

# Sailors and syphilis on Europe's waterways

## International Health Organizations and the Rhine Commissions, c. 1900-1953

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### Introduction

While historians have considered the place of seamen in the emergence of modern health policies before, their research has often been into particular national contexts and has tended to focus on those men working on the open seas.<sup>1</sup> Where those working on the Rhine have been mentioned in previous studies, it has usually been in passing.<sup>2</sup> This article will focus on the efforts to address the problem of sexually-transmitted disease among this labour force in the first half of the twentieth-century as it became a core concern for a wide range of international health organizations in this period. It will explore the reasons why, despite concerted efforts at comprehensive systems of surveillance and treatment,

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1 For general accounts on STDs among seamen, see J. W. Kerr, "Venereal Diseases Among Seamen of the Merchant Marine", *Journal of the American Public Health Association*, 1.3 (March, 1911): 192-197, A. O. F. Ross, "Treatment of Venereal Diseases in the Allied Merchant Navies", *The British Journal of Venereal Diseases*, 21.3 (Sept. 1945): 123-134, "Treatment of Venereal Disease in Merchant Seamen", *The British Journal of Venereal Diseases*, 28.3 (Sept. 1952): 105, C. B. S. Schofield, "Difficulties in the Management of Venereal Disease in Mariners", *Bulletin of the World Health Organization*, 33.6 (1965): 867-880, O. Idsøe and T. Guthe, "The Frequency of Venereal Disease among Seafarers", *Bulletin of the World Health Organization*, 29.6 (1963): 773-780, R. R. Willcox and T. Guthe, "The Management of Venereal Diseases in Ports: an International Survey", *Bulletin of the World Health Organization*, 16.5 (1957): 1033-1038.

2 Apart from reports and news from the field in various journals and bulletins published by the health organizations, particularly the WHO (which should also be regarded as a primary source), very little written has been on this topic. Only a few authors have mentioned the case of the Rhine boatmen in their works. Among others, see P. Weindling, "The politics of international co-ordination to combat sexually transmitted diseases, 1900-1980s", in V. Berridge and P. Strong, eds., *AIDS and contemporary history* (Cambridge, 2002), 93-107, N. M. Goodman, *International Health Organizations and their Work* (London, 1952), 11, and T. J. Bauer, "Half a Century of International Control of the Venereal Diseases", *Public Health Reports*, 68.8 (Aug. 1953): 779-787.

those involved with tackling the problem remained unable to fully realise their plans for the best part of half a century.

## The Rhine and its boatmen

Part of the reason that those working on the Rhine became a focus of efforts at international cooperation in this period is geographical. The river crosses a number of frontiers and its basin embraces – also through navigable canals – large parts of Germany, France, Switzerland, the Netherlands and Belgium, connecting them all with the wider world through the ports of Antwerp and Rotterdam. Given this, the efficient running of traffic on the waterway was important for multiple national economies; by the 1930s it was estimated that the volume of trade along it amounted to 85 million tons of cargo per annum, more than six times that of any other European river. It was carried on around 12000 freight vessels that included passenger boats, tugs and lighters and towards the end of the decade it was estimated that the “floating population” of those who made their livings from transportation along its length numbered between eighty and one hundred thousand people.<sup>3</sup> This flow of goods and of human beings meant that many who worked on the river lived itinerant lives and that it carried a perpetually mobile population. It was certainly believed in policy-making circles that this necessarily brought with it a certain lifestyle, and what the WHO euphemistically referred to in noting “the special risk of frequent infections to which sailors were exposed because of their mode of life”<sup>4</sup> earlier organisations like the Rhine River Commission called simply “alcoholism and debauchery”.<sup>5</sup> This is no surprise as the management of the syphilitic sailor had been discussed by naval surgeons since at least the eighteenth-century<sup>6</sup> and had often involved efforts at international cooperation in the past.<sup>7</sup> As early as 1899 the issue of sailors and venereal disease had been at the heart of wider discussions about how to better coordinate efforts across national borders to control STDs at the Brussels *Conférence internationale pour la prophylaxie de la syphilis et des maladies*

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3 For these numbers, see W. A. Brumfield, “Venereal Disease Control in the Rhine River Valley”, *Journal of Social Hygiene*, 36.1 (Jan. 1950): 13–19, quotation on 14.

4 World Health Organization, “An International Anti-Venereal Disease Commission of the Rhine (IAVDC)”, WHO/VD/20, 20 June 1949, p. 5, WHO/ANTIB, 1–22, World Health Organization Archives, Geneva, Switzerland (henceforward: WHOA). See also: L. M. Pautrier, “A plan for the establishment of an international body for venereal disease control among Rhine River boatmen. Presented at General Assembly of the International Union Against Venereal Diseases, Copenhagen 6–7 September 1948”, p. 7, Rhine River Commission, 465–2–1, WHOA.

