

Venereal Diseases in New Zealand (1922) eBook

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Report.

The Hon. the Minister of Health, Wellington.

Sir,—

The Committee of the Board of Health appointed by you to inquire into and report upon the subject of venereal diseases in New Zealand have the honour to submit herewith their report.

PART I.—INTRODUCTORY AND HISTORICAL.

SECTION 1.—ORIGIN AND SCOPE OF INQUIRY.

A perusal of departmental files reveals that many persons and bodies have during recent times urged upon the Government the desirability of setting up a Committee or Commission of Inquiry to go into this subject. The appointment of the present Committee, however, arose out of a suggestion forwarded to the Chairman of the Board of Health, under date of the 20th June, 1922, from the Council of the New Zealand Branch of the British Medical Association. The Board of Health duly considered the representations of the Association and passed a resolution recommending the Minister to set up a committee to gather data and to make recommendations as to the best means of preventing and combating venereal diseases. The proposal thereafter took concrete form, following the receipt by the members of this Committee of the under-quoted letter, dated 13th July, 1922, sent out under your direction by the Secretary of the Board of Health:—

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"I am directed by the Hon. the Minister of Health, Chairman of this Board, to inform you that, acting upon the recommendation of the Board, he has decided to appoint a special Committee from among the members of the Board to conduct an inquiry into the question of venereal diseases in New Zealand. The following members are being asked to become members of the Committee, and the Chairman trusts you will see your way to accept the position: Dr. Valintine, Dr. Elliott, Lady Luke, Hon. Mr. Triggs, Sir Donald McGavin, Mr. Fraser. The Hon. the Minister has asked the Hon. Mr. Triggs to accept the chairmanship of the Committee.

"I am further directed to state that the function and duty laid upon the Committee is as follows:—

"(1.) To inquire into and report upon the prevalence; of venereal disease in New Zealand.

"(2.) To inquire into and report any special reasons or causes for the existence of venereal disease in New Zealand.

"(3.) To advise as to the best means of combating and preventing venereal disease in New Zealand, and especially as to the necessity or otherwise of fresh legislation in the matter.

"The Minister of Health is anxious that the Committee should hear such evidence and representations on the above-mentioned matters as may be necessary to fully inform the Committee on the items referred to it, and with respect to which it is asked to report, and he further suggests to the Committee that the various organizations and persons likely to be interested should be notified that the Committee will, at a certain place and date, in Wellington, hear any evidence they may desire to tender."

The Committee regrets that owing to ill health Dr. Valintine, Director-General of Health, was unable to act as one of its members. His place was taken by Dr. J.P. Frengley, Deputy Director-General of Health. Unfortunately, illness also overtook Mr. Murdoch Fraser, who has been unable to attend the sittings of the Committee since the middle of August. The remaining members have been present at all sittings of the Committee, details of which are appended in the following table:—

-----+----- ----- Places and Dates of Sittings. Witnesses examined or Work done. -----+----- -----	
Wellington, 26th July, 1922 (forenoon only)	Preliminary meeting.

Wellington, 8th August, 1922 | Dr. M.H. Watt, Director, Division of
(forenoon only) | Public Hygiene.

| Dr. B.F. Aldred, Officer in Charge

| Venereal Diseases Clinic.

Wellington, 9th August, 1922 | Hon. Dr. W.E. Collins, M.L.C.

(forenoon only) | Mr. J. Caughley, M.A., Director of

| Education.

Auckland, 17th August, 1922 | Dr. Falconer Brown, Officer in Charge

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| Venereal Diseases Clinic.
| Dr. Hilda Northcroft.
| Dr. Frank Macky.
| Dr. W. Gilmour, Bacteriologist and
| Pathologist, Auckland Hospital.
| Dr. C.E. Maguire, Medical Superintendent,
| Auckland Hospital.
| Dr. W.H. Parkes.
| Dr. J. Hardie Neil.
| Dr. R. Tracy Inglis, Medical Officer, St.
| Helens Hospital.
| Dr. E.W. Sharman, Port Health Officer.
| Dr. W.H. Pettit.
Auckland, 18th August, 1922 | Mrs. De Treeby, representing Women's
| International and Political League.
| Dr. D.N.W. Murray, Medical Officer to
| Prisons Department.
| Mr. R.J. Pudney.
| Mr. Egerton Gill.
| Mrs. Harrison Lee Cowie.
| Mrs. E.B. Miller.
| Dr. Kenneth Mackenzie.
| Dr. E.H. Milsom.
| Dr. E. Carrick Robertson.
| Rev. Jasper Calder.
| Mr. F.L. Armitage, Government
| Bacteriologist.
| Dr. W.A. Fairclough.
| Dr. A.N. McKelvey, Medical Officer,
| Costley Home.
Christchurch, 29th August, 1922 | Dr. A.C. Thomson, Officer in Charge
| Venereal Diseases Clinic.
| Dr. P.C. Fenwick.
| Mrs. E. Roberts, President Women's
| Branch, Social Hygiene Society.
| Mrs. A.E. Herbert.
| Dr. A.B. Pearson, Bacteriologist and
| Pathologist, Christchurch Hospital.
| Nurse E.M. Stringer, Health Patrol.
| Dr. W. Fox, Medical Superintendent,
| Christchurch Hospital.

| Dr. C.H. Upham, Port Health Officer.
 | Dr. C.L. Nedwill, Medical Officer to
 | Prisons Department.
 | Dr. D.E. Currie.
 | Dr. J. Guthrie.
 | Dr. W. Irving, Medical Officer, St.
 | Helens Hospital.
 | Dr. A.C. Sandston, President, Men's
 | Branch Social Hygiene Society.
 | Major R. Barnes, Salvation Army Officer.
 | Dr. A.B. Lindsay.
 Dunedin, 31st August, 1922 | Dr. A. Marshall, Officer in Charge
 | Venereal Diseases Clinic.
 | Dr. A.R. Falconer, Medical
 | Superintendent, Dunedin Hospital.
 | Dr. H.L. Ferguson, Dean Medical Faculty,
 | Otago University.
 | Dr. Emily H. Seideberg, Medical Officer,
 | St. Helens Hospital.
 | Dr. J.A. Jenkins.
 | Canon E.R. Nevill, representing the
 | Dunedin Council of Sex Education.
 | Miss Pattrick, Director of Plunket
 | Nursing.
 | Mr. J.M. Galloway, representing Society
 | for Protection of Women and Children.
 | Dr. F.R. Riley.
 Wellington, 12th September | Dr. W. Young.
 (forenoon only) | Mr. T.R. Cresswell, Headmaster,
 | Wellington College.
 | Mr. W.W. Cook, Registrar-General.
 | Mr. Malcolm Fraser, Government
 | Statistician.
 | Mr. W.D. Hunt.
 | Rev. R.S. Gray.
 Wellington, 13th September | Dr. Frank Hay, Inspector-General of
 (forenoon only) | Mental Defectives.
 | Mrs. Henderson, Representative Women
 | Prisoners' Welfare Society and
 | Wellington Branch National Council of
 | Women.
 | Rev. Van Staveren, Jewish Rabbi.
 Wellington, 14th September | Dr. Agnes Bennett, Medical Officer, St.
 | Helens Hospital.
 | Mrs. F. McHugh, Health Patrol.
 | Mr. F. Castle, President Pharmacy Board,

| and Chairman Wellington Hospital Board.
| Dr. D.M. Wilson, Medical Superintendent,
| Wellington Hospital.
| Mr. A.H. Wright, Commissioner of Police.

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| Mr. W. Dinnie, ex-Commissioner of Police,
 | representing Bible in Schools
 | Propaganda Committee.
 | Rev. J.T. Pinfold, D.D., representing
 | Wellington Ministers' Association.
 | Canon T. Feilden Taylor, appointed by the
 | Bishop of Wellington.
 Wellington, 15th September | Major Winton, Salvation Army.
 | Mr. W. Beck, Officer in Charge Special
 | Schools Branch, Education Department.
 | Dr. D.E. Platts-Mills, representing Young
 | Women's Christian Association.
 | Mrs. Morpeth, representing Young Women's
 | Christian Association.
 | Miss Dunlop, representing Young Women's
 | Christian Association.
 | Mrs. Glover, Salvation Army.
 Wellington, 26th September | Consideration of report.
 Wellington, 10th October | Consideration of report.
 Wellington, 12th October | Consideration of report.
 Wellington, 13th October | Consideration of report.
 Wellington, 18th October | Final meeting.

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It will thus be seen that, apart from time spent in travelling, the Committee have met on seventeen days and have heard seventy-four witnesses in person.

The Committee would like to express their thanks to the witnesses, many of whom had gone to considerable trouble to collect information and prepare their evidence. Thanks are also due to the British Medical Association for their willing co-operation and assistance; to the large number of members of the medical profession throughout the Dominion who responded to the Committee's request for information; to Dr. J.H.L. Cumpston, Federal Director-General of Health, Melbourne, for much Australian information on the subject, particularly in relation to Commonwealth quarantine provisions; to Dr. Everitt Atkinson, Commissioner of Public Health, Perth, West Australia, for a most lucid and informative report on the working of the legislation in force in that State; and to many other persons who by means of correspondence and literature have placed at the Committee's disposal a large amount of information which

has been of material assistance in considering various aspects of the problems involved.

The Committee desire to acknowledge their indebtedness to their secretary, Mr. C.J. Drake, whose wide knowledge of public-health matters has been of material assistance in their investigations and who has discharged his duties with marked zeal and ability.

SECTION 2.—VENEREAL DISEASES AND THEIR EFFECTS.

One result of the Committee's investigations has been to show that the public in general are very ignorant regarding the nature of venereal diseases, and their lamentable effects not only upon the individuals infected, but upon the health and well-being of the community as a whole. This ignorance of the nature of the problem and of the grave issues involved naturally stands in the way of the evil being grappled with

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effectually. Furthermore, the policy of reticence which has prevailed in the past, while it has led to the omission of proper instruction of the young, either by their parents or as part of our system of education, has not prevented the dissemination of an incomplete or perverted knowledge of the facts relating to sex, which, being derived as a rule from tainted sources of information, has been productive of a great deal of evil.

In these circumstances the Committee feel it their duty, before making known their recommendations, to state in as plain terms as possible the medical aspects of the problem they have had to consider.

There are three forms of venereal diseases namely, syphilis, gonorrhoea, and chancroid—and of these the first two are the common and most serious diseases. That sporadic syphilis existed in antiquity and even in prehistoric times is probable, but there is no doubt that the disease was a malignant European pandemic in the closing years of the fifteenth century. The first reference to its origin is in a work written about the year 1510, wherein it is described as a new affection in Barcelona, unheard of until brought from Hayti by the sailors of Columbus in 1493. The army of Charles *viii* carried the scourge through Italy, and soon Europe was aflame. “Its enormous prevalence in modern times,” says Dr. Creighton, “dates, without doubt, from the European libertinism of the latter part of the fifteenth century.” Gonorrhoea also has its origin in the shades of antiquity, but that it became common in Europe about 1520 is a fact based on the highest authority.

Syphilization follows civilization, and syphilis is an important factor in the extermination of aboriginal races. Syphilis was introduced into Uganda when that country was opened to trade with the coast, and Colonel Lambkin reported that “In some districts 90 per cent. suffer from it.... Owing to the presence of syphilis the entire population stands a good chance of being exterminated in a very few years, or left a degenerate race fit for nothing.” The earliest known account of the introduction of syphilis into the Maori race is in an old Maori song composed in the far North. The Maori population in a village on the shores of Tom Bowline’s Bay was employed in a whaling-station on the Three Kings Islands, and there they became infected and carried the disease to the mainland. Venereal disease is not common now among the Maoris, but it made great ravages in the early days of colonization, to which may be attributed much of the sterility and repeated miscarriages in the transitional period of Maori history.

Through the ages great confusion existed as to the origin and nature of venereal disease, but in 1905 a micro-organism, the *Spironema pallidum*, was demonstrated as the infective agent in syphilis, and the gonococcus as the infecting organism of gonorrhoea had been discovered in 1879. As regards modes of infection, syphilis is contracted usually by sexual congress; occasionally the mode of infection is accidental and innocent, and congenital transmission is not uncommon. Gonorrhoea is contracted

by sexual congress as a rule, but occasionally from innocent contact with discharges, as in lavatories.

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Syphilis, therefore, is a markedly contagious and inoculable disease. It gains entrance, and usually in three weeks (although this period may be much shorter) a slight sore appears at the site of infection. It may be so slight as to pass unnoticed. This is the primary stage of syphilis. Later, often after two months, the secondary stage begins, and if not properly treated may last for two years. The patient is not too ill usually to attend to his avocation, and has severe headache, skin rashes, loss of hair, inflammation of the eyes, or other varied symptoms. The tertiary stage may be early or delayed, and its effects are serious. Masses of cells of low vitality, known as "gummata," with a tendency to break down or ulcerate, may form in almost any part of the body, and the damage that occurs is considerable indeed. Various diseases result which the lay mind would not associate with syphilis, but it would be difficult to overestimate the resultant diseases that may occur in any organ of the body:—

This racks the joints; this fires the veins:
That every labouring sinew strains;
Those in the deeper vitals rage.

Many deaths ascribed to other causes are the direct consequence of syphilis. It cuts off life at its source, being a frequent cause of abortion and early death of infants. It slays those who otherwise would be strong and vigorous, sometimes striking down with palsy men in their prime, or extinguishing the light of reason. It is an important factor in the production of blindness, deafness, throat affections, heart-disease and degeneration of the arteries, stomach and bowel disease, kidney-disease, and affections of the bones. Congenital syphilis often leads to epilepsy or to idiocy, and most of the victims who survive are a charge on the State. This indictment against syphilis is by no means complete. The economic loss resulting from this disease is enormous as regards young, old, middle-aged. It respects not sex, social rank, or years.

Gonorrhoea is characterized in its commonest form by a discharge of pus from the urethra, and causes acute pain at its onset in the male, but in the female it commonly causes little or no discomfort. Unless carefully treated, and treated early, it gives rise to many complications, such as inflammation of the bladder, gleet, stricture, inflammation of joints, abscesses, and rheumatism. It is a common cause of sterility and of miscarriages, and, in the female, of many internal inflammations and disablement, and in its later effects requires often surgical operations on women. It is a very common disease, and the public know little of the evil consequences which may follow what they have persisted in regarding as a simple complaint. From its prevalence and its complications it is one of the most serious diseases that affect mankind.

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As regards treatment of venereal disease of all kinds, it should be clearly understood that the causative germs are well known and can readily be destroyed immediately after exposure to infection by thorough cleansing with antiseptic lotion or ointment. The use of soap and water only would lessen the incidence of infection. On the first suspicious sign of venereal disease the patient should apply at once for medical advice. There are methods of diagnosis, such as microscopic examination and the Wassermann test, the result of recent discovery, which make diagnosis simple and certain; and if treatment is begun early according to modern methods, which are much more effective than the remedies formerly applied, the germs of infection are easily vanquished. When sufficient time, however, is lost to enable these germs to become entrenched in parts of the body not readily accessible to treatment, cure is difficult, prolonged, and perhaps in some cases uncertain.

