To the Graduate Council:

I am submitting herewith a thesis written by Nancy Rebecca Anderson entitled "'It's Not Catching': Hansen Home and the Local Knowledge of Leprosy in the Federation of St. Kitts and Nevis, West Indies." I have examined the final paper copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts with a major in Anthropology.

Faye V. Harrison, Major Professor

We have read this thesis
and recommend its acceptance:

Accepted for the Council:

Vice Chancellor and
Dean of Graduate Studies

# "It's Not Catching":
# Hansen Home and the Local Knowledge of Leprosy in the Federation of St. Kitts and Nevis, West Indies.

A Thesis
Presented for the
Master of Arts
Degree
The University of Tennessee, Knoxville

Nancy Rebecca Anderson
August 2005

# Dedication

This thesis is dedicated to the memory of my father, Franklin Duff Anderson, who always believed in his little girl.

# Acknowledgements

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# Abstract

The purpose of this study was to document the ethnohistory of the leprosarium Hansen Home and to examine the local knowledge of leprosy in the Federation of St. Kitts and Nevis. Kittitians often responded to questions about leprosy in 2000 with the statement "it's not catching." In 2002, the research goal was to address leprosy from a Kittitian vantage point. Through the lens of anthropological inquiry, archival materials were examined and a variety of stories were gathered about Hansen Home and the local knowledge of leprosy. The latter task was accomplished with ethnographic techniques, particularly semi-structured interviews. The accounts collected were multilayered, exposing culturally significant aspects of identity construction and blame assignment. As the local knowledge of leprosy was revealed, a clearer interpretation of this contagion was attained. A consistent trend has been the Othering of leprosy; assigning blame to the Other for bringing leprosy to St. Kitts and more specifically to Sandy Point. Leprosy is currently defined in the context of St. Kitts as not contagious. This is a reflection of Kittitians' ability to cope with leprosy and is a testament to the success of the public health care delivery agenda set in St. Kitts and Nevis. Despite their efforts to eradicate the disease, the legacy of leprosy still affects many people today. This thesis describes the medical pluralism of the local knowledge of leprosy, which is influenced by both biomedical and ethnomedical knowledge. Furthermore, this thesis describes life for the person with leprosy who lived on both the inside and outside of Hansen Home. It also describes a gradual shift in understanding contagion in St. Kitts, from a point of highly contagious to an understanding of not contagious.

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# Part I: Introduction, Theory, and Ethnography

The biggest disease today is not leprosy or tuberculosis,
but rather the feeling of being unwanted.

Mother Teresa 1910-1997

# Chapter 1: It's Not Catching

This chapter aims to introduce the reader to the research location and the research objective. I describe how I came to study the topic of leprosy in St. Kitts and how I came to the decision to find out what it is means to say, "it's not catching." I begin with a story about my fieldwork experience in the summer of 2000. I continue by discussing my return to St. Kitts during the summer 2002 and my research question and methods. I end the chapter with an outline describing the subsequent chapters.

Summer 2000:

> It was Sunday, a day for the beach in St. Kitts. I found myself enjoying a friendly sun when a man, as he had done the previous two Sundays, approached me with goods he had crafted from coconut shells. I had purchased items from him before; no doubt, he hoped I would do so again. We engaged in small talk. As he had done on a number of occasions, he politely inquired about my stay. He assumed that I was a ROSS student (an American school of veterinarian medicine - ROSS University - located on the island) and was, justifiably, more eager to see if I would purchase additional items, than taking any real interest in what I was saying. While I browsed through his goods, I told him that I was there to document the ethnohistory of the Hansen Home as a leprosarium. A bit confused as to what the Hansen Home was, I explained it was the old leper home located towards Sandy Point. He said, with an inquisitive tone, "leper home?" I responded by saying, "Yes, you know leprosy." He said, "No, what is that?" I replied "leprosy, a skin disease, it makes sores on the skin." He was still puzzled. I then used a word that I had come across in my research, "cocobay," or the colloquial term for leprosy. His response was not verbal, but physical. He jumped back from me, suddenly, and quickly made efforts to leave. It was as if I had offended him (at the time, I was unaware of the negative connotations accompanying "cocobay"). Nevertheless, he knew what I meant and wanted nothing more of me. The following Sunday, he did not approach me at all. (Fieldnotes, 2000)

This event took place during the summer of 2000. I first went to St. Kitts in May 2000 to research the cultural heritage of the former leprosarium housed at Charles Fort, a

British colonial site whose history was being reconstructed by an archaeological team headed by University of Tennessee Professor Gerald Schroedl. My objective in 2000 was to research the archival materials salvaged from the leprosarium called Hansen Home as well as other materials from the National Archives and the St. Christopher Heritage Society for any shred of evidence about Hansen Home. Whether this was information about public works or public health, my objective was to dig up as much as I could in eight weeks time. I spoke with individuals who offered their opinions about how and what I should look for in the archives relating to Hansen Home, which has also been referred to as Hansen House — to keep consistent with the archival records, I will use Hansen Home rather than Hansen House. Everyone had advice about my research steps: especially with whom I should talk, and for what I should look. I continually heard statements I first attributed as "misled opinions," but I quickly realized some of those "opinions" were rather popular and, therefore, probably held some merit. A popular "opinion" that especially intrigued me went as follows: "leprosy is not contagious," or "it's not catching." These two statements were repeated to me over and over. My naïve tendency to reduce these remarks to a "misled opinion" was confronted in the following reflection:

> One evening, I shared a taxi with a couple that happened to be going to the same restaurant as I was attending in Old Road. Along the way, the taxi driver asked, "Where we were from," "if we were enjoying our stay," "how long are you here for," and other conversation starters. The couple explained that they were on holiday from London and yes they were loving their trip and that they were set to leave on Sunday. The driver said "and you," referring to me, so I contributed my well rehearsed statement about being an American student here researching a former leprosarium. Sometimes I am asked, "What's that?" and this was one such time. I further explained that a "former leper home called Hansen Home was..." and before I could finish, the driver stopped me and took over. He told the tourists "leprosy is here no more, and anyway it is not contagious." He continued,

> "Hansen Home closed down many years ago and it is run down." I humbly listened to what this Kittitian had to offer. But, suddenly, the couple began to disagree with the driver. The man said to the driver, "Leprosy is contagious, is it not?" and looked at me for approval. I was caught in a hard spot. Should I defend an understanding of contagion that I had been hearing over and over, one I did not even understand, or should I go with my biomedical gut feeling and support what the Englishman was asserting? I firmly responded, "It is not contagious." The Englishman responded, "Really?" Although he was not convinced, however I did achieve silence on the matter, if not peace, in that he no longer questioned the Kittitian authority. The woman asked me, "Are there still lepers in St. Kitts?" The couple was not at all interested in what the driver had already stated. I confirmed the driver's account by stating that the last patient from the home died in 1998, and that the home was closed in 1996. By this time, we pulled up to the restaurant. The couple got out and paid their portion. While I counted my money, the couple walked away. I thanked the driver for his courtesy and paid him. He wished me luck with my research and said he was glad something was going to be done on the subject. As matters turned out, the couple from the cab sat at the same table as I did for dinner. The restaurant is an open-air style with picnic tables and a view of the Caribbean Sea, which is very conducive to mingling. They revisited the topic of leprosy again during dinner, defending their position that leprosy was, indeed, contagious. I reminded them that they are but visitors to the island. I explained that my Westernized understanding of leprosy worked like theirs—that the disease is contagious, but, as I explained, I did not know how "contagious" is defined here in St. Kitts. (Fieldnotes, 2000)

As with the first event, this one took place during the summer of 2000. I noticed two important responses, both of which were defensive. The first story reveals a man's fear of me (due to my association with "cocobay"), fear of "cocobay" itself, or he simply was offended by my use of the word "cocobay." Whatever the man's reasons for his defensive posture, it was obvious he had an opinion. The second story reveals a man's concern with misinformed tourists. This man depends on tourism to make a living, so it is of grave interest to him that he sets the story straight. He is defending his livelihood by defending his home's reputation. Although each man's defense was interesting, it was the challenge of understanding how these two individuals understood leprosy that caught my attention. While one seemed to jump away from me in fear of perhaps catching

"cocobay," the other stood up to leprosy. How do I explain this? It was these types of encounters that led me to want to explore this idea more fully. So, I chose to return to St. Kitts in search of an understanding of how Kittitians make sense of leprosy.

Summer 2002:

Two summers after that initial visit, I returned to St. Kitts, the larger island of a nation-state also encompassing the neighboring island of Nevis, to undertake ethnographic fieldwork. The official name of the country is The Federation of St. Kitts and Nevis, but for short, I will often refer to each island individually with respect to the topic at hand, or collectively as St. Kitts and Nevis. My research objective entailed the collection of more information regarding the government-run leprosarium, Hansen Home, which is in Sandy Point, St. Kitts. Beyond collecting data for writing an ethnohistory of that public health institution, I also set out to meet an even broader objective: to identify local knowledge of disease, delineating how people conceptualize leprosy and explain its causes and effects, whether from biomedical or ethnomedical points of view. As it relates to St. Kitts, leprosy is both a disease (the biological alteration to the body) and an illness (the social suffering resulting from the disease) (Kleinman, 1988:3-10); therefore, I address biomedical and ethnomedical perspectives, as both are reflected within the stories Kittitians tell.

Toward that end, I collected life stories about leprosy, or Hansen's Disease. Stories are intricately connected to knowledge and theory. I will expand on the use of "stories" and their relationship with knowledge and theory in Chapter 3. Using the lens of their own cultural meanings and worldviews, I learned how a variety of Kittitians

make sense of leprosy as a biological and social phenomenon, how they treated the disease, how they coped with the illness, and continued to cope with its legacy. Ultimately, my objective is to demonstrate through a collection of stories just how leprosy is culturally defined and negotiated. My major sources of evidence are archival documents and a purposive sample of individuals who are varyingly socially situated in a specific time, place, and space, including their occupations and multilayered notions of identity.

Research Question:

Based on my summer 2000 experience, when I returned in 2002 I set out to learn about leprosy from people in St. Kitts, specifically Kittitians. My research question was to figure out what it meant to say "it's not catching." Therefore, I focused on learning what the local knowledge of leprosy was. In doing this, I found that one's identity played a role in whether or not information was shared; that identity played a role in who was implicated in the onset of leprosy in St. Kitts; and that identity politics is central to accusation, Othering, and the culture of blame. These three issues overlap with one another, and are therefore embedded in the stories of leprosy and of "cocobay." These stories are told from a number of points of view — the view of government reports, laws, newspapers, and former Hansen Home staff, as well as volunteers and relatives of former patients.

This thesis aims to explore a historically-specific, culturally constructed way of thinking and a way of explaining. It examines the way in which leprosy is talked about or theorized in St. Kitts over a period of time from 1889 to 2002. While this is a large

block of time, it is not continuous. Archival evidence fills in many of the blanks, but the records are not complete. The biomedical accounts about leprosy are global ones in that the same biomedical knowledge about leprosy existed in the United States of America (USA) and India as it did in St. Kitts. Even as early as 1889, the global biomedical community was theorizing about leprosy and exchanging information in a global forum. This global exchange is continuing today. In St. Kitts, interviews with largely Kittitian consultants made up the bulk of the information regarding the last thirty years of the 1889-2002 time frame. Therefore, this thesis offers snap shots in time from which an overall history of leprosy in St. Kitts is written.

In this spirit, this thesis also seeks to document the history of the leprosarium in which the patients suffering from leprosy called home. This collection of stories ranges from 1889, when leprosy was defined as a public health crisis, to a time when people did not give leprosy a second thought, 2002. Some of the stories are about transmission and accusations about transmission, and the roots of leprosy. Other stories are about the particular lives of those who lived with both the disease and the illness or, in other words, the biological alteration to the body and the social ramifications that come with being labeled a "leper." This thesis highlights the experiences of a few people who suffered from leprosy. While they may not be the first people that Kittitians talk about concerning the island's history, at least in this capacity, they are remembered and admired for their struggles.

Research Methods:

My question and goal were to find out what it meant to say "it's not catching." Although this was my overriding objective, I realized that I might never learn the answer. As such, I wanted to make sure I gathered as much information about Hansen Home and leprosy as possible, even more than what I gathered in 2000. I spent countless hours studying various archival materials. These materials were made available from the National Archives, St. Christopher Heritage Society, and Challenger's Museum.

In 2002, I contacted those who had helped me in 2000. We revisited the topic of Hansen Home and leprosy. Some of these conversations were more productive than others in that I received new information or information about other potential consultants. I followed any lead I received. Two individuals offered their assistance in helping me find people to interview. One guide, who by chance I met at a restaurant, spent his days off assisting me. Time was of the essence since the duration of my stay was limited and this particular guide assisted me on several occasions and took it upon himself to make sure I made good contacts. This guide claimed to be void of local politics and advised me that some people might not want to talk to me because he was accompanying me. He reassured me that those who participated did so because they knew he was "cool." He also assisted a great deal as a buffer putting at ease those who at first were very reluctant to talk about leprosy, and were suspicious of me. In addition to this, he also translated some concepts which were spoken in a fast Eastern Caribbean English vernacular. The other guide assisted at the request of a member of the local government. As such, I insisted that he not partake in the interview process. Depending on the environment, meaning if we were in a crowded room or outside doing daily chores, I engaged in semi-

structured interviews. A few people relied on direct questions, but mostly the interviews were really conversations. I tried to establish a relaxed position and let the consultant teach me. I asked questions like "What can you tell me about Hansen Home?" and "How do you get leprosy?" As the conversations developed, I sparingly asked questions as most of the information I was seeking was being offered. Once I returned home, I analyzed the archival materials and interview notes or recording by looking for common themes. From these data, I identified ethnomedical, biomedical, and identity themes.

Chapter Outline:

This thesis is divided into three parts. Part I consists of the first three chapters. Chapter 2: Interpretive Framework contains a literature review. In this chapter, I discuss the key analytical concepts used in this research. In Chapter 3: Challenges of Ethnographic Inquiry, I discuss how the field is defined. This chapter describes the negotiation process that takes place during fieldwork.

Part II consists of Chapters 4, 5, and 6. In Chapter 4: "I am somewhere in the Bahamas!" I provide an overview of St. Kitts and Nevis. This chapter describes the geography, history, identity, and the economics of St. Kitts and Nevis. In Chapter 5: Leprosy and Biomedicine, I discuss the term "leper," as well as the biomedical classification of leprosy. I delineate both the historical and contemporary biomedical accounts regarding leprosy in both a global context and context specific to St. Kitts and Nevis. In Chapter 6: "Cocobay" and Ethnomedicine, I describe the local knowledge of leprosy specific to St. Kitts and explain how this Kittitian local knowledge bridges the gap between traditional concepts of biomedicine and traditional concepts of

ethnomedicine. This chapter also challenges traditional definitions of Obeah and describes the ethnomedical treatments used to treat symptoms associated with leprosy.

Part III consists of chapters 7, 8, and 9. Chapter 7: Expediency and Edict, offers a background into the thinking about leprosy from the historical vantage point of 1889. It describes the location chosen for the leprosarium and the need for such housing. It also provides some background information regarding public health responses to other diseases and the legislation drafted in response to the public health crisis. In Chapter 8: Hansen Home — Life on the Inside, I illustrate Hansen Home not only with a drawing, but with descriptions of the facilities, the stories associated with patient and staff activities, and the stories about the culture within Hansen Home. In Chapter 9: Cleverly Hill — Life on the Outside, I portray the lives of specific individuals who lived with leprosy, but were not residents of Hansen Home.

In Part IV, I bring to a close the analysis of Hansen Home and leprosy in Chapter 10: Conclusions and Final Thoughts. I argue the context of "it's not catching" and how this position is a product of coping with leprosy over a period of historical shifts. I remind the reader of the biomedical position regarding leprosy and how the people of St. Kitts and Nevis can take comfort in knowing that leprosy has been effectively managed. I discuss the culture of blame and shed light on its implications for constructing a unified national identity in the Federation St. Kitts and Nevis. I applaud St. Kitts and Nevis for achieving success in the eradication of leprosy from their nation. I urge Kittitians and Nevisians to be proud of their accomplishment.

# Chapter 2: Interpretive Framework

The purpose of this chapter is to clarify the concepts central to my analysis. Key concepts such as culture, the ethnographic Other, and Othering, identity, knowledge and theory, narrative and discourse, story (as a Caribbean idiom), and the culture of blame are all defined.

## Culture:

The term "culture" is used in a variety of ways from the pop-culture of music or fashion to the bacteria within a cup of yogurt. The word itself is rather generic and is applied to people, events, genres, and to bacteria without really understanding the consequences of the usage of the word. I define culture as knowledge; in other words culture is information. Knowledge or information is an accumulation of lived understandings with which a community makes sense of the world. For consistency, I use the word knowledge throughout this thesis. From an anthropological perspective, Martin Chanock argues:

> The primary problem is to identify what is meant by culture, times at which the notion of culture is invoked, and the uses to which this invocation is put. Many of the problems posed by these questions result from a tendency to posit a concept of cultures as unities, and therefore easily distinguishable from and opposable to each other. After centuries of imperialism, and in the current period of high-velocity cultural globalization, this is a fantasy. There are no longer (if there ever there were) single cultures in any country/polity/legal system, but many. Cultures are very complex conversations within any social formation. The concept of culture has become a prime way of describing groups and is displacing other primary labels like race, class, gender or nationality at a particular time and in particular circumstances (Chanock, 2000:17-18).

The anthropologist should, as Fredrik Barth urges, re-create culture-talk among groups that identify how "culture" could be constructively used without pointing fingers or exoticizing. Like Barth, I use knowledge as a prototype for culture. By using knowledge to define culture, anthropologists can highlight action and the willful engagement or disengagement in the world. It recognizes that in a global village, we are easily able to exchange knowledge. Furthermore, people can participate in multiple cultures simultaneously without characterizing or focusing on difference (Barth, 1995:65). This will be further discussed with reference to identity in the section Identity.

In St. Kitts, I am looking at a local knowledge of leprosy. I am not seeking to define what is different about how Kittitians think or behave, but I am looking simply at how leprosy fits into their worldview or culture. Not all Kittitians will have the same knowledge of leprosy, so to reduce this knowledge of leprosy to represent all Kittitians, or qualify it as "Kittitian culture," is a misrepresentation of the wider population of Kittitians and an irresponsible anthropological analysis. When I define a "culture of blame" it may be easier to grasp my meaning if it is understood that this also defines "knowledge of blame," or "information of blame," as they are used similarly in this thesis. Before I can discuss the culture of blame, I must first identify the meaning of the ethnographic Other.

The Ethnographic "Other" and "Othering":

> Anthropology has a long history of concern with the 'other,' the different, the strange. This focus on others and their cultures provides a reflective lens for understanding ourselves and our own immediate world. However, the places that today serve as the focus of our ethnographic studies differ a great deal from those once inhabited by exotic people seemingly untouched by Western influence – the

> people considered by many to be the main subjects of anthropological scrutiny. The global village is a fact, and the romantic vision of ethnographic adventure in remote places among pristine people is gone (Armstrong, 1998:xi).

If colonization failed to "touch people" with a "Western influence" (or domination), then globalization will definitely make up for it. In the case of the Caribbean, colonial and imperial travel journals depict the region, or the 'Tropics" in general, as a "lush landscape with exotic others" (Sheller, 2003:107). The "Other" is in reference to the additional, or the different; the focus on the different is an emphasis on the objectified other. Othering is the act of objectifying those who are the additional — the subordinated and dominated difference, the extra, or the different. However, anthropology is not the only arena where this has happened.

Tourism depends on the marketing of the exotic; the impression of the exotic place to spend a week of relaxation other than home is quite appealing to anyone needing a break from routine. Anthropology has, perhaps, made this a marketing tool easier to employ. The exotic Caribbean can be described as a place that affords the privileged the opportunity to move closer to a sense of excitement and danger (Sheller, 2003:107). It allows for escapist tourism, while at the same time parts of the region are identified as a dangerous terrain of criminals, unstable governments, disease, and, of course, desperate boat-people (Sheller, 2003:107). Mimi Sheller argues,

> Europeans produced the idea of the Caribbean via a hybrid Orientalist and Africanist discourse characterized by an unstable logic of East vs. West, tradition vs. modernity, and barbarism vs. civilization. This effort at producing boundary distinctions has served to 'orient' the West's relationship to the Caribbean from the moment of its 'discovery' until today (Sheller, 2003:109).

She supports this by building on Bryan Turner's suggestions about Orientalism, which, in his estimation, is a hegemonic language representing the exotic, erotic, and strange. This is not too different from Edward Said's take on Orientalism as a discourse for the production and constitution of the Orient as the object of a particular form of colonial power and knowledge (Sheller, 2003:109). The Caribbean was Orientalized originally by Columbus when he "discovered" the "West Indies." Columbus was lost-- he thought he was in the Indies. The Caribbean islands were called the West Indies in contrast to the original Indies or East Indies (Sheller, 2003:108) that Columbus thought he had reached. Columbus orientalized the Arawaks and Caribs by naming them "Indians." Columbus othered the people or "Indians" he encountered as Arawaks, defined as the "friendly natives," or Caribs, defined as the "fierce savages." We can see how the legacy of Othering continues today through examining the stereotypes of the Other in the Caribbean. The opposition "paradise/hell" (Sheller, 2003:107) as it still applies to a trip to Puerto Rico or Barbados is of course a "paradise vacation," especially in light of the Romanticized news or tourism propaganda, while a trip to Haiti or Cuba, in contrast, is a risk and, therefore, due to all of the politicized news, is viewed as a "hell." Furthermore, if one looks at this polarization of paradise/hell in relation to Jamaica, both the Romanticized and politicized literature will warn against fraternizing with locals outside of the resorts. Therefore, this creates an "imagined paradise" within the resorts, and a "dangerous hell" outside of them. What these sources of Romanticized and politicized news (meaning TV ads, print ads, vacation packages, travel agents, and the CIA) do not report is the responsibility the US has in essentially creating or re-inventing this

polarization through structural adjustment programs and Free Trade Zones, implemented by the International Monetary Fund (IMF) and the World Bank (Kincaid, 2001).

Another example of the legacy of Othering in the Caribbean is the polarities found between the terms "noble savages" and "cannibals," which have conveniently been "politically corrected" now to read as "friendly natives/hostile guerrillas" (Sheller, 2003:107). In the current era of terrorism-talk, the propaganda is reworded to read as "allies or freedom-lovers/insurgents or terrorists" or, as embarrassing as it is to admit in 2005, "civilized/uncivilized." The repercussions of such language are well documented in history as justifications for wars, slavery, occupation, and colonization. The sad and unfortunate reality is that history too often repeats itself.

To identify the Other is not a mere marketing tool, nor a way to emphasize different people. It is a way to subjugate a people. Anthropology has to own its history of contributing to this power dynamic through the creation of the "Ethnographic Other." In owning this history, we have to recognize how subjugating governments have used (or misused) and will continue to use/misuse the information produced through ethnographies in an effort to achieve their political agendas. The phrase "practice safe-ethnography" is as life preserving as "practice safe-sex," because the representation of a people could very well be a matter of life and death.

Othering is also a tool used to subjugate the individual. For example, a child will identify fellow classmates as "the other kids" – usually in the context as "well, 'the other kids' are wearing them." In this case, the child is essentially the different, the one not fitting into the mold carved out by the mainstream population. Othering is the practice of pointing out Others; pointing out differences, and a people's so-called exoticness. As it

relates to this thesis, Othering is an important element of blame that will be discussed in the next section.

Culture of Blame:

The culture of blame is a product of Othering. It is a process that creates blame, re-creates blame, and directs it towards specific individuals or groups of people. What is blame? Blame is assigning fault or causality to something or someone. Paul Farmer identified three avenues of accusation prevalent in the context of Haiti. Farmer argues that the three forms of accusation impute to human agency a significant role in the propagation of a dreaded sickness (Farmer, 1992:245). In the case of Haiti, *sida*, or AIDS, is the dreaded sickness. The sorcery accusation credits humans with the ability to send AIDS to an enemy; this accusation is made by Haitians (Farmer, 1992:244-45). The conspiracy accusation is blaming a concerted effort to weaken the ranks of outcasts (homosexuals, Haitians, ant IV drug users) or to defame black people; this accusation is made by Haitians (Farmer, 1992:244-45). The accusation of Haiti being responsible for the organism causing AIDS and for the pandemic of HIV/AIDS, according to Farmer, is made by some North Americans (scientists and the media) (Farmer, 1992:244-45). Although Farmer identifies a "geography of blame," which brings attention to the global positioning and results of the accusations and the results of these accusations, I am using the notion of a "culture of blame" as a way to identify the cultural logic of blame that cuts across time, class and nationality in both historical and contemporary contexts. In St. Kitts, there are three kinds of accusations. There is the accusation of Obeah, the

accusation of the "Leper," and the accusation of the Other. Each of these accusations will be discussed thoroughly in subsequent chapters.

The "culture of blame" is not unique to St. Kitts or Haiti for that matter. It transcends borders and may or may not be confined to geography. For example, when my father was diagnosed with lung cancer the immediate accusation was against cigarettes. However, after the type of lung cancer was identified, coupled with additional investigation, the accusation then fell on an occupational hazard involving nuclear radiation exposure. Above all, the accusation of "God's will" was invoked. The first accusation in this case is a typical response by Americans. Farmer argues, "fingers are pointed at the poor, or otherwise marginalized people" in an accusatory manner; Americans like to "blame the victim" (Farmer, 1992:248). The victim likes to blame either God or other supernatural powers and therefore, begins to question her/his life's worth, or to blame an external factor, like an occupation or conspiracy. Regardless of who or what is to blame, a cultural logic of blame is applied.

Identity:

Zdzislaw Mach argues that we always define ourselves in relation to others, and the aspects of our identity which are stressed in a given situation depend on these others and their identity (Mach, 1993:9). Richard Jenkins states:

> Similarity and difference are the touchstones of human social identity, which position us with respect to all other people. They tell us who we resemble and from whom we differ. They provide us with at least some idea of what we can expect from others and what they can legitimately ask of us (Jenkins, 2002:117).

Individual identity (the identity of a person) asks the question "who am I in relation to other people?" Collective identity (the identity of a group) asks, "who are we in relation to the other?" (Mach, 1993:4). Regardless of the answers to these questions, identity formation involves a continuous conflict with powerful negative identity elements as an individual's identity is shaped by memories of the past, fears for the future, and elements of the present (Mach, 1993:4). Identity is a social construct; it is imagined, but not imaginary. This is not to suggest that identity is an illusion or a fantasy (Jenkins, 2002:118). Simply put, identity is a result of classifying the world. Classification is the basis of cultural or social constructions (Mach, 1993:5). The construction of identity is the establishment of relationships between a dominant individual or group and a subordinate individual or group. It is through these particular relationships that identity acts to justify and legitimize relations between people and groups (Mach, 1993:6). This construction of identity (by default) allows for the construction of the Other. However, identity must be examined contextually as these relationships are dynamic and in constant renegotiation. According to Jenkins, the context in which an individual or group is identified affects everything, "from which side of the street we can walk on to what we can eat and what we like to eat; from who we can mate with to how we understand our place in the cosmos; from how we live to how we die" (Jenkins, 2002:118).

For example, in St. Kitts, a person's political identity can be visually expressed by whether she or he wears a red or a yellow T-shirt; red is a color used by the Labour Party and Yellow is a color used by the political party People's Action Movement (PAM). Class identity is marked by the bus a person chooses to ride, or even if they have to ride the bus. I was at first oblivious to this until it was explained to me by various

consultants. As a white American foreigner ("American" refers to United States citizens throughout this thesis), I had two different experiences with riding the bus. In 2000, I was picked up with no problems. I lived in the area called New Guinea Estate. I paid $2EC to go to Basseterre. In 2002, I lived in the area called Trinity. I paid $1.50EC to go to Basseterre. I was frequently passed by full buses and not-so full buses. I came to learn that particular drivers had clients for whom they were saving a spot. I also learned that it was a matter of status as to whose bus a person rode. I do not know if this was related to the music that was being played on the bus, or if it was due to where the driver was from (in terms of town or village), or if it was related to the status of the passengers on the bus, or if it was related to color and paint-job on the bus. To say the least, each bus has its own identity.

Since the construction of identity provides the basis for the construction of the Other, it must be understood that the construction of identity can create conflict, membership, and the "feel-good" emotion of belonging. Mach argues:

> Identity is always defined in relation to a partner and to his or her identity, and therefore the same person or groups may assume and express a different identity in different situations. The bigger the cultural distance between partners, the more general is the model of identity, and the less detailed is the image. Therefore, it is also crucial to realize for whom, or in opposition to whom, the particular model of identity has been constructed (Mach, 1993:9).

This cultural distance Mach refers to raises the issue of membership, or what Anthony Cohen qualifies as "belonging" (Jenkins, 2002:117). This explains how membership in many cultures can co-exist without necessarily any conflict. However, where there is conflict, the contextual character of identity is extremely important for understanding social relations (Mach, 1993:11). The feel-good emotions brought about by "belonging"

initiates feelings of positive, warm images of inclusion, mutuality, and security. This inclusion, however, breeds exclusion (Jenkins, 2002:118). It essentially allows an individual or a group to identify "we know who we are – Us—at least in part because we know that we are not Them" (Jenkins, 2002:118); the emphasis on Us and Them magnifies the inclusion and exclusion relationship.

Just as group identity is dynamic, so is the individual's. Mach argues "the more complex is a social system, the more identities a person or group has; one may talk about a professional identity, a class identity, a regional identity, an ethnic identity, or a national identity" (Mach, 1993:9). For example: my professional identity is as a cultural anthropologist; my class identity is what I call poor, "white recycled" working class and what others would identify as "poor white trash"; my regional identity is Southern Appalachian; my ethnic identity is Appalachian white; and my national identity is American. "White recycled" refers to being one and a half steps out of poverty, specifically rural Appalachian poverty otherwise known as "hillbillies," "mountain folks," "rednecks," and "poor white trash." I am the first woman and second person (my brother being the first) in my mother's family to go to college.

As it relates to St. Kitts and Nevis, when I initially met with people, I assumed that they were all Kittitians. I realized that there was much more going on with regards to identity politics than I first realized. I quickly became aware of the need to identify six of these which include: national and transnational identity, island identity (St. Kitts or Nevis), urban/rural identity (neighborhood, village, town, or village specific), political and religious identity, and health identity. In addition, a professional identity exists which is closely related to class identity as it relates to access to higher education, but in

order to keep the identities of the participants anonymous the professional identities are protected. The "leper identity" is discussed in Chapter 5. Although I chose to limit the number of identities to highlight, many more exist. When there is conflict, the perceived differences between people are sharpened; sides of the conflict tend to polarize the world into two opposite domains and ascribe to them opposite values (Mach, 1993:11). The specifics of the six categories of identity will be addressed in Chapter 7.

Knowledge and Theory:

It is important to clarify the concepts of "knowledge" and "theory" as analytical concepts because of their centrality in this study. As I stated above, I define "knowledge" as an accumulation of lived understandings with which a community makes sense of the world. Despite the ability of ordinary people, including the consultants in anthropological research, to create theory, the notion of theory is too often feared, and the specialized language in which it is often spoken is largely inaccessible. In an effort to avoid a language of superiority, I am following the example that Ann Kingsolver (2001) set in *NAFTA Stories: Fears and Hopes in Mexico and the United States*. She provides a framework for expounding the concept of theory and for placing the multiple modes and styles of theorizing on a common critical plane. She accomplishes this by identifying political speeches, legislative debates, newspaper accounts, and ethnographic voices heard in interviews and participant observation as "stories" or as different media for storytelling. Kingsolver defines theory as the "stories we tell ourselves to make sense of life and to determine where we are as we navigate social space" (Kingsolver, 2001:4). In effect, knowledge is an accumulation of culturally negotiated theory related through

different kinds of stories. Kingsolver levels the hierarchical relationship between, on one hand, "knowledge" and "theory" and, on the other hand, the orally transmitted narratives more apt to be labeled "folklore" or "superstition." She uses "story" as an analytic concept to relay and interpret knowledge claims that are informed by lived experiences. Her approach is influenced by recent trends in narrative and discourse analysis which are discussed below.

Narrative and Discourse:

Kingsolver's use of "story" becomes even more significant, especially when considering the parallels that can be drawn between her ideas and those of other prominent anthropologists. Kingsolver uses "story" much like Michel Foucault's "discourse" and Arthur Kleinman's "narrative." Foucault's "discourse" refers to "the way in which patterned cultural discourses maintain both particular ways of knowing the world and a network of power relations among those who know"(Barnard 1996:162-163).

Discourse is essentially a fancy term for the transmission of knowledge and the hegemonic authority maintaining this knowledge. Analyzing ethnographic accounts using Foucault's "discourse" centers the attention on how knowledge and representations (e.g. the construction of "The Other") are produced by and help to reproduce relationships of power in institutions and society (Jordan, 1991:57)

Kleinman's "narrative," as he analyzes it in the context of illness, is a story told by a patient, and by someone significant to the patient, to give coherence to the distinctive events and long-term course of suffering (Kleinman, 1988:49). A narrative is an account of connected events; narratives are used to transmit the knowledge of ordinary

people. Often folklore is explained through the use of the narrative. I am using folklore as a category referring to folktales, myths, legends, proverbs, riddles, and superstitions of a cultural group that can be typified as working class. "Folklore" itself can be seen as a discourse used to deal with the beliefs of the working class by way of dismissing beliefs as fact or "provable" (or disprovable) knowledge. A narrative is a category used to qualify the knowledge that is not necessarily the official discourse, but simply the knowledge shared among ordinary people. According to Edward Bruner, narratives, stories, and dramas are expressions of experiences. He conceptualizes experience in terms of the personal active self that "not only engages in, but shapes an action" (Bruner 1986:3-30). He argues that by focusing on these expressions, anthropology removes a language of superiority and allows the indigenous meanings to surface (Bruner 1986:3-30). In other words, an examination of stories permits an experience-near mode of analysis that acknowledges the significance of local knowledge.

Glenn Jordan warns against a "strong tendency to radically privilege texts over contexts" which, in Jordan's assessment, cultural anthropologists like James Clifford and George Marcus have committed in their contributions to *Writing Culture: The Poetics and Politics of Ethnography* (Jordan, 1991:42). Reflexive, interpretive cultural anthropology tends to privilege readings of text as narrative over readings of texts as discourse. In most cases they "tend to limit themselves to textual questions that relate to the relative power of the author's voice or (narrator's voice) vis-à-vis the voices of Others" (Jordan, 1991:57). In contrast, the power of ethnographer/Other relationship is analyzed as one with institutional grounding that locates authorial authority in this larger context (Jordan, 1991:57). In other words, an analysis that does not consider the power

of the narrator's voice is in danger of producing "Othering ethnography." Johannes Fabian argues that anthropology's Other is dominated by ethnography when the "writing about" becomes "writing at (as in "shot at") through the use of subjugating language (Jordan, 1991:58).

Glenn Jordan qualifies the effectiveness of publications that account for the Others, e.g. ethnographies. He argues that this "effectiveness derives from two principal sources:" 1) "the modes by which the text establishes its authority," and 2) "the modes of representation in the text, i.e., its rhetorical devices" (Jordan, 1991:44). The first principle suggests that a text establishes authority by muffling the challenging voices; the voice of the author is thus the voice of the authority or as Jordan writes (author-ity) (Jordan, 1991:44). The second principle suggests that the ethnographer is narrating a privileged perspective that is more comprehensive than any reader's or informant's perspectives. Since the ethnographer was there making first-hand observations s/he can narrate first-hand accounts or narratives that only an observer in this capacity could know. Therefore, a narrative reinforces that relationship of power and authority (Jordan, 1991:44). Using the word story allows the ethnographer to remove the authoritative voice.

We can also find a similar approach in Paul Farmer's ethnographic work in Haiti. His research led him to the realization that paying close attention to the stories that people express ultimately leads to an "analysis that reveals many interconnections" (Farmer, 1992:12). These interconnections include misfortune, illness, and political economy. Farmer states, "...for many in Do Kay, observations about *sida* [HIV/AIDS]

are worked into stories that relate how misfortune is manifest in the lives of individuals, communities, and even a nation" (Farmer, 1992:12).

