**A Black Scourge? Race and the Rockefeller’s Tuberculosis Commission in Interwar Jamaica**

*Abstract*:

From 1927 till 1942, the Rockefeller Foundation ran a tuberculosis commission in Jamaica that carried out research into the epidemiology of the disease, examined the efficacy of a vaccine with heat-killed tubercle bacilli, and offered basic treatment to tuberculosis sufferers. Drawing amongst others upon the diaries and scientific writings by staff employed by the commission, this article explores the role that race played in the tuberculosis commission. It assesses how race shaped the research carried out by the commission, how it informed staff interactions and staff-patient relations, and the clash and/or confluence of ‘imported’ and local racial ideas in the commission’s work.

*Keywords:*

Tuberculosis, race, Caribbean, global health and Rockefeller Foundation.

**Introduction**

From 1927 till 1942, the Rockefeller Foundation’s International Health Division (IHD) ran a tuberculosis (TB) commission in Jamaica that carried out research into the epidemiology of the disease, examined the efficacy of a new vaccine, and offered basic treatment. The commission was led by Dr Eugene Opie, a leading American TB expert, and employed various other North American doctors and researchers. As was common with other IHD projects in the region, the commission also relied heavily on local staff. Based amongst others on the diaries of the commission’s staff and correspondence between the commission and IHD headquarters in New York, this article explores the role that race played in the Jamaican TB commission. It first explains how and why the commission was set up and sets out the nature of its work. It then moves on to explore the role that race played in the research carried out by the commission. And finally, it looks at the role of race in staff interactions and staff-patient relations.

By centralising race in the Jamaican TB commission, this paper adds to three interlinked sets of scholarship. First, it contributes to existing work on TB. Since the publication in 1989 of Randall Packard’s *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*, various studies on TB outside of Europe and North America have been published, including several on the (former) British Empire. The latter are more concerned with epidemiological and pathological understandings of TB and with institutions to cure the disease in the colonies than with attempts to control and prevent it, and they also focus mainly on India and Africa (Brimnes, 2007; Harrison and Worboys, 1997; Worboys, 1999). Second, this study augments the scholarship on Caribbean health and medicine. While colonial medical history has been an established sub-discipline within the history of medicine since the 1980s, Caribbean medical history is a relatively new field[[1]](#endnote-1) and the few existing studies have largely ignored TB (McCollin, 2009; Heuring, 2012; andJones, 2013). And third, this article adds to existing literature on the history of global health.[[2]](#endnote-2) In particular, it adds to work on the history of international health organisations, including the forerunners of the WHO, such as the Pan American Sanitary Bureau (PASB) and the IHD, the most important health agency working in Latin America and the Caribbean in the interwar years. Existing studies on the IHD have not only largely ignored TB, they have also not explored in any detail the various ways in which race informed the organisation’s work and how this in turn helped to uphold existing racial hierarchies.[[3]](#endnote-3)

**I The TB Commission**

In 1912, TB was made a notifiable disease in Jamaica. There were then 68 cases of TB, nearly all of the pulmonary kind. Numbers soon increased and in 1927 there were 797 cases and a death rate of 13.4 per 10,000 of the population, which was nearly three times that in the UK and the US (Opie and Isaacs, 1930, p.3-4). Yet Jamaica ran far behind some other Caribbean colonies in tackling the disease. The only institution that until 1927 provided care for TB patients was the poor house but it only catered for those in a far advanced stage of the disease (Opie and Isaacs, 1930, p.6). In 1927, the IHD noted from a report by Dr Benjamin Washburn, the head of the IHD in Jamaica, that TB was one of the main causes of death in the island. It thereupon informed Dr Wilson, the Chief Medical Officer, that if the Jamaican government deemed it useful and a ‘competent man be secured for the purpose’, the Rockefeller Foundation could assist in undertaking a TB survey. It stressed that although the survey would be made through the government medical department and be placed under the direction of the Chief Medical Officer, there was no need for a ‘vote of funds by the government’. As all government expenditure had to be paid for from local revenue and which was very limited, this did much to persuade Dr Wilson. And Wilson became even more supportive when he was told that the IHD had secured the services of Dr Eugene Opie. Opie was the Director of the Henry Phipps Institute for the Study, Prevention and Treatment of TB at the University of Pennsylvania in Philadelphia, an institute with a state of the art laboratory, a 50-bed hospital, and large outdoor clinics (Washburn, 6 Jul. 1927; Wilson, 14 Jul. 1927; Wilson, 11 Nov. 1927; Washburn, 5 Dec. 1927).[[4]](#endnote-4) Opie became the consultant for the commission which meant that he trained staff sent out from North America; visited the island once or twice a year; and oversaw the results of tests submitted by local staff.