For their own sakes, as well as for the sake of others, patients suffering from any form of venereal disease should continue treatment, which may be prolonged in the case of syphilis for two years, until their medical adviser is satisfied that further treatment is unnecessary.

Women suffer less pain than men in these diseases, and consequently are more apt to neglect securing medical advice and treatment, and more ready to discontinue treatment before a cure is effected.

SECTION 3.—ACCIDENTAL INFECTION.

Occasionally cases are met with in which syphilis is acquired innocently by direct or indirect contact with syphilitic material, and then the primary sore is often located on some other part of the body than the genitals. Thus the lip may be infected by kissing, or by drinking out of the same glass, or smoking the same pipe as a syphilitic patient. A medical witness reported a case to the Committee in which syphilis was conveyed to two girls "through a young fellow handing them a cigarette which he was smoking." Metchnikoff has proved that the spirochete of syphilis is a delicate organism and quickly loses its virulence outside the human body, and it cannot enter the system through unbroken skin or mucous membrane. It is extremely doubtful if any form of venereal infection can be conveyed in food. Frequently venereal disease is deceitfully attributed by patients to innocent infection, and no doubt some genuine cases do occur, but how seldom is illustrated by the statement of the Officer in Charge of the V.D. Clinic at Christchurch, who said, "I cannot remember a case where I was absolutely certain that infection was acquired innocently or extragenitally."

Gonorrhoea may be conveyed innocently from infective discharge on a closet-seat, or from an infected towel, &c., and undoubtedly gonorrhoeal discharge if brought into contact with the eye sets up a violent suppuration.

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The Committee are of opinion that the extent of accidental infection is greatly exaggerated in the public mind, but a few cases occasionally occur, and the Committee recommend that there should be better provision of public conveniences, especially for women, and the U-shaped closet-seat should be adopted. The use of common towels and drinking-cups in railway-trains, schools, factories, and elsewhere is condemned not only for the reasons stated above, but on general sanitary grounds.

SECTION 4.—PREVIOUS INQUIRIES AND CONFERENCES.

After the repeal of the Contagious Diseases Act in England in 1886, various Committees and Royal Commissions, such as the Inter-departmental Committee on Physical Deterioration in 1904, the Royal Commission on the Poor-laws in 1909, and the Royal Commission on Divorce in 1912, drew attention to the frightful havoc wrought by venereal disease, and urged that further action should be taken to deal with the evil. In 1913 the British Government appointed a Royal Commission to inquire into the prevalence of venereal diseases in the United Kingdom, their effects upon the health of the community, and the means by which these effects could be alleviated or prevented, it being understood that no return to the policy or provisions of the Contagious Diseases Acts was to be regarded as falling within the scope of the inquiry.

The Commission took a great deal of most valuable evidence, and did not present their final report until 1916. They recommended improved facilities for diagnosis and treatment, including free clinics. They came to the conclusion that at that time any system of compulsory personal notification would fail to secure the advantages claimed. The Commission added, however, "it is possible that the situation may be modified when these facilities for diagnosis and treatment [recommended by the Commission] have been in operation for some time, and the question of notification should then be further considered. It is also possible that when the general public become alive to the grave dangers arising from venereal disease, notification in some form will be demanded." The Commission supported the adoption of a recommendation by the Royal Commission on Divorce to the effect that where one of the parties at the time of marriage is suffering from venereal disease in a communicable form and the fact is not disclosed by the party, the other party shall be entitled to obtain a decree annulling the marriage, provided that the suit is instituted within a year of the celebration of the marriage, and there has been no marital intercourse after the discovery of the infection. The Commission urged that more careful instruction should be provided in regard to moral conduct as bearing upon sexual relations throughout all types and grades of education. Such instruction, they urged, should be based upon moral principles and spiritual considerations, and should not be based only on the physical consequences of immoral conduct. They also favoured general propaganda work, and urged that the National Council for Combating Venereal Diseases should be recognized

by Government as an authoritative body for the purpose of spreading knowledge and giving advice.

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Another important Commission, sitting almost simultaneously with that just referred to, was the National Birth-rate Commission, which began its labours on the 24th October, 1913, and presented its first Report on the 28th June, 1916. The Commission was reconstituted, with the Bishop of Birmingham as Chairman, in 1918, to further consider the question, and especially in view of the effects of the Great War upon vital problems of population. Among the terms of reference the Commission were requested to inquire into "the present spread of venereal disease, the chief causes of sterility and degeneracy, and the further menace of these diseases during demobilization." The Commission in their report, presented in 1920, stated that they realized the difficulties involved in the introduction of any efficient scheme of compulsory notification and treatment of venereal diseases, but, they added, they "feel that it has now passed the experimental stage both in our colonies and in forty of the forty-eight of the United States of America, and think it is advisable for the State to make a trial of compulsory notification and treatment in this country, provided that there should be no return to the principles or practice of the Contagious Diseases Act." Referring to the finding of the Royal Commission on Venereal Disease that it would not be possible at present to organize a satisfactory method of certification of fitness for marriage, the National Birth-rate Commission thought this question should now be reconsidered with a view to legislation. "If," says the report, "a certificate of health was to become a legal obligation for persons contemplating marriage, many of the legal, ethical, and professional difficulties surrounding this question would be removed."

In Sweden, where a Venereal Diseases Law was passed in 1918, stress was laid on the importance of general enlightenment with regard to venereal disease and germane subjects, such as sex hygiene. A committee was appointed, consisting of experts in medicine and pedagogy, to inquire into the best means of providing such education. Their report, which has just been issued, is described by the *British Medical Journal* as a document of considerable value, promising to become the charter of a new and complete system of sex education and hygiene in schools throughout Sweden. Further reference will be made to this document in the section of this report dealing with education.

The subject of venereal disease has also been considered by more than one important Medical Conference in Australia and New Zealand.

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At a general meeting of the Australasian Medical Congress held in Melbourne in October, 1908, it was resolved that the executive be recommended to appoint a committee to investigate and report on the facts in regard to syphilis. Such a committee was appointed, and reported to the Congress in Sydney in 1911. In 1914 the Congress was held in Auckland, and a special committee which had been appointed, with the Hon. Dr. W.E. Collins, M.L.C., as chairman, presented a valuable report giving some interesting information in regard to the prevalence of venereal disease, in New Zealand. The committee recommended that syphilis be declared a notifiable disease; that notification be encouraged and discretionary, but not compulsory; and that the Chief Medical Officer of Health be the only person to whom the notification be made. They also recommended the provision of laboratories for the diagnosis of syphilis, and that free treatment for syphilis be provided in the public hospitals and dispensaries. These recommendations were embodied in the report adopted by the Congress.

In February of the present year an important Conference, convened by the Prime Minister of Australia, was held in Parliament House, Melbourne. It was attended by official representatives of the Health Departments of all the States, together with representatives from the British Medical Association, the Women's Medical Staff at the Queen Victoria Hospital Diseases Clinic in Melbourne, and other scientific and medical authorities. The Commonwealth subsidizes the work of the States in combating venereal disease, and the object of the Prime Minister in calling the Conference was in order that it might inquire into the effectiveness of the present system of legislation, of administrative measures, and of clinical methods, with a view of determining whether the best results were being obtained for the expenditure of the money.

Western Australia has an Act, which came into operation in June, 1916, providing for what is known as conditional notification of patients, together with other provisions for the control of venereal disease which are on a more comprehensive scale than has been attempted anywhere with the possible exception of Denmark. In December, 1916, Victoria passed a similar Act, and this example was followed by Queensland, Tasmania, and New South Wales.

The Conference, answering the several questions put to it, found that a greater proportion of persons infected with venereal disease were receiving more effective treatment than before the passing of the Venereal Diseases Act. In the opinion of the Conference this was due partly to the passing of legislation and partly to the opening of clinics affording greater opportunities for free treatment. They considered the operations of the Act had been more successful in bringing men under treatment than it had been in the case of women. Among the opinions expressed by the committee were the following: The Act was not equally successful in respect of private and hospital patients in regard to notification, but was equally successful in respect of securing to both more effective treatment. There has been an apparent reduction in the prevalence of venereal diseases, and the Conference were strongly of opinion that the results so far justify the continuance of these Acts in operation.

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The Conference found that venereal diseases are the most potent of all causes of sterility and of infant and foetal morbidity and mortality. It recommended, among other remedial measures, that prophylactic depots, both for males and females, should be established as widely in the community as possible. Referring to the educational aspect, the Conference urged that children should be instructed in general biological facts up to the age of puberty, when more explicit information concerning facts of sexual life should be given. They urged on all parents and educational, philanthropic, and religious organizations the pressing necessity for a sustained campaign, in co-operation with the medical profession, in order to inculcate in the community higher ideals of personal hygiene and health.

Lastly, it may be mentioned that, at the instance of Lord Dawson of Penn, a highly qualified and representative committee of medical men, with Lord Trevethin as chairman, has been appointed in England to report to the Minister of Health upon "the best medical measures for preventing venereal disease in the civil community, having regard to administrative practicability, including cost." The appointment of such a committee was requested by Lord Dawson chiefly with a view to obtaining an authoritative pronouncement on the subject of medical preventive measures, and the committee's report will be awaited with much interest.

SECTION 5.—LEGISLATION IN NEW ZEALAND, PAST AND PRESENT.

(A) Contagious Diseases Act (repealed).

The Contagious Diseases Act was passed in 1869, and repealed in 1910. Briefly, its aim was to secure periodical examinations of prostitutes, and to detain for treatment those prostitutes found infected with venereal disease.

There appears to be, in some quarters, an apprehension that hidden beneath the movement to combat venereal diseases is an implied desire or intention to reinstate the antiquated and detested provisions of that Act. The Committee deem it necessary to say that they have not found grounds for this suspicion; that no legislation can be effective unless it deals equally and adequately with all men, women, and children sufferers from venereal diseases of all kinds; that it finds little evidence of a definite prostitute class in New Zealand, and, even if there were such, the Contagious Diseases Acts have been proved to be useless as measures towards the prevention of venereal infections; and it is the Committee's individual and collective opinion that anything involving a return to the administrative procedure of the Contagious Diseases Act should have no part whatever in any new legislation in this Dominion.

(B.) Examples of Difficulties—Concrete Cases.

Before proceeding to refer to present and suggested legislation, a few incidents and cases taken from the evidence may help, as concrete examples, to indicate the difficulties to be contended with:—

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Case 1.—A man—young and married, a municipal employee in a city—associated sexually with a female employee in an eating-house frequented by himself and co-employees. In due time he sought the advice of the Medical Officer of Health for (what he suspected) severe syphilis. Steps were taken to obtain his speedy admission to the local hospital. The woman continued in her employment.

Case 2.—A social-hygiene worker in her evidence said: “I think the majority of cases I deal with (girls attending a hospital clinic) are caused through mental depravity, and in some instances you cannot convince them—they continue to carry on. I have tried all I know how to show them the dangers, but they just laugh at me. I think it is really in many cases just a mental condition—mental degeneration, possibly.” This officer explained that even while actually attending the clinic some of these girls (affected with gonorrhoea), without any semblance of reserve or decency, would discuss arrangements for further intercourse with men, and on leaving the clinic (still in an infectious state) were even seen to go off with young men waiting for them.

Case 3.—Asked if he knew of any cases where the disease had been contracted innocently, a medical practitioner stated in evidence: “I know of a case where two girls in — were infected (syphilis) on the lip through a young fellow handing them a cigarette which he was smoking.”

Case 4.—A medical man in private practice, and Medical Superintendent of the hospital in a small country town, states: “Although, judging from an experience of over fifteen years, this district would appear to be peculiarly free from any variety of venereal disease, I think it may be of interest to your Committee to know what happened here in the early part of 1918. At that time there came to reside with her father in —, a township about nine miles south of —, a woman, —, who, shortly after her arrival consulted the late Dr. —, and was found to be the subject of secondary syphilis.... In all, three cases of gonorrhoea, four of soft chancre (three of whom suffered from phagadoemic ulceration which laid them up for weeks), and six cases of purely syphilitic infection came under my care, all traceable to this same woman. As every case of gonorrhoea and soft chancre afterwards developed syphilis, ultimately I had thirteen cases of syphilis under my treatment alone. Others, I have good reason to believe, went to other towns, and doubtless some failed to seek any kind of help.... Having prevailed upon the woman to come to my surgery ... I told her that she was suffering from three varieties of venereal disease, which she was freely disseminating. I then read to her that part of the Act which deals with those who “knowingly and wilfully disseminate venereal infection.” That same afternoon she left for —, where she continued to ply her calling unhindered. Who can estimate

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the sum of the damage done by one such person? Not one of those men infected was properly treated, although I did all I possibly could to convince them of their own danger and of the risk of spreading infection to others. Gradually, as the obvious signs of active disease abated, they drifted away. I may say the Wassermann reaction proved strongly positive in every case.... One of these men passed on his infection (syphilis) to a young girl in this town, and she in turn infected other men, one of whom came to me, while others went to my colleagues. Another man of the first group, about middle age, and previously a very healthy, sober, hard-working fellow, has developed thrombosis of his middle cerebral artery as the result of a syphilitic endarteritis. He is totally incapacitated, and in the Old Men's Home at ——. He remains a permanent charge on the community.”

(C.) *Hospital and Charitable Institutions Act, 1913, Section 19.*

In 1913 the need for detention provisions, to cover any infectious or contagious disease, received the attention of Parliament, and these are embodied in section 19 of the Hospitals and Charitable Institutions Act, 1913, thus:

“19. (1.) The Governor may from time to time, by Order in Council gazetted, make regulations for the reception into any institution under the principal Act of persons suffering from any contagious or infectious disease, and for the detention of such persons in such institution until they may be discharged without danger to the public health.” (2.) Any person in respect of whom an order under this section is made may at any time while such order remains in force appeal therefrom to a Magistrate exercising jurisdiction in the locality, and the Magistrate shall have jurisdiction to hear such appeal and to make such order in the matter as he thinks fit. An order of a Magistrate under this subsection shall be final and conclusive.

“(3.) Regulations under this section may be made to apply generally or to any specified institution or institutions.”

The Committee are advised that this section was not aimed solely at venereal diseases. In that year, and prior thereto, was prominent the difficulty of detaining consumptives who refused to take precautions to prevent the spread of their disease to others; and, again, much attention was being centred on the chronic typhoid and diphtheria “carrier.” It seemed rational to compel isolation of such persons in hospital until there was some assurance that they would no longer be a danger to the community if allowed their liberty. Regulations under the Act were not issued, owing to opposition manifested at the time, and consequently the section never became operative.