5 “Antivenereal disease campaign in the Rhine River region”, p. 1, Rhine River Commission, 465–4–6, WHOA.

6 Idsøe and Guthe, “The Frequency of Venereal Disease”, (see note 1), quotation on 773.

7 Schofield, “Difficulties in the Management”, (see note 1), 867.

vénériennes. But it was the First World War and its aftermath that saw the problem emerge as a priority for a number of the nascent IHOs of that period.

The conflict ensured that by the time it ended there was an increased morbidity rate of syphilis, gonorrhoea and chlamydia in the whole Europe.<sup>8</sup> The causes of this were numerous. Young soldiers flowed backwards and forwards across the continent, as did displaced populations. In many countries, both victorious and defeated, the social order fell apart and the loosening of family ties changed behaviours and attitudes towards sexual contact. Prostitution flourished, mainly near areas of high military activity and in ports, and rapes increased along the main routes of the marching armies.<sup>9</sup> The civilian population of Europe had limited access to pharmaceuticals and medical care. After the First World War the fear that all of these circumstances had combined to leave populations along the Rhine struggling with venereal infections was prevailing.<sup>10</sup>

## Global syphilis and the Brussels Agreement

Before the war organisations like the League of Red Cross Societies (LRCS), the International Office of Public Health (Office International d'Hygiène Publique –

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8 The are numerous references to the critical serological situation in Europe after both world wars, but compiling a data summary for Europe generally, or for Rhine basin in particular, is rather difficult for various reasons, such as lack of systematic statistics, different infection definitions, or data interpretations. However, the data from individual countries show a growing tendency in infection ratio until the end of the war, and then almost equally sharp drop as a result of anti-STD campaigns and prophylaxis. The case of Sweden, where detailed statistics spanning the period 1916–47 are available, is a useful point of reference. The number of reported cases of syphilis in Swedish clinics rose sharply from 2549 in 1916 to 5827 in 1919, and dropped to 2232 in 1921. For chancroid the numbers were, respectively, 1101, 3341, and 867, while for gonorrhoea – 12100, 20471, and 12723. See: M. Tottie, “Mesures prises en Suède contre les maladies vénérienne”, p. 7, Venereal Diseases – Brussels Agreement and Maritime Aspects, Baltic Basin Commission, 465–4–8, WHOA. Similar drop in the number of patients of venereal clinics was reported in Netherland in 1920–25, but in applied only to civilians – the number of infected sailors in Rotterdam ‘remained stubbornly high’. See A. Mooij, *Out of otherness: characters and narrators in the Dutch venereal disease debates 1850–1990* (Amsterdam, 1998), p. 111.

9 See N. Henry, *War and rape: law, memory, and justice* (New York, 2011), p. 28, and R. G. Moeller, *War Stories: The Search for a Usable Past in the Federal Republic of Germany* (Berkeley, 2001), pp. 66–67.

10 Weindling refers to ‘the fear that soldiers might spread the STDs among the civilian populations’ in the time of transition from war to peace, (see note 2), 96. Of course this was not an impact of the First World War limited to the Rhine. For example, shortly after the First World War the level of STD morbidity in Shanghai became a matter of urgent concern for the London-based Eastern Commission of the National Council for Combating Venereal Diseases. In 1921 the council urged the Shanghai Municipal Council to provide free diagnosis and treatment of STDs to sailors, who were labelled a ‘vulnerable population’. See G. Hershatler, *Dangerous pleasures: prostitution and moaernity in twentieth-century Shanghai* (Berkeley, 1997), p. 228.

OIHP), and the International Union against Venereal Diseases (Union Internationale Contre le Péril Vénérien – UICPV) had to some degree produced competing visions of how the challenge of controlling STDs on a global scale should be approached. The LRCS, being heavily based on American views (and funds), strongly condemned prostitution and emphasised moral education and self-control as the most effective weapons against STDs. Meanwhile, organisations like the OIHP which were dominated by those from medical circles in France and Germany emphasised technical solutions such as prevention through wider use of condoms and more effective methods of treatment for diagnosed cases.<sup>11</sup> The OIHP was the first IHO in the post-war world to return to the problem of STDs and its plan mooted an international agreement to provide free medical treatment in ports for infected sailors of all merchant navies. This proposal was considered at the First Maritime Labour Conference in 1920. This was held under the auspices of the newly founded International Labour Organization (ILO) in Geneva and included representatives of various organisations including the International Maritime Federation (IMF) and the International Seaman's Federation (ISF). All agreed to focus their efforts on two goals: first, fostering awareness of the need for detection and treatment of all cases of infection among sailors, and second, to encourage organised “social meetings in ports to combat the idleness of the crews, which resulted in alcoholism and debauchery”.<sup>12</sup> Apparently, the scale of the problem was serious enough for all involved to overcome past disputes and to reach a compromise. While STD infection in mariners was framed clearly as a health issue to be solved by medical means, the American view of its moral roots remained. The medical approach recommended specifically included prophylaxis and treatment centres in all major ports along the Rhine and the inclusion of STDs on the list of disorders for which inland sailors should receive free treatment. Wide dissemination of knowledge about the program among sailors on duty, and particularly those still undergoing training, was also advocated.

