VENEREAL DISEASE AMONGST BRITISH TROOPS IN INDIA.

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I.—Short History.

Chart I shows at a glance the incidence of venereal diseases amongst British troops in India since 1861, and the references will enable those who are interested in studying the history to consult the authorities quoted.

The first attempt to control venereal disease of which we have record was in 1864, when the Rules for Lock Hospitals were framed; these were eventually introduced in 1866 (vide Reference 3). Two years later in
1868 the Contagious Diseases Act was introduced which aimed at the control of prostitutes and brothels.

These efforts appear to have met with considerable success, as between 1861 and 1873 the ratio per 1,000 of strength fell from 369 to 166.

In 1870 the short service system was introduced, and had an adverse effect, the reason being probably the increased turnover of material, i.e., the number of new young soldiers being drafted into the country. In 1882 the married establishment was reduced; in 1872 the married establishment was:

- Staff Serjeants and Serjeants ... ... All
- Trumpeters, Drummers, and Rank and File ... 12 per cent

but in 1882 this was reduced to:

- Warrant Officers and N.C.Os. (Classes 1, 2, 3) ... All
- Classes 4 and 5—
  - Cavalry ... ... ... ... 6 per cent
  - Artillery ... ... ... ... 8 ,, for next five years, and then ... ... 6 ,,  
  - Infantry ... ... ... ... 4 ,,  

This led to a very rapid rise in the venereal rate until it reached 389·5 per 1,000 in 1886. The causes which were considered to have led to this increase are detailed in the Sanitary Commissioner's Report of 1885 (published in 1887). The most interesting note is: "In 1885 married men showed three admissions per 10,000 less than in 1874, and unmarried men 118 per 10,000 more than in 1872"; showing that the reduction of the married establishment had a very marked adverse effect.

Between 1887 and 1890 questions were raised in Parliament regarding the registration and recognition of prostitutes, which led to the Cantonment Act and the establishment of cantonment hospitals in 1890, when the venereal rate had risen to 503·5 per 1,000. These measures appeared to have a beneficial effect, as the rate dropped to 400·7 in 1891, but again rose during the following years until it reached the record figure of 522·3 in 1895. In the same year Act V was passed which practically swept away all regulations regarding the control of prostitution. The following year cantonment hospitals were replaced by followers hospitals and dispensaries, but were re-established in 1899 with consequent control of prostitutes under the Cantonment Act.

From 1899 onward until the outbreak of the Great War there was a very rapid decrease in the incidence of venereal diseases. During this time much greater interest was taken in the welfare of the soldier—the institutes were improved, encouragement was given to sport, trade, and craftsmanship, education was improved, and instruction given in the prevention of disease. These measures, together with the supervision of prostitutes, had the desired effect, and the venereal rate was reduced from 522·3 per 1,000 in 1895 to 29·1 per 1,000 in 1915—a very remarkable achievement.
Unfortunately this improvement was not maintained, and with the outbreak of war the incidence began to rise.

In 1918 the power to close brothels under the Defence of India Rules 1915 was put into force, and no brothels were allowed to exist in cantonments or places where troops were assembled. This measure entirely failed to attain the desired object, and six months after the termination of the war the Defence of India Act, under which these rules were framed, became inoperative with the result that a steady improvement had taken place.

Although properly conducted brothels may now exist in cantonments, they in no way receive official recognition, and periodical examination of women is prohibited.

The above brief résumé of the legal enactments for the control of venereal diseases indicates clearly that a decrease in the incidence of venereal diseases has invariably followed measures which have been adopted for the supervision and control of prostitution. This important point will be referred to later when considering the measures which are required for the prevention of the diseases.

II.—THE INCIDENCE OF DISEASES AMONGST BRITISH TROOPS IN INDIA.