(D.) *The Prisoners Detention Act, 1915.*

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This Act secures that individuals of one class of the community—viz., convicted persons—can be held until freed from venereal disease with which they were known or found to be infected. The measure is of value, but logically seems unsound, because the venereal diseases from which such persons suffer are in no way a greater danger to the public than the same diseases in the law-abiding subject of any class, and, furthermore, the Committee have no reason to conclude from the evidence that convicted persons, as a whole, show a higher percentage of venereal cases than those who never enter a prison. The Controller-General of Prisons submitted a schedule showing that the number of prisoners detained under the Prisoners Detention Act from its commencement in 1916 to 1922 was twenty-eight, consisting of nineteen males and nine females.

(E.) *Social Hygiene Act, 1917.*

In the words of the Commissioner for Public Health of West Australia, who prepared the first comprehensive legislation on venereal diseases in 1915, this Act “can hardly be classed with recent Australian legislation, for the reason that it provides for no notification of the disease and no compulsory examination.” By this Act infected persons are required to consult a medical practitioner and go under treatment by him, or at a hospital; but no penalty is provided, and there is nothing to compel such persons to do either of these things.

Reference to case 1 in the concrete examples cited above will show the weakness of the Act. The waitress continued in employment, handling cups and spoons and cakes, &c. The Medical Officer of Health had every reason to believe she was infected with syphilis, but, not having the power to insist on her obtaining medical advice, he could do nothing to enforce the provisions of section 6 of the Act.

Section 7, making it an offence for any person not being a registered medical practitioner to undertake for payment or other reward the treatment of any venereal disease, has, in the opinion of the Commissioner of Police, proved beneficial in restricting the operation of quacks, but he suggests that it should be amended by deleting the words “for payment or reward,” as it is sometimes easy to prove the treatment and difficult to prove the payment, and it is the treatment by unqualified persons that is aimed at.

Section 8, which makes it an offence knowingly to infect any person with venereal disease, is practically inoperative, as will be shown later in this report, owing to the extreme difficulty, in the absence of any system of notification and compulsory treatment, of proving that the offence was committed knowingly.

The Committee desire to draw attention to section 13. Herein is provided towards hospital maintenance a higher subsidy for venereal patients than is receivable for the maintenance of patients suffering from other infectious diseases. They think that it is

inadvisable to particularize venereal sufferers, or, indeed, to draw any distinction between different classes of diseases in a hospital, and that the ordinary subsidy should be paid in all cases.

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In this Act also is power to make regulations for the “classification, treatment, control, and discipline of persons *detained* in such hospitals,” but apparently, owing to the opposition to the almost analagous provision in the Hospitals and Charitable Institutions Act, 1913, no such regulations have as yet been made.

PART II—PREVALENCE OF VENEREAL DISEASES IN NEW ZEALAND.

SECTION 1.—STATISTICAL.

(A.) Medical Statistics.

The first item on the Committee's order of reference is “To inquire and report, as to prevalence of venereal diseases in New Zealand.”

One of the first matters which engaged the attention of the Committee was the question how reliable information could be gathered which would indicate the present prevalence of these diseases in this country. Recognizing that it would be impossible to obtain trustworthy figures without securing the widespread co-operation of the medical profession, the Committee at an early stage sought and was readily given the help of the British Medical Association in the matter. Representatives of the Association gave their assistance in the preparation of a form to be sent to and filled in by all practising members of the profession, and in the current number of the *New Zealand Medical Journal* an appeal to members for their collaboration was made. Suitable circular letters were also prepared by the Committee asking medical practitioners for their co-operation, and the Committee are pleased to be able to report that out of about 750 in actual practice, no fewer than 635 medical practitioners sent in completed returns. A copy of the form used for these returns will be found as an appendix to this report, as also a tabulated return of the replies received and compilations therefrom.

It will be seen that the total number of cases of all forms of venereal diseases and of diseases attributable to venereal disease under the personal care of the doctors reporting is 3,031; and, taking the population of New Zealand as 1,296,986 (estimated population 31st March, 1922), this means that about one person in every 428 of our population is at present being treated for venereal infection or for the results thereof. Acute and chronic gonorrhoeal infections give a total of 1,598, being about one person in every 812 of the population. This is most likely a very low estimate, for the Committee have had it very definitely in evidence that many persons suffering, at least from acute gonorrhoea, seek treatment at the hands of persons other than registered medical practitioners. For syphilitic infections in all forms the total is 1,419, about one person in every 914 of the population. The return bears out other evidence showing that the chancroid or soft-sore type of infection is rare in this Dominion.

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The Committee regard the result obtained as furnishing some indication of the amount of active venereal disease existing in the Dominion. The Committee consider, however, that these figures must be considerably on the low side, for these reasons: (a) that a number of medical practitioners have not replied: (b) that some diseases attributable to venereal disease may not have been conclusively diagnosed as such, and, therefore, not included in the return. The return necessarily does not include cases, probably numerous, which have not been under medical care for some time, if at all; (c) to secure a complete return would have involved the keeping by each doctor of full records of all cases and a careful and laborious collation of figures.

With respect to the expression of opinion asked of medical practitioners upon the question "If venereal disease in this Dominion has or has not increased in a greater proportion than the population during the last five years," it will be seen that of 322 who replied, 199 answered "Yes" and 203 "No." This is necessarily purely a matter of impression, and it must also be borne in mind that the evidence shows that patients are now using the clinics in large numbers, while others who formerly went to general practitioners now consult specialists who have recently started in practice. On the other hand, it is possible there is a compensating influence in the fact that the public are being educated to the importance of seeking skilled medical treatment for these diseases.

(B.) Clinic Statistics.

A second source of information as to the prevalence of venereal diseases was provided by the statistics which have been compiled by the Department of Health as the result of the establishment of the venereal-diseases clinics. Among the appendices to this report will be found a return showing the number of persons attending at each of these clinics for the years 1920, 1921, and part of 1922, and recorded under the headings "Sexes" and "Diseases." These statistics are valuable inasmuch as they record facts, but with respect to the total prevalence they are but an indication, since they relate only to a small proportion of the population who have become infected and sought treatment. From this table (B) it will be found that the males attending for the first time represent 83.60 per cent. of the total, and females 16.40 per cent., or, roughly, a ratio of six males to every female.

Clinic Distribution.—In the figures for syphilis the following points are worthy of note: Auckland: A distinctly higher number of cases than the other centres. A marked drop in 1921 for males, but the return for this year indicates a rise; female cases show a rise for this year. Wellington: Returns appear fairly uniform, with a slight falling tendency, most marked in the females. Christchurch: A drop in male cases, with a fairly uniform rate of females. Dunedin: Here the rates appear uniform, with exception of a fall for males in 1922.

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As to gonorrhoea, these points may be noted: Auckland: A marked rise. Wellington: Steady rise with exception of females. Christchurch: Slight rise since 1920: females uniform rate. Dunedin: Slight rise, with indication of male increase in 1922.

Age Distribution.—The age-period of persons attending the clinics is mainly eighteen to thirty.

Marital Condition.—From the evidence of the clinics it is very apparent that venereal disease is especially a problem associated with the unmarried.

(C.) Mental Hospital Statistics.

A third source of estimation of prevalence was opened to the Committee by the Inspector-General of Mental Hospitals. The method of investigation adopted by Dr. Hay is based on Fournier's estimate that 3 per cent. of the cases of syphilis existing at any one time will ultimately develop dementia paralytica.

The introduction of the Wassermann test and treatment by salvarsan or other arsenical preparations will vitiate this index in future, for the reasons that by the Wassermann test more cases will be diagnosed, and by the use of recent remedies the complete cure of many more cases will be effected, and consequently fewer will develop dementia paralytica. This disability does not develop until about ten to fifteen years after infection. The Wassermann test and the modern arsenical preparations have not yet been in use for that period, therefore these figures, as an estimate of the prevalence of syphilis in 1921, would not be materially affected by these developments. An estimate based on these data may therefore be regarded in the meantime as approximately correct.

During the past ten years 4,763 males and 3,747 females have been admitted into New Zealand mental hospitals. The percentage of syphilitic admissions of all types was 4.74, while the percentage of cases of dementia paralytica was 3.89. In other words, of the admission of syphilitics 82 out of every 100 cases were dementia paralytica. The average yearly number of deaths from dementia paralytica according to the Government Statistician's returns between 1908 and 1921 was just under 40.

If Fournier's estimate that 3 per cent. of syphilitics ultimately develop dementia paralytica be accepted, one would arrive at the annual infection by multiplying 40 by 33, which gives 1,320. Assuming the average duration of life, after infection, to be twenty-five years, this means that at any given time there are twenty-five years' infections on hand. Dr. Hay computed from this the number of persons in New Zealand now who have, or have had, syphilis to be $1,320 \times 25$, equalling 33,000, or 1 to every 38 of the population. If the average duration of life after infection were assumed to be thirty years, the figures would be 1 to every 32 of the population.

Taking the figure for syphilitic infections over a period of years at 1,320 per annum, this would mean for the population of New Zealand (exclusive of Maoris) 1 fresh infection annually in about every 850 persons.

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(D.) Incidence among Maoris.

It is even more difficult than in the case of the European population to say what is the prevalence of venereal diseases amongst Maoris. The Director of the Division of Maori Hygiene (Dr. Te Rangi Hiroa) in a statement to the Committee says:—

“Venereal disease made great ravages amongst the Maori population in the early days of colonization. To this may be attributed much of the sterility, with histories of repeated miscarriages, that existed in the transitional period of Maori history. Most of the old men—hemiplegias, and paraplegias, and subsequent general paralysis of the insane—gave an old history of syphilis. These cases that I saw twenty years ago have now disappeared.

“In my experience of eighteen years’ constant work amongst the Maoris venereal disease has been comparatively rare. It disappeared amongst the people, only to recrudescence in some localities as fresh infection was introduced by the white man, or brought back to the settlements by visits to the white towns. I see very little of it at present, but now and again hear reports from medical officers that it has cropped up in the settlements near them ... In all these cases I am convinced that the origin is from a white source, and the problem amongst the Maoris is not nearly so serious as amongst Europeans. It seems to me unjust that the idea should be circulated that the Maoris are a source of danger to the European community—the reverse is much more likely.

“It is impossible for me to supply accurate data as to the incidence of the disease amongst the Maori race at present, but I am confident that reports have a natural tendency to become exaggerated. I do not consider that returned Maori soldiers, owing to the treatment they received before being discharged from the service, have been a factor in the introduction of the disease amongst the settlements. If they have in some areas, it has been from fresh infection, which their experience of prostitution in Egypt and Europe has made them more liable to acquire from professional and amateur prostitutes in towns. At the same time, the experience of returned soldiers as to the value of treatment makes them more likely to seek such aid.”

(E.) Death-certificates.

There are no trustworthy statistics in any part of the British Empire of the deaths due to venereal disease. Many persons die from illnesses which result from an initial syphilis contracted perhaps many years prior to death. It is well known that medical practitioners, from a laudable desire to spare the feelings of relatives, refrain from stating the primary cause of death in such cases, and merely enter the secondary or proximate cause. For the same reason, the statistics regarding deaths due to alcoholism, and perhaps in a less degree some other factors in the mortality returns, are incomplete and consequently useless.

Both the Royal Commission on Venereal Diseases and the Birth-rate Commission recommended that the medical attendant should issue two certificates—one, which would be a simple certificate of death, to be handed to the relatives, and the other, a confidential certificate giving the primary cause of death, which would be transmitted to the Registrar.

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The Registrar-General for New Zealand, Mr. W.W. Cook, in his evidence in chief, stated that he did not favour these suggestions. A certificate of death, he said, cannot be regarded as confidential, as the information contained therein is recorded in the death entry, which may be inspected by the public, and of which a copy may be obtained by any applicant. In reply to questions, however, he stated that the law could no doubt be altered so as to make the death-certificate confidential, the information to be given up only on an order from a Court of justice. Apart from the fact that the insurance companies might object, he did not see any objection from the public point of view.

Mr. Malcolm Fraser, the Government Statistician, said that there was considerable division of opinion on this question at the British Empire Statistical Conference held in London in 1920, when statisticians from all parts of the Empire were present. It was generally agreed that the system was good theoretically, but some doubt was expressed whether in practice there would be as much improvement as was expected, since the system would depend entirely on the medical attendant strictly complying therewith and disclosing the true cause of death in every case. Any system of confidential information always had that failing. The witness thought the register must be open for persons having a right to call for copies of entries. In dealing with insurance claims at death the truth or otherwise of the statement in the proposal form was important, and might require verification by inspection of the death entry. At the Conference Dr. Stevenson, the Statistician to the Registrar-General of the United Kingdom, was very pronounced in his advocacy of the confidential form of certificate. The Conference passed the following resolutions: "(1.) That the present system of open certification tends to prevent candid statements of the causes of death, and thus introduces a systematic error into death statistics. (2.) That the error would be eliminated by a system of confidential certification."

The Committee, while agreeing that such a system of registration of deaths would undoubtedly afford better means of approximating to correct returns of mortality not only from venereal diseases but also from alcoholism and some other diseases, would point out that, if New Zealand were to adopt the reform while the rest of the Empire retained the present system, the result would be to place the Dominion in an apparently unfavourable light in comparison with other parts of the Empire in regard to the mortality from these diseases.

SECTION 2.—CAUSES OF THE PREVALENCE OF VENEREAL DISEASES IN NEW ZEALAND.

In discussing this order of reference the Committee desire it clearly understood that these causes are not peculiar to New Zealand, and do not operate more extensively in New Zealand than elsewhere. The Committee are concerned, however, in discussing this question only as it affects New Zealand.

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The causes of the spread of venereal disease may be classified under two main headings: (1) The presence of infected individuals acting as foci of infection; (2) the occurrence of promiscuous sexual intercourse, by which in the great majority of cases the disease is actually transmitted from one individual to another.

(1.) The Presence of Infected Individuals.

These sources of infection arise and persist for the following reasons:—

(1.) Neglect by infected persons to undergo treatment. (2.) Neglect to continue treatment till no longer infective. (3.) The treatment of infected individuals by unqualified persons, such as chemists, herbalists, chiropractors, &c. In these cases the disease becomes chronic, and the best opportunity for its treatment and cure has passed before the case is seen by a medical man. (4.) By the introduction of venereal disease to this country from overseas.

(2.) The Occurrence of Promiscuous Sexual Intercourse.

A striking portion of the evidence placed before the Committee was that which showed the very small amount of professional prostitution in New Zealand. This was supported by the valuable evidence of Mr. W. Dinnie, ex-Commissioner of Police, and Mr. A.H. Wright, Commissioner of Police. The latter witness stated that there were only 104 professional prostitutes in the Dominion.

It would appear also that the professional prostitute, as a result of her knowledge and experience, is less likely to transmit venereal disease than the “amateur.” It is therefore principally to clandestine or amateur prostitution that one must look for the dissemination of the disease, and inquiry into the conditions which tend to the production of the amateur prostitute is a direct inquiry into the causes of the prevalence of venereal disease.

