United States-Mexico Border Public Health Association

Asociación Fronteriza Mexicana-Estadounidense de Salubridad

The active sharing of experiences, knowledge, and ideas, each year enriching the partnership between the United States and Mexico for better health along the border, was continued this year at the 16th annual meeting of the United States-Mexico Border Public Health Association in El Paso, Tex., and Juárez, Chihuahua. From April 7 through 11, 1958, the discussions took stock of progress, drew patterns for future action, and reviewed pioneering techniques. Presiding over this year's meeting was Dr. Malcolm Merrill, director of the State of California Department of Public Health. The President-elect is Alberto Ortiz Irigoyen, director of Potable Water Construction in the Mexican Ministry of Hydraulic Resources. Summaries of selected papers presented at the meeting appear on the following pages.

International Health Aims Translated Into Action

As chairman of one session of the U. S.-Mexico Border Public Health Association meeting in El Paso, Dr. David E. Price, Assistant Surgeon General of the Public Health Service, commended the work of border cities in developing water and sewage facilities, work carried out with aid from the International Boundary and Water Commission and the Mexican Government's *Recursos Hidraulicos*. Specifically, he mentioned sewage facilities in Douglas, Ariz., and Agua Prieta, Sonora, and in the sister cities of Nogales.

Price also paid tribute to the Mexican Ministry of Health and Welfare for its impressive malaria eradication campaign.

Among examples of contributions to border health programs made by the Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization, Price cited the multilingual venereal disease reporting form for international exchange of information on contacts, which is now being adapted for domestic use throughout Mexico and the United States. Together with United States Federal, State, and local health agencies, the bureau is also seeking the optimum means of reporting tuberculosis suspects found through the border X-ray program.

Turning to activities of the United States Indian health program with bearing on border health, he sketched briefly the confused citizenship and residence pattern of the Papagos, almost all of whom have relatives and therefore frequent contacts across the border. Tra-

choma, diarrhea, dysentery, the communicable diseases of childhood, and impetigo are the current challenges among these people, he said, suggesting that exploratory conversations between officials of the Division of Indian Health of the U. S. Public Health Service and their Mexican colleagues might produce improved coordination in work for such tribes.

Another activity he touched on was the study carried out jointly by the Communicable Disease Center, Public Health Service, the Mexican Ministry of Health, PASB, and border States on insectivorous bats, which on occasion infect man. A station has been set up by the Service in Las Cruces, N. Mex., to unravel the puzzling epidemiology of rabies among these bats, of which the Mexican freetailed bat is the predominant species.

He also mentioned Communicable Disease Center studies and demonstrations in enteric disease vector control, coccidioidomycosis, and encephalitis, as well as training programs.

Price concluded with remarks on the international ramifications of research at the National Institutes of Health of the Public Health Service. There are several Mexican participants in the current program, but he wondered whether those most concerned with border health were fully utilizing grant resources. He affirmed the great interest of the Public Health Service in the border area, where, he feels, the philosophy of international health is translated into action.

Urges More Casefinding For Congenital Syphilis

Discussing the methods of finding cases of syphilis among pregnant women, Dr. Edith P. Sappington, regional medical director for the Children's Bureau, San Francisco, Calif., declared that all too many women receive no prenatal care until the second or third trimester. Moreover, though most hospitals give serologic tests for syphilis on all admissions, the cases found are either lost or followed with difficulty because low-income mothers stay in the hospital so briefly.

She advocated wider application of a second test for pregnant women during the third trimester, at least where there is a high prevalence of syphilis, referring to the suggestion that certain patients, such as those in lower socioeconomic groups, unwed mothers, and welfare hospital patients, should have two or more tests during pregnancy.

To bolster casefinding during the infant and preschool period, Sappington suggested that hospital records of mothers of children entering child health conferences be checked for evidence of serologic tests for syphilis. Mothers delivered by midwives might be routinely tested at the conferences. Though laborious, these methods she feels are justified, since congenital syphilis has not decreased in the past 2 years.

Maternal and child health programs also could incorporate such testing into school physical examinations, she added.

Sappington also pointed to the desirability of integrated health care for all members of a family. If all went to a single physician or clinic, congenital syphilis would not easily escape detection.