By 1927, the IHD was already carrying out work in Jamaica, ranging from hookworm, malaria and yaws control projects and school dental clinics to the formation of parochial health departments (Jones, 2013, chap. 6). That the IHD had hitherto avoided TB work in the island was largely because of the Rockefeller Foundation’s experience with TB control work in France during and in the immediate aftermath of the First World War (WWI). In May 1917, it set up a French TB commission that included 200 dispensaries and 4 mobile educational units. After the War ended, problems over the French government’s financial contribution to the commission and other issues soon mounted and by the end of 1922, the work of the IHD’s TB commission in France had virtually ended (Farley, 2003, chap. 3; Picard, 1999). Wycliffe Rose, the IHD’s director, and his successor Fredrick Russell regretted the IHD’s involvement in TB control and vowed never to get involved in TB control work again. This was largely because at the time TB was unlike most of the other diseases that the IHD worked on, such as hookworm or yellow fever, in that there was no insect that could be singled out as the main vector and be attacked by a ‘magic bullet’. In fact, when the IHD undertook its work in France, TB was generally acknowledged as a social disease for which there was no quick fix. The only cure at the time was a good diet, sunlight, and rest.

But by the late 1920s, the idea that TB was curable became more prevalent as patients with mild cases of TB were sent to sanatoria and with artificial pneumothorax (collapsed lung) some recovered, and experiments with a vaccine were undertaken (Farley, 2003, p.185). As a result, the IHD became less averse to undertaking TB work. Yet its experience in France meant that it did not want to offer treatment to TB sufferers in Jamaica but merely provide the Jamaican government with a set of recommendations on how best to prevent, control, and treat TB (Howard, 17 Mar. 1928). To do so, Dr Opie needed more accurate information about its prevalence and nature than the statistics provided by the registrar-general because many cases and especially deaths from TB went unrecorded because patients did not alert medical authorities or the latter failed to recognise TB. To obtain this more accurate information, Dr Washburn, who was appointed as the local director of the TB commission, carried out tuberculin tests in a few schools; lung tissue was gathered from the general hospital, the mental hospital and the poor house in Kingston; and a TB clinic was set up in Kingston in July 1928 with the specific aim of gathering reliable data (Farley, 2003, p.188). This and the later field surveys in rural parts of Jamaica and trial with a heat-killed tubercle bacilli vaccine illustrate that research and not treatment or eradication – as with other IHD campaigns in the island – was the main focus of the TB commission.

*The clinic*

The clinic was the focal point of the TB commission during the first few years. It offered basic treatment and relief for TB patients to encourage people to be tested by means of a tuberculin test, and followed up if the test proved positive. As its main aim was to gather data for the TB survey, the medical officer in charge of the clinic, one of its two nurses, and a clerk were all paid for by the IHD but the building was provided by the Jamaican government as it would take over the clinic after completion of the survey and convert it into a testing and treatment facility. Dr Washburn worked together with Dr Wilson to select the medical officer and a nurse from amongst the Jamaica Medical Service. They initially looked for a doctor with experience in TB work but as none was immediately available, they appointed the white, locally-born Dr Joyce Isaacs. She had a medical degree from University College London and had been a resident obstetric assistant and casualty officer at Westminster hospital. In addition, Helen Walker, a white, English-born woman and former matron of the Kingston hospital, was appointed as the clinic’s head nurse. The local Anti-Tuberculosis League (ATL) provided and paid for a second nurse, while one of the health visitors employed by the Kingston and St Andrew Corporation (KSAC) was ordered to work under the direction of the clinic. These two black nurses were mainly involved in home visiting. And finally, Margaret Manning, another white, locally-born woman, was appointed as clerk for the clinic (Opie, 6 Jul. 1928).

The Kingston clinic followed the procedure established by the Henry Phipps Institute for the collection of data. Each patient received a serial number. As soon as the patient tested positive, his family was placed on a visiting list and received a family number. In a folder under the family number, records were then collected of all members of the household. A nurse visited the family at regular intervals and observed and recorded their housing and habits, and also gave them advice on how they could protect themselves (Farley, 2003, p.186-7; Opie and Isaacs, 1930, p. 8-9). The Phipps procedure was somewhat adapted to conditions in Kingston. Finances, for instance, did not allow the clinic like the Phipps Institute to routinely take X-rays. Isaacs completed regular reports which she forwarded to Opie, who in turn informed Dr Howard at IHD headquarters about progress made. In 1930, the clinic moved to a new and larger building that included an X-ray laboratory. This along with publicity work by the ATL led to an increase in patients. By 1931, already 3,208 patients had been registered (Program for 1932).