After the Conference the challenge of implementing these recommendations was taken up by a range of agencies, the OIHP, the ILO and also the new League of Nations Health Organization (LNHO), to be coordinated by a team made up of representatives of each. In 1923 they were joined by others from the recently founded International Union against Venereal Diseases and Treponematoses (IUAVDT) led by Dr. Andre J. Cavaillon, an official from the French Ministry of Public Health.<sup>13</sup> The outcome of all this coordination was “The Agreement respecting facilities to be

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11 This entanglement has been fully explained in Weindling's “The politics of international co-ordination”, (see note 2), 94–99.

12 “Antivenereal disease campaign in the Rhine”, (see note 5), p. 1.

13 “Obituary. Andre J. Cavaillon, 1887–1967”, *The British Journal of Venereal Diseases*, 44 (1968): 93.

given to merchant seamen for the treatment of venereal diseases”, better known as the Brussels Agreement which was revealed to the world on 1st December 1924.<sup>14</sup>

The Brussels Agreement “prescribed”, as Cavaillon put it, specialised medical centres at all major sea and river ports.<sup>15</sup> The centres had to be accessible to all sailors in need regardless of their nationality. The intention was to offer free treatment to seamen of all nations, whether their governments were signatories to the agreement or not.<sup>16</sup> The medical staff running those facilities were to be specialists trained with the very latest knowledge of venereology. The capacity of each centre, as well as the number of beds, was to be planned by the volume of traffic at the port. Hospitalisation was to be free for as long as the doctor considered it necessary. Finally, patients leaving the clinics were to receive free medication for their journey to the next port.<sup>17</sup> However, putting these ambitious recommendations into practice was not easy. Two main obstacles had to be overcome – the lack of standardisation in the diagnosis and treatment of venereal diseases, and the diversity of welfare services in different countries.

Although an antibody test for syphilis, named after its developer August Paul von Wasserman, had been in wide use since 1906 the emergence of a universal, reliable interpretation of the obtained results remained elusive.<sup>18</sup> In 1923 the LNHO organised in Copenhagen an international team of scientists to test some 500 specimens from eight countries using different techniques, all in order to work out a standardised interpretation.<sup>19</sup> Agreement remained ambiguous however, and the standardization of the Wasserman test remained at the top of the agenda for national and international health bodies throughout the inter-war period<sup>20</sup> and afterwards.<sup>21</sup>

If standardized scientific and medical processes for dealing with syphilis and its treatment remained elusive in this period then so did agreement on how to provide facilities for dealing with the infected among the labour force of the Rhine waterways. It has been argued that because it was limited to technical matters the LNHO did not pay much attention to the second obstacle facing its programme, namely the

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14 Goodman, *International Health Organizations*, (see note 2), p. 11.

15 Cited after “Antivenereal disease campaign in the Rhine”, (see note 5), p. 5.

16 Goodman, *International Health Organizations*, (see note 2), p. 12.

17 “Antivenereal disease campaign in the Rhine”, (see note 5), p. 2.

18 This author is indebted to Dr. Walter Bruchhausen for bringing up the issue of testing standardisation.

19 Weindling, “The politics of international co-ordination”, (see note 2), 99.

20 The progress reports were published regularly in leading medical journals. See, for example, R. Gilbert, “Standardization of the Wassermann Test. Abstract of Progress Test”, *American Journal of Public Health and the Nation's Health*, 20.1 (Jan. 1930): 47-48, R. Gilbert and V. Langworthy, “Standardization of the Wasserman Test. Report of Progress for 1926”, *American Journal of Syphilis, Gonorrhea and Venereal Diseases*, 11 (1927): 475, and others.

21 “International Serodiagnostic Conference to be Organized by WHO”, *Journal of Venereal Disease Information*, 31.7 (July 1950): 193.

financing of medical provision for all sailors regardless of their nationality.<sup>22</sup> Its core recommendation was that those treated or hospitalised would be so for free, an assumption that had clear historical precedents, in the Danish law of 1802 for example, which offered treatment without charge to foreign seamen.<sup>23</sup> Few had followed this example though for the obvious reason noted by Sybil Neville-Rolfe in 1934 in her role as UK representative on the IUAVDT and the Secretary-General of the National Council for Combating Venereal Diseases. She observed that “one cannot expect that governments should offer to foreign seamen advantages which they do not offer to their own nationals”.<sup>24</sup>

## The First Rhine Commission

Britain had unilaterally moved to offering free treatment to those sailors suffering from STDs in the early 1920s and the Netherlands and France joined them in the early 1930s as a response to the Brussels Agreement.<sup>25</sup> By 1938 the agreement had been signed by 56 countries but not all provided free care for sailors with venereal disease.<sup>26</sup> The problem for those working on the waterways of the Rhine Basin was

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22 Weindling, “The politics of international co-ordination”, (see note 2), 100.

