Syphilis and AIDS in Belle Glade, Florida, 1942 and 1992

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George Santayana warned, "Those who cannot remember the past are condemned to repeat it" (1). The venereal disease experience in Belle Glade, Florida, during the past 50 years is a striking case in point. In the 1940s, Belle Glade became the focus of intense scientific interest when an epidemic of syphilis occurred among the poor, predominantly non-white migrant farmworker population living there. Fifty years later, Belle Glade again made headlines when it was found that this small agricultural community in the heart of the Florida Everglades had one of the highest incidences of the acquired immunodeficiency syndrome (AIDS) in the nation (Figure 1).

Between 1985 and 1988 alone, the prevalence of AIDS in Belle Glade quadrupled from 188 to 806 cases per 100 000 persons, figures rivalling those of urban metropolitan areas such as New York and San Francisco (2). Belle Glade has not only experienced an enormous AIDS burden, but aspects of the disease's epidemiology in the town at first appeared to be unique. Early researchers were intrigued by the high percentage of patients with AIDS who had no known risk factors (3). Because the community is situated in a massive estuary, health officials explored the possibility that AIDS might be transmissible by mosquitoes—a possibility that engendered substantial public apprehension and media attention (4). Epidemiologists eventually debunked the mosquito hypothesis and instead strongly implicated sexual intercourse, intravenous drug use, and socioeconomic status as risk factors for HIV seropositivity in Belle Glade (Table 1) (2-4).

Although researchers answered the question of how AIDS was being spread in Belle Glade, an appreciation of the social history of disease in American agricultural society is necessary to understand the more fundamental question of why diseases like AIDS flourish in places like Belle Glade. The socioeconomic conditions seen among the migrant population of Belle Glade in the 1940s remained remarkably constant for 50 years and contributed to epidemics of sexually transmitted disease in both eras. In this essay, the efforts of the federal government to understand the causes for endemic syphilis among migrant farmworkers in pre-World War II Belle Glade are reviewed. In retrospect, the federal government's programs were short-lived and a conservative backlash against the social agenda of the New Deal after World War II left unresolved most of the socioeconomic and behavioral conditions identified by the government as critical factors in the spread of syphilis in Belle Glade. These same conditions currently nurture venereal disease among the agricultural workers of Belle Glade. The similarities between Belle Glade then and Belle Glade now provide dramatic evidence that the past failure to address fundamental social conditions known to promote sexually transmitted diseases may have contributed to the modern AIDS epidemic there.

Rural America and the New Deal

Rural America received the attention of Franklin Roosevelt in the earliest days of his presidency. Among the agencies created during this period of unprecedented federal activism, the Farm Security Administration (FSA) was given a broad mandate for the social, economic, physical, and spiritual rehabilitation of America's "forgotten farmers." Beginning in 1935, the FSA provided low-interest loans to the nations' poorest farmers, gave them the technical expertise to better manage their land, and encouraged the formation of marketing cooperatives. When a substantial number of these low-income farmers defaulted on their loans for reasons of poor health, the FSA created a decentralized program in which basic medical services were paid for through an insurance pool subsidized by the government. Attention to preventive health care practices, such as immunization and nutrition, were important features of the FSA health plans (5).