In 1930, it was decided to enlarge the scope of the survey beyond the clinic and the Canadian Edward Flahiff and the American Hugh Smith were appointed for this work. After a brief training at the Phipps Institute, the men were sent out do field work, first in Smith village, located on the outskirts of Kingston, and later in other parts of the island.[[5]](#endnote-5) This field work, closely modelled on the method employed by the IHD’s hookworm commission, consisted of a medical officer and nurse, moving from house to house in an area and administering tuberculin tests. If found positive, they gave people a note to report for an X-ray and in some small towns and rural areas they even provided positive reactors with transport to the nearest X-ray laboratory, and anyone who failed to turn up to the X-ray examination received a home visit. Men and women whose X-ray showed a lesion had to give a sputum sample, were given a thorough physical examination, and their detailed history was taken. By 1932, the commission acquired a mobile X-ray unit, which considerably sped up this process (Flahiff, 1938, p.563-64). In most areas, about 65 to 90 per cent of the population agreed to take a tuberculin test, which was a very high take-up rate. It also needs to be stressed that until then, nowhere in the world had there ever been such a wide-scale TB survey. The field survey along with the opening of five other clinics led to the appointment of more local black nurses and also necessitated more clerical staff to enter data as well as the appointment of a driver, an assistant medical officer, and more specialist staff. Dr Clifford Wells, for instance, was appointed as head of the X-laboratory and was assisted by a locally-born doctor, who already had some experience in X-ray work (Report on Tuberculosis field survey, 1931).

*The trial*

But the TB commission not only gathered data to provide the government with a plan on how best to control TB, it also carried out trials with a vaccine. Washburn regarded this trial as ‘probably the most important feature of our tuberculosis programme’ (Washburn, 12 Aug. 1931). Research into a vaccine for TB started in the early twentieth century. By 1921, the French scientists Albert Calmette and Camille Guerin of the Pasteur Institute began to trial their live vaccine BCG on human beings. Between 1924 and 1928 some 114,000 infants susceptible of getting TB were vaccinated with BCG. A drop in the mortality rate amongst the vaccinated children suggested that it was an effective vaccine. Yet many still questioned the efficacy of BCG and looked towards an alternative vaccine, which received further impetus from the so-called Lübeck disaster of 1930 in which 73 of 250 vaccinated babies died and 135 became infected and never recovered (Luca and Mihaescue, 2013, p.53-8). An alternative to live BCG was vaccination with heat-killed tubercle bacilli. One of the scientists involved in the development of this vaccine was Dr Opie. In 1932, Opie had taken up a position at Cornell University. He and his team at Cornell first trialled the vaccine on rabbits. And when these animal-trials showed positive results, they then tried it on patients at the Jamaican mental hospital.

Most patients at the mental hospital came from rural districts with little exposure to TB. There were about 2,500 patients in the hospital with around 540 new admissions each year. Except for the ill and most violent, patients were allowed access to large compounds – one for each sex –, with no restrictions on movement. This arrangement along with overcrowded sleeping quarters facilitated the spread of TB. As such, the hospital offered an excellent opportunity to study the spread of contagion and the commission therefore included it very early on in its TB survey. Initially, it was just interested in following patients who tested negative for TB upon entering and determine how quickly they developed the disease (Opie, 15 Mar. 1929). From 1932 onwards, half of all newly-admitted patients that were found negative upon entering were given the vaccine with heat-killed tubercle bacilli and the other half were designated as controls. Initially, the vaccinated group was injected every week for up to ten weeks but gradually a single injection was used and they were tested seven weeks later. If tested negative, they were then given another injection. Both the vaccinated and control groups were given a tuberculin test and an X-ray, every three to four months for the duration of their stay (Program for 1932).

Between 1932 and 1938, about 210 patients were given the vaccine and 206 were used as controls. Some 23 of the vaccinated group developed TB and 39 of the control group, while 16 of the vaccinated and 27 of the controls died from TB. The conclusion reached on the basis of this trial was that heat-killed tubercle bacilli vaccine offered some protection in the first eighteen months after vaccination and that it would be useful for groups at a high risk of infection, such as medical students and trainee nurses. It was, however, admitted that the conclusion was problematic as the vaccinated group had been exposed to severe infection at the time when they were acquiring immunity, while the controls that did not get manifest TB seemed to have acquired infection and were protected by it (Wells, Flahiff and Smith, 1939; Wells, Flahiff and Smith, 1944).

The vaccine trial was gradually extended beyond the mental hospital. First to children at Stony Hill industrial school, Alpha orphanage and the Maxfield orphan asylum because the population in the mental hospital was of a relatively high age and the vaccine’s impact on a younger age cohort needed to be ascertained. About 300 children at these institutions were vaccinated and a similar number were used as controls. From 1939 onwards, the trial was rolled out to children in selected schools largely because teachers were ‘willing and eager to aid in securing the vaccination’ of school children. The children were given a ‘permit slip’ to be signed by parents or guardians several days prior to the tuberculin test, which authorised the child to be tested and vaccinated if necessary. The commission hoped that the schools taking part in the trial would be ‘the channel for broadcasting our work to the homes in the district’ (Flahiff, Jan. 1939). And finally, tests and vaccinations were extended to the general population and carried out in several colleges, the Venereal Disease clinic, the outpatient department of the public hospital in Kingston and also during house-to-house visits in both Kingston and rural areas. In addition, pupil nurses and members of the constabulary and military forces were tested and if necessary vaccinated. Table 1 provides a summary of the general population vaccination trial between 1939 and 1942. The vaccine trial came to an end in 1942 when results showed little difference between vaccinated and non-vaccinated groups. In total 9,167 Jamaican were vaccinated with the heat-killed tubercle bacilli vaccine between 1932 and 1942 (Bryder, 1999, p.1163).

