MIGRATION AS A FACTOR IN VENEREAL DISEASE PROGRAMMES IN THE UNITED STATES*

BY

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I consider it a great privilege to represent the Venereal Disease Programme of the United States of America at this distinguished meeting. I bring you the greetings and best wishes of the V.D. control workers in my country. I am grateful for the opportunity to be present at this important meeting being held in one of the truly great cities of the world. I shall long remember this occasion personally and officially and am genuinely hopeful that the deliberations here will contribute to more effective venereal disease control measures in my own country and throughout the world.

I am sure that many of my colleagues, when they sat down to describe the role of migration in the venereal disease problems and control programmes of the areas in which they are concerned, considered how population movements even in the distant past have been associated with the spread of disease and particularly with the transmission of venereal disease. This, of course, is something which logic would certainly anticipate; we all recognize that, when the active, adventurous, youthful, masculine element of a people sallies forth to conquest, colonization, or livelihood, their energies will not be exclusively directed towards war, territory, or money, and that some of the surplus energy may be devoted to occasional amorous adventures.

It is likely that the clay tablets in Assyria or the Rosetta Stone of Egypt may have recorded some of the communicable disease consequences of such migration. My own personal knowledge of early historical instances in which migration was associated with venereal disease relates to the departure of the children of Israel from Egypt to the promised land. As some of you from the more religious households will remember, even this consecrated migration suffered from exposure to venereal disease when some

of the male members of the tribe dallied with friendly women of their enemies, the Midianites. You all know, too, of the theory that the crew of Columbus initially contracted syphilis in the New World and transmitted the disease back to the Old World.

The international Union has, of course, played an important role in giving recognition to the problems and special programmes which are entailed in venereal disease control among migrants, as for example the Brussels Convention of 1924. While I must confess that my country never ratified this convention, which was concerned with providing medical service for the world's merchant seamen at all ports, those of us who are in venereal disease control have tried to comply with its objectives and our port cities do provide the services which were then recommended. So I believe I may say, speaking for the United States of America, that we do have some concept of human mobility as a significant factor in our venereal disease work.

In fact, our earliest systematic attempts towards venereal disease control in the U.S.A. were addressed to a population in process of migration. I refer, of course, to the young men of 1917 and 1918 who were mobilized for service in Europe at the time of our entry into World War I. You will recall that in those days even Dr. Ehrlich's original salvarsan was not widely available and the treatment of gonorrhoea was also very poorly developed. It was therefore of material concern to the military effort that persons with venereal diseases be excluded from service and that those accepted for service be prevented from acquiring these diseases. Hence, in this first international mass migration of American men on a military mission, our concern was primarily with exclusion and prevention.

In the course of control by prevention, our medical and line officers at home and abroad learned a great deal about the simultaneous migrations of camp followers who, like the Midianite women of the Old Testament, sorely afflicted our Expeditionary Forces.

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World War II found us less unprepared. Our diagnostic tools for syphilis had been standardized, and treatment, although tedious, was effective. The sulpha drugs for gonorrhoea were just coming into vogue.

Although we were better prepared than in World War I, the demands of the mobile environment in World War II led directly to a number of new and more effective processes for venereal disease control, and these processes have provided the conceptual bases for current operations.

Again we were confronted with massive interstate and international migrations. Some 15 million men of military age were taken from their home communities, brought to and transferred between military training and staging areas in the United States and then dispatched on missions throughout the world. Some of them returned home on furlough, others were re-assigned to other foreign stations, and finally within a very short period almost all of them were demobilized and returned to their points of origin.

At the outset and before this induction process had begun to operate on a sizeable scale, the wisdom of public health workers perceived that this mass

migration could spread venereal disease on an alarming scale, particularly if those enrolled in the Armed Services should transmit previously acquired infections. With this in mind, careful clinical and serological studies were performed on all persons entering the Armed Services either as volunteers or through the Selective Service system. Of the men examined, almost three-quarters of a million had a positive serologic test for syphilis, clinical symptoms of the disease, or both (Vonderlehr and Usilton, 1942).

Here was indeed an unparalleled case finding mechanism, and the State and local health departments of the U.S.A. used this to good effect by providing referral and treatment services to this population so that before the war's end some 300,000 of these draft-deferred, infected men were treated, rendered non-infectious, and inducted into the Armed Services. As an additional product of this mass screening programme, we obtained, for the first time, a sound estimate of the size and distribution of the syphilis problem for both whites and non-whites in every State, city, and county of the United States (Fig. 1).