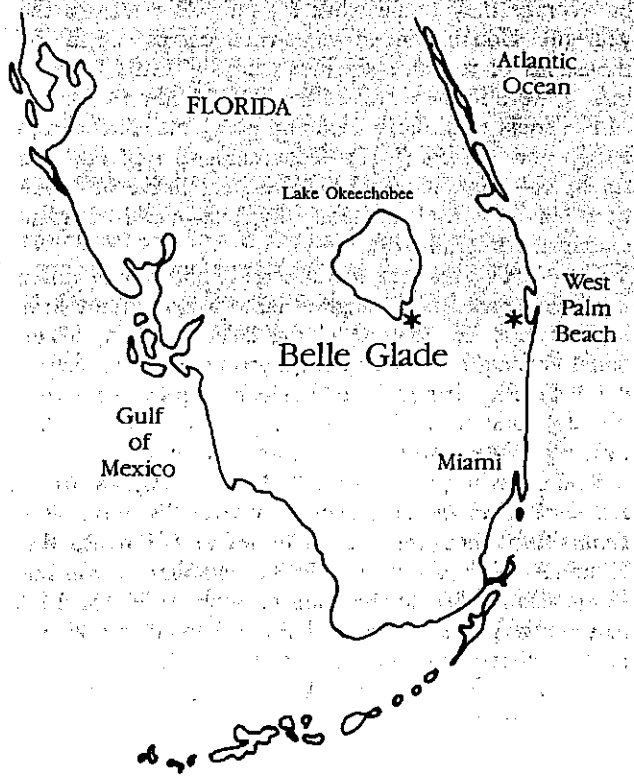

Figure 1. Map of Florida showing the location of Belle Glade.

Table 1. Factors in Venereal Disease Transmission in Belle Glade, Florida*

Syphilis in Belle Glade, 1942†	
Organized prostitution	
Alcohol use	
Sexual promiscuity	
Poverty and overcrowding	
Lack of health care	
AIDS in Belle Glade, 1992‡	
Sex for money	
Intravenous drug abuse	
More than three sexual partners	
Annual income < $10 000	

* AIDS = the acquired immunodeficiency syndrome.
† Adapted from Mott (12).
‡ Adapted from Castro and colleagues (3).

The Great Depression and the New Deal also focused attention on the plight of a unique class in American agriculture: migrant farmworkers. Although pre-World War II America remained a predominantly rural society, trends ongoing since the Civil War rendered agriculture, like the rest of the economy, increasingly mechanized and more capital-intensive. Consequently, smaller family farms were unable to compete with their larger, more efficient competitors. These changes, combined with the worst drought in the nation's history, forced many families off their land, into their cars, and onto the road. More than a million of these people—derided in vernacular expressions referring to their "dustbowl" origins as "Okies" (for Oklahomans) or "Arkies" (for Arkansans)—could only find work in what noted Depression-era sociologist Carey McWilliams called "factories in the fields." Median net income for migrant families was $110 per annum, and on average they found work for only 23 weeks of the year (6). Housing in grower-owned camps, or in the thousands of roadside squatter camps ("Little Oklahomas"), were in the words of the U.S. Children's Bureau "the veriest makeshift, violating every standard of decency and comfort" (7). Tuberculosis, typhoid, and smallpox—communicable diseases that thrive in conditions of poverty and poor hygiene—were rampant among the migrants (8).

The FSA's approach to rural relief and rehabilitation in states dependent on migrant labor was to create farm labor camps. In contrast to the disease-ridden, dilapidated housing provided by local growers, or the numerous "squatter camps," federal camps provided clean, sanitary, and inexpensive housing for migrant families fortunate enough to find temporary residence there. The federal effort to provide decent shelter to migrant workers resulted in the construction of over 250 farm labor camps throughout the country by the end of World War II under the aegis of the FSA. Although a wartime reorganization led to the transfer of many of the FSA migrant programs to the War Food Administration, the administrative and field staff of the medical care programs were substantially unchanged. (For simplicity, the FSA abbreviation is maintained throughout the article.) In addition to providing education and daycare for migrant children, most camps had a medical clinic staffed by full-time nurses and local doctors paid on a per diem or salaried basis. At the peak, more than a half-million migrant workers and their families were eligible for care in the migrant medical care programs of the FSA (9).

The Farm Security Administration in Belle Glade

Belle Glade lies in the heart of the Everglades region of Florida. Economically, the sugar cane industry has dominated the region since the early years of the Great Depression. As is true with many seasonal crops, sugar cane has long been harvested by migratory farm workers, usually recent immigrants or non-white persons, or both. In the 1940s, the socioeconomic conditions of the 25 000 farmworkers, who were primarily male, black migrants drawn to Belle Glade and neighboring towns from the Caribbean islands to cut sugar cane, were appalling. Each day, local growers sent trucks and foremen into town to recruit workers. The scene, as described by one witness, was a crush of impoverished humanity: "The majority of the Negro population live in the commercial quarter of the town. . . . In the hiring yard, the pickers gather at dawn, a couple of thousand of them crowded into two blocks—men, women and children of all ages" (10). Crowded living conditions and a depressed wage scale contributed to wretched conditions of health for Belle Glade residents and migrant workers. Chronic disabling diseases (for example, tuberculosis) and acute infections were rampant among migrants generally and were especially prevalent in Belle Glade (8).

