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MIGRATION, RACISM AND SEXUAL HEALTH IN POSTWAR BRITAIN

by Anne Hanley

In the lead-up to the 2015 General Election and again during the Brexit Referendum, Nigel Farage used his platform as then-leader of the right-wing UK Independence Party to make inflammatory claims about the economic and social costs of treating migrants living with HIV in the UK. During one notorious debate, he asserted that sixty per cent of the 7,000 people diagnosed with HIV each year in Britain were born overseas and that each of these foreign-born patients cost the National Health Service (NHS) up to £25,000 every year.¹ Condemnation and refutation of his comments was swift. The *British Medical Journal* (*BMJ*), for example, highlighted the many inaccuracies and selective interpretations in Farage's claims – claims that were intended to perpetuate narratives about dangerous migrants, and in so doing generate support for his long-standing call to impose immigration controls.² This has become a popular topic for Farage, who regularly asserts the quasi-eugenic need to 'control the quantity and *quality* of people' coming to Britain.³

Contrary to Farage's claims of foreign threats and rampant health tourism, the House of Commons Health and Social Care Committee concluded in 2019 that among the most serious sexual health crises facing England (and the UK more broadly) are inequalities in health outcomes, with communities of Black African and Caribbean heritage receiving systematically poorer care.⁴ Of course, Britain's Black history extends back centuries – a historical reality to which nationalists were, and often remain, antagonistic.⁵ But in the postwar medical and popular press, 'Black' implied 'migrant', with the otherness of both constructed as a biomedical threat.

In the postwar period, scaremongering and moral panic over Britain's immigration policies were part of a wider crisis of national identity, spurred on by decolonization, demographic shifts and economic downturn. Migrants arriving in Britain from around its crumbling empire further redefined what it meant to be British.⁶ Nationalists vilified migrants – especially Black men – as antithetical to a white racialized British identity, presenting them as a danger to young white women and, by extension, the nation itself. In her study of Britain's imperial decline, Wendy Webster notes that the terms 'immigrant' and 'migrant' were fluid, used throughout the nineteenth and twentieth centuries to describe various newcomers who were viewed in some way as problematic.⁷ In the postwar period, it was Black men from the West Indies, more than any other migrant group, who were vilified as vectors of venereal disease (VD). This article examines how the

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sexual health of this community was shaped not only by the stigma surrounding VD but also by opposition to New Commonwealth migration and, especially, miscegenation. It explores how, through aggressive medicalization and othering, Black sexuality and sexual health were constructed as an epidemiological and social threat.

Of course, syphilis and gonorrhoea were just two diseases among many that became bound up with the postwar panic over migration. As Roberta Bivins observes in her study of tuberculosis, there was a rich and wide-ranging discourse that ‘rhetorically fused’ ideas of Britishness and healthiness with whiteness, while constructing migrants as burdens on the NHS.⁸ The same rhetoric was shaping responses to VD, glossing over the fact that VD, like tuberculosis, had long been endemic in Britain. Amid postwar imperial decline and social upheaval, immigration opponents from the 1950s onwards manipulated generalized fears over British identity to marginalize Black migrants and maintain the whiteness of their imagined nation state. Historically associated with prostitution and the white working classes, VD was becoming linked discursively to the otherness of Black bodies.⁹ As we shall see, these racialized associations emerged from a long-established rhetoric of white vulnerability that had been promulgated initially within white settler colonies. With the movement of New Commonwealth migrants to Britain, this rhetoric assumed new forms and meanings. But there were also fears that New Commonwealth migration would trigger a surge in infections.¹⁰

This racialized focus on VD was articulated throughout the 1950s and 1960s, ranging from explicit (and often unsubstantiated) links, through to provocative rhetorical questions – ‘is there any evidence to connect the problem of venereal disease in young people in Great Britain with immigrants?’ – that appeared repeatedly in the press and public debate.¹¹ Elizabeth Buettner notes that the relative rarity of interracial relationships makes the public fear and hostility all the more puzzling.¹² Yet despite the many column inches given to these issues at the time, the intersections between sexual health, migration and racism have received little historiographical attention. British histories of race and medicine have tended to intersect mostly in the study of empire, rather than the post-imperial metropole. With only a handful of exceptions, historians of medicine have rarely explored the impact of racism on health experiences and outcomes among minoritized communities in postwar Britain.¹³ Historians have questioned whether the ‘swinging sixties’ were quite so swinging, identifying continuities in social and moral conservatism, especially when it came to sexuality and race relations.¹⁴ But this work has focused principally on interracial marriage, miscegenation and family planning, rather than VD. Examining the imagined dangers of disease transmission within interracial sexual encounters, this article further challenges assumptions about the extent to which the 1960s were permissive. But it also opens up discussion of an important, understudied part of twentieth-century British history, building a more nuanced picture of the institutional racism and social conservatism that has shaped, and continues to shape, sexual health experiences among minoritized communities in Britain.¹⁵

