



## Fighting Venereal Diseases: Scandinavian Legislation c.1800 to c.1950

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During the late nineteenth and early twentieth centuries the development of bacteriology contributed to a heightened focus on the individual as the carrier of contagious diseases. This raised the question of how the state could shoulder the responsibility of defending public health without infringing on individual civil liberties. How much coercion of the diseased could be tolerated in order to protect the healthy? Pandemics such as plague and cholera had sometimes led to enforced isolation of the diseased; people suffering from leprosy might be confined to special institutions, and tuberculosis could result in long stays in hospitals and sanatoria. In such cases, however, it was also hoped that certain treatments might eventually cure the patients.<sup>1</sup>

In a climate of growing public responsibility for a healthy population, measures to prevent venereal disease (VD) also came up for discussion. This paper will discuss legislation adopted in Scandinavian countries from the nineteenth until the middle of the twentieth century to prevent VD. How uniform was this policy, and what were the differences if any among the Scandinavian countries? Following a short presentation of VD policies in a number of European countries, I will compare Swedish, Danish and Norwegian legislation on VD and point to measures that foreshadowed later welfare state policies. As a conclusion, I shall suggest possible explanations for variations in national trajectories. My sources are programmatic, mainly parliamentary documents. I do not attempt to evaluate how the various laws were practised or what it was like to be subjected to the provisions enacted in the laws.

### Common Characteristics of Scandinavian Policies

Two perceptions of Scandinavian policies can be outlined. On the one hand, the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, are described as a group of small nations with democratic political institutions, a fairly homogenous population and comparatively small class and gender differences. Most international researchers have tended to see these communities as different from the rest of Europe, representing peaceful and economically successful countries where an extended welfare system includes all citizens. Nordic historians have highlighted the importance of a political tradition of negotiation, avoiding revolution and finding compromises. They see this arrangement as rooted in earlier alliances between king and peasants and/or burghers that later developed into trust in the state apparatus. The state was seen as a friend of the individual. An individual-oriented Protestantism and a long-lasting social-democratic hegemony combined to create a mentality that treasured equality and individual freedom.<sup>2</sup> This construction has given

rise to a view of Nordic policies as a homogenous entity and to the idea of a special development into a Nordic model for the welfare state. The Scandinavian countries, Denmark, Norway and Sweden, have been seen as the core countries, with Finland and Iceland joining in at different moments and to different degrees. Historical research also focuses on the roots of these welfare states, seeing some municipal as well as some national policies from the late nineteenth century as precursors of later welfare state provisions.<sup>3</sup>

On the other hand, recent research has questioned parts of this picture. The Social Democrats were not alone in building welfare states. The middle class and bourgeois political parties, peasants, voluntary organizations and women's organizations have played an important role. Welfare policies were often initiated at the municipal level early in the twentieth century, and local provisions were later adopted at a national level. Welfare policies have been criticized for creating new inequalities through bureaucratic clientelism and by neglecting class and gender differences, and the importance of social control, categorization and constraints accompanying welfare policies has been emphasized.<sup>4</sup> It has been stressed that from the early twentieth century health policies were not only about curing the diseased, but also about introducing and enforcing a healthy lifestyle and about building strong professional groups. Through legislation and information campaigns, health authorities attempted to coax the population into adopting measures seen as indispensable in order to maintain or recover good health.<sup>5</sup> Finally, although comparative studies of Scandinavian history are rare, some research has revealed significant differences in political developments in the Scandinavian countries during the nineteenth and twentieth centuries.<sup>6</sup>

This does not change the overall impression that Scandinavia represented a political culture that was distinct among other European countries. Was that true also for policies to fight VD? To answer that question we need to know what policies were adopted in this respect by the main European nations.

## Medicine, Morality and Sex: The European Background

Preventing VD was not solely a medical problem. Perceptions of morality were also of great importance. When authorities discussed how to combat gonorrhoea and syphilis—the two diseases that attracted the most attention—the choice of strategies was influenced by what was seen as the accepted sexual behaviour of good citizens. In the main European countries for most of the nineteenth century, the spread of VD was fought through regulationism, a policy of controlling prostitutes.<sup>7</sup> This policy was introduced in France during the Napoleonic wars and was continued there until 1960.<sup>8</sup> Prostitutes were submitted regularly to enforced medical examinations, and police regulations often demanded that they live in brothels. In some countries regulationism was based on national laws, in others the authorities relied on regional by-laws, or combined the two approaches.<sup>9</sup>

Regulationism was built on a clearly gendered perception of sexuality.<sup>10</sup> Female sexuality was understood as dormant until marriage and mainly important for the creation of offspring. Prostitutes were seen as deviant females, by their own free will choosing a degrading occupation. Male sexuality, on the other hand, was seen as an uncontrollable urge for copulatory orgasm, as a necessity for men's mental and physical health. Since the age of marriage for both men and women was high, regulationism was deemed necessary to give men access to sexual gratification outside marriage with at least some safety against VD. Making sure that prostitutes did not suffer from VD and creating a sharp divide between prostitutes and decent women, between the whore and the Madonna, this system was also meant to protect innocent wives, who might otherwise be infected by husbands and in turn infect new-born babies.

In 1864 the Contagious Diseases Acts, a combination of national and municipal laws regulating prostitution, were adopted in Britain. They were met with strong opposition. Christian circles condemned prostitution and the women's movement demanded the same sexual morals for men as for women. This alliance saw regulationism as acceptance of immorality and succeeded in having the Contagious Diseases Acts repealed

in 1885. Nevertheless, the Criminal Law Amendment Act, adopted the same year, gave the police the means to control working-class women and children.<sup>11</sup>

From England an abolitionist movement fighting regulationism spread to a number of European countries. In Germany, police authority over prostitutes varied within each individual state, both before and after the creation of the German Reich in 1871. In some cities, like Hamburg, brothels were officially accepted and supervised and continued to exist. In 1914, regulation of prostitutes was officially forbidden.<sup>12</sup> In Italy, regulation of prostitutes was introduced by a ministerial decree in 1860, covering all of the new state. The decree was revoked in 1888 as a result of abolitionist protests, but new and similar regulations were issued soon after. Firm Catholic beliefs and a perception of male sexuality corresponding well with regulationist policies have been seen as an explanation of why regulationism persisted in Italy until 1958.<sup>13</sup>

Medical advances stimulated medical interest in VD. The bacterium that caused gonorrhoea was discovered in 1879, that of syphilis in 1905. From 1907 the Wassermann blood test made it easier to diagnose syphilis, and in 1909 the discovery of Salvarsan helped to cure this disease, although at great cost.<sup>14</sup> Against this background, regulationism was abolished in a number of western European countries around the time of the First World War. While Britain developed a liberal individualistic policy, Germany and the Scandinavian countries introduced strict regulation of all VD patients.

In Britain ardent discussions around 1900 singled out men as responsible for spreading VD to innocent wives and children.<sup>15</sup> The women's suffrage movement alleged that men's insistence on their need for extramarital sex was a danger to the nation. Indicating that women's emancipation was the solution to the problem, Christabel Pankhurst coined the slogan "Votes for women—chastity for men". The acute rise in recorded cases of VD during the First World War brought the problem to the fore. It was important to keep soldiers healthy, and special lectures were arranged providing medical advice on how to avoid VD. Early treatment in ablution areas and control of prostitutes were also adopted. But the Defence of the Realm Act, allowing examination of any woman suspected to be a source of infection for soldiers, was met with strong opposition. Following a Royal Commission report of 1916, the Public Health (Venereal diseases) Act of 1917 institutionalized nationwide free, voluntary and confidential treatment of all VD patients. Hundreds of consultation and treatment centres were now set up across the country.<sup>16</sup> This liberal policy refrained from compulsory measures and offered treatment with no strings attached. Although brusque and condemnatory approaches could not be avoided, sources of infection were not criminalized:<sup>17</sup> respect for the civil liberties of the individual was much stronger in Britain than on the European mainland.

During the Second World War and the immediate post-war years, however, British VD policies were influenced by an upsurge of reported cases of VD, especially among soldiers. Notification of contacts named by more than one infected person was required according to the Defence of the Realm Regulation 33B. Despite gender-neutral formulations, in practice this provision targeted women much more heavily than men. This was also the case during the immediate post-war years. British forces taking part in the occupation of Germany between 1945 and 1953 were given special protection through cooperation between the British military police and the German civil police. In Hamburg, young girls seen in the streets during the late evening and night risked being arrested and submitted to enforced medical VD check-ups.<sup>18</sup> But apart from such special crisis provisions, British VD policies were extremely liberal compared to those of the rest of Europe.

In Germany also, the worrying rise in VD during the First World War resulted in new initiatives to combat these diseases. In 1918 emergency legislation threatened transmission of VD with imprisonment for up to three years. Most of those convicted were women, but the penalty was frequently less than three months' imprisonment. A great number of VD Advice Centres were established to facilitate diagnosis. These centres referred patients to local VD specialists, and in some cases also covered the cost of treatment. In 1927, the Act for Combating VD, *Reichstagsgesetz zur Bekämpfung der Geschlechtskrankheiten*, was passed.

According to this law, all VD patients had to undergo treatment by qualified practitioners and health authorities as long as there was a risk of infection. Medical practitioners would report patients who failed to comply with their treatment regimes to the health authorities. This also happened if patients defaulted on treatment or continued to endanger public health by remaining sexually active. Such patients could be committed for further treatment in locked wards of hospitals, and police assistance was sometimes used to enforce compliance. As Lutz Sauerteig has pointed out, by contrast to England, in Germany “the increasing influence of racial hygienists made public health policy value the right of the nation and race to be protected against the spread of venereal infection more highly than the freedom of the individual”.<sup>19</sup>

German VD policies thus allowed for strict control of all diseased individuals in order to protect the healthy. While France and Italy continued to practice regulationism until the middle of the twentieth century, relying on voluntary and free medical treatment, Britain followed a very different, more liberal trajectory in combating VD. How did the Scandinavian countries fit into this picture?