In response to these conditions, the FSA constructed several farm labor camps in the Everglades region. The Migrant Labor Health Association, an incorporated entity funded by the FSA to provide medical care in federal camps, also operated a hospital in Belle Glade. Although not the focus of the present essay, the Association provided acute medical services that were of immediate benefit. The Association's focus on prevention and on infant and maternal health constituted a particularly successful aspect of the federal farm labor medical programs (11).

This class of agricultural worker received an unusual degree of attention during this era, primarily because of their economic importance. Particularly during World War II, acute labor shortages resulted in the importation of foreign workers under treaty arrangements from Latin America, the Caribbean, and even Canada. In Belle Glade, thousands of Caribbean farm laborers were brought in to harvest sugar cane. Strenuous efforts to prevent the importation of workers with disabling or chronic illness, particularly tuberculosis and syphilis, were for naught because most migrants who contracted these diseases did so after their arrival in the United States. The government found that syphilis, a serious public health problem in migrant populations nationally, resulted in many lost workdays among the Belle Glade migrant worker population. This was viewed as a serious threat to the successful prosecution of the war effort on the home front and explains why the migrants of Belle Glade became the target of so much interest (12).

A series of FSA internal memoranda between 1942

and 1945 allude to nearly endemic venereal disease in Belle Glade. A review of the FSA's efforts to understand the causes of the epidemic in Belle Glade illustrates two separate, but related, points. (1) The FSA's investigations, aided by the U.S. Public Health Service (USPHS), indicate that living conditions among the migrants of Belle Glade in 1942 mirror those existing today among the region's migrant population, including those working the sugar cane fields of south-central Florida. (2) These conditions promoted an epidemic of venereal disease in Belle Glade in the 1940s and are strikingly analogous to those that contribute, some 50 years later, to the remarkable prevalence of AIDS there.

The Farm Security Administration Discovers an Epidemic in Belle Glade

Osler wrote that "syphilis . . . remains the despair of the statistician" (13). Despite this warning, some idea of the severity of the national venereal disease problem during the New Deal period provides perspective on the situation in Belle Glade. In 1943, it was estimated that 3.2 million Americans had syphilis and that over 5 000 000 new cases of early syphilis occurred annually. Syphilis was considered the cause of 100 000 deaths each year, and estimates of the annual cost of caring for those blinded, crippled, or rendered mentally incompetent from the disease were over $50 million (14, 15). The 1937 publication of Surgeon General Thomas Parran's bestselling book, *Shadow on the Land*, elevated the Surgeon General to public prominence and identified syphilis as the nation's preeminent public health threat—a situation strikingly similar to that facing Surgeon General C. Everett Koop a half century later (16).

The literature of the time, based on state and national estimates of disease prevalence, showed substantial geographic, racial, and income-related differences in venereal disease rates. Although the South as a region traditionally had higher venereal disease rates than the rest of the country, throughout this period Florida consistently displayed one of the highest rates of syphilis among all U.S. states. Racial differences in the prevalence of syphilis were even more extreme in Florida than those found nationally: 53/100 000 in whites compared with 406/100 000 in non-whites (17).

The racial differences in rates of venereal disease reflect true variation in disease prevalence, as well as distortions due to racial prejudice. During this era, scientists and physicians tended to look for venereal disease only where they expected to find it. Doctors frequently attributed symptoms to venereal disease in blacks, whereas identical symptoms would be assigned to other causes in whites (18). Years of grossly neglected health care was also an important factor. Before the widespread use of penicillin, many physicians believed that blacks could not understand the need for treatment nor the need for follow-up evaluation and consciously withheld accepted, albeit toxic, therapy in their black patients. Finally, economic conditions were generally far worse among blacks and contributed to racial disparities in the prevalence and management of venereal disease. Importantly, although the relation between socioeconomic conditions and health had been understood for decades, for blacks "socioeconomic reasons for the prevalence of VD . . . were generally discounted" (18).