Such a study is not without challenges. Of necessity, this article relies heavily on material from the medical and popular press, most notably the *British Journal of Venereal Disease (BJVD)* – Britain’s leading professional journal at the time for health workers specializing in sexual health. Yet in the countless pages devoted to racialized discussions of the health problems associated with immigration, the voices of ordinary people are rarely present. Their experiences have not survived except as mediated narratives and numerical data points. This was not merely the result of eccentricities in historical record-keeping. As Kennetta Hammond Perry observes in her study of racecraft,¹⁶ such silences are symptomatic of Black disempowerment in the face of whiteness as a privileged ‘proxy for claim making ... produced discursively through the craft and creation of historical writing and assemblages where Black people and their lived experiences are repressed, negated or misremembered.’¹⁷ White health workers in the postwar period detailed their thoughts about interracial disease transmission. Journalists whipped up hostility, often by cherry-picking from the medical press.¹⁸ Their writings were shaped by racialized ideas about predatory Black sexuality and gendered assumptions about the vulnerability of white women, especially young, middle-class women.¹⁹ Indeed, these rhetorically fused stereotypes of predation and victimhood permeate much of the archival material. When white writers broached the subject of Black sexual health they often shoe-horned in discussion of young white women, either as victims or as fellow vectors. In making these connections they rarely drew on hard epidemiological evidence, instead reiterating fictions of Black men preying on white women, fathering mixed-race children and spreading disease. Alternatively, they presented migrants as naïve victims of oversexed working-class teenagers and hardened prostitutes. Likewise, little effort was made to nuance the intersections between class and race. As we shall see, such generalizations also contributed to the skewed health data on which medical authors based their conclusions about disease prevalence and transmission patterns.

Writings about Black sexual health drew on, and reinforced, long-standing assumptions about the relationship between migration and disease without reflecting on the structural inequalities and institutional racism that undermined health outcomes. As the surviving sources reveal, a clear (albeit implicit) hierarchy of sexual health priorities was being established. At the top were white men’s sexual health needs. Just below were those of white women, not-so-subtly stratified by class-based notions of respectability. And at the bottom were New Commonwealth migrants, whose sexual health needed to be addressed not simply to ensure their own wellbeing, but to protect the health of white communities.

Piecing together available archives, this article investigates how such hierarchies, operating discursively and clinically, affected the sexual health experiences of Black men and helped to shape anti-immigrant discourse. It begins with the antagonistic environment in which New Commonwealth migrants found themselves in the 1950s and 1960s, and moves on to explore how, in efforts to capitalize on this antagonism, immigration opponents weaponized racial stereotypes and the rhetoric of white vulnerability, grafting these on to the specific

challenges of sexual healthcare. It demonstrates how available health data was deployed selectively to construct specific narratives around migration and VD. And, because the rhetoric of danger and irresponsibility continues to be deployed against minoritized communities in health crises, the article also reflects on how better understandings of historical inequalities might help us to address similar challenges today.

A HOSTILE ENVIRONMENT

The British Nationality Act 1948 conferred citizenship on Commonwealth subjects, granting them the right to settle in Britain. There are no exact figures for the numbers of West Indian migrants who made use of the Act, though an upper estimate of 300,000 by the beginning of 1964 was suggested in the *International Migration Review* in 1967.²⁰ Politicians, pressure groups, journalists, health authorities and the public all began to speculate that a range of social problems and health challenges were a direct consequence of unchecked immigration. For example, during a talk in 1970 to the South Kensington Young Conservatives on ‘the effects on the community of the influx of immigrants’, Joy Page, the Secretary of the Immigration Control Association, claimed that white Britons had been ‘brainwashed over the past twenty years into accepting unquestioningly the mass-media and Government-fed lies and concealment as to the numbers and effect of immigration’.²¹

But rather than covertly assisting migrants as Page imagined, successive governments throughout the 1950s and 1960s, aided by health authorities, had in fact been working to engender opposition to migrants and unrestricted immigration. The tactics employed were varied, including the setting up of studies and official enquiries.²² Eager to avoid accusations of outright racism, politicians, civil servants and health authorities sought expedient non-racial reasons for implementing race-based controls.²³ As we shall see, VD became one of those reasons. Among the most coordinated of these efforts was the confidential report ‘Social and Economic Problems Arising from the Growing Influx into the United Kingdom of Coloured Workers from other Commonwealth Countries’. Compiled by the Ministry of Health, it focused on tuberculosis and VD, the assumption being that such problems would be easily uncovered.²⁴ Even before the Ministry of Health began collecting data in 1963 on the ‘importation’ of VD, the medical and popular press were provocatively speculating on ‘the extent, if any, to which West Indians bring venereal disease to Great Britain and possibly spread it within the country’.²⁵ But despite growing efforts to link migrants with a resurgence in VD, the Ministry of Health could find no firm grounds for recommending controls. Indeed, the report concluded that, far from introducing infection, migrants more often contracted syphilis or gonorrhoea *after* arriving in Britain.²⁶

