

# **From a Clinical to a Public Health Problem?: The Control of Tuberculosis in Jamaica, c. 1918-1982**

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Since the publication of Randal Packard's *White Plague, Black Labor* in 1989 which examined the control of tuberculosis (TB) in South Africa, the focus of the historical scholarship on TB has gradually moved away from Europe and North America. While much work has been done in recent years on the history of TB in Latin America,<sup>1</sup> the control and treatment of the disease in the British Caribbean has thus far been largely neglected.<sup>2</sup> In July 2012, funded by a grant from the University of York's Centre for Chronic Diseases and Disorders, I undertook a pilot project on TB in the British Caribbean from the early twentieth century until the onset of the HIV/AIDS epidemic in the 1980s that focused on three parts of the region that differed considerably in terms of size, economy and racial make-up: Jamaica, Barbados and Trinidad. I spent a week on each island, visiting their national archives and libraries and also examining papers relating to TB in the Caribbean in the National Archives and the Wellcome Library in London and in the WHO archives in Geneva.

The pilot exercise revealed that there is plenty of scope for a large-scale research project on the history of TB in the British Caribbean that would examine: the extent to which race and ethnicity shaped the research into and the treatment, prevention and control of the disease; the financial and other external support that first the colonial and later the independent governments received in their fight against TB; the role played by voluntary and professional health workers in the prevention, control and treatment of the disease; the

responses of the population to prevention and control campaigns; and the attitude of TB patients towards the treatment offered in clinics, hospitals and sanatoria. As part of this bigger project, for which I will apply for funding from the Wellcome Trust in 2014-15, I want to write a monograph on TB control in Jamaica, the island which has thus far been the subject of my research. This book will trace the development of TB services on the island and more specifically, address the question why TB was not, as it was in many other countries, universalized as a public health problem.

The work that I carried out at the Rockefeller Archive Center (RAC) in July 2013 contributes to this envisioned monograph. From 1927 till 1942, the Rockefeller Foundation (RF)'s International Health Board (IHB) ran a TB commission in Jamaica led by the well-known TB expert Dr. Eugene Opie and which was under the overall-control of the RF's Dr. Benjamin Washburn. The commission not only carried out research into the epidemiology of the disease and examined the efficacy of a vaccine of heated-killed tubercle bacilli, but also offered some basic treatment to TB sufferers in TB dispensaries and in a TB hospital in Kingston. Opie and other members of the commission regularly published findings of their work in such prestigious journals as the *American Journal of Epidemiology*, which along with the annual medical reports for the colony, reports about the IHB's work published in the *Gleaner*—Jamaica's biggest-selling newspaper at the time—and verbatim reports of Legislative Council debates about TB services on the island, enabled me to gain a sense of the workings of the commission and its development over time. Yet these sources left many questions unanswered, in particular:

1. What factors led to the formation of the TB commission in Jamaica and what did the Rockefeller Foundation hope to gain from it?
2. How central were the experiments with the heat-killed tubercle bacilli vaccine to the commission's work?
3. What role did race play in the commission's work?
4. How successful was the commission in controlling TB in Jamaica?
5. What was the relationship between the commission and the Jamaican government?

To answer these questions, I first consulted the RF's project series on TB in Jamaica, (RF RG 1.1. series 437T) which proved less useful than expected, because much of this material had formed the basis of the journal articles produced by the commission's staff that I had already consulted. More useful, however, was the general project series (437) and the project series on health services (437 K), containing Washburn's correspondence with the home office, Dr. Opie, and also with the Director of Medical Services (DMS), as well as memoranda and other miscellaneous material produced by other members of the commission.

This material helped to answer all questions, but in particular questions 1 and 2. Also very useful, most notably for question 5, were the staff diaries by Dr. Edward Flahiff and Washburn (RF RG 12 boxes 154 and 493), the Benjamin Washburn papers (2A 13) and *The Reminiscences of Benjamin Earle Washburn* (RF RG13 box 12). The least useful for the envisioned monograph were the routine reports (RF RG5 IHB/D series 3), which contained mostly the statistical data that formed the basis of the published articles. The reports, however, did contain many interesting photographs, not just of the TB dispensary and hospital and the commission's staff and patients, but also of the living conditions of the people. As such, they are also useful for some of the other projects that I currently work on.