## The Scandinavian *Sonderweg*

In his monumental book on how European states tackled the problem of contagious diseases between 1830 and 1930, Peter Baldwin introduced the term “the Scandinavian *Sonderweg*” for the provisions introduced in Scandinavia after the abolition of regulationism.<sup>20</sup> Two basic and intertwined principles characterized the Scandinavian *Sonderweg*: healing the diseased and reducing the possibility of contagion. Mandatory and free treatment of all citizens provided fast and easy access to medical assistance. Other measures aimed at containing potentially transmitting behaviour. The latter included obligatory notification to the authorities of all cases of VD, contact tracing, medical inspection of suspected victims, and, if necessary, isolation of the afflicted through hospitalization. Criminalization of endangerment and transmission was also adopted to curtail contagion. This policy, also termed “sanitary statism”, in Baldwin's words “treated all infected citizens alike, regardless of their sex, status or profession, and it attacked VD with measures similar to those marshalled against other contagious ailments.” To break the chains of transmission, policies that had traditionally been applied to prostitutes were now applied to all carriers.<sup>21</sup>

Baldwin documents this policy by analysing developments in Sweden from the early nineteenth century up to and including the enactment of the Lex Veneris in 1918. He points out that contemporaries saw this law as unique in Europe, disregarding, as it did, differences of gender and social status, and subjecting all citizens to coercion by the state. Individual liberties were disregarded in order to safeguard society against VD. The law opened the way for widespread coercion in order to prevent the spread of VD, but as Baldwin puts it, “The driving principles were the equality of all before the law and the individual's subordination to the collectivity”.<sup>22</sup>

The Lex Veneris constitutes Baldwin's prototype for the Scandinavian *Sonderweg*. He does not consider the two other Scandinavian countries in his analysis, but his term “Scandinavian *Sonderweg*” implies that provisions enacted through the Swedish Lex Veneris of 1918 represented common Scandinavian policies, which distinguished Scandinavia from other European countries. His thesis is in line with the widespread assumption that the Nordic countries are in some ways different from the rest of Europe, which supports the concept of a Nordic, or at least a Scandinavian, model of the welfare state.

A comparison of policies in the three Scandinavian countries may serve to substantiate or modify Baldwin's thesis.

## Sweden: From Regulationism to the Scandinavian *Sonderweg*

Already in the late eighteenth century, Sweden adopted provisions to contain VD. In 1774, a royal edict for

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provincial physicians started medical inspection to avert epidemics. This led to syphilis inspections of hundreds of people, sometimes of entire municipalities. A royal circular of 1812 codified a practice of general inspection of certain itinerant professions. Medical examination was made mandatory and the result was recorded in the internal passport of each individual.<sup>23</sup> Persons belonging to certain trades or ethnic groups—soldiers, journeymen, peddlers, wet nurses, orphans, “wandering Jews and similar people”<sup>24</sup>—would have to renew their health certificate every three months to obtain permission to travel within the country. This meant monitoring large groups of the population, and also a sharp growth in the number of lock hospitals to cure the diseased. From 1817 the funds needed for treatment were raised by a special tax levied on all Swedish citizens. In 1822 royal instructions for provincial physicians required that the name, age and residence of the diseased be reported to the clergy, and that hospitalization of the most contagious be assured. Investigation of sources of infection (contact tracing) and medical examination of contacts could be performed compulsorily.

These measures, which initially targeted all inhabitants of certain areas or of certain social and occupational groups, gradually narrowed on women. From 1813, a royal circular enabled the examination of women employed in inns, pubs and restaurants as well as loose women who might be suspected of spreading VD. In 1847, for the first time, by-laws in Stockholm exclusively targeted women as possible sources of infection. Gradually, regulationism was introduced in the Swedish capital. From 1859 prostitutes were to be examined weekly, and failure to comply could be punished with a year's hard labour. The preventive focus shifted from class to gender. In 1860 abolition of internal passports weakened the tradition of general examination practices by provincial physicians. Reform of the penal code in 1864 grounded regulationism in the vagrancy law. By the end of the nineteenth century, Sweden provided compulsory, but free, treatment to men and women of certain social groups. But regulationism, practised in a number of the bigger towns, and in Stockholm from 1859 to 1918, singled out prostitutes as an especially dangerous group.<sup>25</sup>

In 1878, the Swedish abolitionist movement, the Federation, started to fight for repeal of the regulation of prostitutes. Although later characterized as the first major women's movement in Sweden, the debate was mainly among men and was mostly concerned with prostitution as a threat to social order, rather than with its consequences for women. By contrast to the situation in Britain, the aim of the Federation was total eradication of prostitution, not the more limited goal of abolishing regulation of prostitutes. The Federation did not, however, succeed in breaking regulationism.<sup>26</sup>

From the turn of the century the number of reported cases of VD in Sweden increased rapidly and regulationism came under heavy attack. In 1918 long discussions finally resulted in the enactment of the Lex Veneris. Anna Lundberg points out that this law was inspired by a new generation of physicians who were opposed to regulationism, and instead advanced prophylaxis and education as ways of preventing VD. Applying the same prophylactic provisions to all citizens, the law built on a tradition of targeting major groups of the population in the fight against VD. But, as Lundberg emphasizes, it was at the same time in line with the burgeoning ideas of welfare and equality that would characterize Scandinavian policies in the twentieth century.<sup>27</sup> In order to cure the diseased, the Lex Veneris required all infected persons, regardless of gender and social status, to submit to medical treatment. In return, medical care was free and confidential. A patient's identity could be divulged only in cases where treatment was part of legal proceedings. In order to curtail contagion, the law made it mandatory to report all cases of infection, to trace contacts, and to inspect and treat all infected contacts. Transmission and endangerment with VD was punishable. The Lex Veneris thus embodied all the essential elements of the Scandinavian *Sonderweg*. It may be added that non-compliance could lead to police assistance in compelling a patient to submit to hospital treatment and that marriage was forbidden for infected individuals and dissolvable if one partner infected the other. Physicians were held responsible for implementing the law and could be fined for neglecting their duties.<sup>28</sup> Lundberg views this process of broadening provisions to contain VD from an initial emphasis on specific social groups, mainly prostitutes, to comprise the whole population, as foreshadowing later welfare state policies.<sup>29</sup> Certain constraints were accepted in order to allow the state to assume responsibility for a healthy community. This

policy carried the day during a time of important social and political changes in Swedish society. From 1921, the Social Democrats held the majority in both chambers of Parliament, women obtained the vote and from 1923 they were allowed to hold government posts.<sup>30</sup>

The Scandinavian *Sonderweg*, as exemplified by the Swedish Lex Veneris, subjected citizens who might pose epidemiological risks to measures that were more or less the same as those previously enforced towards prostitutes. Such a system, in Baldwin's opinion, was possible only where there was widespread consensus on policies that would grant the state power to enforce common interests at the expense of individual rights.<sup>31</sup> But a closer look reveals that the Lex Veneris did not fully disregard social status and gender. It opened more discreet venues of treatment for those who could afford to consult private physicians.<sup>32</sup> And, while in principle this law separated the moral from the medical problem in the prevention of VD, special provisions continued to target prostitutes. The question of morality was referred to the vagrancy law that regulated control of those who, without means of their own, made no attempt to get an honest job. General promiscuity could now lead to a sentence for vagrancy, punishable by hard labour. The penal code allowed for anyone arrested for illicit behaviour to be reported to the sanitary inspector. If such persons were found to be afflicted with VD but refused treatment, they could be forced into treatment through the assistance of the police.<sup>33</sup> Women suspected of prostitution could still be controlled. The criticism that welfare state policies continued to discriminate according to class and gender might also be applied to the Lex Veneris.<sup>34</sup>

To what extent did the principles embodied in the Swedish Lex Veneris also obtain in the two other Scandinavian countries, Denmark and Norway?

## The Danish Trajectory into the Scandinavian *Sonderweg*

In Denmark also, provisions against VD attracted attention from the late eighteenth century. After prolonged attempts by clergy to alert the medical authorities to the dangers posed by these diseases, two Danish physicians, financed by public means, were appointed in 1773 to combat VD on the island of Funen, where these diseases were considered especially prevalent. Similar arrangements were gradually extended to other regions. In 1790 an edict (*Rescript*) broadened these measures to cover the whole nation, except for the capital, where special regulations obtained. The edict obliged “common people” (*Almuens Folk*) to submit to free medical treatment if suffering from VD. Non-compliance could be punished by imprisonment. As late as in 1946, Danish politicians proudly referred to this legal provision as “the first in the world to provide free treatment for VD”.<sup>35</sup> Mandatory and free treatment was introduced for the majority of the Danish population (the common people) as early as 1790, as compared to 1817 in Sweden, where this only obtained for special social groups or regions. Thus Denmark at an early date introduced provisions foreshadowing a central feature of the Scandinavian *Sonderweg*.

Regulation of prostitution was also introduced quite early. A royal ordinance of 1815 initiated such procedures in the capital. The chief of police in Copenhagen was ordered to ensure that women suspected of suffering from VD be submitted to medical examination once a month. The idea of regulationism was introduced earlier in Denmark than in Sweden, where measures targeting women only were not found before the 1830s. But whether, and if so to what extent, the Copenhagen regulation was implemented, is unknown. During the 1840s regulation of prostitutes followed a certain plan of weekly, later bi-weekly, medical examinations. Contact tracing was part of these measures, and police registered the prostitutes in order to keep them under surveillance. Despite medical awareness that men also carried a good deal of responsibility for spreading VD, it was deemed impossible to subject them to similar measures.<sup>36</sup> The police laws of 1863 legitimated the existing system, and at the same time laid down terms for the imprisonment of those who deliberately infected someone with VD. In 1866 a new penal code stated that women who did not heed police warnings and continued to practise fornication would be given a prison sentence. However, if such

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women abided by police rules, they would be left alone. Thus, prostitution was seen as a criminal offence, but if the prostitute followed instructions given by the police, she would not be prosecuted.<sup>37</sup>

These inconsistent rules were accepted by the 1874 Law on Provisions to Counteract the Spread of Venereal Contagion (*Lov om Foranstaltninger til at modarbejde den veneriske Smittes Udbredelse*). This law was later described as a mixture of a law on epidemics, a law on prostitution and a penal code.<sup>38</sup> Most of its provisions dealt with prostitutes. Regulationism was legalized. Prostitution was allowed as long as the prostitute complied with police instructions and agreed to regular medical examinations. In some cases, a prostitute could be ordered to live in a brothel.<sup>39</sup> Three years later, a decree from the Ministry of Justice extended police control of prostitutes, and allowed the police to inspect their homes at any time of day or night.<sup>40</sup> As Karin Lützen has pointed out, the hope of controlling VD by regulating prostitution legitimized this blatant breach of civil liberties. This was all the more striking since a democratic constitution had been passed in 1849 and no control of men was ever even attempted. Men were further protected since the law of 1874 did not repeat the requirement made in the 1840s that prostitutes name the person who might have infected them.<sup>41</sup> In this respect, Danish provisions differed from those accepted in Sweden, where at least some groups of men were seen as possible carriers of VD.

It should, however, be noted that the first paragraphs of the law of 1874 were directed at the whole population. Mandatory and free treatment by a public physician was extended to all citizens, unless they could prove that they were being treated privately. The law further stipulated that a patient could be hospitalized if this was deemed necessary to prevent contagion. The police authorities (*politidirektøren*) decided when this was necessary. Regular medical control was demanded as long as recurrence was likely. Non-compliance would be fined. According to section 10 of the law, VD patients treated in a public hospital would have to stay there for as long as the physician considered it necessary. Non-compliance would result in one month's imprisonment. Coercion was extended to all citizens who did not comply with the legal provisions for preventing the spread of VD. Long before the Swedish *Lex Veneris*, universal mandatory and free treatment as well as coercion, core elements of the Scandinavian *Sonderweg*, were introduced in Denmark.