The evidence before the Committee shows that this promiscuity is very prevalent, and that it is not confined to any particular social strata. The fact is also strikingly demonstrated by Table A in the appendix. From this table it will be seen that during the period 1913-21 there were 10,841 illegitimate births and 33,738 legitimate first births within one year after marriage. If to the illegitimate births we add the total number of live births occurring within the first seven months of marriage *viz.*, 12,235—which may be safely considered to have been conceived before marriage, we get a total of 23,076 births in which conception took place extra-maritally. In other words, more than 50 per cent. of total first births occurring within twelve months of marriage result from sexual contact prior to marriage.

Some factors which contribute in a greater or less degree to the moral laxity which leads to promiscuous sexual intercourse are:—

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(1.) The relaxation of parental control, which was emphasized by many witnesses. Girls stay less at home and assist less in the work of the home, preferring whenever opportunity offers, to go to the pictures or some other form of entertainment.

(2.) Lack of education of the young in the facts pertaining to sex. Especially the Committee would call attention to the unfounded belief of many that continence in young men is injurious to health.

(3.) Bad housing and general conditions of living. When members of both sexes are crowded together in restricted accommodation in which often insufficient conveniences are supplied, it is easy to conceive of a relaxation of the proprieties of life which might lead to acts of immorality. In this connection the Committee desire to call attention to the excellent work done by the Y.W.C.A. and other bodies in the provision of hostels in which girls are provided with board and lodging at very reasonable cost. The Committee were surprised to learn that full advantage was not taken of these provisions, and that the accommodation at these hostels was not fully occupied. It would appear that many girls resent the very slight amount of supervision and restraint exercised over them, precisely as they do parental control. (4.) The presence in the community of individuals, especially girls, who are to some degree mentally defective or morally imbecile. The Committee were given several individual instances in which such girls had acted as foci of infection; they are easily approached, and facile victims for men. In spite of a degree of mental or moral defect they may be physically attractive. (5.) Economic conditions which delay marriage may reasonably be regarded as a factor in conducing to an increased frequency of extra-marital sexual relationship. Graph A in the appendix shows clearly that the age of marriage in both sexes has, with slight fluctuations, steadily increased from 1900 to 1921. (6.) Alcohol tends to the dissemination and persistence of venereal disease: it increases sexual desire, lessens control, causes the individual to be less careful as regards cleanliness, &c., after exposure to infection, and militates against effective treatment. It is to be pointed out, however, that the lower control possessed by some individuals may be the actual predisposing cause, both of laxity in sexual matters and of the excessive ingestion of alcohol. There appears no doubt that alcohol is an important factor in the prevalence of venereal disease, although probably not so potent as represented by some witnesses.

(7.) Accidental infections are undoubtedly rare. They may arise from contact with W.C. seats, dirty towels, and eating and drinking utensils in public places.

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(8.) Other factors of minor importance which were mentioned in evidence were the modern dress of women, which was stated to be in certain cases sexually suggestive, and certain modern forms of dancing. There appears some grounds to suppose that dances conducted under undesirable conditions contribute to sexual immorality, but the Committee see no reason to condemn dancing generally because the coincident conditions under which it has been or is conducted in some cases have contributed to impropriety. The cinema was stated by some witnesses to have an immoral tendency both in the nature of the pictures presented and in the conditions under which they are viewed by the audience. The Committee suggest that a stricter censorship might with advantage be exercised, and should include the posters advertising the films.

It has been stated that venereal disease has increased in New Zealand with the return of the Expeditionary Force from overseas. Ample evidence, however, was given to the Committee that there has been no increase of the disease due to returned soldiers. These men were treated prior to their discharge until non-infective.

PART III.—BEST MEANS OF COMBATING AND PREVENTING VENEREAL DISEASE.

SECTION 1.—EDUCATION AND MORAL CONTROL.

There is no question that the most effective way of avoiding venereal disease is to refrain from promiscuous sexual intercourse. The problem which the Committee have been asked to consider has very important medical aspects, but, while these must not be neglected, it is essential to the health and well-being of the nation that the enemy should be attacked with every moral and spiritual weapon:—

Self reverence, self-knowledge, self-control,—
These three alone lead life to sovereign power.

The absence of proper training and instruction of the young is undoubtedly responsible for a great deal of the evil which has been shown to exist. Children are led into bad habits through ignorance, and young men and young women grow up with utterly false ideals of life, and in many cases fall into deplorable laxity of conduct.

There is an impression among many young men that chastity is either impossible or at least is inconsistent with physical health. There is the highest medical authority for stating that this notion is absolutely wrong, while there is no difference of opinion whatever as to the serious risks of contracting diseases of a very loathsome character incurred by those who do not restrain their passions. Apart from this aspect of the question, it must be obvious to every thinking person that looseness of conduct between the sexes such as is shown to exist in New Zealand is destructive to the high ideals of

family life associated with the finest types of British manhood and womanhood, and if not checked must lead to the decadence of the nation.

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A sounder state of public opinion needs to be cultivated. The moral stigma at present attached to sufferers from venereal disease should rest upon all who sacrifice to their own selfish passions the chivalrous relations which should subsist between the sexes. Those who are unfortunate enough to contract disease incur a punishment so terrible that they deserve our pity and our succour, always provided that they seek skilled treatment and refrain from any conduct likely to communicate the disease to others. The man or woman who negligently or wilfully does anything likely to lead to the infection of any other person is a criminal, and should be treated as such.

To bring about this healthier state of public opinion much might be done by the various Churches, by the Press, and by all who are in a position to influence the thoughts of others. It is a duty which should be shared by all—it cannot be left entirely to the Government, to Parliament, or to the medical profession. If a healthier atmosphere were created for the proper consideration of this subject, instead of the unwholesome fog of prudery in which it has been enveloped in the past, a great deal will have been gained.

One result of the mistaken policy of reticence which has prevailed is to be seen in the fact, already mentioned, that children are allowed to grow up either in ignorance of sex physiology or with perverted ideas due to the want of proper instruction. Nearly every witness who spoke on the subject before the Committee agreed that such instruction would come best from the parents, but there is also practical unanimity among those who gave evidence that very few parents are capable of giving such instruction in the right way, and the vast majority are unwilling to attempt it. In these circumstances our chief hope for the future seems to lie in an endeavour to educate the children in such a way that they, the parents of the future, may be enabled to deal justly with their own children in this vital matter. Nevertheless, the Committee would be failing in their duty did they not point out that all parents have a serious responsibility to their children which they cannot evade without laying themselves open to grave reproach. It is probable, as one of the witnesses remarked, that “nothing they could do for their children’s happiness in life would be of equal value to the outlook which they might give to their children upon this matter. Apart from any possibility of moral ruin or disease, such an outlook would colour the whole mature life of their children in respect to what is probably the foundation of the greatest human happiness—namely, home relationship.”

The Committee recommend that the Department of Health be asked to prepare a suitable pamphlet to assist those parents who desire to instruct their boys and girls on this subject. It is also suggested that where parents feel themselves unable to undertake the necessary instruction, the family doctor should be asked to talk to the boys. Instruction to the girls should certainly come from the mother, but failing this a little wise counsel and advice from a woman doctor should be secured.

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In regard to the teaching of sex hygiene in schools some interesting evidence was given to the Committee by Mr. Caughley, Director of Education, Mr. T.R. Cresswell, Principal of the Wellington College (speaking on behalf of the Secondary Schools Association), and by some of the women doctors and others who were good enough to attend as witnesses.

Mr. Caughley stresses the point that it is not mere knowledge of physiology that will meet the case. He considers that the most important thing of all is to establish in the minds of the children noble ideals with regard to infancy and motherhood. Lessons in connection with the care of all birds and animals for their young, with the love and devotion of parents for their young, with all that is beautiful and tender connected with the homes of animals and birds, would establish a kind of reverence about everything that is connected with birth. He deprecates mechanical, systematic, and consecutive instruction in the mere facts of sex hygiene, for even the fullest knowledge on this subject is known to have very little deterrent effect in the temptations of life. He would rather aim at creating the right atmosphere in a school, such as would make any coarse or unworthy mention of any of these matters in the hearing of a child appear more or less repulsive, and would in general enable him to put in its proper setting any knowledge that might come to him from various sources.

Mr. Cresswell gave the Committee an extremely interesting *resume* of the answers to a *questionnaire* which he addressed to the head of every secondary school in the Dominion. He suggested—(1) That a determined public effort should be made to rouse parents to a sense of their responsibility in regard to this matter by means of broadcasted pamphlets, and that they should be furnished with simple, specially written leaflets to assist them in giving instruction to their children; (2) that sex hygiene be made a compulsory subject in all training-colleges, the instructors being specially qualified doctors; (3) that regular courses of public lectures be delivered in suitable centres; (4) that teachers, and especially physical instructors, be encouraged to stress the value of physical fitness to pupils collectively, and, where need is indicated, to have private talks with individuals; (5) that teachers be advised to take every opportunity during lessons in hygiene, physiology, botany, &c., to give children a sane and normal outlook on sex matters.

Incidentally it was suggested that girls' schools suffer somewhat through being staffed almost exclusively by celibate teachers. "The knowledge and sympathy of a real mother would," it was urged, "be invaluable to many girls in our secondary schools. Does it seem a trivial suggestion that in every girls' school there should be one honoured official, the 'school mother,' a sympathetic motherly person whose duty it should be to get into personal touch not only with individual girls but also with individual parents?"

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The views expressed by the Swedish Committee of Experts in Medicine and Pedagogy are well worthy of quotation: "It is illustrative of the broad view taken by the committee of their task," says the *British Medical Journal*, "that they deal with the education of the child from the time it learns to speak and address inquiries as to how it came into the world. The committee look forward to the time when parents will be so enlightened that they will not tell their children silly stories about babies being brought into the home by storks, but will give a simple account which the child in later years will not discover to be mendacious. The committee hope that the child, who is gradually taught more and more about sex hygiene as it passes from one school grade to another, will eventually become a parent wise enough to instil in the next generation a frank and healthy attitude towards sex problems. Parents, it is hoped, will learn to protect their infants from the undesirable caresses and kisses of strangers ... As for sex teaching in school, this should be associated with the teaching of biology, Christianity, sociology, and psychology. The question of venereal disease should not come into the curriculum until comparatively late, and until the physiology of fertilization and reproduction has been fully taught. Advanced sex teaching should preferably be in the hands of doctors; but they are not always available, in which case other teachers should give instruction on this subject, male teachers dealing with boys and female teachers with girls. Teaching of sex hygiene in high schools for girls should include the subject of venereal disease, and special emphasis should be laid on the protection of infants from infection. A further recommendation is that a carefully supervised library of works on sex hygiene and venereal disease should be compiled at the cost of the State for the use of teachers and classes."

The Committee of the Board of Health agree with the suggestion that teachers should be trained to deal with this question, and that school medical officers or other qualified practitioners should give occasional "talks" to the elder boys and girls. A great deal may be done by physical instructors preaching the gospel of "physical fitness" and personal cleanliness in thought, word, and deed. Bathing and outdoor sports and games of all kinds should be encouraged. The Committee would point out, however, that not all teachers and not all medical men possess the qualities fitting them to give instruction and advice in this delicate matter. The task should be entrusted to those who have shown themselves specially adapted by sympathy and tactfulness for the work, and preferably those who are parents, otherwise harm instead of good may result.

More than one witness spoke with approval of "The Cradleship" and other books by Miss Edith Howes as suitable for use with young children.

The Committee are of opinion that addresses on sex questions by lay persons, except selected teachers, to young people in mass are of doubtful value.

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Sufficient instruction should be given to adolescents regarding venereal diseases and their effects to ensure that if they do contract them it shall not be through ignorance. The Committee cannot too strongly emphasize their belief, however, that knowledge of the effects of venereal diseases is in itself by no means a sufficient safeguard; that in addition to such knowledge the cultivation of a high moral standard is necessary, and if this is reinforced by religious sanctions it is likely to be more effective.

The Committee agree with the view expressed by Dr. E.T.R. Clarkson in a recent textbook, entitled "The Venereal Clinic," that in many instances an excessive stress has been placed upon the factor of fear. He says that a very small proportion of the community are restrained from indulging in promiscuous sexual intercourse through fear, and it is irrational to rely so much upon an emotion which at the best is but slightly inhibitory, and which cannot in itself exercise a direct energizing influence for good. "We do not," he continues, "wish to deter the community from living a life of sexual promiscuity by rendering them fearful of the possibilities of acquiring venereal disease, but we want rather to instil such an ideal into them, whether it be of a religious, ethical, or altruistic nature, as will tend to make them regard such a life as incongruous with those tenets and therefore as undesirable, however much it may be desired on other grounds." He adds that the emphatic reiteration of fear possesses another and dangerous disadvantage. "There is no doubt, as venereologists will testify, that many individuals are seriously suffering from the effects of fear thus engendered in their minds. In some instances the resultant damage to their mentality is more serious than the venereal disease from which they are suffering: whilst in others an obsession that they are infected, when there is no foundation for the fear, may develop in such a manner as to inflict serious and permanent damage."

SECTION 2.—CLINICS FOR THE TREATMENT OF VENEREAL DISEASE.

Early in 1919 clinics for the treatment of venereal disease were established in each of the four main centres. Arrangements were made by the Department of Health for the treatment by Hospital Boards throughout the Dominion of cases of venereal disease, and in the absence of local institutions arrangements were made with private practitioners. There is therefore opportunity for all to receive free treatment, wherever they may be, in New Zealand.

Table B sets out the work done at the four clinics during the two and a half years ended 30th June, 1922. From this table it will be seen that 3,038 males and 596 females attended these clinics during the period named. The total number of attendances was 110,792—101,995 males and 8,797 females. The disproportion between the number of males and females attending is notable. It is clear from the evidence that this does not

represent a difference in the incidence of these diseases in the sexes, but that women do not attend so freely when suffering.

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These clinics are attached to the public hospitals in each centre, and all evidence goes to show that this is most desirable. If the clinics were apart, the object of the patients' visits would be obvious, whereas the actual purpose for which they go to a hospital is not so. It is to be strongly emphasized that the less publicity given to the attendance of these patients, the greater the number of patients who will be likely to take advantage of the treatment offered. This applies especially to the attendance of women.

The clinics are now open only at certain hours. The Committee suggest that they might with advantage remain open continuously (except at certain fixed hours on Sunday). In the absence of the Medical Officer a sister could take charge of the women's clinic, and a trained orderly of the men's clinic. It would be necessary in this case to have separate clinics for male and female patients—the same rooms would not be available for both sexes.

The majority of witnesses asked were of opinion that if a lady doctor were made available for the treatment of women the number of women attending would increase.

It is suggested that in certain cases of gonorrhoea, where it is an advantage that the treatment should be carried out twice or more often daily, arrangements might be made for the supply of the necessary apparatus and drugs to patients at cost price, and in indigent cases free of charge. This is particularly important to women who may have to continue treatment for several months.