Furthermore, invoking the concept of story and going about retrieving them in the praxis of field research may allow for what Faye V. Harrison has identified as a "real dialogue," where meaningful information is not unidirectional, but exchanged and shared (Harrison, 1991:101). Ethnographers engaging in real dialogue are not exempt from scrutiny; they must share personal information about their own lives as a way of exchanging experiences that can create solidarity if not a common understanding of struggle that occurs everywhere (Harrison, 1991:101). "Dialogue involves not only a two-way flow of 'raw-data,' but an exchange of information subjected to analysis and critique. In this manner, the ideological underpinnings of knowledge and belief are exposed and challenged so that a more liberating vision can begin to emerge" (Harrison, 1991:101). Harrison rejects the ethnographic interview that tends to be "unidirectional and unequal in relations of power" where the data flow from the "informant to the investigator" (Harrison, 1991:101). While Harrison does not specifically use the word story, it can be said that her use of dialogue is kin to Kingsolver's story in that it tempers the element of power and allows for multiple voices to be heard.

Story as Caribbean Idiom:

As I have discovered in my research, the word "story" is not to be construed as a derogatory characterization of any data. It is certainly not used to depict fiction or untruthful, imaginative ideas. For additional support outside of Kingsolver, Jordan, and Farmer, I refer to Richard Allsopp's linguistic study spanning from 1973 to 1991 of

Caribbean English usage, which included fieldwork in St. Kitts and Nevis. Allsopp's *Dictionary of Caribbean English Usage* defines "story" as a "home-made Caribbean idiom" (Allsopp, 1996:xvii). "As home-made, the Caribbean linguistic product has always been shame-faced, inhibited both by the dour authority of colonial administrators and their written examinations on the one hand, and by the persistence of the stigmatized Creole languages of the labouring populace on the other"(Allsopp, 1996:xvii). As a poor, but privileged white American, I must remove myself from both an Appalachian English usage of "story" and the American English standard in order to understand the usage in the Caribbean English context. As an anthropologist, I must defend this usage.

The noun "story" in a wider Caribbean and "informal" context is "an account of a happening, an event" (Allsopp, 1996:533). More geographically relevant, the Eastern Caribbean context describes an "anti-formal" "story" as "trouble; a row; a brawl" (Allsopp, 1996:533). "Anti-formal" refers to a deliberate rejection of formality. This linguistic category is one of four levels of formality used in Caribbean English. The four include: Formal, Informal, Anti-formal, and Erroneous. Anti-formal is further divided into four sub-categories: Creole, Jocular, Derogatory, and Vulgar (Allsopp, 1996:1vi). Allsopp, a "native Caribbean," readily admits his own bias in labeling words, but his characterizations of words are based upon linguistic data (Allsopp, 1996:1vii).

Specific to St. Kitts, a phrase used to "bad mouth" a person is a "pound story" (Allsopp, 1996:451, 533). The word or phrase used in a wider Caribbean context for depicting a folk tale is a "Nancy-story" or "Anancy-story" (Allsopp, 1996:30, 398). While "Anancy-stories" are typically used to refer to a "cunning rascal and hero" originating from West Africa (which usually takes the shape of a spider or a man) they

are also used in an anti-formal jocular manner to refer to "nonsense" (Allsopp, 1996:398). A more derogatory meaning applied is simply "a lie" (Allsopp, 1996:398). In Jamaica, "Anancyism" is used to describe trickery (Allsopp, 1996:30). Let me assure all Kittitian and Caribbean readers alike, that despite my name being Nancy, I am in no way telling a "Nancy-Story." In sum, the use of the word "story," by itself, refers to an account, a happening, and an event that I happened to collect.

Biomedicine:

Biomedicine is unique because it has a quality that "decisively distinguishes it from most other healing systems cross-culturally" (Kleinman, 1995:25). It is consistent in its practice and method; "Western biomedicine has become pancultural and is essentially the same regardless of where it is learned or practiced" (Logan, 1996:334). This is due to the history of biomedicine, which is directly "tied to the emergence, application, and diffusion of the Western scientific method" (Logan, 1996:335). Although there is consistency within biomedicine, it is also pluralistic (Kleinman, 1995:24). Kleinman states:

> The same therapeutic technologies—say, for example, particular pharmaceuticals or surgical equipment—are also perceived and employed in different ways in different worlds. Biomedical practitioners in Thailand and India have been shown to be strongly influenced by local norms. While in contrast, technologically advanced Japan, the technology to transplantation surgery is constrained by unwillingness to accept brain death as the authorization to remove life supports and 'harvest' organs for donation. Thus, in cross-cultural perspective it is valid to talk about the cultural processes of indigenization of biomedicine as to implicate the globalization of local therapeutic traditions (Kleinman, 1995:24).

Biomedicine refers to the practice of diagnosing and treating the disease by physicians and surgeons (Anderson, 1996:405). It is the term most anthropologists employ today in place of "Western medicine." Arthur Kleinman argues for the use of the term "biomedicine" in place of "Western medicine" (Kleinman, 1995:25). "Biomedicine has long been a global institution. It is no longer only Western, either in its site of practice or even in its locus of knowledge production and technological innovation" (Kleinman, 1995:25). St. Kitts and Nevis are indeed Western. Developed within the context of Western expansion, Caribbean societies have a long colonial history whose legacy continues to influence their economic, political, and social system. In contrast to the United States, which fits definition of a traditional "Western" identity, St. Kitts and Nevis are not rich, privileged, or dominant. St. Kitts and Nevis together is a poor, young independent nation. The availability of biomedical technology is limited and this creates a condition that demands the use of ethnomedicine. I will discuss ethnomedicine in the subsequent section.

Ethnomedicine:

Ethnomedicine is defined as the "information specific to a given culture that allows its members to seek appropriate therapies for the restoration or the maintenance of a critically ill patient" (Logan, 1996:334). In St. Kitts, the information regarding disease is defined in both biomedical and ethnomedical ways. This is contingent on who is asked the questions about health. Either way, there is a knowledge tradition that provides the information that allows Kittitians to seek appropriate therapies. In the following passage,

medical anthropologist Michael H. Logan qualifies the way in which ethnomedicine has traditionally been used by anthropologists.

> Ethnomedicine has been used as an umbrella term to encompass the health-related beliefs and practices of indigenous peoples, peasants, and those in urban societies who practice alternative healing strategies such as spiritism. As such, ethnomedicine has traditionally referred to any system whose theory and practice fell outside the Western biomedical model (Logan, 1996:334).

In St. Kitts and Nevis, ethnomedicine is practiced independently of biomedicine. Biomedicine is also practiced independently of ethnomedicine, but for the majority of people in St. Kitts, biomedicine is practiced in conjunction with ethnomedicine. In St. Kitts' pluralistic health system, there is a parallel and complementary relationship between these two traditions of medical knowledge, which I refer to as the local knowledge.

Illness, Disease and the Healer:

Arthur Kleinman defines "illness" in a context that emphasizes a wide range of symptoms pertaining to suffering. Illness refers to how the sick person and this individual's family respond to sickness and disability, both in terms of its physical and social aspects (Kleinman, 1988:3). The illness experience is always culturally shaped, meaning an illness is multi-vocal: an illness experience radiates, or conceals, more than one meaning (Kleinman, 1988:3, 5, 8). The term "illness" is meant to "invoke the innately human experience of symptoms and suffering; it is the lived experience of monitoring the bodily processes" as it responds to a disease (Kleinman, 1988:3-4).

A disease in Kleinman's assessment is an alteration in the biological structure or functioning of the body (Kleinman, 1988:5). The notion of disease comes from a biomedical model—it is an alteration of an existing medical normality. Reactions to a disease vary. After all, perspectives on illness come from a diseased person; the disease comes from a practitioner's perspective (Kleinman, 1988:5). A healer "interprets the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic entity an 'it'—the disease" (Kleinman, 1988:5).

Chapter Summary:

This chapter identifies the interpretive framework I have used in this thesis. Specifically, I have addressed my usage of and the anthropological concepts of culture, the Other, a culture of blame, identity construction, knowledge and theory, narrative and discourse, and the use of the word story. I have also introduced the traditions of biomedicine and ethnomedicine and how anthropology defines these. Furthermore, I define the difference between illness and disease. The following chapter discusses the negotiation of the field in the ethnographic process.

# Chapter 3: Challenges of Ethnographic Inquiry

The Field:

I consider "the field" to be a state of mind not limited to actual on-location research. This includes pre-and-post-location research. Therefore, in terms of this research, I entered "the field" in the fall of 1999 as soon as I began thinking about the research questions I would tackle. My foray into "the field" began when I was asked to consider doing archival research in the upcoming summer 2000 archaeological field school. In order to prepare, I began doing my homework on leprosy and St. Kitts. Much to my dismay, I was not successful in finding information about St. Kitts. I went to several travel agents to gather information and I found that very little was known about St. Kitts. This was because St. Kitts was not as popular a destination as more well-known venues; therefore, vacation brochures were not available. The university library also lacked any detailed information about St. Kitts. I was very disappointed. Looking back, I now know this was more of an issue of not knowing how to look for the information rather than the information being absent. At the time, however, I certainly failed to find any detailed information about leprosy in St. Kitts. I did come across a reference to a leper colony in St. Kitts, but that was the extent of it. In terms of disease, St. Kitts listed dengue fever and ciguatera as diseases of concern for tourists. I found this to be true across the board, whether I was getting information from online sources — Centers for Disease Control and Prevention (CDC), World Health Organization (WHO) — or from the university's inoculation advisor. Leprosy was not a problem for St. Kitts.

As a result of not easily being able to dig up information about St. Kitts and leprosy, I shifted towards examining leprosy or Hansen's Disease. The leprosy literature

was convoluted and confusing, especially to a rookie first trying to make sense of it all. According to the literature, by the summer of 2000, there was not a definite answer as to how leprosy was transmitted. The assumption was that leprosy was transmitted through skin to skin contact, but a warning stated that it was not yet known if an insect could be a vector. Despite this hurdle, the more frustrating aspect of learning about leprosy was the classification system assigned for diagnosis. It has since been drastically simplified and will be discussed later on in Chapter 5.

Since I consider the "field" to be a state of mind rather than a physical location, I have never left the "field." I continue to chat online with Kittitians, some who consulted in my research and others, who I have, by chance, run into in cyberspace. For example, recently I exchanged emails with a man from New York, Charles Loeber, whose maternal grandfather worked closely with Hansen Home patients and workers with general supplies and pharmaceuticals. His mother left St. Kitts when his grandfather moved to New York in 1908 where he was employed at Bellevue Hospital. This fellow was researching his family genealogy and came across a post I had placed in a chat room requesting contact information for an author – Margaret Deanne Rouse-Jones – who had written a dissertation entitled "St. Kitts, 1713-1763: A Study of the Development of a Plantation Colony." I had submitted this request initially as a favor for a consultant in St. Kitts, or more specifically Victoria Borg O'Flaherty, the National Archivist (who I may refer to as Viki). In the end, I shared with both Viki and Mr. Loeber information about the hard-to-find dissertation, which we were all in search of. Fortunately, my university's library had a copy. Mr. Loeber of New York also had access to the out-of-print dissertation by Rouse-Jones, but was glad to make contact with me nonetheless.

As a result of my experience in the "field," I am deeply connected to my findings and deeply committed to an accurate representation of my research and of the Kittitian people. I make a distinction between the "field" and "fieldwork." In contrast to the "field," "fieldwork" is the actual labor of archival research, interviews, and living in the host country and community while away from my own family, comforts, and distractions. The research process is indeed work. Therefore, qualifying it as fieldwork is accurate.

A Comment on Ethnography:

While thick descriptive narratives are one example of how ethnographic materials can be written, Glenn Jordan challenges the conventional "*hierarchy of discourses,*" privileging the anthropologist's or ethnographer's voice as the "dominant omniscient and omnipotent authority" (Jordan, 1991:45). Jordan argues against the peripheral placement of the informants' voices which, when heard, are couched in subordinate and pleasing tones (Jordan, 1991:45). While anthropology wants to be acknowledged as an "objective" and "value-free science" (Jordan, 1991:44), it also is identified by its subjective nature. Paul Farmer suggests that the discipline of anthropology is in a "post-paradigm" position (Farmer, 1992:13). This position is a result of the eroding faith in dominant theoretical frameworks. In Farmer's opinion, this is a constructive phase because the existence of multiple theoretical voices adds depth to anthropology (Farmer, 1992:12). In 1991, Jordan called for a "new cultural anthropology" in which anthropologists allow the informants to be heard in conversation with them. This dialogic approach challenges the traditional representational authority ethnographers have held over those they study.

Taking Jordan's suggestions in this research, I am decentering my position as the ethnographer so that Kittitian stories can be heard. As a result, I will play a derivative role of weaving together Kittitian thoughts, suggestions, opinions, feelings, and stories. The encompassing story I tell includes my own experiences. In an effort to decenter my role, I am also borrowing a label that Rosalyn Howard applied to the Black Seminoles who taught her about their Seminole Indian heritage and the journey to the Bahamas (Howard, 2002: 34). She re-identifies the would-be informants as consultants. She recognizes that they indeed educated her. The same is true in my experience. I have not been satisfied with the qualifiers "participant" or "informant" despite their use in my informed consent document. These terms in my opinion do not adequately express the vital role consultants play. After all, without their willingness to share their knowledge, ethnographies and scholarly papers would not legitimately exist.

I spent a total of 108 days, stretched over two summers (2000 and 2002) collecting data in St. Kitts. I experienced life in St. Kitts only during the months of May, June and July, both pre-and post-9/11, marking the shift from a relatively sustainable Kittitian economy to a suffering Kittitian economy. It was explained to me in 2002, that the tourism dollars were not coming in like they did prior to 9/11, plus the sugar economy was not turning a profit. My story, therefore, is only a couple of snap-shots in time. The Kittitian stories relative to this research span over 106 years, from as early as 1896 to 2002. I will in no way pretend to be an authority on "Kittitian Culture," but I hope the way I present this story justly serves those Kittitians who generously helped me in this journey.

During my fieldwork, I collected stories, some of which reflected a public health discourse on leprosy; others were folk narratives about cocobay. More importantly, these stories explain how leprosy is theorized in varying social situations. Specifically, I learned how poor and wealthy Kittitians perceived, labeled, and classified leprosy. These stories reflected a spectrum of perceptions, opinions, beliefs, and agendas, which, I might add, were not so simply divided down the binary opposition between those of the poor and wealthy. My fieldwork suggests that Kittitians do not theorize cocobay in a uniform, homogeneous manner. Their knowledge is variegated, contradictory, and it is negotiated through a process of contestation influenced by the class, gender, and partisan differences that make up the Federation of St. Kitts and Nevis as a postcolonial Caribbean nation-state.

Negotiating Informed Consent:

The Institutional Review Board (IRB) is designed to prevent the exploitation of people in the process of research. IRBs are in place in nearly all universities and are charged with insuring that research projects involving human subjects are heavily scrutinized. This is done in order to set a standard of ethics in an effort to prevent a repeat of human rights abuses such as those that were committed in the name of science, like Nuremberg and Tuskegee. The initial IRBs were designed to protect people from unethical medical testing. Now they monitor research in the social sciences that involve human subjects. As a protective measure, all persons involved in a research project must consent to participate. A document identified as "Informed Consent" (see appendix A) is a statement or contract that outlines the nature of the research and gives the details and

rights a participant would want or need to know. Prior to doing the research specific to this thesis, I had to obtain IRB approval and prepare an informed consent document that would be used to establish the understanding of informed participation.

My research, although it involves leprosy, does not involve any blood, persons with leprosy, any names of people who were related to those who had leprosy, or any names of those who are not part of the public or popular record. It is not a biomedical research project aimed to address leprosy in a clinical setting. It is a project designed to address a local knowledge of leprosy. The most challenging aspect of this research project was obtaining informed consent. I used an informed consent document to do so.

In my case, I was in a rural Third World setting; the "Western lab" was the homes of people willing to talk to me. In most cases, people were insulted by the suggestion of an informed consent document that they had to sign prior to getting to know me. Some folks who were highly educated looked at the form as a joke and proceeded to correct me and in some cases lecture me on the use of "Cocobay," the colloquial term for leprosy. I explained the university's role in ensuring that people are not taken advantage of and that this document was a contract stating that the information that is given to me will never be tied to a specific name. The information giver will never be identified. Having clarified this, I was frequently asked: "If you are not going to use my name, then why should I sign?" "Do I have to sign my real name since you will never use my name anyway?" "What is the point, if you are not going to use my name, why should I write it?" All of these were valid questions and they were usually accompanied by comment on the futility of such a document; frustrated with this document and the process, I agreed. However, I

was diligent and emphasized that the spirit of the IRB and Informed Consent process is needed to ensure that in no way are people put at risk and was indeed important.

Obtaining informed consent was an exercise in negotiation. During this negotiation process, I used an audio tape recorder in order to make my fieldnotes easier, but after introducing the informed consent document, which is a contract, a tape recorder seemed too invasive, and while people were willing to talk with me with no strings attached, some were not willing to sign their names and be audio taped. This decision to use the audio tape recorder was left up to the consultant. I provided copies of the transcripts and audio taped conversations to those who wanted them. In several cases, the consultants reviewed the transcriptions and listened to the audio-tapes and offered retractions, and or corrections, and clarifications.

I did not want to pressure anyone into participating and participation was completely voluntary in that the conditions in which they were consulted were directed by their wishes. When I did use the audio tapes, I always identified myself and I asked permission on tape to record. During semi-structured interviews, consultants would state whether or not what they had just said was available for use. For example, if a consultant made a statement that was politically charged, she or he might say, "you can repeat this," or "just between you and me." When anyone would say "just between you and me" I took this as information that consent for use was not given. I did not have any consultant decide to stop participating. In one case, when I used both the tape and the document, it was clear that he did not want his name recorded, but that he did want to give me information. In some cases, when an audio tape recorder was being used, I was asked to turn it off for a bit. I would wait for their approval to resume the recording.

In some cases, people felt that self-identification on tape was enough consent. In addition to this, I asked them to acknowledge that they were informed about the taping, their anonymity, and their ability to stop participating at any time as well as be able to retract all information. This was evident in that they agreed to being taped so long as their name was never mentioned. I complied. For the most part, as a response to the nature of the Informed Consent document and the anonymity involved, many people signed with an X. I always left the consultant a copy of the document after reading it verbatim to them. Sometimes, this formality took away from the conversation, but once this step was over, then the dialogue flowed.

I found that although the literacy rate in St. Kitts is approximately 97%, my informed consent document was largely difficult to understand for many folks. My IRB criteria for consultants identified a population of older Kittitians who were retired or close to retirement. The formal education of those folks varied. Some were highly educated medical doctors and others were laborers; I suspect all but three were literate. Therefore, I carefully treated each individual with dignity and did not question their ability to read. So, as standard procedure, I began reading the document along with them. Some folks told me to hush, while others followed along with their copy. Therefore, the reality was I had to obtain consent from folks who could read but were unable to access the information due to poor vision. Few clearly "read" the document, but due to a fear of embarrassment they did not let on that they could not read, regardless of whether it was a result of illiteracy or vision.

Another challenge I faced deals with the reality of obtaining informed consent. In the rural Third World, the suspicion of being in collusion with governments is addressed

by the consultants who are not sure of my intent. During one conversation with a male consultant, I found myself in the middle of a dispute. The man's wife became irate at the idea of a document on which he was to sign his name. She was livid. Fortunately, I had a guide with me who helped extinguish the fire that my document set. The man just laughed at his wife and he talked to me anyway. To satisfy his wife, I put the document away just after he signed it with an X. I attribute this to an expected suspicion of a nosy white American who may have been there to swindle them, be a spy for the Kittitian government (at that time a Labour Party spy), or a CIA agent. All of which were far from the truth but valid suspicions nonetheless.

Chapter Summary:

In this chapter, I have discussed the concept of the field and fieldwork. I also offer a comment on ethnography and the relationship between the ethnographer and consultant. I conclude this chapter with an explanation of the IRB and the reason an Informed Consent document is used. I also discuss how I negotiated informed consent especially in situations in which the formality of a contract was resisted.

THE LAZARETTO ST. KITTS.



THE STRANGER'S WELCOME.

The American Tourist staying at his Hotel in Basseterre takes an evening stroll —is accosted by two of our Night Birds.

1*ST. LEPER.* Gie me a cappah! Sar!

2*ND. LEPER.* If you doan gie me someting ur spit on yer.

# Chapter 4: "I am Somewhere in the Bahamas!"

Geography:

> I was walking through Pelican Mall the other day when I heard an American girl (U.S. tourist) tell someone on the phone, 'I am some where in the Bahamas.' I stopped her, pulled her arm, and said, 'No, this is St. Kitts, we are not the Bahamas!' and walked away (Fieldnotes, 2002).

Tamara, a young, spirited Kittitian woman, related this event to me when we, along with her mother Victoria Borg O'Flaherty (the National Archivist), discussed how Americans (referring to U.S. Americans) are generally unaware of the existence of St. Kitts. I agreed; I would argue that the average American is familiar with the Bahamas, Jamaica, Cuba, and Haiti but not the other Caribbean islands, for a variety of political and economic reasons. The most significant of these reasons relates to the tourist industry and its dominant foothold in the scenic and historic locales of the region, but political refugees, political dictators, and disease are also tip-of-the-tongue reflections when the topic of the Caribbean is raised. Outside of the popular islands listed above, Americans are typically not familiar with the geography of the Caribbean.

The Federation of St. Kitts and Nevis is a beautiful set of islands that falls under the "little known to Americans" category. St. Kitts is the larger of the two islands and the focus of my research, see Figure 4.1. Nevis is much smaller than St. Kitts and is located off St. Kitts' southern tip. Both are located among the Leeward Islands of the Lesser Antilles, in the eastern Caribbean, and are only separated by a two-mile stretch known as "The Narrows" (see Figure 4.1) (Dyde, 1999:3). Both islands are completely surrounded by the Caribbean Sea and are among the few that




**Figure 4.1: Map of St. Kitts & Nevis (Graphic Maps, 2002:1).**

do not have an Atlantic coastline; the Atlantic and the Caribbean Sea merge thirty-five miles north of their position (Dyde, 1999:1).

St. Kitts has a latitude of 17°15 N and a longitude of 62° 40 W (Merrill, 1958:18) and is approximately 68 sq miles or 23 by 5 miles. Nevis is approximately 36 sq miles, or 7 miles in diameter (Richardson, 1983:38). These measurements do not account for erosion. Figure 4.1 shows Mt. Misery, which is also called Mt. Liamuiga. Mt. Liamuiga (Liamuiga is Carib for "fertile land") is a dormant volcano and the highest elevation in St. Kitts at 3,792 feet. Mt. Nevis is 3,232 feet in elevation and is also a dormant volcano. Clouds hover over this peak creating a halo of snow, which prompted Christopher Columbus in 1493 to call it "Nuestra Senora de Ls Nieves" when translated means "Our Lady of the Snows" (Nevis Tourism Authority, 2002 [hereafter Authority]).

Figure 4.2 indicates the wide range of islands and coast lines that contribute to the geographic region called the Caribbean or West Indies. Four geographic areas identify the landscape as 1) the Bahamas, 2) Greater Antilles, 3) Lesser Antilles, and 4) South American continental shelf (Goodwin, 2000:99). The Caribbean region, however, should not be limited to these island groupings. The Caribbean landscape expands beyond the areas that are in the midst of the Caribbean Sea with regard to common history and experience. For example, the Atlantic coastline stretching from Florida to the Sea Islands in South Carolina and Georgia might also be included. "To break down the Caribbean region into culture groups presents its own set of problems" (Goodwin, 2000:99); therefore, to limit the definition of what is Caribbean or West Indian by geographic bounds, ignores the people who share common histories and languages that extend to the coastal areas to the north, west and south.




**Figure 4.2: Map of the Caribbean (Graphic Maps, 2002:1).**

The circum-Caribbean includes countries such as Belize and Guyana and the Atlantic coast lines of Columbia, Venezuela, and Mexico. The circum-Caribbean areas shares a similar history of colonial destruction of indigenous peoples like the Arawaks/Caribs, European colonialism and enslavement, and European language and culture assimilation, as well as a political economic culture similar to that of the Caribbean proper (Goodwin, 2000:99). Given that this is a widely accepted description of what constitutes the circum-Caribbean, Faye V. Harrison argues that a more comprehensive mapping of the circum-Caribbean region might include an acknowledgement of particular areas of the United States' South. This specifically refers to the Carolinas' and Georgia's low country and the Sea Islands, the Gulf Coast areas of Southern Louisiana, and both the Gulf and Atlantic coasts of Florida, which basically represent what Harrison calls the United States' South's littoral zone (Harrison, 2003). Support for this argument lies in understanding the reach of the Caribbean diaspora, which has extended to these areas over considerable historical time. Today, the Caribbean diaspora makes connections with Canada and the United States, as well as with colonial powers of Europe that may or may not still have a colonial relationship with the respective islands. Caribbeanist and Political Anthropologist Faye V. Harrison considers some of the implications of transnational cultural circuits and argues that "it is more than appropriate to re-conceptualize and re-imagine the South and the Caribbean by deterritorializing the sociocultural and structural features typically associated with them and then reterritorializing and remapping them across the coordinates of interlocking transnational fields of identity, sociocultural dynamics, power, and political economy" (Harrison, 2003)

*Liamuiga* – Fertile Land:

St. Kitts was occupied by the Arawaks and Caribs long before European invasion. Archaeological evidence indicates human occupation as early as 500 to 600 AD when the indigenous population was at its peak (Hubbard, 2002:10). Archaeological projects are ongoing in identifying not only the colonial history of Nevis, but the pre-Columbian history as well. The work in Nevis is largely being done by archaeologists from the University of Southampton and Bristol University in England and is supported by the Nevis Historical and Conservation Society (Authority, 2002). Archaeological projects continue to be supported in St. Kitts. For example, Gerald Schroedl of the University of Tennessee – Knoxville, continues to excavate areas of Brimstone Hill.

The Caribs called St. Kitts "*Liamuiga*" (pronounced Lee-a-mwee-ga) which meant fertile land (Kreiner, 2000:18). The Arawaks called Nevis "Dulcina," for "Sweet Island" and the Caribs called it "Oualie" for "land of beautiful waters" (Authority, 2002). Evidence of Carib occupation in St. Kitts was seen in petroglyphs that were readily found in river beds, see Figure 4.3. This aspect of Kittitian history is highlighted through Batiks that are crafted at the Caribelle Factory (see Figure 4.3).

In terms of its history, St. Kitts, or St. Christopher, and Nevis were "discovered" first by Spanish explorers led by Christopher Columbus in 1493 (Hubbard, 2002:13). Columbus actually named St. Kitts "San Jorge" and Nevis was "San Martín" (Hubbard, 2002:13). Spanish sailors changed the names for whatever reason and by the early sixteenth century the names were San Cristóbal and Nieves (Hubbard, 2002:13). The contemporary constitution allows for the shortening of St. Christopher's name to



**Figure 4.3: Top Left: Carib Carvings from river bed at Bloody Point (outlined by chalk); Bottom Left: Carib Petroglyphs at the entrance of Wingfield Manor Estate (outlined by chalk); Right: Caribelle Batik Wall Hanging depicting Carib Petroglyphs: Photos taken in 2000.**

"St. Kitts" (Hubbard, 2002:13). St. Kitts is also called the "The Mother Colony" (Armony, 2000:13) or "Sugar City" (Discover St. Kitts, 2004 [hereafter Kitts]) while Nevis is called the "Queen of the Caribees" (Authority, 2002).

On January 28, 1623, Sir Thomas Warner, along with fifteen settlers arrived and founded the first non-Spanish European colony in the Caribbean — St. Christopher (Hubbard, 2002:15). Warner had financial backing and a royal patent for colonization. In 1625, the French sought official sanction and financial backing for a colony. The British and French co-existed on the island until 1666, when tensions began to escalate. The Treaty of Utrecht in 1713 settled the dispute (temporarily), declaring the island British (Hubbard, 2002:60).

Basseterre is the national capital and was founded by Belain d'Esnambuc in 1625. Basseterre became the capital of St. Kitts after the British "took possession of the whole island after 1713" and after the Treaty of Utrecht sorted "out the problems of land ownership in what had been Saint-Christophe" (Dyde, 1999:71). D'Esnambuc was the first Governor of French St. Kitts; St. Christopher was also the first French colony in the Caribbean (Hubbard, 2002:32). He left St. Kitts to settle Martinique in 1635; he died the same year (Hubbard, 2002:33). Since 1727, Basseterre has been "the capital and commercial centre of the whole island" (Dyde, 1999:71).

The Carib population in St. Kitts had somewhat peacefully co-existed with the European explorers since the colonizers "discovered" the island in 1493 (Hubbard, 2002:17). This peace lasted until a 1626 joint operation by the English and French took place; they decided to massacre the remaining indigenous population at the site known as "Bloody Point." The Europeans heard about this plan and decided to act before

Tegremond did (Hubbard, 2002:17). Chief Tegremond had sent word to other islands seeking support from fellow Caribs. The plan called for an attack to defuse the threat that the settlers were posing, which was taking over the island (Hubbard, 2002:17). The Europeans gave a party for the Caribs one night. Once the intoxicated, Caribs returned to their village, the Europeans attacked and killed Chief Tegremond who was asleep in his royal hammock, a Carib invention (Hubbard, 2002:17). The soldiers gathered all remaining 120 villagers and the next day they chased 2000 to 4000 Caribs to the river ravine where an estimated 2000 were murdered (Hubbard, 2002:17). The Caribs were only able to kill about 100 Europeans in this battle (Hubbard, 2002:17). Legend has it, the river ran full of Carib blood for days (Inniss, 1985:3).

The remaining population of Caribs, like most of the colonized islands including Nevis, assimilated into the population. Specifically, In St. Kitts, Nevis and Antigua, around 1640, those Caribs that were not enslaved were forcibly relocated to Dominica (Hubbard, 2002:18). Throughout the Caribbean, the Caribs relocated not only to Dominica, but to Trinidad and Tobago, Belize, and Puerto Rico. Other names that are associated with the Carib Diaspora are Taino, Taino Arawak, Kalina, Garifuna and Black Caribs (Johnson, 2000).

An unfortunate legacy associated with the Caribs is the notion of anthropophagy, or cannibalism. The original depiction of cannibalism in the Caribbean comes from Columbus's journals (Sheller, 2003:148). Essentially, those that were deemed "cannibals" staged resistance to enslavement and colonization. Therefore, the Caribs become the model "fierce savage" and thus created a justification for "taming" the "Indian" through the brutal ways of enslavement and colonization. This also serves to

further confirm the so-called "supremacy of white Europeans" (Sheller, 2003:110, 148). The Arawaks, on the other hand, are depicted as the model "friendly natives" as they are "peaceful" (Sheller, 2003:110, 148).

Columbus made constant efforts to draw a distinction between "friendly natives" or Arawaks and the Carib "fierce savages" and "man-eaters" (Sheller, 2003:110). The argument made by Sheller was in fact that the actual "man-eating" took place not by the Caribs, but by Columbus and other European colonizers. Colonialism was an example of cannibalism; it fed off the excessive greed, and hunger that consumed human bodies for food or profit. The same can be said for contemporary capitalism that through structural violence consumed human bodies, again for profit (Sheller, 2003:148). I mentioned this legacy of cannibalism in an effort to add historical depth to the understanding of the Carib's role in St. Kitts, specifically at Bloody Point. The Caribs resisted and in their hope of keeping their culture whole, they perished.

Repeopling:

The first known occupants of St. Kitts were the Arawaks and then the Caribs; the same was true for Nevis. Both the French and British settled the island, but by and large the vast majority of people who were transplanted to the colony were from Africa. These humans were members of thriving, complex societies who became victims of a European agenda. Enslaved humans were brought to St. Kitts early in its English occupation (Hubbard, 2002:75). At this time, small land holdings were principal, but by 1640, when sugarcane dominated the market, the system employed by large estates grew to govern the colony's economics. By 1700, the enslaved work force greatly outnumbered the

small population of property owners; and by mid-century, 90% of the population consisted of enslaved peoples (Hubbard, 2002:75). The majority of individuals, reduced to a status of property, came from various nations in Africa, specifically in West Africa (Armony, 2000:13). St. Kitts was the Mother Colony for England (Armony, 2000:13); perhaps it was also a Grandmother to all English speaking Caribbean nations. St. Kitts was the first non-Spanish European colony in the Caribbean and, therefore, the amalgamation of peoples (Arawaks/Caribs, Europeans, and Africans) identified as the Creolized West Indies can be argued to have been launched in St. Kitts. Independence Square, formerly known as Pall Mall Square (see Figure 4.4) in Basseterre, St. Kitts was once the location for the auctioning of humans who were probably transported from Nevis, which the Royal African Company designated as a major depot for supplying enslaved labor to all the Leeward Islands (Inniss, 1985:15). Currently, a movement has begun to erect a monument in Independence Square to honor the memory of those who were enslaved and sold.

Emancipation in St. Kitts occurred in 1838, but earned wages were not capable of supporting the majority of people. This caused many to migrate to Trinidad and British Guiana (currently Guyana) where the wages were higher. Some returned with their hard earned cash only to find a home country where epidemics and poverty were flourishing. People were migrating to St. Kitts as well. In 1858, as many as 452 Portuguese came to work on the sugar estates (Hubbard, 2002:119). During this time, there were approximately 345 people per square mile (Olwig, 1995:54). The population between 1838 and 1884 grew from 21,578 to 28,177, and in Nevis, it grew from 7,470 to 9,570 (Olwig, 1995:166).




**Figure 4.4: Independence Square — Top Entrance, Bottom Fountain, St. Kitts; Photos taken in 2002.**

Today, the combined population is approximately 38,000, of which only 9,000 live on Nevis. The people in St. Kitts, or Kittitians, and Nevis, or Nevisians, are largely of African-Caribbean ancestry. But the population also includes individuals who ethnically are defined in terms of their British, Portuguese, and Lebanese descent (Goodwill, 2001:1). The life expectancy rests at 70.73 years and the infant mortality rate is 15.39/1000 (2003 est.) (CIA, 2003:1). While literacy is 97%, and unemployment rates are staggering at 12% (Goodwill, 2001:1). The average wage rate reported in 1991 in St. Kitts and Nevis is US$1.00 or EC$2.70 per hour (Potter, 2000:192). St. Kitts and Nevis gained Independence from Britain on September 19, 1983. Their Federation has been a rocky union, which I will discuss further below. The current political parties are the St. Kitts and Nevis Labour Party (SKNLP/WL), People's Action Movemement (PAM), Concerned Citizens Movement (CCM – Nevis based) and Nevis Reformation Party (NRP); universal suffrage is enjoyed at the age of eighteen. As it relates to this research, I only met with people who were either PAM or Labour members. I did not do this by design, but since my research was based in St. Kitts, this is not all that surprising.

The Union:

St. Kitts and Nevis became one nation-state on September 19, 1983. A nation state is defined by Cornelia Navari as "a polity of homogeneous people who share the same culture and same language, and who are governed by some of their own number who server their interests" (Navari in Mach, 1993:95). Many Kittitians and Nevisians would no doubt argue that they are not represented, but this gets into the bipartisan political debates that are not unlike those that occur between Republicans and Democrats.

Nonetheless, the people of St. Kitts and Nevis are represented by a self-elected government. Although the country gained independence from Great Britain in 1983, it remains part of the British Commonwealth.

This union, however, was not an easy one to come by. These two islands were essentially forced together through colonial rule. Between 1623 and 1967, the imperial domination of these two islands was expressed in various arrangements. During the 18th and 19th centuries, St. Kitts and Nevis maintained separate identities. Each island had its own Administrators and Lieutenant Governors. There was evidence early on that Nevisians and Kittitians did not want to be identified with one another. In 1862 Governor K.B. Hamilton stated "a gentleman of Nevis says that is a duty he has inherited to abhor everything belonging to St. Kitts, which, he adds, is the faith of all true Nevisians" (Daniel, 2001:11).

Nevis "joined" the Leeward Islands Federation on December 1, 1869. This membership came about via a conspiracy by the Lieutenant Governor (Daniel, 2001:12). Due to a boycott of this vote by the elected members of the House of Assembly, the Lieutenant Governor arranged to appoint just enough new members to the House of Assembly to have a valid meeting. He then represented Nevis to the British Government as in-favor of joining the Leeward Islands Federation (Daniel, 2001:11). This would not be the last time that Nevis felt betrayed. In December of 1882, the Governor of the Leeward Islands announced that on January 1 of 1883, the union of two Presidencies would take place. The blow came when it was further stated that the Union of St. Christopher and Nevis as one presidency would mean that the Legislative Council of the Presidency of Nevis would be disbanded (Daniel, 2001:14). This union was made to

simplify administrative duties for the British Government (Daniel, 2001:14). The Presidency of St. Kitts and Nevis also included Anguilla, but it was not called The Presidency of St. Kitts, Nevis and Anguilla until 1951 (Inniss, 1985:80).