A reference to the chart shows that there was a rapid rise in the incidence of disease after the outbreak of war, or rather after 1915. The ratio per thousand of strength during the last ten years has been:

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
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<tbody>
<tr>
<td>1914</td>
<td>55.2</td>
</tr>
<tr>
<td>1915</td>
<td>29.1</td>
</tr>
<tr>
<td>1916</td>
<td>36.8</td>
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<tr>
<td>1917</td>
<td>52.0</td>
</tr>
<tr>
<td>1918</td>
<td>62.5</td>
</tr>
<tr>
<td>1919</td>
<td>87.6</td>
</tr>
<tr>
<td>1920</td>
<td>118.2</td>
</tr>
<tr>
<td>1921</td>
<td>110.4</td>
</tr>
<tr>
<td>1922</td>
<td>84.7</td>
</tr>
<tr>
<td>1923</td>
<td>72.0  (Estimated.)</td>
</tr>
</tbody>
</table>

The ratio in 1915 was the lowest on record, and was, no doubt, mainly attributable to the anxiety of the troops then serving in India for active service. It was well known that a man with venereal disease would not be sent on active service. Another factor which had a considerable effect was that the Regular troops were being relieved by Territorials who were of a somewhat higher social scale and had a large proportion of married men; that these two advantages were soon counterbalanced by the unsteady effect of war and environment was soon demonstrated.

The closure of brothels in cantonments had a very adverse effect, as was only to be expected; the result was that all diseased prostitutes were turned out of the brothels to seek their living on the roadside on the
borders of cantonments; whilst those not so diseased found a ready employment in brothels kept for natives, so that the British soldier suffered and the native benefited.

This state of affairs still existed when I took over the duties of consulting dermatologist on April 1, 1921. The monthly ratio per 1,000 of strength was 10.8, and was rising. Early treatment rooms were just being taken into use, but the majority were very crude, and being poorly equipped and badly managed they were, in my opinion, doing more harm than good. Judging by the returns for the first half-year it was estimated that the rate for 1921 would be 124 per 1,000. That this figure was not reached, the figure actually dropped to 110.4, was undoubtedly due to the interest taken by commanding officers in the subject and the provision of prophylactic measures. Although this reduction is satisfactory, it is not sufficient, and if the necessary measures are adopted I believe it can be reduced to below the pre-war figure in a short time. Even under the present half-hearted measures the monthly rate fell to 4.9 in October, 1923.

The highest rate is in the seaport towns—Bombay, Calcutta, Rangoon, Madras, and Karachi. The main reasons for this are the situation of the barracks in large towns surrounded by native dwellings with easy accessibility to the barracks (except in the case of Calcutta and Madras), the large number of places of entertainment such as cinemas where Eurasian prostitutes resort, and the European brothels where the scum of European prostitutes are collected. It is perhaps something in their favour that the majority of men prefer to "go with a white woman," but unfortunately she is often the most dangerous.

In some towns, Rangoon, Karachi and Quetta, early treatment rooms have been established in the part of the town most frequented by the soldiers, and have had a most beneficial effect.

III.—The Organization of Control.

(a) Medical.
(b) Regimental or unit.

The medical control consists of:

(1) The consulting dermatologist at Army headquarters.
(2) The specialists in dermatology, one to each district.
(3) The officer in charge of the Central Dermatological Laboratory, located at Poona.
(4) The medical officer in medical charge of each unit.

(1) The duties of the consulting dermatologist are:

(a) To supervise and co-ordinate the work of all specialists and the work in the Central Dermatological Laboratory, and to inspect the venereal sections of all British and Indian station hospitals in India, Burma and Aden; and advise on the treatment of cases and ensure that all technical equipment is correct and up-to-date, and investigate and consult with the local military authorities regarding general procedure for prevention of disease.
(b) To lecture periodically to all British units throughout India, Burma and Aden.

c) To inspect all early treatment rooms of British and Indian units, and advise commanding officers on the procedure and system necessary to make these rooms effective.

d) To collect and consolidate all statistics regarding venereal disease of the British and Indian Armies in India; and investigate immediately the factors causing exceptional or abnormal monthly incidence at any particular place.

e) To investigate cases of poisoning and deaths, and all cases of intolerance to the drugs in common use.