Immigration opponents also capitalized on rising rates of VD contracted by migrants *after* arriving in Britain, claiming this as another reason to impose controls.²⁷ Writing in 1965, Neville Rosedale, consultant venereologist at the West Middlesex Hospital, argued that recently arrived migrants became infected because they were ‘not of high intelligence and bring the social and sexual

customs of their native lands with them'.²⁸ The following year, venereologists Richard Willcox, F.J.G. Jefferiss and E.M. Naughten insisted that migrants' 'home background and basic philosophy tend to encourage promiscuity and therefore high venereal disease rates even at home, and their behavioural characteristics are maintained after arrival in the United Kingdom.'²⁹ These types of racialized assessments were used to cast migrants as burdens on an already-struggling NHS and as visceral threats to the individual and national body.

Medicalized racism formed an important part of the wider context from which the 1962 Commonwealth Immigrants Act emerged, imposing a range of new entry restrictions. The 1965 Race Relations Act went some way towards prohibiting racial discrimination, while also outlawing the distribution of material that might provoke racial hatred or discrimination. Yet historians have rightly observed that it was 'a narrow and weakly enforced attempt to ban racism'.³⁰ The Act did not, for example, curtail the thinly veiled anti-immigrant agenda pursued in the medical and popular press.

IMAGINED VULNERABILITIES

Numerous historians have demonstrated how hostility to migrants was rationalized by recourse to a series of racial stereotypes emphasising contagion, degeneracy, sexuality and social disorder.³¹ These stereotypes had a long colonial history; imagined 'black perils' were the product of wider anxieties about the maintenance of colonial identity and power.³² In debates over postwar migration, especially following the 1958 Notting Hill race riots, the rhetoric of empire that had been used for so long in white settler colonies converged in Britain with that deployed by immigration opponents. It was exacerbated by a shift away from heroic imperial masculinity towards a domestic, inward-looking national identity.³³ As Chris Waters notes, this shift gave rise to a new national character that was read as feminine and under threat from the 'predatory' sexuality of former imperial subjects.³⁴ White settlers and British nationalists both presented themselves as vulnerable. To quote Camilla Schofield, this rhetorical 'rear-guard protection of white privilege' produced 'a myth of Britain permanently under siege' – a myth deliberately cultivated by conservatives, most notoriously Enoch Powell.³⁵

There was also a long history of associating high rates of VD with colonial outposts.³⁶ This may have resulted in part from epidemiological links being drawn between syphilis and the tropical disease yaws.³⁷ Or it may have resulted from medical assumptions that 'tropical forms' of VD 'were nastier and more potent'.³⁸ But more pervasive were narratives of hypersexual Black masculinity – narratives that were shaping medical responses to VD well into the postwar period.³⁹ Writing in the *BJVD* in 1962, Manchester's regional venereological adviser, Sydney Laird, insisted that transmission rates were high because Black men had failed to assimilate into 'the less active sexual pattern of their new country'.⁴⁰ Laird was not alone in his views. In a 1966 article on the links between immigration and VD, Willcox, consultant venereologist to St Mary's Hospital,

London, and then President of the Medical Society for the Study of Venereal Diseases, concluded that ‘the reasons why immigrants are prone to contact [sic] venereal disease are manifold. Some . . . come from areas where promiscuity is commonplace . . . and such persons merely continue their accustomed way of life.’⁴¹ The frequency with which doctors returned to this topic suggests a persistent, racialized focus on the sexual habits of Black men. And these views were mirrored in the popular press, such as the insistence in *The Birmingham Post* that

West Indian modes of life and morals were very different from those of this country and there was little chance of breaking some immigrants of the habit of promiscuity. One of the great problems is presented by the increasing number of English girls who are bearing children by coloured men.⁴²

Most postwar efforts to limit immigration were based, at least superficially, on claims of *cultural* difference. But racial stereotypes of Black sexuality nonetheless remained heavily infused with the eugenic rhetoric of ‘degeneration’ and ‘genetic quality’.⁴³ Certainly, not everyone who used the language of eugenics would have self-identified as a eugenicist. As Lucy Bland and Lesley Hall have noted, membership of Britain’s Eugenics Society never exceeded 800, ‘yet it would be wrong to reduce the eugenics movement to the Society alone, for its influence stretched beyond organisational confines’.⁴⁴ Eugenic theories of racial difference remained pervasive in postwar Britain. We see this, for example, in the writings of C.S. Nicol, head of the VD Department at St Thomas’s and St Bartholomew’s Hospitals, London. For him, the ‘degeneration’ triggered by immigration was not only physical but moral – migrants would undermine national fitness not only through miscegenation and the spread of VD, but also through moral decline.⁴⁵ And such ideas were also recycled beyond medical circles to assuage and, in some cases, play on wider postwar insecurities. For example, in her talk to Kensington’s Young Conservatives, Page went on to describe immigration as ‘national suicide’, seemingly drawing on eugenic theories of ‘race suicide’.⁴⁶ Her language was deliberate, chosen to suggest that a metaphorical and literal incursion into white spaces would be degenerative.