On February 27, 1967, St. Kitts, Nevis and Anguilla became an Associated State of Great Britain. This meant that the people could practice "full internal self-government" and experience "internal independence" (Bryant, 1993:5). Statehood gave the people of St. Kitts, Nevis and Anguilla the power to amend or revoke their constitution without the consent of Great Britain (Bryant, 1993:5). This tri-union did not last long. The Anguillians identified their status in this statehood as oppressed and, on May 30, 1967, the Anguillians staged a revolt to secede from the Union. They demanded a return to the status of a British colony. This was granted in 1971 by means of the Anguilla Act, and St. Kitts and Nevis were on their own (Daniel, 2001:23). Nevis made several attempts to secede from St. Kitts and the desire to do so remains. Together, however, they gained independence in 1983. Built into the arrangement was the formal separation of Anguilla from the Associated State. The Anguilla Act stipulated that as a condition of independence for St. Kitts and Nevis, Anguilla would be formally separated. Independence in 1983 thus created the new Federation of St. Kitts and Nevis.

The sentiment between the two islands as a unified nation-state is not much better now than how the "Nevis gentleman in 1862" phrased it. In the 1983 publication of *Whither Bound St. Kitts – Nevis?* by Sir Probyn Inniss, the following statement was made:

> And so, it came to pass that in the year of 1883 Nevis was dragged into a union with St. Kitts in order that St. Kitts would bear the costs when Nevis could not. The Mother Colony, St. Kitts was saddled with a financial burden which was

> clearly the responsibility of the Mother country, England. Exactly one hundred years later, on 19 September, 1983, as if dogged by a cruel Fate, St. Kitts is being dragged into Independence with Nevis so that St. Kitts will continue to serve her sole purpose of carrying the financial burden (Inniss, 1983:5).

Nearly 20 years after Sir Probyn Inniss made this statement, I found that the distinction between St. Kitts and Nevis is being redefined, at least through the tourism literature which boasts "Two Islands, One Paradise" (St. Kitts and Nevis Hotel and Tourism Authority, 2001 [hereafter Hotel and Tourism Association]). However, there are important distinctions to note. Although there is a single flag (Figure 4.5) there is not one single word or label to represent a person from this country. There is either a "Kittitian" or a "Nevisian." I am not taking into account any foreign nationals who may be defined in another way. A Kittitian may define her or himself specifically as to the town or village from which s/he comes. The same is true for Nevisians. When talking to people in St. Kitts who are actually Nevisians, they make a point to let you know that they are from Nevis. Among Kittitians, Sandy Pointers are quick to identify themselves as Sandy Pointers. Essentially St. Kitts and Nevis is one country with two national labels for its people. The dynamics of the Kittitian/Nevisian relationship will be revisited through an examination of identity, which factors in when and why blame for leprosy is assigned.

Multilayered Identity:

In Chapter 2, I defined six layers of identity which include: national and transnational identity, island identity (St. Kitts or Nevis), urban/rural identity (village, town, or village specific), political and religious identity and health identity. Some of



**Figure 4.5: Mural of National Flag of St. Kitts & Nevis; Photo taken in 2000.**

these layers are really combinations of multiple identities, but they are closely related and demonstrate a similar pattern in expression.

*National and Transnational Identity —*

St. Kitts has a number of non-Kittitians living on the island. Some are just visiting and some have made St. Kitts their home. The same is true for Nevis. Some people identify themselves as American, or Indian (East Indian), or as Antiguan, or British. Those who have made St. Kitts their home still identify themselves with their original home. One example of the complexity of transnational identity comes from my interactions online with people searching for information about their heritage. Through the use of social networking online and searching for information I came to know many more people who knew about Hansen Home than I expected. Some of these people were people tracing their own genealogy and by chance sent me an email.

One example of the transnational connection, which makes the "field" boundless, refers to two individuals who are connected by St. Kitts. One of these individuals is a consultant located in St. Kitts. The other is a New Yorker who I met online. Perhaps this example will add to the depth of understanding at how boundless identity is.

The New Yorker, Mr. Loeber, is of Kittitian descent. His mother was born in St. Kitts to a father who was French – St. Barthelemy and a mother who was English. Mr. Loeber's maternal grandfather whose surname was LaPlace was a clerk/manager type who did a bit of everything to make a living. He was also a "chemist," as the British would say, who worked at a drug store. Today he might have been called a pharmacist. His connection with Hansen Home was as a supplier or dispenser. Mr. Loeber

understands that his grandfather's experience with Hansen Home helped him to earn a position at Bellevue Hospital in New York when he left St. Kitts in 1908.

Mr. Loeber's great-aunt, sister-in-law to his grandfather mentioned above, was married to Doctor Joseph Numa Rat, who was the Medical Officer in St. Kitts during the inception of the leprosarium, and well known for his work with Yaws in St. Kitts. Mr. Loeber described his heritage as being largely European. Through an email about Hansen Home, Mr. Loeber explains how his heritage transcends time and connects New York to St. Kitts, and Europe. He expanded to explain how it is also connected by marriage to Malta.

The National Archivist, Victoria Borg O'Flaherty, is from Malta. She married a Kittitian and has three children. Evidently, Mr. Loeber and Viki are related distantly through Mr. Loeber's mother's maternal grandmother's side. A small world indeed; this example further explains how "field" is not bound to national borders and it is not bound by time. When I first started out, I never dreamed I would come across a descendant here in the United States that would be tuned into the history of Hansen Home, especially since finding a shred of information about this initially was difficult.

*Island Identity —*

Although the dynamics of one country with two national labels for its people has been discussed in Chapter 4, I will emphasize how this identity was further defined. Most people in St. Kitts were Kittitian, and most in Nevis were Nevisians. However, one woman I talked to in Basseterre told me that despite the fact that she had lived in St. Kitts for 20 years, she was from Nevis. She was born in Nevis and she had her children in

Nevis. Conversely, while in Nevis, I met an officer who was not only from St. Kitts, but was a Sandy Pointer. He remembered Hansen Home and remembered someone who had lived there. He was a small child when his mother would visit the Home, but even in this casual conversation he pointed out that leprosy did not come from Sandy Point and that it was brought to Sandy Point. He also took the opportunity to inform me that Sandy Point was the first capital of St. Kitts. I heard this fact time and time again which shows how this piece of history is a marker of Sandy Pointer pride and history. Hansen Home is perhaps a piece of history some Sandy Pointers might want to erase considering the recurring reference to this facility being forced upon Sandy Pointers.

Nevis, although a joint partner in the Federation of St. Kitts and Nevis, is still viewed by some as an "other island." Many islands are implicated in the transport of leprosy to St. Kitts, but it is not unlikely that since these other islands were experiencing endemic leprosy, then so was St. Kitts (BlueBooks, 1890-1899). At the time in which the leprosarium was opened in St. Kitts, the United States was looking for ways to deal with leprosy too. It is not unreasonable to conclude that St. Kitts was just as affected by leprosy as was Nevis, Antigua, Anguilla, Tortola, Cuba, Jamaica, Trinidad, just to name a few – and therefore, contributed to its own health crisis. The important fact to remember is that St. Kitts and Nevis did something about it and eradicated it from both islands.

*Urban/Rural Identity —*

Since the leprosarium was in Sandy Point, it is important to know whether or not the information about leprosy offered in consultation was from those who lived in Sandy Point or from people from other parts of the island. The unfortunate fact I came across

was that with the younger population, unless you were from Sandy Point, you did not even know Hansen Home existed. This is a sign that the general population is not concerned about leprosy, but it shows that this important piece of history is threatened. Finding out if someone was a Sandy Pointer is not hard. Sandy Pointers are very proud of their town. They want people to know about their role in the history of St. Kitts. Many Sandy Pointers would skip over the first question by not even identifying themselves as Kittitian, but as Sandy Pointers. On several occasions, I had the assistance of guides. One guide introduced me to a man who stated: "although I am PAM, I will help you because a Sandy Pointer asks." If it had been left to politics, I would not have received the aid I did; as the consultant continued, "despite the fact that our representative is Labour, I will help you." The only reason I received help in many cases was due to the fact that a Sandy Pointer had asked people to help.

*Political Identity —*

The next level concerns political affiliation. I only came into contact with people who were either Peoples' Action Movement (PAM) or Labour Party members. In 2002, I did my best not to wear either red (Labour) or yellow (PAM) clothing when I went to interview people. I did not want to be misconstrued as being a representative of a particular party. This was primarily due to a lesson learned in 2000. In 2000, I was sponsored by the government; a sponsorship that I did not realize would affect the kinds of information I received. When I returned in 2002, I went on my own – meaning that I did not have governmental support, save for authorization. In 2002, I paid close attention to my shirt color. I did not want to cause any consultant grief for talking to me. In

comparing the information gathered in 2000 and 2002, people were more open about politics and religion. I learned that some of my consultants were related, but were members of different political parties. Due to party politics, these relatives chose to meet on neutral ground.

Political identity is a strong element to both Kittitian and Nevisian identity construction. The tension regarding the "forced union" of these islands is only one layer. The internal politics within each island is yet another layer. A dissertation or a life's work could be devoted to understanding all of the intricacies of this complex social layer of identity. For the purposes of this thesis, it is important to note that politics plays a role in gaining access to information and that politics underlines the positioning of St. Kitts in opposition to Nevis.

*Religious Identity* —

The Federation of St. Kitts and Nevis is classified as a Christian nation, but it is religiously diverse including the religions of Islam, Hindu, and RasTafarI. By 1887, the total population was estimated at 25,000. Of these, the immigrant population included 295 Africans, 838 Portuguese, 61 East Indians, and 218 Irish and English (Hubbard, 2002:119). A number of Lebanese also migrated to St. Kitts during the 19$^{th}$ century. The diversity of people in St. Kitts greatly contributed to the religious diversity. St. Kitts attracts migrants from all parts of the world, from the Middle East, China, India, the United Kingdom and North America. The religious diversity found today in St. Kitts continues to be a reflection of the peoples' diversity.

I did not specifically ask questions about religious beliefs, but information regarding transmission of leprosy was presented to me through identifying religious affiliation. Some people identified themselves through statements like: "I go to Church, but I believe that obeah is real," and others stated "I am a Christian, I am not worried about obeah, it cannot touch me."

I attended a few Christian church services where the use of anointing oils and communion of Christ took place. Among the Christian ideology, a variety of denominations exist. The majority of the traditional churches are of the Anglican, Catholic, or Methodist denominations. I only found one Baptist church. There were a great number of Pentecostal churches, the most obvious of which is the Church of God. These "way-side" churches, as they are called, are typically smaller than the large Anglican cathedrals, but then again they are also in higher attendance. I often saw these churches with worshipers standing in the door ways and windows.

Among the religious diversity in St. Kitts, a relatively large population of Muslims exists. Many of these Muslims are descendents of immigrant East Indians, Africans, Lebanese, and other Mid-Eastern peoples. Furthermore, Hindu and Buddhism are also represented by their Chinese and East Indian population. RasTafarI is also practiced. In addition to these religions, Nevis has the historic remains of a thriving Jewish community, with a Jewish cemetery and historic synagogue. Both islands have been home to many Jews fleeing persecutions over the centuries (Hubbard, 2002:25, 92). Dr. Edgar Victor Strisiver, a German Jew, escaped Hitler and came to St. Kitts where he worked as a Medical Superintendent and Surgeon of the Cunningham Hospital during the WWII (Sebastian, 2001:80).

*Health Identity* —

In identifying health, I did not pry into the private health information of the consultants assisting me. Instead, I sought to identify the historical accounts of those afflicted with "cocobay." In this venture, I found in the historical records those who were identified with leprosy. Among these histories were the multilayered identities of those who were first described as a "leper." These identities included national identities (people from other countries/islands), island identity (Kittitian and Nevisian), political and religious identity. The "leper identity" is further discussed in Chapter 5.

Health identity involves the legacy of leprosy. The social suffering of leprosy is the result of the illness. When a person was identified as a "leper," she or he then by default marked their family. Her or his family was under suspicion for having the disease, for working obeah, and/or for having obeah worked on them.

*Shoogoh* or Sugar: (Richardson, 2002)

The economy of St. Kitts, has largely been unchanged since the 17th century. It has depended on the production and processing of sugarcane. As of 2000, the sugarcane industry was still the largest resource for employment, but it was produced at a loss (Inniss, 2000:25). As a result, the government of St. Kitts and Nevis recently announced the end of government supported sugar production in St. Kitts. The Associated Press via Yahoo reported on March 31, 2005 that St. Kitts received a European Union Grants of $3.9 million in economic reform. The Associated Press via Yahoo reports:

> The European Union has granted St. Kitts euro3 million (US$3.9million) in aid for economic reform, following the tiny Caribbean island nation's decision to stop producing sugar, the government announced Thursday. The grant is a

> supplement to an original allocation of euro3.2 million (US$4.1million) from the European Union (EU) and will be 'earmarked for information technology education in the context of economic reform away from sugar dependence,' the government stated, citing an EU press release. The government decided to shut down it debt-ridden sugar industry earlier this month after 300 years of production, saying this year's harvest will be its last. About 2,000 workers began the four-month harvest March 14; this year, 7,900 acres of state-owned land are expected to produce 12,360tons (Associated Press via Yahoo, 2005).

The year 2005 will mark the end of a 300 year history of sugar production. By the harvest end, there will be a great deal of people out of work. I suspect this decision is met with both excitement and caution.

Over the years, the Federation has received international support for agricultural diversification. Countries that have assisted greatly in this venture include France, specifically the French Cooperation and the French Alliance of Basseterre, the Republic of China, and the United States, specifically the Peace Corps (St. Kitts and Nevis Ministry of Tourism, 2000:37 [hereafter Tourism]). Cotton production and peanut production are examples of the type of agricultural diversification that is gaining support. Potatoes, corn and tomatoes and are cultivated in small private gardens in St. Kitts.

Historically, tobacco was the first cash crop to be cultivated in large quantity by Europeans in St. Kitts. Ginger and indigo were also among the first cash crops, but were produced in smaller quantities (Hubbard, 2002:24). Ultimately, sugarcane became the most profitable and successful crop thus far in St. Kitts' history. The land, as the Caribs had proclaimed, is fertile and it continues to be so today. Since the 1640's, sugarcane was central to the stability and instability of the economic situation on St. Kitts. It was the basis of their economy. As of 2002, the government owned about 90% of the arable land and sugarcane is harvested in about thirty estates in St. Kitts. The remaining arable

lands are privately owned. In 1996, the production rate of sugar was approximately 20,249 tons. In 1953, however, sugar production reached 51,579 tons coming from sixty estates (Tourism, 2000:27).

Nevis was also involved in the sugarcane market, but to a lesser degree. Because of infertile soils and natural disasters (earthquakes and hurricanes) many residents turned to small scale share-cropping in the production of sugarcane and other crops (Inniss, 1983: 2, 8). It has succeeded in doing so; today people largely engage in small scale agriculture. Interestingly though, Nevis has a thriving cotton crop that produces the soft Sea Island cotton, which is used in great quantity by Caribelle Batik factory in St. Kitts (Tourism, 2000:36).

Tourism has increasingly become critical to the local economy. More specifically, ecotourism affords the opportunities for entrepreneurship such as tour guides involving horses, ATVs and other 4-wheel drive vehicles, boats and watercraft, all for exploration of the environment, from hikes to the volcano's crater in the rainforest to scuba dives among the vast amount of shipwrecks and pristine coral reefs. Other economic activities as a result of tourism include construction jobs, service jobs, and informal market strategies of street venders that surface when cruise ships come into port. Tourism is a growing industry in St. Kitts, along with manufacturing of electronic components, furniture, and food processing (Inniss, 2000:25), and as one consultant informed me in 2002, a growing industry exists in ship or boat building.

St. Kitts and Nevis have a great deal of students that live and attend international universities located there. For example, ROSS University is an American school of veterinarian medicine. ROSS University is currently establishing a school of nursing.

Three medical schools are also located on both islands. The students and faculty members for these institutions contribute a great deal to the local economy.

Marketing — Old and New:

A market economy started during slavery. Sidney Mintz argues, "on both British and French islands [St. Kitts was once both] the enslaved distributed surpluses from their subsistence grounds at regularly scheduled markets, thereby earning small amounts of money and providing the historical underpinning for similar markets that still exist throughout the Caribbean region today (Mintz in Richardson, 1992:68) .

In both St. Kitts and Nevis, it is common to have a small garden. Some have small scale farms where they have a few pigs, cows, or goats and sheep along with their small gardens. Others have small scale fisheries, where they routinely set fish traps. These serve to supply their families or family owned restaurants with fresh vegetables and fruits, herbs and roots, as well as meat and fish. Those who generate a surplus take their goods to market where they can be sold or exchanged for other products. Figure 4.6 illustrates some of the fish available at market.

Going to market early on Saturdays is a tradition in St. Kitts and Nevis. This regularly set time and place was carried over from the traditions established during slavery. At market, people trade or barter their goods (bananas, mangos, breadfruit, teas, and meats) in exchange for money or other products. Fresh fish is in high demand at market, which is an exciting place where people are busy, rushing around in the early hours of the morning. Figure 4.7 shows a typical market scene. This bustling economic



**Figure 4.6: Varity of fish available at Market; Snapper, Parrot and Mahi Mahi; Photos taken 2002.**



**Figure 4.7: People at Market in Basseterre; Photo taken in 2002.**

exchange has sustained a people whose wages are not able to accommodate the high cost of imported goods. Figure 4.8 shows the Sandy Point market in the 1920s, and as it appears today. This market is no longer in regular use. The market in Basseterre serves as the central location for the exchange of local goods. Large American and British style grocery stores are becoming increasingly more common. More affluent Kittitians frequent these stores. Some grocery supermarkets have pharmacies. They are also open on Sundays, a day that costs employers more to operate due to labor laws. The average Kittitian buys a few specific items at these larger supermarkets, but the majority of their needs are met from the smaller grocers and at market. A number of smaller grocers meet nearly all of the needs of the locals, but are not located where tourists frequent. I found they, too, can meet the needs of the visitor both in variety and price. People shop around to find the best price for the best product. This is true also for the traditional market. The traditional market is very important to many people who cannot afford to shop at any of the grocery stores. At the traditional market, the option of negotiation still exists.

Chapter Summary:

This chapter introduces the reader to the geography of the Caribbean and of St. Kitts and Nevis. It also serves as an introduction to the general history of both islands. I address the pre-Columbian and colonial history of St. Kitts and Nevis including the union of these two islands. The sugar and tourism industries are discussed as well as the complexity of identity. The chapter ends with the discussion of the traditional market economy. The following chapter begins a lengthy discussion about leprosy and biomedicine.



**Figure 4.8: Left, Market in Sandy Point ~1920's (courtesy of National Archives); Right Market in Sandy Point; Photo taken in 2002.**

# Chapter 5: Leprosy and Biomedicine

This chapter identifies the biomedical knowledge regarding leprosy or Hansen's disease. It addresses the use of the word "leper" and the historical and contemporary legacy of leprosy. It also addresses the biomedical explanation of the causal agent, the mode of transmission, and treatment of leprosy.

L-Word:

> Jose Ramirez, Jr.
>
> The Bible has historically legitimized the use of the "L" word. Many journalists, gossip columnists, editors of religious articles, sports writers and users of the Internet have recently found it acceptable to use this odious word when attempting to cite examples of sin, hopelessness, failure, stigma, fear, dark humor and unacceptable comparisons.
>
> Unfortunately, there have been instances that have perpetuated the spread of grossly inaccurate myths. For example, issuance of special money for use in leprosaria, sterilization of persons with leprosy, fumigation of mail, laws to incarcerate and/or divorce anyone with leprosy, and denial of rights such as voting.
>
> The first time I was referred to by the "L" word was on the day of my diagnosis in 1969. After months of going to physicians, dermatologists and *curanderos* (folk healers), I was finally diagnosed with Hansen's disease, more commonly known as leprosy. The public health official who informed me of my diagnosis attempted to reassure me that there was "nothing to fear" and that I would soon be back on my feet. He was telling me this while referring to me by the "L" word. My family was morbidly silent and the hospital initiated a strict plan of isolation, forcing visitors and medical staff to be shrouded in caps, gloves, gowns and masks when entering my room (The Nippon Foundation –Jose Ramirez Jr., 2002 [hereafter Nippon Foundation]).

Jose Ramirez Jr. speaks out about his experience with persecution as a person with leprosy. Ramirez lived at the leprosarium located in Carville, Louisiana. The Nippon

Foundation, which supports the elimination of leprosy globally, qualifies the word leper as the L-Word and has used Ramirez's example since 1997 (Nippon Foundation, 2002). The foundation makes the following statement with regards to the use of the L-Word:

> Words are often used to objectify people. We group others, using derisive language and thus insulate ourselves from their humanity. In the case of leprosy, insulation enables isolation. And the pain produced can destroy lives (Nippon Foundation, 2002).

Since I do not have any of the personal stories directly from the people who lived in St. Kitts with leprosy, I cannot fully relay the amount of pain they may have endured by being labeled "leper" or "cocobay." However, considering that the treatment for leprosy, as it was dictated by the Chief Medical Officer, was the same given to patients at Carville, Louisiana, it is safe to say that people with leprosy share a common history of stigmatization and isolation. Therefore, Jose's story is a universal biomedical story that represents all people who struggle against the stigmatization of the "leper."

In Arthur Kleinman's discussion of the nature of "stigma," he notes that a "stigma" often carries a "religious significance" and, by default, "the stigmatized person is defined as an alien other, upon whose persona is projected the attributes the group regards as opposite to the ones it values" (Kleinman, 1988:159). Therefore, a "stigma defines the social identity of a group," which, when culturally marked by an illness label, negatively affects relationships (Kleinman, 1988:159). This creates an environment conducive to social rejection, which, in turn, often leads to ostracism. Leprosy fits Kleinman's criterion for stigmatization. A person labeled by illnesses akin to leprosy are often "shunned, derided, disconfirmed, and degraded by those around him [or her]," save for the immediate family; these individuals anticipate this abuse and have internalized it

to a point that a "deep sense of shame and a spoiled identity" are created (Kleinman, 1988:160). This is especially true for patients of leprosy, as the immediate family suffers the social consequences of the illness beyond the death of the family member with the disease. It was once debated by the biomedical community that leprosy was hereditary; this debate has led to the lay assumption that if one person in a family has leprosy, then they all have the potential for carrying the disease. Unfortunately, the family of the afflicted endures an illness label. The immediate family will find itself having to respond in one of two ways: by coping with the stigma as best it can or by distancing its members socially and spatially as much as possible from the given infected family member. The following entry from my fieldnotes illuminates this very dilemma:

> On several occasions, I found through public records and interviews information linking a particular Kittitian family, which shall remain anonymous, with leprosy. This family, as it turned out, happened to be wealthy and was, as a result, a constant target for those who would like nothing else but to see them suffer. Despite my knowledge of the disparaging rumors (leveling mechanisms) I had stumbled upon, I decided to approach the family with a request for an interview. This was, as it turned out, the biggest mistake of my fieldwork experience. Whether legitimate or not, I found myself confronted with the possibility of deportation. As if that was not bad enough, I was threatened with lawsuits, and, later, I received an unannounced visit by a member of the family at my home. The individual sought to reinforce the initial threats, and drive home the power existing behind their actions. As I quickly realized, the family had worked very hard to overcome the stigma the illness label of leprosy possesses. The family explained to me that due to the nature of the businesses they owned, just talking with me would jeopardize their livelihood because my reputation on the island was that of a student studying leprosy. Associations with me would lead people to talk. They did not want to lose patrons from the two medical schools and one veterinarian school located on the island. Clearly, even the possibility of having an illness label such as "leper" linked to this family would be devastating to their business. I assured the family that I would neither approach their property nor act as a patron of any of their businesses.
>
> I was very humbled by this experience. I was never given the opportunity to explain the nature of the project I was conducting. Without having the chance to defend my research, I was abruptly told, "this research was not wanted," "what gives you the right to come here and stir things up again?" and, "you Americans,

> can't you leave things alone?" The immense fear displayed by the family when they came into contact with the term "cocobay" or "leprosy," stemmed from a concern that the stigma surrounding their family will not stop with their present generation. That the family made such efforts to force me to keep my distance from their lives and enterprises opened my eyes to the sheer vastness of "cocobay"/ "leper" power—the wake of this stigma was far more powerful than I had previously imagined.
>
> I was shocked to get this response from this family, especially considering the level of cooperation I had received from everyone else I had spoken with, including representatives from all spectrums of the island, ranging from a government Minister to a coffin builder. I was treated with the utmost respect by these persons. Upon reflection, I realized the response from the family was justified, especially considering the levels of mistreatment and mislabeling they had endured in the past. Nearly all of the individuals that I had spoken with had not experienced the problematic social consequences the family had undergone. This family, like many others I either read about in the public records or learned about through interviews, had come to endure an illness label left behind generations after the disease itself had passed. They found themselves continually affected by the unfortunate situation of an individual who possessed a common surname. Despite the fact that this family assured me that "leprosy has never been in our family," and "you got the wrong [surname of family]," the family has found, and continues to find, that sharing the same surname as an individual with leprosy carries a troublesome and wearing social legacy (Fieldnotes, 2002).

I cannot imagine what it would be like to be called a leper and to know that the name-calling was founded in the public knowledge of my medical condition. No privacy is awarded to those with this disease as the public claims authority over this knowledge as having a right-to-know. Unfortunately, this also translates into a right-to-accuse.

Building on this concept, I found a disparity between my understandings of treatment of individuals with leprosy in my two visits to the island. My first impression of the treatment of patients with leprosy in St. Kitts was positive. I left St. Kitts in 2000 with an impression that the individuals charged with the care-taking of these patients performed admirably. Upon my return to the island in 2002, I realized my first impression did not accurately represent the experiences of the former patients discharged

from the home. Instead, I discovered that my initial view of the situation was tainted by the view of people who took care of the patients. To my knowledge, I did not interview anyone who was diagnosed with leprosy. However, some of the individuals whom I interviewed had family members with the disease. Some of the individuals, whose family members were patients at Hansen Home, either worked or volunteered there.

Through interviews, I learned how some people mistreated the patients, and how the patients and the families of these patients coped with the stigma the disease and illness presented. I want to make clear that this mistreatment was not at the hands of those who worked at Hansen Home. I heard details about how people were abused. For example, some individuals would laugh at them, take their crutches from them, call them "cocobay." This information came from individuals who may have been guilty of contributing to the mistreatment of the people with leprosy, but it was my impression that a good number of these accounts of abuse were from people who actually witnessed the abuse of a loved one. There was an enormous amount of emotional pain associated with recalling how some of those folks then were treated. On the other hand, there were also episodes of laughter in recalling how some of the "feistier" patients responded to abusers.

This brings me to highlight what Kleinman alluded to when he wrote about a "deep sense of shame and a spoiled identity" (Kleinman, 1988:160). A "leper" identity is indeed created as a result of the intense shame and isolation. Kleinman argues that a patient will either resist the stigmatizing identity or accept it; either way the patient is "radically altered" (Kleinman, 1988:160). His argument is supported by Nancy Waxler (1981) who identified Sri Lankan patients with leprosy as people who "learn[ed] to feel and behave like lepers" (Kleinman, 1988:160). Christian missionaries in Africa are

credited with offering leprosy patients a new identity of liberation through their experience as lepers (Vaughan, 1991:79). This identity was essentially the creation of a "village" community within the asylum which in some cases perpetuated the invention of new ethnic identities and customs (Vaughan, 1991:79). The Christian perception of leprosy qualified lepers as the "living dead," despite the hope of the healing miracles found in St. Luke's Gospel which have been interpreted as the "leper being specially chosen by God for salvation – the leper's sufferings in this world would be compensated for in the next" (Vaughan, 1991:79). Michel Foucault points out the obvious that this is certainly a strange kind of salvation, but it is achieved through exclusion: "in a strange reversibility that is the opposite of good works and prayer, they are saved by the hand that is not stretched out" (Foucault in Vaughan, 1991:79).

In the case of St. Kitts, leprosy did indeed radically alter a person's identity. St. Kitts and Nevis are contributors to a solidification of a "leper" or "cocobay" identity. The opinions expressed through biomedical policies, programs, and research projects suggested that leprosy was a disease that required segregation, isolation, and by extension, objectification. Not only were patients affected, but their families were branded in many cases due to a lack of understanding of the biomedical authority concerning hereditary and contagion. As a result, campaigns to segregate, isolate, and objectify the "leper" continued beyond the precedent set by religious doctrine.

Biomedical Accounts:

I define the following section as biomedical accounts because these opinions are the widely expressed view of the global biomedical community. The biomedical

authority is grounded in the universal scientific method that examines theories through trial and error. These accounts are the foundation from which all persons with leprosy are currently medically treated. St. Kitts is no different than Tennessee in its reliance on biomedical knowledge; it is dependent on biomedicine. In regards to biomedical procedures, St. Kitts followed the same prescription of diagnosis and treatment as the United States, India, and Great Britain. Their accounts are universal despite having changed through time, research, and trail and error.

*Biomedical Treatment —*

In 1873, Gerhard Armauer Hansen identified the *Mycobacterium leprae* as the causal agent of leprosy (Win, 1999). Hansen's Disease (HD) became the new, anxiety-lessened name for leprosy. Despite the new name, a fruitful treatment did not come until the 1940's when Dapsone (Sebastian, 2001:152) was introduced. Prior to Dapsone, Chaulmoogra or Chaulmugra Oil was widely used, at least in areas where British medical doctors, who worked in India, could influence treatment tactics (Buckingham, 2002:94). At the Carville leprosarium in Louisiana, researchers developed the first effective drug for treating leprosy, called Promin in the mid-1940s, but within a few years, Dapsone replaced the painful daily Promin injections (Win, 1999). From all indications, Promin was never used in St. Kitts. Chaulmugra oil was the only treatment available prior to Dapsone in St. Kitts. Chaulmugra Oil was adopted from the ethnomedicinal practices of indigenous peoples in India. This treatment was used topically and subcutaneously; it was adopted by the British by the 1870s (Buckingham, 2002:94). It was not until 1938 that it was officially recognized as a valid treatment by The International Leprosy

Congress (Buckingham, 2002:94). Chaulmoogra Oil was used in St. Kitts to treat leprosy at the leprosarium as early as 1922 (BlueBook, 1922). When the sulphone drug, Dapsone, became the new drug of choice in the 1940's, it was used in combination with Chaulmoogra Oil to treat the patients in St. Kitts (Sebastian, 2001:152). Because of the overuse of Dapsone, *Mycobacterium leprae* began to develop a resistance to this drug. In response to the Dapsone resistant *M. leprae*, the World Health Organization (WHO) initiated a Multi-Drug Therapy or MDT. This therapy proved successful and it is winning the struggle against this bacterium thus minimizing any resistance the bacterium may build (World Health Organization /Leprosy, 2003 [hereafter WHO/LEP]). The current drugs that are used in the MDT are Rifampicin, Clofazimine, and Dapsone. Promising drugs that are gaining attention include ofloxacin-a fluoroquinolone, minocycline-a tetracycline, and clarithromycin-a macrolide (WHO/LEP, 2003). If a person is diagnosed with leprosy today, chances are great that the person will never endure the extent of physical deformities that so many suffered in the past, provided that treatment is received.

*Biomedical Classification Methods —*

Leprosy has been meticulously studied and historically categorized into two systems known as the Madrid classification (1953) and the Ridley and Jopling classification (1962) (World Health Origination, 1988:18-22 [hereafter WHO]). Fortunately, the World Health Organization's (WHO) recommended and updated version is simple; the type determination is accomplished through skin smears. This method is not meant to replace the existing two systems, instead it is meant for use in the control

programs. In essence, it makes the treatment process easier and allows the two systems to work together (WHO, 1988:27). The WHO's classification for negative and positive skin smears are Paucibacillary leprosy (PB) and Multibacillary leprosy (MB), respectively (WHO/LEP, 2003). Paucibacillary is otherwise known as Tuberculoid while Multibacillary is known as Lepromatous. The Madrid and Ridley and Jopling classifications identify degrees of infection within the Lepromatous and Tuberculoid manifestations, like borderline and indeterminate (WHO, 1988:23-29). However, for simplicity, I will follow the WHO example of identifying type by using the control program's method.

The Madrid Classification uses the categories of Indeterminant (I) and Tuberculoid (T), which translates to WHO's classification system as Paucibacillary (PB). The Ripley and Jopling classification uses the categories of Indeterminant (I), Tuberculoid (TT) and Borderline-Tuberculoid (BT), which translates to Paucibacillary (PB) leprosy. The Madrid Classification uses Lepromatous (L) and Borderline (B) categories which translate to Multibacillary (MB) leprosy in WHO's classification system. The Ripley and Jopling classification uses the categories of Lepromatous (LL), Borderline Lepromatous (BL), and Mid-Borderline (BB), which translate to the Multibacillary (MB) category assigned by WHO. To better visualize these classification systems, I developed a chart, seen in Figure 5.1.

*Biomedical Transmission* —

Leprosy is a chronic, mildly communicable disease primarily affecting the skin, mucous membranes, peripheral nerves, eyes, bones, and testes (Louisiana Office of

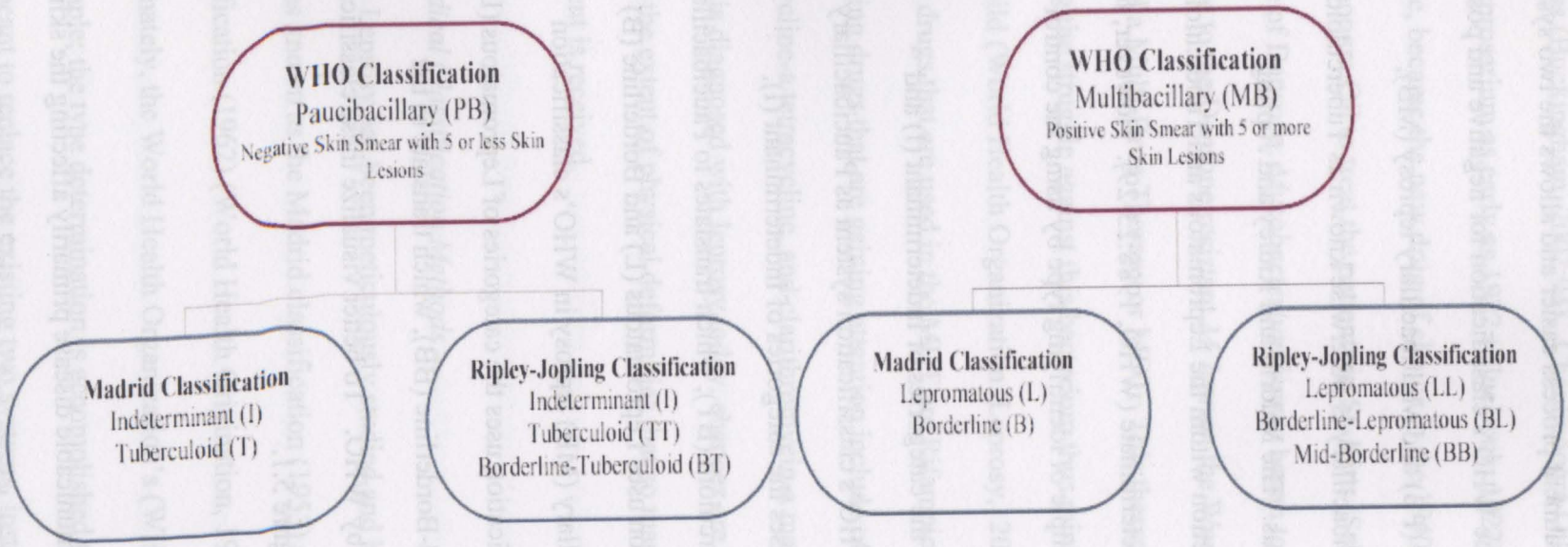



**Figure 5.1: WHO Classification — Madrid, and Ridley and Jopling Systems; created by Nancy Anderson.**

Public Health, 2004:1 [hereafter Health]). Despite all of the research, the mode of transmission of *M. leprae* is still inconclusive (Health, 2004:1). About nine in every ten people infected with leprosy bacteria do not show any signs of disease; some of the remainder have a mild and self-healing infection; a few have a more active and extensive disease (Richards, 1977:xvi). The chance of infection is higher among those who are in close association with leprosy patients (WHO/LEP, 2003).There is no evidence that "skin to skin" or "intimate" contact is the mode of transmission. In other words, persons having non-physical contact with patients are at no less risk than those having physical contact. In a family setting, the afflicted may sneeze into a handkerchief. The soiled cloth may not be discarded immediately or perhaps another family member may use the handkerchief, and unknowingly comes into contact with the bacilli.