23 J. Huisman, “Venereal Diseases (Sexually Transmitted Diseases: STD)” in W. H. G. Goethe et al., eds., *Handbook of Nautical Medicine Berlin* (Berlin, 1984), 207–212, quotation on 207.

24 Cited after “Antivenereal disease campaign in the Rhine”, (see note 5), p. 4.

25 R. R. Willcox, “IV Harrison Lecture 1981: the international venereological scene as viewed by Harrison and St Mary’s”, *The British Journal of Venereal Diseases*, 58 (1982): 72–85, quotation on 76. While French and Dutch accession was a result of their joining the Brussels Agreement, the exception remained the United States, which until the outbreak of the Second World War had not signed it. However, with the passing of its Venereal Disease Control Act of 1938, the United States opened its ports’ specialised medical centres to foreign sailors. A network of such clinics was set up in major US ports under this act, and their locations were included in the informational materials distributed among sailors as part of the activities of the European venereal clinics set up under the Agreement. See Bauer, “Half a Century of International Control”, (see note 2), 782.

26 No detailed listing is available, but by 1931 the Agreement claimed the following signatories (in order of their signing): 1925 – Great Britain, Canada, New Zealand; 1926 – Belgium, Finland, Greece; 1927 – Romania; 1928 – Denmark, Italy, Island, Australia; 1930 – France, Netherlands, Ireland, and 1931 – Sweden, Poland. The total of 56 includes colonies, on behalf of which the agreement was signed by their metropolises, and as such in 1926 Great Britain signed the agreement for most of her overseas colonies, including Ceylon, Gibraltar and the Seychelles; 1927 – France for Morocco, and Belgium for Congo, 1928 – Great Britain for Iraq and in 1930 for Cyprus. This list comes from an annex to the Polish enactment of 1931, published in the Polish Journal of Laws in February 1932. See “Oświadczenie rządowe z dnia 17 lutego 1932 r. w sprawie zgłoszenia przez Polskę przystąpienia do porozumienia w sprawie ułatwień marynarzom handlowym leczenia chorób wenerycznych, wraz z protokołem podpisania, podpisanych w Brukseli 1 grudnia 1924”, *Dziennik Ustaw. Poz. 92*, 17 February 1932.

that even where free medicine and treatment was notionally available sailors had to navigate the complexities of the different social insurance systems of each nation they passed through. For the Rhine boatmen this could mean facing multiple bureaucracies on a single trip down the river. In practice this became so complex that in 1929 various insurance companies asked the Central Rhine Commission (CRC a body established after the 1815 Congress of Vienna to ensure free navigation on the river) to take steps to coordinate the relevant parts of the social security systems in the Rhine countries and in Belgium. Observers remained suspicious of their motives however, arguing that in this period insurance providers

seek out all boat men who travelled along the Rhine through the territory of each state ... to claim social insurance contributions from them. This ultimately led to an intolerable superimposition of taxation; on the other hand these same social insurance institutions were by no means averse to evading their responsibilities by invoking the fact that the Rhine boatmen were foreigners when the latter, in the case of illness or accident, applied for special insurance benefits.<sup>27</sup>

Because the situation in the Rhine basin was so complex the General Assembly of the IUAVDT in Amsterdam decided to appoint a new body to coordinate the work along the river between Germany, Belgium, France, the Netherlands and Switzerland. The first Rhine Commission met in Strasbourg in December 1936 and elected its chair, Lucien M. Pautrier, a Professor of Dermatology at the Medical Faculty of the University of Strasbourg. From the moment of its inception the Commission worked to solve the legal and organisational issues hindering the introduction of a programme to tackle the STD epidemic among the Rhine boatmen. This was no easy task, since two of the Commission's member countries, Switzerland and Germany, had not signed the Brussels Agreement.<sup>28</sup>

Despite these problems there is some evidence that the Brussels Agreement did have some impacts on the ground in the Rhine. Education and information were very important in the plan and a register of specialised centres at all European ports was created, which by the end of March 1933 had been sent out to diplomatic missions in Paris, and to the ministries of foreign affairs of the countries involved.<sup>29</sup> The Agreement also recommended that all sailors visiting clinics or hospitals for treatment of STDs be provided with individual treatment books in which their medical history was recorded. The sailor-patients would also receive free medicines and a map that showed other ports and clinics where they could get further help, if required, as well as a variety of educational materials in different languages.<sup>30</sup> Between

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27 Pautrier, "A plan for the establishment", (see note 4), p. 16–17.

