VENEREAL DISEASE IN WOMEN PRISONERS*†

BY

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Before I started the V.D. clinic in Holloway Prison I had no knowledge of prison administration or of the conditions I should meet. I shall therefore give a resumé of the general arrangements in this prison, the position regarding venereal disease as I found it in July, 1949, and how the clinic has since gradually expanded.

The Prison Commission has given me permission to read this paper but I must make it clear that the opinions expressed in it are my own, and not necessarily those of the Prison Commission.

Holloway Prison, London, built in 1855, serves an area of 23 counties, from as far west as Dorset and as far north as the Wash. The population consists of two classes: those who are on remand, and those who are convicted. Their ages vary from 16 to over 80 years, with an occasional 15-year-old admitted under special circumstances. The population is further divided into those in the prison itself and those in the prison hospital.

The prison contains convicted women and also those on a "straight" remand from the courts, *i.e.*, women remanded in custody while the Probation Officer makes further inquiries, usually to find out whether they have any previous convictions. These women are kept in a separate wing.

The prison hospital, with 104 beds, contains:

- (1) Women who are under special observation for physical or mental reasons.
- (2) Women who are sick.
- (3) Women who are pregnant.
- (4) Nursing mothers and their young babies.
- (5) Women remanded for a medical report.

The position I found in Holloway in July, 1949, was that only two classes of women were examined and tested for venereal diseases:

- (1) Women on remand for a medical report.

- (2) Convicted women who were found to have symptoms or were suspected of having venereal disease when examined by the medical officer in the Receiving Room.

Those on remand, being in hospital, were examined for venereal disease under reasonable conditions. However, if the convicted women were thought to be infected, they were put into a special wing in the prison with skin cases of all kinds, the commonest conditions being scabies and pediculosis. This wing contained a small, dark, examination room comprising two cells knocked together, badly lit, and almost without any equipment. The woman who was placed in this wing with known or merely suspected venereal disease at the beginning of her sentence, remained there for the whole of her time, which might be years. As might be expected, although the wing had a large proportion of skin cases, it was labelled by the prisoners "the venereal disease wing". It can be understood why a woman would not confess to having been in the midst of treatment at an outside clinic if she knew she would be placed in this wing and branded as suffering from venereal disease for her entire sentence. Not only was she branded by her location, but she was also branded by the type of work she was allowed to perform.

The senior medical officer was most helpful when I put the position before him and agreed to let me examine the women in the main hospital surgery. This was a step forward, but it was not ideal, as inevitably there were many interruptions by the nursing sisters coming in for drugs, instruments, etc. I was also given beds for infectious cases, three initially, but later as many as I needed. For my part, I guaranteed to be responsible for seeing that women with infectious lesions were isolated until fit to mix with others, and after this they were transferred to a suitable location, *i.e.*, to any wing

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of the prison if convicted, or to a ward in hospital if on remand. This enabled the women to have some of the privacy of a hospital clinic. The effect on the women was quite dramatic; they obviously appreciated the hospital atmosphere, and became less aggressive and more willing to volunteer information about themselves.

After a month, I started taking routine blood tests from all convicted women, seeing the new cases the day after admission, and gradually working through those already in prison. Most of the women were quite cooperative, but now and then there would be a batch which refused *en masse*, having agreed to do so before entering the surgery, our only waiting-room at that time being a bench in the corridor. Some of the "old-stagers" were the worst, knowing as well as I did, that I could not enforce anything. However, during the last 7 years, even the old-timers have given in more or less gracefully, and have had blood tests, some indicating quite pleasantly that it is just to satisfy my whim for blood-letting. The one exception is a woman who always threatens to "knock my 'unprintable' block off" if I go near her. As she has been in more than once for doing grievous bodily harm, my persistence has given way to prudence.

At the end of 1949, I discovered the existence of the wing in the prison containing the "straight" remands who had not previously had tests. The majority were youngsters and, having obtained permission, I began seeing them in January, 1950.

At the beginning, they were very difficult and I was repeatedly told that medical reports were not required for them and that they could not be compelled to have tests, but by persuasion and perseverance most of them were examined. In 1950, our first full year, 1,292 remand cases were examined, and of these 214 were found to be infected: 140 with gonorrhoea and 74 with syphilis (the latter including three cases of primary and two cases of secondary syphilis). Of these 214, 97 had been remanded for a medical report, but 117 were the "straight" remands, in whom the incidence of venereal disease was higher (Fig. 1). These results justified all the trouble taken, and from then onwards I was able to see all these girls without opposition.