FIG. 1.—Selectee syphilis rates per 1,000 in the U.S.A. in the second world war, 1942, by state.

The southern states had prevalence rates averaging four times as great as some of the north central states. This new information provided programme direction during the entire decade of the 1940s.

But the men in uniform, as might be expected, continued to acquire venereal disease. And because of their high mobility, it was difficult to locate the foci of infection from which this disease was acquired. To meet the needs of military venereal disease control personnel, analysis and action were undertaken to establish the epidemiologic geography of disease transmission (Fig. 2). A study of that period indicated that 48.1 per cent. of the sex contacts reported by military personnel in one Army district lived in States other than that of the infected soldier's duty station (Norris, Doyle, and Iskrant, 1943). Acting on the knowledge that an interstate referral system was imperative to cope with the large-scale migration of military personnel, this system was created for the military but also contributed much to civilian venereal disease control in that period. At this time, too, largely because of representations by the Norwegian Embassy, we issued a special directory of venereal disease clinics for foreign seamen, many of whom

were unable to return to their own countries which were being overrun by invasion. To cope with the increasing numbers of mobile prostitutes, special hospital facilities were established, serving them as well as other civilian infected persons. Penicillin therapy was first tested and tentatively evaluated at these special treatment centres.

Finally, to ensure the protection of the civilian population against diseases introduced by the returning Servicemen, all American Servicemen were again examined and tested before demobilization, the civilian health departments assuming responsibility for treatment of those found infected on demobilization.

In retrospect, our experience during World War II seems to indicate at least a possibility that venereal disease control can be furthered instead of frustrated by certain types of migration under government control.

In the post-war period, no further mass movements were observed in the United States, though this did not mean that the aggregate mobility of people diminished; in fact, it was observed that the mobility experienced in wartime served as an impetus to

FIG. 2.—Residence of sex contacts reported by infected soldiers in third service command, 1942, showing numbers from each state.

mobility in time of peace. With increasing post-war prosperity, the trend became more pronounced.

The population mobility is reflected not only in terms of people moving, and we know that about 30 million Americans move each year, but also in terms of leisure travel. In 1956, Americans in their leisure time travelled over 33 billion miles in their own private cars, which is the means of transportation in about 85 per cent. of leisure travel in the United States. The volume of travel has actually doubled since 1941, and has increased more than 20-fold since the early 1920s. This continuing upward trend has been attributed to larger incomes, longer vacations, and improved transportation and travel facilities.

This, indeed, is a more difficult movement of people for a venereal disease control programme to cope with than the regulated movement of soldiers in war-time. However, the experience gained in World War II in mass testing and contact tracing was effectively applied to venereal disease control during this post-war period in the United States (Fig. 3).

You may be interested in some of the specific facets of civilian migration in the United States. Of these, perhaps, the largest is the slow continuous movement of people to the big metropolitan areas. This population movement, which had started several decades ago, was accelerated by World War II in the late 1940s and the early 1950s. It involves people from all socio-economic strata moving simultaneously in many directions; there is, for example, the westward movement to California by all socio-economic groups largely from the Midwest, the movement of the Southern Negro to industrial cities in the North and

West, movement from the farms to urban employment, and Puerto Ricans migrating to New York City.

The recipient cities keep a close surveillance on venereal diseases, and tailor their health services to the aggregate result of these movements, and at the same time, in many rural areas and small cities there has been a downward trend in the number of clinics, clinic sessions, and scheduled clinic hours (Donohue, 1959).

Although these slow continuous movements create venereal disease problems in some areas, there is usually adequate time for the affected areas to strengthen their control programmes and keep abreast with events.

A second major movement arises from the seasonal flow of domestic migrant labour throughout the country, especially during the summer months. These workers travel on many different circuits from state to state (U.S. Public Health Service, 1957). Fig. 4 (opposite) shows how they travel to every corner of the United States to harvest and process such diverse agricultural crops as sugar beet in Michigan, Colorado, and California, vegetables for canning in California and Wisconsin, cotton from the Mississippi Delta to the Pacific Coast, truck crops for the fresh market of the Eastern and Western Seaboard and Rio Grande Valley, and fruit crops from Florida to California. On many of these circuits, the workers have a tight schedule from state to state, arriving at each destination just as the crop is ready to be harvested and moving on to the next state and crop as soon as their work is completed (Fig. 5, opposite).

FIG. 3.—Reported annual number of cases of primary and secondary syphilis in the U.S.A., 1950–1959.