Existing data does not indicate whether the adults that took part in the trial or who gave permission for their children to be vaccinated were fully aware of what they were participating in. That many were eager to take part should first of all be seen in light of the publicity given to the general population trial. While the trials in the mental hospital, industrial school and orphanages were never mentioned in public, the general population trial was regularly and positively referred to in the island’s main newspaper *The Gleaner*. In fact, the IHD even placed adverts in the paper calling upon people who had recently migrated to Kingston to get vaccinated. And the general population trial was also mentioned in a radio broadcast by Dr Cory, the island’s TB officer, in 1939.[[6]](#endnote-6) And that so many people came forward can also be explained by the low standard of medical care. As mentioned, TB was a leading cause of death before the arrival of the TB commission. In 1934, Opie provided the government with a set of recommendations to control and treat the disease. A lack of funds, however, meant that the government could not implement all recommendations so that by the late 1930s there was still relatively little treatment available for TB sufferers. There was a TB hospital in Kingston run by the KSAC and most, but not all, poor houses had a TB ward but these were the last resort for TB patients. Hence many people welcomed a ‘magic bullet’ to prevent infection with TB.

**II Race and Research**

The main focus of the Jamaican TB commission was, as mentioned, research. It first of all tried to assess the prevalence, nature, and spread of TB. When the survey was extended beyond the Kingston clinic, it soon became apparent that the incidence of the disease was lower in rural than urban parishes. And the survey also revealed that TB was mostly confined to adults and took a very rapid course. But the survey furthermore tried to assess whether black people were more susceptible to TB than whites, and/or if the disease took a different course in them.[[7]](#endnote-7) Opie had already examined differences between white and black patients at the Phipps Institute. The data collected in Jamaica had to enable him to explore in more detail whether the ‘characters, clinic course and mode of spread’ in blacks varied from that of whites (Report on Tuberculosis work, 1932).

To assess the impact of race, the forms used by the clinic and in field work included data on skin colour. Like other IHD projects in the Americas, the TB commission struggled to devise a racial classification system and map people onto it (Palmer, 2010, p.132-133). It came up with a range of skin colour designations that were a mix of locally-used and imported terms: black, dark brown, light brown, pale brown, white, East Indian and Chinese. An additional locally-used designation ‘Sambo brown’ was added in 1932. Staff particularly struggled to place ‘racial mixtures’, such as African-Chinese people. Should these be entered under ‘light brown with no reference to the racial mixture?’ or should additional categories be added for ‘half Chinese, half Syrian, or half something else?’ (Smith 29 Oct. 1932). It is very likely that locally-born staff put people in different categories than expat staff. Education, income, speech, propriety, ownership of property and so on affected how locals perceived skin tone. If they considered a person to be of the more common type, they would place them in any of the categories on the darker side of the colour spectrum. But if they saw them more as a member of the better class, then they would place them in any of the categories on the lighter side. Thus a dark-skinned head teacher was most likely returned as ‘sambo brown’ rather than ‘black’ because of his occupational status (Altink, forthcoming, chap. 3).

Because there were so few Whites, Chinese and East Indians affected with TB, the studies published by the TB commission concentrated on ‘the Negro race’. The term ‘Negro race’ was not commonly used in Jamaica at the time and not even by the colonial government, which used the following terms to designate race in the census and official correspondence: White, Black, Coloured, Chinese, East Indian, and Other. The use of the term ‘Negro race’, then, clearly indicates that the studies were geared first and foremost towards the American medical establishment. The commission concluded that TB in ‘the Negro race in Jamaica’ was of a different kind than TB in whites in Europe and America, pursuing a more rapid and fatal course and spreading more quickly in them. But by adding that more African Jamaicans than ‘American Negroes’ showed tubercle bacilli in their sputum and had more ‘infiltrating pulmonary lesions of the childhood or first infection type’, the TB commission suggested that race was not the main explanatory variable. In fact, they attributed the ‘more rapid course’ and type of TB that affected the ‘Jamaican Negroes’ to their socio-economic circumstances and culture: ‘uncleanly habits, unhygienic housing conditions, and lack of facilities for segregation of those who suffer with the disease’ (Putnam, Saward and Opie, 1941, p.22 and 31).