(f) To prepare pamphlets and instructions for circulation to all specialists on the latest methods of treatment, equipment, scientific methods of diagnosis, laboratory investigations and means of prevention.

g) To supervise the training of special treatment orderlies and the instruction of junior R.A.M.C. and I.M.S. officers.

(h) To prepare the annual venereal report for submission to the Secretary of State, and the section on venereal diseases of the Sanitary Commissioner's Report, and the Army Medical Report.

To give some idea of what the above duties entail it may be of interest to state that during the 2½ years (April, 1921 to December, 1923) I held the appointment I travelled over 52,000 miles and delivered 120 lectures to the troops.

The pay of the appointment is, for an officer of over twenty-five years service, Rs. 2,400 per month; for an officer under twenty-five years' service, Rs. 2,200 per month. If held by a major it carries the local rank of lieutenant-colonel; an officer holding the appointment is graded as an A.D.M.S.

The case cards of both British and Indian troops are disposed of in the office of the consulting dermatologist, over 12,000 cards are dealt with annually.

Graphs showing the ratio per 1,000 of strength of fresh and relapse cases are maintained for each district monthly, and a record of the actual admissions in each station is kept separately.

(2) The duties of specialists in dermatology are:

a) The medical charge of the venereal section of the British station hospital at the station of the headquarters of the district.

b) To visit periodically the venereal wards of each station hospital (British and Indian) in the district, and to supervise the treatment of venereal diseases in each.

c) To obtain each month from the office of the A.D.M.S. the statistics of venereal disease of each station in the district, and investigate and report on the causes of any marked increase of disease.

d) To arrange for the instruction and training of N.C.O.s and men of the R.A.M.C. as special treatment orderlies.
As facilities occur to arrange post graduate lectures for officers of the R.A.M.C. and I.M.S. on recent advances in the principles of diagnosis and treatment.

(f) To advise officers commanding units on the organization and equipment of early treatment rooms and on all points in connexion with the prevention of venereal diseases.

It is very necessary that each specialist should keep in close touch with the consulting dermatologist. This need not always be done through official channels, in fact, it is much better done by an occasional D.O. or private letter. In a huge country like India the local conditions vary considerably in each station, and unless the consulting dermatologist is kept fully informed of these conditions it is impossible for him to appreciate the difficulties which arise or the causes of a decrease or increase in the incidence of disease in any particular district or station.

Duly qualified specialists receive an allowance of Rs. 75 per month in addition to the pay of their rank.

Specialists are available for any other duty in the station, but to carry out their duties efficiently it is most desirable that, except for their tour of duty as orderly officer, they should be only employed in their own particular work. They are seldom moved from the station to which they are originally posted.

(3) The duties of the officer in charge of the Central Dermatologist Laboratory, Poona, are:

(a) To test all sera sent by British and Indian station hospitals for the Wassermann reaction. Over 20,000 tests are carried out yearly.
(b) To make microscopical examination of specimens for the S. pallida or other organisms.
(c) To make pathological examinations in connexion with venereal disease.
(d) To instruct in laboratory work newly joined officers of the R.A.M.C. and I.M.S. and to arrange classes of instruction for civilian practitioners.
(e) To carry out research work in connexion with venereal or skin diseases.

Owing to the large number of sera dealt with the work in this laboratory is heavy and somewhat monotonous; but the officer is somewhat compensated by having a permanent appointment situated in a good station and a well equipped laboratory.

The officer in charge of the laboratory receives an allowance of Rs. 100 per month, in addition to the pay of his rank.

If considered necessary by the officer dispatching the serum the result of the test is sent by telegram, so as to save delay in commencing treatment.