FIG. 4.—Travel patterns of domestic migratory agricultural workers in the U.S.A.

FIG. 5.—Field testing station for migratory agricultural workers.

In many state venereal disease control programmes these workers are tested in the field, and if reactive, diagnosed and treated in the next few days before going on to harvest a crop in another state. These programmes have been very helpful in case-finding and have occasionally prevented an epidemic spreading through the group. Other migrant labour circuits, including fishermen, oyster shuckers, resort employees, racetrack workers, entertainers, construction gangs, musicians, and carnival workers, are also

tested periodically and followed rapidly before the workers leave the area (Fig. 6).

Superimposed on these continuous and seasonal migrant movements are all short-time sojourners like the travelling businessmen, holiday makers, construction workers, and truck drivers.

In 1953, a study of the sex contacts of venereal disease patients indicated that, on the average, 14 per cent. of all sex contacts named by a patient lived in another state (V.D. Branch, unpublished). Rapid

FIG. 6.—Testing a seaman at the docks.

contact-tracing by a trained corps of paramedical investigators and a fast contact report referral network, frequently enables contacts to be brought to examination in 24 hours, and even in cities a 1,000 miles away they may be traced within a few days. A standard epidemiological report form and interstate routing system for exchanging such reports accelerates the exchange of contact information between states. Contact information of infectious syphilis patients are transmitted immediately by telegram to other health departments to speed up diagnosis and treatment and to minimize any possible spread as a result of rapid mobility.

In addition to interstate and interurban mobility, there is an almost unbelievable block-to-block mobility within certain sectors of the urban environment, where the population may have as its only semi-constant address a telephone number in a tavern. Although members of this group usually sleep within four walls, they are essentially homeless.

It is clear then that migration plays a large and continued role in shaping a venereal disease programme, and that an intimate knowledge of the mobility habits of the groups at risk is fundamental to it.

I will now turn to the question of international as opposed to internal mobility. In years past, immigrants to the United States, merchant seamen, and returning military personnel have been the means of introducing disease from foreign sources. These groups were subject to more or less close medical supervision, and could be well screened. But the increased tempo of travel, relaxation of travel restrictions, and development of travel-now, pay-later credit plans, have made international travel more accessible to increasing numbers of Americans. In fact, almost a million Americans will visit foreign countries in 1959, of whom about half will go to Europe; this figure does not include millions of visits to Canada and Mexico, where Americans do not need a passport for crossing the border. Certain immunizations may be required but no other medical supervision is imposed on the American traveller. We are not concerned only with the American traveller bringing a venereal infection home to the United States, but also with those who may take disease out of the country.

In addition, people from other countries are now visiting the United States in increasing numbers for the first time since World War II. As international travel increases, international control measures will become more and more important. Just as we had difficulty in the transmission of epidemiological information from one *state* to another, we shall have even more difficulty in arranging for the *international*

transmission of this information. This has, however, been facilitated by a standard form, developed by the Pan-American Health Organization, printed in three languages (Fig. 7, overleaf). This form is routed directly from the health department of one country to that of the other using the language of the recipient country. Simple instructions for preparing and routing the form are given as well as a three-language glossary of terms (Pan-American Sanitary Bureau, 1956).

At the present time, we attempt to transmit contact information to many countries outside North and South America, but the procedure for doing this for civilians is at best cumbersome and ill-defined. The military services have established liaison with various countries and apparently experience little difficulty in many areas of the world in transmitting such information locally. For example, in 1951, the United States Navy transmitted epidemiological information on some 23,000 foreign civilian contacts to nations all over the world, and these nations reported back to the Navy the action taken on 90 per cent. of these reports (V.D. Branch, unpublished).

As the incidence of syphilis decreases to the point where mass or routine serological screening becomes impractical, and as the volume of international travel continues to increase, it will become more and more necessary to identify foci of infection through transmitting contact information in all parts of the world.

In closing, I should like to tell you about a problem which existed on the southern border of the United States. The solution, which was worked out co-operatively by the Mexican Ministry of Health and Welfare and the United States Public Health Service, turned out to be a decided asset to both nations (Smith, Stuart, and Watson, 1958). Fig. 8 (overleaf) shows the five points of entry of Mexican workers and three of the major migratory centres in Mexico (Robinson, 1958). Some 4 to 5 hundred thousand Mexicans enter the United States each year for the purpose of performing the seasonal tasks of crop harvesting. After entering the United States, the Mexican agricultural workers follow roughly the same routes as the domestic agricultural workers shown in Fig. 4.