Both the skin and the upper respiratory tract are identified as portals of entry into the human body for the *M. leprae*. It most likely leaves the human host through nasal secretions, but the skin is also a potential source. A majority of the Lepromatous patients secrete bacilli from their nose (Health, 2004:1). The nasal secretions can survive up to thirty-six hours outside of the human host (WHO/LEP, 2003). In tropical conditions, the nasal secretions have been documented to live up to nine days (WHO/LEP, 2003). The initial onset of the disease has been documented in infants and in the elderly; incubation is as short as a few weeks and as long as thirty years (WHO/LEP, 2003). *M. leprae* can be dormant within the human host, and strike when the survival chances of the bacterium are greatest. If a person's immune system is strong and reacts against the infection quickly the skin is not severely disfigured, but periphery nerve damage can occur due to the intense reaction around bacteria lodged within them (Richards, 1977:xvi). If

untreated the fingers and toes may become paralyzed. Because feeling is lost, the appendages become easily injured and infected (Richards, 1977:xvi). Likewise, if a person's immune system is suppressed and does not respond against the infection, the disease essentially goes unchecked (Richards 1977:xvi). The result, if untreated, is the appearance of large lumpy and eventually discharging lesions on the skin. The voice becomes raspy, vision is lost, and the nerves are destroyed (Richards 1977:xvi).

Social and environmental factors, such as poor sanitation, malnutrition, inadequate access to health care, play a role in the transmission of leprosy. The disease is more "successful" in someone with a compromised immune system (Health, 2004:2). In a family situation, a member can transmit leprosy by just being in close proximity to another family member. This is achieved through the sharing of space, and with sharing space, comes the sharing of other items like pillows and linens where *M. leprae* is known to live outside the host (Health, 2004:2). Crowding, poor sanitation, and malnutrition are key conditions favorable to this disease (Health 2004:2). The suggestion that leprosy is hereditary is false; it is found in families simply because the members of a family live in close proximity to one another and/or it is related to having similar immune systems which are compromised by malnutrition, other disease, or stress (Health, 2004:2).

*Biomedical Troubleshooting—*

Insects have not been ruled out as a source of transmission, but most research is focused on the respiratory system's role in transmission (WHO/LEP, 2003). A major setback in the research on leprosy is the inability to reproduce *M. leprae* culture in vitro. Both mice and armadillos have been used in experimental trials involving in vivo culture

research. Save for the armadillo, humans seem to be the only host for *M. leprae* (WHO/LEP, 2003), except for two vague cases involving a single mangabey monkey and a single chimpanzee (Health, 2004:1). Mice have been extensively used in research and researchers have successfully infected immuno-suppressed mice through the spraying of an aerosol containing *M. leprae* (Health, 2004:1). In St. Kitts, the lizard is believed to harbor the disease. It is used as a transporter from an Obeah practitioner to an unsuspecting individual. There is no biomedical documentation for this belief, however.

Research funding for leprosy has been cut over the years as other more aggressive diseases have taken priority. Leprosy is not a disease that kills (although it can); instead it essentially makes life deplorable. Perhaps due to the "absence" of this disease in contemporary America, the need for funding is overlooked. I am always being asked, "Does leprosy still exist?" Unfortunately, the average person is not aware of the devastating affects leprosy causes on a global basis. Some 513,798 people have tested positive for this disease in 2004 (International Federation of Anti-Leprosy, 2005 [hereafter ILEP]).

The Presence of Leprosy:

*Historic Global Situation —*

Where on earth has leprosy not been found? This question reflects the adaptability and mobility of leprosy. While leprosy once thrived in England, it is largely absent today. Nonetheless, leprosy is an evolutionarily successful disease. It has been endemic to most regions of the world for centuries. Despite measures taken throughout

history to eradicate the disease, the disease has adapted. Perhaps this is why the disease can lie dormant in a human host for long periods of time.

Leprosy was common in Medieval Europe. It was an epidemic during that period and, as a result, there are an abundance of references to leprosy in Medieval Europe. The inherent problem with these references includes the catch-all perspective that all skin ailments and lesions were leprosy. The Bible uses "leprosy" or (*zara'ath*) as a generic word embracing a number of different diseases (Howe, 1997:79). Another Biblical term, *sāra'at*, appears thirty-five times in the Hebrew Old Testament and refers to certain skin conditions (Lieber, 2000:100). Medieval doctors could not distinguish leprosy from other skin diseases while medieval authors were liberal with their descriptions of what they assumed was leprosy (Brody, 1974:21-22). Leprosy was considered a "moral disease" (Brody, 1974:22); the Biblical reference also implied "moral uncleanliness" (Howe, 1997:79). Leprosy was written about by the Greeks, Indians, Chinese, Japanese, and the Spanish conquistadores. It is not a disease that can be pinpointed as to its origin (Zivanovic, 1982:230-231).

In the Caribbean, "cocobay" is the term used to refer to "a skin that looks diseased or repulsive with sores" or "leprosy" (Allsopp, 1996:161). Cocobay and Yaws are often associated with one another, as in the proverb "if you gat cocobay you can't get yaws (if you are in the very worst of troubles a lesser trouble cannot affect you)" (Allsopp, 1996:161). I found that cocobay is on occasion used interchangeably with leprosy and yaws, yet yaws also had another name, "tobo" or "toboe" (Fieldnotes, 2002). However, "toboe," in the wider Caribbean context, refers to a "swollen, infected foot" (Allsopp, 1996:559).

It is important to understand that modern day leprosy is not the Biblical leprosy with which most are familiar. "Hansen's Disease" is the way in which leprosy is referred to in most medical texts, but "leprosy" is also used and I would argue embraced by many eradication efforts as a way to bring attention to their cause. The term "leprosy," of course, is widely known, unlike Hansen's Disease.

In 1999/2000, ninety-one countries reported leprosy; it is endemic in twenty-four countries (American Leprosy Missions, 2005 [hereafter Missions]). The ten most afflicted countries, starting with the highest numbers are as follows: India, Brazil, Myanmar (Burma), Indonesia, Nepal, Madagascar, Ethiopia, Mozambique, Democratic Republic of the Congo, and Tanzania (Missions, 2005). India ranks the highest, accounting for 73% of the world's cases. Specifically, five states in India: Bihar, Madhya Pradesh, Orissa, Uttar Pradesh, and West Bengal represent 70% of all new cases in India and 51% of newly detected cases worldwide.

It is important to contrast the situation in India with that of St. Kitts. St. Kitts and India were both once under the colonial rule of the British. Therefore, similar policies towards the "leper" were put into place, such as the Leper Act and segregated housing (Buckingham, 2002:161). The British medical officers viewed the disease primarily as a physical condition (Buckingham, 2002:31). This is true in both locations. The majority of the care for patients with leprosy in India came from missionaries. In India, a spiritual component was more influential in the care of people with leprosy. People of the Hindu tradition provided a similar approach to leprosy as found in medieval Europe (Buckingham, 2002:31), they rejected the "leper." In other words, leprosy was not simply a physical sickness, but the manifestation of the sufferer's spiritual conditions

(Buckingham, 2002:31). Segregation attempts were not very successful in India (Buckingham, 2002:31). Despite the rejection from those of the Hindu tradition, Islamic law prevented this sort of rejection and called for the care of an infirmed relative (Buckingham, 2002:31). There was not a simple solution as was the case in St. Kitts.

Although the entire population of St. Kitts probably does not equate to that of a village in India, the conditions under which leprosy thrives was the same for both places. Over crowding, poor sanitation, malnutrition, and complications from other diseases such as filariasis and malaria created an environment conducive for this disease. The difference between St. Kitts and India has quite a bit to do with population size. St. Kitts was successful in eradicating this disease, as well as many others like filariasis and malaria, due to its aggressive public health initiative that essentially started with the segregation of patients with leprosy.

*Contemporary Global Situation* —

Segregation of patients with leprosy is no longer needed and is arguably a violation of human rights. The WHO issued a statement at the seventh WHO Expert Committee on Leprosy (June 1997) in regards to the human rights of people with leprosy. WHO is a division of the United Nations, whose human rights agenda is charged with "promoting human rights." The statement promotes the following:

> Patients on MDT, and those cured of disease, should not suffer from restrictions in areas such as employment, education and travel. Any special legal measures that might increase prejudice against leprosy or prevent early cases from presenting themselves for diagnosis and treatment should be abolished. In some countries, the human rights problem is particularly serious among female patients,

> firstly, because of their gender, and secondly, because of the stigmatization associated with leprosy (WHO/LEP, 2003).

The United States still maintains a leprosarium at the Kalaupapa National Park Molokai, Hawaii (Service, 2004). Many other countries still have leprosariums, yet forced segregation is not practiced. Leprosariums provide a sanctuary for the patients who suffer from the physical effects despite being "cured" of the disease. In other words, they still suffer the illness. Although Kalaupapa is geographically isolated, visitors with a proper health certificate can travel to this island (Service, 2004).

On January 9, 2000 FOX aired episode #236 of "The Simpsons," which depicted leprosy as a condition of "uncleanliness" (Omine, 2000). Homer and Bart Simpson were sent to the Kalaupapa colony only to find out later that they did not have leprosy. In the end, because they were treated so well, Homer and Bart did not want to leave the leprosarium (Omine, 2000). The painful "needle treatment" was bearable so long as they were able to enjoy the exotic beach (Omine, 2000). "Family Guy" perpetuates the erroneous assumption that a person with leprosy looses their limbs by depicting people with leprosy having to reattach their arm that just fell off (Weitzman, 2001). The USA cable network show "MONK" qualifies the main character, Adrian Monk, who suffers from Obsessive Compulsive Disorder (OCD), as a "leper," due to his social disorder causing people to avoid him. This pilot episode is called "Mr. Monk and the Candidate" (Season 1 Episode 1). This illustrates how disconnected Americans are with this disease and how some people (writers, producers, and media) exploit the human suffering caused by leprosy for the humor of the viewing audience. Our only positive connection with leprosy is through making light of the disease.

Another television series "The X-Files" addresses the collective, historical fear of leprosy by situating the disease as part of a United States government conspiracy. In Season 3, Episode 10 of "The X-Files," the audience is led to believe that a secret leprosarium in West Virginia houses "aliens"; but hold on, let us not fear these "creatures" because they are actually radiated "lepers" (Spotnitz, 1995:3x10 731). The audience is left with an impression that a leper must be so disfigured that a medical doctor would mistake the victim for an alien. Below you can read a portion of the episode description:

> Skully tracks down Dr. Zama, who is actually a brilliant scientist named Ishimaru to a Hansen's Disease Research Facility in Virginia (he was hidden in the U.S. after World War II so he could continue his experiments). Scully drives to the research facility, where she encounters Escalante, a hideously deformed man. Escalante explains that the facility was once a leper colony, but the staff, including Zama, fled when death squads arrived to kill the patients. Escalante was being treated for leprosy, but hundreds of other patients were interned at the camp with symptoms that resembled the disease. The creatures [people with leprosy] were kept apart from the patients and apparently tortured. Meanwhile, Mulder is on a secret train with an "alien." Scully believes the creature aboard the train isn't an alien being after all. She is convinced that Ishimaru used the railroad to conduct secret radiation tests on lepers, the homeless, and the insane. As proof, she reminds Mulder about the President's public apology for secret radiation tests that were conducted on innocent people until 1974 (Spotnitz, 1995:3X10 731).

Figure 5.2 depicts the "rounding up" of the "lepers" from this facility in Perkey, West Virginia; later they were shot and placed in a mass grave (Spotnitz, 1995:3X10 731). To my knowledge, there has never been a Hansen Disease Research Facility in Perkey, West Virginia. But, then again, "[t]he truth is out there" (Spotnitz, 1995: 3X10 731).

Building off the concept of "radiated lepers," a very popular Massively Multiplayer Online Role Playing Game (MMORPG) called "World of Warcraft" (WOW)



**Figure 5.2: "Alien Lepers" The X-Files: 731 (Spotnitz, 1995: 3x10 731).**

offers the opportunity to "kill" as many radiated leper gnomes as possible (see Figure 5.3). The game manual to WOW explains that the area indigenous to gnomes, Gnomeregan, was a techno-city. As a result of an invasion, a pressure valve was opened in an effort to kill off the invading Troggs. In doing so, toxic radiation was released and nearly all the gnomes died. Those that survived and stayed in Gnomeregan are called "leper gnomes" (Blizzard, 2004b:174).

I mention the pop-culture representation of leprosy in an effort to bring attention to the current status of leprosy. Leprosy is, on one hand, being talked about, but it is largely forgotten in terms of a disease that could strike Americans. On the other hand, it is being completely misrepresented. This portrayal of leprosy, whether it is in "good humor" or in "bad taste," is still contributing to a legacy of objectifying those who are living through this suffering. Groups like the International Federation of Anti-Leprosy Associations and The Nippon Foundation must compete with pop-media in order to get the truth out about leprosy and about people living with leprosy.

The current global situation is not comical and cannot be reduced to purposes of entertainment. Leprosy is not a disease that can be capsulated into a television show. The illness cannot be further reduced to a mere episode. However, the very real, lived illness of leprosy can reflect stories of devastated peoples who have truly suffered, remarkably survived, and triumphed over the atrocities caused by this disease. According to the American Leprosy Missions, over the past fifteen years, an estimated ten million leprosy patients have been cured (Missions, 2005).

Leprosy continues to destroy lives. Indeed many people have been cured, but despite the promising treatments, some cases of leprosy are proving to be drug resistant




**Figure 5.3: "Leper Gnome" from World of Warcraft (Blizzard, 2004a).**

(Health, 2004:11). It is important to recognize that this disease can make a come back in the countries that have thus far eradicated the disease. Through migration, leprosy can be re-introduced to populations where it has been relatively absent. Leprosy also tends to be underreported (Epidemiological Bulletin PAHO, 2002). It is naïve to assume that *Mycobacterium leprae* cannot make a come back.

Chapter Summary:

This chapter defined the biomedical knowledge regarding leprosy. It also addressed the use of the L-word and the legacy of shame associated with leprosy. Furthermore, this chapter places leprosy in the global context. The following chapter discusses "cocobay," the Caribbean word for leprosy. It also addresses the ethnomedical practices in St. Kitts, as well as the medical pluralism that characterizes the health care situation in St. Kitts.

# Chapter 6: Cocobay and Ethnomedicine

This chapter starts out by defining the usage of "cocobay," a colloquial term for leprosy. It also discusses popular belief in Obeah, as well as the anthropological perception of it. I will also discuss blame through recounting and interpreting stories I collected from my research consultants. I will then focus on St. Kitts' system of medical pluralism, which encompasses both ethnomedicine and biomedicine. This chapter then moves on to several medicinal plants used to treat some of leprosy's side-effects. I end with a discussion on the transmission of leprosy and a gradual shift in public awareness of leprosy's nature as a disease/illness in past chapters of a given society's history.

"Cocobay":

"C-o-c-o-b-a-y" is the most common spelling for the vernacular term that Kittitians use for leprosy. However, it is not unheard of to see it in the following ways: cocabeh, kuckabeh, cockabeh, cocobe, cocobea, and kokobe (Allsopp, 1996:161). An erroneous spelling is "cocobear" despite an "r" sound that is sometimes included in the pronunciation of "cocobay." One consultant, who was not born in St. Kitts, but has lived there for more than thirty years, also hears an "r" sound. This naturalized citizen helped me with the assumed spelling. The first individual I heard use this word in its context articulated an "r" sound at the end. This pronunciation is probably an aspect of dialect or a West Indian accent, but by in large, the "cocobear" spelling was a mistake. No ethnography is perfect, and this is an example of how easy it is to misunderstand an informant. My Informed Consent document has the heading "Cocobear" (see Appendix A). In almost every case, while I introduced the "Informed Consent" document, I was

laughed at, critiqued, and ultimately corrected. I think two particular consultants felt sorry for me, so they sat down with me and made sure I wrote down the correct spelling for cocobay, and a few other words that will be introduced later. I was initially taken back, as I had done my homework and had someone spell it for me during my first fieldwork experience. I quickly found that despite being a resident, this particular consultant was not a native speaker of Kittitian West Indian English. So, as the interviews went on, I began to laugh at myself and readily admitted my mistake. As a promise to my informants, I have now set the record straight. According to at least five informants, the correct and most common Kittitian spelling is cocobay, but I was warned that I might see it as cocobah.

Technically, cocobay is used in a derogatory manner. However, none of my informants used it in this way towards another individual; they simply explained how it was used colloquially. Passages from *Sonny Jim of Sandy Point* reveal how cocobay is used to identify both place and people: "The Lazaretto is the 'Leper Home' where all the 'cocobay' people used to live," and "[a]ll of the cocobay people who used to live over by the foot of Brimstone Hill, had nicknames" (Jones-Hendrickson, 1991:170, 172). In the wider Caribbean the noun refers to "leprosy" (Allsopp, 1996:161). As an adjective it is an anti-formal-derogatory term used as "personal abuse"; in this case, it refers to someone "having a skin that looks diseased or repulsive with sores" (Allsopp, 1996:161). In other words, cocobay is used with hurtful intent much like the intent behind calling someone ugly. However, as the following proverbs will indicate, cocobay also represents a condition. These proverbs are not specific to St. Kitts, but are common throughout the Caribbean: "*If you gat cocobay you can't get yaws* (if you are in the very worst of

troubles, a lesser trouble cannot affect you), and *To have cocobay on top of yaws* (to have much worse trouble added to already bad trouble)" (Allsopp, 1996:161).

Cocobay sounds like an exotic beach, a nice place to vacation. Oddly enough, there is such a place. In Antigua, a resort opened in the summer of 2000 called Cocobay, and it is spelled the same way. I wonder if the executives of this resort know the vernacular meaning of this word. I also wonder if Antiguans see this resort's name as a joke on foreign tourists. Leprosy affected many people in Antigua. Rat Island, Antigua was the location for both an insane asylum and a leprosarium which is now closed, but not erased from the memory of Antiguans. A 1998 report indicates that ten people were living with leprosy in Antigua, but the leprosarium was no longer in use (PAHO, 1998:13).

Obeah:

Within an Caribbean context, Obeah is most commonly spelled "obeah;" other spellings found in published texts are obia, obiah, and obea (Allsopp, 1996:414). Obeah is used as a noun, an adjective, and a verb.

> As a noun, obeah is a set or system of secret beliefs in the use of supernatural forces to attain or defend against evil ends; it is African in origin and varies greatly in kind, requirements, and practice, ranging from the simple, such as the use of items like oils, herbs, bones, grave-dirt and fresh animal blood, to the criminal (though rare), such as the sacrifice of a child's life; it is carried on or worked by hidden practitioners in order to gain for their clients success, protection, or cures for mysterious illness, as well as cause trouble for or the death of an enemy. As an adjective, obeah is related to, carrying on or practicing obeah. The verb obeah is defined as a way "to make somebody suffer unexplained failure in health or continual misfortune through the effects of obeah (Allsopp, 1996: 414).

These definitions are the most comprehensive and least condescending explanations of obeah.

Obeah in some contexts has been equated with "sorcery or witchcraft," and subsequently, a practitioner of obeah, the obeahman/woman, is, therefore, viewed as a sorcerer (Edwards, 1985:19). Lawrence Fisher applies Max Marwick's use of sorcery as an "illegitimate use of destructive magic" taking note that the definition of obeah usually includes the words sorcery, witchcraft, and magic. Fisher argues that Marwick's sorcery does not cover the entire scope of the folk-belief of obeah. Fisher notes that Marwick fails to recognize that obeah is used in harmless ways, like assisting an individual in getting a job, or being an agent responsible for beneficial cures for illness (Fisher, 1985:105). However, Fisher, who looks at obeah as a "religious form," "erroneously equates obeah with balmyard cults and pocomania" (Lazarus-Black, 1994:46), both of which are faith-healing ceremonies that employ dancing and speaking in tongues (Allsopp, 1996:73, 445). Fisher uses "obeah as a metaphor for bad living, misfortune, and poverty" (Fisher, 1985:106). He argues that in the presence of illness, people can talk in the idiom of obeah (Fisher, 1985:106). This is done when someone assigns blame. In Fisher's case, it is expressed in terms of "[s]omebody must be working something on me" (Fisher, 1985:106). In St. Kitts, this was expressed in the following way: "someone set a jumbie on you," "someone put something in his water," and "someone sent it to you" (Fieldnotes, 2002). We must be careful not to reduce these statements to support what Barry Chevannes writes about the obeahman as one who is invested with the right knowledge that allows for control over the spirit world; this knowledge is used "mainly for harm" (Chevannes, 1995b:26). Chevannes distinguishes between the practice of

healing and the practice of obeah defining the latter as a practice using "fetishes, oils and powders to achieve personal ends such as success in ventures, debilitating an enemy, winning a case in court, winning the affection of a potential lover; he too qualifies the obeahman as sorcerer"(Chevannes, 1995a:5-6).

Marsha Quinlan defends sorcery as a vehicle for all personalistic illnesses in Dominica and claims that locals call sorcerers "obeahmen or witches" (Quinlan, 2004:55). A personalistic illness is one where blame is applied to the supernatural intervention of another. This intervention could be on the behalf of a human, non-human, ghost, evil spirit, or a god (Quinlan, 2004:54). Quinlan identifies the classic distinction anthropologist that E.E. Evans-Pritchard (1937) proposed between witchcraft and sorcery. Quinlan argues that Evans-Pritchard's classification is an accepted convention in cultural anthropology. She continues by repeating what Evans-Pritchard defined as witches and as sorcerers: "witches are practitioners with accepted intrinsic, inborn abilities to inflict harm or manipulate reality to one's advantage"; "sorcerers are reckoned to achieve their status via learned rituals and knowledge" (Quinlan, 2004:55).

I want to challenge the blanketing use of "witchcraft" and "sorcery," both demeaning and demoralizing terms. I disagree with the qualifications existing around the traditional use of these terms; I see both terms as ones inherently emphasizing difference and exoticism. Evans-Pritchard's use of "witchcraft" and "sorcery" rings of an era dominated by exotic portrayals of other peoples and cultures, many of whom were exploited by existing colonial powers and colonial scholarship. Evans-Pritchard was also known to categorize the Zande people who were assisting him in his trek to Nuerland as servants. He is quoted as writing: "stormy weather prevented my luggage from joining

me at Marseilles, and owing to errors, for which I was not responsible, my food stores were not forwarded from Malakal and my Zande servants were not instructed to meet me" (Jordan, 1991:45). The words "witches" and "sorcerers" are loaded with baggage that comes from a colonial discourse that can be related to what Pem Davidson Buck calls "Cargo-Cult Discourse" (Buck, 1991:25). Should we, as anthropologists, rely on terms whose 1937 definitions represent our consultants in such a demeaning and colonizing light? Buck explains:

> The category itself was produced as part of the discourse carried on by colonial anthropologists, missionaries, and administrators against the backdrop of the conscious reorganizations of traditional economies to provide laborers and, later, peasants. Cargo-cult discourse, then, despite the fact that it often provided what may be accurate descriptions of both cargo beliefs and rituals, [sic] cannot be seen as a contextless pro- duction [sic] of social scientific truth. It is, instead, part of the field of knowledge constituted by and contributing to power relationships in the colonial setting of Papua New Guinea. Its reproduction provides what Bourdieu (1977) calls 'learned ignorance.' For European social science this has meant as [Edward] Said (1978) describes for Orientalism, '[...] that political imperialism governs an entire field of study, imagination, and scholarly institution in such a way as to make its avoidance an intellectual and historical impossibility' (Buck, 1991:25).

Although the shift from this practice has been slow, the challenge to old stereotypical and problematic categories like witches and sorcery is vital.

As an anthropologist working in the context of St. Kitts and Nevis, a post-colonial nation state, I must consider the power certain categories that are products of a colonial discourse wield, and how they can damage the population of St. Kitts and Nevis. I advocate the use of the word "obeah" to mean a system of beliefs, like any other belief related to the supernatural, with a dichotomy of just and unjust. I do not imply that I am using obeah interchangeably with "sorcery" or "witchcraft." I define obeah in a context

that allows it to stand on its own, without the hegemonic and demonizing connotations associated with the terms "sorcery" and "witchcraft." Furthermore, in distinguishing obeah from "witchcraft and sorcery" I am able to differentiate the worldview of Kittitians from potential misperceptions by "escapist" tourists, scholars, or visitors to the island may hold if they were to encounter such outdated and damaging characterizations. This not only benefits Kittitians, but the Caribbean as a whole.

In the case of St. Kitts, obeah not only "works within the medical system," it serves as an avenue for general advice related to personal affairs like "bad luck, financial problems, matrimonial problems, broken relationships and anything which is connected in someway to the supernatural"(Richards-Kingori, 1996:35). In support of my use of obeah, Mindie Lazarus-Black makes the following statement about how obeah is operationalized in Antigua and Barbuda:

> If we confined obeah to the realm of African survivals, to the domain of magic and religion, or even to the political praxis of a disgruntled underclass, we miss the ways in which it exemplifies and manipulates the politics of inter- and intraclass relations, as well as gender hierarchy. Obeah's continuing significance lies partly in its persistence within a broader system of illegalities that confronts hegemony and partly in its generative capacity to "work" law, enfolding obeah within a wider creole legal sensibility and practice (Lazarus-Black, 1994:47).

Creole here refers to the created legalities and illegalities formed under the conditions of New World plantation society where the end result is a distinctive Caribbean legal sensibility that incorporates both formal law and obeah (Lazarus-Black, 1994:43-4). Lazarus-Black argues that "obeah offered a contrasting ideology of justice" (Lazarus-Black, 1994:129), which allows women to manage or cope with the behavior of men who mistreat them and/or their children. This is a process of negotiating relationships (Lazarus-Black, 1994:161). Obeah serves to bring justice to issues that the courts may

not recognize as legitimate grievances. Their grievances most often entail intraclass rather than interclass conflicts, but this does not mean to say that it is not wielded between people of different classes (Lazarus-Black, 1994:160). Although Lazarus-Black is writing about Antigua and Barbuda, her assessment is equally relevant to St. Kitts and Nevis, because at one time the islands were governed under the jurisdiction of the Leeward Islands (Lazarus-Black, 1994:20). Furthermore, St. Kitts and Antigua share a history of leprosy that will be touched upon later.

According to Chevannes, in Jamaica the traditional healer has erroneously acquired the name obeahman. "Obeahman" has become the generic designation in reference to all traditional healers; this is a result of colonial prejudices and lack of understanding Myal (Chevannes, 1995a:7). Myal was a folk religion found in Jamaica; the practice invokes the power of dead spirits in an effort to cure ills or counteract evil, specifically obeah" (Allsopp, 1996:395). Quinlan argues that in Dominica the obeahman is an agent acting on behalf of his clients and therefore is both an agent of illness and an agent of healing (Quinlan, 2004:59). The obeahman or obeahwoman is one who learns and carries out the practices of obeah, which is a secret profession, with paying clients (Allsopp, 1996:412). The client is an important aspect of the obeah practitioner. The clientele consists of the immediate and extended family as well as the immediate community (Laguerre, 1987:60-1). The clients are obeahists, which are defined as those who rely on the help of obeah (Allsopp, 1996:412).

The terms obeahman or obeahwoman are problematic. "Obeahman" has become the standard in referring to the practitioners of obeah in the literature (Fisher, 1985:107). "Obeahman" is referenced more often than obeahwoman. However, in the case of St.

Kitts, the obeahwoman was described more often. I talked with men who may have been obeahists, but not obeahmen. I spoke with an obeahwoman and a woman who had been accused of being an obeahwoman. I also spoke with a woman who was the daughter of an obeahwoman or at least the daughter of a woman accused of being an obeahwoman. All were working-class people. Based on my experience, I would predict that there are perhaps more obeahwomen than obeahmen in St. Kitts. Yet this is not the only reference to the apparent dominance of women in this role. In his novel, S. B. Jones-Hendrickson, a Kittitian, makes reference to the squabbles among obeahwomen. He never mentions an obeahman (Jones-Hendrickson, 1991:183). Although this is a novel, the people about whom he writes coincidently have the same names and occupations as those identified in the archival record as well as by my consultants. I recognized this during interviews and archival research. Lazarus-Black claims that women as more likely to engage in obeah than men; the reason is that all of the formal institutions in Antigua are controlled by men (Lazarus-Black, 1994:160-1). In the case of St. Kitts, although women are not absent from the "formal institutions," men comprise the majority. This reminds me of the attitudes towards obeah that I encountered among individuals who would qualify as members of the upper- middle class and elites. These individuals held high ranking positions in the "formal institutions." A male consultant told me the following: "Obeah is nonsense, it is folklore. Be sure to write that in your report." A female consultant stated: "A cocobay lizard will give you cocobay. When I was a child I use to be afraid of cocobay lizards. Obeah sends the cocobay." In Antigua, "neither educational background nor religious affiliation prevents a person from consulting an obeah specialist" (Lazarus-Black, 1994:160). In St. Kitts, some folks who professed their status

as Christians refused to entertain thoughts about obeah, but I tend to agree that a high level of educational attainment does not lead people to abandon the idiom of obeah.

In writing this section, I have challenged the condescending connotations that accompany the words "sorcery" and "witchcraft." It is clear that any definition of obeah that embraces this colonial discourse by default limits the depth of understanding available. However, the colonial history is not to be forgotten. Obeah united and empowered the enslaved and enabled group resistance (Lazarus-Black, 1994:46). Although obeah's first practitioners came from Africa, obeah evolved within an entirely new mode of cultural and economic production, unique hierarchical social, economic and political arrangements, and competing ideologies. It flourished outside the rule of law as an alternative system using different technologies of power and other modes of domination and resistance (Lazarus-Black, 1994:47). Obeah was used by the enslaved to "poison, to prevent crops from growing, to inhibit conception, to cause abortion, to wage psychological warfare, and to effect retribution" (Lazarus-Black, 1994:44). Obeah was also used to send disease. Colonists tried to suppress obeah, but failed to do so. Obeah is credited for a pivotal role in master-slave relationships and in instigating slave rebellions (Lazarus-Black, 1994:45). Attempts to condemn obeah continue in post-colonial St. Kitts. One minister was noted for openly denouncing obeah during a Sunday service calling it "nothing but the highest form of evil" (Richards-Kingori, 1996:35). The lesson to learn here is not to reject the history of colonialism, but as anthropologists we do not have to perpetuate the colonial language that too often continues to exoticize people.

Blame and the Origins of Leprosy:

As I stated in Chapter 2, the culture of blame is a product of Othering. In St. Kitts there are accusations against obeah, the leper, and the Other (which is sometimes the leper). Obeah is identified as one culprit in the blame equation. The practitioners of obeah are also blamed due to their "bringing" obeah to St. Kitts. The following are stories identifying some of the culprits:

*Obeah* —

> ---'s mother got it (leprosy). Obeah is why she got it. She had powders on her front door step. When she came out, she stepped in it (Consultant Interview).

> Spannerman said that someone had put something in his water. He left containers at the foot of the mountain to collect water for bathing. Shortly after bathing he started itching and his skin turned black. He was born with "fair light skin" and he would often pull his shirt up and show his original color (Consultant Interview).

*The Leper*—

> Another Leper Milkman
> We have to record another case of a leper who has been for sometime in the habit of milking his own cows and selling the milk to his customers in Basseterre. This man Benjamin lives in College Street and though he has lost the tips of his fingers, manages to milk with the stumps (Boon, 1891:No15).

> The Ubiquitous Leper Milkman
> On the 12th instant, we applied to the Police Magistrate for a warrant, under the new Act to apprehend and segregate in the Leper Asylum a leper by the name Sebastian. The individual in question was employed by one Barrington Hennigan to milk his cow from which he supplied us with milk. Sebastian has been examined by a medical man who certifies that he is a leper with his left hand covered with leprous ulcers. We publish these facts that people who object to leprous milk may be on their guard against obtaining it from a man who is so criminally careless as to employ a leper to milk his cows. This man was so well known by his own class to be a leper that it is quite impossible that Barrington

> could have been ignorant of it. We imagine that very many of our St. Kitts readers would discover a similar state of things in the people who supply them with food. We were told a few weeks ago by a gentleman in Sandy Point of his having met with a similar disagreeable experience in his milk woman. In that case the milk was kept in a room in which a leper lived (Boon, 1891:No15).

*The Other—*

"Lepers came from other islands for treatment. This was not of St. Kitts" (Consultant Interview). This is the general sentiment about the origins of leprosy in St. Kitts. I suspect that Charles H. Boon, producer of *The Lazaretto* (a newspaper aimed towards addressing leprosy in St. Kitts), printed any article submitted or rumor he heard about a person with leprosy provided it supported his position and his subscribers' desire to promote compulsory segregation. One report from *The Lazaretto* identifies the following "violation" (Boon, 1891:No31).

> Antigua Leprous Bakers
> On Friday last a leper of disgusting appearance with tubercles on his face &c., was arrested by Inspector Thom and made to re-embark on board the sloop in which he had arrived from Antigua. The man stated that he was a baker which trade he had carried on in St. John's, [and] Antigua, for many years. He of course disputed that he was a leper and said that he was suffering from a 'heat of the blood.' He was examined by a medical man in Basseterre, who certified that he was a leper.

Another reference to the origins of leprosy in St. Kitts involves a storm. "You see there was a hurricane that hit Nevis which destroyed their hospital. Their lepers then came to St. Kitts" (Consultant Interview). When I heard the last statement I did some investigating and found that in 1899 a hurricane did indeed destroy the hospital in Nevis (Daniel, 2001:16). The patients were temporarily sent to the prison in Nevis; this was the only place to send them. This temporary setting lasted for more than five years (Daniel,

2001:16). This is a source of historical conflict in that the blame is assigned to St. Kitts for not sending Nevis the warning signal about the storm. It is also pointed out that St. Kitts was not using the hospital re-construction fund properly (Daniel, 2001:16). In actuality, the patients with leprosy in Nevis began to be transferred to the leprosarium at Charles Fort as early as 1892.

Other stories regarding the origins of leprosy in St. Kitts are as follows:

> The Lepers came from Nevis and other islands. I use to go to Nevis and buy bread and cheese. I said to a guy once, 'you should be at Sandy Point.' A big boat would bring lepers directly to Pump Bay, Sandy Point, and then a smaller boat would then bring them ashore. For all other things, the boats went to Basseterre, but not for bringing lepers (Consultant Interview).

> Oh, lepers came from Nevis, Tortola, and Antigua. But, most came from Nevis. The tailor at the Hansen Home was from Nevis. Spannerman was from Dieppe Bay (St. Kitts), and Alice was from Tortola. Some were from Irish Town (in Basseterre, St. Kitts), but most were from Nevis. One Man, who was from Anguilla, did not fit in, so he begged and begged and was eventually sent home (Consultant Interview).

> A man from another island – very attractive worked for a rental car place. He drove a doctor around. The doctor noticed the signs of leprosy in his ears (very heavy). He asked him to be tested. He was quarantined, but showed no physical side effect. Once released, he needed work, but could not get it. He then demanded help from those who quarantined him. The only job available was driving the garbage truck. So that is what he did (Consultant Interview).
>
> *Why so many from Nevis?* Nevis has better obeah than St. Kitts. Haiti has the best, but Nevis is also good (Consultant Interview).

On several occasions, the origins of leprosy were not denied as an endemic problem in St. Kitts, but as a problem that came to Sandy Point. Leprosy was not in Sandy Point. It was brought there. The government chose to place the Home in Charles Fort because it was the best place at the time. Therefore, the Government brought

leprosy to Sandy Point, and at the time in which the place was chosen, "the Government" meant the will of the British Colonial authority. This was emphasized again and again through statements like "I am a Sandy Pointer and I know that leprosy is not from Sandy Point. It came to us and we took care of them" (Consultant Interview).

Medical Pluralism:

Momordica charantia

> Momordica charantia is a common plant called Maiden Apple, Lizard Food, Maiden blush, Washer Woman. For coughs, colds, fever, diabetes, high blood pressure and gripe, a tea is made by steeping the leaves. To treat skin problems, the leaves are crushed and massaged into the affected area. For relief from sprains and stiff neck, the vines are wrapped around the affected body part. A poultice made from the plant can also be used. The tea from the leaves is drunk to improve appetite. It has been reported that the bush is also used in cases of early cancer and for abortions. The fruit is said to contain bitter glycosides while carotenoids and insulin-type peptides have been found in the plant (Whittaker, 2001:162).

This plant is a common plant used to treat diabetes, but it is also used in combination with biomedically prescribed pharmaceuticals. This represents an example of how ethnomedicine can come together with biomedicine to form an exciting new pluralistic relationship, one which flows between these two medical paradigms. The local knowledge of healing in St. Kitts is the combination of ethnomedicine and biomedicine. It is through this combination, that St. Kitts and Nevis are successful in achieving a healthy society despite the status of being a poor nation.