Already in their first published report from 1930 based on data gathered by the clinic, Isaacs and Opie had attributed some of the marked differences in the incidence and nature of the disease between Jamaican ‘negroes’ and Philadelphia whites to culture. They concluded, for instance, that it was not just poverty but also particular habits that facilitated the quick spread of the disease, such as ‘promiscuous relations’ and ignorance of ‘habits of cleanliness’ (Opie and Isaacs, 1930, p.19-20). Thus while officers of the TB commission did not state that black people were naturally predisposed to TB or a particular type of TB, they still saw race as a factor in the epidemiology of TB but which was now packaged as ‘culture’ rather than ‘nature’. It could be argued, then, that their reports reflect the onset of the shift from a scientific to a cultural racism, which gained momentum after the Second World War (Barkan, 1992).

But although the evidence gathered showed almost from the start that TB was a social disease and that certain racial groups were not predisposed to it, many IHD staff could not shake off their belief that blacks were naturally more susceptible. For instance, Dr Rufus Cole, the scientific director of the IHD, remarked that the findings of the TB survey ‘would be applicable not only to other tropical countries’ but also to ‘our Southern States’ (Cole, 1931). And the commission’s pre-occupation with the role of skin colour equally demonstrates a reluctance to let get go of the idea that race in and of itself played a role in the transmission and nature of the disease. The TB commission was not just concerned to see if TB was different in black than white people but also tried to assess whether there were any marked differences between ‘black’ and lighter-skinned African Jamaicans with regards to the incidence and nature of TB. This focus most likely arose because of concern expressed by various groups in America at the time about racial intermixing. In fact, it was not the first time that Jamaica was used as a laboratory to assess the impact of racial mixing. Elsewhere I have explored a study undertaken in 1927-28 by the American Eugenics Record Office to assess the impact of human miscegenation. In this study, some 100 ‘blacks’, 100 ‘browns’ and 100 ‘whites’ were subjected to various physical and mental tests and it was argued by the authors that there were physical and mental disharmonies amongst the hybrid race of the browns’, which warned against racial mixing (Altink, 2007).

A preliminary report about the role of colour in TB transmission was completed in 1934, based on surveys conducted in four parts of Kingston that had a similar class status. Although the population was given one of the afore-mentioned colour designations, they were for this study divided into two broad categories: ‘black and dark brown’ and ‘light brown and others’. On the basis of X-rays, it was concluded that ‘childhood lesions did not vary with color but that adult lesions increased definitely as color shades became lighter’ (Putnam, 24 Sept. 1934). The relation between colour and incidence and nature of the disease was also addressed in the survey of rural parts of Jamaica. But here where more than 90 per cent of the population was returned as ‘black’, it was found that ‘tuberculin reaction among persons of racial mixture does not differ in frequency from that of those wholly Negro’ (Wells, Flahiff and Smith, 1939, p.155). Thus over time, there was less insistence that race and colour in and of themselves enhanced the risk of contagion or nature of the disease and greater emphasis was placed on socio-economic factors – urban versus rural, middle class versus lower class, etc.

Race was not just a variable in the epidemiological research of the TB commission but also the reason why the vaccine was trialled in Jamaica. The Jamaican trial was one of several experiments in the years surrounding the Second World War in which black bodies were used in order to advance American medical science. The most well-known is the Tuskegee syphilis experiment that ran from 1932 till 1972 and in which 439 men with late stage syphilis and 185 controls without the disease were watched but not adequately treated for their disease. And another that has become known more recently is the STD study in Guatemala undertaken by the US Public Health Service from 1946 till 1948 in which 1300 men and women were infected with syphilis and other STDs but only half were treated (Reverby, 2012; Washington, 2006). That Opie decided to trial the vaccine not in Philadelphia or any other part of the US but in Jamaica was, as in the case of the Eugenics Record Office experiment, because conditions in the island made it relatively easy to do this research. Jamaica was an English-speaking country and there was a chief medical officer interested in preventive TB work, who helped the commission secure human subjects without involving a consenting process. It would have been far more difficult, albeit it not impossible as the Tuskegee experiment shows, to undertake such a wide-spread trial in the US. In the US, it would have been harder to find officials to agree to undertake trials in orphanages and mental hospitals, and race relations were such that it would also have been more difficult to get adult black men and women to take part in a vaccination trial once experiments with selected groups were completed.

The vaccine trial started in the mental hospital, followed by the orphanages and industrial school, and was finally rolled out to selected schools and the general population. That it started with groups that were not in a position to consent, is unsurprising because, as Washburn told Howard, in Jamaica ‘as elsewhere people don’t like to feel that they are being “experimented” upon’ (Washburn, 24 Mar. 1931). Nearly all patients in the mental hospital and the children in the orphanages and industrial school were ‘black’ and ‘dark brown’ because of the close link between class and colour at the time. We do not know what they were told about the tests that they were subjected to and the inoculations they received – while most received a single injection others were given multiple injections – but it is unlikely that many would have questioned this process. They were then, as John Farley has argued more generally of people who took part in IHD research, ‘convenient guinea pigs’ (Farley, 2003, p.189).