In this year also, I kept a record of the venereal disease found in the convicted women by means of routine blood tests alone, *i.e.*, in addition to those found or suspected to have venereal disease when examined by the medical officer on reception. The number of convicted women seen was 1,312 of whom 55 refused blood tests; of the remaining 1,257 who were tested (Fig. 2), 129 (10.3 per cent.) were found to have venereal disease: 44 gonorrhoea and 85 syphilis. Of the latter, two had primary syphilis, three secondary syphilis, ten neurosyphilis, and four had cardiovascular syphilis.

FIG. 1.—Number of cases of syphilis and gonorrhoea found in 1,292 prisoners on remand in 1950.

FIG. 2.—Cases of syphilis and gonorrhoea found by routine blood tests of 1,292 on remand and 1,257 convicted women in 1950, shown as percentage of total admissions.

From this, I concluded that routine blood tests should be continued, and I am certain that this is a very important part of the work, as it affords the opportunity of seeing the patient and often recognizing her, either as a defaulter from an outside clinic, or as a patient previously partly treated in prison, who has returned under another name. Some of them have many names, but the trouble is that they can rarely remember where or when they have used which alias. From 1950 onwards, therefore, all admissions to the prison have been seen in the hospital clinic. The few exceptions comprised those too ill physically or mentally, a few political cases, and some who refused. The women are seen the day after admission, and this is now taken as part of the routine.

It was soon evident that the volume of work (in 1950, there were 10,248 attendances to see the venereologist and 4,814 attendances for intermediate treatments and injections) required larger premises. A new clinic was built and came into use in 1952. By the end of 1950, I had obtained a clerk and a part-time social worker, and since 1952, I have also had a full-time social worker.

Since 1951, I have been able to keep the records classified in the same manner as those for the Ministry of Health, and from these the following figures have been extracted. I have shown the total number of cases of venereal disease as a percentage of admissions from 1951–1956 (Table I and Fig. 3, opposite); this includes women who have had some treatment in the past, however little, either in outside clinics or in Holloway.

The percentage appears to be high; it is drawn from a constantly changing population with a comparatively small number of recidivists, the latter being partly responsible for keeping up the figure of

TABLE I

TOTAL NUMBER OF CASES OF VENEREAL DISEASE IN THE PRISON POPULATION, AS A PERCENTAGE OF ADMISSIONS FROM 1951 TO 1956

Year	Syphilis	Gonorrhoea	Total
1951	8.8	7.1	15.9
1952	7.8	7.4	15.2
1953	6.9	12.5	19.4
1954	6.2	12.2	18.4
1955	6.6	9.3	15.9
1956	5.6	10.1	15.7

FIG. 3.—Total venerea disease in prison population, 1951–1956.

TABLE II

NEW INFECTIONS FOUND ON ROUTINE INVESTIGATION

Year	Syphilis	Gonorrhoea	Total
1951	83	91	174
1952	80	134	214
1953	79	297	376
1954	61	235	296
1955	48	148	196
1956	36	162	198

FIG. 4.—New infections found on routine serological and bacteriological investigation.

syphilis, as the rate of their infection is high. Even so, there has been a gradual decrease in syphilis over these years, mainly due to the treatment of these recidivists. By the end of 1956, I had discharged as cured 198 cases of syphilis, most of whom had received all their treatment and surveillance during their sentences in Holloway.

Gonorrhoea was found mainly in the younger women, the number of cases varying according to the year, and seeming to follow the same pattern of rise and fall as is found in other clinics. This is shown in Table II and Fig. 4 which give the number of new infections from 1951 to 1956. The incidence not only of acute but also of latent syphilis shows a steady decrease; 7 years of routine testing has eliminated a large number of women, among them many habitual criminals, and has played an important part in reducing the incidence of syphilis in this population. Gonorrhoea is prevalent mainly among the young promiscuous women and prostitutes, and I am quite sure that more exists than we actually find.

Time is our difficulty. Remand cases are usually in for 6 whole days, but if a week-end intervenes, the time available from the point of view of the clinic is reduced to 4 days. Some magistrates remand

women for only from 1 to 3 days and the woman is back in the court before the result of her tests is known. The same difficulty arises with those given short sentences of 7 or 14 days, often with the option of a fine; this means they may go out the moment someone arrives at the prison to pay the fine. In many women, gonorrhoea is suspected clinically, but the first tests are negative. Tests are of course repeated as often as time allows. The specimens are taken to the Royal Northern Hospital laboratory each day at 4.30 p.m., and the results of blood tests and smears become available the following afternoon.