The RAC material revealed, more than the sources I had already consulted, that it was the government of Jamaica that had asked the RF for a commission, rather than vice versa. The government wanted the RF, which had already done some work on the island, to provide it with a program for the control of TB, which by the late 1920s was one of the main causes of death. The RF accepted the invitation largely because it considered Jamaica an ideal place to test the TB survey method pioneered by the Henry Phipps Institute in Philadelphia, which had started TB work amongst African Americans in 1914, on a much larger scale. Its interest was first and foremost research into TB: "The only reason for our entering the field [of TB] at all is to bring a scientific point of view to bear on a problem that has been treated too much in

the past by rule of thumb and by imitation. We have an opportunity in Jamaica to make a real advance in a subject, which has always been most difficult and important.”<sup>3</sup>

Yet the commission could not completely ignore treatment as Dr. Opie explained:

The purpose of the clinic [set up in Kingston in 1928] will be the collection of the information about tuberculosis, but evidently some treatment and relief work will be necessary to make the clinic function and maintain an interest in it. For actual relief it would seem to me the expenditure should be very small and effort should be made to make use of any existing agencies, however inadequate they may be.<sup>4</sup>

The home office fully agreed, stressing that by asking existing agencies like the Anti-Tuberculosis League to pay towards the basic treatment offered by the clinic, the RF would avoid the appearance of “embarking on a tuberculosis control campaign,” which it deemed to be the remit—financially and otherwise—of the Jamaican government.<sup>5</sup> For the survey, which was started in Kingston and gradually rolled out to rural parishes, the commission used the reporting mechanisms pioneered by the Phipps Institute. The survey, which soon came to rely on X-rays and clinics other than the one set up in Kingston, proceeded so smoothly that the RF also adopted it in other parts of the region.

The other strand of “the scientific point of view” that the RF brought to the TB problem in Jamaica was the testing of a vaccine with heat-killed tubercle bacilli. This was started in 1931 at a mental hospital.<sup>6</sup> Although highly problematic, because these institutions did not have facilities to segregate the inoculated from the non-inoculated members of the control groups, results were deemed sufficiently satisfactory to trial the vaccine on a large scale. During the last few years of its presence on the island, then, the commission began to inoculate members of the general public, starting, as in the case of the survey, with Kingston and then gradually moving to rural parishes. The RAC records regarding this latter stage of the TB commission’s work, not only revealed the increasing opposition from the government, because it wanted the RF to focus on control and treatment, but also the reluctance of the population to take part in it. At the time, rumors circulated that it was a ploy by the white race

to destroy the black race. Moreover, as the trial, with the vaccine in the general population coincided with the formation of the first birth control clinic in the island, it was also asserted that it would leave women barren, a myth which the commission's nurses found hard to dispel. The RAC material relating to the trial of the vaccine in the general population has raised several new questions for me. In particular, why did the commission continue with the trial when it already appeared in the early stages that it was difficult to follow up vaccinated cases, because many people moved around or died without being medically certified? Similarly, why did it persevere with a vaccine when elsewhere, tests with *Bacillus Calmette-Guerin* (BCG) were in a far advanced stages and had shown considerably more positive results.