Even though the general population trial was reported in the newspaper, it seems not to have been clearly conveyed that not everyone would be vaccinated. In fact, the commission feared that many of the controls would demand to be vaccinated. It also fully realised that it would be difficult to follow up the vaccinated and control groups in the poorer sections of Kingston, where the population was very unstable, a problem that also plagued the Tuskegee experiment (Memorandum for Jamaica, 1942). Flahiff made a suggestion to counteract this problem; namely, an additional trial in a rural part of Quebec (Canada), where TB was also highly prevalent but the population fairly stable. Yet he soon questioned this because it might be ‘much more difficult’ to explain to the Quebecois than to the Jamaicans why some individuals were vaccinated and others were not (Flahiff diary). So again, we see that stereotypical ideas of race informed the work of the commission. Flahiff clearly assumed that African Jamaicans were less intelligent than white Quebecois and could thus more easily be fooled into accepting why they were not vaccinated.

**III Race and Staff Interaction and Staff-Patient Relations**

In countries with significant racial minorities – or majorities in the case of the British West Indies – , dominant ideas about race and colour informed the IHD’s employment of local staff. Steven Palmer (2006, p. 23), for instance, has shown that the US directors of the hookworm commissions in Guyana and Trinidad favoured Indo-Caribbean men as microscopists but preferred black men as home visitors. The Jamaican TB commission was marked by a similar racial hierarchy: the most senior posts were held by white (local or ex-pat) staff and the most junior posts were occupied by dark-skinned Jamaicans. At the time, there were African-Jamaican doctors, who were as well trained as Isaacs and like her lacked experience in TB work. Yet none was ever considered for the post and it was a white, locally-born doctor, who was appointed as Isaac’s assistant: Dr Richard Cory. The IHD was convinced that it was best to appoint ‘black nurses’ for both home visiting work and the field surveys ‘as it would be easier for them to adjust themselves to local conditions’ (Washburn, Oct. 1936).

Yet the most prestigious nursing positions, such as head nurse of the clinic, were reserved for white women. When Helen Walker resigned in 1930, the aim was to get another white woman to replace her. In an island where whites made up less than 2 per cent of the total population and nursing was seen as a lower middle-class profession, it was quickly realised that this would not be easy unless the Overseas Nursing Association were to be asked to supply a nurse from England. As this would take too much time, it was suggested to offer the position to a ‘brown girl’, who had only been at the clinic for two months but was seen to be ‘by far the best nurse with any colored blood’ (Carley, 15 Jul 1930). This ‘brown’ nurse was clearly regarded as second-best. And to further illustrate that white women were preferred for the more senior nursing posts, when Dr Wells was appointed in 1932, Howard asked if it ‘would be possible to get a suitable white nurse in Jamaica’ to work with him. Considering concerns about racial mixing in the US at the time, this is unsurprising as Wells would have had to work closely together with this nurse. Attempts were made to meet this request. Mrs Dun, the white wife of a local government official who had been trained and worked as an X-ray technician in the US, was seen as the ideal candidate and also came highly recommended by the Chief Medical Officer (Howard, 2 Jul. 1930).

The racial hierarchy operated by the TB commission mapped closely onto that of the government medical service. The most senior positions in the government medical service, such as head of a hospital or matron, were always held by white expats. Local whites were the second-highest ranking officers. As I have shown elsewhere, they were often appointed to posts for which there were more experienced or better qualified African Jamaicans available. Some – mostly very light-skinned –[[8]](#endnote-8) African-Jamaican doctors and some nurses occupied fairly high roles in the service but they were only appointed to more senior posts in an acting capacity. And finally, the bottom rung of the government medical service was made up of un- or poorly-trained nursing staff, such as the mental hospital attendants and rural midwives (Altink 2012 and 2013).

The sources on which this article is based reveal little overt discrimination of white ex-pat staff towards black staff, like that expressed by Dr Cornelius Rhoads, who undertook research for the IHD into anaemia in Puerto Rico and complained that Puerto Rican people were the “laziest, most degenerate and thievish race of men” (Farley, 2003, p.81). Yet they do reveal that North American doctors were informed by the racial prejudices and ideas of their own society. For instance, the IHD bio-statistician Dr Hugo Muench visited Jamaica in 1932 and included in the diary of his visit, several lists of made-up first names that he had read while analysing data from the Kingston clinic, such as Viris and Synsent. These names, he argued, showed ‘imagination and some originality!’ (Munch diary, 1932). The exclamation mark conveys that he, like many white Americans today who deride black names, did not mean this as a compliment.[[9]](#endnote-9) Wells, on the other hand, was highly critical of the non-white members of the commission. He wrote, for instance, that ‘one familiar with local personnel in Jamaica fully realizes their short-comings and the necessity for prolonged instruction and training’ (Wells, 2 Feb. 1932). And Dr John Weir, who worked on the general population vaccination trial, was also less than appreciative of local staff, claiming for instance that local nurses had developed a ‘Rockefeller Foundation complex’, asking for taxis to take them to and back from work (Weir, diary). Muench, Wells and Weir, then, drew upon the stereotypical ideas about black people of their own society – as lazy, stupid etc. – and most clearly expressed by Weir, were also keen to see a similar racial order as in their own society in which blacks knew their place.