The hospital administrator for the Migrant Labor Health Association in Belle Glade later recalled the following: "Venereal disease was a problem, and the only cure for venereal diseases in those days was a center somewhere around Jacksonville where we had to send all of them. This was mandatory. Once a week we would have a bus, load these people and send them up. But they never educated them on prevention, or anything like that. They'd go up there for rapid treatment . . . be discharged and they'd be back in a short time" (Mayers H. Personal communication). In fact, awareness of the epidemic in Belle Glade reached the highest levels of the FSA and the USPHS. Chief Medical Officer of the FSA, Dr. Frederick Mott wrote to Surgeon General Parran that "I have been very much concerned about the acute venereal disease problem . . . in the Everglades region, Palm Beach County, Florida. . . . Of all the areas that I am familiar with where large numbers of migratory agricultural workers are concentrated, the venereal disease problem in the Everglades is by far the most serious (12).

Nongovernment agencies, too, were aware of the situation in Belle Glade. The American Social Hygiene Association (ASHA), an influential private organization participating in national venereal disease control efforts for three decades, offered to send its own investigators to the area (19). In response to the ASHA offer, Dr. John Newdorp, FSA Regional Field Operations Medical Officer in Atlanta, wrote: "The situation in the vicinity of Belle Glade, Florida, is such that we would welcome any help that we can get" (20). The FSA's Dr. Mott agreed, "There is no question that such a field investigation is indicated (21). Eventually, ASHA was enlisted to conduct a confidential report (22).

It was the federal government, particularly the USPHS and the FSA, that took the lead in investigating the epidemic in Belle Glade, however. The USPHS's long-standing, intimate relationship with the FSA medical programs, as well as Surgeon General Parran's prominent position in the national anti-venereal disease campaign, encouraged this role (5, 16). Indeed, as early as 1942 the USPHS assigned a venereal disease control officer to Palm Beach County, but his efforts were mostly confined to the city of West Palm Beach. Nevertheless, this officer reported an "acute" venereal disease problem in the Everglades (12). In 1943, the USPHS dispatched Dr. Sy Axelrod, a venereal disease consultant, to Florida to investigate the syphilis epidemic. Axelrod spent considerable time in Belle Glade and the surrounding towns of Osceola, Okeechobee, and Pahokee. He also visited the FSA camps and farm labor camps owned by U.S. Sugar Corporation, the largest employer in the region (23). Axelrod's investigation unearthed those factors promoting venereal disease in Belle Glade, factors that are familiar and discomforting to modern day observers of the AIDS epidemic.

Axelrod found a plethora of brothels and saloons operating near all the farm labor camps, both private and federal. Analogous situations existed for the armed

services, where it was common for a perimeter of brothels to surround army camps or naval bases. He uncovered evidence of "organized vice in the form of prostitution and taxi-driver procurers, in addition to poorly policed and wide-open 'juke joints' flourishing" (12). One enterprising madam apparently ran a free taxi-cab service that picked men up in the camps and brought them to her place of business! In the view of the USPHS, the widespread availability of alcohol in these "juke joints" fostered venereal disease by promoting both sexual and social intercourse. Alcohol reduced behavioral inhibitions, and its availability brought men and women together (23). In summary, Axelrod found that prostitution, alcohol use and abuse, sexual promiscuity, and conditions of poverty all contributed to the syphilis epidemic in Belle Glade (*see* Table 1).

In response to Axelrod's report, FSA Chief Medical Officer Mott wrote to Surgeon General Parran that "the problem of venereal disease in the Belle Glade is a serious one. In close proximity to the Okeechobee camps are two establishments selling liquor. . . . Taxis now pick the men up and bring them to the dives and brothels of Pahokee and Belle Glade" (12). Dr. Mott's observations can be easily compared with those found 50 years later in an article on AIDS in Belle Glade: "All persons seropositive for HIV were black . . . resided in the southwest-central part of Belle Glade which is characterized by crowded living conditions and high rates of drug abuse, sexually-transmitted disease, and prostitution (3)." Clearly, the socioeconomic and behavioral conditions in Belle Glade in the 1940s differ little from those seen currently in the town.