These ideas of racial difference also shaped several clinical studies in the 1950s and 1960s, such as Willcox’s 1958 survey of responses to phenoxymethyl penicillin in white and Black patients, in which he suggested without reliable evidence that a patient’s race made them more or less responsive to new therapies: ‘suspected failures [in treatment] occurred nearly three times more frequently in coloured persons.’⁴⁷ It is important to note that his conclusions were based on a dubiously small sample of thirty-three white men and fifty-two Black men.⁴⁸ Given the growing evidence that migrants were becoming infected *after* arriving in Britain, he could not persuasively argue that more virulent strains were being brought to Britain by Black men. Instead, he focused on the idea that their sexuality was accelerating the emergence of antibiotic resistance. Citing himself the following year, Willcox insisted that

the view has been advanced that the lessened sensitivity of the gonococcus is being developed more quickly in this ethnic minority (and their mainly prostitute consorts) by the oft repeated exposure of the gonococcus to the low levels of penicillin carried by this group ... as a result of their repeated treatments for the disease.⁴⁹

He went on to conjecture that 'the gonococcus is becoming relatively more resistant in West Indians ... than in white persons' and that 'a basic biological difference between West Indian ... patients and white patients as regards the absorption, utilization and excretion of penicillin might explain the differences in the results in the two groups.'⁵⁰ Like so many other studies in this period, Willcox's article gave little consideration to the complex social factors affecting a person's access to treatment. Similarly little attention was paid to the socioeconomic pressures that contributed to higher infection rates in the first place, or to the possibility that discrimination in clinics resulted in greater rates of default among migrants, who may have later returned to continue their treatment. The limit of his reflections on 'social factors' was to observe that 'the greater number of suspected relapses in non-white patients is largely due to reinfections following a return to the same or to a similar sexual environment before the female consorts have been secured for treatment'.⁵¹

In 1964, the British Cooperative Clinical Group (BCCG; established in 1951 to collect data on VD in Britain), similarly argued that rising gonorrhoeal infections among Black men were likely the result of 'more frequent promiscuity' and that 'the treatment of repeated infections ... with antibiotics' may have been undermining the effectiveness of treatment.⁵² Doctors were not only arguing that Black patients were less responsive to penicillin, thereby posing a biomedical threat. They were also implying that Black patients' supposed immorality, manifesting through frequent promiscuity, constituted a potential epidemiological disaster by contributing disproportionately to the emergence of antibiotic resistance.

This in turn reinforced fears about supposed white vulnerabilities while also seemingly lending credence to the belief that migrants were catalysing the spread of infection.⁵³ Blaming foreigners for the spread of VD had taken various forms for centuries.⁵⁴ But from the Second World War onwards, infection spikes were attributed to 'the floating population of unattached males normally to be found in London, from the Allied Forces of wartime to the most recent West Indian immigrants.'⁵⁵ But what such claims overlooked was the erosion of sexual health services. The rapid decline in infection rates during the immediate postwar period prompted some local authorities either to direct resources away from their VD clinics or to close them entirely. Then as now, sexual health was seriously underfunded.⁵⁶ One of the biggest factors undermining sexual health among migrants was (and remains) the unavailability or inaccessibility of culturally sensitive care in the destination country.⁵⁷ The underfunding and inaccessibility of VD clinics as well as a lack of clear sexual health messaging, as much as demographic shifts or changing patterns in sexual behaviour, contributed to the

rising infection rates about which health authorities were so concerned in the late 1950s and 1960s.

Those who blamed migrants for rising infection rates also tried to disassociate themselves from racism by emphasizing that migrant men, ‘removed from the home influences which tended to limit promiscuity, [were] more prone to contract venereal infections than men of the same age group in the home population.’⁵⁸ Yet these same voices, who focused so intently on the role of migrants in spreading VD, were comparatively quiet on the dangers posed by vast numbers of white British men abroad in the Overseas Civil Service and armed forces.⁵⁹ As Willcox reported in 1966, just over twenty per cent of primary and secondary syphilis cases among these men were ‘imported’.⁶⁰ Also ‘removed from the influences of home’, they were heavily implicated in the spread of VD. Yet disease prevalence among this demographic remained of secondary interest. It was easy and more politically expedient to focus on vulnerable groups such as migrants and working-class women, and to insist, as the *Daily Mirror* disingenuously did in 1965, that ‘prostitutes dealt almost exclusively with one race [so] the risk of white men being infected could largely be ruled out’.⁶¹ In making such claims, the *Daily Mirror* was trying to absolve and distance white men from VD transmission.

Attempts to deny responsibility were also symptomatic of a much larger problem in public health messaging. Ernest Prebble, Director of the VD Department at the Liverpool Royal Infirmary, lamented in 1962 that concerted wartime efforts to consolidate public sexual health knowledge had fallen by the wayside and that ‘even today many people still believe that venereal diseases do not attack so-called “nice” people’.⁶² As we shall see, in the minds of many white Britons, migrant men were not ‘nice’ people.

