História, Ciências, Saúde - Manguinhos
ISSN: 0104-5970
hscience@coc.fiocruz.br
Fundação Oswaldo Cruz
Brasil

Pemberton, Rita
Dirt, disease and death: control, resistance and change in the post-emancipation Caribbean
História, Ciências, Saúde - Manguinhos, vol. 19, diciembre, 2012, pp. 47-58
Fundação Oswaldo Cruz
Rio de Janeiro, Brasil

Dirt, disease and death: control, resistance and change in the post-emancipation Caribbean

Sujeira, doença e morte: controle, resistência e mudança no Caribe pós-emancipação

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Received for publication in August 2011.
Approved for publication in May 2012.

PEMBERTON, Rita. Dirt, disease and death: control, resistance and change in the post-emancipation Caribbean. *História, Ciências, Saúde – Manguinhos,* Rio de Janeiro, v.19, supl., dez. 2012, p.47-58.

Abstract

This study examines how health facilities and services were used as an agency of worker control in the British Caribbean between 1838 and 1860. It argues that planter health strategies were based on flawed assumptions. The resultant policy of deprivation of access to medical services by the labouring population backfired within 16 years of freedom when a cholera epidemic rocked the region. It exposed the poor living conditions of the free villages and generated fear and panic among the local elite who were forced to make policy changes regarding health and sanitation. As a result the first steps towards the establishment of public health services in the British Caribbean were stimulated.

Keywords: British Caribbean; emancipation of slaves; health policy; sanitation; cholera.

Resumo

Examina o uso de instalações e serviços de saúde como instrumento de controle dos trabalhadores no Caribe britânico entre 1838 e 1860. Argumenta-se que as estratégias sobre a saúde adotadas pelos proprietários rurais baseavam-se em suposições inconsistentes. A decisão de privar a população trabalhadora de acesso a serviços médicos teve graves consequências: 16 anos após a abolição da escravidão uma epidemia de cólera abalou a região, desnudando as precárias condições de vida das aldeias libertas e gerando pânico na elite local, então forçada a fazer mudanças na política de saúde e saneamento. Só então foram estabelecidos os primeiros serviços de saúde pública no Caribe britânico.

Palavras-chave: Caribe britânico; abolição da escravidão; política de saúde; saneamento; cólera.

> the boon of freedom granted … has proved a source of misery…
> (Sturge, Harvey, 1968, p.132-133).

The narrative of the post-emancipation history of the Caribbean has been heavily influenced by the plantocracy and its concerns. The very first assessments of the Caribbean in this period were stimulated by planter responses to emancipation. Their attitude to, and predictions of, emancipation and its consequences became the focus of various interest groups. In the attempt to prove or disprove the planters, the early reports of the free society focussed on the responses to freedom by the affected groups and the overall impact of emancipation on the society and economy of the region. For example, in seeking to establish the progress made by the free people in Antigua since emancipation, Sewell (1968, p.144-150, 256-257) discusses the growth of the free villages, attendance at schools and the state of sugar production, vice and immorality. Reflecting this trajectory, scholarly attention has focussed on the celebration of emancipation day, post-emancipation labour relations, the sugar industry and its problems and the growth of free villages and their communities.

As a consequence the existing historiography has addressed comprehensively the economic and varying aspects of the social issues pertaining to the post-emancipation Caribbean. With respect to social issues, focus has been placed on social relations, the growth of free villages, education, religion, morality and cultural expression. There have been descriptions of the physical state of the free villages and their communities but there has been no comprehensive attention to issues of health and their relationship to the ethos of post-emancipation societies. However, as Hilary Beckles (2001, p.199) has argued, it is necessary to adopt a "wide social vision" and not be restricted by "conceptual cul-de-sacs" when dealing with Caribbean social history for "so much is overlooked when we sidelined social processes". This study therefore seeks to widen the social vision and bring developments in heath centre stage to expose this aspect of the Caribbean historical experience and provide another perspective for analysing the region's history. This is done by an examination of the health issues of the first two decades after emancipation to determine their role in the evolution of Caribbean societies. The study discusses how health service provisions were used by the planting community as a commodity to be traded for labour services during the immediate post-emancipation years and the consequences both to workers and the wider society.