As my current book-length project examines racial discrimination in Jamaica in the era of decolonization, I was particularly interested in any references to race in the reports, diaries, letters and other material. With a few exceptions, such as Dr. Joyce Isaacs, who ran the TB clinic in Kingston, most of the commission's doctors were American. In the U.S. all shades of black were collapsed into the uniform and inferior category of "negro," even in the North, where there was no formal color bar. In Jamaica on the other hand, distinctions were made on the basis of "shade" and there were far more racial mixtures than in the U.S. The material reveals various incidents where these two different systems of race clashed. As mentioned when the survey started, the forms used were those of the Phipps Institute, largely in order to facilitate comparisons between African Americans and African Jamaicans. With regards to the color of the participants, however, the forms soon proved problematic. For example, Dr. Persis Putnam asked Dr. Opie what color should be given for "an individual who is half Chinese," should it be "light brown" or should perhaps a "separate category" be set up for "half Chinese, half Syrian or half something else?"<sup>7</sup> For analysis purposes, however, the commission gradually focused on four "racial" categories: black, dark brown,

light brown, and other. Attempts were made to explore whether the incidence and nature of the disease affected these four categories in different ways. By 1934, however, it was generally agreed that skin color in itself did not affect the incidence and nature of the disease.

The binary system of race that white American doctors of the commission had grown up with not only shaped their research questions and methodologies, but also their attitudes towards the non-white staff of the commission and the subjects of their tests. When they first arrived many were skeptical about the non-white nurses and other junior local members of the commission. In fact, demands were made at the start by some to employ only white nurses on the commission. This, however, was dismissed, not just because of the paucity of white nurses on the island—less than two per cent of the population was white—but also because black nurses were seen as essential in encouraging the people to participate in the survey, since they could enter homes with more ease than the white nurses. Yet, for the more senior nursing positions on the commission, white women were appointed, mostly from the U.S. or the U.K., a practice in line with what existed in government medical service at the time.<sup>8</sup>

Although many white American doctors on the commission changed their opinion about the capabilities of the non-white members of the commission, they remained very dismissive of the “black” and “brown” population and at times invoked common racial stereotypes, such as black ignorance. But race also played a role in other areas besides the interaction between the white American staff and the local non-white staff. Regularly, for example, the Director of Medical Services or the head of the TB commission, Dr. Washburn, would ask the home office to offer a fellowship to a local doctor or nurse to specialize in TB or other work. If skin color was not mentioned in this request, the home office would first try to ascertain the skin color of the person in question. If the individual was non-white, it was often suggested that he or she should train in the U.K. or only in one of few U.S. hospitals.

Was the commission successful in controlling TB? To answer this question would require an analysis of the number of cases prior to the arrival of the commission and after its departure as well. Yet, as the commission repeatedly stated in its letters to the home office, there was an absence of relevant statistics. Even such basic data as the number of people there were on the island was lacking. For example, a census was held in 1921, but not in 1931, due to a lack of funds and the next one was not held until 1943. The material at the RAC shows that while the Jamaican population was initially reluctant to participate in the survey and attend the clinics, they soon came forward in great numbers. Yet to bring down the incidence of the disease was not just dependent on people being tested. It also required infected cases to take bed-rest, eat healthy food and in some instances have collapse therapy or other surgery as well, which the commission began to offer beginning in 1934. Bringing down the incidence of the disease also necessitated the development of places to segregate and treat TB sufferers. The financial circumstances of both the people and the government did not facilitate this. Washburn's correspondence and some other material clearly show that the government was often unable to meet its pledged contribution to the commission's work. Additionally, monthly reports show that many TB sufferers were unable to take time off from work or buy nutritious food and hence died within less than a year of contracting the disease, while of course in the meantime they infected others as they lived in cramped conditions due to their economic circumstances.

Considering the main question of the envisioned monograph on TB in Jamaica, I hoped that the RAC files would shed more light on the government's attitude towards the commission than the material I had already consulted. The latter had shown that although the government had invited the commission, it was reluctant to implement the set of proposals drawn up by Opie to control the disease. In 1932 he had suggested that the government should first of all build dispensaries to discover cases, second build TB hospitals or add

wards to rural hospitals and poor houses to treat advanced cases of TB and train local doctors and nurses in the detection and basic treatment of TB, and only as a last step build a sanatorium for the long continued treatment of chronic TB cases, because such a building would be so costly that it would likely absorb all of the resources available for the prevention and control of tuberculosis.