CONSTRUCTED VILLAINY, CONTESTED VICTIMHOOD

Although it was well understood by the postwar period that gonorrhoea could cause infertility and impotence, rising infection rates among Black men were nonetheless interpreted as evidence of their heightened virility and, by extension, the emasculation of white men.⁶³ Tropes of white vulnerability, or what one correspondent to the *Cheshire Observer* described as ‘sexual jealousy’, had become so pervasive that they were even being deployed sarcastically by the same voices that derided Black sexuality as threatening and degenerate.⁶⁴ More than any other migrant group, Black men were accused not only of yielding to base sexual instincts but also of enacting what the satirist and freelance journalist Colin MacInnes termed ‘racial revenge’ for past imperial violence and injustice.⁶⁵ Such flippant suggestions that Black men might be corrupting white women by encouraging them into extra-marital liaisons and prostitution were drawing on and feeding well-established racist tropes.

Historically and historiographically, discussion of these anxieties has tended to focus on miscegenation.⁶⁶ But just as disturbing to some was the idea that interracial sexual encounters might also be the catalyst for the spread of VD into white communities. For example, Jefferiss, consultant venereologist to St Mary’s

Hospital, London, envisaged scenarios where migrants ‘spread it around among a certain small group of promiscuous local women, who also have indiscriminate sexual relations with men of other races’.⁶⁷ Various newspapers also drew explicit, spurious links between immigration, miscegenation and disease transmission by using discussion of VD to make racially motivated claims about mixed-race relationships and the promiscuity of Black men. For conservatives, it marked what Webster describes as ‘the reversal of the manly and powerful authoritarian version of empire through the evocation of a powerless white woman under siege’.⁶⁸ But in a 1963 *BJVD* article linking VD and declining moral standards, Nicol conceded that ‘there was no evidence that the increases in the proportion of infected immigrant males and teenage females were directly connected.’⁶⁹ Indeed, rising rates of infection among teenagers was, as a number of medical authors acknowledged, ‘a world-wide phenomenon’, including in countries without significant inward migration.⁷⁰ Beyond patchy contact tracing, there was no epidemiological data linking these groups. But even where there was no proven correlation, authors rarely missed an opportunity to speculate.

Surveying rates of gonorrhoea in Manchester, Laird pointedly remarked that ‘it would be of interest to ascertain the country of origin of the male partners of the female teenagers with gonorrhoea.’⁷¹ He and Nicol both criticised the ‘increased promiscuity’ of white teenagers and the birth of ‘maladjusted’ mixed-race children.⁷² Like a number of their contemporaries, both men produced selective comparisons of available data to argue that these children were a marker of dysfunctional homelife and social instability, which they in turn presented as contributing factors for higher rates of VD transmission.⁷³

Miscegenation was becoming shorthand for patterns of VD transmission. In 1963 *The Birmingham Post* told its readers that ‘the problem is highlighted by two features of the statistics of the disease – the incidence of infection among coloured people and the number of teenage girls who are being referred for treatment.’⁷⁴ But at no point did the *Post* (or any other newspapers, for that matter) demonstrate how these statistics were linked. In the absence of clear epidemiological evidence, reporters and health workers fell back on insinuations and assumptions. As we saw, Laird deemed it ‘interesting’ that those clinics in Manchester returning the highest infection rates among migrant men were the same clinics with the highest rates among teenage girls. Yet he stopped short of reflecting on the larger social problems, such as poverty, that might have explained high infection rates in both groups.

By the 1960s, the idea that migrants were importing VD and infecting white women had become so widespread that any suggestions to the contrary were met with derision. There was, for example, outrage over Sara Robson’s reporting in the *Daily Mirror* on ‘homesick’ immigrants who, ‘free from disease when they arrive in this country . . . fall prey to it because the only people who offer them affection are the promiscuous young or prostitutes.’⁷⁵ One outraged letter writer demanded to know whether Robson was ‘honestly under the impression that most immigrants catch the disease when they arrive in this country’.⁷⁶ It was inconceivable to this reader that Black men might contract VD from white

women. And such disbelief was shared by health workers. Writing in the *BMJ* in 1961, the venereologist Leslie Watt insisted without citing specific data that ‘in white female adolescents a significant proportion of infection occurs *after* association with coloured males, all of older age-groups than the girls themselves’.⁷⁷

Yet constructions of Black men preying on vulnerable, infantilized young women sat awkwardly with lingering Victorian notions that VD was a product of unchecked female sexuality.⁷⁸ The distinctions between innocent victim and promiscuous villain were becoming increasingly fluid, resulting in medical authors presenting Black men and white working-class women as equally culpable in each other’s moral and physical degradation.⁷⁹ Jefferiss claimed in 1962 that ‘it is well known that there are some immigrants who are vicious as well as promiscuous and live on the immoral earnings of low-grade [white] prostitutes.’⁸⁰ This 1967 account of contact tracing by a VD social worker is another example of the derogatory way that some medical authors talked about interracial sexual encounters:

A British West Indian . . . did not know his contact’s name, but he found out her address and that she was living at the top of the house with ‘a tall British West Indian’, who was a ponce and brought in the clients. The girl was making £100 per week which the ponce spent mainly on gambling.⁸¹

When it came to interpretations of VD transmission, the Black male body and the white working-class female body had become interchangeable as the principal source of metaphorical and literal contagion. These constructions underpinned clinical studies that, through demographic surveys of patients attending metropolitan VD clinics, focused on VD as a problem that intersected class and race.⁸² In his study of the sexual habits of migrant men attending the VD clinic at St Thomas’ Hospital, Nicol found that ‘296 coloured men had 380 different contacts’ and was keen to emphasize that 166 were white women, categorizing these contacts according to their relationship to his Black patients.⁸³ Similarly, in 1967, two social workers from the VD clinics at the London and St Thomas’ Hospitals fixated on the breakdown of gonorrhoea patients according to race: ‘In the first nine months of 1965, there were 796 male patients who attended with gonorrhoea. Of these 295 were coloured, and 115 of their contacts who attended were white girls, 73 under 25 years of age.’⁸⁴ This preoccupation with race and interracial relationships was more than just a concern for public health. It was motivated by the belief that Black men and white working-class women were not only vectors of VD, but fundamentally sexually irresponsible.⁸⁵

These attempts to link infection rates among migrants and white women were based primarily on patchy contact tracing. The VD social workers responsible for contact tracing criticized their Black patients as inherently unreliable.⁸⁶ Yet, as recent migrants, these men also lacked the social and familial networks on which contact tracing depended. The same lack of social capital often hindered access to VD services, further reinforcing assumptions that they constituted a biomedical threat. This criticism also embodied the

popular belief that Black men were the main clients of prostitutes, who were also believed to be difficult to trace. Together, they received sustained condemnation, not only for subverting traditional sexual boundaries but also for supposedly undermining efforts to trace and prevent infections.⁸⁷

FUDGING THE NUMBERS

Efforts to link infections among Black men and white women were matched by a preoccupation with relative infection rates among those men and the deliberate exclusion of non-white patients from studies of the 'social factors' affecting sexual health outcomes and experiences. Throughout the 1950s and 1960s, studies attempted to correlate increased disease transmission and the arrival of Black men from the West Indies.⁸⁸ Black Caribbean men presented with the highest relative gonorrhoeal infection rates for the size of their estimated population in Britain. But absolute infection numbers were highest among white men throughout the 1950s and 1960s. This did not, however, deter health authorities from focusing heavily on infections among Black men and their white 'consorts'. In their analyses of available data medical authors often gave the impression – unintentionally or not – that Black Caribbean men had the highest *absolute* infection numbers rather than highest *relative* infection rates. Such studies emphasized correlations between West Indian immigration and rising infection rates, but stopped short of reflecting on the socioeconomic factors that contributed to the high relative infection rates among West Indian men.⁸⁹ As in other official studies and reports from the postwar decades, ethnicity as a contributing factor to health inequalities was mostly absent.⁹⁰

Studies that focused on the socioeconomic factors affecting disease prevalence often explicitly excluded Black migrants. The authors of such studies claimed that migrants' cultural backgrounds and attitudes to sex were too different for inclusion among, or even comparisons with, white patients. As we have seen, they also insisted that migrants lacked the ability to provide 'clear and intelligible' accounts of their sexual contacts.⁹¹ Consequently, opportunities were lost for understanding social and structural determinants that may have exacerbated sexual health disparities between migrant and white communities. Little effort was made to understand how racial inequalities increased the risks of acquiring VD, limited the availability of care or undermined long-term health outcomes. Then as now, minoritized communities tended to be socially and economically disadvantaged, experiencing poorer health outcomes as a result. Recent studies have begun mapping the far-reaching, long-term health impacts of racial discrimination. Reduced quality of, or access to, healthcare, as well as psychological stress and diminished trust in health services have all been found to affect minoritized communities.⁹² Available historical data suggests that the same was true for New Commonwealth migrants in the postwar period.