Reviews Clinical Aspects Of Congenital Syphilis

During the past 12 years, the cases of congenital syphilis reported annually in the United States have fallen only by 50 percent, compared with a drop of more than 90 percent in acquired early syphilis. This was pointed out by Dr. Willie G. Simpson, assistant chief, Venereal Disease Branch, Communicable Disease Center, Public Health Service, Atlanta, Ga., who feels that the current incidence of congenital syphilis is excessive in the light of the availability of penicillin.

Simpson described the clinical aspects of congenital syphilis in considerable detail. In his comments, he mentioned:

- In the early stages of congenital syphilis, demonstrable lesions may be absent, but they usually appear in the first 2 to 3 months of life if not already present at birth. Bone changes occur within the first 6 weeks, compared with scurvy changes after 6 months, and rachitic changes between the 8th and 18th months.
- In diagnosing asymptomatic congenital syphilis in the newborn, only an increasing titer and positive serology at 3 months of age are significant. Before then, reagin found in serology tests may be from the mother. Conversely, infants with negative serology but diseased mothers should be followed up for at least 3 months. Syphilis may be suspected at birth if the serology report shows a higher titer than for the mother at the time.
- Since adults with the congenital disease will be seropositive long after treatment, retreatment should be based on definite signs of relapse.
- A higher rate of seronegativity is attained in those treated during the first year of life, than in those treated later, regardless of the amount of penicillin given above the minimum adequate dosage. The patterns of response resemble those for treatment of acquired early syphilis and during latency after 2 years of infection respectively.
- Treponemal antigen tests are valuable in cases of clinically suspected congenital syphilis with reactive or nonreactive reagin tests.

VD Control Intensified In Bracero Home Areas

In the home states of most of the braceros, the Mexican Ministry of Health and Welfare has broadened efforts to gather venereal disease data, to test prospective agricultural migrant workers serologically, and to treat those infected.

Other aspects of the Mexican Government's drive against venereal disease described by Dr. Antonio Campos Salas, chief of the Ministry's campaign against venereal diseases, have also been expanded. In spite of a general downward trend in syphilis mortality and morbidity in Mexico since 1948, he said,

the disease was fifth among registered communicable diseases in 1957. He also pointed out that there were considerable numbers of recently infected as well as untreated persons and some cases with high indexes of positive serology.

The great majority of cases of venereal disease in Mexico are latent, he asserted. For that reason, serologic test laboratories and equipment have been augmented. Measures have also been taken to standardize and coordinate serologic test reports from all sources, and to make VDRL antigens available to all national laboratories. Training, briefing, and specialized instruction for the venereal disease campaign have been emphasized for personnel of medical agencies and institutions, private physicians, and community leaders, on whom the Ministry depends heavily in this drive.

As a public education device supplementing posters, pamphlets, and lectures, a film was produced in color and exhibited in leading cities. Campos Salas remarked on the growing facility in organizing public meetings for campaign purposes.

Venereal Disease Control Progress Report

In presenting the United States program in venereal disease control, Dr. William J. Brown, chief of the Venereal Disease Branch, Public Health Service, reported that in the United States the rate for syphilis has dropped from 447 to 81 per 100,000 population since 1943, the year penicillin came into use.

Although institutional care of the syphilitic insane still costs an estimated $46 million a year, over a 10-year period first admissions of such patients have dropped from 7,000 to 2,150 annually.

In the past 6 years, an increasing number of States have been reporting more early syphilis. Reported cases of primary and secondary syphilis are 11 percent higher this year than last. Gonorrhea rates, at the same time, have shown little change. An alarming percentage of venereal disease is being found in young people. Many infectious disease cases treated by private physicians are not being interviewed for sex contacts.

Brown reviewed the following current developments:

- Rapid plasma reagin test is revolutionizing the testing of migrant laborers. Immediate diagnosis and treatment prevents spread of infection and returns the once infected person to work without delay.
- Reiter protein complement fixation test, a specific treponemal test for diagnosticians, promises important savings in costs.
- Fluorescent antibody tests for both syphilis and gonorrhea may eventually provide rapid and inexpensive methods of detection.
- A casefinding procedure called "cluster testing" covering friends and associates of infected persons as well as sexual contacts may double the epidemiological yield.
- The training of 1,500 public health workers in 1957 by the Public Health Service is promoting more effective interviewing techniques.
- Epidemiological services to patients of private physicians have been demonstrated as a practical control measure and are being extended to many areas.
- A uniform report form for reporting venereal disease contacts and suspects in the United States has been developed, and many State health departments are considering its adoption in the interest of standardization of interstate routing of the forms.