28 See Weindling, "The politics of international co-ordination", (see note 2), 97.

29 "Antivenereal disease campaign in the Rhine", (see note 5), p. 3.

30 Pautrier, "A plan for the establishment", (see note 4), p. 9.

1930 and 1938 nineteen thousand such books were distributed which provides a glimpse of the numbers of those passing through the system.

Detailed data exists for Strasbourg, which shows that between 1921 and 1936 three thousand and ninety-three syphilitic sailors sought help from the special venereal clinic at the Skin and Syphilis Department of the Civic Hospital in the city.<sup>31</sup> They were treated for free and 835 received arsenical injections, 934 bismuth injections, and 480 mercury injections. Thirty-one were hospitalised.<sup>32</sup> Those assisted included French, German, Belgian, Dutch and Swiss nationals.<sup>33</sup> Only ninety-six answered the questionnaires they were presented with at the clinics, and of these forty reckoned they had been infected in France (30 in Strasbourg and 10 in the interior), eighteen in Germany, five in the Lower Rhine, three in the Netherlands, and two in Switzerland. Twenty-seven did not remember, or chose not to remember, where they had been poxed.<sup>34</sup> In reviewing the data from Strasbourg Pautrier himself stated that he was satisfied with these “considerable results” although he admitted that they might appear “insignificant in view of the number of boatmen who travel up and down the Rhine”.<sup>35</sup> Seventy-five thousand sailors visited Strasbourg in 1937 alone.<sup>36</sup>

## The Second World War and the new Rhine Commission

In the wake of the Second World War efforts to control STDs among those working on the waterways of the Rhine basin seemed to become more tangled and time-consuming. For example, starting from 1949, boatmen crossing the German-Dutch border on their tugs and barges were forced to stop in the small Dutch village of Lobith to have their cargo and shipping documents checked by customs officers. While there they were subjected to compulsory serological testing, and if adult family members travelling with them these were also forced to undergo examination.<sup>37</sup>

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31 Ibid., p. 10.

32 Ibid.

33 Ibid., p. 7–10. The ethnic composition of this number is unknown, but one may assume that the vast majority must have been of foreign origin. This can be concluded from Pautrier’s own estimates for 1937, when the river port in Strasbourg received over twelve thousand vessels, which included 8893 lighters and 1236 tugs. Well over half of these vessels were sailing under the Dutch flag. According to Pautrier, French vessels amounted to less than 5%. One may assume that percentage of French patients visiting the clinic was similar.

34 Ibid., p. 12. This result suggests that sailors usually sought help in the same port in which they were infected.

35 Ibid., p. 12.

36 Ibid., p. 7.

37 L. M. Pautrier, “The Anti-Venereal Organization of the Rhine Traffic. A report delivered at General Assembly of the International Union Against Venereal Diseases, Rome, 12–16 Sept. 1949”, p. 8. Various correspondence with: Union Internationale Contre Le Péril Vénérien, Paris, 465-2-1, WHOA.

It is perhaps for this reason that Paul Weindling has stated that the newly founded World Health Organization had a “special concern for Rhine River Boatmen and conditions in Poland” in this period.<sup>38</sup> As far as Poland was concerned the WHO had little to do but cheer it on as it embarked on its own ambitious anti-STD programme as early as 1946.<sup>39</sup> However, the WHO was certainly a more active participant in the Rhine boatmen issue and looked to the work of the pre-war Rhine Commission as it began implementing the different health programmes it had taken on, including the regulation of the Brussels Agreement.<sup>40</sup> Other groups became involved as the CRC returned to the issue of social insurance for Rhine boatmen and set up a special sub-committee for this purpose. In 1947 it made contact with the Transport Commission of the ILO about the matter.<sup>41</sup>

The starting point for their efforts was a technical report, presented by Pautrier, on the activities of the pre-war incarnation of the Rhine Commission. The report argued that if the boatmen were to be “induced to use” medical facilities for the treatment of STDs the system would have to be designed with a “maximum degree of simplification” so that medical support to sailors was provided on a walk-in basis without the need for them to provide any type of insurance documents. He also pointed out that sailors rarely stayed longer than two days in port, and so would not have the time to visit an insurance office twice, to pick up a health book, and then to collect a refund. Pautrier argued that coordination between the organisations funding national health schemes would have to be in place to make the system work; “co-operation between the social insurance institutions can, from an administrative

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38 Weindling, “The politics of international co-ordination”, (see note 2), 102.