But not all expat members of the commission held negative opinions about local black people. Washburn, for example, disputed Wells’ observation, claiming that local staff were ‘as efficient as any I have had in any place in which I have worked’ (Washburn, 5 Feb. 1931). And because Flahiff seemed to relate well to local staff, Opie decided to put him and not Wells in charge of the vaccination trial because ‘he is less likely to make up his mind beforehand and works in closer sympathy with his associates’ (Opie, 1 Sep. 1937). Flahiff even went the extra mile for some local staff. In 1939, for instance, he asked IHD headquarters if there was a possibility for Dr Parkin, who assisted in the taking of X-rays in the field, to take a course in radiology in the US. He was asked to provide not just information about Parkin’s ‘training and experience’ but also whether he was ‘white or colored’ (Lambert, 15 Aug. 1939). This question points to the racism in American hospitals at the time because even in the non-segregated North there was a strong dislike of dark-skinned doctors (Byrd and Clayton, 2001, p.21s). As Flahiff was keen for Parkin to get onto a course, he described him not as ‘colored’ but as ‘“swarthy”; that is, nearer a light brown’ (Flahiff, 8 Sept. 1939).

While there was a high take-up of the tuberculin test in the field survey, not all Jamaicans welcomed the commission and its work. When the commission extended its work beyond the clinic to a survey of selected areas in Kingston, they encountered considerable opposition from locals. In fact, even the locally-born sanitary inspectors, who undertook a census of each person living in the area and handed out letters to householders explaining the survey, were ill-treated. Rumours circulated that the tuberculin test was an instrument used by the ‘white race to destroy the colored race’. And more particularly, it was claimed that it would lead to infertility in women, which particularly caused concern as lower-class men and women placed a high value on fertility. A successful way used to overcome this opposition was to offer everyone who submitted to a tuberculin test also an X-ray: the novelty of being able to see their own lungs on a screen led many men and women to take a test (Report on tuberculosis field survey, 1931).

Like the sanitary inspectors, local nurses were also not immune from abuse. The nurses attached to the Kingston clinic, for instance, often had to deal with patients, who did not want to be visited because their neighbours would realise they had TB and shun them (Report Kingston Clinic, March 1931-32). It was especially when the vaccination trial was rolled out across the general population that the nurses encountered much opposition. This should largely be seen in light of a birth control campaign started around the same time and which was widely reported in the press.[[10]](#endnote-10) It was assumed by many men and women that the nurses wanted to trick people into adopting birth control. And others refused to cooperate with the trial because they saw it as ‘a campaign initiated by the white people to poison all the black people in the island’ (Flahiff, diary Feb. 1939). These two objections often merged together. One nurse, for example, encountered a soap box orator in Trench Penn, who told a crowd that ‘at present the black population was in ratio of 14 to 1 white man, that white people were, therefore trying to decrease the black population. That was why they were going around injecting people, particularly women, to dry up their wombs’ (Flahiff, diary Mar. 1939). The island-wide labour riots that had occurred only a year earlier and which had done much to raise race consciousness also do much to explain this opposition to the vaccination trial.[[11]](#endnote-11)

**Conclusions**

Studies on race and medicine published in recent years fall into two categories: narratives of abuse and suffering and narratives in which non-white people triumph over adversity (Revereby, 2007). The story presented here is largely one of abuse: the bodies of the most vulnerable black Jamaicans were used to test a vaccine that was to help first and foremost white bodies. It is less a story of non-white people triumphing over adversity. Although African Jamaicans did not uncritically accept the work of the TB commission, many welcomed the Kingston clinic and others that were set up in its wake and willingly took part in the general population trial with the heat-killed tubercle bacilli vaccine. The sheer fact that TB was one of the main causes of death and that medical care was limited, like in other British colonies with black majorities, largely explains why so many African Jamaicans did not actively resist the work of the commission.

But this does not minimise the role that race played in the work of the commission. The commission’s research into the epidemiology of TB emerged out of a particular understanding of race; namely, that black and white were inherently different and that this difference mattered when it came to disease. Although the commission concluded that it was not biology but socio-economic circumstances that explained why TB in African Jamaicans took such a rapid and fatal course, it struggled to shake off this belief in the natural difference between white and black. Yet while race informed the commission’s research into the transmission and nature of TB, it did not shape its research into an alternative vaccine: it never attempted to assess whether white and black people responded differently to the vaccine but merely wanted to test whether the vaccine was as effective in human beings as it was in the rabbits used by Opie in his lab at Cornell. But it is no coincidence that it trialled the vaccine on black rather than white bodies as they were easily available and of lesser value. In doing so, the commission followed a long tradition in which black bodies were (mis)used to advance American medical science. During the era of slavery, African Americans – both as patients and cadavers – were subjected to surgical and other medical experiments (e.g. Kenny, 2015). And this exposure to untried drugs and other experiments continued after emancipation, culminating in the Tuskegee syphilis experiment (Washington, 2006). Furthermore, as illustrated by amongst others the US Public Health Service VD experiment in Guatemala, African Jamaicans were but one of several groups of black men and women outside the US at the time, whose bodies were experimented upon by American medical scientists.