I argue that health provided avenues for a display of power relations in the post-emancipation situation. In his discussion of the role of doctors in 19th century Cuba, Steven Palmer (2009, p.54-55, 57) identifies a pattern that was similar to that in the 18th century British Caribbean. However, he notes that whereas in Cuba the role of doctors and medical personnel became more important after the end of enslavement, in the British Caribbean, the community of European-trained doctors diminished significantly as some migrated to Cuba. This made medical services scarce and expensive in the British Caribbean, thereby empowering the planters to manipulate such health services as were available for their own ends. Indeed, the evidence suggests that even before full freedom in 1838 there

were indications that health would be used as an agency of planter control in the era of freedom. There are three important areas of manipulation of the free population through health and medicine in Caribbean history that are instructive. The state of free children during the period of apprenticeship, the medical provisions of the Emancipation Act and the prejudiced attitudes regarding Africans' illnesses all reveal the lack of concern for the welfare of the free people.

The racialization of medicine was evident in the practices of the Spaniards, who believed that there were basic physiological differences between the indigenous people and the Europeans, which led to the formulation of a colonial medical system that was based on racial lines (Sowell, 2009, p.79). In the post-emancipation British Caribbean, this racism was commonly displayed with reference to the 'dirty' habits of the freed Africans. The caution expressed by Resident W. R Inglis of the Turks and Caicos Islands that "disease begins with the poor but could extend to the more fortunate classes, and therefore is it that our own preservation should induce the attempt to ameliorate their condition" (Inglis, 15 Jan. 1855) reveals both the ingrained prejudice against the lower classes and the primacy of upper-class benefit in stimulating social intervention. I also argue here that the post-emancipation period offered the opportunity for the 'commoditization' of health. It was used as an item for bargaining with workers for their labour. It was assumed that the free people attached a similar value as the planter to access to plantation health facilities and that disease and death would drive them back to the estates. The assumption was wrong and this research shows how the strategy backfired. The study begins with a discussion of free society in the British Caribbean to identify those issues that are relevant to this discourse.

Free society

In his discussion of Caribbean free society, Franklin Knight (1990, p.164) suggests that there are two angles from which the dismantling of Caribbean slave systems can be approached: "the metropolitan dimension and the local perspective. Neither can be fully understood without the other". He explains that the metropolitan dimension reflected a concern with politics and international economics and in this processes the welfare of the enslaved was "an incidental part of official policy" since "concern for commerce prevailed over concern for humanity" (p.167). As a consequence, the predominant concern of planters and policy makers of the region was related to the maintenance of plantation operations and their profits. Central to their policy interest was the question of labour, which planters had anticipated would be problematic during the era of freedom. This conviction resulted in the implementation of a number of mechanisms to control labour which planters saw as essential to the survival of their plantations. These strategies included repeated use of particular expressions to refer to the freed Africans.

With regard to the language of freedom, Demetrius Eudell (2002, p.56) refers to the "unambiguous attempt to control labour" citing a committee of planters in Jamaica who stated that: "we know the habits of negroes... without coercion they will not labour". Implied here is not merely the expectation that the free workers should, but a conviction that they must, comply with planter expectations or be made to do so. Hence, as Bridget

Brereton and Kelvin Yelvington have argued, although the African population was legally free after 1838 "everywhere they were in chains" bound by "colonial chains ... and, more often than is supposed, by naked force" (Brereton, Yelvington, 1999, p.5).

After 1838, labour was the prime commodity in the region. It was central to the operations of the plantations and the social, economic and political structures that they bred. Unable even to conceive of a society without controlled labourers, plantation owners devised strategies to ensure themselves such a labour supply in the era of freedom. Despite emancipation, planters continued to regard the freed Africans as estate labourers who would remain in perpetual service of the sugar plantations. This attitude, and the fact that planters controlled the apparatus of colonial government, had implications for the "boon of freedom" (Sturge, Harvey, 1968, p.132). Thus, in the quest to understand the local perspective regarding the dismantling of the slave system in the Caribbean, it is essential to consider the concerns of the two major groups in the society. The local perspective must therefore reflect actions and reactions of both planters and free people, particularly to labour, in the era of freedom.

Post-emancipation labour strategies were centred upon reducing the costs of labour and maintaining planter control of the labour force. Low wages, reduced planter obligations to workers and the importation of indentured labour were facets of the planters' strategy. Philip Curtin (1970, p.51) observed that medical services "of a sort" were provided on the estates during enslavement when it was in the planters' interest to keep their enslaved populations alive. Wanting to be spared this expense during freedom, their focus was on importing indentured labour while the "creole Jamaicans died from lack of sanitation and medical care".