The migrants start work in the southern part of the country and fan out to the north and east as the various crops ripen. Before 1956, physical examinations were given to these workers at the migratory centres south of the border and also at the reception centre on the American side of the border. But because of organization and financial difficulties, no serological tests were performed and workers without evident clinical symptoms of venereal disease were allowed to enter the United States. During a 2-month

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Fig. 7.—INTER-AMERICAN NOTIFICATION OF A VENEREAL DISEASE CONTACT

CONTACT'S LAST NAME		GIVEN NAMES		(And Nicknames)		CONTACT'S COMPLETE ADDRESS (Include State or its equivalent and Country)	
DATE REPORTED	AGE	COLOR OR RACE	SEX	MARITAL STATUS		OTHER IDENTIFYING AND LOCATING INFORMATION (As Speech, Teeth, Physical defects, Place and hours of employment, Hang-outs, Friends, Relatives, etc., be Specific)	
			M ☐ F ☐ S ☐ M ☐ W ☐ D ☐ Sep. ☐ Unk. ☐				
HEIGHT	SIZE	HAIR (Color, Style)	COMPLEXION (Skin color)	OCCUPATION			
DATE OF LAST EXPOSURE		PLACE OF EXPOSURE (Establishment Name and Address)					
PLACE (And Hour) OF ENCOUNTER							
CONTACT REPORTED BY PATIENT WITH: Gonorrhea Syphilis Other VD ☐ ☐ Stage ☐ Specify						PATIENT No.	
CONTACT'S RELATION TO PATIENT ☐ Wife or ☐ Husband ☐ Friend ☐ Other ☐ Specify						INTERVIEWER'S NAME	
REPORTING AGENCY (Complete Name)						USE REVERSE SIDE OF FIRST COPY FOR DRAWING A MAP IF HELPFUL (Mailing Address to Which Completed Disposition is to be Sent)	

INVESTIGATING AGENCY		DISPOSITION		DATE OF DISPOSITION		INVESTIGATOR	
IF INFECTED ENTER DISEASE AND STAGE IN APPROPRIATE BOXES BELOW				IF NOT INFECTED OR DIAGNOSIS NOT ESTABLISHED, CHECK BELOW			
ACTION TAKEN		DISEASE		STAGE		LOCATED—UNCOOPERATIVE—NOT EXAMINED	
BROUGHT TO TREATMENT (Previously Untreated This Infection)						NOT INFECTED	
RETURNED TO TREATMENT (Previously Treated This Infection)						CANNOT LOCATE—REASON:	
UNDER TREATMENT						MOVED (If Known Enter New Address On Reverse Side)	
ALREADY TREATED						INSUFFICIENT INFORMATION TO BEGIN INVESTIGATION	
REFUSED TREATMENT						EPIDEMIOLOGIC TREATMENT—SYPHILIS	
OTHER (Specify)						EPIDEMIOLOGIC TREATMENT—GONORRHEA	
						OTHER (Specify)	

NOM DU SUJET—CONTACT		PRENOM		(SURNOM)		ADRESSE COMPLETE DU SUJET—CONTACT (Y compris l'Etat, la Province ou leur équivalent dans le Pays)	
DATE DU RAPPORT	AGE	COULEUR OU RACE	SEXE	ETAT-CIVIL		AUTRES RENSEIGNEMENTS PERMETTANT D'IDENTIFIER ET DE LOCALISER LA PERSONNE (Indications précises sur: façon de parler, denture, défauts corporels, lieu et heures de travail, place habituelle, amis, parents, etc.)	
			M ☐ F ☐ C ☐ M ☐ V ☐ D ☐ Sép. ☐ Inc. ☐				
TAILLE	POIDS OU CORPULANCE	CHEVEUX (Couleur et forme)	PEAU (couleur de la peau)	OCCUPATION			
DATE DU DERNIER CONTACT		LIEU DU CONTACT (Nom et adresse de l'établissement)					
LIEU (et heure) DE LA RENCONTRE							
CONTACT NOTIFIE PAR UN INDIVIDU SOUFFRANT DE: Blennorragie Syphilis Autre maladie Vénérienne ☐ ☐ Période ☐ Veuillez préciser						No. DU PATIENT	
RELATION EXISTANT ENTRE LE SUJET—CONTACT ET LE PATIENT: ☐ Epoux(se) ☐ Ami(e) ☐ Autre ☐ Veuillez préciser						NOM DE L'INTERVIEWER	
BUREAU DE NOTIFICATION (Nom complet)						AU BESOIN DÉSSEINEZ UNE CARTE AU VERSO ADRESSE OU L'ON PEUT TRANSMETTRE LE RESULTAT DE L'ENQUETE	

