease is discussed. The association is not necessarily so simple as it first appears, for the effect of alcohol on the causation of venereal diseases seems to be more indirect than direct. Alcohol may encourage prostitution and contrariwise prostitution may boost the sales of alcohol.

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