New Mexico Aims To Stop Primary VD Infection

During the first quarter of 1958, accelerated casefinding in New Mexico was a factor in a 193 percent rise in reported syphilis and a 166 percent increase in reported gonorrhea, over the same period in 1957, according to members of the New Mexico Department of Public Health: Dr. Arthur D'Jang, director of the division of chronic disease, Dawson T. Kilcrease, health program representative in the division of venereal disease, Marion McBreen, associate bacteriologist, public health laboratory, and Dr. Stanley J. Leland, State director.

The effectiveness of the State's program, they said, is indicated by the rate of first admissions to State mental hospitals for all psychoses due to syphilis in 1955: it was 0.7 per 100,000 population, lower than the mean rate for continental United States.

Program Highlights

A confidential survey of physicians in New Mexico conducted in October 1957 revealed 640 more cases of venereal disease than were obtained from morbidity reports in the first 6 months of 1957. To stimulate reporting, the department devised a private physician's information packet with suggested treatment schedules, health education materials, evaluation of serologic reactions, and an interpretation of the new treponemal tests. Also offered was medicine for the physician's indigent patients.

Besides following up about 85 percent of the reported reactive serologic tests for syphilis and investigating 97.6 percent of reactors among braceros, the department trained several Navajo Indians and employed them as venereal disease investigators. Although Indians represent 5 percent of the people in the State, they contributed about 50 percent of the morbidity from venereal disease in 1957. In a survey including inmates of 4 prisons in the Navajo training experimental health district, a total of 2,129 serologic tests were made from June 1957 through February 1958. Navajos accounted for 96 percent of those tested. In the Navajo group, 10.1 percent were reactors, compared with 7.1 for the others.

Serologic Test Laws

Premarital serologic tests are required by a law passed in May 1957 in New Mexico, they said. Another law approved in 1949 requires all pregnant women to be tested for syphilis before delivery.

A serologic test is incorporated in a multiphasic survey among school and college students and teachers

and among industrial workers. During a migrant survey in 1957, a mobile unit with laboratory facilities was used, and another unit added in 1958 provided medical facilities for sparse population areas.

Three more programs were begun during 1957–58: the rapid plasma reagin test, the unheated serum reagin test, and the mass Frei skin test.

In reviewing phases of the control program, D'Jang and associates drew attention to the emphasis on primary prevention of venereal diseases, through health and sex education in schools and clubs; prophylaxis instruction in defense installations; provision of recreational facilities; and suppression of prostitution. They underlined the value of facilities for early diagnosis and treatment, believing that the cooperation of the public rests not only on mass education about symptoms and modes of spread but on the availability of diagnosis and treatment facilities without respect to the infected patient's economic status.

Los Angeles District Surveyed for MCH Needs

Two maternal and child health surveys carried out in the Northeast Health District of Los Angeles, Calif., during 1956 were reported by Dr. Stella B. Soroker, district health officer, and Thelma Herold, health educator, Los Angeles City Health Department.

Health problems in Boyle and Lincoln Heights, the survey sites, resemble those on the border, they explained. These sections have more residents of Mexican origin or descent than any border city. The northeastern area, moreover, is a port of entry for Mexican arrivals.

Citing statistics depicting needs of these areas, especially with respect to infant mortality, they said that, because of extraordinary mobility of the population, newcomers are often unaware of local health resources. During 1955 one-third of the prenatal cases and one-half of the newborn received some health department supervision. The MCH surveys sought to determine the gaps in health care for those unreached and reasons for the gaps.

Boyle Heights Survey

With volunteers from local societies, a hospital, and a junior college, the department began interviewing 500 to 600 Boyle Heights families with babies born during February through April 1955.

The interviewers found that of 232 families reached out of 662 families with children born a year before, 66 percent knew of MCH facilities and 87 percent of the mothers had received prenatal care. No protection against diphtheria, whooping cough, and tetanus was given to 22 percent of the 1-year-old population; 35 percent were not vaccinated against smallpox; and 9 percent had no health supervision. Sixty-eight percent of the families interviewed knew of services and locations of well-baby clinics.

Among reasons for not seeking protection from childhood diseases were lack of information as to the need or availability of services, indifference, and parental fear.

It was also ascertained that by 1 year of age, respiratory diseases accounted for 40 percent of conditions needing medical care, and accidents, 11 percent.