But regulationism continued, and opposition to this method of containing VD soon flourished. The Association against Legitimized Immorality (*Foreningen imod Lovbeskyttelse for Usædelighed*) was founded in 1879, inspired by similar organizations in the United Kingdom and on the continent. While the debate over regulationism in Sweden mostly involved men, Danish women were active in the leadership of the Association against Legitimized Immorality. The first board consisted of six men and six women of the upper middle class. Some of the women members also belonged to the Danish Women's Association (*Dansk Kvindesamfund*), established in 1871. Despite criticism that such matters were unsuitable for modest and virtuous women, they argued strongly for the same sexual morals for men and women, that is, accepting that sexuality belonged within marriage and that extramarital sex for men could not be condoned.<sup>42</sup> The activities of the Association against Legitimized Immorality were credited with the first limitation in control of prostitutes, which took place in 1895.<sup>43</sup> A change in the law abolished the requirement that prostitutes be forced to live in brothels: it was admitted that brothels did not improve public propriety, indeed they furthered social degradation. In 1901 brothels were prohibited.<sup>44</sup>

As in Sweden twenty years later, this legislation coincided with an important shift in Danish politics. The year 1894 saw the end of a long period in which a conservative government had reigned through provisional edicts.<sup>45</sup> A growing Social Democratic Party strengthened the opposition and in 1901 the principle of parliamentarianism was introduced. The king now had to accept a government based on a parliamentary majority, and the first Liberal government was formed. A period of democratic reform followed, and an attack on VD legislation was part of this process. A complete revision of the 1874 law was proposed in 1904. Following prolonged discussions in the Danish Parliament, the Law to Prevent Public Impropriety and Venereal Disease (*Lov om Modarbejdelse af offentlig Usædelighed og venerisk Smitte*) was enacted in

1906. A parliamentary minority, consisting of a small group of social democrats and a few radical liberals, wanted to stop all control of prostitution and to have free and voluntary medical treatment adopted as the main weapon against VD, but their amendments were defeated. Their approach was very similar to the policies introduced in 1917 in the United Kingdom, but found little support in Scandinavia. The 1906 law did, however, put an end to the system of regulation of prostitutes, twelve years before the Swedish Lex Veneris did the same. As Merete Bøge Pedersen has pointed out, medical provisions to combat VD now assumed greater importance. Physicians joined the police on the front line in this combat. Yet, one of the purposes of the law remained the discouragement of public immorality. To this end, the law introduced measures on vagrancy that continued to allow police interference with fornication as a trade, and with those who offended public propriety. Such behaviour could be punished by imprisonment, hard labour or at best fines. The social democratic and radical liberal minority strongly opposed these provisions, and criticized the gender and class inequality inherent in the practice of the vagrancy law, to no avail.<sup>46</sup>

Other provisions of the 1906 law followed the principle of the Scandinavian *Sonderweg*. Mandatory and free treatment for any person suffering from VD was continued, as was criminalization of transmission in accordance with the penal code of 1866. There was no discussion of these measures. Mandatory notification of all cases of VD was a new provision, as was the duty of general practitioners to inform patients about the danger of contagion and remind them that infecting others was a criminal act. As in Sweden, Danish physicians assumed responsibility for implementing the law. General practitioners had to report recalcitrant patients to superior medical authorities, who might then decide to call in police assistance.<sup>47</sup> Unlike in Sweden, Danish law did not prohibit marriage if one of the partners suffered from VD, but physicians were reminded to warn against marriage as long as there was a danger of contagion. Failure to perform these duties might result in a physician being fined. Thus coercion as a means to prevent VD was applied not only to all patients, but also to physicians.

The 1906 Danish law allowed continued control of prostitution, while simultaneously embodying most of the provisions characterizing the Scandinavian *Sonderweg*. The only central item still lacking was mandatory contact tracing. This was not introduced until 1947.

## The 1947 Law on Prevention of Venereal Disease

In 1947 a new law on VD came into effect in Denmark. The committee appointed by the Health Department in 1946 to prepare the law pointed out that during a period of forty years so many changes had occurred that a new law on VD was required.<sup>48</sup> The provisions regarding marriage, for example, had been moved to the law on marriage and divorce of 1922.<sup>49</sup> More importantly, all the provisions regarding the problem of prostitution had been removed and enacted in the penal code of 1930. A ban on advertising contraception, introduced in 1906, had been lifted in 1937. This meant that legislation to combat VD had been formally separated from the fight against public immorality. The title of the new law mirrored this change. While the 1906 law had been entitled 'Law to Prevent Public Impropriety and Venereal Disease', the law enacted in 1947 was called 'Law on Prevention of Venereal Disease' (*Lov til Bekæmpelse af Kønssygdomme*). It was expressly stated that the 1947 law was a law on epidemics.<sup>50</sup>

The committee further pointed to medical advances that, since 1906, had changed the situation. Earlier diagnosis of both gonorrhoea and syphilis, an important precondition for reducing the danger of infection, was made possible by bacteriology. The Wassermann blood test and the gonococcus-reaction test had proved efficient. According to the report, there were now better possibilities of curing both diseases: penicillin held out hopes for the future.<sup>51</sup>

Increases in the number of reported cases of VD were, however, worrying. During the German occupation of 1940–45, recorded cases of syphilis soared to eight times and of gonorrhoea to three times the 1940 levels. This was all the more conspicuous since the inter-war period had seen a spectacular reduction in the



number of recorded cases of VD, reaching a nadir in 1940. It was also of concern that while VD had until then been more pronounced among men, almost half of reported cases in 1944 related to women.<sup>52</sup> All this was seen to warrant a completely new law for the prevention of VD.

The most important new element in the 1947 law was mandatory contact tracing. All patients were required to inform the physician of who might have infected them, and all physicians were to do their best to find sources of infection.<sup>53</sup> However, patients could not be forced to indicate those whom they might themselves have infected. Consciously infecting someone else was still a criminal act and no one could be under the obligation to disclose his/her own criminal acts. Each individual physician would have to decide how much effort should be vested in discovering those whom a patient might have infected.<sup>54</sup> This was seen as especially important where spouses were concerned, since such disclosure might endanger marital relations.<sup>55</sup> According to the Penal Code, a person who had infected his or her spouse could only be indicted at the request of the infected spouse. The Danish Women's Association tried in vain to win support for a change of this clause, arguing that it was especially hurtful for wives.<sup>56</sup> For all the gender-neutral formulations in the law, discussions in Parliament revealed that women were still seen as the main carriers of infection.<sup>57</sup>

The other main provisions characterizing the Scandinavian *Sonderweg* were continued, although slightly modified.<sup>58</sup> Treatment was still mandatory for all citizens, but it was emphasized that treatment would be free only as long as the disease was in the infectious stage, and only when a public physician was consulted. Otherwise, a patient would have to pay or to rely on sickness insurance. A long debate in Parliament did not change these provisions.

The desire to stop infection continued to warrant monitoring of the diseased. The obligation to submit to medical treatment was extended to include not only persons who knew that they suffered from VD, but also those who had reason to suspect this. Physicians continued to assume the responsibility for implementing the law. Failure to respect medical advice could result in action by the police, and the result could be fines or, in aggravating circumstances, imprisonment for up to six months. Mandatory hospitalization was enacted for negligent patients, patients suffering from mental deficiency, patients indicted for public impropriety, or when earlier behaviour suggested the patient would not comply with medical orders. This allusion to prostitution allowed for continued suspicion of women. Decisions on mandatory hospitalization were to be made by cooperation between medical and police authorities. Police involvement in the fight against VD continued, and, although the 1947 law made no allusions to prostitution, none the less it still enabled the control of prostitutes. Yet despite these repressive measures, there were signs of a new approach to the prevention of VD: information directed at young people was seen as important, although there was no agreement in Parliament on whether this should be a parental obligation or a responsibility for schools.<sup>59</sup>

The 1947 law completed Danish adherence to the Scandinavian *Sonderweg* by adding the only element lacking in 1906: mandatory contact tracing. The core provisions enacted in 1874 and 1906 were continued and even sharpened. All citizens were treated the same, but, like the Swedish *Lex Veneris* of 1918, the Danish law of 1947 permitted people with means to avoid control by the public services. Despite absolute gender-neutral wording, the law also offered a means of controlling prostitutes.

Finally, we consider the case of Norway.

## Norway: A Latecomer at the National Level

Norway was definitely a latecomer when it came to introducing *national* routine measures to prevent VD. Only in 1947 could Norway be said to follow the Scandinavian *Sonderweg*. Until then, VD policies were

inscribed in municipal by-laws. My discussion will focus on the measures implemented in Oslo, the country's capital.<sup>60</sup>

Before 1914 Norway was united with Denmark in a common kingdom, and it may be assumed that the Danish edict of 1790 was also valid for Norway, although this remains to be confirmed. If this was the case, it would mean that in Norway common people enjoyed free but mandatory medical treatment for VD as early as the late eighteenth century. We do not know what may have happened to this measure when the Norwegian-Danish union was dissolved in 1814 and Norway entered into a political union with Sweden. A common king and common foreign policies united Norway and Sweden from 1814 to 1905, although internal affairs were regulated through each national parliament.

Regulationism was introduced as early as 1816 in Bergen, then the biggest of the Norwegian towns. Oslo followed in 1840, Trondheim in 1844.<sup>61</sup> The main intention of these early measures was to control the spread of VD through the medical policing of prostitutes, making it mandatory for any registered prostitute to submit to regular medical check-ups with the police physician. A prostitute who was found to suffer from VD would be sent to hospital, and would stay there until she was believed to be no longer contagious. Other regulations aimed at maintaining public order by limiting the movements of prostitutes to certain areas.

In 1842, two years after Oslo had introduced regulationism, the penal code stamped fornication as a crime. Thus, the situation in Norway was the same as in Denmark: regulationism conflicted with the penal code. While this continued to apply where women were concerned, Aina Schiøtz has pointed out that the Norwegian penal code of 1842 exempted men from punishment since it was deemed less damaging if a man had sexual intercourse with a prostitute than with any other woman to whom he was not married. Control of prostitutes was continually strengthened, and in 1876 Oslo municipal by-laws introduced an elaborate system of regulations. Non-adherence could be punished by up to six months of hard labour. This may have been inspired by a revision of the national penal code two years earlier, which instituted prison sentences of six months to three years for infecting someone with VD.<sup>62</sup> This section did not exempt men.