Many medical officers do not appear to realize that when a serum is returned as "septic" that this is not the fault of the laboratory, but is a reflection on their own technical skill when taking the serum.
It has been frequently suggested that the tests for the Wassermann reaction should not be centralized in one laboratory, but should be carried out in district or brigade laboratories. Apart from the increased expense that would be involved I am strongly against this suggestion, and consider it essential (anyhow until the test becomes simplified) that the tests should be carried out in one laboratory where a large number are done daily, and the personal error is reduced to a minimum.

(4) The medical officer in charge of units.

It hardly appears necessary to detail the duties of the medical officer, but a few points may be of use to junior officers of the corps.

To carry out his duties successfully the first essential is that the medical officer should be on the best of terms with the officers of the unit and especially with the commanding officer. He should keep the commanding officer fully informed as to the sick state of the unit, and make practical recommendations for its reduction. He should never make any recommendation that is not practical and which he is not prepared to prove can be carried out. Advice should be given and recommendations made by a personal interview with the commanding officer, and correspondence and reports avoided. By being keen himself he will very soon stimulate keenness in others.

Every N.C.O. and man in the unit should be known to him personally. This is often difficult in a large unit such as a regiment until he has been with them for some considerable time, but it is the object to be aimed at.

Periodical medical inspections of the whole unit, and of all drafts and men returning from leave should be made.

Each case of venereal disease should be fully investigated and an endeavour made to trace the source of infection.

He should frequently visit the early treatment room and advise the commanding officer regarding its management and equipment. It is not the duty of the medical officer to equip the room or to try to run it himself. He should keep in touch with the officer in charge of the venereal ward so as to be able to keep the commanding officer informed of the progress of the cases, and when they are likely to be discharged from hospital.

(b) Regimental or unit control.

The unit control consists of:

(1) The officer commanding.

(2) The company, platoon, squadron or section commanders.

(3) The sergeant-major and N.C.O.s.

(4) The provost sergeant.

(1) and (2) The commanding officer of a unit is responsible for all that goes on in the unit, and for the health of the men under his command. By strict discipline, taking an interest in the welfare of his men, encouraging sport and entertainments, and by stimulating a spirit of esprit de corps in the unit he can do an enormous amount to reduce and control the incidence of venereal disease. His subordinate commanders, by taking an
equal interest and encouraging *esprit de corps* can help to control the venereal rate.

It is often noticed that the court martial rate and the venereal rate in a unit go hand in hand.

(3) What has been said regarding the officers applies equally to the sergeant-major and N.C.O.s, but they can undoubtedly exercise a much greater direct influence. I often tell them that when any man goes into hospital with venereal disease they should visit him in hospital, and try to find out where he contracted the disease, then when the man rejoins from hospital they should make him understand that he can "make good" if he chooses; and if he is a decent fellow he will do his best to do so. The man who is frequently in hospital with venereal disease should be made to understand that he is no good to them.

(4) The Provost Sergeant.—This N.C.O. can often do more good than any other. If he is carrying out his duties properly and has the police under him in proper control, he very soon knows where the men go for women, who are regular offenders, and from which women men contract disease.

It does not appear to be generally known that the power to examine or expel from cantonments women who are suspected of being infected still exists under the Cantonment Act and should be enforced. The periodical examination of women is prohibited.

IV.—Prevention.

For the sake of brevity and to save repetition I will not discuss in detail the various measures in connexion with discipline, education, improved conditions of the soldier, etc., which are in vogue as means of prevention, but will mention later how I think they can be still further improved.

The medical prophylactic measures are:—

(1) Early treatment rooms in the lines of each unit.

(2) The provision of prophylactic "outfits" on sale to the men by the attendant in charge of the early treatment room or the company storeman. These packets are sold for four annas each. They are not provided free for the following reasons:—

(a) It is unlikely that the Government of India would sanction the expenditure, even if they were asked to do so, which has not been done.

(b) It is not considered desirable to supply them indiscriminately, as then they come into the possession of young soldiers who may be tempted into vice purely out of curiosity.

(c) If a man buys one he does so deliberately and with full intention of using it.