BUREAU ENQUETEUR		RESULTAT DE L'ENQUETE		DATE		ENQUETEUR	
CONTACT INFECTE (Consignez la maladie et sa période sous la rubrique appropriée)				CONTACT NON INFECTE OU DIAGNOSTIC NON ETABLI (Indiquez ci-dessous)			
MESURES PRISES		MALADIE		PERIODE		PERSONNE LOCALISEE—Refuse de coopérer—Elle n'a pas été examinée	
MIS EN TRAITEMENT (Pas de traitement antérieur pour cette infection)						IL OU ELLE N'EST PAS INFECTE(E)	
REPRISE DU TRAITEMENT (Préalablement traité pour cette infection)						IL OU ELLE NE PEUT ETRE LOCALISE(E)—MOTIF:	
EN TRAITEMENT						IL OU ELLE A DEMENAGE (Nouvelle adresse, si possible, au verso)	
DEJA TRAITE						INFORMATION INSUFFISANTE pour commencer l'enquête	
A REFUSE D'ETRE TRAITE						TRAITEMENT PROPHYLACTIQUE POUR SYPHILIS	
AUTRE (Veuillez préciser)						TRAITEMENT PROPHYLACTIQUE POUR BLENNORRAGIE	
						AUTRE (Veuillez préciser)	

Fig. 7.—INTER-AMERICAN NOTIFICATION OF A VENEREAL DISEASE CONTACT—*contd.*

APELLIDO DEL CONTACTO		NOMBRES DADOS		(Y Apodos)		DIRECCION COMPLETA DEL CONTACTO (Incluyendo Estado o su equivalente y País)	
FECHA NOTIFICADO	EDAD	COLOR O RAZA	SEXO M ☐ F ☐	ESTADO CIVIL S ☐ C ☐ V ☐ D ☐ Sep. Desc. ☐		OTRA INFORMACION PARA IDENTIFICACION Y LOCALIZACION (Como modo de hablar, dientes, defectos físicos, lugar y horas de trabajo, guaridas, amigos, parientes, etc., especifíquese)	
ESTATURA	PESO O COMPLEXION	CABELLO (Color y estilo)	CUTIS (Color de la piel)		Ocupacion		
FECHA DEL ULTIMO CONTACTO		LUGAR DEL CONTACTO (Nombre y Dirección del Establecimiento)					
LUGAR (y hora) DEL ENCUENTRO							
CONTACTO NOTIFICADO POR UN PACIENTE CON: Blenorragia ☐ Sífilis ☐ Período ☐ Otra Enf. Venérea ☐ Especifíquese ☐						No. DEL PACIENTE	
RELACION ENTRE CONTACTO Y PACIENTE OTRA ☐ Expos (a) ☐ Amigo (a) ☐ Especifíquese ☐						NOMBRE DEL ENTREVISTADOR	
OFICINA QUE NOTIFICA (NOMBRE COMPLETO)						SI ES UTIL DIBUJE UN MAPA EN EL REVERSO DE LA PRIMERA COPIA DIRECCION DONDE SE PUEDE MANDAR EL RESULTADO DE LA INVESTIGACION	

OFICINA INVESTIGADORA	RESULTADO DE LA INVESTIGACION	FECHA	INVESTIGADOR
SI INFECTADO (Escriba la enfermedad y período en las casillas apropiadas abajo)	CONTACTO NO INFECTADO O DIAGNOSTICO NO ESTABLECIDO (Márquese abajo)		
Accion Tomada	Enfermedad	Período	LOCALIZADO—NO COOPERATIVO—NO EXAMINADO
PUESTO BAJO TRATAMIENTO (Sin tratamiento previo para esta infección)			NO INFECTADO
PUESTO DE NUEVO BAJO TRATAMIENTO (Con tratamiento previo para esta infección)			NO SE PUDO LOCALIZAR—RAZON:
BAJO TRATAMIENTO			SE HA MUDADO (Si se sabe escríbase la dirección nueva en el reverso)
YA TRATADO			INFORMACION INSUFICIENTE PARA PRINCIPIAR LA INVESTIGACION
REHUSO TRATAMIENTO			TRATAMIENTO PROTECTIVO PARA SIFILIS
OTRA (Especifíquese)			TRATAMIENTO PROTECTIVO PARA BLENORRAGIA
			OTRA (Especifíquese)