West Indians were explicitly excluded from the types of socioeconomic surveys that might have otherwise highlighted why relative infection rates were so high and, by extension, identified ways to improve sexual health outcomes. Nicol, along with an almoner, a statistician and a male supervisor from St

Thomas's Hospital, conducted a survey in 1960 of the 'social status and sex habits' of migrants attending their VD clinic. But their definition of 'social status' was narrow, focusing exclusively on country of origin, marital status, numbers of children and sex contacts.⁹³ Similarly, Jefferiss's acknowledgment that 'immigrants live under bad and crowded housing conditions' was the extent of his attention to the social inequalities affecting migrant health.⁹⁴ The closest we get to a discussion of the adverse cultural or socioeconomic conditions that undermined migrants' sexual health is in Sheila Patterson's 1969 study *Immigration and Race Relations*. Patterson argued that migrants' health was undermined by the social dislocation of immigration, poorer housing and working conditions and greater stresses resulting from reduced social capital. Tackling disease prevalence within these communities therefore required 'measures to . . . provide better social circumstances and readily available facilities for diagnosis and treatment' while also establishing 'good after-care' – the same measures for which service users and activists are still campaigning.⁹⁵

The reasons given for migrants' exclusion from these studies were variations on the claim that racial differences were insurmountable, leading to unworkable clinical investigations. In a 1965 study R.K.T. Stubbs, social worker to the VD Department at St Thomas' Hospital, excluded migrants 'because they were considered to have a different cultural background'.⁹⁶ Likewise, when examining VD transmission within marriage, J.R. Seale of St Thomas' Hospital deliberately excluded 'all coloured patients . . . because their cultural background was different from that of the white patients'.⁹⁷ Seale's study aimed to 'obtain a profile of the married couples who attended a venereal disease clinic' and to 'assess the disturbance of marriage and emotional reaction . . . caused by infection'.⁹⁸ He excluded migrants because he believed that their culture (coded, we assume, for him into their skin colour) produced a different emotional reality. His exclusion of Black men was grounded in the belief that they (and any white women married to them) had less developed emotional sensibilities than his white patients in monoethnic marriages. This belief was widely held and reiterated repeatedly in the claims that Black men and their white 'consorts' were sexually feckless, lacking the emotional maturity for stable relationships. The deliberate omission of Black experiences not only skewed epidemiological data. It also helped to establish and reinforce the biomedical otherness and marginality of migrant communities. As bioethicists and historians have observed, for Black men and women, becoming patients meant also becoming subjects of unethical experimentation.⁹⁹ But as we have seen here, the deliberate exclusion of Black patients from health studies also perpetuates inequalities, undermining health experiences and outcomes.

Alongside such omissions, health workers cherry-picked data to support conclusions about a migrant VD 'problem'. On some occasions, they made a point of focusing on VD clinics in urban areas with growing West Indian communities and extrapolated this to assume race-based infection spikes in other cities.¹⁰⁰ On other occasions, they focused on statistical outliers from clinics with large West Indian patient bases. The following from the BCCG's 1960

country-of-origin study is a case in point: 'In Huddersfield in 1958, for example, no less than 77.3 per cent of the patients were West Indians, while a proportion over 45 per cent was exceeded in Birmingham, Ipswich, and three London clinics.'¹⁰¹ It should be noted, however, that these were the only clinics in 1958 where absolute infection numbers were higher among West Indian men than among white men. The Huddersfield returns may have been 77.3 per cent, but the total percentage of West Indian cases in Yorkshire was no greater than 35 per cent. In 1958, West Indian men constituted only 24 per cent of the 15,387 gonorrhoea cases treated in England and Wales.¹⁰² In Scotland, only 0.13 per cent of men with gonorrhoea were West Indian.¹⁰³

Certainly, relative gonorrhoeal infection rates were considerably higher among West Indian men than the wider British population. But in extracting and highlighting as it did the Huddersfield returns from Yorkshire's sexual health data, the BCCG – unintentionally or not – was treating outlying data points as representative. And as we have already seen, high relative infection rates rarely prompted nuanced considerations about the socioeconomic factors that contributed to those high rates. The highest absolute infection numbers were found consistently among white patients – a fact that remained of secondary interest in the analysis of sexual health data. Indeed, the BCCG's 1965 study of gonorrhoea found that 52.8 per cent of male patients in England and Wales were born in Britain (the implicit assumption being that these British-born patients were white). Of female patients with gonorrhoea, 82.8 per cent were born in Britain.¹⁰⁴ Syphilis infections had never been high among West Indian migrants and, from 1963, the BCCG's studies found that cases of gonorrhoea were also falling.¹⁰⁵

Yet health authorities and the popular press remained focused on those cities or clinics retuning the highest relative gonorrhoeal infection rates among West Indians, thereby constructing a narrative about a growing Black sexual health threat. Willcox's studies are a good example.¹⁰⁶ For his statistics on infections among Black men to be meaningful, they would need to be compared to relative infection rates among white men in the same age and socioeconomic groups. Yet as Laird noted, 'a larger proportion of males born in the UK were in the armed services during their late teens and early twenties and venereal infections contracted by such men did not appear in the statistics of civilian clinics.'¹⁰⁷ Extending Willcox's principle that 'the home influences ... tended to limit promiscuity', these men would have been at a higher risk of contracting VD.¹⁰⁸ Neither did the ending of National Service in the early 1960s help to facilitate comparisons in sexual health data. Patients from the middle and upper classes were also less likely to attend VD clinics and therefore less likely to appear in the returns. Historically, the VD Service – Britain's first universal health service free at the point of use – had been used largely by the working and lower middle classes.¹⁰⁹ Although data does not survive for changing patterns in sexual health-seeking behaviours before and after 1948, it is possible that the establishment of the NHS resulted in even more VD sufferers choosing the privacy of a GP clinic. As Jefferiss put it in 1962, 'more patients ... are being