During the 1860s, protests came from house owners who saw the value of their properties reduced by the proximity of brothels, and from clergy who wanted to enforce the penal code to put an end to prostitution. In the early 1880s the newly established Association for Propriety (*Sedelighetsforeningen*) also joined the criticism of regulationism. This association recruited clerics and academic men, but the majority of its members were women. The aim of the Association was to promote Christian morals. The Association criticized the lack of a sense of justice and the brutalization of women inherent in regulationism, and appealed to the individual prostitute to change her lifestyle. The male members attempted to influence public opinion through lectures and leaflets, and put pressure on the political authorities to abolish regulationism. Women who were members of the Association visited hospitalized and imprisoned prostitutes and tried to persuade them to respect Christian morals and stop soliciting. The Association for the Emancipation of Women (*Kvinnesaksforeningen*) argued that economic problems propelled women into prostitution, or into marriage as a way of maintaining themselves. They strongly recommended the same sexual standards for men as for women, and attacked regulationism for offering a false guarantee against infection and thus promoting prostitution. The Social Democrats stressed economic reasons for prostitution and saw it as resulting from capitalist society. However, despite their different arguments, all three groups agreed in their opposition to regulationism.

Against the background of civil debate, the Ministry of Justice asked various medical experts for advice in 1884.<sup>63</sup> The Oslo city physician (*stadsfysikus*) recommended that VD be treated like any other contagious disease, and, despite considerable resistance, regulationism was abolished in the city from 1888.<sup>64</sup> The municipal board of health referred to the Health Law of 1860 (*Sunnhetsloven*), and passed by-laws that gave a designated physician the responsibility for combating VD. Instructions were issued as to how monitoring and hospitalization should be performed. Well-founded suspicions of transmission of VD were

made a precondition for mandatory medical examination. A patient could either submit to examination or produce a medical certificate proving his or her health condition. If a person did not go for his/her examination and there were strong indications of endangerment, police assistance could be called in. If infection could not be prevented in other ways, a patient could be hospitalized.<sup>65</sup> Mandatory reporting on cases of VD was also introduced, indicating sex and age of the patients and whether hospitalization had been necessary. Physicians were urged to find out as much as possible about contacts with a view to identifying sources of infection. These duties were extended also to physicians who treated patients privately. Since "the highest discretion would be respected" it was not feared that this would cause patients any inconvenience.<sup>66</sup> The new scheme applied to all citizens.

As early as 1888, therefore, the Oslo by-laws introduced some of the central elements of the Scandinavian *Sonderweg*: universal mandatory treatment, police assistance in cases of recalcitrant patients, mandatory reporting of all cases of VD, admonition of physicians to do their best in contact tracing, and the assignment of responsibilities to designated physicians in the fight against VD.

The Municipal by-laws in Oslo formally separated the problem of prostitution from that of VD from 1888. This was not done until 1906 in Denmark, and 1918 in Sweden. But nowhere did that mean that prostitution had become an accepted phenomenon. As in the two other Scandinavian countries, other means of legitimizing the control of prostitutes were at hand in Oslo. The health law of 1860 authorized municipal health boards to isolate people in the event of danger of contagion, and the penal code could be invoked to imprison anyone who deliberately infected others with a disease. The vagrancy law, enacted in 1900, punished those who could not prove that they lived by respectable means with imprisonment for up to three months or hard labour for up to three years. The burden of proof to be produced by the police in such cases was reduced in 1910.<sup>67</sup> Kari Melby has shown that the discussion of regulation of prostitution and prevention of VD around the turn of the century was based on confrontations between an older criminological perception of guilt as a question of morals, highlighting the responsibility of each individual and free choice, and a new criminology stressing social, psychological and biological reasons and weighing the advantage both for society and for the individual of possible punitive measures.<sup>68</sup>

It may not be a mere coincidence that regulationism was abolished in Oslo shortly after 1884, when the liberal opposition carried the day in Parliament and the principle of parliamentarianism was introduced. In addition, in 1887, the Norwegian Labour Party was established. Thus, the process of democratization that also influenced Swedish and Danish VD policies came earlier in Norway than in the other two Scandinavian countries. Yet it did not lead to national provisions against VD. Why this was so will be discussed below.

One very important item of the Scandinavian *Sonderweg* was lacking in the Oslo municipal by-laws. Patients still as a rule had to pay for their treatment. According to the health law of 1860, however, the municipal board of health had to pay for patients whom it decided to hospitalize in order to avoid contagion. Otherwise patients without means had to resort to stigmatizing poor relief, and this must have been seen as an obstacle to curing as many patients as possible, because in 1899 it was decided to let the most needy patients receive free medicine. In 1907, Oslo's chief medical officer urged the state to offer free treatment for all as the best means to combat VD.<sup>69</sup> But this did not happen until forty years later when a national law on VD was finally enacted.

## The Long Road to National Legislation

In 1892 and again in 1901/2 attempts were made to provide national legislation on how to prevent VD and on how to control prostitution. These bills included free medical treatment for all citizens. Since the main idea was to prevent the spread of VD, free treatment was to be available only for patients suffering from VD in the contagious stages. Such considerations foreshadowed the law that was finally enacted in 1947. However, it proved impossible to reach a decision. The Association for Propriety and the Norwegian

Women's Association protested vehemently against legislation that they saw as an attempt to reintroduce some of the elements of regulationism, while medical experts wanted to extend VD control to all prison inmates. It was also argued that control measures would be expensive and might have little effect. For some, the best way to prevent VD was to respect Christian morals and limit sexual intercourse to married life.<sup>70</sup>

As a result of attempts to harmonize Nordic marriage laws, a new marriage law was adopted in Norway in 1918. As in Denmark, where one partner suffered from contagious VD, marriage would be allowed only on condition that the other partner was informed of the situation.<sup>71</sup> The Swedish *Lex Veneris* of 1918 inspired further attempts to legislate on VD, and a bill drafted between 1919 and 1923 followed the same principles as the Swedish law. The Norwegian Medical Association, the Oslo branch of the Norwegian Women's National Organization (*Oslo Kvinneråd*) and the small Women's United Front (*Kvinnenes Enhetsfront*) all urged that the law be adopted, but economic considerations made this impossible. Although by the end of the 1920s the major towns had established outpatient clinics offering free treatment, it was feared that the costs involved in a national law would be too high. Even the offer of state contribution to VD treatment in the major towns, where about two-thirds of the cases were found, was rejected with a reference to the prevailing difficult economic situation.<sup>72</sup> However, during the 1930s the state agreed to cover the costs of Salvarsan, the most expensive remedy, for people without means, and to offer sailors free treatment in the major ports. It was not until 1947 that free treatment was offered to all Norwegian citizens suffering from VD.<sup>73</sup> This is a major difference between Norway and the other two Scandinavian countries, since Denmark had offered universal free treatment from 1874 and Sweden from 1918.

Despite different national approaches to VD during the inter-war period, the Scandinavian countries all experienced a great reduction in the number of reported cases of VD.<sup>74</sup> And despite different experiences during the Second World War, all three countries suffered a sharp increase in these diseases after 1940. War undoubtedly had a more marked impact on Norway and Denmark than on Sweden, and both these countries adopted laws on VD in 1947. But the war had a stronger effect on Norwegian than on Danish VD policies. In the summer of 1945, the Norwegian authorities adopted very strict measures to curb VD, which especially targeted women. Internment camps were established for women who were suspected of possibly infecting others with VD.<sup>75</sup> The parliamentary committee preparing the 1947 bill explicitly referred to what was perceived as the positive effects of these measures and blamed the growth in recorded cases of VD during the war mainly on the great number of infected women. It was maintained that these women had become a chronic danger for the male population.<sup>76</sup> Although the rise in VD among women was also a point considered in the Danish parliament when the law of 1947 was discussed, no special measures targeting women were adopted. This difference in policies may be attributed to the much harsher regime obtaining in Norway than in Denmark during the German occupation of the two countries. After the war this led to different ways of tackling the problem of prosecuting war criminals and people who were perceived as traitors to the nation, among them women who had been friendly with German soldiers.<sup>77</sup>

However, in Norway also mandatory and free treatment for all citizens was now seen as the most important means of combating VD. The Swedish *Lex Veneris* of 1918 was cited as a good example of this policy, and the fact that economic problems had made it impossible to follow this example during the inter-war period was lamented.<sup>78</sup> In November 1947, the Law on Measures against Venereal Disease (*Lov um átgjærder mot kjønnsykdom*) was accepted unanimously and without discussion by the Norwegian Parliament.<sup>79</sup> Provisions against VD very similar to those long practised in Oslo were now applied to the whole country. As with a number of other welfare state measures, municipal by-laws paved the way for national legislation.<sup>80</sup>

Free and confidential treatment for everybody was now extended to the whole nation. Costs were no longer covered under poor law budgets but through insurance schemes or in public health budgets.<sup>81</sup> The law also made central elements of the Scandinavian *Sonderweg*, practised in Oslo from 1888, apply nationwide, such as mandatory treatment, contact tracing and police assistance in tracing and treating sources of



infection. Physicians were made responsible for enforcing the law, but police assistance could be called in if necessary. Criminalization of transmission was enacted in the penal code. Norway had finally joined the Scandinavian *Sonderweg*.

The law concentrated on medical problems pertaining to VD. But parliamentary drafting also attached importance to the social circumstances favouring prostitution. It was said that during the war years full employment secured an income for everyone, but since there was a scarcity of goods as a result of the war many men could now afford to visit prostitutes, and this favoured an increase in prostitution and consequently of VD. It was also stressed that increased consumption of alcohol, lack of housing, and other difficult social conditions contributed to this development. Social policies and matter of fact information on sexual questions with a strong ethical appeal were provisions recommended to curb VD. The bill on VD was seen in a broad social perspective and it was emphasized that free treatment and free medicine, made available for VD patients through the new law, ought as soon as possible to be made generally accessible for any diseased person.<sup>82</sup> It was hoped that the principle of universalism embodied in the 1947 law would be a stepping-stone on the road to a welfare society.

From 1947, Norway followed the example set by Denmark and Sweden. Since in 1947 mandatory contact tracing was also introduced in Denmark, the Scandinavian character of the Scandinavian *Sonderweg* was now complete. A combination of coercion and free treatment was offered to all citizens, one of many steps introducing the Scandinavian welfare state. But although these policies in principle comprised all citizens, contrary to Baldwin's claim,<sup>83</sup> they did not obliterate traditional differences created by class and gender. Money still provided the means of buying services other than those offered free of charge, and, under other legislation, authorities had the means to continue the control of prostitutes. Moreover, when the gender-neutral laws were put into practice, women were targeted much more often than men.<sup>84</sup>

## Why Different Scandinavian Trajectories?

Sweden was the first of the Scandinavian countries to enact all the elements of sanitary statism, but in many respects Denmark was the pioneering country. Norway lagged behind in its reliance on municipal by-laws, and it was not until 1947 that all three countries had adopted the Scandinavian *Sonderweg*. How can such differences be explained?