The health department recommended intensifying efforts to reach newcomers through publicity, nursing visits, and civic and religious organizations, stressing accident prevention among younger age groups, and conducting Red Cross classes for expectant parents.

Lincoln Heights Survey

In Lincoln Heights, they said, a newly formed committee of community leaders, PTA delegates, and professional persons, aided by volunteer residents, interviewed 275 families with children between 2 and 5 years old. Sampling required visiting 15 out of 100 households.

Applying the findings to the approximate total of 3,000 preschool children in the area, they estimated that 82 percent are protected against diphtheria, whooping cough, and tetanus, 71 percent against smallpox, and 48 percent against poliomyelitis. Sixty-nine percent of the families knew about the well-baby clinics, and the reasons for not seeking protective services matched those in Boyle Heights.

Outlines Health Agency Role In Chronic Disease Battle

Advances to be made in long-term patient care, in the opinion of Dr. Wilfred D. David, chief of Program Services, Chronic Disease Program, Public Health Service, will be closely bound up with progress in public health, medical care, and in developing adequate hospital facilities.

Prevention of certain diseases, he said, is the proper direction for many programs related to chronic ills and health needs of the aged. He remarked that preventive action is now possible for more than 50 chronic diseases. Preventive programs can stop or slow a disease's progress by early detection and early therapy, and can soften the economic and social effects of the disease for patient, family, and community.

He emphasized that these programs must be started by community initiative, be part of the total community health drive, and be spurred by health agency aid.

Types of activities of the Public Health Service in support of State and local programs named were training, consultation, dissemination of information, demonstrations, and technical assistance as well as regional seminars.

David suggested the following fields for community action: diabetes casefinding with referral for diagnosis, the techniques of which have been refined; diabetes patient instruction on diet, self-administration of insulin, and personal hygiene; glaucoma screening through tonometry performed by an ophthalmologist, with referral arrangements; restorative services for patients with cerebral vascular accidents; and improvement of nursing home facilities through consultation

and training of nursing home operators and aides.

In conclusion, he reported that many States have initiated new services for the aged and chronically ill through appropriations voted by Congress for that purpose in 1957.

About 30 percent of the population of the United States is 45 years of age or over, he noted, and 40 percent of the chronically ill are 65 years of age or more.

Isoniazid Reduces TB In Children

A year's work by the Public Health Service investigating the effect of isoniazid on 2,700 children with primary tuberculosis in the United States, Puerto Rico, Mexico, and Canada has presented physicians with a new method for control of this disease.

Dr. Edward T. Blomquist, chief of the Tuberculosis Program, Public Health Service, reported that among the children who have been taking isoniazid, the major complications of childhood tuberculosis have been practically eliminated. He advocated small daily doses of isoniazid for a year for infants who are tuberculin positive and those between 1 and 4 years old with X-ray evidence of the disease.

Another branch of the study will measure the prophylactic potential of isoniazid among older persons who, although not now exposed to tuberculosis, were infected in childhood. Evidence is accumulating, Blomquist said, that most new cases of clinical tuberculosis appear to occur among persons with subclinical infection which becomes active during stress or lowered resistance.

Care and supervision of nonhospitalized tuberculous patients must be expanded and strengthened by health departments, he feels, to meet the shift in emphasis from institutional to home care for tuberculosis patients. Health agencies, with their responsibility to protect the public from the disease, can do so by keeping active cases under care until noninfectious, with broadened clinical and nursing services, and by keeping information on nonhospitalized patients current. Their program, he concluded, must include diagnostic, treatment, and social services, as well as public health supervision.

Home TB Care Boon To Low-Budget Lands

For countries without ample means, ambulatory home care of tuberculosis patients, instead of hospital treatment, has opened up new horizons, stated Dr. Donato G. Alarcón, chief of the campaign against tuberculosis, Ministry of Health and Welfare, Mexico.

Together with modern medication, this therapy allows such countries to undertake broad campaigns against tuberculosis without dependence upon related social and economic factors. Mexico's mortality rate from tuberculosis, he said, has dropped from 69 per 100,000 population in 1930 to 38.

Describing the antituberculosis campaign in Acapulco (population, 50,000) as a low-cost pilot project, Alarcón reviewed results of 2 years' work there: 1,025 cases of active tuberculosis were discovered; 57.3 percent of school children 6 to 12 years old were found to have positive tuberculin reactions; and during the first year of the campaign, negative concentration smears were obtained for 70 percent of tuberculosis cases.