An appreciable amount of salpingitis is found. There were twenty cases in 1950; the numbers gradually declined to eleven in 1954, but have risen again to fourteen in 1955 and fifteen in 1956. Salpingitis is largely found in the prostitutes, and when once it occurs in this type of patient, she tends to have repeated relapses which become more and more resistant to treatment. Two women who have returned to the prison many times during the last 7 years, and who have had repeated attacks of salpingitis, finally had to have an operation last year.

This was in spite of vigorous treatment with several of the antibiotics followed by short-wave therapy.

As a large proportion of the gonorrhoea in Holloway was found in the prostitutes, I started keeping figures of their venereal disease in 1953. In that year, the figures only related to those who admitted to us that they were prostitutes, but, from 1954 onwards, we took steps to obtain more accurate figures, and kept other records regarding their history, charges, previous infections, age, etc.

It has been said that the prostitutes who come to prison are sent there because it is thought they have venereal disease, but this is not so, because more than half come in for charges other than soliciting. The commonest charges are for being drunk and disorderly, for indecency, stealing, larceny, wilful damage, and for being concerned in a robbery with one or more persons. When a woman is arrested for soliciting, she comes to prison because she has not the price of her fine, but, in most cases, she still has the option of it being paid for her, and this is very often done by her friends or her protector. Many are sentenced for indecency as they have no professional premises, and instead use the parks and other public places. A large number are detained for stealing, which sometimes means removing their client's wallet; and a further large group come in for being drunk and disorderly. This last group, as would be expected, is composed mainly of the older women of from 40 to 50 years of age, who have lost whatever good looks they once had, and are deteriorating rapidly; and a sad sight it is to see them come in so regularly, each time looking more raddled, more alcoholic, and more hopeless. Prostitutes and criminals have always tended to consort together, and in this way many are accused of being concerned in a robbery with another person. Again, the client may be the victim and the prostitute may be the decoy.

Gonorrhoea is usually easily demonstrated in the young inexperienced prostitute, partly because she has not learnt to take care of herself, and, even if she has been so instructed, she still has a juvenile and carefree outlook on life and tends to be careless.

The experienced and hardened prostitute using her condoms and antiseptic douches presents quite a different picture. It is rare to establish the presence of gonorrhoea at the first three tests and certainly not during the first week, which explains why so many of them are presumed free from infection when they go to a clinic for their examination. Divorce the prostitute from her douche can for a week or 10 days and she usually presents a very different clinical picture. It is the minority who are symptom-free, the majority developing a vaginal discharge of some

kind. Even with the advent of symptoms, it may be a long time before the gonococcus can be demonstrated. During last year, three prostitutes, who were all in prison on charges involving long sentences, were being treated for vaginal discharges and having regular tests after their periods: one was found to have gonorrhoea after 4 months, one after 5 months, and the third after 8 months.

Acute syphilis is now a rare disease. That it was not so in the past is reflected by the amount of latent syphilis found in the prostitutes, including cardiovascular and neurosyphilis in the older women. Primary and secondary syphilis has been found in varying degrees; the prostitutes accounted for all primary and secondary syphilis found in the prison in 1954, for one-sixth in 1955, and for one-half in 1956. Table III and Fig. 5 show the incidence of V.D. found in prostitutes examined.

TABLE III
INCIDENCE OF VENEREAL DISEASE FOUND IN
PROSTITUTES EXAMINED (PERCENTAGES)

Year	Syphilis	Gonorrhoea	Total
1953	16.0	62.8	78.8
1954	15.1	42.9	58.0
1955	14.7	35.8	50.5
1956	13.6	32.0	45.6

FIG. 5.—Incidence of venereal disease in prostitutes examined.

In each of the years under review, a large proportion of the prostitutes found to have venereal disease, gave a history of previous infections: 1954, 43 per cent.; 1955, 52 per cent.; 1956, 74 per cent.; and, even of the women found to be free from infection, the number giving a history of previous infections was practically the same (see Tables IV and V, opposite): 1954, 45 per cent.; 1955, 55 per cent.; 1956, 70 per cent. From these figures it can be deduced that the majority of prostitutes contract

TABLE IV

PREVIOUS NUMBER OF INFECTIONS IN PROSTITUTES
INFECTED AT TIME OF EXAMINATION

Year	No. of Prostitutes Examined	Syphilis Infection		Gonorrhoea Infection		Total Venereal Disease (Per cent.)
		No.	Per cent.	No.	Per cent.	
1954	138	10	7	50	36	43
1955	98	4	4	47	48	52
1956	77	4	5	53	69	74

TABLE V

PREVIOUS NUMBER OF INFECTIONS IN UNINFECTED
PROSTITUTES

Year	No. of Prostitutes Examined	Syphilis Infection		Gonorrhoea Infection		Total Venereal Disease (Per cent.)
		No.	Per cent.	No.	Per cent.	
1954	100	10	10	35	35	45
1955	96	11	11	42	44	55
1956	92	8	9	57	61	70

venereal disease in some year of their working life, and that they are particularly prone to venereal disease, which is obviously, in fact, their occupational hazard. I feel certain that the same incidence of infection prevails in the average street-walker who does not come to prison; there would not otherwise be so many men infected by prostitutes. It is only a minute proportion who come to prison, and those whom I have seen in Holloway, with the exception of a few beginners, take all the usual precautions.