Charges of neglect of the freed people can be made against both the imperial and the colonial administrations. To substantiate these claims, evidence has been drawn from the continued planter control of the colonial administration and the overall support for their activities by the imperial government to the detriment of the free people. In fact, it was clear that the imperial intent was to maintain the system of production without the stigma of enslavement attached to plantation operations. This is indicated by the Emancipation Act of 1833, which left room for planters to manipulate the system as suited them to ensure that the traditional mode of plantation operations was not disturbed. Ultimately, reduced humanitarian involvement in matters relating to the newly freed population, the preoccupation of British Parliamentary debates with other matters after the initial years of emancipation and the absence of social legislation and welfare programmes in the region provide the strongest evidence of this neglect. Conditions in most of the free villages reflected this neglect.

In his discussion of the post-emancipation Caribbean, William Green (1976, p.302-303) notes that there were both haphazard and planned villages in post-emancipation Jamaica and Guyana. Missionaries in Jamaica and communal effort in Guyana were the driving forces behind these planned villages. In an effort to exonerate planters of the dearth of their welfare efforts in the free communities, Green blames the downturn in the economy. He states:

> There was a revival of interest in social legislation when sugar prices turned upward in the late 1850s, but prices quickly subsided in the 1860s. By that time conditions had deteriorated among the working people and in many colonies a distinct polarization had developed between the European and Afro-Creole culture groups. Although it is easy and convenient to blame the planter class for this polarization, an examination of just one aspect of public welfare – medical service – offers insight into the great fissure which separated West Indian social welfare from the meagre resources available to cope with them (Green, 1976, p.309).

He claims that the smaller islands were unable to afford new structures to improve the welfare of the population because of their economic circumstances, especially the difficulties created by the imposition of the Sugar Duties Act in 1846 (Green, 1976, p.309), but the evidence does not support this claim. The fact is that in the 1850s, when cholera broke out in the region, it stimulated such fear and panic that the authorities were forced to implement some modicum of welfare provisions in their attempt to stop the ravages of the epidemic, despite the prevailing economic circumstances.

Planters were consistently ungenerous with their concern for the welfare of their enslaved charges. As is illustrated in the observations of Sturge and Harvey (1968) in their discussion of the West Indies on the eve of full emancipation, this pattern of behaviour did not change during the era of freedom. Developments during the Apprenticeship period provide a preview of planter actions in the years of full freedom. They note that in 1837:

> The medical attention to which the negros are legally entitled, is accorded to them in the same imperfect and grudging measure as the means of subsistence. The neglect and oppression of the sick is the frequent subject of complaint with the negros … The medical men, imbued with colonial habits and prejudices, and dependent on the planters for professional income, are in most instances subservient agents of oppression. On many of the smaller properties, there is no hospital nor medicine chest, and the apprentices are frequently left destitute of medical treatment …. The Act in Aid of the Abolition Act, (c.VII) declares, 'that the apprentices shall be subject to all such necessary sanatory restraint and control, as the medical attendant shall direct' (Sturge, Harvey, 1968, p.361-362).

Describing Jamaica in the period, Philip Curtin (1970, p.160) refers to the "frightful sanitation" in Kingston and rural areas. He states that while the population suffered from hookworm and malnutrition, the assembly refused to spend more on public health favouring immigration.

Similar stories emanate from other British Caribbean territories. Sewell (1968, p.77, 84, 204) observes the decay of the capital of St. Vincent, the dilapidated state of St. Georges and filthy towns of Kingston and Falmouth. George Brizan (1998, p.180) notes the unhealthy surroundings of the lower classes prevalent in urban and rural areas of Grenada, and argues that they reflected "the relative neglect of the social conditions of the working people after 1838". Citing Trinidad's mortality rates as 4.27% in 1848, 4.02% in 1849, 4.12% in 1850, 5.13% in 1851 and an average total mortality for the period of 1 in 27-70 persons, Hector Gavin (July 1852, p.6) concluded that the excessive mortality of the town and in particular, the infant mortality rate, was proof of its defective sanitary conditions. He reported that the 'wretched dwellings' of the poorer classes were generally overcrowded in both the towns and country (Colebrooke, 12 July 1854).

Commenting on the situation in the Turks and Caicos islands in 1855, Resident Inglis (15 Jan. 1855) describes free people surviving on "the poor most meagre diet in the wretched hovels, and under circumstances where any attention whatever to cleanliness or other sanitary condition, would be too much to expect".