The clinics should be more widely advertised by notices in public conveniences and other suitable places.

The Committee are impressed with the valuable work done at these clinics, and recommend their extension to other centres as opportunity offers and necessity is shown to exist.

The existing clinics are conducted by medical men who have had special experience and training in the treatment of these diseases. The Dunedin clinic is attended by medical students for purposes of instruction. In view of recent advances in the processes of diagnosis and treatment of these diseases, the Committee consider that opportunity should be given to medical practitioners to attend these clinics in order to familiarize themselves with the most recent advances in this field. It would be an advantage also if nurses in the course of their training attended the female clinics, so that they might be taught to recognize the commoner manifestations of these diseases.

The most disappointing feature in the records of the clinics is the cessation of treatment by so many patients before they have ceased to be infective. The following evidence was given in this connection:—

Percentage of Cases attending till Non-infective. Auckland Clinic: 80 per cent. cases of syphilis, 50 per cent. cases of gonorrhoea. It was stated that no woman suffering from gonorrhoea continued treatment till non-infective.

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Wellington Clinic: 40 per cent. of all cases continued treatment till non-infective, and very few of these were women.

Christchurch Clinic: Men with syphilis, 75 per cent.: men with gonorrhoea, 98 per cent.: women with syphilis, 50 per cent.: women with gonorrhoea, 14 per cent.

Dunedin Clinic: In this clinic only thirty-one males suffering from gonorrhoea were discharged cured: thirty-two absented themselves while still infective; three female cases remained under treatment till cured, and six ceased to attend while still infective. Forty male syphilitics remained till non-infective, and seventy-four ceased treatment before it was completed. For female syphilitics the figures are four and eighteen.

It will be noted that in each case the proportion of women who attend till non-infective is much smaller than of men, especially in cases of gonorrhoea. The reasons for this are probably that owing to anatomical considerations women infected with venereal disease suffer less pain and the disease is less obvious than in men. On cessation of the more urgent and obvious signs and symptoms they stop treatment. Again, it is probable that the publicity of attending the clinics is felt more by women than men. A third reason is the prolonged period of treatment (often extending over many months) necessary to eradicate gonorrhoea in women. These difficulties could to some extent be mitigated by the provision of arrangements for women to carry out treatment in their homes, which would avoid the publicity and loss of time entailed in attending clinics.

The Committee were impressed with the value of the work done by the lady patrol in Christchurch, and considers that lady patrols would help greatly in securing the attendance of women at the clinics. It is recommended that these patrols should be attached to the Hospital Boards and that they should be trained nurses. They would be available to give advice to patients as to treatment in their homes.

The Committee would also draw attention to the very valuable work done by the Social Hygiene Society in Christchurch, and recommended the establishment of similar voluntary societies in other centres.

The Committee recommend that all bacteriological and other examinations required for the diagnosis and treatment of cases of venereal diseases should be carried out in laboratories of the Department of Health and public hospitals free of cost, on the recommendation of medical practitioners.

The Committee made inquiries from competent witnesses as to the present position of the complement fixation test in gonorrhoea. It appears that this test has not reached yet such a degree of reliability as to render it of great diagnostic value, but that it is reasonable to hope that it may be perfected to such an extent to give it a value in the diagnosis of gonorrhoea comparable to that of the Wassermann test in syphilis.

SECTION 3.—LICENSED BROTHELS.

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Inasmuch as one of the many letters addressed to the Committee favoured the adoption of the Continental system of licensed houses of prostitution, with medical inspection of the inmates, it seems desirable to examine the arguments for and against such a proposal. Those who support it contend that so long as human nature remains as it is prostitution will continue, therefore it is better that it should be regulated with a view to controlling the spread of disease. It is also urged that the system acts as a safeguard against sexual perversion by providing an outlet for the unrestricted appetites of men; that in its absence clandestine prostitution increases, and innocent girls are more likely to be led astray or become the victims of sexual violence. Apart from the moral aspect of the case, these arguments are entirely fallacious; and even in the countries where the licensed-house system prevails enlightened public opinion has come to that conclusion. In the first place, the idea that the system tends to lessen disease is a dangerous delusion. Owing to the fact, already referred to, that venereal disease in the early stages is difficult to detect in women, even by skilled experts working with the best methods and with practically unlimited time at their disposal, the routine inspection given, for example, in the French and German houses is no guarantee of the inmates being free from communicable disease even at the time of inspection.

Flexner, who spent two years in making inquiries and writing his classic work on "Prostitution in Europe," is most emphatic on this point. The experience of the American troops in the Great War is further strong confirmation. The following is an extract from an article published by the American Red Cross in May, 1918: "During the months of August, September, October, and the first half of November, the houses of prostitution flourished and were half-filled with soldiers. On November 15th rigid orders were issued placing these houses out of bounds, and the immediate result was a great reduction of sexual contacts. As a result there was a steady decline in venereal infections, and the monthly rate per 1,000, which in October reached 16.8, dropped in January to 2.1 among the white troops. During the same period there was an even more striking drop in the infections among the negro labourers, the percentage dropping from 108.7 per 1,000 a month to 11 per 1,000. No statistics could speak more eloquently for the doctrine of closing the houses of prostitution. Our studies showed numerous infections coming from houses 'inspected' three times a week."

In May, 1921, a conference (the North European Conference on Venereal Diseases), in which England, Finland, Germany, Holland, Norway, Sweden, and Denmark participated, passed the following resolution: "This conference, having considered the general measures for the combating of venereal diseases which have been adopted by the participating countries, is unanimously of the opinion, so far as the experience of these countries is concerned, that the legal and official toleration of professional prostitution has been found to be medically useless as a check on the spread of venereal diseases, and may even prove positively harmful, tending as it does to give official sanction to a vicious trade."

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On the same point Flexner says: "It is a truism that physicians requiring to equip themselves as specialists in venereal disease resort to the crowded clinics of Paris, Vienna, and Berlin, all regulated towns, because there disease is found in greatest abundance and richest variety—a strange comment on the alleged efficacy of regulation."

Dr. Clarkson, in "The Venereal Clinic," already quoted, says, in reference to the fancied security of licensed houses, "It may strengthen the hands of practitioners to be able to tell interrogators in this subject that in the opinion of leading venereologists, &c., no foundation exists for any such feeling of confidence or security. In other words, the system of licensed houses is a failure, and the 'red light' of lust shines out as the lurid signal of disease and death."

It is surely hardly necessary to urge the moral objections to the proposal. The United States Public Health Service not long ago sent out a *questionnaire* to representative citizens in various walks of life asking for opinion in regard to open houses of prostitution. There was an overwhelming preponderance of replies against the system on moral as well as hygienic grounds. One Illinois miner answered: "The life of a prostitute is short, and her place must be filled when she dies, and, being the father of two girls, I would not want mine to fill a vacancy, and I think all parents think the same." A Colorado carpenter replied: "The woman engaged in such business may not be my wife, mother, sister, or daughter, but she is somebody's wife, mother, sister, or daughter. It is a violation of all law." One Chief of Police wrote: "Open houses of prostitution breed disease, crime, increase the number of prostitutes, corrupt the morals of the community, and are a menace to the youth of the country." Another replied: "The only reason I have ever heard advanced in favour of houses of prostitution is that they protect innocent girls. I am opposed to sacrificing any woman to benefit others."

If statistics could be obtained it would be probably found that the system tends not only to increase disease, but the volume of sexual immorality and crime. From the most materialistic point of view the system is indefensible; while, looking at it from the moral aspect, it is inconceivable that British people, who spent millions of money to stop the traffic in black slaves, would ever officially countenance a system which enslaves the souls as well as the bodies of its victims and defiles the community in which it exists.

SECTION 4.—EXCLUSION OF VENEREAL CASES FROM OVERSEAS.

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The Committee are of the opinion that by the strict exercise of the provisions of section 111 of the Health Act, 1920, much may be done to prevent introduction of venereal diseases from overseas. They suggest, however, that where any person so suffering is required or permitted to attend a clinic he should be accompanied by some responsible officer of the ship, or person authorized by the shipping company concerned, and that the question on the "Report of Master of the Ship" defined by regulations—"Are you aware of the presence on board of any person suffering from ... (b) venereal disease?"—might be strengthened by adopting the Australian quarantine service equivalent viz., "Is there now or has there been on board during the voyage any person suffering from demonstrable syphilis in an active condition, or other communicable disease?"

The evidence given does not show that the number of venereal-diseases cases already in the Dominion is greatly added to by the introduction of cases from overseas. Since 1903 persons suffering from syphilis have been "prohibited immigrants" within the meaning of the Immigration Restriction Act.

SECTION 5.—PROPHYLAXIS.

Before discussing this question it is desirable clearly to distinguish between the procedures which are included under this term. These are—

(1.) The supply of drugs and appliances which are made available for use by the individual before exposure to infection. This may be described as "anticipatory prophylaxis," and has commonly been designated the "packet system." The Committee condemn this procedure, for these reasons: (i) That the system suggests a moral sanction to vice; (ii) that the individual is lulled into a false sense of security, and may thereby be encouraged repeatedly to expose himself to infection; (iii) that the individual may be thereby deterred from seeking early advice or treatment; (iv) that the drugs supplied may be used for treating disease should it arise, and so delay may result in seeking skilled treatment in the early stages when it is likely to be most effective. (2.) Treatment applied after exposure to infection. This is called "early treatment." This term is inapplicable, as a disease cannot be treated before it exists. It is also likely to be confused with "abortive treatment," which implies treatment immediately on the appearance of symptoms. The evidence before the Committee shows that this form of prophylaxis, if applied by skilled persons and within a few hours of exposure, is effective in preventing disease in a great majority of the cases in which it is used.

The Inter-departmental Committee on Infectious Diseases set up by the Ministry of Health in 1919 in connection with demobilization, in a note on "Prophylaxis against venereal disease," reported among its

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conclusions based on service experience, "That where preventive treatment is provided by a skilled attendant after exposure to infection the results are better than when the same measures are taken by the individual affected, even after the most careful instruction." After exposure to infection there appears no reason why these diseases should not be regarded in precisely the same manner as other infectious diseases, and precautions taken to sterilize the parts which have been exposed to infection.

It is to be noted that it is recommended that the prophylactic treatment is to be carried out by some properly instructed person. This need not necessarily be a medical man. It is suggested that this form of prophylaxis might be carried out by an orderly at the venereal-disease clinics. The notices posted in the public conveniences and other suitable places indicating the existence of the clinics and the necessity for treatment might include a guarded reference to their use for this purpose.

This form of prophylaxis applies to males. In the case of females the methods adopted would be also contraceptive, and the Committee do not recommend that facilities should be provided for this.

The Committee must not be supposed to advocate prophylaxis as in any way a substitute for continence and the cultivation of that high moral tone that repels any suggestion of promiscuous sexual relationships, but they feel that they could not properly ignore reference to a method of prevention of these diseases which has proved very efficient in the services, to which there appears no reasonable ethical objection, and which brings their prophylaxis into line with that of other infectious diseases.

SECTION 6.—LEGISLATION REQUIRED.

(A.) Conditional Notification.

The only subjects of importance upon which the witnesses examined differed materially in opinion were—(1) whether there ought to be any system of notification of cases of venereal disease, and (2) what steps, if any, should be taken to deal with persons suffering from such disease in a communicable form who refused to be treated, and in some cases were even known to be spreading the disease broadcast. Ladies who attended to give evidence on behalf of the National Council of Women and one or two other women's organizations objected to notification and compulsory treatment. They argued that there was at present a "scare" on the subject of venereal disease, and deprecated "panic legislation." They contended that the adoption of notification would deter patients from seeking treatment for fear of publicity. They were opposed to compulsory treatment of recalcitrant patients, arguing that any law of the kind would be used most oppressively against women. They contended that reliance should be

placed on greater facilities for free treatment at the clinics, the work of women patrols, suppression of liquor, and above all education and propaganda on moral lines.

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When confronted with typical cases of difficulty already quoted some of the witnesses admitted that it was not easy to see how such cases could be dealt with satisfactorily without compulsion of some kind. But they argued that, even so, it would be a greater evil if the fear of publicity and the fear of compulsion should have the effect of deterring sufferers from seeking treatment and so drive the disease underground.

The National Council of Women, by a substantial majority, at a recent conference in Christchurch, carried a resolution protesting against a proposal to introduce compulsory notification and treatment of venereal diseases, and urging the Government to increase the facilities for free treatment. The President of the Council, however, informed the Committee that most of the nineteen societies affiliated to the Auckland Branch of the National Council are in favour of some form of compulsion, but a number of the southern branches are opposed to it. Speaking as an individual, and not as President of the National Council of Women, she added:

“Personally, I have no first-hand knowledge as to whether the disease is so prevalent in the community as to demand urgent measures, but there is an opinion among women social workers and medical practitioners, whom I have consulted, that something should be done, and they are in favour of compulsion under the Act, provided its administration is satisfactory. There is no doubt that there is a genuine and widespread fear among a large number of women that, although in the Act itself there is no discrimination between men and women, in actual practice there will be, and they fear that the Act will be enforced against women, and particularly immoral women, while the men concerned will be allowed to go free. This fear arises partly from the remembrance, particularly among elderly women, of the old Contagious Diseases Acts, both here and in England, and partly from the reports of the working of compulsion in Western Australia and elsewhere. I am of opinion that there is no serious ground for fear in view of the changed attitude in the public mind in connection with these diseases, the fuller knowledge that people generally have, and the high status of women in our country; also the ready access that all persons have to the protection of the law and the Courts in the event of false information being given, and the safeguards embodied in the Bill as I understand it is drafted. My view is that the objection to the compulsory clauses of the Bill would be removed in the opinion of many women if women patrols or women police were appointed, so that the administration of the Act in its compulsory clauses wherever it treated women could be in the hands of those women officers.”

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Among the witnesses questioned on this subject there was an overwhelming preponderance of opinion that the time had now arrived for the adoption of notification of all cases of venereal disease by number or symbol, if only for the purpose of getting more accurate statistics; the notification by name of those recalcitrant patients who refused to continue treatment until cured; and compulsory examination of those whom the Director-General of Health had good grounds for believing to be suffering from the disease and likely to communicate it to others, and who refused to produce a medical certificate as to their condition. Only three medical men expressed themselves as being against these proposals. On the other hand, the lady doctors examined (two of them members of the National Council of Women, and the third representing the Young Women's Christian Association) gave evidence in favour of conditional notification, and compulsory examination, and compulsory treatment of recalcitrants. It should be added that all the witnesses who were engaged in rescue work, or other work bringing them face to face with the horrors of venereal disease, were most emphatic in their opinion that compulsory notification and treatment should be adopted.