Spurred by Axelrod's investigation, the USPHS authorized the placement of a venereal disease control officer, under FSA auspices, in Belle Glade. This physician was to provide clinical services to migrants within both the federal camps and those of the U.S. Sugar Corporation. He was to be responsible for an "educational campaign in the area as well as the establishment of prophylactic facilities where needed" (23). The FSA's Dr. Newdorp noted that "any venereal disease program . . . is doomed to failure as long as the sources of infection remain untouched," and he urged that "the entire population" be included in the effort (23). This position was echoed by others within the USPHS and the FSA. Consequently, public health nurses and case workers, whose responsibilities were to extend the physician's efforts outside the boundaries of the farm labor camps, were included in Axelrod's final recommendations.

In 1944, a physician was assigned to Belle Glade as a venereal disease control officer, working closely with the Migrant Labor Health Association. Chief Medical Officer Mott acknowledged that previously assigned medical officers had antagonized local doctors but believed that "if such an officer were detailed under the conditions outlined and . . . confined [in] his activities to that part of the country which is geographically and sociologically distant from the City of West Palm Beach, i.e., the Everglades region, no opposition would be encountered from local and medical groups" (12).

Mott's prediction was accurate. In fact, the response of the medical profession to the anti-venereal disease efforts of the FSA in Belle Glade and elsewhere was mostly favorable, especially during the war years when medical manpower in rural areas was severely depleted. Even in this era when the organized medical profession regularly went on record as opposing federal involvement in medical care delivery, Palm Beach County doctors supported funding for a county-wide venereal disease educational campaign, for staffing and operation of federally funded rapid treatment centers, and for case-finding, prophylaxis, and even treatment through the migrant medical care program itself.

Ideologic and economic factors explain why physicians allowed venereal disease control programs to be primarily a government function. The collapse of traditional patterns of charity, caused by the Great Depression, proved an enormous strain on both rural and urban physicians. Consequently, the focus of the FSA on rural indigent groups that had historically been unable or unwilling to pay for medical services, made the programs more palatable to general practitioners eager to ease the financial and humanitarian burden of uncompensated care (5). The profession's acquiescence also followed from Parran's strategic employment of the private practitioner in case-finding and treatment throughout the venereal disease control efforts spearheaded by the USPHS. This private-public strategy proved extremely successful in the eventual control of venereal disease nationwide and served as a model for later communicable-disease control programs. In addition, treatment for venereal diseases was ill-paid for the private practitioner and for this reason and others was disdained by many doctors. Finally, the organized medical profession feared wider-reaching reforms, such as national health insurance, which were hotly debated at the time. They were therefore willing to forego organized opposition to the less threatening (and more popular) USPHS-sponsored anti-venereal disease campaign (18).

Conclusion

Unfortunately, the vigor with which the federal government investigated the epidemic of venereal disease in Belle Glade was not sustained through the political, social, and economic changes wrought by the war. Federal funding for the FSA was terminated soon after V-J day. The FSA camps were turned over to local and state authorities, private employers, and civic organizations. For the most part, the migrant health programs that operated out of the federal camp system did not make this transition intact. Some states and communities continued to provide health services to domestic migrant workers, often with federal financial aid. However, the scope and availability of these services varied widely, with little regional and no national coordination (24). The FSA's broad attack on rural poverty died out, ending the federal government's singular involvement in rural health issues.

In retrospect, the FSA effort altered too sparsely and too briefly the conditions under which migrants lived and worked. Although the agency built, staffed, and operated farm labor camps that were often model communities, the fraction of workers living in the federal

camps remained small; fewer than 25% of all agricultural workers were eligible for treatment through the medical care programs sponsored under the auspices of the FSA. Had it not been for the importance of migrant labor to the war economy and the jeopardy that chronic diseases such as syphilis represented, Belle Glade might never have received such focused attention. With the successful conclusion of the war, the economic necessity of a healthy agricultural work force lessened, and national interest in the health and welfare of migrant farmworkers waned.