39 This author argues that Poland had egged herself on to start such a programme. Its mass anti-STD campaign, simply called “Operation ‘W’” (where the W stood for *weneryczny* – Polish for ‘venereal’), was launched in 1948, based partly on an assumed abundance of penicillin from the country’s first penicillin factory, which was then still under construction. The factory had been promised in early 1946 by the United Nations Relief and Rehabilitation Administration (UNRRA) as part of a larger rehabilitation programme for war-torn Eastern Europe. However, for various reasons construction was delayed by two-and-a-half years and ‘Operation W’ finally launched basing entirely on imported antibiotic. For a detailed account on the origin, realisation and broad consequences of UNRRA’s penicillin plant program see S. Łotysz, “A ‘Lasting Memorial’ to the UNRRA? Implementation of the Penicillin Plant Programme in Poland, 1946–1949”, *ICON: Journal of the International Committee for the History of Technology*, 20.2 (2014): 70–91. Nevertheless “Operation ‘W’” was praised by the WHO’s experts as being the world’s first fully comprehensive plan to combat STDs – see the *Official Records of the World Health Organization*, 14 (1948): 20. It aimed at reducing the post-war STD epidemic to a “socially meaningless extent” to cite M. Kacprzak, *Choroby weneryczne i ich zwalczanie* (Warszawa, 1948), p. 3–4. For a general account on combating STDs in post-war Poland see, among others, P. Barański, “Walka z chorobami wenerycznymi w Polsce w latach 1948–1949”, pp. 11–97 in M. Kula, ed., *Kłopoty z seksem w PRL* (Warszawa, 2012).

40 Willcox and Guthe, “The Management of Venereal Diseases in Ports”, (see note 1), quotation on 1033.

41 Pautrier, A plan for the establishment, (see note 4), p. 17.

standpoint, facilitate venereal disease prophylaxis on the river”.<sup>42</sup> In his opinion the easiest solution was to impose the costs of any periods of hospitalisation on the respective state treasury, through the ministries of health or competent national institutes of public hygiene. He argued that since the number of cases requiring hospital care would be relatively low, the cost to tax payers would not be excessive.<sup>43</sup>

In January 1948 the Expert Committee on Venereal Diseases of the WHO confirmed the commitment of the Organization to ensure free treatment of STDs for all sailors and to provide them with a wide range of social services, as “prescribed” by the Brussels Agreement. The Committee also stressed the importance of tracking the sources of infection on an international scale, and went as far as advocating the extension of the provisions of the Brussels Agreement to all displaced persons and migrants.<sup>44</sup> Had it done so, the Agreement could have evolved into a broader international welfare scheme.<sup>45</sup> Pautrier pushed further. In September 1948, at the General Assembly of the IUAVDT in Copenhagen, he called for the creation of an international group to focus on the Rhine on the lines of the pre-War body.<sup>46</sup> His position was supported at the Expert Committee’s second meeting in October 1948 and was greeted with a positive response from all the Rhine countries.<sup>47</sup> At the end of May 1949 their delegates, mainly members of the pre-war Rhine Commission, met in Paris and recommended the formation of the International Anti-venereal Disease Commission of the Rhine (IAVDCR). In practice this would be the second Rhine Commission, but this time it would operate under the auspices of the WHO.<sup>48</sup> The

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42 Ibid.

43 Ibid., p. 18.

44 Ibid., p. 6.

45 Significantly, the recommendations of the Expert Committee were incorporated into the provisions of the first General Assembly of the WHO, which took place in Geneva in June and July of 1948.

46 When presenting the plan, Pautrier proposed his native Strasbourg as the seat of the new Rhine Commission. Specifically, he was thinking of the Palais du Rhin in the city. Since 1920 it had been the headquarters of the Central Rhine Commission. Prior to that it had first been established in Mainz, and then in 1868 relocated to Mannheim, both in Germany. Pautrier stressed Strasbourg’s central location, midway between Basel and the Ruhr. Besides, he said, the most important waterways connecting the Rhine with the heart of France start from there: the Marne-Rhine canal running towards Paris and the Rhone-Rhine heading towards Lyon. Of course, this was only the French perspective. Both the geographical and economic centre of the Rhine basin was lower down the river in Germany. Obviously, in early post-WWII Europe the French position was strong enough to support such claims. In the CRC France was the only occupying power. Meanwhile Germany, now split into zones, was represented by members of British, American and French military administrations. See Pautrier, “A plan for the establishment”, (see note 4), *passim*.

47 “Antivenereal disease campaign in the Rhine”, (see note 5), p. 6.