The usual penalty of a forty shilling fine or 14 days in prison, which was imposed 118 years ago, bears no relation to present-day circumstances, from the point of view either of the value of money or of the conditions in the prisons. Prison to-day is a very different place from what it was over a century ago, and the confirmed prostitutes who come to prison for 14 days do not seem to mind it at all—in fact, most of them enjoy the rest and are quite agreeable to having repeated tests for venereal disease. The majority are too lazy to give up their free time and go to a clinic, but in prison it is different. They come to the clinic in their working time, when it makes a break in the monotony of the day, and if they are found to be infected, they are anxious for treatment in order to be fit for business on release.

However idealistic we may be, prostitution, to some degree, will always be with us; indeed, many people consider it is a safeguard to decent women, particularly in the large seaports. Also, a large number of prostitutes cater exclusively for pervers, and this safeguards not only other women, but

possibly also children. What, therefore, can be done to reduce the high incidence of infection?

It is generally considered that the law of prostitution is archaic and needs modernizing. As it is useless to try to rehabilitate the confirmed prostitute, I, for my part, should like to see the recurring fine interspersed with periods of residence for a minimum of a month in a special hospital or institution. I am sure that in this way a great deal of infection could be cleared up. As to the cost of upkeep of such institutions, perhaps some of the immense revenue from the prostitutes' fines could be put aside to cover it.

As regards the teenage prostitute, a great effort should be made to rehabilitate her, as I am certain that, only in the early stages, and by this I mean months and not years, is there any hope of persuading these girls to give up prostitution. Table VI shows how large the numbers are in the 15- to 20-year age group.

TABLE VI

NUMBER OF CASES IN EACH AGE GROUP OF PROSTITUTES
IN THE YEARS 1954, 1955 AND 1956

Age Group (yrs)	Year		
	1954	1955	1956
15-20	71	47	41
21-25	84	54	56
26-30	37	39	32
31-40	38	55	50
41-50	20	14	15
Over 50	6	6	7

There is a law which could help these girls, and it is used to some degree, but not nearly as often as it could be. I refer to Section 26 of the Criminal Justice Act, 1948, which has made it possible to send a woman to prison on remand for a physical and mental report, if she is charged before a magistrate's court with an offence punishable by imprisonment. Only nine out of 41 teenage prostitutes came into prison under this Section last year.

A girl coming in in this way is placed in the prison hospital where she is thoroughly examined. The medical officer goes into her whole history and background, and physical and mental health; the psychologist gives a report on her mental ability and response to various tests; the venereologist gives a report, and if she is found to be infected, she is also seen by the venereal disease social worker. The probation officer finds out about her family, and visits the home, or has the home visited by her local counterpart if it is in another part of the country. The knowledge gained is combined into one report to the court suggesting what should be done with the girl.

Help can be given in so many ways. Many a young girl has run away from home because she is in trouble of some kind and is afraid to face her parents. She often starts prostitution, not because she has intended to do so, but because, being a stranger in a large city, she has met some person who has put her on the streets, and I believe it is more often women than men who are on the lookout for these youngsters. I have seen such youngsters come to prison after a few weeks of prostitution; they don't like it, they are frightened, and they are only too glad for the path to be smoothed for a return home. Many are mentally defective and are being used by pimps. I well remember one young girl of 17 years who was working for a man aged 38, and was only one of his many employees. He gave her a room, food, and clothing, and £3 a week pocket money; in return, she earned for him £15 a night. She came into Holloway five times in one year, each time with a fresh gonorrhoea infection; finally she was sent in under Section 26, was found to be mentally defective, and certified. If the home environment is not suitable, the girl can be helped by being put on probation and being sent to a hostel, after which work is found for her. This at least removes her from old companions and gives her a chance to make a fresh start. It must also be remembered that it is to the young prostitute that the dope peddlars attach themselves, and it can be a short path from a night club hostess to a drug addict.

If only the magistrate would send every young prostitute to prison under Section 26 on her first appearance for soliciting, I am sure many of these girls would never return to prostitution; the worst thing a magistrate can do is to fine a young prostitute because she has a pretty face and appealing ways, for he is only sending her back to the streets to earn the price of her fine.