The result was the prevalence of disease in the free settlements across the region. Epidemics were common and there were tragic episodes of cholera and smallpox in free society. The incidence of yaws increased after 1838 and the more common diseases of the fevers and the fluxes continued as everyday occurrences. But the failure to provide accessible health services to the freed population and the use of health as a commodity for bargaining for labour backfired on the elite population. The cholera epidemic of the 1850s caused widespread panic as the disease raged through the region leaving a trail of mortality and stench as it stimulated a belated attempt to sanitize the society by the introduction of a variety of sanitary measures. These included the establishment of health boards, the provision of district health services, pipe-borne water and street cleaning services in urban areas, hospital accommodation and smallpox vaccination.

Backlash: the cholera epidemic

The cholera epidemic in the British Caribbean, which began in Jamaica in October 1850, spread to The Bahamas in 1852, St. Thomas and Nevis in 1853, Trinidad, Barbados, Jamaica, Grenada and the Eastern Caribbean in 1854, Turks and Caicos in 1855 and Guyana in 1856. The cholera experience, which was similar in the colonies of the region, well illustrates 'the misery' that came with freedom. Before the epidemic reached the British Caribbean possessions and as cholera made its way around the world, the British Government was jolted into action. A medical team comprising doctors Gavin Milroy, Hector Gavin and Thomas Cooper was sent to the region to assess the state of the colonies and to recommend measures to pre-empt the looming scourge. They recommended the creation of sanitary administration in the colonies, the introduction of laws with punishments and the appointment of sanitary inspectors with powers to charge offenders in order to ensure compliance with the sanitary regulations.

Jamaica, which also suffered epidemics of smallpox and influenza in the same year, had one of the highest mortality rates for the disease. This island lost 10-12 per cent of its population, about 30- 40,000 people. Barbados's death toll was about 20,000 or 13 percent of its population, and St. Kitts's was 16 percent (Huggins, Kiple, 1991, p.42-43). In Grenada, where 12 percent of the population was lost in three months, the death toll was 3778 (Steele, 2003, p.213). In the Turks and Caicos Islands, the outbreak, which was confined to Salt Cay, killed fifty people (Inglis, 15 Jan. 1855).

The epidemic caused a severe disruption of society. There was a serious loss of labour and a suspension of much economic activity, as both domestic and field labour became short. W. Alex Furtado (1890, p.29) reports that deaths from cholera were so numerous that in Spanish Town, Jamaica, a race course was adopted as a burial ground, putting an end to horse racing there for years. Political activities were also affected (Holt, 1992, p.230). As the disease swept through the territories it created terror in the population. People were

dying like flies (Carter 1990, p.405), corpses (and some living people) (Bowerbank, 4 Apr. 1866, p.401) were piled into carts and taken to the cholera grounds for burial. The graveyards overflowed and there was a shortage of grave space. Given the heavy demand for burials, the regulation requiring a six-feet depth was often disregarded and many graves were not properly covered (Brizan, 1998, p.182). There were also instances when "the dead could not be buried, and corpses were left for days on the ground: a prey to dogs and vultures" (Milroy, 1854, p.16).

The authorities resorted to mass burials as the only way to cope with the large numbers of the dead. There was also a shortage of grave diggers and carters as the panic-stricken people avoided those jobs which brought them in contact with victims of the disease. The solution, devised by the administration, was to use prisoners as carters and grave diggers. Thus the disease was introduced into the prisons, where it decimated the inmate population. Seized with fear, people fled from their homes and from afflicted areas in an effort to escape the disease. Panicked estate owners fled their estates (Steele, 2003, p.314). There was a tendency for people to seek sanctuary in the rural areas in order to isolate themselves, but this movement only facilitated the spread of the disease from one area to another. Afflicted people were chased from their homes and communities and were shunned and abandoned by their relatives (Carter, 1990, p.405). This was certainly a time of misery.

The sequel

Alvin Carter (1990, p.417)describes the cholera epidemic as "a blessing in disguise" as it revealed the state of abject poverty and neglect of the free communities and underlined the need for action in vital areas of public health. The cautions of Resident Inglis of the Turks and Caicos island resonated in the region as the official response to the disease was a frenzied sanitization campaign which included placing blame for the disaster on the 'dirty habits' of the people (and in the process exonerating themselves from any responsibility) as they sought to create an environment that was safe for themselves.