It is noteworthy that when the notification of ordinary infectious disease was first proposed in England almost exactly the same arguments were brought against the proposal as are now advanced against the notification of venereal disease. Sir W. Foster, member for Ilkeston, and a medical man of standing, speaking in the House of Commons in the debate on the Infectious Diseases Notification Bill, on the 31st July, 1889, said,

"The Bill calls upon medical men to perform something more than the ordinary duties of citizenship by requiring them to become informers of the occurrence of diseases. The relation of a medical men to his patient ought to be one of complete confidence, and anything that comes to the knowledge of a medical man in the practice of his profession is practically an inviolable secret; and I do not like any Bill to interfere with that relationship. I know myself that one of the results of this Bill, if passed into law, will be that in scores of cases medical men will not be called in to attend people suffering from infectious diseases ... I admit the difficulty of the position, but I am anxious that no measure should pass into law which will induce the public to keep these diseases more secret than they have been in the past, with the risk of adding to the spreading of them. We must be very cautious not to do anything which will prevent the public from placing full and implicit confidence in their medical man. I can quite conceive it to be possible that, if an outbreak of infectious disease occurs in a populous part of London, the people may, in order to prevent exposure, refuse to allow a medical man to come in, and in such cases we shall have tenfold more difficulty than at present. Therefore, while I am anxious to promote the notification of disease, I do not want the Government to promote rebellion on the part of the public."

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Needless to say, these gloomy anticipations have not been realized. Probably the more enlightened generations to succeed us will wonder how there could ever have been any opposition to the notification of venereal disease, just as we to-day read Sir W. Foster's words and marvel that any person of intelligence could have committed himself to such statements.

Notification of infectious diseases and isolation of patients suffering from such diseases have for many years been compulsory. Isolation, when spoken of by opponents to a similar measure for venereal diseases, is opprobriously described as "compulsory detention." For twenty years it has been the law in New Zealand that an authorized medical practitioner may examine any person suspected to be suffering from any infectious diseases (save venereal diseases), and the Medical Officer of Health may, if he deems it expedient in the interests of the public health, compel the removal to a hospital of any person so suffering. This long-established procedure as referable to venereal diseases is by antagonists termed "compulsory examination" and "compulsory removal."

It is contended by some witnesses that notification will drive these diseases underground; but syphilis and gonorrhoea for generations past have been underground.

Under the present system numbers of unfortunate persons either delay calling in medical assistance until the case has become almost desperate so far as the patient is concerned, or they resort to unqualified persons, with the result that in most cases what was in the first instance a simple attack, capable of treatment, results in serious complications most difficult to deal with. In either case the patient may be communicating diseases to others, and should this come to the knowledge of the Health Department it has no effective means of checking him—no power to warn those who are being endangered by his criminal neglect.

The Committee think there is some force in the argument that notification by name, in the first instance, as in the case of ordinary infectious diseases, would tend to discourage some from coming forward for medical treatment. They recommend, therefore, the adoption of what is known as the system of conditional notification embodied in the West Australia Act. Under this plan the cases are notified by the doctor to the Health Department by number or symbol only. The name is not sent in unless the patient discontinues treatment before he is free from infection and refuses either to go to a clinic or to another doctor. In cases of those who "play the game," the name of the patient is kept confidential, and does not pass beyond the medical man attending him. It is only in cases of those who contumaciously refuse to do what is necessary for their own safety and the safety of others that the name is sent to the Health Department, in order that appropriate steps may be taken in the interests of public health. Even then the name is given only to officers who are pledged to keep it confidential.

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Following are the clauses in suggestions for a Bill, drawn up by the Health Department, which in the opinion of the Committee should in substance be adopted:—

“(1.) Every medical practitioner shall forthwith give notice to the Director-General of Health, in the prescribed form, upon becoming aware that any person attended or treated by him is suffering from any venereal disease in a communicable form. The notice shall state the age and sex and occupation of the patient and the nature of the disease, but shall omit the patient’s name and address.”(2.) Every medical practitioner, other than the medical officer in charge of a public hospital or of a clinic established by direction of the Minister of Health, shall be paid for each such notification a fee to be prescribed by regulation.

“(3.) The provisions of subsection (1) hereof shall apply in the case of a child under the age of sixteen years who is suffering from congenital syphilis.

“(4.) Whenever a patient has changed his medical adviser, in accordance with subsection (2) hereof, the medical practitioner under whose care the patient has placed himself shall notify the Director-General of Health in accordance with subsection (1) hereof, and shall include in such notice the name and address of the previous medical adviser.”

Without some such system of preliminary notification no adequate statistics can be collected as to the prevalence of venereal diseases in New Zealand, and no conclusion could be arrived at in the future as to the effect of the whole or any part of the programme for combating these scourges. Again, without such notification, and the attachment thereto of some method of ensuring that the patient is made definitely acquainted with his condition, it is practically impossible to enforce the provisions of section 8 of the Social Hygiene Act for the crime of “knowingly” infecting any other person.

Here the Committee would refer to case 2 quoted above. Of what use is it to provide free clinics if those who make use of them are permitted, as soon as the urgent symptoms are relieved, to disseminate disease broadcast, widening the circle of infection? Again, where is our humanity if no step is to be taken to try to prevent a syphilitic child being born to the man in case 1?

A very valuable result of anonymous notification would be the possibility afforded of observing any unusual “flare-up” or succession of cases, especially in country districts and small towns. Study of case 4 will show the great value it would have been to have a record of an unusual increase of syphilis in that township, giving an opportunity for prompt investigation by the Medical Officer of Health for the district.

(B.) *Compulsory Examination and Treatment.*

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This question obviously presents more difficulty than that of notification, but it is clear that unless some means are provided of bringing under treatment and, if necessary, isolating persons who are suffering from highly contagious diseases, and who will not avail themselves of medical treatment although this is provided free of cost by the State, and who are knowingly or recklessly communicating the disease to others, it will be impossible to keep in check this terrible scourge. Without such provision any abandoned woman, as in case 4, or any male libertine, may continue to sow disease broadcast without any power to stop them. Failing some such measure, table articles and food may continue to be smeared by hands soiled with syphilitic material, as in case 1; section 6 of the Social Hygiene Act remains mere useless verbiage, and the infecting of innocents, as in case 3, may continue unchecked.

Legislation dealing with this subject needs to be carefully framed with suitable safeguards, but the Committee think that an amendment of the Social Hygiene Act on the lines proposed by the Department of Health should be adopted. These provisions are:—

(1.) That whenever the Director-General of Health has reason to believe that any person is suffering from venereal disease, and has infected or is liable to infect other persons, he may give notice in writing to such person directing him to consult a medical practitioner, and to produce within a time specified in the notice a certificate from such medical practitioner to the satisfaction of the Director-General of Health that such person is or is not suffering from venereal disease.(2.) Should the person not comply with this request, the Director-General of Health may obtain a warrant from a Magistrate ordering such person to undergo examination to prove the existence, or non-existence, of venereal disease.(3.) Making it possible for a Magistrate, on the application of the Director-General of Health, to order the detention in a hospital or other approved place of a person who is likely to be a danger to other persons until that person is cured of venereal disease.

These provisions are applicable equally to both sexes, and the Committee see no reason to fear that the law would not be carefully and impartially administered. If it should appear that more women than men came under the operation of the law this result would be due to the fact that, as disclosed in the evidence, a much larger proportion of women than men fail to seek treatment, and of those treated a much larger proportion of women fail to continue treatment until no longer infectious.

It is hardly conceivable that a responsible officer, such as the Director-General of Health, would take action under these provisions unless he had strong reason to believe that such action was justified. But, even if he makes a mistake or is misinformed, the worst that can happen to an innocent person wrongfully suspected is that he or she will be required to produce a medical certificate, which can be procured free of cost from any hospital or V.D. clinic. This is wholly different from the provisions of the Contagious

Diseases Act, under which a woman suspected of prostitution was liable to be arrested by a constable in the street.

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The Committee recommend that the serving of notices, &c., under these sections be done by officers of the Health Department and not by the police. They also recommend that all proceedings taken under any Act having reference to venereal diseases should be heard in private unless the defendant applies for a hearing in open Court.

With regard to the effects of the actual operation of notification, examination, and isolation, the Commissioner of Public Health for West Australia, under date 25th August, 1922, advises the Committee that there is an increase in the number of cases attending public clinics, and that this is regarded not as evidence of increased incidence, but of increased interest and appreciation of early treatment by those suffering from the diseases.

SECTION 7.—MARRIAGE CERTIFICATE OF HEALTH.

The Royal Commission on Venereal Disease reported that there was a vast amount of ignorance as to the dangers arising from the sexual intercourse of married persons one of whom had previously to the marriage contracted syphilis or gonorrhoea. The effect upon the birth-rate, and the misery caused during married life, and in many cases to the offspring who survive, as they pointed out, are most serious, and the fact that the actual cause of the trouble often remains unknown and unrecognized prevents the calamity from serving the purpose of example or warning.

Some of the witnesses heard before the present Committee have urged that a certificate of good health, or at least a certificate of freedom from communicable disease, should be required from each party to a proposed marriage before the Registrar issued a license to marry. The Royal Commission considered that "it would not be possible at present to organize a satisfactory method of certification of fitness for marriage." The National Birth-rate Commission, however, reported that in their opinion the question should be reconsidered with a view to legislation.

There is much to be said in favour of such a proposal from the point of view of national health. If the system were adopted the certificate should, in the opinion of the present Committee, include freedom from mental disease as well as freedom from communicable disease. But there are manifest difficulties in the way, chiefly in regard to the delicate and searching examination which would be required in the case of women before a doctor could certify positively to the absence of communicable disease.

The Committee recommend that instead of a medical certificate each party to a proposed marriage should be required to answer appropriate questions in regard to the presence or absence of communicable and mental disease, and to make a sworn statement before the Registrar as to the truth of the answers. It should be the duty of the Registrar to communicate the contents of the statements to the other party in the event of any admission of the presence of communicable disease.

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In addition to the penalty for making a false statement it might be provided, as in the Queensland Act, that venereal disease shall be a ground for annulling a marriage contract when one party is suffering at the time of marriage from such disease in an infectious state, provided the other party was not informed of the fact prior to marriage.

The Committee would also recommend the adoption of a further provision that it should be the duty of a medical practitioner attending a case of venereal disease which is or is likely to become infective, if he has reason to believe that the patient intends to marry, to warn him or her against doing so, and if he or she persists it should be the duty of the doctor forthwith to notify the case by name to the Director-General of Health, whose duty it should be to inform the other party. It should also be provided that *bona fide* communications made in such a case, either by the Director-General of Health or the doctor, to the other party to the marriage, or to the parents or guardian of such party, shall be privileged.

SECTION 8.—TREATMENT BY UNQUALIFIED PERSONS.

The evidence given before the Committee shows that while reputable chemists refer to a medical man patients coming to them for treatment for venereal disease, and while these constitute the great majority of the profession, there are still far too many cases of venereal disease treated by chemists, herbalists, chiropractors, and other unqualified persons. The treatment of venereal disease has become a specialized branch of medicine, and many general practitioners prefer to refer such cases to experts. The result of trusting to unqualified persons for the treatment of such serious and difficult diseases is that the patient usually drifts on uncured, and serious complications may occur. One specialist in venereal disease informed the Committee that of 200 of his cases whose cards showed particulars, 104 consulted chemists in the first place and received more or less treatment from them. He was able to give details of twenty-three cases showing the type of treatment given. In several cases there were severe complications which could have been avoided by proper treatment. There were also cases in which the patient, after taking medicine for a time, had communicated the infection to others. This witness further stated that some chemists charged consultation fees in addition to charges for drugs applied, and in certain cases charges for drugs were made which were little short of blackmail.

The Committee recommend that, in place of section 7 of the Social Hygiene Act, a more comprehensive clause from the West Australian Act be adopted. This is to the following effect: "No person [other than a registered medical practitioner] should attend or prescribe for any person for the purpose of curing, alleviating, or treating venereal disease, whether such person is in fact suffering from such disease or not."

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The Committee would suggest that if the Pharmaceutical Society were to do all in its power to discourage its members from treating these diseases it would have a good effect.

SECTION 9.—MENTALLY DEFECTIVE ADOLESCENTS.

Mr. J. Caughley, Director of Education, stated in evidence: "From a general inquiry made by the Department a few years ago it was ascertained that there were at least six hundred or seven hundred mental defectives in New Zealand under the age of twenty-one. I need scarcely point out the moral danger to the community of so many of these defectives being at large. In particular, the girls are a source of danger to themselves and to the community, since they have little or no will-power or sense of restraint. I am of opinion that all such cases should be registered, and that, unless it can be shown that the mental defective is under thoroughly safe and proper care at home, he should be taken charge of by the State. I am certain that by this means the increasing number of mental defectives would be reduced to a minimum, since mental defectiveness is almost entirely hereditary."

Mr. Beck, Officer in Charge of the Special Schools under the Education Department, cited illustrative cases, one of which may be thus stated: "Two feeble-minded parents in New Zealand have had up to the present time ten degenerate children, all of whom are a lifelong burden on the State. Taking the case of these children, and assessing the cost to the State of maintaining them, the total amount for this family will not be less than L16,000."

The Committee are of opinion that supervision of mentally defective children and adolescents is an important factor in lessening venereal disease, and urge the Government as soon as possible to adopt a system of registration and classification of mental defectives, and of segregation where necessary, either in mental hospitals or in special institutions where these defectives may be suitably taught, and, where possible, usefully employed to defray the cost of their maintenance.

PART IV.—SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS.

SECTION 1.—CONCLUSIONS.

Following are some of the conclusions drawn from the evidence by the Committee:—

There is very general ignorance among the public on the subject of venereal disease, and this has stood in the way of its being grappled with effectively.



Syphilis not only causes loss of life directly, but many deaths ascribed to other causes in the Registrar-General's returns are due to the after-effects of this disease. It is responsible for many still-births and abortions, and its evil effects are seen in such children as survive. These effects may persist until the third generation.

Gonorrhoea, popularly, but quite erroneously, supposed to be a comparatively mild complaint, is regarded by medical men as being as serious a disease as syphilis. It is difficult to cure, especially in women, unless properly treated at the outset. It is a great cause of sterility in both sexes.

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Owing to the absence of accurate statistics it is impossible to make comparisons between New Zealand and other countries as regards the prevalence of venereal disease, or to say whether it is increasing or decreasing in this country.

There are in New Zealand no fewer than 3,031 persons being treated by registered medical practitioners for venereal disease in some form, or for the effects thereof—1 person in every 428 of our population. At the clinics since their establishment 3,634 patients have been treated—3,038 males, 596 females.

An interesting calculation as to the prevalence of syphilis in New Zealand has been made by Dr. Hay, Inspector-General of Mental Hospitals. Working on what is known as Fournier's Index—the relation of the number of cases of dementia paralytica existing at any one time to the number of concurrent syphilitic infectious—he computes the number of persons in New Zealand now who have or have had syphilis to be 33,000, or 1 to every 38 of the population.

The Committee desire to state, however, that in their opinion there can be no accurate estimate of the prevalence of venereal disease until some system of obtaining accurate statistics has been adopted. One point which has come out clearly in their investigations is that venereal disease is sufficiently prevalent to cause serious concern and to call for energetic action.