In the opinion of Alarcón and Dr. Salvador Roquet Perez, secretary of the Ministry's campaign against tuberculosis, consistent recovery of tuberculosis patients depends more on their economic status, education, and attitude toward the disease than on hospital facilities. They attributed to social and economic factors the fact that in a previous study 65 percent of the ambulatory patients who received thoracoplasty and pneumothorax were classified as arrested and later cured. These results compared favorably with results for long-hospitalized patients elsewhere.

Although home ambulatory treatment for tuberculosis has been endorsed, there is still a hospital shortage in Mexico. They concluded with details of Mexico's plans for expansion of tuberculosis hospital space in Mexico City, San Fernando, Monterrey, Tampico, and Xaltianguis.

Bovine TB Hazard Still Looms

Although tuberculosis in cattle has been reduced to 0.156 percent in the United States, dangerous foci of the infection remain. Dr. Donald Miller, veterinarian in charge, Animal Disease Eradication Division, Agricultural Research Service, U. S. Department of Agriculture, Phoenix, Ariz., stated that, during fiscal year 1957, 28.9 percent of cattle reacting to the tuberculin test showed gross lesions.

Eradication in Border States

In discussing eradication of the disease on the border, he described as essential the vigorous tracing by epidemiological means of herds of origin when infection is found postmortem at regular kill in a packing house. For example, the recent tracing of the source of such a lesion in Texas ended in finding 40 reactors in a herd of 139.

During fiscal year 1957, Texas had 611 reactors of which 22.8 percent showed gross lesions. In New Mexico, with a consistently low level of infection, reaccreditation will be tried for 6 years instead of the usual 3. Miller explained that reaccreditation may be given when infection is under one-half of 1 percent of area cattle tested. Arizona also has low incidence, due, in his opinion, to such measures as testing all dairy and purebred cattle and 20 percent of all pastured beef cattle every 3 years.

For California, faced with nonspecific reactions in certain herds and areas, Federal and State officials have developed trial testing procedures using intradermic tests with mammalian and avian tuberculins and johnin; cervical, caudal, and ophthalmic tests; and careful epidemiological studies and complete postmortems.

National Figures

Nationally, fiscal year 1957 was the third straight year with a slight infection rise, Miller said. Among 8,976,409 tuberculin-tested cattle infection appeared in 13,974. Of 14,054 reactors slaughtered, 319 carcasses, or 2.3 percent, were condemned.

Miller alluded to the lack of veterinary personnel in eradication programs. "This is no time for the veterinarians, health officials, and cattle growers to leave the field because we have a comfortable lead" he said. According to Miller, if we slacken in eradicating bovine tuberculosis, the progress of 10 years will be erased.

A Look Backward

Roughly 10 percent of tuberculosis in humans is of bovine origin, according to a study cited by Dr. Robert D. Courter, assistant chief, Veterinary Public Health Section, Communicable Disease Center, Public Health Service. But in areas with heavily infected herds the percentage is as high as 50.

About 378 million tuberculin tests have been made in cattle since the program's inception 40 years ago. Then, the program's harm to agriculture was prophesied, and the communicability of bovine tuberculosis to humans doubted. In fact, Koch, discoverer of the tubercle bacillus, was unconvinced of the need for protection against consumption of food from infected cattle.

Since antiquity, Courter related, man's attitude toward the disease has fluctuated between abhorrence and indifference. Eighteenth century laws levied drastic penalties, including exile, on those who sold meat of tuberculous cattle. Tuberculosis was then believed identical with syphilis, but when it was understood that the two diseases were not the same, aversions to such meat faded.

In the nineteenth century, he continued, when the infectious nature of tuberculosis was recognized, German veterinarians advised farmers to dispose of tuberculous animals and to cook milk before feeding young animals, presaging pasteurization decades later.

The effects of pasteurization and the reduction in bovine tuberculosis in the United States elude easy evaluation, in Courter's opinion. A commonly used index of progress in eradicating the disease is the fall in deaths from extrapulmonary forms of tuberculosis in humans. Since the drop in mortality from the pulmonary form has paralleled that from the extrapulmonary, he feels that such an index fails to consider effects of improved social and economic conditions and control measures among humans.