A deplorable lack of comparative research in Scandinavian history makes it difficult to answer this question with any degree of certainty. Nevertheless, some suggestions may be made. The small time lag between Denmark and Sweden may be more of a coincidence than the result of noticeable social or political processes. But it seems possible that the defence of regulationism was stronger in Sweden than in Denmark. Even between 1910 and 1918 there was strong resistance to the abolition of this way of combating VD, and vehement discussion in the Swedish parliament, whereas in 1906 only one Danish MP attempted to defend regulationism.<sup>85</sup> He found no support in the Danish parliament. However, the arduous debate on delinquency provisions in the 1906 Danish law may have convinced hesitant Danish MPs that even without accepting regulationism, it was perfectly possible to control prostitutes.

As for the considerable difference in timing between Denmark and Sweden on the one hand, and Norway on the other, a number of factors may be of importance, including economics, urbanization, a decentralized political process, religion and the women's movement.

In 1923, concerns for the Norwegian national economy were put forward as the main reason for not adopting the bill that proposed a law along the same lines as those by then adopted in Denmark and Sweden. In the same year, a bill on old age pension schemes was also dropped due to economic

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considerations, and the important state support for institutions fighting tuberculosis was curtailed.<sup>86</sup> As in many other countries, until the middle of the 1930s the inter-war period in Norway was marred by a number of economic crises. This made it difficult to implement social policies, even those already adopted by parliament. The free treatment inherent in the Scandinavian *Sonderweg* would have to wait. This argument may have been strengthened by the reduction in reported cases of VD after the First World War, which lasted until 1940.

Further, since the problems connected to VD were especially evident in urban communities, nuances in VD policies may also have been caused by different processes of industrialization and later and less pronounced urbanization in Norway than in Denmark and Sweden.<sup>87</sup> In the latter two countries the development of an industrial economy was a long process, allowing for a gradual acceptance of the problems accompanying urbanization. In contrast, while starting later, Norwegian industrialization occurred more rapidly, and was not necessarily accompanied by urbanization. Extensive use of hydroelectric power made it necessary to implant important industrial undertakings into otherwise strictly agrarian regions, resulting in a decentralization of Norwegian industry and later and less pronounced urbanization. The need for a national law may have been less pressing.

This seems all the more plausible, since by 1940 municipalities in Bergen and Trondheim had established outpatient clinics and offered free treatment for all VD patients. In Oslo, needy patients had been given free treatment since 1899. Municipal authorities in the major towns where most of the VD patients were found shouldered most of the expenses involved.<sup>88</sup> As in many other areas of welfare policies, the importance of municipal policies was clear in the question of treating VD.

Decentralization of the political process had a long historical tradition that was stronger in Norway than in the other two Scandinavian countries. The Norwegian centre for political decisions and for administration had for centuries been Copenhagen, and, from 1814, at least partly Stockholm. Opposition first to Danish, then to Swedish authorities promoted regional and local policies and a strong national movement stressing the democratic decentralized homeland.<sup>89</sup> In this context the somewhat different role of municipal councils in the three Scandinavian countries may also have made an impact. Swedish policies were primarily dictated by central government, with only little scope for local initiatives.<sup>90</sup> Swedish municipal councils adhered to a principle of thrifty economy and circumspect social policies that to a great extent was directed by guidelines formulated at state level. Politics from above met little opposition. In Denmark and Norway, however, municipalities played an important initiating role in social policies. In both countries, municipal inventiveness often predated national welfare initiatives. The result was that thorough reforms at the municipal level were carried through well before similar reforms at the national level.<sup>91</sup>

While this is true for both Denmark and Norway, relations between the social democratic parties and the liberal parties gave municipal policies somewhat different connotations in these two countries. In Denmark the two parties cooperated against the conservative regime until 1901, and by 1913 cooperation had started at government level. All through the inter-war period, Danish social democrats remained strongly reformist and resumed government responsibilities between 1929 and 1940. They had less need for municipal strongholds to carry through social reforms, but were able to formulate their policies at the national level. For the Norwegian Labour Party municipal socialism was a stepping-stone to socialism at the national level. The deep split between a revolutionary socialist party on the one hand, and liberal and conservative parties on the other, during the 1920s and until the mid-1930s made municipal socialist strongholds all the more important. Although radical liberals also worked for social reforms, it was not until 1935 that cooperation between liberal and social democratic parties at the government level was accepted. Meanwhile, the economic crises that hit many municipal economies hard during the 1920s created widely different possibilities for municipal councils to follow up social reforms. After 1945 these experiences paved the way for national policies with the aim of levelling out differences between rich and poor municipalities. With the Labour Party safely installed in government, national laws on social policies no longer risked holding back

social reforms.<sup>92</sup> All the more so, since during the first post-war years an atmosphere of political cooperation prevailed: a national law on how to fight VD now seemed a safe project.

The question of Christian morality, so deeply embedded in VD policies, may also help to explain the persistence of a decentralized policy in Norway. In the absence of an explicitly comparative analysis let me point to some indications of different religious climates in the three Scandinavian countries. Freedom of religion was introduced earlier in Denmark than in the two other Scandinavian countries, last of all in Norway. Social questions that strongly engaged religious circles, such as the decriminalization of abortion and of homosexuality, took much longer to solve in Norway than in Denmark and Sweden.<sup>93</sup>

In Denmark agrarian liberalism was expressed particularly through the predominance of “*grundtvigianism*”, a religious trend within the Danish state church that encouraged open dialogue and discussion, not only of religious but also of cultural and political matters. Through an extensive network of schools for young peasants, this version of the Christian faith gained great influence in Danish society, educating youth to individual responsibility and liberal attitudes.<sup>94</sup> In Norway strong regional countercultures from the late nineteenth century led to the politicization of religion, and the creation of the Christian People's Party (*Kristelig Folkeparti*) in 1933, which from 1945 held a strong foothold as a nationwide party. One result of the importance of pietistic religious circles was the establishment in 1909 of the Congregation Faculty (*Menighetsfakultetet*), an alternative to the faculty of theology at the University of Oslo. Within a short period, the Congregation Faculty produced more clergymen than did the University. Repeated conflicts between these two schools and their adherents kept religious life especially vivid and turbulent well into the post-war period.<sup>95</sup>

In this climate, legislating about VD became a complicated undertaking. Since support for conservative and puritan religious movements was strongest in the south-western coastal areas, it may have been wise to leave the problem to local municipal authorities. As Koren has pointed out, Norwegian attitudes to VD policies varied significantly from one municipality to the other, and letting municipal authorities decide permitted local public opinion to have its way.<sup>96</sup> Consequently, the prevailing religious climate may be another important reason why the Norwegian authorities were so late in adopting a national law on these matters.

Finally, as we have seen, women were eagerly engaged in the fight against regulationism. The roles played by the women's movement in VD questions in the three countries may also be worth considering. I would posit that it had more influence in Denmark and in Norway than in Sweden.

Women in Denmark organized earlier than in the two other Scandinavian countries. As mentioned, the Danish Women's Society was created in 1871. Consequently, women had some experience in public discussions when criticism of regulationism was voiced by the Association for Propriety. They asserted their interests in fighting regulationism not only through their activities within the Association for Propriety, but also through their own organization.<sup>97</sup> The establishment in the 1880s of more liberal suffrage associations made women a not unimportant group when changes in the political regime occurred in 1894 and 1901, and they were credited with the changes enacted in 1895 and 1901. Being without the franchise until 1915, they had no direct impact on parliamentary discussions leading up to the law of 1906. Few and inexperienced as MPs, they argued in vain for amendments to the law adopted in 1947.<sup>98</sup>

Swedish and Norwegian women did not organize until 1884. In Sweden, the claim for women's suffrage did not emerge until 1899 and a national association for women's suffrage was organized only in 1903.<sup>99</sup> As already noted, discussions on the law adopted in Sweden in 1918 took place mainly among men. The Swedish Women's movement does not seem to have had much influence on the outcome. Events in Norway again contrast.

The Norwegian women's movement started at the same time as the Swedish movement, in 1884, but the

Norwegian women's associations adopted a more aggressive policy than the Swedish associations.<sup>100</sup> The question of women's national suffrage was raised as early as 1885, later than in Denmark, but almost twenty years earlier than in Sweden.<sup>101</sup> When the question of abolishing regulationism in Oslo became acute in the late 1880s, women had already organized to voice their opinion on public matters. Democratic reforms, offering both men and women a wider scope, came earlier in Norway than in Sweden,<sup>102</sup> and the Norwegian women's movement joined the critics of the 1892 and 1901/2 bills that made it impossible for the Norwegian parliament to reach agreement on a VD law before the First World War. Yet women's efforts to obtain a law during the 1920s did not succeed. The 1947 law was, however, adopted in the Norwegian parliament unanimously and without debate.

Thus, in both Denmark and Norway women made some impact on the question of abolishing regulationism, but they had little influence on the laws on VD adopted by Scandinavian parliaments until the middle of the twentieth century.

In conclusion, the differences in the timing of Scandinavian VD laws may be explained mainly by differences in economic considerations. Variations in patterns of industrialization and urbanization may also have played a role. The importance given to municipal policies, and a regionally varied and politically important religious climate in Norway may also help to explain the late acceptance of the Scandinavian *Sonderweg* in this country. The relative strengths of the women's movements may have had some importance for the timing of the abolition of regulationism, but legislation was almost exclusively a masculine prerogative.

Despite differences in the timing of the adoption of central items of the Scandinavian *Sonderweg* during the late nineteenth and early twentieth century, the Scandinavian countries by and large followed similar policies in their fight to reduce the occurrence of VD. It seems probable that this may be explained by the political culture which paved the way to the Scandinavian welfare states: a strong communality and the perception of the state as a friend and ally. But social control and constraints were built into this policy. The Scandinavian *Sonderweg* in practice continued traditions of focusing on women as the main sources of infection and did not fully rule out status and class as a differentiating category in the implementation of policies of control.

## Footnotes

<sup>1</sup> There is a comprehensive literature on this problem. See, for instance, Dorothy Porter (ed.), *The history of public health and the modern state*, Amsterdam and Atlanta, Rodopi, 1994; and Peter Baldwin, *Contagion and the state in Europe, 1830–1930*, Cambridge University Press, 1999. For a recent general overview, see Mark Harrison, *Disease and the modern world: 1500 to the present day*, Cambridge, Polity Press, 2004, pp. 118–44. See also A-L Seip, *Sosialhjelpstaten blir til: norsk sosialpolitikk 1740–1920*, Oslo, Gyldendal, 1994, pp. 235–9; O G Moseng, *Ansvar for undersåttens helse, 1603–1850*, series: *Det offentlige helsevesen i Norge 1603–2003*, vol. 1, Oslo, Universitetsforlaget, 2003, pp. 55–72; Aina Schiøtz, *Folkets helse–landets styrke 1850–2003*, series: *Det offentlige helsevesen i Norge 1603–2003*, vol. 2, Oslo, Universitetsforlaget, 2003, pp. 206–18; and Kari Tove Elvbakken, Svanaug Fjær and Thor Øivind Jensen, 'Forebygging og politikk; historie, dilemma og grenser', in Kari Tove Elvbakken, Svanaug Fjær and Thor Øivind Jensen (eds), *Mellom påbud og påvirkning: tradisjoner, institusjoner og politikk i forebyggende helsearbeid*, [Oslo], Gyldendal, 1994, pp. 11–26.