48 Representing France was Professor Lucien M. Pautrier of Strasbourg. Representing Belgium was Dr. Paul van de Calseyde, the Director-General of Hygiene in the Ministry of Public Health, while the Netherlands sent Dr. Edward M. Hermans, who was a Professor of Dermato-Venerology in Rotterdam. From Switzerland came Dr. Rudolf Schuppli, the Director of the

idea proved to be of wider interest and by the end of the year Poland, Finland, Sweden, Norway and Denmark had approached the WHO for help in setting up something similar for the Baltic region.<sup>49</sup> The WHO also considered taking the model to Southeast Asia and the Mediterranean.<sup>50</sup> Eventually the IAVDCR was formally established on 27 January 1951.<sup>51</sup>

The revived Rhine Commission resumed its pre-war activities, such as distributing educational leaflets and maps of medical centres from the fifteen largest ports along the Rhine.<sup>52</sup> The information now also included details of tuberculosis clinics, maternal and paediatric health centres, and hostels for sailors. The Commission even dusted off the idea of issuing a multi-language treatment book for each patient too. The books would be written in four languages, German, French, Dutch and English. The latter was included because many British and American sailors who worked the tugs and lighters on the Rhine, so were as exposed to infection as their continental colleagues.

While much of this may have seemed like treading old ground the second Rhine Commission was more effective than its predecessor in one regard. Its greatest achievement was the creation of the Rotterdam Port Demonstration Centre, a combined medical clinic, research lab and training centre. This idea originated at the

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Dermato-Venerology Clinic from the university in Basel. Present for Germany were: Major General J. Gill of the British occupation zone, Dr. J. Chanton from the French zone, Dr. W. Radcliffe of the American zone, and representatives of the German Public Health Administration from Westphalia and Württemberg, Dr. Lange and Dr. A. Unger respectively. The meeting was also attended by observers from the WHO (Dr. W. Bonne, Dr. T. Guthe, and Dr. A. Spillmann), ILO (Dr. de Viado, Miss Bodmer), IUAVDT (Dr. A. Cavaillon), and the Central Rhine Commission (M. Bonet-Maury). See Brumfield, "Venereal Disease Control", (see note 3), 16.

49 *Chronicle of the World Health Organization*, 4.3 (March 1950): 82. As for the health conditions in the post-War Baltic basin see H. Gordziakowski, "The pathology of foreign seamen in the port of Gdańsk", *Bulletin of the Institute of Marine and Tropical Medicine of the Medical Academy in Gdańsk, Polana*, 2:1-2 (1949), 9-25, T. Putkonen, "Gonorrhoea among merchant seamen in Finland: material collected 1946-9, and the official measures to prevent the danger", *Bulletin of World Health Organization*, 4 (1951): 121-129, and O. Idsøe and T. Guthe, "The rise and fall of the treponematoses. Ecological aspects and international trends in venereal syphilis", *British Journal of Venereal Diseases*, 43 (1967): 238. A comprehensive accounts on Poland's activities in realization of Brussels Agreement in communist Poland can be found in M. Krzyżanowski, "Control of venereal diseases in seamen", *Bulletin of the Institute of Marine and Tropical Medicine of the Medical Academy in Gdańsk, Poland*, 2.3-4 (1949): 255-266, and H. Gordziakowski, "Organization of Maritime Health Service in Poland", *Bulletin of the Institute of Marine and Tropical Medicine of the Medical Academy in Gdańsk, Polana*, 2.1-2 (1949): 3-7.

50 World Health Organization, Maritime aspects of venereal disease control, WHO/VD/53, 10 December 1949, p. 5, WHOA.

51 "WHO appoints International Anti-Venereal Disease Commission of the Rhine", *Journal of venereal disease information*, 32.4 (April 1951): 99-100.

52 These were: Amsterdam, Antwerp, Basle, Cologne, Dordrecht, Duisburg-Ruhrbort, Dusseldorff, Frankfurt am Main, Gand, Karlsruhe, Liege, Mannheim-Ludwigshaven, Mayence, Rotterdam and Strasbourg. See Brumfield, "Venereal Disease Control", (see note 3), 16.

1947 IUAVDT General Assembly in Paris, and was then taken up by the WHO through its Expert Committee on Venereal Diseases. Rotterdam was the obvious choice for the hub as it was the largest seaport on the continent and also the destination of most of the inland traffic on the Rhine. Another advantage was that it was already home to a state medical clinic for sailors established in 1925.<sup>53</sup> It also boasted well-equipped laboratories and a profusion of qualified medical personnel.<sup>54</sup> The Rotterdam Port Demonstration Centre opened its doors on 21 December 1951, with Dr. M. Hermans as acting Director. From its first few days the Centre ran training courses for personnel from other medical centres along the Rhine.