Four Polio Vaccine Doses Recommended in Mexico

Based on field observations, modification of the standard dosage plan for administering poliomyelitis vaccine was suggested for use in Mexico by Dr. Carlos Calderón, Dr. Carlos Ortiz Mariotte, Dr. Adán Ornelas Hernandez, and Dr. Louis Gutíerrez Villegas of the Mexican Ministry of Health and Welfare.

In a program administering Salk-type vaccine, which was carried out by the Ministry from October 1956 to December 1957 on about 221,000 children aged 6 months to 3 years, more than half of the observed poliomyelitis cases among those injected had onset from 1 to 3 months after the second dose. This led to the proposal that a dose be added from 1 to 3 months after the second, and that the reactivation dose be given 7 months later.

They found that the attack rate for those not immunized was at least 3 times higher than for children vaccinated; and among those immunized, the attack rate was higher, the fewer doses received.

Another observation was that among 150 blood specimens taken from children under 5 years old, only 10 percent of those from children having 3 doses were without antibodies. One-third from those not immunized showed antibodies, one-fourth having titrations of 1:64 or more. These results suggest that the vaccine stimulates antibody formation.

The vaccine, they explained, is made in Mexico using 2 parts, instead of 1, of type 1 strain, isolated in practically all cases of acute poliomyelitis in Mexico. Instead of Salk strains, those attenuated by Sabin are used. Studies carried out on about 5,000 children in 3 districts of high prevalence in 1956 and 1957 had already indicated the children's tolerance to the vaccine as well as its effectiveness. Further studies are recommended to test vaccine made in Mexico from strains used by Salk, they said.

Study Burial of Refuse As Curb on Flies

Whether prompt burial effectively inhibits fly emergence from refuse, which during collection in warm weather already abounds in fly eggs and larvae, was the subject of studies carried out by the bureau of vector control, California State Department of Public Health.

Ralph J. Black, senior vector control specialist with the department, reported that laboratory tests during the summer of 1955 showed that fly emergence was prevented if the soil was compacted at or near the optimum moisture content, in layers varying from 1⅝ inches to 2¼ inches deep. Houseflies emerged through 60 inches of uncompacted earth.

Conclusions from these and subsequent field tests underlined as essential factors soil that can be compacted, adequate range of soil moisture, suitable equipment for compacting, and adequate enough thickness of cover. Generally, sand, nearly pure clay, silt, and crushed rock do not compact well enough to prevent fly emergence, he said. Field moisture content of soil is adequate if a solid clod can be formed by hand squeezing. A bulldozer was suitable for soil compaction with repeated tracking over the cover material. When applying the earth cover, tractor operators must compact side slopes as well as the top cover to prevent fly emergence.

He estimates that, under field conditions, a 6-inch layer of compacted earth cover should prevent fly emergence.

Fly emergency traps can be used to determine the required thickness of cover and the amount of compactive effort necessary for local conditions. When the covering soil is not compacted, he said, flies can be reduced by quickly covering the refuse with a thin cover of soil to prevent more fly oviposition.

Reporting Aids Suggested In Diarrhea Seminar

Morbidity data on diarrheal disease, not officially reportable, can be gleaned from sampling surveys or from the evaluation of requests for services received by public health nurses, according to a recommendation emerging from the seminar on diarrheal diseases.

Participants stressed that in sections with a deficiency of health services, family cooperation is particularly important, even in reporting deaths. Therefore, health agencies were urged to convince families that their information will produce benefits in the form of health services. Since mortality reporting depends on competent diagnosis, it was agreed that improvement must develop locally.

Among needs mentioned to circulate and apply laboratory knowledge and resources were simplified, standardized laboratory methods and kits for shipping specimens.

Piping water into the home, as a means of reducing the sources of diarrheal disease, is usually the responsibility of agencies other than the health department. Such achievement, it was agreed, would result only from combined effort of all agencies, with encouragement from community organizations and active participation by individuals.

Though the importance of flies as vectors is recognized, fly control measures, according to the discussions, are less effective than piping water into individual homes. During peak periods of infection, suppression of flies should be encouraged, it was agreed, but with the realization that "flies are resistant to everything but sanitation."

Educational efforts were urged to explain the advantages of putting animal quarters in a separate building and to emphasize the ease with which food, particularly meat and fowl, can be infected during slaughtering and processing.