<sup>2</sup> Øystein Sørensen and Bo Stråth, 'Introduction: the cultural construction of Norden', in Øystein Sørensen and Bo Stråth (eds), *The cultural construction of Norden*, Oslo, Stockholm, Scandinavian University Press, 1997, pp. 1–24; Uffe Østergård, 'The geopolitics of Nordic identity: from composite states to nation-states', in *ibid.*, pp. 25–71, on p. 25. On the Nordic Welfare State, see Gösta Esping-Andersen, *The three worlds of welfare capitalism*, Cambridge, Polity Press, 1990; Niels Finn Christiansen, 'What is Nordic about the Nordic welfare states?' in Kari Melby, Anu Pylkkänen, Bente Rosenbeck, and Christina Carlsson Wetterberg (eds), *The Nordic model of marriage and the welfare state*, Copenhagen, Nordic Council of Ministers, 2000, pp. 197–205.



<sup>3</sup> Søren Kolstrup, *Velfærdsstatens rødder: fra kommunesocialisme til Folkepension*, SFAH-skriftserie nr. 38, Copenhagen, Selskabet til Forskning i Arbejderbevægelsens Historie, 1996; Anne-Hilde Nagel (ed.), *Velfærds kommunen: kommunenes rolle i udviklingen av velfærdsstaten*, Bergen, Alma Mater, 1991; Lena Eriksson, 'De arbetslöses förening: Förutsättningar för mobilisering och handlingsutrymme 1919: En fallstudie i Stockholm', in Anders Berge, Walter Korpi, Joakim Palme, Sten-Åke Stenberg and Klas Åmark (eds), *Välfärdsstat i brytningstid: historisk-samhällsvetenskapliga studier om genus och klass, ojämlikhet och fattigdom*, Örebro, Sociologisk forskning: Supplement, 1999, pp. 93–127; Sten-Åke Stenberg, 'Arbetslöshet och fattigdom i Sverige från 1920-tal till 1990-tal: en kombinerad makro- och mikroanalys', in *ibid.*, pp. 192–217; Birgitta Plymoth, 'Familjeförsörjande kvinnor och fattigvård. Om möjligheter och egenansvar under sent 1800-tal', in *ibid.*, pp. 192–217; Klas Åmark, 'Arbetarrörelsen, socialförsäkringssystemet och genusordningen 1932–1970', in *ibid.*, pp. 253–85.

<sup>4</sup> Peter Baldwin, *The politics of social solidarity: class bases of the European welfare state 1875–1975*, Cambridge University Press, 1990; Nagel (ed.), *op. cit.*, note 3 above; Aksel Hatland, Stein Kuhnle and Tor Inge Romøren (eds), *Den norske velfærdsstaten*, Oslo, Ad Notam Gyldendal, 1994; Anne-Hilde Nagel (ed.), *Kjønn og velfærdsstat*, Bergen, Alma Mater, 1998; Hilda Rømer Christensen, 'Med kvinderne til velfærdsstaten. Kvindeorganisering i Danmark, 1920–1940', *Kvinder, Køn og Forskning*, 1999, no. 4, pp. 6–20; Marja T Sjöberg and Tinne Vammen (eds), *På trøskeln till välfärden*, Stockholm, Carlsson bokförlag, 1995; Hilda Rømer Christensen, Urban Lundberg and Klaus Petersen (eds), *Frihed, lighed og tryghed. Velfærds politik i Norden*, Aarhus, Skrifter udgivet af Jysk Selskab for Historie nr. 48, 2001. Among other themes, this report documents the coercion practised in all the Nordic countries from the early 1930s particularly with regard to the laws on sterilization.

<sup>5</sup> Lena Sommestad, 'Privat eller offentlig välfärd? Ett genusperspektiv på välfärdsstaternas historiska formering', *Historisk Tidskrift* (Sweden), 1994, 4: 602–29; Ida Blom, 'Don't spit on the floor': changing a social norm in early twentieth-century Norway', in Hilde Sandvik, Kari Telste and Gunnar Thorvaldsen (eds), *Pathways of the past: essays in honour of Sølvi Sogner*, Oslo, Novus, 2002, pp. 231–42; Ida Blom, 'Fra tvang til frivillighet? – Forebygging av veneriske sykdommer i Kristiania, 1888–1910', in Edgeir Benum, Per Haave, Hilde Ibsen, Aina Schiøtz and Ellen Schrupf (eds), *Den mangfoldige velferden: festskrift til Anne-Lise Seip*, Oslo, Gyldendal Norsk Forlag, 2003, pp. 125–40; Signild Vallgård, 'Det goda livet och det goda samhället. Styrning i folkhälsopolitiken eller hur välfärdsstaten söker forma människor', in Christensen, Lundberg and Petersen (eds), *op. cit.*, note 4 above, pp. 90–107; Signild Vallgård, *Folkesundhed som politik: Danmark og Sverige fra 1930 til i dag*, Aarhus, Aarhus Universitetsforlag, 2003.

<sup>6</sup> Lauri Karvonen and Jan Sundberg (eds), *Social democracy in transition in northern, southern and eastern Europe*, Aldershot, Dartmouth Publishing, 1991; Lauri Karvonen and Per Selle (eds), *Women in Nordic politics: closing the gap*, Aldershot, Dartmouth Publishing, 1995; Lennart Jørberg, 'The industrial revolution in Scandinavia, 1850–1914', in Carlo M Cipolla (ed.), *The Fontana economic history of Europe*, vol. 4: 1700–1914: the emergence of industrial societies, Part Two, London, Fontana Books, 1970.

<sup>7</sup> See 'Introduction', Roger Davidson and Leslie Hall (eds), *Sex, sin and suffering: venereal disease and European society since 1870*, London and New York, Routledge, 2001, pp.1–14, for an excellent overview.

<sup>8</sup> Andrew Aisenberg, 'Syphilis and prostitution: a regulatory couplet in nineteenth-century France', in Davidson and Hall (eds), *op. cit.*, note 7 above, pp. 15–28; Yvonne Svanström, *Policing public women: the regulation of prostitution in Stockholm 1812–1880*, Stockholm, Atlas, 2000, pp. 74–9.

<sup>9</sup> For a comprehensive overview of regulationist practices, see Svanström *op. cit.*, note 8 above, pp. 69–112.

<sup>10</sup> Mary Spongberg, *Feminizing venereal disease: the body of the prostitute in nineteenth-century medical discourse*, Basingstoke, Macmillan, 1997; Judith Walkowitz, *Prostitution and Victorian society: women, class, and*

the state, Cambridge University Press, 1980; Lutz Sauerteig, *Krankheit, Sexualität, Gesellschaft: Geschlechtskrankheiten und Gesundheitspolitik in Deutschland im 19. und frühen 20. Jahrhundert*, Stuttgart, Franz Steiner, 1999, pp. 57–62, 89–125. For Sweden, see Svanstrøm, op. cit., note 8 above, pp. 82–6. For Norway, see Aina Schiøtz, 'Prostitusjon og prostituerte i 1880-åras Kristiania', in Anne-Marit Gotaas, Brita Gulli, Kari Melby and Aina Schiøtz, *Det kriminelle kjønn: om barnefødsel i dølgsmål, abort og prostitusjon*, Oslo, Pax, 1980, pp. 35–9; and Kari Melby, 'Prostitusjon og kontroll', in *ibid.*, pp. 83–5. For Denmark, see Karin Lützen, *Byen tæmmes: kernefamilie, sociale reformer og velgørenhed i 1800-tallets København*, Copenhagen, Hans Reitzel, 1998, pp. 219–85. An early analysis of this discussion in the Scandinavian countries is in Elias Bredsdorff, *Den store nordiske krig om seksualmoralen*, Copenhagen, Gyldendal, 1973.

<sup>11</sup> Svanstrøm, op. cit., note 8 above, p. 86. Svanstrøm builds on Walkowitz, op. cit., note 10 above, p. 202.

<sup>12</sup> Svanstrøm, op. cit., note 8 above, pp. 90–1, 109.

<sup>13</sup> *Ibid.*, pp. 86–8. Svanstrøm builds on Mary Gibson, *Prostitution and the state in Italy, 1860–1915*, New Brunswick, Rutgers University Press, 1986. See also Bruno P F Wanrooij, 'The thorns of love': sexuality, syphilis and social control in modern Italy', in Davidson and Hall (eds), op. cit., note 7 above, pp. 137–59.

<sup>14</sup> Anne Hardy, *Health and medicine in Britain since 1860*, Basingstone, Macmillan, 2000, pp. 68–9.

<sup>15</sup> Lesley A Hall, 'Venereal diseases and society in Britain, from the Contagious Diseases Acts to the National Health Service', in Davidson and Hall (eds), op. cit., note 7 above, pp. 120–36.

<sup>16</sup> Hardy, op. cit., note 14 above, pp. 68–9; Hall, op. cit. note 15 above, pp. 120, 124–7.

<sup>17</sup> Hardy, op. cit., note 14 above, p. 69; Ulrike Lindner, 'Unterschiedliche Traditionen und Konzepte: Frauen und Geschlechtskrankheiten als Problem der Gesundheitspolitik in Grossbritannien und Deutschland', in Ulrike Lindner and Merith Niehuss (eds), *Ärztinnen – Patientinnen. Frauen im deutschen und britischen Gesundheitswesen des 20. Jahrhunderts*, Cologne, Böhlau, 2002, pp. 216–41, on p. 226.

<sup>18</sup> Michaela Freund, 'Women, venereal disease and the control of female sexuality in post-war Hamburg', in Davidson and Hall (eds), op. cit., note 7, pp. 205–19.

<sup>19</sup> Lutz D H Sauerteig, 'The Fatherland is in danger, save the Fatherland!' Venereal disease, sexuality and gender in Imperial and Weimar Germany', in Davidson and Hall (eds), op. cit., note 7 above, pp. 76–92, on p. 78; Baldwin, op. cit., note 1 above, pp. 476–81; see also Lindner, op. cit., note 17 above.

<sup>20</sup> Baldwin, op. cit., note 1 above, pp. 400–18.

<sup>21</sup> *Ibid.*, pp. 400–1.

<sup>22</sup> *Ibid.*, p. 408.

<sup>23</sup> Anna Lundberg, *Care and coercion: medical knowledge, social policy and patients with venereal disease in Sweden 1785–1903*, Report No. 14 from the Demographic Data Base, Umeå University, 1999, pp. 94–106; Baldwin, op. cit., note 1 above, pp. 401–4.

<sup>24</sup> Baldwin, op. cit., note 1 above, p. 142.

<sup>25</sup> Svanstrøm, op. cit., note 8, pp. 136–57.