Since Kittitians and Nevisians use both ethnomedicine and biomedicine, there are those who are loyal to one more so than the other. In some cases, people use one exclusively. On one hand, people reject ethnomedical knowledge that relates to medicinal plants or what people call "bush teas" or "bush medicine." This rejection can

be linked to a desire to put distance between them and from what is seen as "country" or a rejection of the unsophisticated or poor. On the other hand, many people reject biomedicine. This rejection comes from either suspicion of what is seen as "white man's medicine" or from the cost. Despite evidence that some people practice either one or the other, many people pull from both traditions. This rejection is also influenced by education, class, and age. More importantly, I suspect that the rejections of the biomedical practices are found more commonly in the older generation, while the rejection of ethnomedical practices are found more commonly in the younger generations. The generation identified in the United States as the "Baby Boomers" is more likely to pull from both traditions.

One consultant explained to me that individuals use both plants and prepackaged herbs or pharmaceuticals to cure what ails them. Although the bush is local, accessible, and often free, there is a new market for pre-packaged versions of the same plant, root, herb, at a higher cost (Richards-Kingori, 1996:31). Evidently an unspoken motto exists in "imported is best" and is applicable to a wide range of goods including foreign medicines (Richards-Kingori, 1996:31).

Pat Richards-Kingori documented that "new wealth on the islands has resulted in a rise in affluence and this 'affluence' has brought about a new dimension to the use of homeopathy and ethnomedicines" (Richards-Kingori, 1996:31). This new category of wealthy people includes Kittitians, British, Canadians, and Americans who have either returned home or chosen to move to St. Kitts for opportunities for entrepreneurship. Kittitians who may want to distinguish themselves from the perception of "country" may only buy items available in stores because going to the open-air market is not as

prestigious as shopping in an American-style grocery/pharmacy store. Or, they do not want to be seen "picking bush"; "it was not the drinking, but the picking which was the status symbol" (Richards-Kingori, 1996:44). This is not to say that just because someone is a member of an elite class they will not use tried-and-true methods of self-medication, i.e. taking from the bush, but they may have a private supplier or grow their own supply. In the latter case, they would have someone else (a hired maid or gardener or someone of lower status) pick the bush or buy it from a supplier either at market or in private (Richards-Kingori, 1996:44).

In other cases, Kittitians resort to buying prepackaged herbs or pharmaceuticals because their bush supplier is out of a specific plant or the pharmacy that carries oils and vitamins is short on supply. One sixty-eight year-old woman, as Richard-Kingori documented, described her use of the pharmaceuticals digoxin and glyceril trinitrate as an alternative when her drug store runs out of Vitamin E and olive oil. This person thought of biomedicines as a complement to her ethnomedicines. "Olive oil is prescribed by God," she explained and due to her feeling of misdiagnoses by medical doctors, she chose to treat herself using a combination of bush teas, oils and vitamins (Richards-Kingori, 1996:37).

The acquisition of ethnomedical knowledge about bush medicines is done so through dissemination from those who possess existing knowledge about bush medicines. In St. Kitts, the ethnomedical knowledge about bush medicines may depend upon class distinction. There is a risk that this information may not be passed to the younger generation. Fortunately, Milton Whittaker, along with his research assistants, collected information on 180 medicinal plants that Kittitians and Nevisians use regularly

(Whittaker, 2001:vii). This collection of plants, as well as the scientific documentation of these plants, supports the ethnomedical knowledge that biomedicine seeks to borrow. Cultural piracy and the intellectual property rights of indigenous peoples are at risk when pharmaceutical companies gain from the ethnomedical knowledge of indigenous peoples, a gain that is sizeable, both medically and financially (Logan, 1996:337). So long as the Kittitian and Nevisian people can maintain ownership of their ethnomedical knowledge, then they will not be forced, due to a drug patent, to purchase a drug made from a local plant in order to control her or his diabetes.

The people of St. Kitts and Nevis are, in some ways, empowered from the advantages of combining ethnomedicine with biomedicine into a form of medical pluralism. Having a firm grasp on what the natural environment can offer is a heritage of which Kittitians and Nevisians alike should be proud of and be willing to preserve. The ethnomedical knowledge is unfortunately not as popular within the younger generations. Hopefully, with Whittaker's important work, a greater interest in inheriting this knowledge will arise.

Using the "Bush":

Regardless of whether or not people want to be seen "picking from the bush," this is a tradition that continues today. Inside of the leprosarium, a flourishing garden provided the patients with access to the "bush." Leprosy is a disease that affects the skin, the eyes, the body temperature, muscles, the nerves, and the bones. There is not a part of the body that cannot be damaged by this disease. Among the extensive bush medicines available in St. Kitts and Nevis, there are none identified for the specific treatment of

leprosy. There are, however, many that would treat the side-effects of the disease, like pain, itchy skin, and fevers to name a few. The following selection of plants represents a larger number of plants used to treat various conditions that are found in patients suffering with leprosy. In addition, the final two plants listed here are specifically used to with obeah, or as Whittaker defines "witchcraft." I have included these two plants since obeah is implicated in the transmission of leprosy.

*Aloe vera*

*Aloe vera* is a cultivated plant commonly called aloes or simpee wiry in St. Kitts and Nevis. It is a popular plant used for a variety of applications. For falls, a pain in the chest, and stomach, the gel is soaked in water and drunk or the aloes is sliced, the juice collected and taken. Squares of gel may be cut and added to beverages, then taken with or without egg white. For swelling, bites, boils and skin ulcers the aloes is cut, roasted and a dash of salt added before applications. The gel may also be sprinkled with salt, then applied to cuts, bruises and boils. The latex is said to heal wounds and burns. The leaf constituents can be used as a laxative on one hand and as a hair shampoo on the other. A distinction is made between the leaf gel, a carbohydrate which is used for the skin treatment and another substance from the leaf which contains the laxative aloin. The constituent, babaloin, shows activity against tuberculosis bacilli," which I might add is a cousin to Mycobacterium leprae, leprosy (Whittaker, 2001:12)

*Musa paradisiacal*

*Musa paradisiacal* is a cultivated plant commonly called a Plantain or plantin in St. Kitts and Nevis. The heart of the rotting plant, combined with Epsom salts and vinegar, is used as a poultice for aching joints. The ripe plantain skin is used as a poultice in much the same way as the ripe banana (*Musa sapientum*) skin to relieve pain. Organic acids are found in the leaves. The astringent properties are due to the high concentration of tannins. Antibiotic activity is demonstrated in the plant while antifungal properties are associated with the root. As with this species, the green fruit shows anti-ulcerogenic properties. The ripe fruit is rich in calcium, phosphorus, iron, magnesium, potassium and sodium. Serotonin and dopamine are found in the skin and pulp of the fruit, while tannin is present in the entire plant. The fruit is said to possess aphrodisiac properties. *Musa acuminate* [dwarf banana] shows weak activity

[activity nonetheless] against *Mycobacterium tuberculosis* (Whittaker, 2001:166), again a cousin of *Mycobacterium leprae*.

*Mammea americana*

*Mammea americana* is a scare plant commonly called mansiport or marmee apple. When used in the treatment of "Toe-boe", ringworm and yaws, the seed is grated mixed with kerosene and the mixture tied to the affected area. The fruit is used in pies, jams and jellies or eaten fresh. The seed of the fruit is rubbed on the heels to alleviate cracking. Insecticidal substances, mammein and other coumarins, are present in the seeds. The bark is used in the tanning industry (Whittaker, 2001:148-149).

Toe-boe, tobo and toboe are used to both describe someone with an infected foot and someone with yaws. Cocobay is sometimes used to label people with yaws (Consultant Interview).

*Bursera simaruba*

The *Bursera simaruba* is commonly called gum bush or turpentine tree in St. Kitts and Nevis. The gum from the bark is used for abscesses and other boils. The gum may be spread on a heated leaf before the leaf is applied to the affected area. A cloth may be substituted for the leaf. The leaves are steeped and the tea is taken for colds, fever and cleansing. Gum leaves are boiled with other bushes and the mixture is used as a bath. The leaves are also slept on to relieve fever and colds. The roots are boiled to treat skin ulcers. The plant leaves have been boiled with other bushes and the tea taken to relieve diarrhea (Whittaker, 2001:44).

*Carica papaya*

*Carica papaya* is commonly called papaw or papaya in St. Kitts and Nevis. The blossoms of this plant are boiled and taken for worms. The seeds can also be swallowed for the same purpose. A tea from the yellow leaves is taken for diabetes. A poultice of the leaves is used to treat back pains. Water from boiled green fruit is taken for high blood pressure. A poultice from the green fruit or milk from the unripe fruit or stem is used for skin ulcers. The sap can also be used to treat gum boils or abscesses. Painful joints can also be massaged with boiled sap (Whittaker, 2001:52-53).

*Merremia quinquefolia*

*Merremia quinquefolia* is fairly common and is called five finger or obeah plant in St. Kitts and Nevis. The dried leaves are steeped to make a tea for the treatment of colds and fever. The tea is also taken as "water" to relieve period pains. Mixed with other bushes, the leaves are used in making baths. *Merremia dissecta* has the same medicinal uses as *M. quinquefolia.* The plant has been used in witchcraft and to cure diseases caused by obeah. The seeds are kept in purses for good luck (Whittaker, 2001:158).

*Achyranthes indica*

*Achyranthes indica* is a commonly found plant called devil's horse whip, man better man, or man stronger than man in St. Kitts and Nevis. A tea made from the leaves is taken to treat colds and fever. The leaves are boiled and used as a bath for Black Magic [sic]. Potassium chloride is present in the plant. The seeds contain *saponin*, an expectorant (Whittaker, 2001:6, 257).

Understanding the role that bush medicines play enriches the understanding of the local knowledge of leprosy. Kittitians and Nevisians alike take an active role in their health. From self diagnoses to self medication, they use the medicinal knowledge passed on to them. They continue to pass this along to younger generations, but it is increasingly being supplemented by pre-packaged goods or pharmaceuticals. The pluralism demonstrated in St. Kitts is an example of a highly effective health care delivery system.

Local Healing Strategy:

The majority of the local medicinal knowledge stems from individuals who are especially well versed in healing, from people who share a household, to those who share a community, a church, and a neighborhood. Michel Laguerre identified five niches that serve to transmit "folk medical knowledge and practice: the household, multi-household, ethnic church, folk clinic, and voluntary associations" (Laguerre, 1987:35). Laguerre

uses "niche" to mean small clusters of cultures that are not mutually exclusive. Within the household and multi-household niches, family members and neighbors share information on the specific recipes that work and those that are ineffective. The "ethnic church" niche hosts avenues of faith healing (Laguerre, 1987:36); Pentecostal churches, or what are referred to as "way-side churches" in St. Kitts, fit this pattern by having ministers who perform healing services. The "folk clinic" niche is a location where the healer treats patients or clients (Laguerre, 1987:36). The folk clinic addresses illnesses originating in the supernatural and in spirit possession. I fail to see a distinct difference in this folk clinic healer and the faith healer. Unless Laguerre's goal is to position the church, or folk Christian communities over other spiritual leaders, whom he defines as "cult leader[s]" of Voodoo and Candomble (Laguerre, 1987:36), the obeah healer would fall into his category of cult leader. A voluntary association is a club or special interest group such as the historical societies or preservations clubs that may document folk medicines, such as the St. Christopher Heritage Society (SCHS) which assisted in the production of a comprehensive guide to the *Medicinal Plants of St. Kitts & Nevis* compiled and written by Milton C. Whittaker, Ph.D.

In St. Kitts, there are many types of healers: faith healers, clinical healers (medical doctors, nurses, and registered midwives), obeahmen and obeahwomen (who can also serve as "unhealers"). In some cases, clinical healers are known to incorporate other types of healing into their treatment regimen. The average person in St. Kitts has at her or his disposal information about the environment that makes each individual potentially her/his own self-healer. A local healer can be any of the above and a combination of the above categories. A traditional healer is one that speaks or practices

healing techniques that are not a product of mainstream institutionalized knowledge which include bush medicines and faith based healing. Institutional knowledge of healing refers to the knowledge a person has acquired while attending a university for the express purpose of becoming a trained professional, that someone recognized internationally for their knowledge. Therefore, medical doctors, registered nurses, nurse practitioners, physicians' assistants, registered midwifes, physical therapists, psychologists, and dentists fit the category of people who paid a lot of money to earn a degree that states that they are capable of healing. However, being capable of healing and being a person who genuinely puts forth an ethic of care that reaches beyond the payment counter is not the same. The unfortunate reality of the biomedical model of healing is that all too often primary emphasis is given to managing (or mismanaging) health rather than healing.

In St. Kitts, the household and multi-household model is most prominent, at least within the older generation and for those who live in what is considered the country. For these persons, bush medicines are chosen first over seeing a physician or nurse. Bush medicines are naturally and locally grown herbs, roots, and other plants that are used medicinally. In this sense, persons versed in healing via traditional knowledge are those who are identified as parents, matrons, some nurses, midwifes, religious ministers, and obeah practitioners.

Michel Laguerre synthesized the convoluted literature defining healers, or what he defined as "black healers in the Caribbean"; he classified folk medicine into three categories: physical, spiritual, and magical. Although there are three categories, they are not mutually exclusive realms of folk medicine; these classifications are merely

analytical tools. The healer, in other words, does not abide by the analytical rules and is more than likely engaging in more than one form of medical practice. Many healers may be mutually exclusive, but this does not mean that the clients or patients restrict themselves to these domains. According to Laguerre the categories are as follows:

> 1) Physical Medicine: the curers, including all those who practice medicine without adding any religious or magical ritual to it. These practitioners are not cult leaders. Some of these curers are generalists, while others are specialists, like the midwife, bone setter, and blood letter.
>
> 2) Spiritual Medicine: the faith healers, whose power, which can be used for good purposes only, comes from God, a saint or a given spirit. The herbal remedies they use are dictated to them through dream, possession, or direct revelation by a God, saint, or spirit. They also play the role of the folk psychiatrist.
>
> 3) Magical Medicine: The magical doctors who include those reputed to be able to manipulate the spirit world for good or evil purposes (Laguerre, 1987:55).

In an effort to translate this into something applicable to St. Kitts, I have placed the Kittitian local healers into these categories. Biomedicine is the dominant form of physical medicine, and many Kittitians visit health clinics for their medication. Although biomedicine is not technically addressed by Laguerre, I am applying his categories because in St. Kitts, on some level among a certain segment of the population, what is defined as biomedicine is indeed ethnomedicine. Ethnomedicine is defined as the "information specific to a given culture that allows its members to seek appropriate therapies for the restoration or the maintenance of a critically ill patient" (Logan, 1996:334). Since Logan's definition of ethnomedicine is a more appropriate use of the term, which lends itself to societies who enjoy medical pluralism, it is logical to apply Laguerre's category to a society whose practice of the physical medicine is that of a pluralistic practice that combines both traditional concepts of ethnomedicine and

biomedicine. Arthur Kleinman argues that a "challenge to biomedicine is for physicians to recognize that folk healers are important not just in the Third World, but in contemporary Western society, too." This is assuming that the Third World is not Western which is an argument Sidney Mintz makes against the use of a Western/non-Western dichotomy in understanding the historical development of Caribbean societies and cultural forms (Mintz, 1974). Biomedicine is all some people know; it is the physical medicine. Furthermore, the clinics and biomedical institutions must recognize the use of bush medicines and try to incorporate them into the biomedical plan, which creates medical pluralism or a local healing strategy. In addition, the Kittitian woman who picks from the bush in her yard and self-medicates her diabetes or high blood pressure is practicing a traditional healing strategy that Laguerre would also qualify as Physical Medicine. The minister of a Christian church, specifically a Pentecostal church, Church of God, who uses anointing oils in an effort to heal, would be identified by Laguerre as a practitioner of "Spiritual Medicine." The obeahman or obeahwoman in St. Kitts would be, according to Laguerre, "Magical Medicine" practitioners. In the case of St. Kitts, all three of these categories exist and co-exist in mutually constitutive ways.

The relationship existing between the healing solutions presented by bush medicine (including social notions of "illness") and those presented by institutional medicine (where the focus is more on "disease") is extremely interesting. I have mentioned how participants in these processes may regularly fluctuate between these knowledges, for example, in seeking out healing solutions. In discussing the relationship between traditional and institutional knowledge, I would be remiss in not mentioning efforts made by health care professionals to discredit or work against the traditional

knowledge. In many ways, these actions are just as intriguing as the class-based situations dictating actions by other healing-seeking individuals. Many trained medical professionals operate against bush medicines, viewing them as interfering with their own diagnoses. In an effort to reduce complications, some doctors ask their patients to stop taking bush medicines while they are taking prescription drugs. Some do not take bush medicines into consideration at all. However, as one doctor stated, "to denounce ethnomedicines would be to demonstrate cultural foolishness; to denounce biomedicine would be committing professional suicide, personal and financial ruin and demonstrate ignorance in the face of scientific objectivity" (Richards-Kingori, 1996:46). This same doctor said that before a patient would identify the bush as not working they would blame the biomedical treatments for not working (Richards-Kingori, 1996:46). Another doctor explained that she tries to find out what bush medicine a patient is taking in order to make treatments work. She tries to find a balance especially when treating diabetics. There are so many bush options in St. Kitts for treating diabetes; in this case the doctor tries to find a balance in the amount of *Momordica charantia* or maiden-apple (a proven hypoglycemic) bush tea being consumed and the hypoglycemic tablets prescribed (Richards-Kingori, 1996:46). This attempt to come to an understanding of the use of bush medicines is important and is a real example of how medical pluralism can work to the benefit of all involved, the patient, the institutional/clinical healer, and the traditional healer. In St. Kitts, this pluralism is what I refer to as local knowledge.

A Gradual Shift in Leprosy Talk:

The shift from understanding leprosy as a catastrophic public health threat to hearing Charles H. Boon, writer and producer of *The Lazaretto*, portray it as "it is not contagious," represents significant change over time concerning this disease. Time has allowed for several events to take place which have led to this shift in understanding about the contagious nature of leprosy. The first event relates to the practice of a moderate compulsory system of segregation. Since not everyone with leprosy was required to reside in the leprosarium, people were confronted with the disease on a more personal account. The second event is a product of natural attrition, meaning that the disease itself was not successful. A successful disease is one that can continue to spread. Due to the segregation and treatment, the ability for this disease to spread was hindered. Patients were kept in Hansen Home unless and until they were declared "cured" or "burnt out." Deaths also contributed to the attrition of the disease.

Furthermore, the Home became a place of refuge for people who technically did not require the services of the Home for the treatment of their disease, but needed assistance in care of the illness. People became more and more comfortable with the Home and its residents. Many patients were discharged, but some remained despite being given the option to leave. They could not necessarily cope with the "leper" identity on the outside; they needed the comfort of the Home to protect them from society's rejection of the "cocobay." As medicines became better and more accessible, people were simply treated in what is now called an out-patient care system.

Those who were discharged were deemed inactive or "burnt-out." Therefore, they did not pose any public health threat. Sandy Pointers interacted with these people

again and again. This led to the understanding that the disease was "not catching." Witnessing the interaction between healthy folks and those with leprosy, both Hansen Home residents and "burnt-outs," gave solid proof to many that leprosy was not contagious, especially since the healthy folks did not contract the disease. Furthermore, as I mentioned before, Dr. MacLean made an effort to show Sandy Pointers that they could not get the disease from the cabbage grown at the Home. His willingness to eat the food that the patients cared for and produced made a bigger statement than any public health document could portray – it is not contagious. Supporting this local theory, none of the staff members who worked closely with the patients were ever said to have contracted the disease, nor did they.

Another example of leprosy talk regarding contagion is found in S.B. Jones-Hendrickson's novel *Sonny Jim of Sandy Point*. His fiction writing describes a time when Sonny Jim went to Hansen Home to steal mangoes and to buy cabbages and lettuce from the patients. He writes about a woman he called Miss Stancha who frequented the Home for garden provisions. Miss Stancha thought that as long as the food from the Home is cooked, nothing would happen. Sonny Jim theorized:

> "If she [Miss Stancha] was eating cocobay people food all her life, and she did not have cocobay, then I reasoned, it must be safe for me to buy the cabbage and the lettuce and the sweet potatoes from the cocobay people. And it must be safe to steal the mangoes outside of the wall of the Leper Home" (Jones-Hendrickson, 1991:180).

Transmission:

I have discussed the gradual shift towards "it's not catching," but what does this have to do with transmission? Since leprosy is "not contagious," then how is it

transmitted from person to person? The biomedical explanation for this has already been argued. However, since this thesis aims to delineate a local knowledge of leprosy, I must examine the aspect of transmission that does not fit the biomedical model, but rather blends both biomedical and ethnomedical models. Obeah is identified as the agent of transmission. However, it is not as simple as "obeah is to blame." Once again I must stress that while obeah was identified by many consultants as an agent of transmission, the understanding of the biomedical explanation is not all together absent. For many there is a duality in the explanation, such as "if leprosy is in your blood, then it not obeah; but if it is not in your blood, then you got it through obeah" (Consultant Interview). Regardless of how complex this duality is, I will explain the obeah side of the equation, but not before I emphasize that these statements do not represent Kittitians as a whole, keeping in mind that out of approximately thirty thousand Kittitians in St. Kitts in 2000 and 2002, I talked with fifty, and not all were in agreement. At the request of several consultants, I owe this qualifying statement.

Jealousy is often associated with obeah. The most common example of jealously and obeah I heard regards a scorned woman who wants to steal a man from another woman. Either the other woman or the desired man is the target of obeah. The man may come down with a sickness or may lose some fortune. The other woman may suffer the same.

> My mother once had obeah put on her. There was this woman who wanted my dad and my mother found powders on her door step. At first she did not believe, but all sorts of bad things started happening. My mother was ill, she had a car wreck, and things did not seem right. One afternoon after church, a bunch of women came to the house and did this thing to get rid of it. They prayed and stuff (Consultant Interview).

In this case, the jealous woman used obeah in a negative way to affect the consultant's parents. However, obeah can be used in positive ways as well. A woman may choose to evoke obeah to keep "the other woman" away from her husband. Whether or not obeah is seen in a positive or negative light really depends on whether you are on the receiving or sending end.

Another example of obeah is the story about theft. Several consultants told me if a person steals money, then what ever is purchased with this money will burst into flames. One story in particular recalled a woman who had stolen some clothes and while she was walking, she caught fire and all that burned was her clothing. The fire did not affect her skin, just her clothing. In some cases, a Jumbie, or ghost, is said to have set the fire, again acting as an agent of obeah. This leveling mechanism provides a tool for society to use to warn people that they may indeed catch fire for committing the crime of theft. A societal belief in this story serves to deter such activity. This story, or at least five variations of this story, comes from a range of consultants differing in age, education, and class. It is popular and, therefore, stands to reason that it serves more than just a way to teach right from wrong. It is said that this does not happen to everyone who steals, but only those foolish enough to steal from individuals who can use obeah or know someone who can use obeah. Obeah is used to send the fire to the thief and in this way it can be seen as a method of protection.

Sending something through the means of obeah is the way in which transmission occurs. Obeah is "worked" on an object, person or animal. Each can function as a vector. The "something" that is sent is either a fire, a disease, a curse, a fortune, but regardless of what is sent, the goal is to manipulate the situation for either good or not-so-

good ends. The perspective of whether or not it is a good or not-so-good end is contextual and partisan. Once the person, for whom the obeah is directed, comes into contact with the vector, then the transmission is complete. One consultant recalled how a neighbor's mother contracted leprosy:

> ---'s mother got it [leprosy]. Obeah is why she got it. She had powders on her front door step. When she came out, she stepped in it (Consultant Interview).

During this same consultation, I was informed about undoing obeah. Specifically, this was in the case of finding powders on the steps.

> You do not to cross over the powders; you leave your home from another way, like a window or a back door, or call a neighbor to help. Of course you have to be careful not to cross another area where powders have been laid. You must go to the sea in the morning; morning time is best or late in the evening, when the water is warm and collect sea water. Pour this water over the area to wash away the powders, you should be all right. If you come into contact, then you must immediately go to the sea, it is better in the early morning, to get rid of it. *What does the sea water do?* Obeah cannot cross the sea (Consultant Interview).

Whether or not obeah can cross the sea, it does travel rather well through the use of vectors. Specific to leprosy, one vector thought to carry this affliction is the lizard. On several occasions, I heard about a "cocobay lizard." Therefore, I began to ask about any particular animals that were used to transmit leprosy, and the lizard was the only agent implicated. Jokingly, one consultant recalled being terrified of lizards as a child, but also admitted to being reluctant to get close to any lizard with a protruding neck. In hearing about the lizard's role in transmitting disease, I was informed about how the lizard can convey, through obeah, diseases other than leprosy including: "big foot" (Filariasis) and "tobo" (Yaws). Another consultant remarked about the "cocobay lizard":

> It was a fact that the lizard is used to transmit many things. The "cocobay lizard" is just when the lizard is carrying leprosy, but it will not give it to you unless you are the intended person. Lizard urine causes "big foot," (elephantiasis /Filariasis) so you don't want to step in a puddle (Consultant Interview).

A "cocobay lizard" is identified by my consultants as a lizard that has first been worked by obeah, and second it must also have a protruding neck. "A puffy neck," as it was described, is actually the dewlap. A dewlap is a "little flap of skin that is extended underneath the chin like the one shown in Figure 6.1. It is actually a rib of cartilage attached to the bottom of the throat that can be expanded and retracted at will" (Gorgoy, 2005). Males and females both have dewlaps and are used for breeding and territorial displays (Gorgoy, 2005). I tried my best to find a lizard that fit this description, but my search was in vain.

Chapter Summary:

This chapter started out by defining two important terms that are used when discussing leprosy, "cocobay" and obeah. I discuss the derogatory nature of "cocobay" and how it is applied much like the "L-word." I also discuss the anthropological literature defining obeah and offer an alternative way of understanding its usage. Stories about blame and the origins of leprosy were discussed. I also address the plurality of healing strategies in St. Kitts with its use of both ethnomedicine and biomedicine and how it produces a local knowledge of leprosy. This chapter proves a list of bush medicines that are used for side-effects of leprosy and for obeah. The chapter continues with a discussion on the local knowledge of transmission and how a shift in

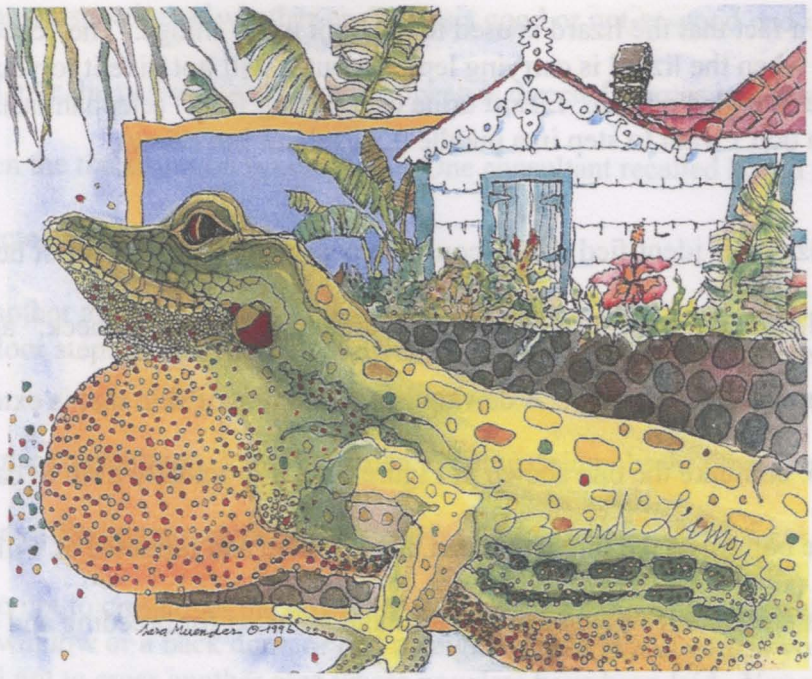



**Figure 6.1: Card from St. Martin depicting the lizard with an expanded dewlap: Artwork by Sera Meunder 1996.**

understanding contagion took place. This chapter ends with understanding how obeah is used to send leprosy and its possible vectors for this use.

# THE PETITION TO THE QUEEN

By the inhabitants of St. Kitts and Nevis

## FOR

COMPULSORY SEGREGATION

of the lepers of all classes.

Forwarded to-day to His Excellency the Governor for transmission to Her Majesty.

---

THIS PETITION is signed by 8 Doctors (all of the Government Medical Officers except 2).

It is signed by 12 Ministers of Religion; in fact by every Minister of Religion of all denominations to whom it has been presented.

That we would have obtained the signatures of the other 6 Clergy we are well assured if we may judge by the alacrity with which the other 12 signed.

These are the two Professions whose avocations take them among all classes of our population. They are brought into intimate contact with every individual in these Leprosy-ridden islands; and the demand for the compulsory segregation, the crying demand on the Government by all classes for the stamping out of this fearful disease, finds just expression through these two confidential mouthpieces of the people—the Doctor and the Parson.

It is signed by the Inspector of Schools. It is signed by nearly every Merchant in St. Kitts.

And to further show the universal demand for compulsory segregation, we may say that out of the 98 educated people and 39 tradesmen in St. Kitts to whom the petition has been presented we have met with only 6 refusals to sign. And with one exception the sole objection to signature brought forward by those gentlemen was that they had no guarantee that in the event of any of their children contracting leprosy they would not be segregated with the common herd. If they could be assured on that point they would willingly have signed.

It remains with our Governor Sir William Haynes-Smith and the members of the Federal Council resolutely to do their duty without fear or favour.

# Chapter 7: Expediency and Edict

In this chapter, I present a brief history of Sandy Point and its relation to Hansen Home. I review the choice in selecting Charles Fort as the home of the leprosarium. I also address the need for a leprosarium as well as identify the other health care facilities available. This chapter also discusses the number of patients housed at the leprosarium. I end this chapter with a brief discussion of how the island has dealt with other public health crises.

Sandy Point:

> "The reason Sandy Point is no longer the capital is because of the leper home. The leper home was put here to take away the title of capital of St. Kitts" (Consultant Interview).

This idea was suggested to me by a clergy member whose tenure in St. Kitts was limited. He was a recent immigrant living in Sandy Point who only expected to stay for a two year period. His assessment of the reasons behind the capital move was historically inaccurate, but nonetheless he probably came to this opinion because of the influence of other Sandy Pointers. Basseterre was selected due to its accessibility both via the sea and road as well as its proximity to a sheltered bay (Inniss, 1985:7). Moreover, the new capital was chosen 162 years prior to legislation establishing the leper home, which occurred in 1889.

Sandy Point is a town located at the north-west section of the island of St. Kitts. It was established circa 1624 with the settlement of Thomas Warner (Inniss, 1985:76). Sandy Point is two miles in length and one mile in width. It stretches between New

Guinea Land and Fig Tree. Settlement areas in Sandy Point run along the coastline reserving the interior for sugar estates. Major neighborhoods include: Cleverly Hill, Crab Hill, and The Alley. Sandy Point became the home of two health facilities in the late 19th century. The first being the "leper" asylum, as it was then called. The second was Pogson Hospital which I will discuss later. Figure 7.1 is a map of St. Kitts; notice Sandy Point, Charles Fort, and Brimstone Hill.

Charles Fort:

Prior to its role as a leprosarium, Charles Fort was a military post from 1672 until 1854 (Schroedl, 2000:2). It was occupied by both the English and the French at various times of war (Hubbard, 2002:54). This fort was a key position protecting the town of Sandy Point. The British and the French co-existed on the island of St. Kitts and throughout the region until 1666 when tensions began to escalate (Hubbard, 2002:50). Sandy Point divided the French and British with the boundary line at Fig Tree (Rawlins, 1987:17). The British laid claim to the lands that belonged to the French, and as a result, the French retaliated. An English army of 1400 was defeated by a French army of 350 in the Battle of Sandy Point, April 22, 1666. Sandy Point and St. Kitts was under French occupation and control (Hubbard, 2002:43). The English planned an attack with 2000 men. They were unsuccessful due the hurricane of August 15, 1666 (Hubbard, 2002:43). The French enjoyed this disaster and used it to their advantage. After a number of battles, the French decided to move their capital to Martinique in 1669. The French returned the previously owned English lands to the English in 1669 (Hubbard, 2002:50). Construction of Charles Fort began soon thereafter and was ready for troop occupation

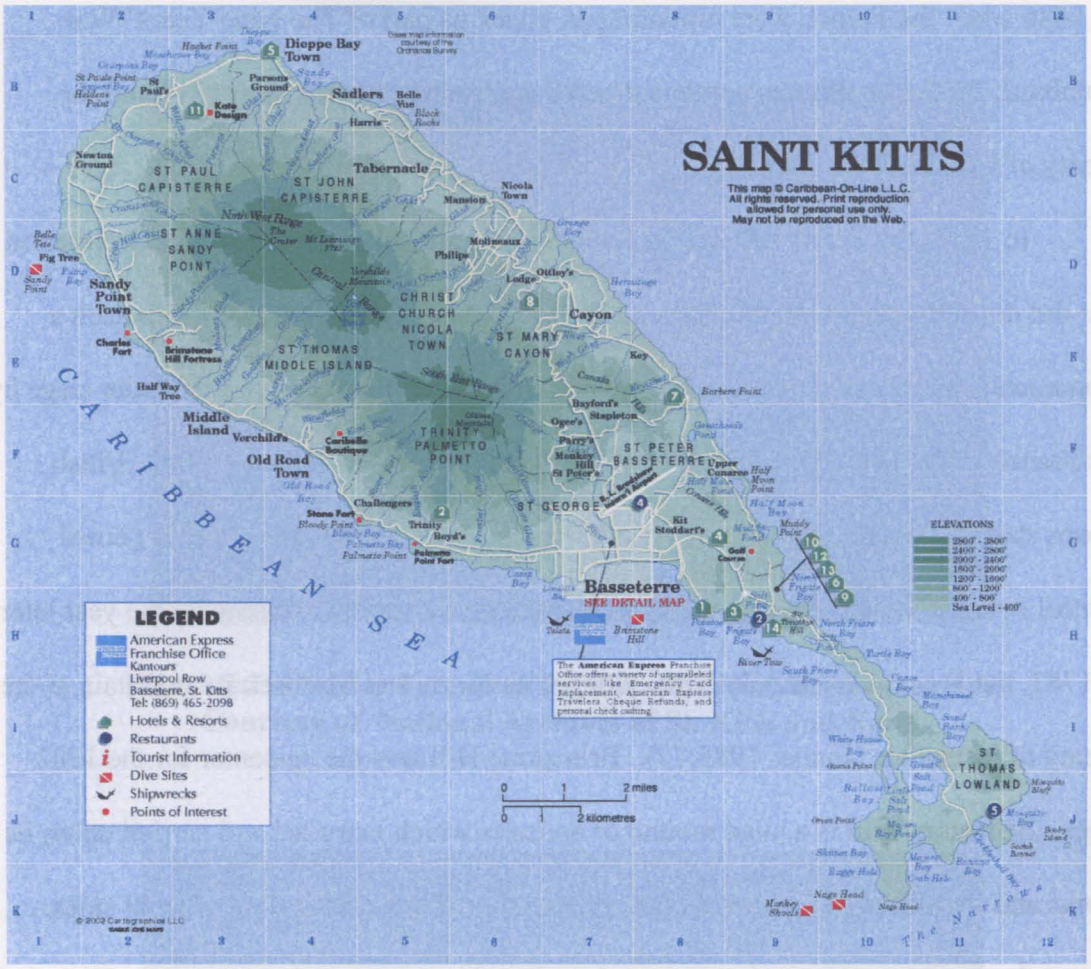



**Figure 7.1: Map of St. Kitts Courtesy of Caribbean-on-line.com (Caribbean-on-line.com, 2002).**

by 1686 when the French were mounting an attack as part of The Nine Years' War (Hubbard, 2002:51). Battles continued and the French prevailed until 1713 and the Treaty of Utrecht.

In 1713, the Treaty of Utrecht declared St. Kitts a British territory, a declaration that did not settle well with the French. By 1782, the French were ready to launch a monumental siege and regain control of St. Kitts. When Fort George was under siege by the French in the 1782 battle, the French led 8,000 soldiers against the 1,000 British troops stationed there. Not surprisingly, the French won that battle and thus gained control over the island once again. However, France's reign was limited. One year later, in 1783, the French restored St. Kitts, along with Nevis and Montserrat, to Britain at the Treaty of Versailles (Inniss, 1985:77). Brimstone Hill was the epicenter for the 1782 siege. Brimstone Hill is a huge mound of andesite which extruded and carried up on its flanks and shoulders the upturned beds of limestone that occur around it on all sides, except the northeast (Merrill, 1958:23). It is found in the northwest area of St. Kitts, just south of Sandy Point, and rising 779 feet in elevation (Merrill, 1958:20). Figures 7.2 and 7.3 are images of Charles Fort looking down from Brimstone Hill. Figure 7.2 is a post card from the 1920s. Figure 7.3 is a photo of Charles Fort that I took standing on Brimstone Hill. The recent image shows the fort in disarray. It is overgrown with weeds and uninhabited. The sea wall is eroding and essentially falling into the sea. Figure 7.4 is a photo I took in 2002 standing in front of Charles Fort; this is the entrance to the fort.