(d) If a man can afford to pay several rupees to go with a prostitute he can well afford to pay four annas for a packet and so try to protect himself against disease. If he does not do so he is, in my opinion, not worth
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protecting. Except against syphilis I am very doubtful of the efficacy of these packets and prefer to rely more on the use of the early treatment room.

That these measures are of considerable use, but are not sufficient, is proved by the results, so I will now detail the measures I consider necessary to reduce the incidence of venereal disease to a minimum.

Measures necessary to reduce venereal diseases in India. These are dependent, to a great extent, on policy; and it is not considered politic by the authorities to introduce the measures I am about to advocate.

To my mind the time is now passed for us to act the part of the ostrich and hide our heads in the sand. We must recognize the fact that immorality exists and will exist until the social and religious education of the community has been brought to a state of perfection that immorality will not be tolerated. Having accepted this, then we must not confine our energies to dealing only with one half of the problem, as is being done at present, i.e., protecting the male community, but must attack the whole question fearlessly and legislate for dealing with the women.

One has only to study the history of venereal disease in India and the various measures which have been taken from time to time in an endeavour to control the disease, to find that the measures which have met with the greatest success have been those which aimed at the control of prostitution.

The following are the measures which I consider necessary:

(1) The recognition and control of brothels. The main advantages are:

(a) The area of prostitution is limited.
(b) The number can be limited.
(c) Regular examination of the women can be carried out, and diseased ones excluded.
(d) Foci of infection can be traced and eliminated.
(e) Clandestine prostitution would diminish.
(f) The women themselves are under better living conditions and able to maintain cleanliness and to prevent disease in themselves.
(g) Early treatment can be provided in the brothel, so that no time is wasted.

I do not for one moment suggest that infection would never occur in a recognized brothel, as medical men well know the extreme difficulty of detecting venereal diseases in women, but it stands to reason the chances of infection would be enormously decreased.

The abolition of "blue lamp" rooms in Germany was invariably followed by an increase of clandestine prostitution. In Paris in 1917 only 5 cases of venereal disease were traced to licensed houses, whereas out of 100 women detained from the streets on one night, 91 were found infected, and on another occasion out of 71 women examined 55 were found infected.

(2) The use of the early treatment room of the unit by all men who have exposed themselves to infection must be made compulsory, and
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neglect of this precaution made punishable. Men who use the room, and can prove they have done so, would receive no punishment and would only forfeit hospital stoppages and loss of proficiency pay during the time they are in hospital. The legality of such an order is beyond question. In order to prevent malaria a commanding officer issues an order that all men must let down their mosquito nets at night, and disciplinary action is taken against any man disobeying this order. A man who indulges in promiscuous intercourse is deliberately exposing himself to disease, and I consider that if he fails to utilize the prophylactic measures provided, he should be punished in the same way as the man who fails to obey the order regarding the mosquito net.

The principle involved is analogous to that of prevention of "trench foot" in France when prophylactic measures were advised by the medical authorities, but it was not until the strictest disciplinary action was enforced, that the disease was controlled and almost eradicated.

Owing to the lack of uniformity in the methods adopted in India, some units keep a record of attendances, whilst others do not, it is impossible to quote figures in support of the effectiveness of early treatment rooms, but in one unit recently visited where records of attendances were kept I found that the average number using the room was 80 per month and only one case of venereal disease had occurred in 10 months.

It is not claimed that the prophylactic treatment is as efficacious against gonorrhoea as against syphilis; this is shown by comparing the admissions for 1921 and 1922. The reduction was:

<table>
<thead>
<tr>
<th>Disease</th>
<th>1921</th>
<th>1922</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
<td></td>
<td></td>
<td>31 per cent.</td>
</tr>
<tr>
<td>Soft sore</td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td></td>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>

There are no doubt just as many women infected with syphilis as before; a man cannot chose whether he is going with a woman infected with syphilis or with one infected with gonorrhoea; therefore the only way that one can account for this very marked reduction is by the prophylactic measures adopted.