The second Rhine Commission lasted little more than two years and in 1953 it was abruptly disbanded. This despite fresh reports at the time that European “port cities have not had the decline in venereal disease evident in many inland areas”.<sup>55</sup> In considering this Weindling has concluded that “WHO initiatives for the eradication of syphilis were unsuccessful” because Rhine boatmen remained “reservoirs of STDs”.<sup>56</sup> The decision in part reflected post-War expectations that a wider “socialisation of medicine with free and universal medical treatment for all health problems”<sup>57</sup> in European countries would ensure that Rhine boatmen would find it easier to access medical care for all their problems and not just for venereal disease. This was not always the case however. For example, in France sailors had been offered a free bed in clinics since the early 1930s under the Brussels Agreement. Everything changed with the introduction of social insurance in April 1945. According to the new rules each sailor-patient had to pay for the equivalent of third-class hospital accommodation at a rate of 946 francs a day in the expectation that their expenses would later be reimbursed by their insurance company. This worked for French boat workers who paid their social security dues in that country, but not for others who were not part of the national scheme.

It also appeared that, perhaps because of the wider availability of penicillin in this period, there was an increasing tendency toward treating the symptoms of STDs on

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53 The Netherlands acceded to the Brussels Agreement in 1930, and from that moment the care of sailors was the responsibility of the Dutch state. See Mooij, *Out of otherness*, (see note 8), p. 113.

54 “The agreement of Brussels, 1924, respecting facilities to be given to merchant seamen for the treatment of venereal diseases. Report of a Study Group (which met in Oslo, from 3 to 7 December 1956)”, *World Health Organization Technical Report Series*, 150 (1958): 12. The location was negotiated between the Dutch government, the WHO regional office for Europe, the Rotterdam municipal authorities, and the port management.

55 “Venereal Disease Control Center”, *American Journal of Public Health*, 42 (Feb. 1952): 225.

56 Weindling, “The politics of international co-ordination”, (see note 2), quotation on 102 and 95 respectively.

57 *Ibid.*, quotation on 95.

board ships without waiting for the results of properly conducted serological tests.<sup>58</sup> To this end the WHO took to recommending that all ships employ “a reliable medical technician to ensure that all marines treated at sea are referred to a venereologist at the next port”<sup>59</sup> but it is not at all clear that many bothered with this. The new medicines of the 1950s seemed to offer the infected on the Rhine quick and easy remedies without the need for time-consuming contact with the region’s health bureaucracies, even if those remedies were not always effective.

## Conclusions

Despite international cooperation on the issue of STDs among Rhine boatmen throughout the first half of the twentieth-century concerted action failed to have significant impacts on the problem. A range of IHOs and international organizations that included health among their remits created a wider context of collaboration on venereal disease throughout the first decades of the twentieth-century. The League of Red Cross Societies, the International Office of Public Health, the International Union against Venereal Diseases and the League of Nations all played parts in the process that lead to the Brussels Agreement on facilities for infected sailors that was designed to have a global impact. The complexities of applying it in the Rhine basin meant that more focused international cooperation was considered necessary and this explains the creation of the Rhine Commission in 1936 and its reformulation under the WHO after the Second World War. Throughout the assumption was that international bodies and agreements were the best ways to deal with the problem of STDs in the region.

One key reason that the impact of international cooperation on the problem of STDs along the Rhine remained limited seems to be the technocratic nature of the proposals that emerged. The emphasis on cure that emerged was suited to the medical and scientific mind of the doctors and bureaucrats that populated the IHOs but did not always fit in with the thinking of those infected. George Scott has argued that the Brussels Agreement largely failed because after an initial visit to the clinic, patients “rarely continued their attendance until thoroughly cured. The moment the outward signs of the disease have vanished they cease to attend”.<sup>60</sup> Of course the principle that treatment should be free was laudable but in the context of the Rhine its practical application proved to be a long-running problem. The differences between the health and national insurance systems of the various countries along the Rhine were difficult

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58 G. L. M. Mcelligott, “Venereal Disease and the Public Health”, *Bulletin of the World Health Organization*, 36.4 (Dec. 1960): 207–215, quotation on 207.

59 Schofield, “Difficulties in the Management”, (see note 1), quotation on 869.

60 See G. R. Scott, *A history of prostitution from antiquity to the present day* (New York, 1976), p. 208.

to resolve. Even where agreement was forged on the provision of free treatment to syphilitic sailors on the river the practicalities of implementing this in ways that were consistent with each nation's system could present formidable obstacles to accessing facilities and medicines for boatmen that had neither time or money to spare.

Despite this they were unable to overcome national differences and agendas along the river. Political circumstances were often against them. Neither Germany or Switzerland signed up to the Brussels agreement between the wars. Rivalry and tensions between France and Germany impacted upon cooperation on syphilis throughout the period. For example, France was initially against German participation in the International Union against Venereal Diseases and only agreed to it under Anglo-American pressure.<sup>61</sup> By 1933 Germany had withdrawn from the League of Nations so no longer participated in its Health Organization or the ILO. It seems that impulses towards greater international cooperation in this period could often be overwhelmed by stronger currents in the tides of the period.

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<sup>61</sup> Weindling, "The politics of international co-ordination", (see note 2), 97.

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