treated by private practitioners and are therefore left out of the national statistics gathered from the clinics.¹¹⁰ If wealthier patients were making greater use of private clinics, then their apparent infection rates would be depressed and the relative infection rates of working-class and New Commonwealth patients would be inflated. Yet studies like those by Willcox rarely accounted for this.¹¹¹ Although Willcox was correct in his insistence that rates of infection were *proportionally* higher among Black men, the extent of this could not be accurately judged without the full set of returns for white men.¹¹² At all stages, comparisons in the health data were not being properly controlled. Knowing that there were large gaps in the data – that an indeterminate (but nonetheless significant) number of infections were not being counted – it was disingenuous to insist that Black men posed the most significant sexual health threat in postwar Britain.

High rates of gonorrhoea among West Indian migrants were, as Bivins puts it, ‘an evanescent problem’. Their high relative gonorrhoeal infection rates began tapering off by the end of the 1960s. Yet this drop did not stop immigration opponents selectively using epidemiological data to push for immigration restrictions.¹¹³ Most medical authors stopped short of explicitly recommending greater controls, though several, including Nicol and Willcox, applauded the passing of the 1962 Commonwealth Immigrants Act. For example, citing ‘unpublished data’, Willcox wrote that, ‘since the passing of the Immigration Act, there has been a significant decline’ in cases.¹¹⁴ Such conclusions were also a staple of the popular press, like *The Birmingham Post’s* insistence that ‘the Commonwealth Immigration Act might halt the increasing incidence through it was doubtful if the low level of the middle 1950s would ever again be attained.’¹¹⁵ But as in other countries, these lower levels of infection had more to do with the introduction of new treatments than the absence of migrants.¹¹⁶

CONCLUSIONS

Persistent efforts to identify race-based explanations for disease prevalence repeatedly stopped short of reflecting on the cultural or socioeconomic factors that were undermining Black sexual health. The only variable that medical authors considered was race, conflating it with socioeconomic status and ignoring age, class and income. Moreover, they looked only at VD clinics, ignoring the fact that many white patients were probably receiving care from GPs. High infection rates among Black men fed racialized tropes of recklessness and promiscuity as well as fears of a looming sexual health crisis in which Black bodies and Black sexuality constituted a palpable social and epidemiological threat to a fragile, feminized nation.

Many of the historical prejudices, health inequalities and accessibility problems outlined in this article continue to undermine migrant and minoritized health experiences and outcomes. And these problems are not unique to the field of sexual health, appearing in discussions about a variety of diseases, most recently Covid.¹¹⁷ But rather than addressing the causes of these inequalities, conservative voices are again falling back on a racialized rhetoric of blame and vilification. Barriers to testing and treatment today are very similar to those faced

by Black and migrant patients in the postwar decades: fear of legal repercussions; shame, stigma and discrimination; and a lack of culturally competent services.¹¹⁸ A commonly proposed remedy is an ethnicity-blind approach. But this risks perpetuating inequalities by overlooking, for example, the impact of racism on health experiences and outcomes. Instead, the planning, delivery and evaluation of sexual health services should be community-led. Researchers, policymakers and health providers need to work *with* migrant and minoritized communities to deliver services that, crucially, are designed and staffed by health workers from those communities.¹¹⁹ When it comes to sexual health, one size does not fit all. To understand how diverse social, cultural and economic factors have affected, and continue to affect, health experiences and outcomes among Black Britons, we need to find ways to look past aggregated data and mediated case notes. As historians, we need to find new ways of writing about these important health histories, such as through the collecting of oral histories, that prioritize the communities whose unique and complex experiences have been sidelined in the written archives.

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79 Dora Willcock discusses this in her research (conducted as part of the MA History of Medicine at Birkbeck, University of London) on the medical and popular representations of women in interracial relationships in 1960s Britain.

80 B. Jefferiss, 'The Return of the Venereal Diseases', p. 1752.

81 B. Muspratt and L.I. Ponting, 'Improved Methods of Contact Tracing', *BJVD* 43:3, 1967, pp. 204–9, 205.

82 See for example Royal London Hospital Archives and Museum, The Ambrose King Centre, Male Confidential Registers (1930–2000) RLHAK/1/3/1–77.

83 C.S. Nicol et al., 'Social Status and Sex Habits of Immigrants Attending a VD Clinic in London', *BJVD* 36:1, 1960, pp. 44–48, 47.

84 Muspratt and Ponting, 'Improved Methods', p. 205.

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102 BCCG, 'Country of Origin', p. 237.

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107 Laird, 'Gonorrhoea in the City of Manchester', p. 137. The same point is made in Watt, 'Venereal Disease in Adolescents', p. 859.

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