Not only was the government slow in implementing steps one and two—by the late 1930s most rural hospitals and poor houses still lacked a TB ward—it especially dismissed Opie's suggestion that a sanatorium should be the last step in a control program. Already in the mid-1930s it applied for funds from the Imperial government and set up a local fund to raise money for a large-scale sanatorium. This deviation from Opie's plan caused considerable friction between the commission and the government. While existing material had already provided me with a great insight into the government's decision to deviate from Opie's plan and its struggle with the black elected members of the Legislative Council over the site for the sanatorium,<sup>9</sup> the material at the RAC, especially the Washburn papers, shed much light on the commission's opposition to the government's decision to build a sanatorium.

The RAC documents furthermore highlighted that the government's opposition to the commission increased over time when the commission increasingly began to focus on research into the efficacy of the vaccine. This, and also the government's increasing lack of funds, which made it unable to meet its contribution to the commission's work, facilitated the decision to disband the commission in 1942. The material, especially the personal diaries of the staff, also revealed a more complex relationship between the DMS and the commission than suggested in the material I had already consulted. The latter suggested that the DMS, in particular Hallinan, was a major obstacle in the commission's work. Yet the RAC material showed that the commission came into being largely because of the efforts of DMS Basil M.

Wilson, and that while DMS Hallinan did not see eye to eye with the commission on the sanatorium, he supported many other aspects of its work. In fact, some members of the commission, such as Dr. Flahiff, visited Hallinan several times a week and managed to gain important concessions from him, such as extending the vaccination program to include Jamaicans who were about to migrate to Panama and refugees from war-torn Europe based at Gibraltar camp.

However, the documents consulted at the RAC have not only filled some important gaps in my knowledge about the TB commission, it has also extended my awareness of the development of public health services in Jamaica. In previous work, I have explored the development of maternal and child welfare services.<sup>10</sup> By the early 1940s, most parishes had a public health nurse whose work was mainly with mothers and children. This system of public health nursing, I have now learned, was an outgrowth of the TB commission. In 1936, one of the commission's nurses was assigned not only to a rural parish to deal mainly with TB patients, but also to treat other cases. The aim was to use this nurse—who had no prior experience in public health nursing—for six months, and if successful, use it to put pressure on the government to set up a public health nursing scheme. While the nurse's work was very positively received in the area by the local health boards, social workers etc. and was extended to three other parishes, neither the DMS nor the central government was very positive about setting up a public health nursing service. In fact, it took a few more years and above-all pressure from local government before central government finally decided to fund one public health nurse per parish.

Central government's attitude towards the commission's proposed public health nursing scheme hints at a major factor as to why TB was not universalized as a public health problem in Jamaica. Central government was biased towards curative medicine. This was primarily because most doctors in government service had been trained in curative medicine

and also the more general fact that preventive medicine has always played second fiddle to curative medicine. The bias however, should also be seen in light of the race relations that underpinned the colonial project. Preventive medicine in Jamaica focused on the majority of the population, i.e. lower-class and dark-complexioned Jamaicans. Even the African-Jamaican doctors in government service were keen to distance themselves from this group, like so many other middle-class blacks and for similar reasons black politicians were generally more inclined to vote sums for new hospitals and more doctors than for rural health centers and public health nurses. This general bias towards curative medicine also affected TB work on the island, as clearly demonstrated by the fact that the government was more concerned to build a massive sanatorium than to implement Dr. Opie's suggestion that doctors and nurses be trained in TB work so that throughout the island, and not just in Kingston, there would be medical staff capable of detecting and treating TB. This led Dr. Opie to conclude in 1938 that "control of tuberculosis by the government medical service is approached from a therapeutic rather than a public health standpoint."<sup>11</sup>