Evidence was given to the Committee to show that children with mental and physical defects due to venereal diseases may become a charge on the State; that a proportion of these on being released become parents of defective children, who in their turn have to be supported at the public expense. It was also shown that such defectives have little sexual control, and are usually very prolific.

According to the Commissioner of Police there are only 104 professional prostitutes in New Zealand.

There is, however, a great deal of "amateur" prostitution, and this is chiefly responsible for the spread of venereal diseases.

The evidence points to a good deal of laxity of conduct among young people of all social conditions, especially in the large towns. This is generally attributed by the witnesses to the weakening of home influence and the restlessness of the age.

Apart from the venereal disease among those who indulge in promiscuous intercourse, there are many cases in which innocent wives are infected by their husbands, and other cases (not so frequent) of innocent husbands being infected by their wives.

Children suffer innocently from venereal disease, not only by inheritance from infected parents, but by accidentally coming in contact with the germs on towels, &c., which have

been used by a patient. There are also cases which come before the Courts where disease has been conveyed directly in crimes of violence by sexual perverts.

The free clinics in the chief centres are conducted by experts, and are doing good work. Their influence for good is greatly impaired, however, by the fact that a proportion of the male patients and the majority of the female patients leave off treatment before they are cured. As the law stands there is no power to compel them to continue treatment, and in many cases they resume promiscuous intercourse and spread the disease.

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Evidence has been given of other cases, some of them of a very shocking character, in which persons suffering from venereal disease are not seeking medical treatment and are communicating the disease to others. As the law stands at present there is no power to restrain them from such conduct or to compel them to receive medical treatment.

SECTION 2.—RECOMMENDATIONS.

The Committee stress in the strongest terms the duty of moral self-control.

They urge the cultivation of a healthier state of public opinion. The stigma at present attached to sufferers from venereal disease should be transferred to those who indulge in promiscuous sexual intercourse.

Parents have a great responsibility as regards the instruction and training of their children so as to safeguard them against the dangers resulting from ignorance of sexual laws. There is too little parental control generally in New Zealand. The Committee recommend the training of teachers, and provision for giving appropriate instruction in schools.

Classification and, where necessary, segregation of mentally defective adolescents is recommended.

The following medical measures for preventing and combating the disease are recommended:—

The clinics should be made more available by being open continuously. Every effort should be made to secure privacy. A specially trained nurse should be in attendance at women's clinics, and women doctors should be secured where possible.

The Committee recommend that provision be made at the clinics for prompt preventive treatment of those who have exposed themselves to infection.

Lady patrols should be appointed in other centres to perform the kind of work that is being carried on in Christchurch.

The Committee, having regard to the good work especially of an educational nature which is being done by the Social Hygiene Society, Christchurch, consider voluntary effort of the same kind in other centres would be very helpful.

The Committee are entirely opposed to the Continental system of licensed brothels, or a revival of the C.D. Acts in any shape or form.

They recommend legislation be introduced providing for what is known as conditional notification of venereal disease. It will be the duty of a doctor to notify to the Health Department, by number or symbol only, each case of venereal disease he treats. If a patient, however, refuses to continue treatment until cured, and will not consult some other doctor or attend a clinic, it will then be the duty of the doctor last in attendance to notify the case to the Department by name.

If the patient continues recalcitrant and refuses to allow himself to be examined by the medical practitioner appointed by the Director-General of Health, then the latter should be empowered to apply to a Magistrate for the arrest of such person and his detention in a public hospital or other place of treatment until he is non-infective.

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The Committee also recommend further provision to deal with cases in which persons suffering from venereal disease are not under medical treatment and are likely to infect others. If the Director-General of Health has reason to believe that any person is so suffering he may call on that person to produce a medical certificate, which may be procured free of charge from any hospital or venereal-disease clinic. If the person refuses to produce such a certificate he or she may be taken before a Magistrate, who may order a medical examination. Penalties, including detention in a prison hospital, should be provided for recalcitrant cases. The proceedings in all these cases are to be heard in private unless defendant desires a public hearing.

The Committee recommend that before a license to marry is issued the intending parties must sign a paper answering certain questions as to freedom from communicable disease and from mental disease, and must make a sworn statement that the answers to such questions are true.

They recommend the adoption of a provision in the Queensland Act making venereal disease a ground for annulling a marriage contracted whilst one party is suffering from such a disease in an infectious stage, provided the other party was not informed of the fact prior to marriage. Also that it should be the duty of a medical practitioner attending a case of venereal disease, if he has reason to believe that the patient intends to marry, to warn him or her against doing so, and if he or she persists it should be the duty of the doctor to notify the case by name to the Director-General of Health, whose duty it should be to inform the other party, or the parents or guardian of such other party. Such communications made in good faith either by the doctor or the Director-General of Health should be absolutely privileged.

The Committee recommend that the law prohibiting treatment of patients for venereal disease by unqualified persons shall be strengthened, and suggest that the Pharmaceutical Society might assist in preventing such practices.

SECTION 3.—CONCLUDING REMARKS.

The Committee in carrying out their task have been brought into contact with some uninviting aspects of our social life. Some of the facts disclosed are of a character to give serious concern to those lovers of their country who rightly regard it as exceptionally favoured by nature, and desire to see its people healthy and vigorous, clean in body and mind, worthy of their heritage. The late war showed that the pick of our population, physically as well as mentally, were of the finest possible type, the admiration of all who saw them; but the medical examination of the recruits disclosed that of 135,282 examined after the introduction of the Military Service Act—mostly young men in the prime of life—only 57,382, or say, 42½ per cent., could be accepted as fit for training, unmistakably proving that the nation as a whole was much below the standard of physical fitness which it ought to exhibit.

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The investigations of the Committee show that already there is far too large a proportion of mental and physical defectives reproducing their kind. In the absence of accurate statistics it is impossible to say what proportion of these defectives are the direct product of venereal disease, but there is clear evidence that a tendency to lead dissolute lives is especially noticeable in the females belonging to this unfortunate class. "A feeble-minded girl," says Mr. Beck, "has not sense enough to protect herself from the perils to which women are subjected. Often amiable in disposition and physically attractive, they either marry and bring forth a new generation of defectives, or they become irresponsible sources of corruption and debauchery in the communities where they live." Obviously some method of dealing with mental defectives—by segregation or otherwise—must be found as part of the problem of dealing with venereal disease.

As regards the effect of venereal disease on the general health of the community, we have the statement of the late Sir William Osler that he regards syphilis as "third on the list of killing diseases"; while Neisser, a leading authority, says that "with the exception of measles, gonorrhoea is the most widely spread of all diseases. It is the most potent factor in the production of involuntary race suicide, and by sterilization and abortion does more to depopulate the country than does any other cause."

In view of the facts brought out in the course of the inquiry, the Committee are strongly of opinion that it would be criminal neglect to allow the evil to go on without taking energetic steps to check its ravages. They believe that the legislative and other measures which they recommend for the medical prevention and treatment of venereal disease will, if given effect to with the loyal co-operation of the medical profession, have a very beneficial result in reducing the prevalence of disease, and will save an incalculable amount of sorrow and suffering which in too many cases falls upon the innocent. In what is proposed in this report there is nothing approaching a revival of the old Contagious Diseases Acts. To use the words of Dr. Emily Seideberg, the principle of the legislation now proposed is "To improve the health of the community, and not, as in the old Contagious Diseases Acts, to make sexual immorality safe for men of low morals."

The Committee are of opinion that, far from conditional notification and compulsory treatment on the lines proposed being prejudicial to woman in any way, it is they who will reap the greatest benefit from these measures. In fact, sufferers from venereal disease, as a whole, have everything to gain and nothing to lose so long as they will continue under treatment, and to enable them to do this the best medical skill is placed at their disposal free of cost. The only persons in the community who will be penalized by the proposed legislation are those who, having contracted venereal disease, are so reckless and unprincipled that they will take no pains to avoid communicating it to others.

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The Committee, it will be seen, regard the legislative and medical measures which they propose as of great importance, but with all the earnestness at their command they desire in conclusion to emphasize the moral and social aspects of the question. With the changing social conditions, especially in the larger towns, we are losing the home influence and home training which are the best safeguards to preserve the young against the temptations and dangers which beset their path in life. The Committee would impress upon parents the paramount duty they owe to their children in this matter. There is also a duty cast upon all leaders of public opinion, and upon the community at large, to do what is possible to bring about better living-conditions, especially for girls in the towns, to encourage all forms of healthy sport and amusement, and to cultivate a higher moral standard. Whatever sanitary laws may be passed, and whatever success may be attained in dealing with bodily disease, there can be no true health if the soul of the nation remains corrupt. If this inquiry should serve to remove some of the popular ignorance regarding venereal disease, and to quicken the public conscience so that appropriate steps may be taken to deal with this dreadful scourge, the Committee feel that their labours will not have been in vain.

W.H. TRIGGS, Chairman.
J.S. ELLIOTT, \
M. FRASER, \ Members
J.P. FRENGLEY, > of
JACOBINA LUKE, / Committee.
D. McGAVIN, /

APPENDIX.

GRAPH A.

AVERAGE AGES OF BRIDEGROOM AND BRIDE AT MARRIAGE, 1900-1921.

[Illustration]

TABLE A.

ILLEGITIMATE BIRTHS, AND BIRTHS WITHIN ONE YEAR AFTER MARRIAGE, IN NEW ZEALAND, 1913-21.

NOTE.—The figures refer to accouchements, not to children born, multiple cases being counted once only (Only live births are included.)

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[illegible]

MALCOLM FRASER,
Government Statistician.

TABLE SHOWING NUMBER OF CASES TREATED AND ATTENDANCES
AT THE VENEREAL-DISEASE CLINICS DURING THE YEARS 1920-21
AND UP TO JUNE, 1922.



-----+-----													
--+													
Auckland													
-----+-----+-----													
1920 1921 1922													
-----+---+---+---+---+---+---+													
Number of persons dealt													
with at or in connection													
with the out-patients'													
clinic for the first time													
and found to be													
suffering from--		M.		F.		M.		F.		M.		F.	
Syphilis		174		30		100		44		81		29	
Chancroid		10		..		25		..		10		..	
Gonorrhoea		81		8		345		24		189		20	
No V.D.		59		10		73		25		21		8	
Total attendance of all													
persons at the													
out-patients' clinic who													
were suffering from--													
Syphilis		1,875		462		1,759		474		830		313	
Chancroid		100		..		72		..		37		..	
Gonorrhoea		4,702		95		9,232		141		3,384		172	
No V.D.		134		26		227		35		53		17	
Aggregate number of													
in-patients' days of													
treatment given to													
persons suffering from--													

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Syphilis | ..| ..| ..| ..| ..| ..|
 Gonorrhoea | ..| ..| ..| ..| ..| ..|
 -----+-----+-----+-----+-----+-----+
 pre>

-----+-----+-----+-----+-----+-----+
 -----+
 | Wellington |
 |-----+-----+-----+
 | 1920 | 1921 | 1922 |
 -----+-----+-----+-----+-----+-----+
 +
 Number of persons dealt | | | | | | |
 with at or in connection | | | | | | |
 with the out-patients' | | | | | | |
 clinic for the first time | | | | | | |
 and found to be | | | | | | |
 suffering from-- | M. | F. | M. | F. | M. | F. |
 Syphilis | 93| 34| 80| 10| 41| 8|
 Chancroid | 1| ..| 8| ..| 7| ..|
 Gonorrhoea | 190| 18| 298| 11| 141| 9|
 No V.D. | 40| 10| 52| 25| 33| 17|
 Total attendance of all | | | | | | |
 persons at the | | | | | | |
 out-patients' clinic who | | | | | | |
 were suffering from-- | | | | | | |
 Syphilis | 1,388|448| 2,089|616| 1,156|269|
 Chancroid | 6| ..| 16| ..| 29| ..|
 Gonorrhoea |13,436|180|19,369|520|10,853|423|
 No V.D. | 40| 10| 89| 35| 68| 35|
 Aggregate number of | | | | | | |
 in-patients' days of | | | | | | |
 treatment given to | | | | | | |
 persons suffering from-- | | | | | | |
 Syphilis | 1,624| ..| 1,711| ..| 790| ..|
 Gonorrhoea | 3,024| 77| 4,098| ..| 1,998| ..|
 -----+-----+-----+-----+-----+-----+
 +
 -----+-----+-----+-----+-----+-----+
 ---+



Christchurch							
-----+-----+-----							
1920	1921	1922					
-----+-----+-----+-----+-----+-----+-----							
Number of persons dealt							
with at or in connection							
with the out-patients'							
clinic for the first time							
and found to be							
suffering from--		M.	F.	M.	F.	M.	F.
Syphilis		60 25	46 21	25 13			
Chancroid		8 ..	6 ..	5 ..			
Gonorrhoea		120 32	139 35	70 21			
No V.D.		20 10	62 31	31 16			
Total attendance of all							
persons at the							
out-patients' clinic who							
were suffering from--							
Syphilis		786 450	903 473	632 248			
Chancroid		110 ..	45 ..	37 ..			

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Gonorrhoea          |2,132|245|3,968|902|2,239| 339|
No V.D.             | 186| 98| 215|187| 96| 52|
Aggregate number of |   |   |   |   |   |   |
in-patients' days of |   |   |   |   |   |   |
treatment given to  |   |   |   |   |   |   |
persons suffering from-- |   |   |   |   |   |   |
Syphilis            | 232| 80| 619| 44| 310| 9|
Gonorrhoea          | 460|216| 725|161| 221| 157|
-----+-----+-----+-----+-----+-----+
/pre>

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-----+-----+
|      Dunedin      |
|-----+-----+
| 1920 | 1921 | 1922 |
|-----+-----+-----+-----+-----+
Number of persons dealt |   |   |   |   |   |   |
with at or in connection |   |   |   |   |   |   |
with the out-patients' |   |   |   |   |   |   |
clinic for the first time|   |   |   |   |   |   |
and found to be         |   |   |   |   |   |   |
suffering from--       | M.| F.| M.| F.| M.| F.|
Syphilis               | 54| 13| 55| 11| 12| 9|
Chancroid               | ..| ..| ..| ..| ..| ..|
Gonorrhoea              | 37|   | 55| 9| 46| 6|
No V.D.                 | 6| 2| 28| 2| 1| ..|
Total attendance of all |   |   |   |   |   |   |
persons at the          |   |   |   |   |   |   |
out-patients' clinic who |   |   |   |   |   |   |
were suffering from--   |   |   |   |   |   |   |
Syphilis                |816|143|505| 84|432|115|
Chancroid               | ..| ..| ..| ..| ..| ..|
Gonorrhoea              |465| ..|814| 67|638| 63|
No V.D.                 | 6| 2| 21| 1| 1|   |
Aggregate number of    |   |   |   |   |   |   |
in-patients' days of   |   |   |   |   |   |   |
treatment given to     |   |   |   |   |   |   |
persons suffering from-- |   |   |   |   |   |   |
Syphilis                | 74| 55|169|106| 20| ..|
Gonorrhoea              | 66| ..|335|166| 28| 59|
-----+-----+-----+-----+-----+

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-----+-----									
-----+									
Total for Years									
-----+-----+-----									
1920 1921 1922									
-----+-----+-----+-----+-----+-----									
+-----+									
Number of persons dealt									
with at or in connection									
with the out-patients'									
clinic for the first time									
and found to be									
suffering from--		M.		F.		M.		F.	
Syphilis		381		102		281		86	
Chancroid		19		..		39		..	
Gonorrhoea		428		58		837		79	
No V.D.		125		32		215		83	
Total attendance of all									
persons at the									
-----+-----+-----+									
Totals		Grand							
according		Totals							
to Sex									
-----+-----+-----+-----+									
Number of persons dealt									
with at or in connection									
with the out-patients'									
clinic for the first time									
and found to be									
suffering from--		M.		F.					
Syphilis		821		247		1,068			
Chancroid		80				80			
Gonorrhoea		1,711		193		1,904			
No V.D.		426		156		582			
Total attendance of all		-----+-----+-----+							
persons at the		3,038		596		3,634			
out-patients' clinic who		-----+-----+-----+							
were suffering from--									
Syphilis		13,171		4,098		17,269			
Chancroid		452		..		452			
Gonorrhoea		70,802		3,167		73,969			
No V.D.		1,146		502		1,648			
Aggregate number of									
in-patients' days of									
treatment given to									

persons suffering from--			
Syphilis	5,549	194	5,743
Gonorrhoea	10,875	836	11,711
-----+-----+-----+-----+			

TABLE C.