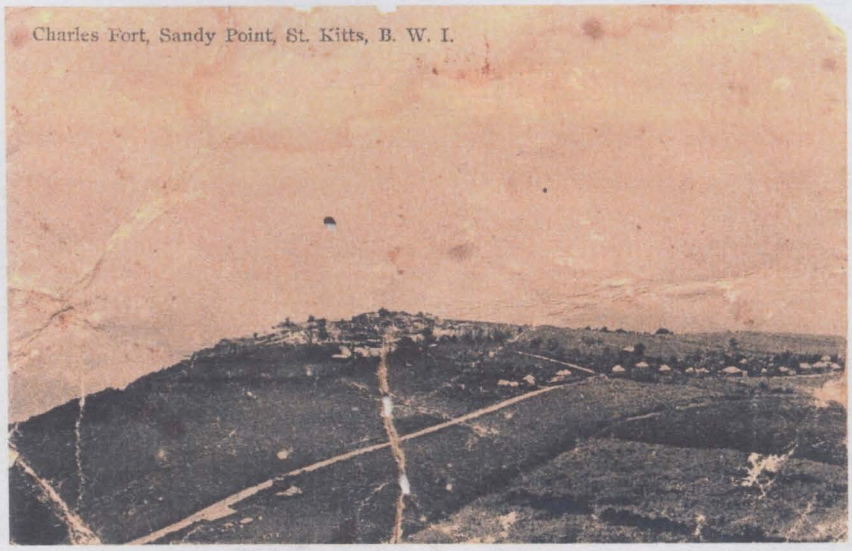



**Figure 7.2: Charles Fort circa 1920's; view from Brimstone Hill; Courtesy of National Archives of St. Kitts and Nevis.**

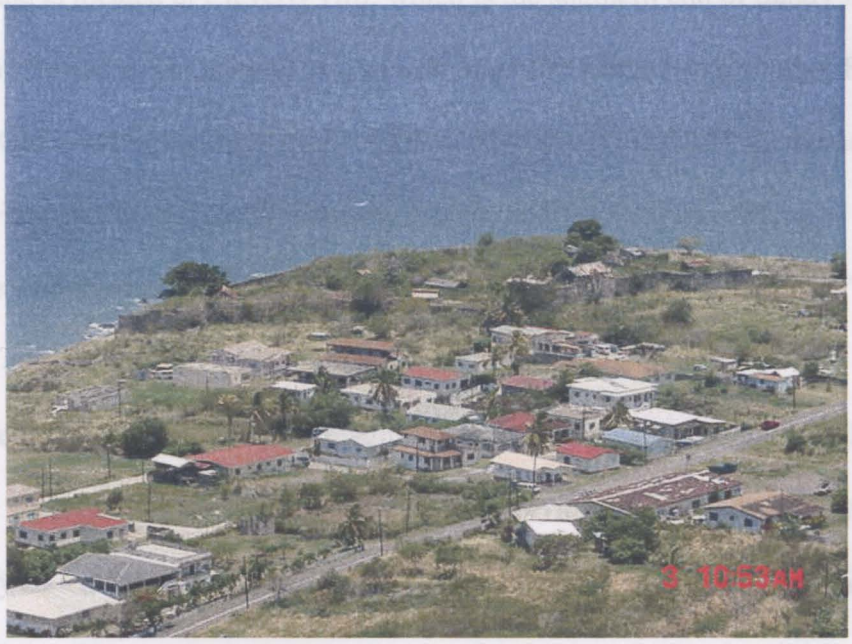



**Figure 7.3: Charles Fort 2002; View from Brimstone Hill; Photo taken in 2002.**



**Figure 7.4: Entrance to Hansen Home; Photo taken in 2002.**

The Need:

> Fort Charles is on high ground on the seaside. The breeze from the sea blows directly over it. It is a few hundred yards from the main road and about a mile from the residence of the District Medical Officer. It thus fulfills two conditions in being healthy and accessible. The land inside the Fort accounts between three and four acres and in ... that the quarters for the male inmates could be place at some distance from those for the females. There is enough land to afford the inmates occupation in cultivating it. Toward the center there is a depression where heavy rain water collects this could be drained with a very ... outlay. The wall surrounding the Fort is very high and the whole place appears to us specially adapted for a leper asylum. We are of opinion that one hundred lepers could be maintained here without over crowding (Search Committee Minutes, 1889 [hereafter Minutes]).

The leprosarium was established in 1890 after a government commissioned committee concluded on May 18, 1889, that "Fort Charles near Brimstone Hill" was the "most suitable" location (Minutes, 1889). Charles Fort housed the leprosarium between 1890 and 1996 and is located at Cleverly Hill, which is the southern end of Sandy Point. It is more often referred to as Charles Fort, so as to not be confused with another Fort Charles located in Old Road village in St. Kitts (Schroedl, 2000:2). In 1920, the home adopted the name Hansen Home after Dr. Hansen, who is credited with identifying *Mycobacterium leprae*. Locally, the home has been referred to as: the "leper" home, colony, or asylum, lazaretto, Hansen Home, and cocobay home.

The fear of this disease was magnified by a newspaper publication called *The Lazaretto*. This publication highlighted events involving people with leprosy and specifically called for the strict compulsory segregation of people with leprosy from the general public. This newspaper was printed and published during the 1890's by Charles Henry Boon in St. Kitts. Within *The Lazaretto* there are references to a Dr. Boon. However, it is unlikely that this is Charles H. Boon. Perhaps it was a relative? What is

known about Charles H. Boon is that he was the owner of a metal work shop or foundry. He repaired machinery for the sugar estates. Publishing *The Lazaretto* was a hobby of sorts. Boon's first interest was in writing about technical developments on the sugar estates. The complete archival collection of *The Lazaretto* has been digitized and is available for review at the National Archives of St. Kitts and Nevis.

Compulsory segregation typically involves identifying all cases of leprosy, keeping a close eye on the person and confining them to a leprosarium by force; in other words, compulsory segregation essentially treats the person with leprosy very similar to the treatment of criminals (Hasseltine, 1938:119). A modified compulsory segregation system gives the medical officers the ability to quarantine people with leprosy in hopes they will opt to going to the leprosarium. Essentially this leprosarium has strict rules, but allows for recreational activities, visitors, and an atmosphere conducive to physical, social, and mental recovery (Hasseltine, 1938:120). Voluntary segregation is simply the person with leprosy coming to the medical authority and requesting treatment. Home segregation is an option that is typically restricted to those in higher social classes; it is restricted by default due to the financial burden. Most people with leprosy do not have the income to support themselves and those who care for them.

In St. Kitts, all of these forms of segregation apply. The leprosarium in St. Kitts started out with a modified compulsory segregation system. This was heavily criticized by Boon in *The Lazaretto*, No. 16, February 9, 1891. Boon argued that the Governor has yet to produce a set of rules for which the leprosarium can use for guidance. He said that the Leper Bill or Leper Act is not enough. He then proceeded to offer eight rules for the Governor to consider (Boon, 1891:No 16):

1. No poultry or live stock should be kept in or near the asylum.
2. No food should be allowed to be sent out of the asylum and visitors should be rigidly searched on leaving.
3. Friends and visitors should be allowed to send or bring anything in reason that may conduce to the comfort of the inmates.
4. Children, (not being themselves lepers) should not be allowed to reside in the asylum.
5. The nurses should not be allowed to give lodging in their quarters to any of their friends or relations.
6. Any resident official who desires to leave the asylum temporarily or otherwise should not be allowed to wear the asylum clothes outside.
7. A uniform of some sort should be worn by all resident officials.
8. The lepers should wear a uniform of some distinctive colour (a bright yellow for instance).

The rules that the leprosarium followed were those outlined in the Leper Act. A full reproduction of this 1890 act can be found in two sources: *The Lazaretto*, No. 3 August 12, 1890, pages two and three; and *St. Kitts—100 Years of Medicine*, *Chapter 12: The Leper Asylum*, by Sir Cuthbert M. Sebastian. I am only reproducing the gist of each of the sixteen rules (Boon, 1890:No 3):

1. The governor can establish a Leper Asylum at Charles Fort.
2. Any person with leprosy, or suspected of having the disease, and is not capable of supporting themselves or found soliciting alms will be taken before the District Magistrate and if found guilty of being poor and having leprosy then they are detained at the leprosarium.
3. Any one with leprosy can apply for admission to the leprosarium if they are so poor that they cannot subsist.
4. No one with leprosy can prepare, collect, sell food or any food byproduct; if found guilty of doing so, then the person may be detained at the leprosarium.
5. Any detained person who is found outside of the leprosarium will by force be returned to the leprosarium.
6. The District Magistrate must have a medical certificate qualifying a person as having leprosy.
7. When a person is deemed cured of leprosy, they are at once to be discharged.
8. Any person ordered to be detained as a result of having leprosy must pay two securities in the sum no less than £50 so that when they are

discharged, they can receive proper medical care and be maintained so as to avoid spreading the disease.

9. The Governor can hire as many people as seen fit to manage the leprosarium.
10. The Governor can create, and re-create any rules regarding the asylum and the patients, including who and when and if visitors are allowed. All violations of the rules have a fine of no more than £5 or imprisonment with or without hard labor, but not exceeding a month.
11. The Governor can remove any person with leprosy from the prison and send them to the leprosarium.
12. Governor can remove any person with leprosy from the lunatic asylum and send them to the leprosarium.
13. Governor can alter the rules to fit a prisoner or a lunatic.
14. No one can enter the country with the disease of leprosy; if they arrive then they must be turned away.
15. District Medical Officers must provide statistics regarding the number of cases within their districts to the Governor.
16. Governor can alter the budget allotted for the leprosarium.

Boon and others were not happy with the situation at St. Kitts. They felt that the government was not doing an adequate job of preventing the spread of leprosy. They went so far as to petition the Queen of England for the compulsory segregation of all lepers (Boon, 1890:No 6). Their petition was signed by six Government Medical Officers, twelve religious ministers, Inspector of Schools, ninety eight "educated people" and thirty nine "tradesmen." The efforts were intense as many people were behind the compulsory segregation. This sentiment was also felt by people in Antigua who also wanted a compulsory segregation system; from all indications they were not successful and also had a modified compulsory system (Boon, 1891:No 3). Although the leprosarium had elements that qualify as part of the compulsory system, using Hasseltine's definition, St. Kitts used a modified compulsory system which included voluntary segregation and home segregation.

*The Lazaretto* was long out of publication by June 12, 1912, when a revised Leper Act was passed. Despite all of Boon's efforts, St. Kitts did not adopt a compulsory segregation model. This act called for several new features; for the most part, it spells out the specifics of each rule. It is more detailed than the Leper Act of 1890. The first new feature was the rule concerning the Administrator in Council power to declare any building and land a "leper home." A "leper home" was defined as any building erected for the purpose of housing a person with leprosy (Legislation, 1912). There are some changes to the monetary amount given as a bond to secure a person's discharge. This meant any person wishing to receive treatment in their home would be segregated from the general public and be able to afford the bond. The amount of the bond is two hundred and forty dollars (Legislation, 1912). This meant that home segregation was possible, provided the person with leprosy had the money and family support to do so. The act also listed a number of trades that are forbidden. They included: baker, barber, boot-maker, butcher, chemist, cook, dairyman, domestic servant, fishmonger, nurse, tailor, and washer or any other trade where contact is made with food, drink, drugs, medicines, tobacco or clothing (Legislation, 1912). All visitors to the leprosarium had to have official permission or they will be charged with trespassing. Anyone who assists a patient in escaping or in hiding will also be criminally charged. This act gave the Administrator in Council custody of any infant separated from a parent suffering from leprosy (Legislation, 1912).

Statistics:

I collected statistical data concerning the number of people with leprosy in St. Kitts and Nevis between 1889 and 1945 (see Table 7.1). What I found were reports on the number of people with leprosy in the following institutions: Antigua's Rat Island Leper and Insane Asylum, Dominica Lazarus, Nevis Infirmary, Montserrat, Seaman's Ward Lazarus, and St. Kitts Charles Fort. Tortola Virgin Islands did not report any cases of leprosy and as a result is not listed in this chart. However, I do have evidence that some of the patients at Charles Fort were from Tortola. I did not expect to find any information regarding the patients at Charles Fort in 1889, but I looked for evidence of people being diagnosed with leprosy. The records were incomplete. For now I am referring to the leprosarium as such or as Charles Fort, to be consistent with the records; it did not adopt the name Hansen Home until 1920.

By 1892, the patients at the Nevis Infirmary were transferred to the leprosarium at Charles Fort. According to three consultants, Antigua and St. Kitts exchanged patients. St. Kitts sent people who needed treatment in their mental health facility and Antigua sent people with leprosy to St. Kitts. According to the consultants, St. Kitts became the main leprosarium for the Leeward Islands, which meant that people came from all over to seek treatment in St. Kitts.

Data for Charles Fort were first recorded in 1891. There were seventy-one patients. However, according to Boon and *The Lazaretto*, in 1891 there were over 100 people with leprosy. Boon asserts that the District Medical Officers were attempting to "decrease" the numbers by altering the "figures" (Boon, 1891:No 23). Furthermore, Boon argues that the Medical Officers were stating that the majority of the cases were

**Table 7.1: Early Leprosy Reports from Bluebooks**

| Leeward Islands | 1889 | 1890 | 1891 | 1892 | 1939 | Longest stay for resident | 1945 |
|---|---|---|---|---|---|---|---|
| St. Kitts Charles Fort | n/a | n/a | 71T | 25F, 43M, 68T | 19F, 24M, 43T | 48yrs F, 46yrs M | 24F, 31M, 55T |
| Nevis Infirmary | 5F, 4M, 9T | 5F, 4M, 9T | 5F, 4M, 9T | No more on Nevis | n/a | n/a | n/a |
| Antigua Rat Island | 28T | 28T | 34T | 16F, 14M 30T | 18F, 21M 39T | 45yrs F, 36yrs M | 17F, 36M 53T |
| Dominica Lazarus | 5T | 5T | 4T | 4T | 9F, 10M 19T | 2yrs M, 2yrs F | n/a |
| Montserrat | 5T | n/a | n/a | n/a | n/a | n/a | n/a |
| Seaman's Ward Lazarus | 9T | 9T | 9T | 9T | n/a | n/a | n/a |
| Total | 56T | 56T | 127T | 111T | 101T | | 108T |

hearsay and not clinical diagnoses (Boon, 1981:No 23). Boon claims the following number of people with leprosy existed in these particular years: 1817: 95; 1855:53; 1872:72; 1891:110. His estimate was that there were, in 1891, sixty persons from St. Kitts, three who were from other countries, three who died in the lazaretto, and forty-eight at large or "fugitives." He again estimated that 120 people with leprosy were residing in St. Kitts. He excluded figures from Nevis in his estimation (Boon, 1891:No 23). Regardless of how the figures are added, Boon's statistics are not consistent, even in the same article (Boon, 1891:No 23).

In order to assess Boon's claims about the number of leprosy cases in St. Kitts; it is necessary to remember that leprosy was frequently misdiagnosed and is often confused with the biblical leprosy, a catch all diagnosis for any severe dermatological diseases. *Mycobacterium leprae* was not identified until 1873, so a fair number of the cases prior to this date could have been other diseases. For example, socially, the Caribbean term "cocobay" has been used to also identify people with yaws. In the Middle East and India, endemic syphilis, chronic psoriasis, and vitiligo or leucoderma, have also been confused with leprosy (Lieber, 2000:102). There is evidence that other dermatological diseases such as scurvy or pellagra may have been defined as leprosy prior to Dr. Hansen's isolation and identification of the bacterium responsible for leprosy (Howe, 1997:80). In light of this, it is valid to accept the St. Kitts Medical Officers' assertion that many of the cases that Boon was claiming were hearsay. This does not diminish the fact that leprosy was indeed endemic at this point throughout the Caribbean.

In 2000, I meticulously searched through all of the records salvaged from Hansen Home. The books published in the 1980s were in no better shape than those with 1890s

dates. They had endured quite a bit of water damage as they were left behind at the Home when it closed in 1996. I also searched other records in hopes of finding information for the block of time between 1900 and 1996. Fortunately, the oral history I collected covers a great deal of the missing time frame. The down side is that there are few statistics. Tables 7.2 and 7.3 are combinations of the fragmentary statistical data available about the number of patients housed at Hansen Home.

I consulted two former managers of Hansen Home who sequentially covered a time span of fifty-four years. The more senior of the two worked there from 1942-1973. He recalled fifty-two patients, more males than females. He recalled that in 1971 eleven patients were ready to vote at the polling station set up at the Home. The more junior manager worked from the time of the senior's retirement: 1973- 1996. He remembered nine patients, five of whom were female and four males. He also said that the Home stopped admitting patients in 1994. On January 16, 1996 he was present for the institution's closing. It closed simply because it was not economically feasible to provide salaries for five or so employees to care for one patient. It was too expensive to maintain despite a generous donation left to Hansen Home by benefactor Wilford Duncan Thompson (Schroedl, 2000:38). The final patient was transferred in 1996. Another consultant was a nursing attendant who began work on December 24, 1981, when there were only five patients and five caretakers. She stayed until her work position was transferred, with the closing of Hansen Home, to the Cardin Home in 1996. The final patient was also transferred to Cardin Home, where she died in 1998. This particular

**Table 7.2: Mid 20th Century Leprosy Returns for Hansen Home**

| St. Kitts, Nevis, and Anguilla @ Hansen Home | 1939 | | | 1945 | | | 1949 * | 1950 | | | 1953 * | 1954 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | T | F | M | T | F | M | | T | F | M | | T | F | M |
| Daily Average | 43 | 19 | 24 | 55 | 24 | 31 | n/a | 41 | n/a | n/a | 30 | 25 | n/a | n/a |
| Open or infectious | n/a | | | n/a | | | n/a | 27 | n/a | n/a | n/a | 1 | n/a | n/a |
| Active, but not infectious | n/a | | | n/a | | | n/a | 9 | n/a | n/a | n/a | 10 | n/a | n/a |
| Arrested with deformity | n/a | | | n/a | | | n/a | 3 | n/a | n/a | n/a | 3 | n/a | n/a |
| Infirm | n/a | | | n/a | | | n/a | n/a | | | n/a | 3 | n/a | n/a |
| Temporary Admissions | n/a | | | n/a | | | n/a | n/a | | | n/a | 2 | n/a | n/a |
| Discharged | n/a | | | n/a | | | n/a | 2 | 0 | 2 | n/a | 9 | n/a | n/a |
| Deaths | 7 | 2 | 5 | n/a | | | n/a | 4 | 0 | 4 | | 0 | | |
| New Cases Admitted total | 3 | 1 | 2 | n/a | | | n/a | 2 | 0 | 2 | 2 | 2 | 1 | 1 |
| End of year totals given in the records | 39 | n/a | n/a | 31 | n/a | n/a | 41 | 39 | 18 | 21 | n/a | 19 | n/a | n/a |
| End of the year totals computed data given | 39 | 18 | 21 | | | | | 37 | | | | 20 | | |

*1949 was mentioned in the 1950 returns; 1953 was mentioned in the 1954 returns for the Annual Medical and Sanitary Report of St. Kitts, Nevis, Anguilla.

**Table 7.3: Mid to Late 20th Century Population Statistics for the Hansen Home**

| Hansen Home (HH) | Early 1940s | 1942 | 1971 | 1973 | | 1981 | 1994 | Jan 16, 1996 Closed | 1998 Cardin Home |
|---|---|---|---|---|---|---|---|---|---|
| HH Manager 1942-1973 | | n=52 More Males | n=11 | | | | | | |
| St. Kitts 100 Years of Med. | *100 | | | | | | | | |
| HH Manager 1973-1996 | | | | n=9 | 5 F 4M | | Stopped Admitting | n=1 (discharged) | |
| HH Nurse 1981-1996 | | | | | | n=5 | | 1 F (Transfers to Cardin Home) | Transferred patient dies |

* St. Kitts—100 Years of Medicine by Sir Cuthbert M. Sebastian (Sebastian, 2001:152).

nurse was favored by the last patient and unfortunately to the nurse's dismay, she died while she was on vacation. Cardin Home is a nursing home. It is often called the Poor House. This home takes in those who are unable to care for themselves and cannot afford a private caretaker. This brings me to briefly discuss the other health care facilities on the island and examples of other public health crises.

Public Heath Care Facilities:

*Hospitals—*

Formal hospitals were non-existent in St. Kitts until the mid 19th century. Cunningham Hospital opened in Basseterre in 1848. It was named for Charles Thornton Cunningham who was the Lieutenant Governor and founder of the hospital. Cunningham died just prior to the hospital's opening (Sebastian, 2001:107). This hospital cared for the thousands who were afflicted by the cholera epidemic of 1854 (Sebastian, 2001:109). At first, the hospital was qualified as a place where one might get sick rather than well (Sebastian, 2001:109), but in time, with a trained staff, the hospital became quite efficient in providing care. Cunningham Hospital was the main hospital for 120 years and it was the only hospital until 1892.

Pogson Hospital opened in Sandy Point on March 31, 1892 (Hospital, 1992:1). This hospital was named after Edward Pogson, who owned Bourkes Estate where the hospital was built. Prior to this hospital, people sought care at a doctor's house on Downing Street, Sandy Point (Pogson Hospital, 1992:1[hereafter Hospital]). A trip to Cunningham Hospital proved difficult for most living in Sandy Point and the surrounding areas. When Pogson Hospital was built, it became responsible for serving the population

stretching from Challengers Village to East Dieppe Bay (Hospital, 1992:2). The most important ward of this facility is the Maternity Ward which was established as a condition of Edward Pogson. Pogson stipulated in his agreement that this facility will always have a maternity ward and forbad the hospital from closing for more than twenty-four hours. If this stipulation is not kept, then the property will return to his living heirs (Hospital, 1992:2). The hospital has undergone several periods of renovations, but most importantly, in 1961, Pogson Hospital opened a new maternity wing (Sebastian, 2001:137). Figures 7.5 and 7.6 show both Cunningham and Pogson Hospitals.

In 1967, a new hospital was built in Basseterre. Joseph N. France General Hospital, or JNF General for short, was named after Joseph N. France. France was the Minister of Health when the hospital opened (Sebastian, 2001:143). Although, JNF General is the largest and best equipped hospital in St. Kitts, given its recent renovations of the pediatric and maternity wards, it is incapable of serving the entire population. In 1986, Mary Charles Hospital opened in Molyneaux on the east side of St. Kitts (Sebastian, 2001:107).

Nevis had a hospital as early as the mid 17$^{th}$ century, and it was located on, what was rightfully named, Old Hospital Road near the cemetery north of Charlestown (Daniel, 2001:16). The land used for this facility was donated to the government by James Ling, an estate owner (Daniel, 2001:16). This hospital was destroyed in the 1899 hurricane and the patients were transferred to the Charlestown jail. In 1909, an investigation into the progress (or lack there of) of reconstruction of this hospital was made. The promise for a new facility was thwarted as the existing Government House

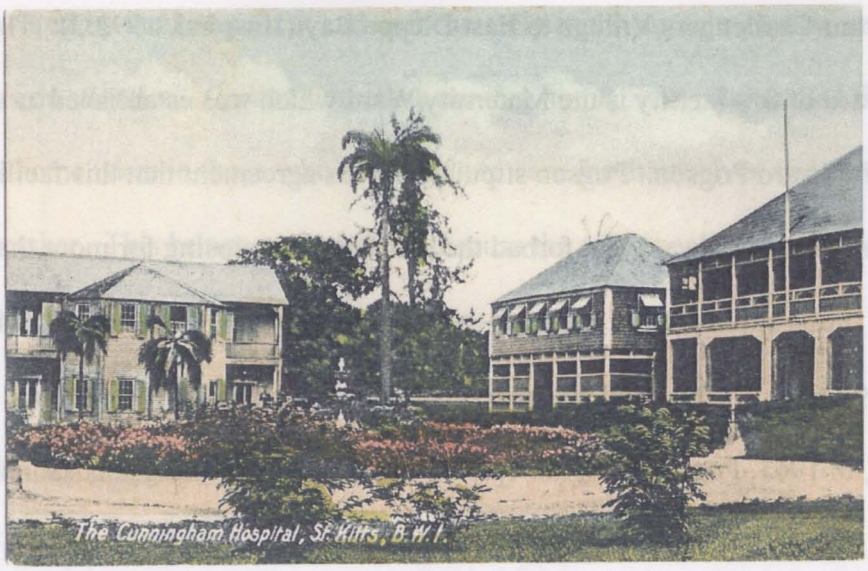



**Figure 7.5: Cunningham Hospital ca 1930s; Original Photo post cards were produced by V. E. John, courtesy of St. Kitts National Archives.**

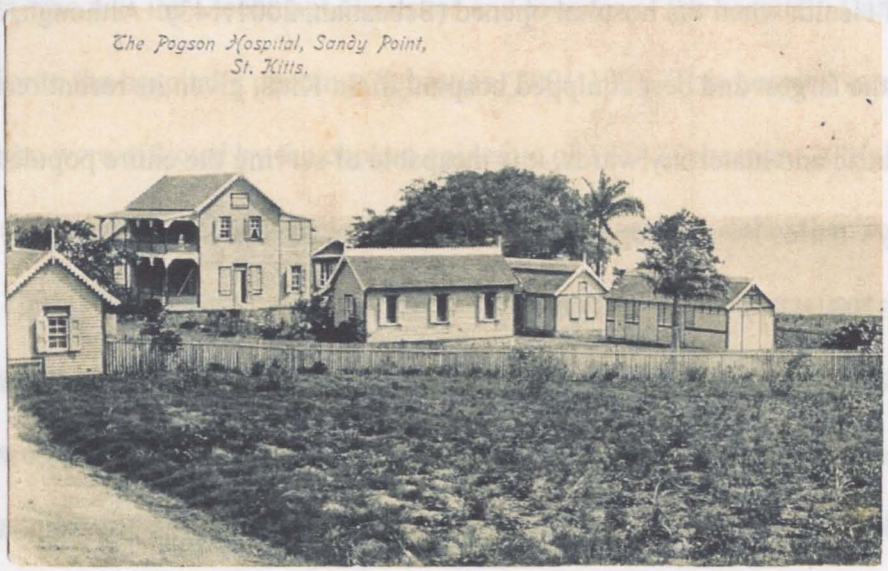



**Figure 7.6: Pogson Hospital ca 1930s. Original Photo post cards were produced by V. E. John, courtesy of St. Kitts National Archives.**

was converted into a new hospital and named after Queen Alexandra (Daniel, 2001:16-17). Alexandra Hospital continues to serve the island of Nevis. Like JNF General, it is staffed with full-time physicians, surgeons, and trained nurses. This is the only hospital in Nevis and it serves approximately a population of 9,500, but is limited to fifty beds (Consultant Interview).

*Infirmaries—*

In Nevis, the Infirmary was where the patients with leprosy lived. There is no clear distinction between the Nevis Infirmary and the hospital at Old Hospital Road. The Nevis Infirmary stopped reporting patients with leprosy in 1899, the year a major hurricane hit the island. The statistical returns reported after the 1899 hurricane evidently represented patients kept at the Charlestown jail.

Cardin Home is located in Basseterre. J.D. Cardin funded an institution for the infirm, which was named after him in the 1930s (Inniss, 1985:37). I realized that this home was not just for the poor, as I understood, but for those who perhaps did not have anyone to care for their specific long-term medical needs. This nursing home was the location where the last patient from the Hansen Home came to live prior to her death. Cardin Home also tended to the care of those who were without a home.

According to a consultant, to place a family member in this nursing facility is an embarrassment for many. Long-term medical care for the mentally impaired, or for those with Alzheimer's, is expensive. Many families are faced with trying to care for a family member alone or with hired nursing care. For those who simply cannot afford this luxury, Cardin Home has been their only option for years.

The Grange Enterprises LTD is a health care facility that provides residential accommodations and assisted living arrangements for people with a variety of conditions. This facility opened in August 2000. The majority of the patients I met there were afflicted with Alzheimer's Disease. Pat Richards-Kingóri is the Chief Executive and founder of what is locally called "The Grange." I learned that this facility has a mission to provide care for people who cannot afford a round-the-clock home health care provider and they cannot (due to social stigmas related to class) place their family member in Cardin Home. This facility is privately owned and managed. It relies solely on donations and on monies collected from patients (or their executors) for rent, provisions, and care. Richards-Kingóri is both an anthropologist and a nurse, but above all, a Kittitian who saw a need for a care facility that met the needs of many people in St. Kitts and Nevis. Figure 7.7 is a photo of the front entrance to The Grange and a photo of the side from a distance. It is located just below Ottley's Plantation Inn and above Grange Bay, which is located on the northeast side of the island of St. Kitts. The buildings are new and the facilities rival some in the United States.

*Health Centres—*

Dotted around the islands of St. Kitts and Nevis were Health Centres. These were implemented by Dr. P.I. Boyd in the mid to late 1940s (Sebastian, 2001:72). The idea for this came from Dr. J. P. O'Mahoney who proposed this plan in 1944 just prior to his transfer to Barbados (Sebastian, 2001:72). Health Centres brought health care to everyone and not just those who could travel to the main hospitals. Each Health Centre was staffed with a public health nurse, a nurse midwife, a sanitary officer, and the

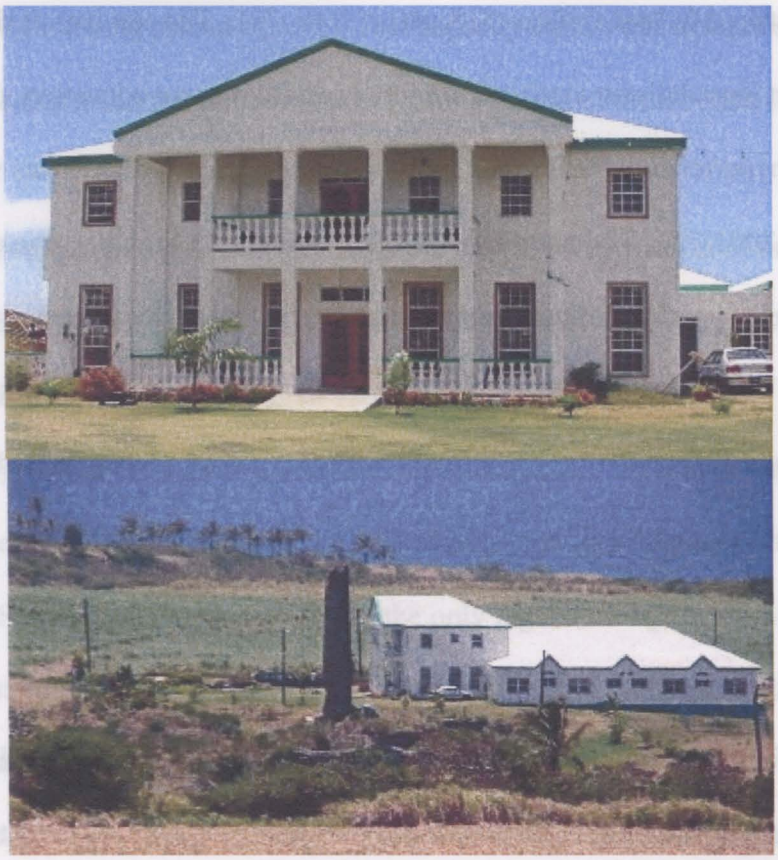


**Figure 7.7: Front and Side View of The Grange Enterprises LTD; Photo taken in 2002.**

visiting District Medical Officer (Sebastian, 2001:72). The services at these centres ranged from inoculations, antenatal clinics, venereal disease education, diabetes education, hypertension clinics, and food-handlers clinics. All services were free (Sebastian, 2001:72). The nurses were highly trained. In St. Kitts, one of the most highly respected and dignified occupations, which women dominated, were the position of a nurse. These Health Centres, due to their close proximity and accessibility to all, were particularly credited for the virtual disappearance of gonorrhea and venereal syphilis (Sebastian, 2001:73).

Public Health Initiatives:

So far as the word "contagious" goes, there is a common biomedical understanding of contagion. It is clear that viruses and bacteria can be transmitted from one person to another person through sneezes, coughs, and sex, to name a few. It is also clear that mosquitoes, rats, monkeys, and other organisms carry disease. Aggressive public health initiatives took place during the colonial history of St. Kitts and Nevis. In one of Boon's pleas for compulsory segregation, he made the following statement which, if true, indicates an awareness of the public health threat that leprosy posed.

> Before the emancipation of the slaves Leprosy was prevalent but was kept in check because it was considered contagious, and all slaves afflicted with it were kept apart from the others. After Emancipation nothing was done in the way of segregation, lepers were left to take care of themselves. The result was that leprosy spread surely but slowly (Boon, 1890:no11).

Leprosy incubates for a long period of time. This capacity makes this disease a "smart one." This means that it can remain dormant for a long period of time before it becomes symptomatic.

Another example of a public health initiative was the construction of the Springfield Cemetery, Basseterre in 1855. Prior to its establishment, people were buried in their respective church's graveyards. In 1854 an epidemic of cholera killed 17% of the population, or approximately four thousand people (Inniss, 1985:35). The decision to create this cemetery was in response to the 1,514 persons who died in Basseterre alone in 1854. By 1858, Springfield Cemetery became the only legal burial ground in Basseterre, or St. George Parish. In Sandy Point, there is a cemetery called Cholera Ground, which served as a central burial ground for Sandy Point or St. Anne Parish.

St. Kitts and Nevis have been impacted by a number of diseases besides leprosy. Malaria and filariasis are two mosquito borne diseases that are no longer seen in St. Kitts and Nevis. Dengue Fever is the only mosquito borne disease that still affects local people. In 2002, there were a number of patients in Pogson Hospital recovering from Dengue Fever, or what is locally called Break Bone Fever. The other disease that people were enduring at this hospital was ciguatera, a specific kind of fish poisoning.

One consultant shared his experience of traveling around the island to give each person a penicillin injection. This event caught the attention of the World Health Organization, which was impressed by this event. This single action was reported to wipe out yaws and tuberculosis, along with other respiratory and bacterial diseases. Each child received a shot as did each adult. Evidently, everyone in the entire population received a single dose of 300,000 units (Sebastian, 2001:121).

Ivan Buchanan, Chief Public Health Inspector, Health Department of St. Kitts, and consultant to this research, shared with me many of these events. Buchanan went on to do a number of other astonishing measures in the interest of public health and sanitation; he received a number of awards and honors for his commitment to the public health and sanitation initiatives implemented in St. Kitts. He also shared with me photos and documents honoring his role in massive eradication of disease in St. Kitts. His contribution and innovation to the public health care system in St. Kitts must be recognized here.

Another major public health initiative, one in which Buchanan was also involved, was the eradication of the Planorbid water snail which acts as an intermediate host for a parasitic fluke, one causing Schistosomiasis. This disease is no longer found in St. Kitts. St. Kitts and Nevis received international attention for the success in eradicating the Planorbid water snail. They addressed this problem with two methods. The first measure involved the introduction of an aggressive Brazilian Marisa snail, which would smother the smaller Planorbid snail and eventually dominate the environment. The second measure was with the assistance of the Bayer chemical company in Germany who produced a molluscicide called Bayer 73. This combination did the job and the streams and rivers in St. Kitts are free of this parasite.

The public health initiatives mentioned are just a small sample of the aggressive and effective methods used in St. Kitts and Nevis. St. Kitts and Nevis have success public health care delivery. Recent campaigns to educate the youth about HIV/AIDS are very proactive. Signs are distributed throughout the islands to serve as a reminder to play

it safe. Despite being a poor country, St. Kitts and Nevis have an aggressive health care delivery plan that has a proven record of success.

Chapter Summary:

This chapter provides an understanding of Sandy Point's selection as the home town of the leprosarium. It also provides a brief history of Charles Fort and, in that context, shed light on the historical significance of Sandy Point. The chapter goes on to addresses the need for a leprosarium in St. Kitts as well as the propaganda and legislation surrounding the inception of the leprosarium at Charles Fort. Fragmentary statistics provide a glimpse into how many people were segregated at Charles Fort. A brief survey of the public health care facilities, in the past and the present, is presented along with a description of how the public health system has successfully combated a number of crises. The following chapter gives a tour of Hansen Home and describes what life was like on the inside.