And race also informed staff interaction and staff-patient relationships. Expat members of the commission brought with them their particular understandings of race. They assumed that for certain positions only whites were suitable and looked down upon the norms, values, and practices of African Jamaicans. As such, this study lends further support to existing work that exposes the structural racism integral to American medicine. But not only the commission also the government medical service was not free from institutionalised racism. Many members of the commission were appointed by the chief medical officer in liaison with Washburn and Opie. This meant that the staff hierarchy of the commission was effectively a race/colour/class hierarchy.

Although of a very different nature than the Tuskegee and Guatemala trials, the Jamaican TB commission’s trial with an alternative vaccine and its research into the transmission and nature of TB too drew upon and helped to reinforce the idea that black bodies had a lesser value than white bodies. And even though it gradually came to see race less as a biological and more as a socio-economic category, the commission’s work was filtered through with assumptions about white superiority and black inferiority that shaped day-to-day interactions between staff on the one hand and staff and patients on the other. While Jamaica and others former British Caribbean colonies have long been independent, they still act as convenient ‘laboratories’ for American medical science. Johns Hopkins university, for instance, carries out genetic research in Barbados because this allows it ‘to ethically address the African diaspora without the quandaries of accusations and recriminations experienced in carrying out such work in urban America(Whitmarsh, 2011, p.177). The reason why many African-Caribbean men and women today willingly participate in trials conducted by American researchers – and often without being paid – is the same as that of the Jamaican men and women attended the TB clinics and participated in the general population trial; namely, the low standard of local medical care. An important lesson, then, that this case study provides is that black bodies in the Caribbean and other parts of the Americas will continue to be (mis)used to advance American medical science unless governments provide their people with affordable and adequate medical care.

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1. The first edited collection on the history of Caribbean health and medicine (De Barros, Palmer, Wright, 2009) was only published in 2009. [↑](#endnote-ref-1)
2. Global health has been defined in different ways by different disciplines (e.g. Beaglehole and Bonita, 2010; Koplan et all, 2009). Here the term refers to health issues and initiatives that transcend national borders and aim to bring about health equity globally. On the history of global health, Packard (2016). For the rise of the subfield of global health history and its main themes and issues, see (e.g. Harrison 2015, Johnson, 2016, Lowy) [↑](#endnote-ref-2)
3. There is a substantial body of work on the IHD. The first studies were mostly institutional histories. A second wave offered a sharp critique of the IHD, questioning its humanitarian claims and presented it as little more than an instrument of US imperialism. But the most recent work on the IHD, which tends to focus on a single location or a single disease, has presented a more nuanced picture by paying as much attention to Rockefeller staff as local players, strategies, health traditions and institutions and their interplay (e.g. Cueto, 1994; Palmer, 2010). In his ‘biography’ of the IHD, John Farley (2003) has devoted only four pages to the Jamaican TB commission and has only briefly touched upon race in IHD campaigns. [↑](#endnote-ref-3)
4. Although Opie took up a position at Cornell University in 1932, the IHD continued to finance his work. By then, he had moved on to develop a ‘magic bullet’ for TB: a vaccine with heat-killed tubercle bacilli (Farley, 2003, p. 189). [↑](#endnote-ref-4)
5. The men selected areas that allowed them to determine crucial factors in the spread and nature of the disease. Hence some areas were isolated, while others were more urban and some had a high and others a low proportion of people with a high socio-economic standing. [↑](#endnote-ref-5)
6. See, for instance, *Gleaner* (4 March 1939, 23 March 1939, and 22 January 1940). [↑](#endnote-ref-6)
7. Also in other places and for other diseases did the IHD collect information on race and ethnicity but not always with the overt aim to determine whether race was a major factor in the nature and spread of disease (Palmer, 2010). [↑](#endnote-ref-7)
8. That these were mostly light-skinned men and women is because their positions required a secondary school education. And as class and colour were closely entwined at the time, it was mostly light-skinned boys and girls, who went to secondary school (Altink, forthcoming, chaps 1 and 2). [↑](#endnote-ref-8)
9. Even today, black first names in the US are often derided as ‘ridiculous’ or ‘stupid’ and men and women with names such as Keisha or LaTroy are treated less favourably than those with more Anglo-American names as Kate and John (Holbrook, Fessler and Navarette, 2016). [↑](#endnote-ref-9)
10. Bourbonnais (2012) has explored this campaign in detail. [↑](#endnote-ref-10)
11. Thomas Holt (1992) has provided a detailed account of the riots. [↑](#endnote-ref-11)