In his report on St. Kitts, Medical Inspector Cooper (1855, p.10) blames "the general habits of the black and coloured population... a dislike to regular medical attendance upon them; they prefer to quack themselves with herbs and barks". While commending the efforts of the Barbados legislature for their "liberal" provisions to dispense relief and save many lives, Governor Colebrook (12 July 1854, p.10) lamented that "from the habits of the people it will be necessary to take prompt and energetic measures to guard against a recurrence of this Epidemic". Commenting on the outbreak in Jamaica in 1851, he also stated that fear of its spread induced the legislatures to attend to the sanitary condition of the town in which, "through the neglect of wholesome regulations, a population had grown up in habits the most favourable to the reception and propagation of epidemic diseases (Colebrooke, 27 Nov. 1854). Gavin Milroy (1854, p.15, 18, 46, 49) blamed the lower orders for their own misery and Governor Keate blamed the people of Grenada for the outbreak (Brizan, 1998, p.219). The prevalence of the view that the disaster resulted from natural tendencies of the African people exonerated the administration from any

blame in the matter and gave support to the need for legislation and punishments to force the naturally dirty people to adopt the desirable clean habits.

John Parkin (1852, p.38) notes that in Jamaica, the measures instituted to deal with the disease were of two types – individual and community-based. Individual measures included house-to-house visitation in an effort to detect the disease in its earliest stages, when the chances of cure were greater. This presented difficulties as there were never enough medical personnel on the island to make this strategy effective. The second aspect of the strategy sought to establish a cleaner environment by the removal of the causes of disease, nuisances of the society, stagnant smelly drains, open cesspools, piles of dirt, and provide the population with clean water. Special cholera hospitals were established to try to contain the disease and public welfare provisions, which included soup kitchens and the distribution of medication, were instituted (Feurtado, 1890, p.30).

In Barbados, a centralised public health machinery was created by the 1856 Public Health Act. The general hospital was brought under the central administration and hygiene was added to the school curriculum. The Central Board of Health was reconstituted and district boards were established (Beckles, 2006, p.142). Sanitary bodies were created and given responsibility for sanitation in both urban and rural areas and sanitary inspectors were appointed (Carter, 1990, p.396). Bridgetown was divided into seven medical districts with two medical officers each. Welfare provisions in Barbados included the establishment of a House of Refuge and soup kitchens to serve the poor. A daily service of water distribution was also instituted (Carter, 1990, p.408-414). The services of the Director of Public Works in Trinidad, Lewis Samuel, were retained to construct water and sewage works for the town of Bridgetown (Colebrooke, 27 Nov. 1854). Piped water was introduced in the city in 1861. In Trinidad, Boards of Health were established in Port of Spain and San Fernando and sanitation laws were passed for the island. Noting the deficiencies of the existing sanitary regulations, Hector Gavin (July 1852, p.5-10, 12-14) drew up appropriate regulations for the colony and recommended the improvement of the water supply, the establishment of public baths and wash houses and an improvement in roads and public establishments.

The cholera outbreak stimulated a clean-up campaign in Grenada. The campaign included the institution of garbage disposal measures in the town, cleaning vacant lots, attention to drainage and whitewashing dwellings and the institution of quarantine measures (Steele, 2003, p.215-216). Medical relief was provided by the establishment of temporary cholera hospitals and the institution of house-to-house visits to the afflicted. Like elsewhere in the region, this did not prove practicable and was abandoned. The cholera hospital in St. Georges became the colony hospital (Brizan, 1998, p.182). A doctor was appointed for each parish for vaccination and treating the poor. The water question was considered but there was no pipe-borne water in Grenada until 1882 (Steele, 2003, p.217, 289). The Guyana government expended $30,000 to deal with the cholera epidemic of 1856 (Webber, 1931, p.249). As sanitation was emphasised, additional staff was allocated to the Board of Health to provide sanitary inspectors for the six new sanitary districts which were created in the town. Temporary hospitals were created in each district (The Colonist, 29 Dec. 1856).