REPLY FORM.—VENEREAL DISEASES.

(Confidential.)

I, the undersigned registered medical practitioner,
desire to advise the Committee on Venereal Diseases
of the Board of Health that I had under my personal
care on Saturday, 16th September, 1922,[A] cases of
venereal disease, and of affections attributable to
venereal disease, as under:—

NUMBER
OF CASES.

Male.

Female. Total.

1. Cases of recent infection:—

(a.) Gonorrhoea (including gonorrhoeal ophthalmia)

(b.) Soft chancre

(c.) Syphilis, primary and/or secondary

2. Cases of distant infection:—

(a.) Chronic gonorrhoeal affections or disabilities

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directly attributable to gonorrhoea infection—*e.g.*,
stricture, gleet, arthritis, abscesses, salpingitis,
&c.

(*b.*) Congenital syphilis

(*c.*) Tertiary syphilitic manifestations or
disabilities

directly attributable to syphilis infection:—

(*i.*) Affecting nervous system—*e.g.*,
gumma,

locomotor, G.P.I., &c.

(*ii.*) Affecting ear, eye, &c. (special
senses)—*e.g.*, optic
atrophy, &c.

(*iii.*) Affecting respiratory system—*e.g.*,
syphilitic laryngitis, &c.

(*iv.*) Affecting digestive system—*e.g.*,
syphilitic stricture of rectum, &c.

(*v.*) Affecting circulatory system—*e.g.*,
syphilitic angina, aneurism, &c.

(*vi.*) Affecting spleen

(*vii.*) Affecting skin, bones, joints, muscles

(*viii.*) Affecting genito-urinary system, including
abortions, &c.

NOTE.—No case should be recorded under
more than one of these headings.

Total number of cases under my personal care

My opinion is that venereal disease in this Dominion
has [not] increased in a greater proportion than the
population during the last five years.

[*Signature*
of medical practitioner.]

Date of posting:
practising or name or }
names of institutions
concerned: }

Town where

[A] "Under my personal care on Saturday, 16th September, 1922," is to be interpreted to include all patients suffering from the conditions enumerated whom you are attending or have attended, and who you believe in the event of requiring further attendance would call you in or consult you, in other words, *bona fide* patients of your own. It is not intended that you are to enumerate only the patients actually seen by you on that date. Medical superintendents or medical officers in charge of institutions will regard all patients in or attending their institutions as "under my personal care on Saturday, 16th September, 1922," irrespective of whom the actual medical attendant may be.

Please post this Reply Form as soon as possible after 16th September, 1922, and not later than 20th September, 1922.

Additional copies of this form are obtainable from the Medical

Officers of Health, or the Secretary of the Board of Health,
P.O. Box 1146, Wellington.

TABLE D.

VENEREAL DISEASES IN NEW ZEALAND AS AT 16TH SEPTEMBER, 1922.—NUMBERS IN HEALTH DISTRICTS.

Cases of Recent Infection.				
Health District	Gonorrhoea	Soft Chancre	Syphilis	Total
North Auckland	10	..	1	14
Auckland	279	3	165	447
Hawke's Bay	35	3	17	55

Cases of Distant Infection					
Health District	Chronic Gonorrhoea	Congenital Syphilis	Tertiary Syphilis	Total	Grand Total
North Auckland	10	1	5	16	30
Auckland	229	51	239	519	966



Hawke's Bay		32	10	30	72	127
Wanganui		97	10	42	149	247
Wellington		279	56	220	555	860
Canterbury		83	17	111	211	387
Otago		120	23	88	231	414
-----+-----+-----+-----+-----+-----+						
Dominion totals		850	168	735	1,753	3,031

-----+-----+-----+						
Expression of Opinion						
Health	-----+-----+-----					
District		Increase	Decrease	Not		
		stated				

North Auckland		7	2	11
Auckland		34	53	82
Hawke's Bay		6	19	24
Wanganui		13	16	24
Wellington		29	36	68
Canterbury		16	47	53
Otago		14	30	51
-----+-----+-----+-----				
Dominion totals		119	203	313

Total replies received, 635.

TABLE E.

VENEREAL DISEASES IN NEW ZEALAND AS AT 16TH SEPTEMBER, 1922. TOTALS (ALL FORMS) OF GONORRHOEA, SOFT CHANCRE, AND SYPHILIS, AND PERCENTAGE OF GRAND TOTAL.

-----+-----+-----+				
-----+				
Totals (all Forms) of each Disease Grand				
Health District	-----+-----+-----+	Total		
Gonorrhoea	Soft Chancre	Syphilis		
-----+-----+-----+-----+				
----+				
North Auckland	20	..	10	30
Auckland	508	3	455	966
Hawke's Bay	67	3	57	127



Wanganui		156	2	89	247
Wellington		466	4	390	860
Canterbury		182	2	203	387

-----+-----

--+

|Percentages (all forms) to Grand Total|

Health District +-----+-----+-----+

| Gonorrhoea | Soft Chancre | Syphilis |

-----+-----+-----+

North Auckland		66.67	..	33.33
Auckland		52.59	0.31	47.10
Hawke's Bay		52.76	2.36	44.88
Wanganui		63.16	0.81	36.03
Wellington		54.19	0.46	15.35
Canterbury		47.03	0.52	52.45
Otago		48.07	..	51.93

+-----+-----+-----+

Dominion totals | 52.72| 0.46| 46.82|

-----+-----+-----+

re>

TABLE F.

VENEREAL DISEASES IN NEW ZEALAND AS AT 16TH SEPTEMBER, 1922.—INCIDENCE IN CHIEF CENTRES SHOWING RATE PER 1,000 ESTIMATED POPULATION.

-----+-----+-----

-----+

| Cases of Recent Infection |

| +-----+-----+-----+

| Gonorrhoea | Syphilis | Total |

| | | |

|Estimated +-----+-----+-----+

Urban Area |Population| C |Rate| C |Rate| C |Rate|

|1st | a |per | a |per | a |per |

|April, | s |1,000| s |1,000| s |1,000|

|1922 | e | | e | | e | |

| | s | | s | | s | |

-----+-----+-----+-----+-----+-----

--+

Auckland		164,450		214	1.30	146	0.89	360	2.19
Wellington		110,680		159	1.44	99	0.89	258	2.33

Christchurch		110,200		79		0.72		59		0.53		138		1.25	
Dunedin		73,470		54		0.74		102		1.39		156		2.12	
Hamilton		14,950		15		1.01		3		0.20		18		1.20	
Cisborne		14,920		7		0.47			7		0.47	
Napier		17,670		17		0.96		13		0.74		30		1.70	
Hastings		13,530			2		0.15		2		0.15	
New Plymouth		13,510		3		0.22			3		0.22	
Wanganui		24,170		14		0.58		12		0.50		26		1.08	
Palmerston North		17,510		5		0.29		13		0.80		18		1.03	
Nelson		10,880		1		0.09			1		0.09	
Timaru		16,040		6		0.37		1		0.06		7		0.44	
Invercargill		19,590		1		0.05			1		0.05	

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

--+

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

| Cases of Distant Infection | Grand |

|-----+-----+-----+-----+-----+-----+-----+-----+-----+-----| Total +

TABLE G.

VENEREAL DISEASES IN NEW ZEALAND AS AT 16TH SEPTEMBER, 1922. —PROPORTION OF CASES PER 1,000 OF POPULATION IN EACH HEALTH DISTRICT.

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

| | Total Cases | Proportion Cases per 1,000 |

Health |Estimated | (all Diseases) | Estimated Population |

District |Population+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

|1st April,|Recent |Distant |Grand|Recent |Distant |Grand|

|1922 |Infection|Infection|Total|Infection|Infection|Total|

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

N. Auckland		36,930		14		16		30		0.38		0.43		0.81	
Auckland		323,436		447		519		966		1.38		1.60		2.99	
Hawke's Bay		80,242		55		72		127		0.62		0.81		1.42	
Wanganui		110,866		98		149		247		0.88		1.34		2.23	
Wellington		242,830		305		555		860		1.26		2.28		3.54	
Canterbury		240,387		176		211		387		0.73		0.88		1.61	
Otago		200,574		183		231		414		0.91		1.15		2.06	



	+	-----	+	-----	+	-----	+	-----	+	-----	+	
	-----	+	-----	+								
Dominion												
Totals		1,244,265		1,278		1,753	3,031		1.03		1.41	2.44
	-----	+	-----	+	-----	+	-----	+	-----	+	-----	+

TABLE H.

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VENEREAL DISEASES IN NEW ZEALAND AS AT 16TH SEPTEMBER, 1922. —SEX NUMBERS AND PROPORTIONS IN HEALTH DISTRICTS.

Key: %% = F. to 100 M.

Cases of Recent Infection											
Health District	Gonorrhoea			Syphilis			Totals				
	M	F	%%	M	F	%%	M	F	%%		
N. Auckland	10	3	1	33	13	1	8		
Auckland	224	55	25	112	53	47	336	108	32		
Hawke's Bay	28	7	25	12	5	42	40	12	30		
Wanganui	40	19	48	25	12	48	65	31	48		
Wellington	143	44	31	95	19	20	238	63	26		
Canterbury	63	36	57	48	27	56	111	63	57		
Otago	62	17	27	89	15	17	151	32	21		
Dominion											
Totals	570	178	31	384	132	34	954	310	32		

pre>

Cases of Distant Infection											
Health District	Chronic			Congenital			Tertiary			Totals	
	M	F	%%	M	F	%%	M	F	%%	M	F

N. Auckland		8		2		25		..		1		..		4		1		25		12		4		33	
Auckland		156		73		47		33		18		55		168		71		42		357		162		45	
Hawke's Bay		27		5		19		7		3		43		22		8		36		56		16		29	
Wanganui		74		23		31		5		5		100		29		13		45		108		41		38	
Wellington		225		54		24		31		25		81		156		64		41		412		143		35	
Canterbury		65		18		29		7		10		143		81		30		37		153		58		38	
Otago		101		19		19		15		8		53		58		30		52		174		57		33	

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

+-+-----+-----+

Dominion																									
Totals		656		194		30		98		70		71		518		217		42		1,272		481		38	

-----+-----+-----+-----+-----+-----+-----+-----+-----+-----

+-+-----+-----+

-----+-----+-----+			
Health		Grand Totals	
District	+	-----+-----+-----+	+
M		F	% %

-----+-----+-----+			
North Auckland		25	5 20
Auckland		693	270 39
Hawke's Bay		96	28 29
Wanganui		173	72 42
Wellington		650	206 32
Canterbury		264	121 46
Otago		325	89 27

-----+-----+-----+			
Dominion			
Totals		2,226	791 36

-----+-----+-----+-----+

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Approximate Cost of Paper.—Preparation,
not given;
printing (1,225 copies), L45.

* * * *
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Price 9d.



	Chronic Gonorrhoea		Congenital Syphilis		Tertiary Syphilis		Total							
	a	s per 1,000 e s	C	a per 1,000 e s	Rate	C	a per 1,000 e s	Rate	C	a per 1,000 e s	Rate	C	a per 1,000 e s	Rate
Urban Area.														
Auckland	147	0.89	42	0.26	194	1.18	383	2.33	743	4.52				
Wellington	240	2.17	42	0.38	183	1.65	465	4.20	723	6.53				
Christchurch	63	0.57	15	0.14	87	0.79	165	1.50	303	2.75				
Dunedin	96	1.31	18	0.25	59	0.80	173	2.35	329	4.48				
Hamilton	22	1.47	10	0.67	32	2.14	50	3.34				
Cisborne	9	0.60	2	0.13	9	0.60	20	1.34	27	1.81				
Napier	8	0.45	3	0.17	9	0.51	20	1.13	50	2.83				
Hastings	1	0.07	2	0.15	2	0.15	5	0.37	7	0.52				
New Plymouth	3	0.22	3	0.22	6	0.52				
Wanganui	29	1.20	6	0.25	21	0.87	56	2.32	82	3.39				
Palmerston N.	12	0.69	5	0.29	3	0.17	20	1.14	38	2.17				
Nelson	4	0.37	10	0.92	14	1.29	15	1.38				
Timaru	5	0.31	8	0.50	13	0.81	20	1.25				
Invercargill	7	0.36	10	0.51	17	0.87	18	0.92				

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Otago		199	..	215	414
-----+-----+-----+-----+					
Dominion totals		1,598	14	1,419	3,031
-----+-----+-----+-----+					
----+					

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Wanganui		59	2	37	98
Wellington		187	4	114	305
Canterbury		99	2	75	176
Otago		79	..	104	183
-----+-----+-----+-----+-----+					
Dominion totals		748	14	516	1,278
-----+-----+-----+-----+-----+					

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out-patients' clinic who							
were suffering from--							
Syphilis	4,865	1,503	5,256	1,647	3,050	948	
Chancroid	216	..	133	..	103	..	
Gonorrhoea	20,105	520	33,583	1,630	17,114	1,017	
No V.D.	366	136	562	258	218	108	
Aggregate number of							
in-patients' days of							
treatment given to							
persons suffering from--							
Syphilis	1,930	35	2,499	150	1,120	9	
Gonorrhoea	3,550	293	5,168	327	2,157	216	
-----+-----+-----+-----+-----+-----							
+-----+							