<sup>26</sup> Anna Lundberg, 'Passing the "Black Judgment": Swedish social policy on venereal disease in the early twentieth century', in Davidson and Hall (eds), op. cit., note 7 above, pp. 29–43, on p. 30.

<sup>27</sup> Ibid., p. 40.

<sup>28</sup> Ibid., pp. 39–40.

<sup>29</sup> Ibid., p. 41.

<sup>30</sup> Ibid., p. 41.

<sup>31</sup> Baldwin, op. cit., note 1 above, p. 418.

<sup>32</sup> Ibid., p. 408, n.177.

<sup>33</sup> Lundberg, op. cit., note 26 above, pp. 40–1; Tomas Söderblom, *Horan och batongen. Prostitution och repression i folkhemmet*, Stockholm, Gidlund, 1992, cited in Lundberg, op. cit., note 26 above, p. 43; Svanstrøm, op. cit., note 8 above, on pp. 431–2.

<sup>34</sup> Berge, *et al.* (eds), op. cit., note 3 above.

<sup>35</sup> Report from the Committee appointed by the Home Secretary concerning Revision of Law no. 81 of 30 March 1906 to Prevent Public Impropriety and Venereal Contagion, *Betænkning afgivet af det af Indenrigsministeriet nedsatte Udvalg angaaende Revision af Lov Nr. 81 af 30. Marts 1906 om Modarbejdelse af offentlig Usædelighed og venerisk Smitte*, Copenhagen, J H Schultz A/S Universitets-Bogtrykkeri, 1946, p. 7.

<sup>36</sup> Lützen, op. cit., note 10 above, pp. 219–46; Merete Bøge Pedersen, *Den reglementerede prostitution i København fra 1874 til 1906*, Copenhagen, Museum Tusulanums, 2000, pp. 15–22; Svanstrøm, op. cit., note 8 above, pp. 96–100.

<sup>37</sup> There were two police laws of 1863: *Lov angaaende Omordning af Kjøbenhavns Politi m.v.* (Law concerning rearrangements of the Copenhagen police, etc.) and *Lov indeholdende nogle Forandringer i Bestemmelserne om Behandlingen af offentlige politisager i Kjøbenhavn m.m.* (Law containing some changes in the regulations concerning the treatment of police matters in Copenhagen, etc.). Both were enacted on 11 Feb. 1863. Sections 180 and 181 in *Straffeloven av 1866* (the Penal Code of 1866) were interpreted as simultaneously allowing control of, and at the same time prohibiting, prostitution. For a thorough analysis of the development of legislation on prostitution from 1860 to 1906, see Merete Bøge Pedersen, ‘Prostitutionen og Grundloven. Regulering af og debat om prostitution i Danmark i perioden ca. 1860–1906’, unpublished PhD thesis, Aarhus, Institut for Historie og Områdestudier, Historisk Afdeling, Aarhus University, 2003.

<sup>38</sup> Report, op. cit., note 35 above, p. 8.

<sup>39</sup> *Lov om Foranstaltninger til at modarbejde den veneriske Smittes Udbredelse*, sections 3–6.

<sup>40</sup> Bøge Pedersen, op. cit., note 37 above, pp. 20–1.

<sup>41</sup> Lützen, op. cit., note 10 above, pp. 226, 240; Bøge Pedersen, op. cit., note 37 above, pp. 136–9.

<sup>42</sup> Lützen, op. cit., note 10 above, pp. 247–59; Bøge Pedersen, op. cit., note 37 above, pp. 143–50.

<sup>43</sup> Report, op. cit., note 35 above, p. 1.

<sup>44</sup> Bøge Pedersen, op. cit., note 37 above, pp. 205–40.

<sup>45</sup> Kolstrup, op. cit., note 3 above, pp. 50–3.

<sup>46</sup> Danish parliamentary documents: Upper House Chronicle (*Landstingstidende*) and Proceedings of the Upper House (*Landstingets Forhandlinger*), 1904–1905 and 1905–1906. Lower House Chronicle (*Folketingstidende*) and Proceedings of the Lower House (*Folketingets Forhandlinger*) 1905–1906. The author is currently working on an analysis of the Danish debate on the law of 1906.

<sup>47</sup> The city or district physician (*den offentlig Læge*) and the visiting physician (*den visiterende Læge*), who travelled the rural districts to facilitate access to medical consultation were responsible for efficient measures against VD. The full text of the law is printed in Bøge Petersen, op. cit., note 36 above, pp. 155–9.

<sup>48</sup> Report, op. cit., note 35 above, pp. 8–9.

<sup>49</sup> Ibid., pp. 8–9.

<sup>50</sup> Ibid., p. 67.

<sup>51</sup> Ibid., pp. 11–12. Treatment with Salvarsan, sometimes combined with “vismuth” preparations, was mentioned as being helpful in curing syphilis. In the case of gonorrhea a combination of sulfa and fever therapy was indicated, but treatment was expensive and long-lasting.

<sup>52</sup> Ibid., pp. 7–20.

<sup>53</sup> *Lov til Bekæmpelse af Kønssygdomme*, sections 3 and 11.

<sup>54</sup> Municipal clinics in Copenhagen and Aarhus (the second-largest city) and outpatient clinics at some major hospitals were given the same duties as individual physicians. Report, op. cit., note 35 above, pp. 27–31.

<sup>55</sup> Ibid., p. 73.

<sup>56</sup> Parliamentary documents, Chronicle of the Lower House (*Folketingstidende*) 1946, cols 51 and 73.

<sup>57</sup> Parliamentary documents, Proceedings of the Lower House (*Folketingets Forhandlinger*) cols 1104–1105, 1110–1111, 1114; Chronicle of the Lower House (*Folketingstidende*), cols 1314, 1348, 1353, 1355, 1359, 1368. For an in depth analysis of the Parliamentary discussion, see Ida Blom, ‘From coercive policies to voluntary initiatives: legislating to prevent venereal diseases in Denmark 1947–1988’, unpublished manuscript.

<sup>58</sup> The bill is printed as Bill no. 20, Law on Prevention of Venereal Disease, The Lower House 1946–47, Sheet No. 37 (*Lovforslag Nr. 20. Forslag til Lov om Bekæmpelse af Kønssygdomme. Folketinget 1946–47, Blad Nr. 37*), pp. 1–7.

<sup>59</sup> Parliamentary documents, *Folketingstidende 1946*, cols 1108, 1347, 1348, 1364–1365, 1369, 1390, 3813, 3833, 3835.

<sup>60</sup> The name of the Norwegian capital was changed from Kristiania to Oslo in 1924. In this paper, the name Oslo will be used for the whole period.

<sup>61</sup> For Oslo, see Schiøtz, ‘Prostitusjon og prostituerte’, op. cit., note 10 above; Melby, op. cit., note 10 above; Blom, ‘Fra tvang til frivillighet?’, op. cit., note 5 above, pp. 125–40. For Bergen, see E Koren, ‘En Trusel for selve Samfundene.’ Venerisk sykdom: tiltak, medisinsk forståelse og moraldebatt i Norge 1880–1927’, Bergen, unpublished MA thesis, Department of History, University of Bergen, 2003, pp. 89–91; Christopher J Harris, ‘Kontroll av prostituerte i Bergen’, in Kari Tove Elvbakken and Grete Riise (eds), *Byen og helsearbeidet*, Bergen, Fagbokforlaget, 2003, pp. 157–74. There are no other local studies of Norwegian VD policies.



<sup>62</sup> Schiøtz, 'Prostitusjon og prostituerte', op. cit., note 10 above, pp. 43–8, and Schiøtz, *Folkets helse*, op. cit., note 1 above, pp. 76–7.

Med Hist <sup>63</sup> Melby, op. cit., note 10 above, pp. 89–103; Wenche Rand Øyre, 'I lidenskapens storm': "Kristiania Forening til Fremme af Sædelighed" 1892–1907, analysert gjennom tidsskrifta: *Til Moralens Fremme, Moral og Værn*, Bergen, unpublished MA thesis, Department of History, University of Bergen, 1995, pp. 56–63. For a comprehensive analysis of the abolition of regulationism in Oslo, see Blom, 'Fra tvang til frivillighet?', op. cit., note 5 above.

<sup>64</sup> 'Sedelighed og prostitusjon', *Tidsskrift for Praktisk Medicin*, 1888, **8**: 116–21.

<sup>65</sup> Ibid., p. 117.

<sup>66</sup> Ibid., p. 121.

<sup>67</sup> Blom, 'Fra tvang til frivillighet?', op. cit., note 5 above, p. 101; Melby, op. cit., note 10 above, pp. 113–15.

<sup>68</sup> Melby, op. cit., note 10 above, pp. 112–18.

Med Hist <sup>69</sup> Blom, 'Fra tvang til frivillighet?', op. cit., note 5 above, pp. 134–6. The municipal authorities in Bergen did not wait for this to happen. From 1893 they gradually offered free treatment to broader circles of patients. By 1927 most VD patients in that city were treated free of charge. Koren, op. cit., note 61 above, pp. 69, 101.

<sup>70</sup> Melby, op. cit., note 10 above, pp. 108–13.

<sup>71</sup> 'Introduction', Kari Melby, Anu Pykkänen, Bente Rosenbeck, Christina Carlsson Wetterberg (eds), *The Nordic model of marriage and the welfare state*, Copenhagen, Nordic Council of Ministers, 2000, pp. 13–34, on p. 16.

<sup>72</sup> St. meld. nr. 32, 1928, p. 10; Koren, op. cit., note 61 above, pp. 52–5; Anne-Lise Seip, *Veiene til velferdsstaten: norsk sosialpolitikk 1920–1975*, Oslo, Gyldendal, 1994, pp. 100–3.

<sup>73</sup> Ida Blom, 'Contagious women and male clients: public policies to prevent venereal diseases in Norway, 1888–1960', *Scand. J. Hist.*, 2004, **29**: 97–117.

Med Hist <sup>74</sup> Sweden saw the number of reported cases of syphilis reduced from 100 per 100,000 inhabitants in 1919 to 6 in 1939. For Norway, the figures for syphilis were 57 per 100,000 inhabitants in 1919, down to 12 in 1939. Figures for gonorrhoea in both countries fell only slightly, from 240 cases in Sweden and 210 in Norway in 1919 to 190 cases per 100,000 inhabitants in both countries in 1939. Parliamentary document, Ot.prp.nr. 5, 1947, p. 5. In Denmark, where the number of reported cases was much higher, recorded cases of acquired syphilis fell from 142 in 1919 to 13 in 1940, for gonorrhoea from 477 in 1919 to 204 in 1940, all per 100,000 inhabitants. (*Betænkning*, op. cit., note 35 above, p. 17).