The number of admissions to hospital during 1922 was 5,099 for all forms of venereal diseases, as against 6,479 in 1921. The average duration in hospital was 44 days, making a total of 224,356 working days lost during the year, and is practically equivalent to the loss of a whole battalion of infantry.

I am convinced that until the strictest disciplinary action is taken to enforce the prophylactic measures devised by the medical authorities, little further improvement is likely to accrue.

(3) Improved conditions for the comfort of the troops. Although a certain amount has been done during the last few years to improve the conditions of life for the soldier, there is still considerable room for improvement.
Many barrack rooms in India are still lit by an oil lamp only one wick of which can be lighted, owing to the small allowance of oil, and by which it is impossible to read a home letter, and even if recourse be made to the regimental institute the conditions are very little, if any, better. The provision of comfortable and well-lighted barrack and recreation rooms will do more to keep men in barracks and away from temptation than anything else.

Lord Roberts' idea of making the canteen as unattractive as possible was undoubtedly a mistake. What is required is a club for the soldier where a man can either drink beer or coffee, served in the same room; the clerical element of control should be eliminated. Major-General Sir H. C. Uniacke has started an excellent club in the Muree Hills, and Major-General Holman has converted his own house into a soldiers club at Karachi; so by individual effort a little is being done; but what are one or two stations in the whole of India?

The methods of preparation and service of food in barracks are also most unsatisfactory and in very few are dining rooms provided. To my mind it is marvellous how the sick rate has been reduced in India by sanitation and inoculation in spite of little or no improvement in the feeding arrangements.

There are many other measures that might be advocated, such as increased powers to deal with procurers, pimps, etc., but if only the three measures mentioned above were taken in hand at once and thoroughly carried out I am convinced that there would be an immediate and marked improvement.

I should like to take this opportunity of thanking the many officers of the corps who have extended to me the greatest help, kindness and hospitality during my tours of inspection in India.
REFERENCES.

[1] 1864. Act XXII of 1864: To make Provision for the Administration of Military Cantonments (Gazette of India, January to June, 1864). Section xvii authorizes power to make Rules and Regulations. Section six, Rules and Regulations, under xvii, Clause 7 may provide for Inspecting and Controlling Houses of Ill-fame and for Preventing the Spread of Venereal Disease. Lock Hospital Rules were framed under this Clause (vide Reference 3).


[11] 1887. Ratio 361-9 per 1,000. The Lock Hospitals mentioned under Reference 8 above were re-opened. Sanitary Commissioner's Report, 1897.


[15] 1893. Ratio 466 per 1,000. There were 2,619 men, or equivalent to three regiments, constantly in hospital for venereal disease—a total of 32,068 cases.


[17] 1895. Act V passed; excludes Rules being applicable to Examination or Registration of Prostitutes.

[18] 1896. Percentage of married men to strength, 1872-73, 11-19; 1892-93, 3-29. Venereal Disease ratio per 1,000 of strength, 1872-73, 166-7; 1892-93, 409-9.


[23] 1907. Indian Army Order D/22/2/07. C.-in-C's (Lord Kitchener) gratification at reduction of rate of 281-4 in 1902 to 118-0 in 1906.


[25] 1916. Defence of India (Consolidation). Rules 1915, made under Section ii, Defence of India (Criminal Law Amendment), Act 1915. Rule 12 C (inserted by Notification, No. 1636, D/19/7/18, vide Gazette of India, 1918, Part I, p. 1191) gives power to close brothels in places where troops are assembled. (Legislation and Orders relating to the War Government of India, Legislative Department, 1919.)

[26] 1919. C.-in-C. directed that this rule was to be generally applied, (No. 04745-1 (A.G. 5) D/2/8/18.)

[27] 1919. Act XXII of 1919 amends Cantonment Act of 1910, and gives power under Section xxiii for expulsion from cantonments "of prostitutes and procurers." (Indian Acts, 1913.)