Despite periodic renewed interest—for example, Edward R. Murrow's dramatic 1961 exposé "Harvest of Shame" and President Johnson's War on Poverty—the litany of social, economic, and health problems that characterize migrant labor in the United States persists in only too familiar form even today (25). Belle Glade in 1992 closely resembles Belle Glade in 1942. Crowded living conditions, poverty, varying access to health care, and other resulting factors (namely, substance abuse and sexual promiscuity) promote AIDS in Belle Glade much as they did syphilis 50 years before. So it is that in a rural community whose prevalence of AIDS rivals large metropolitan centers and where a bare plurality of the population is non-white, more than 95% of all patients with AIDS are non-whites (2, 3, 6). In a prescient comment made during his assessment of the venereal disease problem in Belle Glade in 1942, the FSA's Dr. Newdorp wrote that unless the effort to control venereal disease in the Everglades was done with the full participation of the local community and "on a permanent basis . . . the improvement will be of temporary nature only and in the long run, the situation will probably become worse instead of better" (23). Statistics on AIDS in Belle Glade indicate that Dr. Newdorp's prediction hit tragically on the mark.

Societal characteristics that promote sexually transmitted diseases are deeply rooted in our society. The response to the syphilis epidemic in Belle Glade in the 1940s shows that others have studied and attempted to reform these conditions. However, the historical experience of Belle Glade also indicates that this attention tends to be short-lived and limited in scope. The FSA migrant health programs were important for the humanitarian assistance provided to those brought into the more nurturing environment of the federal camps, as well as for the economic benefits derived from a healthier work force. Nevertheless, the federal farm labor programs tempered but did not eliminate the appalling social condition of America's migrant agricultural workers.

Since the time of Hippocrates, physicians have commented on the interplay between poverty and disease. It comes as no surprise that AIDS, like many previous scourges, is expanding among socially disadvantaged persons. When the role of mosquitoes in AIDs transmission was first considered, Belle Glade attracted intense national attention. When this hypothesis was disproved, however, the attention quickly waned. The fact that the root causes driving the epidemic are deeper and more complex makes Belle Glade more, not less, worthy of the attention of our basic scientists, research clinicians, anthropologists, and health policymakers. Belle Glade stands as a stark reminder of the socioeconomic conditions that sustain public health threats. Medicine and society must maintain an ongoing battle against both diseases and the social ills that nurture them if we are ever to control current and prevent future plagues.

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What I would like to do is use the time that is coming now to talk about some things that have come to mind. We're in such a hurry most of the time we never get much chance to talk. The result is a kind of endless day-to-day shallowness, a monotony that leaves a person wondering years later where all the time went and sorry that it's all gone. Now that we do have some time and know it I would like to use the time to talk in some depth about things that seem important.

What is in mind is a sort of Chautauqua—that's the only name I can think of for it—like the traveling tent show Chautauquas that used to move across America, this America, the one that we are in now, an old-time series of popular talks intended to edify and entertain, improve the mind and bring culture and enlightenment to the ears and thoughts of the hearer. The Chautauquas were pushed aside by faster paced radio, movies and TV and it seems to me the change was not entirely an improvement. Perhaps because of these changes the stream of national consciousness moves faster now and is broader but it seems to run less deep. The old channels cannot contain it and in its search for new ones there seems to be growing havoc and destruction along its banks. In this Chautauqua I would like not to cut any new channels of consciousness but simply dig deeper into old ones that have become silted in with the debris of thoughts grown stale and platitudes too often repeated. What's new is an interesting and broadening eternal question but one which if pursued exclusively results only in an endless parade of trivia and fashion, the silt of tomorrow. I would like instead to be concerned with the question what is best, a question which cuts deeply rather than broadly, a question whose answers tend to move the silt downstream. There are eras of human history in which the channels of thought have been too deeply cut and no change was possible and nothing new ever happened and best was a matter of dogma. But that is not the situation now. Now the stream of our common consciousness seems to be obliterating its own banks, losing its central direction and purpose, flooding the lowlands, disconnecting and isolating the highlands, and to no particular purpose other than the wasteful fulfillment of its own internal momentum. Some channel deepening seems called for.

Robert Pirsig
Zen and the Art of Motorcycle Maintenance
W. Morrow & Co., 1974, p. 15