<sup>75</sup> Kåre Olsen, *Krigens barn: de norske krigsbarna og deres mødre*, Oslo, Forum: Aschehoug, 1998, pp. 284–302; Ida Blom, 'Krig og kjønnsykdom. Norge 1946–1953', in Göran Fredriksson, et al. (eds), *Könsmaktens förvandlingar: en vänbok till Anita Göransson*, Gothenburg, Institutionen för Arbetsvetenskap, 2003, pp. 13–31; Blom, 'Contagious women', op. cit., note 73 above.

<sup>76</sup> Parliamentary document, Ot.prp.nr. 5, 1947, pp. 2–3.

Med Hist <sup>77</sup> Denmark capitulated to German forces immediately on 9 April 1940, and until 1943 the Danish government attempted to cooperate with the German occupying forces. In Norway the German occupation started only after a short war with Germany. The Norwegian government and King fled to the United Kingdom and the German Reichskommissar Josef Terboven took over the central power, from 1942 with Vidkun Quisling as

“ministerpresident”. Berge Furre, *Norsk historie 1905–1990*, Oslo, Det norske Samlaget, 1993, pp. 169–77. Ditlev Tamm has indicated a more comprehensive and strict legal settlement after the Second World War in Norway than in Denmark. Ditlev Tamm, *Retsovgjøret efter besættelsen*, Copenhagen, Jurist- og Økonomforbundets, 1984, pp. 702–6. Olsen, op. cit., note 75 above, pp. 448–51, suggests that the strong position of the German Lebensborn organization in Norway may be one reason for stricter policies against “the German hussies” (*tyskertøsene*) and their children than in any other country that had been occupied by German forces. For treatment of Danish women who had had sexual relations with Germans during the war, see Anette Warring, *Tyskerpiger: under besættelse og retsovgjør*, Copenhagen, Gyldendal, 1994, pp. 175, 180, 186–7; and for an analysis of these policies in European countries occupied by Germany during the Second World War, see *idem*, ‘Intimate and sexual relations’, European Science Foundation Programme, unprinted manuscript.

<sup>78</sup> Parliamentary document, Ot.prp.nr. 5, 1947, p. 1.

<sup>79</sup> Parliamentary proceedings 1947, *Stortingsforhandlinger*, p. 848.

<sup>80</sup> See references in note 3 above.

<sup>81</sup> Parliamentary document, *Innstilling til odelstinget* O.XXV, 1947, p. 3. For a full account of the enactment of this law, see Blom, ‘Contagious women’, op. cit., note 73 above, pp. 111–17.

<sup>82</sup> *Innstilling til odelstinget*, op. cit., note 81 above, p. 4.

<sup>83</sup> Baldwin, op. cit., note 1 above, pp. 400–1.

<sup>84</sup> Marlene Spanger, ‘Den løstgite kvinde – prostitution, køn og magt i Danmark 1920–1960’, in Eva Helen Ulvros, *Køn makt völd: konferensrapport från det sjunde nordiska kvinnohistorikermötet 8–11 augusti 2002*, Gothenburg, Göteborgs Universitet, 2002, pp. 47–52; Anna Lundberg, ‘Inne får jag väl fängelse?’ En studie av Lex veneris, dess utformning, praktisering och inverkan på enskilda människors liv 1919–1945’, *Historisk Tidskrift* (Swedish), 2001, 4: 631–48; Blom, ‘Krig og kjønnsykdom’, op. cit., note 75 above, pp. 15–23.

<sup>85</sup> Lundberg, op. cit., note 26 above, pp. 34–9. I have not personally analysed the Swedish debates, but Lundberg does not mention this argument once in her presentation of this material. The Danish debate is analysed in Blom, ‘From coercive policies’, op. cit., note 57 above. Sources are Parliamentary debates of 20 March 1906 (*Folketingstidende* 1905–6), cols. 5959–5960, 5963, 5977–80, 5985, 5987–5988, 5996–5997.

<sup>86</sup> Koren, op. cit., note 61 above, pp. 54–5; Seip, op. cit., note 72 above, pp. 100–3; Schiøtz, *Folkets helse*, op. cit., note 1 above, pp. 187–99. An indication of the relative poverty of this country is a survey of social security coverage placing Norway second to last among European countries in the early 1930s. See Stein Kuhnle, ‘Norway’, in Peter Flora (ed.), *Growth to limits: the Western European welfare states since world war II*, European University Institute, Series C Political and Social Sciences 6, Berlin, De Gruyter, 1986, Berlin, vol. 1, pp. 120–1.

<sup>87</sup> Jørberg, op. cit., note 6 above, pp. 375–485, on pp. 385, 457–79.

<sup>88</sup> Parliamentary document, St.meddelelse, nr. 32, 1928, p. 11. Annual Report from the Oslo Board of Health for the Year 1940 (*Beretning fra Oslo helseråd for året 1940*), document no. 15, pp. 16–18.

<sup>89</sup> A separate study would be needed to go further into the question of centralized versus decentralized political processes in Scandinavia. Torkel Jansson points to the different impact of histories of societies and of local histories in Norway (and in Finland), as compared with Sweden, where the state has been the centre of historical studies. Unlike Norway, Sweden has no special institution with responsibility for local history. Torkel Jansson, ‘Eine historische Auseinandersetzung. Als die schwedische Bürgernation den Grossmachtstaat ablösen sollte’,

<sup>90</sup> Lundberg, op. cit., note 26 above, pp. 40–1.

<sup>91</sup> Kolstrup, op. cit., note 3 above, Tore Grønlie, ‘Velferdskommunen’, in Nagel (ed.), op. cit., note 3 above, pp. 43–52.

<sup>92</sup> Yngve Flo, ‘Staten og sjølvstyret. Ideologiar og strategiar knytt til det lokale og regionale styringsverket etter 1900’, unpublished doctoral thesis, Department of History, University of Bergen, 2004, chs 4 and 9; Ida Blom, ‘Prelude to welfare states: introduction’, in Helmuth Gruber and Pamela Graves (eds), *Women and socialism, socialism and women: Europe between the two world wars*, New York and Oxford, Berghahn Books, 1998, pp. 415–20.

<sup>93</sup> Freedom of religion was introduced in Denmark in 1849, in Sweden in 1951 and in Norway in 1969. Aila Lauha and Ingun Montgomery, ‘Virkelighedsbilleder efter krigen’, in Jens Holger Schjørring (ed.), *Nordiske folkekirker i opbrud: national identitet og international nyorientering efter 1945*, Aarhus, Aarhus universitetsforlag, 2001, pp. 47–52. Decriminalization of abortion was legislated in Denmark in 1937, in Sweden in 1938, in Norway in 1960. Decriminalization of homosexuality occurred in Denmark in 1930, in Sweden in 1944 and in Norway in 1972. David Bradley, ‘Family laws and welfare states’, in Melby, *et al.* (eds), note 2 above, pp. 37–66, on pp. 39–48.

<sup>94</sup> Frands Ove Overgaard, ‘Vækkelse—kirke—samfund i efterkrigstidens Danmark’, in Schjørring (ed.), op. cit. note 93 above, pp. 296–300.

<sup>95</sup> Jostein Nerbøvik, *Norsk historie 1870–1905*, Oslo, Det norske Samlaget, 1986, pp. 138, 186–202; Ståle Dyrvik and Ole Feldbæk, *Mellom brødre: 1780–1830*, vol. 7 of *Aschehous Norgeshistorie*, ed. Knut Helle, 12 vols, Oslo, Aschehoug, 1994–1998, pp. 66–73; Anne-Lise Seip, *Nasjonen bygges 1830–1870*, vol. 8 of *Aschehous Norgeshistorie*, Oslo, Aschehoug, 1997, pp. 143–9; Gro Hagemann, *Det moderne gjennombrudd: 1870–1905*, vol. 9 of *Aschehous Norgeshistorie*, Oslo, Aschehoug, 1997, pp. 56–9; Knut Kjeldstadli, *Et splittet samfunn 1905–35*, vol. 10 of *Aschehous Norgeshistorie*, Oslo, Aschehoug, 1994, pp. 34–5, 146–9; Even Lange, *Samling om felles mål, 1935–1990*, vol. 11 of *Aschehous Norgeshistorie*, Oslo, Aschehoug, 1998, p. 12; see also Ingun Montgomery, ‘Norge: att finna vägen tillbaka’, in Schjørring (ed.), op. cit., note 93 above, pp. 74–7, on the heated conflict in the 1950s on the meaning of hell.

<sup>96</sup> Koren, op. cit., note 61 above, pp. 57–8.

<sup>97</sup> The Danish Association of Women (*Dansk Kvindesamfund*) was organized in 1871. The Female Progressive Association (*Kvindelig Fremskridtsforening*), established in 1885, recruited liberal and social democratic women, and in 1889 the Women's Suffrage Association (*Kvindevalgretsforeningen*) started working for general female suffrage. Drude Dahlerup, *Rødstrømperne: den danske rødstrømpebevægelses udvikling, nytænkning og gennemslag, 1970–1985*, Copenhagen, Gyldendal, 1998, pp. 124–7.

<sup>98</sup> Ida Blom, ‘From coercive policies’, op. cit., note 57 above.

<sup>99</sup> Beata Losman, ‘Kvinnorganisering och kvinnorörelser i Sverige’, in Gunhild Kyle (ed.), *Handbok i svensk kvinnohistoria*, Stockholm, Carlsson, 1987, pp. 197–225. *Frederika-Bremer-Förbundet*, a moderately conservative association was established in 1884.

<sup>100</sup> Gro Hagemann, ‘De stummes leir? 1800–1900’, in Ida Blom and Sølvi Sogner, (eds), *Med kjønnsperspektiv på norsk historie. Fra Vikingtid til 2000-årsskiftet*, Oslo, Cappelen Akademisk, 2005, pp. 217–22; Ida Blom, ‘Modernity and the Norwegian women's movement from the 1880s to 1914’, in Sylvia Paletschek and Bianka Pietrow-Ennker (eds), *Women's emancipation movements in the nineteenth century: a European perspective*, Stanford University Press, 2004, pp. 125–51.

<sup>101</sup> The Norwegian Women's Association was established in 1884. In 1885 a liberal group of women split off and started the Norwegian Women's Suffrage Association (*Norsk Kvinnestemmerettsforening*), and in 1898 a still more radical organization, the National Association for Women's Suffrage (*Landskvindestemmeretsforeningen*), demanded general female suffrage.

<sup>102</sup> General national suffrage for men was attained in Norway in 1898, for women in 1913, in Sweden in 1909 and 1921 respectively. The principle of parliamentarism was introduced in Norway in 1884, in Sweden not until 1909. While a conservative Swedish nationalism built on traditions of a great northern European power blossomed around 1900, Norwegian nationalism looked for roots in an idealized peasant society and stressed the democratic nature of the Norwegian nation. Jansson, op. cit. note 89 above, pp. 16–44; Ida Blom, 'Nation – class – gender: Scandinavia at the turn of the century', *Scand. J. Hist.*, 1992, **21**: 1–16.

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