# Chapter 8: Hansen Home—Life on the Inside

In this chapter, I describe the Hansen Home facilities. I also describe the activities in which both patients and staff members engaged. Furthermore, I relay some information about some of the patients, particularly concerning their faith and occupational history before being committed to the Home. I end the chapter with a discussion on the very last patients and offer some images of the structures within the Home.

Orientation:

When I talked with people in 2000, I needed a map. I searched through the archives and I inquired about one at Public Works, but to my disappointment, none was available. So, one afternoon, I went to the Hansen Home and attempted to sketch out the facility. Figure 8.1 is a reduced copy of my original. I used this "map" as a springboard for conversations. All of the information crammed onto this sketch came from people identifying structures, what was in these structures, and, in some cases, who lived in these structures. I also encouraged participation in correcting any errors that the "map" had. Overall, my sketch depicts an accurate representation of the information given to me. It is not drawn to scale, however, and I am sure it is missing some information. It is also a representation of what was visible above ground. Erosion is not considered, as some of the Fort is missing due that process. Keep in mind that I did not have access to a professional map of Hansen Home or of Charles Fort in 2000 that showed the structures within it. In 2002, a professional map was published, but I continued to use the map I sketched. I was asked by a

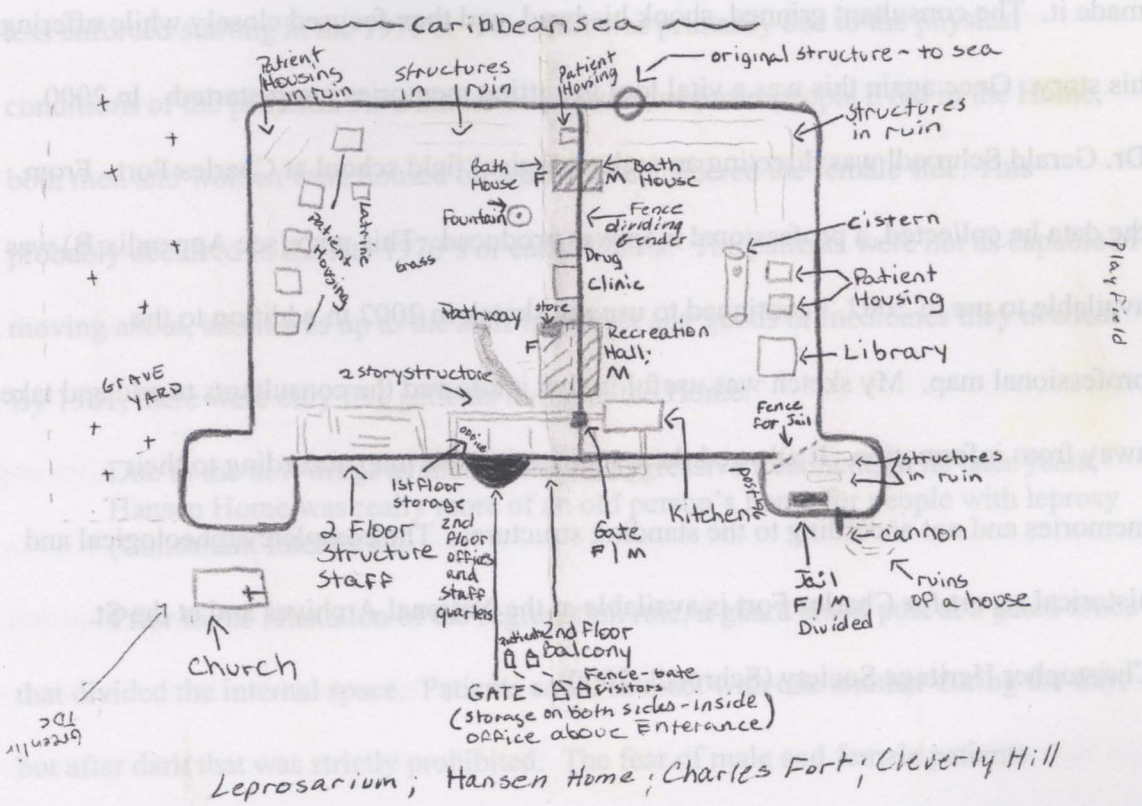



**Figure 8.1: Sketch Map of Hansen Home drawn by Nancy Anderson, 2000.**

consultant "where did you get this?" referring to my sketch. I laughed and admitted that I made it. The consultant grinned, shook his head, and then focused closely while offering his story. Once again this was a vital tool in getting memories jump-started. In 2000, Dr. Gerald Schroedl was directing an archaeological field school at Charles Fort. From the data he collected, a professional map was produced. This map (see Appendix B) was available to me in 2002, I continued to use my sketch in 2002 in addition to the professional map. My sketch was useful in that it allowed the consultants to add and take away from information. It allowed them to negotiate the map according to their memories and not according to the standing structures. The complete archeological and historical report for Charles Fort is available at the National Archives and at the St. Christopher Heritage Society (Schroedl, 2000).

The Great Divide:

The sketched map shows a dividing line running the length of the fort (see Figure 8.1). This barrier served to segregate the patients by gender; it was enforced at night. Patients could interact with one another during the day, especially with activities like gardening. This segregation rule was in place from 1890 until 1978. I asked the following questions (in italics) and the consultant responded in the following manner:

> *When did you start working at the Hansen Home?* I started working down here about 1973. When I came there were nine patients, five female and four male. There were two sections, a male section and a female section. After they started to get unable, all came over to one side, so we had both males and females on the same side.
> *What year was it when they came on the same side?* Um, '78, everybody came together in 1978. There was one senior attendant, which was me, an orderly, a nurse, a maid, a washer, and a cook (Consultant Interview).

However, according to former employees this gender segregation rule became less and less enforced starting in the 1970's. This shift was primarily due to the physical conditions of the patients. As a matter of logistics, as fewer people lived in the Home, both men and women were housed on what was considered the female side. This probably occurred in the late 1970's or early 1980's. The patients were not as capable of moving about, and it was up to the staff to deliver any goods or medicines they needed. By 1981, there were only five patients living in the Home.

> Due to the new drugs available and the aggressive treatment, in its later years, Hansen Home was really more of an old person's home for people with leprosy (Consultant Interview).

Prior to the relaxation of the segregation rule, a guard stood post at a gated fence that divided the internal space. Patients could interact with one another during the day, but after dark that was strictly prohibited. The fear of male and female patients fraternizing was created out of the biomedical uncertainty at the time that leprosy could be sexually transmitted, and there was a desire to prevent any pregnancies. Patients looked out for one another as one consultant recalls:

> I can remember a case when there was a male and he was sick. There was a lady, another female patient, who used to go and try to help him with his wounds. She was a friend. He didn't like being by himself, you know. She would check on him (Consultant Interview).

Patients:

Names of patients who lived in the Home are a matter of public record. Specific patients remembered by consultants are Olive Payne, Nicholas Berry, a teacher named Zach Walwyn, a tailor named Chad Sutton, Benjamin Jones, Benjamin Brown, Lillian Bartlett, Samuel Watson, Edwin Stewart, and Edwin Spanner. I have also included a

small number of names from the receipt booklet for burials below. This receipt booklet was used to document the services rendered by a minister performing a funeral. The receipts list the date, the reverend or minister, the denomination, and the age at death. Unfortunately, the receipt booklet is fragmentary; and only a small portion of it is readable. Appendix C is a chart listing these receipts and the available information. I have included the first name or initial and surname or initial, age at death and the year of death. I include the religious affiliation and the minister's name, when readable. Some of the names and information are labeled as Unknown or "n/r" for "not readable." Several receipts list the minister, but do not identify the denomination; therefore I use an "n/a" that this information is not available. I also use "n/a" to identify where other information is absent. The receipts I have date from 1947 to 1994. Each receipt is given a number; the highest completed in this group being 396, which is indicative of at least 396 possible burials along side of Hansen Home (see Appendix C). It is estimated that there could be 200 to 500 burials in this cemetery (Schroedl, 2000:48).

Hansen Cemetery:

Church ministers would also offer last-rights to those who died in the Home and perform the funerals. The cemetery for the Home is along the south side of the Fort's wall. It is estimated to be 30 to 50m wide with a distance of nearly 100m (Schroedl, 2000:48). There are two cemeteries close by that are not to be confused with the unmarked cemetery of Hansen Home. These include the Old Catholic Cemetery and Cholera Ground, both of which are north of the fort. If standing in front of the Home the cemetery used to bury people with leprosy is to the left around the corner. According to

the most recent manager there were about eighty-four people buried during his tenure (1973-1996) as manager.

The graves were left unmarked not because they did not want to mark the graves, but it was a matter of money. Since the residents had the status of paupers, there was little expectation that the families, provided patients had any family members that would admit relation, would pay for a head stone. The patients would dress the body and dig a plot for burial. Since the graves were not marked, they would often come across another grave. They would just cover it back up and move over to another spot and try again. I met a man who once was a coffin builder. This consultant made a number of coffins that were used by the folks in the Home. He built two kinds of coffins for paupers. Both were made of white pine, but for those who were deemed "lepers," they received a plain box. This box was absent any lining or pillows. Handles were also absent. In comparison to a regular pauper's white pine box, the same was true, no lining, pillow, or handles. However, the distinct difference between the two was that the "leper" coffins were not painted. The regular pauper's coffin was painted black. It was customary to burn any of the property belonging to a decedent if that person had been diagnosed with leprosy. The trash and other waste from the Home was burned rather than mixed with the general population's garbage. The burning of this waste took place along the side of the Home where the cemetery was located.

Hansen Church:

Just outside (to the left, looking at the entrance) of the Home is a church (see Figure 8.2). Figure 8.3 shows the interior of the church. This church was non-



**Figure 8.2: Non-Denominational Church used by residents of Hansen Home; Photo taken in 2002.**



**Figure 8.3: Inside of Hansen Church; Photo taken in 2002.**

denominational, where various ministers would rotate and offer services for the patients in the Home. A dedication stone is set in the concrete wall on the west side. It reads: "This stone was laid; By His Excely [Excellence] Sir Eustace Fiennes Bart; Governor of the Colony; The 21st April 1926" (Schroedl, 2000:35). According to one consultant, a missionary named Mr. Hope, who volunteered at Hansen Home, ministered each Tuesday. He also performed graveside services for people from the Home who were not members of a traditional church. There was another man, who will remain anonymous here, who volunteered countless hours to the care of the patients. He also coordinated a number of Kittitians to volunteer at the Home. This was also a time for the patients to see family members, who, with permission, could attend services with them. As patients became less able to walk to the outside church, services would take place in the Recreation Hall.

> Most of the residents belonged to separate denominations before their admission to the asylum. And as a matter of fact in the area the church up there had different priests who used to go up there. They had a separate father for the Methodists, a separate father for the Anglicans and so on (Consultant Interview).

Recreation Hall:

The patients could interact with one another at the Recreation Hall, but it was still divided. The males sat on one side and the females sat on the other. This hall was used for group activities, some Church services or events, and for serving meals. Visitors could also come into the Home and visit in the recreation hall, provided they had permission. It was also the site of the first television on the island in the 1960's. As the atmosphere relaxed, it is said that many people came to see the television despite it being kept in the Home. The television was evidently donated by a Church group in the United

States (Fieldnotes, 2000). Figure 8.4 is a landscape photo showing the Recreation Hall on the left, office and staff quarters on the right. Figure 8.5 is a photo of the Recreation Hall. Figures 8.6 and 8.7 are images of the interior of the Recreation Hall. These photos were taken in 2000. The buildings show neglect due to the closing of the facility and weather damage. By 2004, this building was completely destroyed (Gerald F. Schroedl, personal communication, 2005).

Holidays:

During the Christmas holiday, traveling troupes of masqueraders would participate in Christmas Sports, which included plays and dances. The masqueraders were dressed as Biblical characters, mummies, pilgrims, Indians (Caribs) and Africans. The preparation for this began after Hallows Eve. The masquerade always put the Home on their stop list; they would go to the Home and perform. This time of the year many people brought items for the patients. The masqueraders would earn tips for their performances. The patients at the Home looked forward to this event, and they also tipped the performers. Some of the patients who were long-timers really looked forward to seeing the children who would come by during this event. Easter was another holiday when special events took place. Dinner was served in the Recreational Hall. Those who wanted rum could get rum. Having any contact, especially emotional contact, with folks on the outside really brought joy to the majority of the residents. However, this contact also brought heartache. It was a stark reminder of their isolation.



**Figure 8.4: Recreation Hall on Left, Office and Staff Quarters on Right; Photo taken in 2000.**



**Figure 8.5: Recreation Hall; Photo taken in 2000.**



**Figure 8.6: Inside Recreation Hall 1; Photo taken in 2000.**



**Figure 8.7: Inside Recreation Hall 2; Photo taken in 2000.**

Polls:

Hansen Home is in the district of St. Anne's and during the years it was open it was also home to a polling station. The patients were allowed to continue exercising their right to vote. I was told that the majority of the patients were supporters of PAM, but then again, I was told this by a People's Action Movement supporter. I was also told that the majority of the patients were supporters of Labour, but then again, I was told this by a Labour supporter. I suspect that since several of the patients were from Nevis, that the political parties of Nevis, Nevis Reform Party (NRP) and Concerned Citizens Movement (CCM), were also represented.

Fun:

On the right side of the fort (again looking toward the gate) just around the corner was an empty field. This field was a popular spot for cricket games. On occasion, football (soccer) was played there. The patients would gather along the wall to watch. Some patients had their own radios and were avid fans of various cricket or football teams. Those who were capable played cricket. The last patient to leave the home was Olive Payne. She was best known for two things: her Bible and her cricket. Although she was very interested in politics and always voted, two things did not leave her side: her Bible and her radio for cricket games. From the beginning, the Home had a library that was stocked with donated books and magazines. *The Lazaretto* published updates on the donated materials. In 1891, the library at the Home received 152 magazines, fifty-six novels, and two other books (Boon, 1891:No 17). In later years, beginning around the 1950's when the library building was in disrepair and was not available to the patients. It

is unclear as to when the building became completely in ruin. The reading material was kept in a storage closet in Structure 5 (see Appendix B) and was available for the use of the patients and staff.

Jail:

There were two detention buildings; see Appendix B for exact locations of Structures 3 and 16 (Schroedl, 2000:10, 20). The oldest detention center, Structure16, was located on the women's side. The newer jail, Structure 3, was built probably after World War II and it was located on the men's side (Schroedl, 2000:11). Structure 16 may have been used for a women's detention center while Structure 3 was used for the men. Alternatively, Structure 16 may have also been used for some of the transferred prisoners who were serving time for a felony crime. Legislation called for all prisoners with leprosy to be transferred. The other structure, Structure 3, may have been reserved for those who committed offenses while residing in the Home. Given the location of Structure 16, it may have been converted to housing (Schroedl, 2002:20). The jail that remains dominant in the memories of my consultants is Structure 3. Structure 16 is in ruin. Structure 3 is divided into two rooms, each with an outside entry and a single window. In later years, one room was used for women and the other for men. Figure 8.8 shows Structure 3. Notice the bars on the windows.

Offenses committed while residing in Hansen Home required detention. These offenses were for acts such as escaping, fraternizing with the opposite sex, or starting a fight. Those incarcerated were, in some cases, subjected to hard labor. More often than not, males spent more time in jail than women. It is unclear whether or not a prisoner



**Figure 8.8: Hansen Home Jail; Structure 3; Photo taken in 2000.**

from the male jail in Basseterre, if transferred to the Home, was kept in the Home's jail or was allowed to roam about in the male quarters. Given that there were two detention structures; one may have in fact been used for the criminals. However, this, of course, would vary, I suppose, according to his or her crime.

In 1917, there was quite a debate between some government officials regarding jurisdiction, responsibility for capture, and capture of a "fugitive leper" (Administrator of Government, 1917:A7/21,22 [hereafter Administrator]). William Prince escaped custody and was known to be living or hiding in Lodge Mountain in labourers' shelters and subsisting by digging provisions and by milking peasants' cows. He was evidently touching labourers and peasants, both male and female (Administrator, 1917:A7/21,22). This individual was quick to run from capture and the police could not prevent his escape. The police defended their case by stating that they could not hand-cuff Mr. Prince, nor get too close to him. They admitted that some sort of hand-cuffs or rope needed to be used because Mr. Prince could "bolt" at any time. They also pointed out that Mr. Prince was not a criminal, just a person with leprosy, arguing that they had more serious duties to perform than tracking down a fugitive who was not a criminal and had never been arrested for a serious criminal charge (Administrator, 1917:A7/21,22). The public health threat was high enough for the jurisdiction to be lifted and all efforts made to capture the individual. The individual was at large from as early as June 9, 1917 to at least as late as December 8, 1917. There are two letters debating the issue of capture, responsibility for capture, and jurisdiction (Administrator, 1917:A7/21, 22). It is unclear whether or not he was caught. I suspect that if Mr. Prince were ever caught, he would

have spent a conditional number of days in the jail at Hansen Home. And if so, I also suspect that he would have attempted, even if not successful, to escape again.

Resistance:

Many attempts were made to escape, and some were successful. It was to the advantage of the escapees to scare the police, as many would not approach them. In 1890, *The Lazaretto* reported "it must be borne in the mind that to a leper breaking the laws, moral or penal, there are no consequences—the consequences fall on the member or members of the community who suffer for his crime" (Boon, 1890:No 10). The following letter was written to the Governor. Although the intensions of this letter were to prevent the patients from getting their way or manipulating the system, it also conveys what some patients were willing to do in order to get out, if just for a day.

> St. Kitts - Nevis No. 25 Government House 20th February 1905
>
> Sir, I have the honour to report that three lepers broke out of the asylum on the night of the 14th ultimo, and assaulted and severely beat a rural constable by name Daniel Richards, against whom they had a grudge.
>
> These men were ordered by the officer in charge of discipline at the Asylum cells as punishment for their offence [sic]; but they refused to obey and successfully defied the Asylum staff. They claimed that it was their right to be tried before a Magistrate, and as I believe they have this right. I gave permission for them to be brought before the Magistrate at Sandy Point, who committed them for trial.
>
> They were to have come up for trial during the present session, but I have learnt that they subpoenaed the whole leper asylum staff and many lepers, including some of the very worst cases. It is therefore, very undesirable that the case should be tried in the court house at Basseterre, and I have therefore instructed the assistant to the Attorney General to ask that the case may be postponed; to which the Chief Justice assented.
>
> The lepers who broke out of the Asylum are notoriously bad characters and a danger to the people in the vicinity of the Asylum against whom they have a grudge. I am therefore particularly anxious that they should be dealt with as severely as possible, especially as it is generally believed by the lepers that their unfortunate condition places them practically out of reach of the law and that the

worst that can happen to them is to be sent back to the Asylum cells. A trip to Basseterre therefore for the purpose of being tried, or giving evidence, is regarded more in the light of a holiday than anything else.

I understand from the Assistant to the Attorney General that the case could be tried at the Asylum if your Excellency could see your way to do this, as I hope may be the case. It would have an excellent moral effect upon the lepers.

I have the honour to be,

Sir, your most obedient humble servant,

---- ---- Administrator

One consultant recalled how some of the children would run in the area around the Home and yell out profanities that would call attention to the conditions of the patients. Some patients from the Home were known to respond to these children by hurling rocks at them as they ran away.

Children:

> I was there as a child. My mother worked there as a nurse for many years and we lived there. My mother worked from 7am to 4pm and was off until 8pm when she had to be back for lockdown. She got this extended until 9pm so she could care for her mother, my grandmother. I had to carry a dinner to my grandmother around 5pm after I ate with my mom about 4:30 at the Home. I got my first two novels from the Home's supply closet, which had donated records and books. I learned to ride a bicycle in the Home. The bike belonged to the manager of the Home (Consultant Interview).

Evidently, the workers did not fear the disease, as it was rather common for children to come around to wait on their mothers at the Home; or like the story above, the child lived in the Home with his parent who was a staff member. In 1891, The Lazaretto reports (Boon, 1891:No 16):

> We also have heard of one of the nurses lodging her two young children in her room in the asylum. We refuse to believe that such can be the case. The nurse no doubt would be quite ignorant enough of the frightful risks of contagion to do such a foolish thing, but no medical officer believing in the communicability of

> leprosy would allow it, and the Governor would not have appointed to such an office a medical man of whose knowledge of the communicability of leprosy he was not well assured.

Due to this rumor, Boon's proposed rules, No. 4 and No. 5, for the asylum included one on children and nurses (Boon, 1891:No 16):

4. Children, (not being themselves lepers) should not be allowed to reside in the asylum.
5. The nurses should not be allowed to give lodging in their quarters to any of their friends or relations.

There were very few if any children who lived in the home as patients. The only evidence of one is in reference to Olive Payne, who may have first arrived at the Home when she was thirteen. It is my understanding that she lived the majority of her life at the Home. She was the last one to leave the Home and was transferred to Cardin Home in 1996, where she died two years afterwards in 1998. Other than this account, all references to children were in response to them staying at the home with a staff member or to their being born to a patient and subsequently placed in adoption. One consultant recalls:

> I remember a girl who had a child to bear and you could not get the baby near her. We would give the baby to the nurses there and they would take the baby to the hospital and then there would be someone to adopt the baby. I can remember delivering the baby and him going to the hospital to be taken care of where it was then given to Mrs. ----- and she had him until he was a little boy. She gave him up for adoption to an American and he went to America to go to American schools. But the child would not be here if the mother had not been able to get the tablets. The tablets were good treatment and the mother was able to produce or bear the child (Consultant Interview). .

Breast feeding was not allowed for any new mother who was afflicted with leprosy. Babies were taken from their birth mothers so that the risk for transmission was reduced

if not prevented. Another consultant recalled a child being born in the home to a patient; the baby died shortly after birth. Forced adoption not only affected women, men were also impacted as well by the adoption policies of babies born within the Home to parents with leprosy.

> There was a chap who had sixty-four years here. He came here when he was twenty-four years in 1930. He developed influenza in 1992, but he spent sixty odd years here; he also had a son born here who's a doctor somewhere in England. His name is ----, he was born at the Hansen Home and reared at the Pogson Hospital and then somebody took care of him. There are other children born here who've gone to the States and things like that— the reason that we had a male side and a female, is that they didn't want a male to get along with a female... you know. So, there was a heavy restriction on that, but when they were caught with an infected male or a female alone in here they'd go to prison (Consultant Interview).

Allowance:

The patients earned a monthly allowance. They earned seven dollars a week and were paid thirteen times a year. The government provided food rations. If a patient wanted to buy something, s/he could ask one of the staff members to buy it for them. Patients wanted to work and earn money, as one consultant recalled:

> The patients could work odd jobs like tending to the gardens or cleaning. The ones who worked the most would get paid the most. They were always anxious to get the most money. They would do extra work. A garden duty man used to get paid for the work plus they used to give them fifty or sixty cents a week. So that money used to belong to the treasure and would be paid to them. We called it annuity (Consultant Interview).

Kitchen:

To the right, just after walking through the breezeway entrance, stood the kitchen where the cook prepared meals. The patients in the cottages were able to prepare some of their own meals. The same may be true for others, but the impression I got was that this

was an activity that took place once patients were unable to make the trip to the Recreation Hall where they would eat. Figures 8.9 and 8.10 are photos of the Kitchen taken in 2002.

Diet:

Table 8.1 shows a dietary schedule set forth by the government for the patients at the leprosarium for 1892 and 1893. The patients' chief complaint regarding the food was the lack of variety. There were only two scheduled meals a day in 1892. In 1893 another daily meal was added bringing the total to three daily meals. I do not offer an analysis of the caloric or nutritional intake of the patients, rather I will simply identify the types and quantity of food consumed. Table 8.2 shows the dietary schedule for 1898; by then there were four scheduled daily meals and additional fat allowances. There was more variety in the diet and more food in general. The difference in the tables from 1892/3 to the table in 1898 may be just a matter of what was officially the diet of the leprosarium, and a matter of logistics in terms of how long legislation took to make an official dietary schedule.

Table 8.3 shows the dietary schedule for 1925. This schedule took a while to create since debates about it stemmed from 1922 about the types of diets available. The 1925 scale was based on the scale and reports from 1922. The patients filed numerous complaints during this period about the quality of the food being served. Upon a number of inspections, the food was being handled with a lack of care. Minutes regarding the Home reported "[t]he dinner today, which was to consist of salt meat and sweet potatoes,



**Figure 8.9: Kitchen straight ahead; Photo taken in 2002.**




**Figure 8.10: Inside the Kitchen; Photo taken in 2002.**

**Table 8.1: Dietary Table for 1892 & 1893 Leprosarium Charles Fort — Data Collected from Bluebooks A5/63 and A5/64 from National Archives St. Kitts & Nevis**

| 1892 Dietary Table Leprosarium Charles Fort | Breakfast 9am | Dinner 2:30pm | Other |
|---|---|---|---|
| Monday - Sunday | 2oz sugar, 5oz bread<br>3oz milk | | Tobacco, Spirits<br>Hollands |
| Monday | | 12oz potatoes<br>½lb salt fish, 5oz bread | |
| Tuesday | | 12oz rice, ½lb salt fish<br>5oz bread | |
| Wednesday & Thursday | | 12oz potatoes,<br>6oz mutton, 1oz barley<br>5oz bread | |
| Friday | | ½lb cornmeal<br>½lb salt fish, 5oz bread | |
| Saturday & Sunday | | 12oz potatoes<br>6oz beef or mutton<br>1oz barley, 5oz bread | |
| **1893 Dietary Table Leprosarium Charles Fort** | **Breakfast 10am** | **Dinner 2pm** | **Supper 6pm** |
| Monday – Sunday | 5oz bread, 2oz sugar<br>6oz milk<br>½d chocolate or coffee<br>1/2d tobacco | | 5/4 oz crackers<br>2oz sugar |
| Monday, Tuesday, Friday | | 5oz bread<br>½lb fresh/salt fish<br>12oz rice, 1oz gin | |
| Wednesday & Thursday | | 5oz bread, 6oz mutton<br>1oz barley<br>12oz potatoes or ½lb<br>flour, 1oz gin | |
| Saturday & Sunday | | 5oz bread, 6oz beef<br>1oz barley<br>12oz potatoes or ½lb<br>flour, 1oz gin | |

**Table 8.2: Dietary Table for 1898 Leprosarium Charles Fort — Data Collected from Bluebooks A5/63 and A5/64 from National Archives St. Kitts & Nevis.**

| 1898 Dietary Table Leprosarium Charles Fort | Early Morning 8am | Breakfast 10am | Dinner 2pm | Supper 6pm | Fat Allowances |
|---|---|---|---|---|---|
| **Monday – Sunday** | ½ pt hot water 1oz sugar 2oz bread | 3oz milk, 2oz sugar, 4oz bread ½ pt tea, choc. or coffee | | 3oz milk 1oz sugar 3oz crackers | 1lb of fried fish – 1oz pork 1lb boiled fish – 1/4oz butter |
| **Monday, Tuesday, Friday** | | | 4oz bread, ½lb fresh/salt fish 4oz rice, 8oz potatoes | | 1lb salt fish – ½ pork, Boiled rice – ½oz butter |
| **Wednesday** | | | 4oz bread, ½lb mutton soup, 1oz barley, 8oz potatoes, 4oz cornmeal | | Boiled cornmeal – ½oz fat pork 5lb mutton – 1oz butter |
| **Thursday** | | | 4oz bread ½lb mutton stew ½oz flour, 4oz rice, 8oz potatoes | | Vinegar and salt – to taste. Fowl soup – 3 times a week for a few weaker patients |
| **Saturday** | | | 4oz bread, ½oz barley, ½lb beef in soup, 4oz rice, 8oz potatoes | | Up to 5 mangoes each during season on Sat. 2lb trussed fowl, 2oz barley |
| **Sunday** | | | 4oz bread, ½lb corned beef, 4oz rice, 8oz potatoes 4oz bun | | 2oz salt pork ea. gal. of broth ½lb tannias, 1oz butter, 1oz herbs, Herbs and Thyme |

**Table 8.3: 1925 Hansen Home Dietary Schedule: Data Collected from Minutes 805/1922 and 1925 from National Archives St. Kitts & Nevis.**

| 1925 Dietary Table | Leprosarium Hansen Home Ordinary Diet |
|---|---|
| Dailey Totals | 13oz Bread, 4oz Sugar, 6oz Milk,<br>Tea, Chocolate, or Coffee = ½ pint for each patient |
| Early Morning 6am | **Sat.** = sugar 1oz with hot water and 3oz bread |
| Breakfast 10am Daily | **Sun.** = one egg when obtainable; when eggs are not obtainable cheese 1oz for each patient / **Mon.** = fat port, 1½ oz for each patient / **Tues.** = cheese 1 oz / **Wed. & Fri.** = ¼lb fresh fish / **Thurs.** = ¼ salmon tin / **Sat.** = sausages 1 ½oz |
| Dinner 2pm Daily | **Sun.** = ½lb fresh beef, 4oz rice, 2oz split peas, 8oz potatoes / **Mon.** = ½lb salt fish, ¼ flour, ½ potatoes / **Tues.** = 3oz salt beef, 1pint split pea soup, ¼lb flour 4oz rice / **Wed.** = ½lb mutton, ½ pint roasted or mutton soup with ½lb boiled mutton, 8 oz potatoes, 4 oz rice. / **Thurs.** = ½lb fresh pork, 4oz cornmeal, 8oz potatoes / **Fri.** = ½lb salt fish, ¼ lb flour, 8oz potatoes<br>**Sat.** = ½lb fresh pork, 4oz rice, 8oz potatoes |
| Supper 6pm | **Tues.** = sugar 1oz with coffee, tea, or ½ pint chocolate, 3oz bread, 1oz cheese<br>**Sat.** = sugar 1oz with coffee, tea or ½ pint chocolate, and bun |
| Pudding Recipe Serving 8 | Sago, Tapioca, Arrowroot or Rice ½lb<br>2pints Milk, ½lb sugar, and special flavor |
| **1925 Dietary Table** | **Leprosarium Hansen Home Milk Diet** |
| Monday – Sunday | 3 pints of Milk daily for each person |
| Thursdays | ½lb fresh pork, 4oz cornmeal, 8oz potatoes |
| Fridays | ½lb salt fish, ¼lb flour, 8oz potatoes |
| Saturdays | 4oz bun |
| Doctors' Orders | Fresh fruit when obtainable. **No substitutes** allowed even if it is the same price<br>Special Diet = Soups: fowl, Pea or tannia, and mutton |
| Supper 6pm | **Tues.** = sugar 1oz with coffee, tea, or ½ pint chocolate, 3oz bread, 1oz cheese<br>**Sat.** = sugar 1oz with coffee, tea or ½ pint chocolate, and bun |
| **1925 Dietary Table** | **Leprosarium Hansen Home Invalid Diet** |
| Early Morning 6am | **Sun.– Fri.** = 1oz sugar with hot water, 3oz of bread |
| Breakfast 10am | **Mon. & Fri.** = sago pudding / **Tues.** = tapioca pudding / **Wed.** = rice pudding<br>**Thurs.** = arrowroot or corn flour pudding<br>**Sun.** = tea, chocolate or coffee ½ pint, 3oz bread, 2 oz sugar, 1egg |
| Dinner 2pm | **Sun.** = 1pint beef soup with Irish potatoes or tannias, ¼lb bread & butter pudding<br>**Mon.** = 1pint fowl soup with ¼lb flour dumpling **Tues.**= 1 pint pea or tannia soup with ¼lb potatoes / **Wed.**= 1pint mutton soup with ½lb sweet potatoes / **Thurs.**= Pea or Tannia soup with ¼lb flour dumpling / **Fri.**= fowl soup ½ pint with ¼lb flour dumpling<br>**Sat.** = beef soup ½ pint with ½lb potatoes |

was lying about in this dirty store-room; no attempt being made to keep it clean" (Administrator of Government 805, 1922:1 [hereafter Government]). By 1925, they continued with four scheduled meals per day and fat allowances. However, during this time there were more complications with the diet. Patients were either on an "ordinary diet," a "milk diet," or an "invalid diet." While the variety in the meals was not drastic, there were no substitutions allowed. In other words, if a patient who was on the ordinary diet wanted to eat the potatoes instead of rice, this would not be allowed. The policy against permitting substitutions was the chief complaint among the patients. Although the diet was the major concern of the ration report, the availability of items like soap and oil also differed in quantities and frequencies of distribution (Government, 1922:1). I do not have records regarding the diet afforded the patients in the later years of the Home, but I suspect it did not change much in terms of the kinds of food being offered. My impression, given the debates about the problems patients were having with substituting items, is that the strict meal plan of 1925 was relaxed by the 1930's. I do know that in the later years many of the patients cooked their own meals in their room and or would go to the kitchen and request a particular meal. Most of the rooms were equipped with portable hotplates, so if patients wanted to cook oatmeal or make tea in their rooms they could do so with ease. The majority of the patients in the later years were simply not able to walk to the Recreation Hall or to the kitchen, so either the cooking was done in their rooms or a staff member carried a meal to them.

A cistern measuring 5.25m wide and 14.5m in length was used for the storage of water (Schroedl, 2000:33). This structure was part of the original fortress (Schroedl, 2000:33). It was perhaps used up until the public standpipe or water pipe was installed in

the 1930's (Payne, 2001:2). Water was obtained through this standpipe for cooking, and hygiene related activities.

Garden:

Despite apparent dietary limitations because of an absence of a variety of fruit and vegetables patients were able to supplement their diets by tending to gardens, fruit trees, and raising fowl, goats, sheep, and the occasional cow. In 1891, *The Lazaretto* reports the delivery of 300 ornamental plants, chiefly crotons, to the leprosarium. It is not known just how many plants were brought into the garden or how many were naturally growing within the boundaries of the Fort, but what is known is that the patients tended to an elaborate garden. Boon argued for rules advocating (Boon, 1891:No 16):

1. No poultry or live stock should be kept in or near the asylum.
2. No food should be allowed to be sent out of the asylum and visitors should be rigidly searched on leaving.

Both of these proscriptions were ignored. Chickens, sheep, and goats were kept and cared for by the patients. This may have been an avenue for the patients to earn their allowances. Furthermore, it gave patients some sense of responsibility as well as an activity to keep them occupied. Evidently there was a cow that stayed there, but I do not know if this was a milking cow or one raised for slaughter. Perhaps there were more cows, but sheep and goats were kept more frequently. They were allotted the surrounding area just outside of the Fort to serve as grazing land for the livestock. Men had a separate area to cultivate just outside of the Home.

As for plants, there were all kinds of flowers, fruits and vegetables. The most recognized and remembered flowers were the roses. Almost everyone remarked about

the beautiful rose gardens within the Home. Also herbs, tea bushes, and thyme were abundant. In terms of fruit, they had mango, breadfruit, passion fruit, oranges, bananas, tomatoes, and grapefruit. As for vegetables, they grew beans, cucumber, cabbage, eggplant, sweet potatoes, Irish potatoes, green peppers, yams, peas, and squash. Cabbages were mentioned over and over again during talks with consultants. The cabbages were unusually large; one consultant estimated the cabbage to be as big as four pounds. A similar comment involved a fruit, the "biggest bunches of bananas you ever see" (Consultant Interview). Questions linger even today about how cabbage (or bananas) could grow so big in the Home and not in other places when the soil is the same. Perhaps the soil in the Home was more fertile or perhaps it was due to something altogether different. It was explained to me this way: "some of them use Obeah" (Consultant Interview). When I heard this at first I did not understand. Therefore, I sought out people who could explain this to me.

> I spoke with a woman whose mother was said to be an obeahwoman. Her mother was accused of this due to her quick recovery from leprosy. The mother went to Hansen Home as a patient and only lived there a short while. The mother came home and never had the disease again. As a result, it is said that the mother was an obeahwoman. The daughter with whom I spoke taught me a little about obeah. The daughter said that some people accuse her of being an obeahwoman like her mother. As I visited this consultant's home, I noticed a crucifix, ears of corn tied, a water glass, and an aloe plant on the door. I asked about the significance of any of these items. She said that the water glass in the window was offered for good spirits. The aloe plant over the door prevents spirits from crossing into her home. This consultant continued to explain obeah's role in the garden at the Home. She said that the reason the cabbage and the garden in general was so big was due to obeah. Clarifying that people were jealous and envious of even those in the Home. She continued stating that since a number of the patients in the Home were from Nevis, and since Nevis has better obeah than St. Kitts, it was not difficult to understand why the fruit and vegetables cultivated by the patients, especially those from Nevis, would be larger than what is normally grown in St. Kitts (Fieldnotes, 2002).

Figure 8.11 is a photo of the garden inside the Hansen Home. This picture postcard, which was produced by V.E. John, was probably taken either in the 1920's or 1930's. It is the only known photo of the inside of the Home. Although the photo is not clear, it is evident that the gardens were carefully designed, maintained, and beautiful. The original postcard has a caption stating "Garden Leper Asylum, Basseterre, St. Kitts, BWI." It is interesting how this representation positions the leprosarium in Basseterre.