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NOTIFICACION INTERAMERICANA DE UN CONTACTO DE ENFERMEDAD VENEREA

Fig. 8.—Entry routes of immigrant Mexican seasonal labourers.

period in the early autumn of 1956, serological tests were given to workers passing through two of the reception centres on the United States side of the border; 115,000 workers were tested and 9,240 (8 per cent.) were found to be reactive to the V.D.R.L. test. But the workers remained in the reception centre only a few hours and, by the time the test results were available, had moved on to their place of work. By the time the form of initial assignment of the worker could be located and the positive test report transmitted, the worker had often moved to his next assignment. So it was that eventually only 77 per cent. of the reactors were located for final diagnosis and treatment. For those workers who could not be located in the United States, Pan-American Health Organization "suspect report" form, the standard form for reporting venereal disease suspects in the Americas which I mentioned and showed earlier, was completed and sent to the Mexican state health department having jurisdiction over the place of Mexican residence of the workers so that diagnosis could be completed when the workers returned home from the United States.

In addition to screening the Mexican workers, we also prepared suspect reports on 7,000 wives of men

with reactive tests and transmitted them to Mexico for action. According to reports returned to the United States after completion of disposition, 20 per cent. of the wives examined were put under treatment for syphilis.

Although the testing of Mexican workers in 1956 was a good start, the case-finding problems caused by the delay in obtaining serological results made it evident that a rapid on-the-spot test for syphilis had to be developed before any further progress could be made. A simple rapid test was developed by the Venereal Disease Experimental Laboratory of the U.S. Public Health Service and was put into use in 1957. The test, known as the Rapid Plasma Reagin (RPR) test (Portnoy, Garson, and Smith, 1957), compares favourably in sensitivity and specificity with other standard tests for syphilis.

In 1957 and 1958, this new test was used for 395,500 migrant workers on their arrival at the reception centres. Diagnosis and treatment, if indicated, was completed during the few hours the worker was in the reception centre, and approximately 27,200 of the workers (6.9 per cent.) were diagnosed and treated for syphilis in this way (V.D. Branch, unpublished).

The RPR test was developed to expedite the Mexican border testing programme, but after the test had been developed, we found that we had a new tool which is useful in our domestic programme, in many situations where standard serological testing is too slow. Itinerants who have only a few hours to stay in a given place lend themselves to RPR testing. Any suspects or contacts among the homeless persons mentioned above might be candidates for the RPR test when they are located. This rapid test has also proved effective in the serological screening of domestic migrant workers and of persons detained in jail for a few hours on minor charges.

Summary

Although population mobility has caused problems in V.D. control, the problems have not been insurmountable and have usually been turned into control aids. Mobilization in World War II provided a tremendous opportunity for the serological screening of all the males in the nation between the ages of 18 and 44, so that hundreds of thousands of cases were found and treated. The extent and geographical distribution of the problem was determined, and the

techniques learned were successfully used in civilian control programmes in the post-war era.

Similar developments in efficient and methodical case-finding have sprung from the serological screening of the thousands of Mexican agricultural workers who migrate annually between Mexico and the United States.

Our experience shows that population movements should be viewed not so much as a hazard in the spread of venereal disease, nor as an insurmountable problem of control, but as opportunities which can be used to advantage in the control of venereal disease.

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Migration comme facteur dans les plans d'action antivenérienne aux Etats Unis

Résumé

Bien que les mouvements de population aient posé des problèmes à la lutte antivenérienne, les difficultés qu'ils engendraient ne furent pas insurmontables et on arriva même à en tirer avantage. La mobilisation pendant la deuxième guerre mondiale présenta une occasion magnifique pour faire des examens sérologiques chez tous les mâles de la nation âgés de 18 à 44 ans, de manière que des centaines de milliers de cas furent dépistés et traités. La magnitude et la distribution géographique du problème furent déterminées et les méthodes ainsi apprises furent incorporées avec succès aux plans de campagne civile après la guerre.

Des résultats similaires d'un dépistage efficace et méthodique furent obtenus en conséquence des examens sérologiques des milliers de travailleurs mexicains migrant tous les ans entre Le Mexique et les Etats Unis.

Notre expérience montre qu'on ne doit pas regarder un mouvement de population comme un péril dans la propagation des maladies vénériennes, ou un obstacle insurmontable aux tentatives de les contenir, mais comme une occasion dont on peut profiter dans la lutte antivenérienne.