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 conquer, 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.

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 reassigned 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).

![Map of Selectee syphilis rates per 1,000 in the U.S.A. in the second world war, 1942, by state.](http://sti.bmj.com/)

**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

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**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 removing, 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).
MIGRATION AS A FACTOR IN V.D. PROGRAMMES IN U.S.A.

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
contact-tracing by a trained corps of paramedical
investigators and a fast contact report referral net-
work, 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 treat-
ment 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 mobi-
ity 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 pro-
gramme, 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, immi-
grants 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 re-
lictions, 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 infor-
mation 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 trans-
mitting 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
collaboratively 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 examina-
tions 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**

#### CONTACTS LAST NAME | GIVEN NAMES | CONTACTS COMPLETE ADDRESS (Include State or its equivalent and Country)
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<table>
<thead>
<tr>
<th>DATE REPORTED</th>
<th>AGE</th>
<th>COLOR OR RACE</th>
<th>SEX</th>
<th>MARITAL STATUS</th>
<th>COMPLEXION</th>
<th>OCCUPATION</th>
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<th>SIZE</th>
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<th>DATE OF LAST EXPOSURE</th>
<th>PLACE OF EXPOSURE (Establishment Name and Address)</th>
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<tr>
<th>PLACE (And Hour) OF ENCOUNTER</th>
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<tr>
<th>CONTACT REPORTED BY PATIENT WITH:</th>
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<tr>
<td>Gonorrhea Syphilis</td>
<td>Other YD</td>
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<tr>
<th>CONTACT'S RELATION TO PATIENT</th>
<th>INTERVIEWER'S NAME</th>
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<tbody>
<tr>
<td>Husband</td>
<td>Friend</td>
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<table>
<thead>
<tr>
<th>REPORTING AGENCY</th>
<th>Complete Name (And Nicknames)</th>
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#### DISPOSITION

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<th>REPORTING AGENCY</th>
<th>INVESTIGATOR</th>
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<tr>
<th>IF INFECTED ENTER DISEASE AND STAGE IN APPROPRIATE BOXES BELOW</th>
<th>IF NOT INFECTED OR DIAGNOSIS NOT ESTABLISHED, CHECK BELOW</th>
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<tr>
<th>ACTION TAKEN</th>
<th>DISEASE</th>
<th>STAGE</th>
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<tbody>
<tr>
<td>Brought to Treatment (Previously Untreated this Infection)</td>
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<tr>
<th>Returned to Treatment (Previously Treated this Infection)</th>
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<th>Under Treatment</th>
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<th>Already Treated</th>
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<th>Other (Specify)</th>
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#### NOM DU SUJET—CONTACT

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<thead>
<tr>
<th>Prénom</th>
<th>SURNOM</th>
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| ADRESSE COMPLÈTE DU SUJET—CONTACT (Y compris l’État, la Province ou leur équivalent dans le Pays) |

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<th>POIDS OU CORPS-LÈNCE</th>
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<th>PEAU (Couleur de la peau)</th>
<th>OCCUPATION</th>
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<th>LIEU DU CONTACT (Nom et adresse de l’établissement)</th>
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<th>LIEU (et heure) DE LA RENCONTRE</th>
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<tr>
<th>CONTACT NOSIE PAR UN INDIVIDU SOUFFRANT DE:</th>
<th>No. DU PATIENT</th>
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<tbody>
<tr>
<td>Borneragia Syphilis</td>
<td>Autre maladie Vénérienne</td>
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<th>NOM DE L’INTERVIEWER</th>
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<th>RESULTAT DE L’ENQUETE</th>
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<th>MALADIE</th>
<th>PÉRIODE</th>
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<tr>
<th>IL OU ELLE HÔT PAS INFECTE(E)</th>
<th>IL OU ELLE NE PEUT ETRE LOCALISE(E)—MOTIF:</th>
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<tr>
<th>TRAITEMENT PROPHYLACTIQUE POUR SYphilis</th>
<th>TRAITEMENT PROPHYLACTIQUE POUR BLENNORRAGIE</th>
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<th>AUTRE (Veuillez préciser)</th>
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**AUTRES RENSEIGNEMENTS PERMETTANT D’IDENTIFIER ET DE LOCALISER LA PERSONNE (Indications précises sur: façon de parler, denture, défectuosités corporelles, lieu et heures de travail, place habituelle, amis, parents, etc.)**

**AU BESOIN DESSINEZ UNE CARTE AU VERSO**

**ADRESSE OU L’ON PEUET TRANSMETTRE LE RESULTAT DE L’ENQUETE**
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 farm 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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Veneral Disease Branch, Communicable Disease Center. Unpublished data.


**Migration comme facteur dans les plans d’action antivénérienne aux Etats Unis**

**Résumé**

Bien que les mouvements de population aient posé des problèmes à la lutte antivénérienne, les difficultés qu’ils engendraient ne furent pas insurmontables et on arriva même à en tirer avantage. La mobilisation pendant la deuxième guerre mondiale présente 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 antivénérienne.
Migration as a Factor in V.D. Programmes in the U.S.A

William J. Brown

Br J Vener Dis 1960 36: 49-58
doi: 10.1136/sti.36.1.49

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