Yet RAC records have also suggested another reason why TB was not universalized as a public health problem in Jamaica: the organization and funding of the health services. Before their independence in 1962, the Jamaican health service was divided into two separate units: a preventive/public health unit and a curative/clinical unit. However, this was at the central level; there was also a division between centrally funded/organized health services and locally funded/organized health services. Under this system, the main focus in terms of money, staffing, and administrative support was on curative services and most of the preventive work was done by local health services. During the time of the TB commission, the work done by the local health services was paid for mostly by parochial boards. To pay for these and other services, they were empowered to levy local rates and taxes and issue trade licenses and collect market fees. In 1934, the commission visited nearly all parishes on

the island to ascertain what, if any, services were offered with regards to TB. The reports of these visits (RF RG 1.1. 437) highlight that because some parishes had a higher income from licenses, fees, taxes, etc. than others, they were able to do more for TB sufferers. Some, for example, had already set up TB wards in their poor houses before Dr. Opie had made this recommendation to the central government, while others had to wait until the late 1930s or even early 1940s to erect them, when the central government finally set funds aside for this purpose.

In conclusion, although the material on the TB commission in Jamaica at the RAC is particularly insightful about the methodologies and outcomes of the research that it pursued, it has also shed considerable light on two aspects of the commission that I am most interested in and which other material is largely silent about: the role of race and the relationship between the government and the commission, and more importantly, it has lent more fuel to an argument that I have already developed for post-WWII, regarding the island's failure to universalize TB as a public health problem, namely, that it was due to a bias against preventive medicine and the organization and funding of the health services.<sup>12</sup>

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## ENDNOTES:

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<sup>1</sup> See, for example, Diego Armus, *The Ailing City: Health, Tuberculosis, and Culture in Buenos Aires, 1870-1950*. Durham, North Carolina: Duke University Press, 2011.

<sup>2</sup> For some notable exceptions, see Margaret Jones, *Public Health in Jamaica, 1850-1940: Neglect, Philanthropy and Development*. Mona, Kingston 7, Jamaica: University of the West Indies Press, 2013; Jill Briggs, ““Jamaica Advancing”?: The Rockefeller Tuberculosis Commission and the Tensions Between Research and Eradication.” RAC Research Report at: <http://www.rockarch.org/publications/resrep/briggs.pdf> (accessed September 10, 2013).

<sup>3</sup> Letter Russell to Howard, May 11, 1931, Series 437, Box 6, Folder 70, Record Group (RG) 1.1, Projects, Rockefeller Foundation records (RF), Rockefeller Archive Center (RAC).

<sup>4</sup> Letter Opie to Washburn, April 3, 1928, Series 437 K, Box 2, Folder 27, RG 1.1., RF, RAC.

<sup>5</sup> Letter Howard to Opie, March 24, 1928, Box 4, Folder 33, Washburn papers, RF, RAC.

<sup>6</sup> I have briefly touched upon this trial in “Modernity, Race, and Mental Health Care in Jamaica, c. 1918-1944.” *Journal of the Department of Behavioural Sciences*. 2: 1 (2012).

<sup>7</sup> Letter Putnam to Opie, November 7, 1932, Series 437, Box 6, Folder 80, RG 1.1. RF, RAC.

<sup>8</sup> See my “A True Maverick: The Political Career of Dr. Oswald E. Anderson, 1919-1944.” *New West Indian Guide* 87 (2013), pp. 3-29.

<sup>9</sup> As I have set out in my conference paper, “White Plague and Black Resistance: Tuberculosis and the Challenge to Crown Colony Government in Jamaica.” annual conference of the Social History Society, University of Leeds, West Yorkshire, England, U.K., April 2013.

<sup>10</sup> See my *Destined for a Life of Service: Defining African-Jamaican Womanhood, 1865-1938*. Manchester: Manchester University Press, England, U.K., 2011, Chapter 3.

<sup>11</sup> “Tuberculosis in Jamaica: Report of a Visit to Jamaica, June 11-July 7, 1938.” Series 437T, Box 4, Folder 54, RG 1.1., RF, RAC.

<sup>12</sup> See my, “Fight TB with BCG: Mass Vaccination Campaigns in the British Caribbean, 1951-56.” *Medical History* (currently under review).