Final considerations

The years after emancipation were characterised by a policy of deprivation of health and medical services to the free communities. The Emancipation Act imposed no obligation on the planting community with respect to health care and medical services for the freed Africans and the colonial authorities did not consider themselves responsible for such services. Indeed, given their general opposition to emancipation because of the feeling that it would bring them economic ruin, they were not likely to be willing to assume responsibilities which imposed additional financial burdens on them. As a result health services, considered essential during the period of enslavement and stipulated for the period of apprenticeship, were not provided for at emancipation. Responsibility for social services was not yet considered in the portfolio of the political administration in the British colonies, particularly in a period when sugar planters were clamouring for assistance, and costs for services not related to sugar production were considered unnecessary. Exercising their discretionary power, planters opted to save on costs and shed all responsibility for the medical costs of free workers. But they actively pursued strategies to enhance their labour supply as labour was, for them, the prime commodity of the era. At all costs labour must be obtained. Hence, without due consideration of the existence of a worldwide cholera pandemic, the planters, with imperial government support, sanctioned immigration from India, the place where the disease was believed to have originated. In order to entice the free people to subject themselves to planter control and accept unfavourable terms of labour, incentives were provided. Planters took advantage of the latitude given by the deficiencies of the Emancipation Act and tied access to medical services to estate labour.

Plantation medical services were offered as a privilege only to those who gave their labour to the estates. For those who refused there were no medical provisions. The services of European trained doctors, which were significantly reduced after emancipation, were beyond the means of the freed people. This, combined with the absence of any specific legal requirement, provided planters leverage in the bargaining process. By using these services as an incentive for labour, health services were transformed into a commodity for trade. It is argued here that the policy of deprivation which was pursued in the years after emancipation led to the commodification of health services in the British Caribbean region during the immediate post-emancipation years. Health services were considered the responsibility of neither the imperial nor the colonial authorities and so they could be traded.

This commodification of health services backfired in two important ways. It stimulated a resistance which can only be understood with reference to the living conditions in most of the free villages in the British Caribbean. Rather than compromise their independence to planter control, the freed Africans opted to live in the villages which sprang up after 1838. For the most part these were unplanned settlements which were devoid of basic infrastructure. As a consequence villagers lived in conditions of squalor, alongside dirt, disease and death. Post-emancipation resistance went beyond the mere establishment of free villages, the acquisition of property and clashes with the ruling class. Braving the living conditions which deteriorated in face of the continual deprivation of sanitary

arrangements and medical facilities constituted an important aspect of this resistance, which reflected the extent of workers' determination to attain true independence.

Secondly, these conditions provided the avenue for the spread of diseases which were common in the village communities. While disease struck mainly the crowded communities of the black population, whites were not immune. This was amply demonstrated by the spread of the deadly cholera epidemic, which affected all classes and racial groups in the society. But the high death rate among the labouring classes affected planters, who experienced a severe shortage of labour during the later part of the 1850s.

Shocked into action, the imperial and colonial authorities were forced to change their approach to medical and welfare services. Within official circles, there was an immediate terror-inspired obsession with cleanliness and sanitation. New sanitary provisions were introduced in the territories which were underscored by racial slurs on the natural inclinations of the African people towards dirty habits and the need to educate them. Hence the school curriculum was adjusted to include hygiene and the schools were used to spread the new gospel of sanitation and personal cleanliness. While there was an emphasis on legislation to force people out of their dirty inclinations, there was a conviction that some measures had to be taken to prevent the spread of disease which could affect the upper classes. Thus, the provision of these new sanitary measures was inspired more by fears for the safety of the upper classes than by humanitarian concerns or any sense of administrative responsibility for the welfare of the population.

The measures included vaccinations and water supplies for communities in addition to sanitary laws. While a full-fledged public health system did not emerge immediately, there was recognition that if the society bred disease, all groups were vulnerable. Life with dirt, disease and death was a demonstration of resistance in the era of freedom to the attempt, through medical services, to force workers to surrender their freedom. This resistance reflected the resolve of the free people and helped to wring change in the attitudes of the ruling class to the provision of public health services in the region. The elite vision of the old order of a Caribbean society composed of planters and labourers was shaken and the existence of a 'public' with a need for social services was recognised. The change was, of course, neither fast-paced nor dramatic, for the notion of a 'dirty' labouring class remained an *ideé fixe* among members of the administrative and elite classes beyond the 19th century and policy decisions continued to favour planter interests. However the cholera experience left an indelible mark on the psyche of the ruling class. Having amply demonstrated how "the boon of freedom granted… has proved a source of misery" (Sturge, Harvey, 1968, p.132-133), it stimulated a recognition of, and action regarding, the *noblesse oblige* of the ruling class. The closing decades of the 19th century would therefore see incremental improvements in sanitation and medical services in the British Caribbean which were partly stimulated by the desire to avoid a repeat of the cholera experience.

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