The need for proper investigation of the young prostitute in the 15-20 years age group is emphasized by the figures of their rates of infection with gonorrhoea during the last 3 years.

Year	No. Examined	Cases of Gonorrhoea	
		No.	Per cent.
1954	70	36	51
1955	44	26	58
1956	39	18	46

In each year, one girl had gonorrhoea twice.

As mentioned before, only nine girls last year were sentenced under Section 26; the remaining 32 came in on a straight remand, which means that,

apart from the routine physical examination on reception, they had no investigation except that for venereal disease.

Problems of Prison Work

Leaving this subject, I should like to come to some of the problems encountered when working in a prison. The main one is the prisoner's reluctance to give information. The woman who has served several sentences tends to look upon everyone with distrust, and, if she is on remand, is afraid of giving information regarding infection or contact with infection, fearing that it will affect her case when she goes to court. In other cases, it has just become a habit to hide the past, and in trying to do so, a woman may have acquired dozens of aliases. Over the last few years, this reluctance to give information has greatly decreased, mainly through the present reputation of the clinic. A large number of non-venereal conditions are also being treated, and, in addition, the medical officers send women to us for gynaecological examinations. Women with any pelvic complaint, themselves now ask to be referred to the clinic. All this has taken away the stigma, and the number of women refusing to be seen or to have tests has dropped from 7 per cent. in 1951 to 3 per cent. in 1956. The fact that it is now regarded chiefly as a clinic for women's ailments is most important in prison where rumour is so rife.

As regards treatment, the women are with very few exceptions, most cooperative. How grateful they can be may be illustrated by the story of the young girl who, having been treated for gonorrhoeal salpingitis, rose to her feet at the Christmas party in the hospital and publicly thanked the clinic sister for "making her tummy better".

On the other hand, a small minority take their treatment on sufferance. For instance, two girls were waiting outside my office one day for their injections; the first was extolling our kindness for treating her; the other, a very rough prostitute, was heard to answer, "Grateful be damned: it's bl—dy fools like you and me who keep these bl—dy fools in work"—indeed a sobering thought!

One of our main difficulties is to get these women, of whatever age, to attend a clinic on release. They may have their treatment very willingly while in Holloway, but in spite of the combined efforts of venereologist and social worker, there is still a large percentage who never go to a clinic on release. We have some hold over the woman on remand who is put on probation, as the social worker is in touch with her probation officer, but we have no hold whatsoever over the convicted woman who is

released after completing her sentence, and we are dependent on her statements and promises. Women have come and thanked me with tears in their eyes for what has been done for them, promising so faithfully to attend a clinic on release. Only afterwards have I found out that, whilst they wept and promised, they were giving me a false address. Whether they do this deliberately, or whether it is their instinctive reaction to cover their tracks, I still do not know. The social worker interviews all the patients before release and makes arrangements for them to attend their nearest clinic. Letters of introduction, including the times of the clinic are given, and they are escorted there by the social worker if they wish. Nevertheless, last year, only 57 per cent. of the women attended other clinics. With this high default rate, it is essential to give as much of the necessary treatment as possible during the time the patient is in prison.

Summary

(1) In a large woman's prison, the incidence of venereal disease is very high in both the convicted and remand classes of prisoner. The routine testing of all women prisoners is therefore necessary, not only for their own sake but also from the public health viewpoint.

(2) The incidence of syphilis has decreased during the last 7 years. The reduction in early syphilis

amongst civilians is reflected by a decreasing incidence in the prison. Latent syphilis has decreased markedly, mainly because of routine testing of all women and subsequent treatment.

(3) Gonorrhoea, mainly found in younger women and particularly in promiscuous girls and prostitutes, fluctuates annually, corresponding to the rise and fall of incidence in the general public.

(4) The attitude of women to investigation has changed from one of distrust to one of pleasant co-operation in the majority of cases; the treatment of a large number of minor gynaecological conditions in the clinic has largely contributed to this change.

(5) The prostitutes examined in prison are found to be very prone to venereal disease, and no doubt the same rate of infection persists in the average street-walker. It is therefore time that the old law of prostitution was altered so that prostitutes may be controlled, at least in respect of infectious venereal disease, if not in other ways also.

(6) Special care and investigation is needed for the teenage prostitute, not only because these girls show a high rate of infection, but, and this is most important, because only in the very early beginner is there any hope of rehabilitation. The existing Section 26 of the Criminal Justice Act, 1948, could be used to this end much more frequently than it is at present. Reduce the number of young prostitutes, and the total number of prostitutes will gradually decrease.