For treating dehydration, the principal cause of death in diarrhea victims, the prevailing opinion was that the local health agency should train suitable persons in simple methods. The chosen personnel, who must be acceptable to the families, should evaluate the adequacy of treatment facilities in the home and inform the mother of procedures to be used. The success of treatment hinges on how well the mother has been taught to recognize dehydration and on how promptly the treatment starts.

Turning to the financing and coordination of efforts by border communities, the participants advised cooperation by adjacent communities in defining joint problems, sharing observations and methods, and standardizing procedures. Communities can then either persuade higher-level agencies to take action, or they can rely on local resources. In many communities, a school teacher has been a key person in promoting the program, not only among pupils but also among families and local authorities.

Diarrhea Incidence Highest in Mexican Uplands

Mexico's highlands, in spite of their temperate or cold climate, have more diarrhea than other sectors when similar adverse environmental or social factors are present. This was one of the findings from field studies mentioned by Dr. Manuel E. Pesqueira, Deputy Minister of Health and Welfare in Mexico. Less diarrhea mortality occurs in tropical regions with abundant water and food. Attacks in these regions, though less frequent, may be more violent.

Although mortality from diarrhea in Mexico is decreasing, he emphasized that the rate of 235.2 per 100,000 persons for 1952–56 is still higher than for all other communicable diseases registered during that time. To develop more exact statistics on the disease, the Ministry is contemplating setting up one or more areas of careful registry in each state.

In almost all of the Mexican states, the government has projects for water supply systems, building public baths and laundries, improving homes, installing latrines, and destroying insect-breeding grounds. In all such communities, he said, health education and maternal and child health are stressed. Mothers are taught correct baby care and feeding and are trained in home sanitation, aspects of home economics, and home care of sick children, including prevention of dehydration when diarrhea strikes.

Mexican VD Health Workers Trained in Mobile Units

In a detailed description of how a mobile unit contributes to the Mexican venereal disease campaign, Dr. Alfonso Verduzco Peñafiel, epidemiologist with the antivenereal campaign of the Mexican Ministry of Health and Welfare, related that the unit was first acquired by the Ministry in 1956 both to train personnel and to standardize control techniques throughout the country.

In addition to a laboratory for technician training and for evaluating local laboratory facilities for syphilis serodiagnosis, the unit has audiovisual units for health education and material for serologic tests, treatment, and prophylaxis.

A teacher of health sciences specializing in the program techniques and a trained contact interviewer comprise the unit's personnel, he said. After presenting the program's objectives, methods, organization, and personnel to local officials, the team begins fieldwork with public health nurses seeking such training. Among the groups tested are prostitutes, prisoners, and soldiers. The unit supplies the local laboratory with basic equipment and mate-

rial for diagnosis and trains the health personnel in campaign methods.

For treatment of prostitutes, the team recommended weekly dosages of 300,000 units of penicillin procaine with aluminum monostearate or 600,000 units of penicillin benzathine every 2 weeks.

Goals for Community Action Against Alcoholism

What should the community do about alcoholism? What would you like to see in your community 20 years from now? Here are some of the things that I think can be attained in the next 20 years, if we make use of the things we now know:

★ Citizens who recognize that some people cannot drink in moderation and that those people cannot be blamed for the conditions that made them alcoholic. In other words, an informed public.

★ Police officers who have some knowledge of alcoholism and who consider helping alcoholics part of their job as well as protecting the rights of others.

★ Courts and laws which recognize that help for the alcoholic is far more effective than is punishment.

★ Physicians who are ready, willing, and able to treat the acute phases of alcoholism and to use their skills to join with the community team that offers help for the chronic aspects of the illness.

★ General hospitals whose beds are as available to acutely intoxicated patients as they are to diabetics, and nursing staffs who recognize that there is more to alcoholism than intoxication.

★ Clergymen who are aware of the spiritual problems faced by alcoholics and their families and are ready to use their counseling skills to help rather than condemn.

★ Social agencies who offer their help to families where alcoholism has intensified normal social problems and who use their skills to help the individual alcoholic.

★ Health departments that feel as much responsibility toward alcoholism as they do any other public health problem.

★ Employers who recognize the early symptoms of alcoholism in employees, and who protect the investment they have made in these people, by getting help for them before they jeopardize their jobs.

—RALPH W. DANIEL, *executive director, Michigan State Board of Alcoholism (from a speech given at the Midwest Institute on Alcohol Studies, June 23–27, 1958).*