Whether obeah fertilized the gardens or not, people from the outside sought the goods grown in the Home. Dr. MacLean, a medical officer and medical superintendent in the 1950's, made an impression on many people with regards to leprosy and obeah. This doctor evidently assisted with planting crops. He was instrumental in alleviating the fears associated with the food that people with leprosy touched.

> Dr. MacLean showed people that leprosy was not contagious. He ate cabbage and other foods from the Home. MacLean could deal with obeah; he could tell if obeah is being worked on you (Consultant Interview).

Frequently, people would buy or trade for the foods produced in the garden. Despite the warnings against buying anything from the patients, people did it anyway. Furthermore, there were many people who were simply hungry and it was known that several patients would save a meal for someone on the outside.

Sanitation:

It was not uncommon for a person diagnosed with leprosy to have their property burned. In some cases this meant that their home was burned along with all the property within it. In other cases, this meant that their clothing was burned. The trash



**Figure 8.11: Picture postcard of the interior of leprosarium Hansen Home by V. E. John (Schroedl, 2000:6); Note that the caption does not show.**

and waste from Hansen Home was taken outside of the Home along the south side near the cemetery and burned. Once a person died, their belongings were also often burned.

Throughout St. Kitts, public latrines and public baths were established to provide better living conditions and to create better public health. These were implemented during the 1930s and 1940s (Payne, 2001:2). Inside Hansen Home, patients had access to toilets, bath, and laundry facilities. Bath and laundry facilities were provided on both the male and female sides of the Home. A toilet was placed along the dividing fence, with the north end was for men and the south end was for women (Schroedl, 2000:25, 26, 28). A new toilet was built in 1973 to accommodate the women's side of the facility. Once all patients were moved to the women's side of the Home, this toilet accommodated the older more infirmed patients who could not walk the distance to the other facilities.

Staff:

The on-site staff members included people holding the following positions: managers, guard, orderly, nurse, maid, and cook. They were given living quarters on-site, but most if not all had additional living arrangements outside of the Home. The doctor assigned to Hansen Home was the chief medical officer for Sandy Point and Pogson Hospital. He did not live at Hansen Home, but resided in Sandy Point. All of the former workers at the Home whom I met and consulted were from Sandy Point. Besides their given duties (changing beds, washing clothes, changing bandages, giving medication, cooking food, ordering supplies, maintaining order), there is little evidence about how the staff interacted with one another. I did learn that in the later years of the Home's existence, when the staff members had free time, they would at times play cards

or dominoes together. These activities took place when there were fewer than ten patients. The staff members in the early years followed the diets and food rations offered to the patients. In the later years, they were known to bring Coca Cola to some of the patients. The most recent staff members were very concerned with the care of the patients. They did their best to accommodate the patients' every need. Some patients would confide in particular staff members, and others were probably seen as the only family they had. If a particular specialty item was wanted, staff members would make an effort to secure this item for the patient. Olive Payne was rather attached to the nurse who took care of her at both Hansen and Cardin Home. Olive's nurse transferred to Cardin Home with the closing Hansen Home. This nurse put forth an extra effort of truly caring.

Curfew:

The staff members and patients were both subjected to a curfew. The staff was given a period of time off during the day to tend to their own families, typically at 4 pm. The staff members had to return by 6 pm for lockdown. This was when the gate coming in the Home and the dividing gated fence within the Home were closed, thus segregating the men from the women. This was done in an attempt to prevent runaways. At 9 pm, there was a roll call which meant that all the men and women were accounted for in their respective rooms. However, as soon as this was over, those who were going to sneak-out, did so.

Class:

Leprosy is a disease that afflicts people of all classes. In 1890, Boon classified people with leprosy into three classes: 1) educated class, 2) middle classes – shop keepers, handicraftsmen of the best sort, and 3) the labouring population. Given enough money, Boon would have advocated for three separate asylums, but he created a budget for an asylum to house 250 "pauper lepers" (Boon, 1890:No 11). In Boon's budget, he claims that the estimated number of people with leprosy in the Leeward Islands was 300. He states that of these 300, ten to twelve are of the first class, forty to sixty are of the second, and the rest are of the third class. Boon goes on to note (Boon, 1890:No 11):

> "Naturally, these poor wretches included in the latter class (third) are more poverty stricken and degraded than the others, more indifferent to family ties and to home associations. For them one common asylum, as has been proposed, is the best thing, the farther removed from the centres of population the better."

Boon also applies a number of characterizations to people with leprosy such as "lepers are very jealous creatures" (Boon, 1894:No 39) and that (Boon, 1890:No 12):

> "Lepers of the better classes do not, as a rule, show the hideous deformities of the tuberculous type. Good living and cleanliness retard the progress of the disease, and, if with a strong constitution, sometimes end in triumphing over the disease."

Boon (1890:No 10) and his subscribers display their arrogance towards people with leprosy through their fight for compulsory segregation despite class differences. For example:

> "There seems to be some inherent quality in Leprosy that perverts the moral sense of its victims. It is notorious that lepers of all classes exhibit a selfishness and what may be termed an active disregard to the safety of others in the matter of contagion. We are prepared to give names and facts (and not isolated ones) to prove that this charge applies to the upper quite as much as to the lower classes of lepers in this Island. The knowledge of this fact is one of the chief reasons of our instance that Compulsory Segregation of All Classes is the only means of providing for the safety of the Community."

Since Boon supported a compulsory segregation model, he did not agree with the policies that the Governor set forth regarding the ability to declare any property a "leper home" (see Chapter 7 for a discussion of "leper act of 1890 and of 1912"). This ability allowed for individuals who were of the higher economic and social classes to be quarantined and treated at home. Anyone who could afford both the bond and private medical care could take this option. A good majority, however, were not so lucky.

The occupations of many of the patients were remembered by the staff members with whom I consulted. Several people were skilled in crafts. One man was a tailor from Nevis. Another was a teacher from Nevis. Some of the ladies had worked as nursing assistants, maids, and cooks. Continuing to work in many of these positions were forbidden by order of the 1912 revised "Leper Act" (Legislation, 1912:217lepers). For some, conceding to a life inside of Hansen Home meant giving up not only a life in which they were treated as human, but also giving up the status that came with their previous occupations or the income they secured in their previous occupations.

Olive Payne:

I have mentioned Olive Payne a number of times thus far, but I want to expand a bit on her and her life. Figure 8.12 is the cottage identified as the one in which she lived. Some consultants referred to her as Alice Payne, but on authority of Hansen Home records and from her nurse, her name was indeed Olive. From all indications, Olive came to Hansen Home as early as thirteen. From what is known, she lived the majority of her life in the Home. She was the last patient residing at Hansen Home in 1996. Her




**Figure 8.12: Olive Payne's Cottage; Photo taken in 2000.**

leprosy was non-contagious. She could have been discharged, but she chose to live at the Home. Olive may have been from Tabernacle or from St. Paul's, villages in St. Kitts. She had a brother who was also afflicted with leprosy, but he spent the majority of his life on the outside. Edwin Spanner is reputed to have been her brother. However, I found in the death records a man named Samuel Payne who died in 1981 at the age of 64. Perhaps this was her brother or a relative. In 1996, she transferred to the Cardin Home where she remained under the care of one nurse who was also transferred from Hansen Home. In 1998, Olive passed away; she was in her eighties.

Olive was a devoted Christian. She loved her Bible and she took comfort in her faith. Olive was also a devoted cricket fan who would anxiously sit next to her radio while she listened to a cricket match. Politically, Olive was very active. She wanted to know everything. She was eager to hear the latest and was always ready to vote. She lived in a cottage on the female side of the Home. Its address was number ten.
Olive had difficulty getting around. Her bandages were described as "soiled with blood"; she practically walked on her knees (Consultant Interview). Despite this, she was always friendly and had a smile.

Other Structures:

Some other features are worthy of mention. The gothic shaped entrance to the Home has a wood painted sign above which reads "Hansen House," see Figure 8.13 (Schroedl, 2000:38). I have used "Hansen Home" to keep consistent with the archival record. Figure 8.13 and 8.14 are photos of the entrance; Figure 8.14 is a photo taken while the Home was still in use (Heyliger-Dolphin, 1987:20). The male in the image

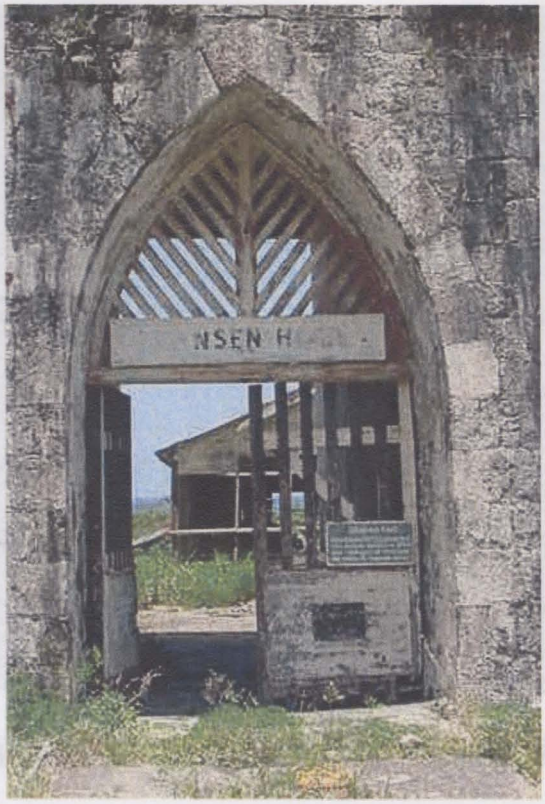



**Figure 8.13: Entrance to Hansen Home; Photo taken in 2002.**

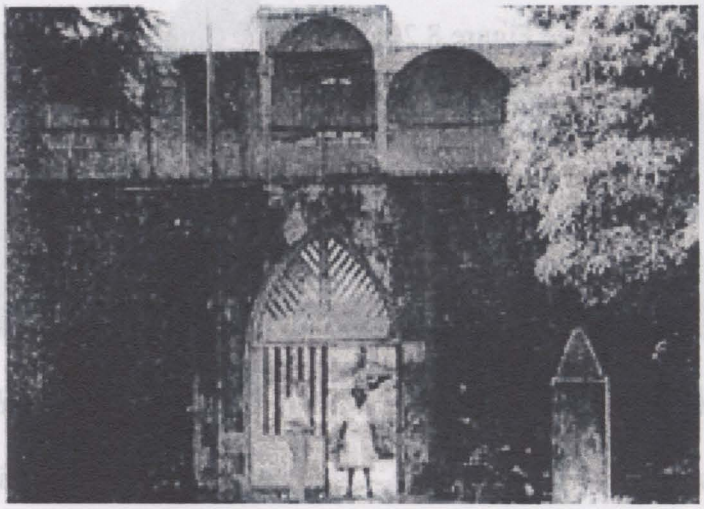


**Figure 8.14: Entrance to Hansen Home while still in use (Heyliger-Dolphin, 1987:20).**

is probably a medical doctor and the woman at the gate is probably a nurse. The gate itself has a solid bottom and a wooded planked upper. The bottom panels faintly say "Out of Bounds." The right gate has a sign stating "Charles Fort; Founded in 1672 Converted; into a leper asylum in 1890" (Schroedl, 2001:38). Just inside the gate, on the right side of the wall, rests a white marble plaque, see Figure 8.15. According to one consultant, there was a large amount of money awaiting use for the care of the facility and patients. Accusations against political parties and political figures surround the discussion about this money. I did not find any record of the funds left to benefit the well being of the patients, but I suspect that these records were among the many that were severely water damaged.

The types of housing available for the patients varied, but the structures that were used in the last decade of the home still remain. The following figures represent these cottages, see Figures 8.16, 8.17, 8.18, 8.19 are cottages use for patient housing. Patients also had access to a clinic (see Figure 8.20), where the Chief Medical Officer visited, and a dispensary (see Figure 8.21), where their medication was distributed.

Chapter Summary:

This chapter has painted a picture of what life was like on the inside of Hansen Home. The facilities available to the patients are described as well as the activities in which the patients were able to participate. The Hansen Church is also discussed along with the burial records and practices in the Hansen Cemetery. The dietary schedules for a number of years are outlined. The garden, which supplemented the meals provided by




**Figure 8.15: Wilford Duncan Thompson benefactor of the patients at Hansen Home; Photo taken in 2002.**



**Figure 8.16: Patient Housing Cottages; Photo taken in 2000.**



**Figure 8.17: Patient Housing 1; Photo taken in 2000.**



**Figure 8.18: Patient Housing 2; Photo taken in 2000.**



**Figure 8.19: Patient Housing 3; Photo taken in 2000.**



**Figure 8.20: Patient Clinic; Photo taken in 2000.**



**Figure 8.21: Patient Dispensary; Photo taken in 2000.**

the government, is discussed in light the connection that patients had with people on the outside. The only patient who is discussed at some length is Olive Payne. Several photos and descriptions are provided in order to give a holistic impression of Hansen Home. The following chapter discusses the lives of several persons with leprosy who were not residents at Hansen Home.

# Chapter 9: Cleverly Hill — Life on the Outside

This chapter discusses how persons with leprosy lived on the outside of Hansen Home. Many patients were discharged from Hansen Home once it was determined that they were no longer contagious and that treatment was complete. This chapter aims to give the people who have been depicted as the "living dead" as actual engaging individuals with true emotions, beliefs, and actions.

## Cleverly Hill:

Cleverly Hill is on the southern end of Sandy Point just below Brimstone Hill; it is the hill on which Charles Fort rests. Cleverly Hill sits on the boarder of the area called New Guinea, but is technically part of Sandy Point. New Guinea or New Guinea Estate sits between Sandy Point and Half Way Tree. New Guinea is not marked by a sign or by a tourist attraction, but it is the area that is identified with the former patients of Hansen Home. Figure 9.1 is a map which focuses on Sandy Point, but it includes Half Way Tree. On this map, the area between Charles Fort (more specifically just south of the road going to Brimstone Hill) and Half Way Tree is the area defined as New Guinea. Although it may look like it is quite a distance, it is less than a mile.

Figure 9.2 shows a map of the area marked as Sandy Point. Charles Fort is included in this map that indicates the use of the land in Sandy Point for 1977. The area surrounding Hansen Home is identified as an "open space in the built up area" (V.O.W., 1977:5). The plot to the north of the Home is where cricket matches took place. The plot to the south of the Home is where the livestock from the Home were kept and where many discharged patients made their new homes. In 2000, I lived in a guest-house in

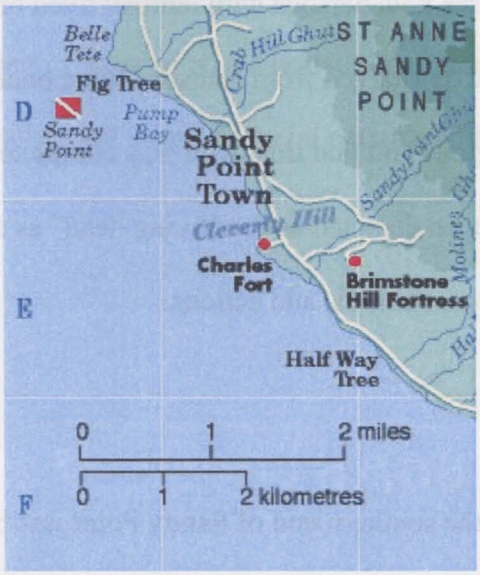



**Figure 9.1: Close Up of Sandy Point; (Caribbean-on-line.com, 2002).**

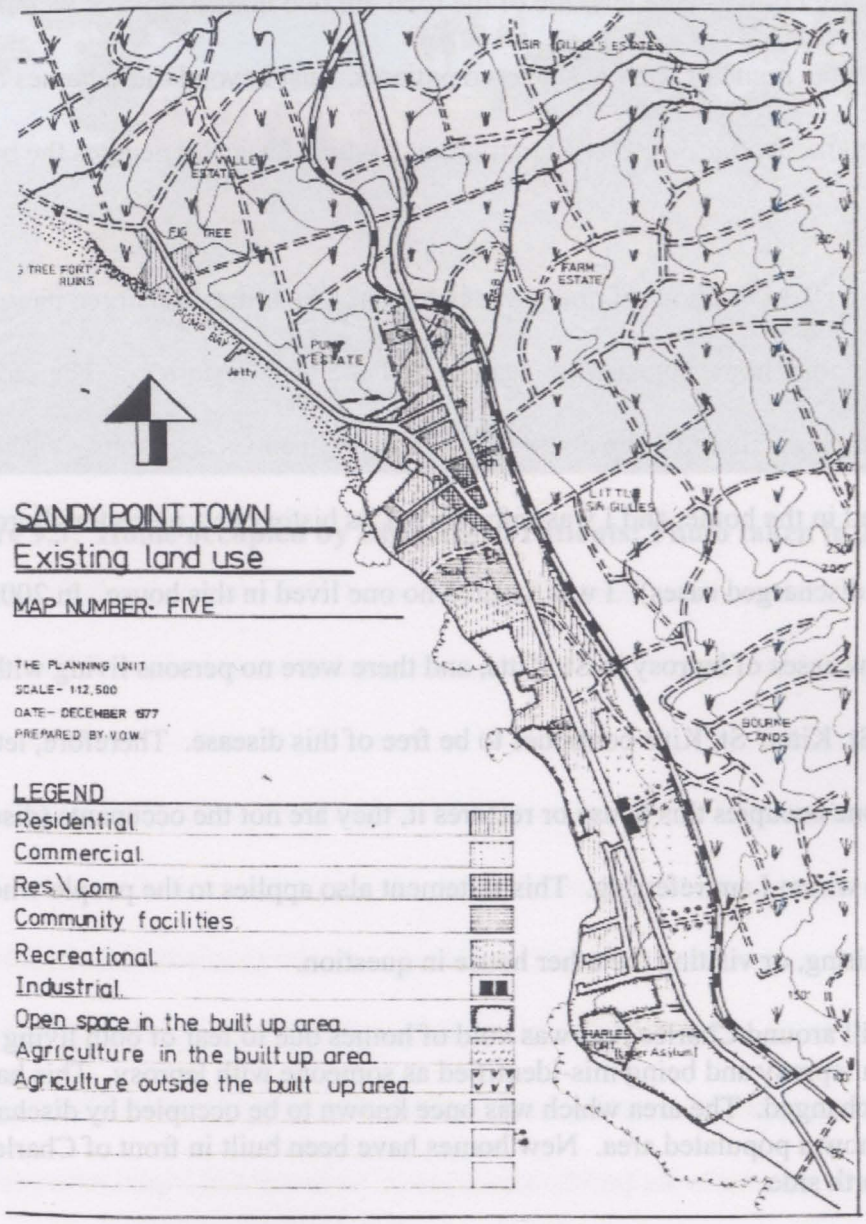



**Figure 9.2: Sandy Point Town Map December 1977; Courtesy of the National Archives of St. Kitts and Nevis (V.O.W., 1977).**

New Guinea. This house sat just beneath Brimstone Hill; several homes were located behind the house I lived in, but they were not directly along the main road. Further north towards Sandy Point, on the left side of the road are two homes, both of which were known to be the home of some discharged patients. Just beyond these homes on the right is the landmark "Dollar Stretcher Supermarket," which basically denotes the beginning of Sandy Point.

Figure 9.3 is a photo of one of the homes in which the discharged patients lived. In 2002, the other home appeared to be occupied and/or in restoration. Therefore, I did not photograph that home. The home I did photograph appeared vacant. I asked if anyone lived in the home, and I was informed of its history as a place for "burnt-out lepers" (or discharged cases). I was assured no one lived in this house. In 2002, there were no new cases of leprosy in St. Kitts, and there were no persons living with the disease in St. Kitts. St. Kitts continues to be free of this disease. Therefore, let it be clear that if anyone occupies this house or restores it, they are not the occupants (discharged patients) to whom I am referring. This statement also applies to the people who were living, repairing, or visiting the other house in question.

Cleverly Hill around Charles Fort was void of homes due to fear of both living near people with leprosy and being mis-identified as someone with leprosy. This has drastically changed. The area which was once known to be occupied by discharged patients is now a populated area. New homes have been built in front of Charles Fort and along its north side.



**Figure 9.3: Home occupied by Discharged Patients; Photo taken in 2002.**

Discharged Patients:

Not everyone with leprosy lived at the Hansen Home. However, those who were discharged would often stay close by. Once a patient was discharged from the Home, they were free to do anything. Although this sounds promising, they were still very much still prisoners – prisoners of leprosy. They still had to abide by the rules set by the Leper Act of 1912 concerning job restrictions. Too often, due to the persecutions of life on the outside, they would often return to the home for the comfort and security it offered.

The people with leprosy mentioned in this section are deceased. Perhaps they are buried along the side of Hansen Home. Although they are physically gone, they live on through many stories told about their lives. I will mention four such persons who are imbedded in the memories of many Sandy Pointers. These four individuals are also mentioned in S.B. Jones-Hendrickson's autobiographical novel of his childhood, published in 1991.

S.B. Jones-Hendrickson wrote a novel entitled *Sonny Jim of Sandy Point.* This novel is based on fictionalized accounts of real life experiences; however, the author also qualifies "any resemblance to any person living or dead is purely coincidental" (Jones-Hendrickson, 1991). This novel mentions several people with leprosy and people who interacted with people with leprosy both inside and outside of Hansen Home. While he may claim that the names are purely coincidental, I interviewed a particular person mentioned by name and occupation in the book who was quite annoyed how she was represented. My consultant insisted that although the names and occupations matched real people, the story narrated about them was largely fictional. Although the names may be "purely coincidental," I found that many of my consultants were unaware of his book

or of its contents. Nonetheless, these consultants informed me about many of the very same people featured in Jones-Hendrickson's book. Based on the historical record, Hansen Home documents, and on interviews with consultants, the following persons did indeed live in Sandy Point and did shape the local knowledge of leprosy.

Sam:

> Sam got a fish from Willy George. The fish gets him on his arm and it starts bleeding – didn't feel it. Finally he puts the fish in a bag and wrapped it around his arm. He had no fingers to hold the fish. He didn't know the fish was biting him (Consultant Interview).

The above story was told to me with much laughter. What was evidently humorous about this event was that Sam, as this person was called, could not feel the fish biting him. The fish was not dead and was resisting like any fish would out of water. Sam could not grasp the fish with his hands so he was doing the best he could using his forearms. The fish was placed in a bag, which he could not properly hold except with his arms.

Sam was a discharged patient, a "burnt-out"; "a burn out" refers to someone who is no longer contagious, a state that some call "cured." According to death records from Hansen Home, this Sam may have been Samuel Payne. Sam was disfigured as a result of leprosy. He was a "leper," a "cocobay" who, along with a few other very well known persons with leprosy in St. Kitts, was in some ways larger than life. Sam was rather quiet; he did not speak to people when passing. For obvious reasons, Sam was probably trying to avoid being laughed at or teased. Sam had been written about before by Sandy Pointer S. B. Jones-Hendrickson. The "Sam" Jones-Hendrickson wrote about stood five

feet, six inches tall and rode a bicycle up and down Cleverly Hill (Jones-Hendrickson, 1991:170-2). I draw a link between the Sam who was written about, and the Sam I heard described in the above story. Furthermore, I sense a possible connection between this Sam and one described to me by a different consultant. In this interview, a man named "Samuel" was said to work at the Hansen Home in the garden. He left this position to work with the government, but after a while he returned to the Hansen Home because he had no one to care for him. Evidently, in Samuel's case, his leprosy was inactive, non-infectious, or "burnt-out" as it was called; nonetheless, he chose to return to the Home for further care (when he had no one else to attend to him) (Consultant Interview). Samuel Payne died at Hansen Home in 1981 at the age of sixty-four. Returning to Hansen Home was a very common thing for many of the discharged patients who suffered persecution. Many of the burnt-out cases never left the Home, or if they did, they were not gone for long.

Sam was just one individual I heard about during the course of my research. Many more interesting people were recalled. In talking with consultants about their interactions with survivors of leprosy, I found that the stories gave vivid characterizations of these individuals. Surprisingly, many consultants assumed that the people with leprosy, whom they were describing, were devoid of feeling. This is a common assumption, but it ignores the emotions that the people with leprosy did indeed have. These same consultants, when describing these "people who could not feel" portrayed them very charismatically.

Crab and Memjoe:

Two more individuals who lived with leprosy on the outside were known as Crab and Memjoe ("Mem-Joe," as Jones-Hendrickson writes). These were individuals about whom S. B. Jones-Hendrickson wrote as well. Intrigued by Jones-Hendrickson's accounts, I asked my consultants about each of these documented names. No one remembered a person known as Crab, and only in one case did the name Memjoe ring a bell.

According to Jones-Hendrickson, Crab was cured of leprosy, but remained debilitated from the physical side effects of the disease. He was about "two-feet off the ground" and moved about using a "bench and a stick"; he "crawled" and "looked like a crab" (Jones-Hendrickson, 1991:172). Crab was rather tortured by kids who would steal his stick or his bench leaving him helpless; Crab retaliated with using "bad words" aimed at his tormentors' mothers (Jones-Hendrickson, 1991:172). He evidently lived a miserable life full of persecution.

Memjoe, on the other hand, was the only woman outside of the Home who was recalled. According to my consultant, Memjoe had a real bad case of leprosy, but never lived in the Hansen Home. Jones-Hendrickson describes her has having a "post-hole nose" (Jones-Hendrickson, 1991:174). It was not uncommon for the nose to be heavily infected by the disease, where the nose is often described as "falling off."

Spannerman:

Another person with leprosy who lived on the outside of Hansen Home is known by two names: "Spannerman" and "Man-Above." I will refer to him as Spannerman (or

"Spanner-man," as Jones-Hendrickson writes). When I asked my consultants about known patients with leprosy, Spannerman or Man-Above was the tip-of-the-tongue response.

The Hanson Home records indicate that Spannerman's name was Edwin Spanner and that he received treatments periodically. Spannerman did not make a habit of extended-stay visits to the Home, but he was known to go there from time to time when he was most ill. Spannerman would return to the home in his later years, and he stayed there until his death in the 1980s.

Spannerman has an interesting history that I think is sometimes transferred to Sam, or possibly vice versa. Of specific interest was the fact that Spannerman was known to ride a donkey and a bicycle. I have more accounts of him riding a donkey than a bicycle. Those who said he rode a bicycle were not familiar with Sam, and Sam's own bicycle-riding exploits. On one occasion, I was corrected with information identifying Sam as "Man-Above." While it is possible that "Sam" could be another name for Spannerman, I do not believe this is the case. Spannerman, due to his notoriety, probably transferred his reputation to Sam. Surnames that have been associated with Sam include: Walton and Watson. Death records as I mentioned above indicate a patient named Samuel Payne. Spannerman's surname is also documented in the records at Hansen Home. However, Spannerman is said to have received this name "Spannerman" in one of two ways: (1) "Spanner" was his father's surname and Williams was his mother's surname, therefore, "Spannerman" was only a nickname; or (2) a spanner is a tool used to turn a nut on a bolt. Spannerman had hands that were withdrawn, due to leprosy, and looked like a spanner.

As I previously mentioned, Spannerman was also known as "Man-Above." The story behind this name is interesting; it definitely makes for good gossip. The story goes as follows: Man-Above was a ladies' man. A man challenged him to prove that he could "get with women." So, Spannerman told his challenger to go to a certain place, specifically an out-of-the-way tree. The challenger went to the specified location and hid up in the tree. Spannerman took a lady up to the foot of this tree and had sex with her. During intercourse, Spannerman said to the challenger in the tree, "Man-Above, you see what I do; you see I get the women." The challenger returned home and told everyone the "Man-Above story." This woman has been described as cheap, but her role is not relevant except in one way. Evidently, the woman thought that Spannerman was talking to God, while they were having sex. This same story was told to me about Sam, whose surname was Walton, as recorded in Hansen Home documents. The only variation in the story is that instead of a man being up in a tree, he was up on a wall outside of the Hansen Home.

One consultant was friendly, but not friends, with Spannerman. This distinction was very important to the consultant as he did not want to be linked to Spannerman in any way other than as an acquaintance. I suspect this is due to the legacy that still assigns a stigma to those with the disease/illness leprosy. Spannerman told him how he got leprosy.

> Spannerman said that someone had put something in his water. He left containers at the foot of the mountain to collect water for bathing. Shortly after bathing he started itching and his skin turned black. He was born with "fair light skin" and he would often pull his shirt up and show his original color (Consultant Interview).

The "something in the water" was explained to be the work of obeah. Spannerman was a successful man, and it was thought that someone was jealous of him. He was also known "to have many women," which could also have been the root of jealously. Spannerman was said to be a "ladies' man." According to several people, he had lots of children, none of whom would ever admit to being his child. Evidently many women were attracted to him, despite his appearance. It was suggested that it was due to his wealth.

Spannerman was a character whose life story is larger than life. He was known to have a bicycle, a donkey, a boat, and a church. He was described as an entrepreneur and an opportunist. He was a school teacher, guitar player, liquor runner, and a minister. He taught school before he contracted the disease. There are discrepancies in where he was from: some say he was from Dieppe Bay, and others say he was from Fig Tree. It is clear, however, that he made Sandy Point his home. Spannerman was a vocal individual. He was not shy and would let people know real quick how he felt. Jones-Hendrickson described Spannerman as "bold" (Jones-Hendrickson, 1991:174). One consultant remarked how Spannerman gave people a different impression of leprosy and about people with leprosy. People who knew him or had some interaction with him were not afraid of him. Unlike Sam, who was said to pass by without comment, Spannerman would engage in conversation with people and let it be known that he was a person, he had an opinion, and more importantly he had the ability to feel. He did not tolerate persecution.

As a liquor runner Spannerman's wealth accumulated. He owned a boat that was able to go back and forth to Saba. Given the condition of his hands, it is unlikely he actually made the trip; even though he was reported to have been able to catch fish using

his boat (he probably had some fish traps). Running hammond was illegal; hammond is essentially what Americans know as moonshine. Spannerman, as noted earlier, was an entrepreneur. He allowed other men to use his boat to run the hammond, while he collected a fee. He was an opportunist in that he knew that the police could intercept his boat. The catch is that the police were afraid of any person with leprosy, so Spannerman would make it nearly impossible for the police to come into contact with his boat and, by extension, the products and people in the boat. When the police would approach, he would scratch, cough, and be loud which convinced the police that they did not want to come any closer. Spannerman used his condition for profit. I have to admire him, for this was indeed clever.

Spannerman had another side to him. At some point he decided to become a minister. Jones-Hendrickson wrote about a missionary from England who started a church in Sandy Point called Bethel (see Figure 9.4). His name was Mr. Hope. The church was a "way-side" or "side-way" church, which basically meant that it was not Anglican, Catholic, or Methodist (Jones-Hendrickson, 1991:174). It was a Pentecostal church. Mr. Hope was suspicious-looking, according to many. He did not fit the mold of the traditional missionary that Kittitians expected. Mr. Hope was not an Anglican, Catholic, or Methodist minister. His church was a non-traditional Pentecostal denomination. Sandy Pointers were not accustomed to having such an unusual minister.

Jones-Hendrickson points out that once Spannerman became a minister, he decided to start his own church elsewhere, because Mr. Hope would not let him minister to the people of Mr. Hope's church, Bethel Church, or, according to an interview, the Gospel House (Jones-Hendrickson, 1991:176). In my investigations, I found



**Figure 9.4: Bethel Church Sandy Point; Photo taken in 2002.**

information that was contradictory. When I was trying to locate where Spannerman's church was alleged to be located, I only found Bethel. Some people vaguely remembered Spannerman ministering at a different location; most confirmed that Bethel was his church. No one mentioned Mr. Hope by name in a conversation about Spannerman, but he was mentioned with regards to Hansen Home. It was suggested to me that perhaps Mr. Hope helped Spannerman start his own church. Nonetheless, Bethel is the church associated with Spannerman.

Spannerman is referred to as an "ex-cocobay" by Jones-Hendrickson, a perception that may have led people to attend his church (Jones-Hendrickson, 1991:176). Spannerman's services were described as being loud and exciting. He had a style that was unique. Evidently, his charisma attracted established members of the Anglican, Catholic, and Methodist churches (Jones-Hendrickson, 1991:175). Although known as an "ex-cocobay," Spannerman was not always perceived this way. For him to be referred to as an "ex-cocobay" implies that the people who attended his church did not fear him. Regarding Spannerman's unique church services, I was told that he offered not wine or grape juice to represent the blood of Christ, but Coca-Cola.

Spannerman did have one tie to Hansen Home. An observation made by Jones-Hendrickson was that Spannerman and Memjoe could have passed for brother and sister; he noticed that they had the "same facial looks" (Jones-Hendrickson, 1991:174). If Jones-Hendrickson is referring to the same trademark of tissue destruction that leprosy is famous for, then, they may have looked alike. However, this assumed connection is very interesting because Spannerman did indeed have a sister who had leprosy, but her story is in the realm of Hansen Home, as it is said she lived in custody for nearly all of her life.

According to three consultants, Edwin Spanner and Olive Payne, the last patient from the Home, were siblings. As I indicated earlier, Samuel Payne may have actually been her brother. Perhaps Sam or Samuel and Spannerman are all the same person. I also understand that Sam and Spannerman were friends; their close association with one another may have also contributed to the fusing of each individuals' life histories. I believe that there were these two men who definitely had an impact on how people with leprosy were viewed, but I think that the legacy each man has left has been transferred to one another.

As I have said, the story of Spannerman's life is extraordinary. He was a man that made an impact on Sandy Pointers. Perhaps if he had not been afflicted with leprosy, he might not be remembered as vividly. Nevertheless, he was respected. People either had stories about his church, and what a Godly man he was, or they had stories about his money making schemes and his women. Spannerman may have spent his final days in the Hansen Home, but he spent the majority of his life engaging the outside. Considering I heard so many accounts about Spannerman, he is probably the most well-known individual with leprosy on the island.

Consequences:

Life was not easy on the outside. Spannerman's case makes it sound as though life was great and that there were many opportunities for those with leprosy. Although someone could be deemed "cured," "burnt-out," or an "ex-cocobay," most lived with their scarring for life. Socially, they were persecuted and treated with no respect. Spannerman was the only exception to this, but he still met social barriers. Physically,

they were often debilitated and forbidden to work in many positions, especially those involving the handling of food. I mentioned before that Spannerman allegedly had a number of children, none of whom would claim him as their father. I did not meet anyone who was a descendant of Spannerman, and I did not expect this event would happen. To be related, associated, or in contact with a "cocobay" was, and still is, to a person's disadvantage. People whose livelihood brought them into voluntary or professional contact with the Hansen Home and with its residents were not stigmatized, for they were seen as fulfilling their duties. However, if you were not a volunteer or an employee of Hansen Home, then association with persons with leprosy — or with some American researcher asking questions about leprosy, Hansen Home, and cocobay — then you ran the risk of being linked in possibly some negative way to the disease, and therefore by extension to the social stereotypes. To be seen talking with me (the U.S. researcher) made some people feel that old rumors and allegations of illness would resurface.

All of the knowledge that I have accumulated suggests that there are no more people living with the disease in St. Kitts. Interestingly, one of my guides tried to locate a woman who was supposed to have leprosy and who lived alone in St. Paul's, or Dieppe Bay. He searched for two days only to learn that she had passed away a few years back. I did not find anyone living with leprosy, but what I did find were people who were threatened by its past. As I said, no one currently had the disease, but I must argue that people are still living with the illness—at least its legacy. Life on the outside was not easy for those who were kin to individuals with leprosy. Socially, leprosy was associated with families. As soon as it was known that a person in a family had leprosy, the entire

family was socially branded. The illness is the symptom and the social suffering. In this case, despite a person being free of the disease, in the event that a person in their family, often years ago, was known to have leprosy, then it is assumed that they may carry the disease. In this way, people continue to endure the illness.

Two social consequences of leprosy were expressed repeatedly to me. First, to be branded a "cocobay" could ultimately cost a person their life or at least their livelihood. It was explained to me that this label could result in an end to economic prosperity. For example, if a person owned a restaurant or a tourist shop, and it became known that this person had a history of leprosy in her or his family, then people, especially tourists and students, would abandon, and perhaps boycott, the businesses. This happened to a person who was rumored to have contracted HIV/AIDS; the rumors turned out to be false, but the damage had already been done and this person was forced to move off-island in order to regain dignity and reestablish a business.

The second consequence concerns marriage. I learned that if a person had a relative known to have leprosy, then the decision to marry this person would be scrutinized closely by the family. This did not mean that marriage was out of the question, but it was definitely evaluated. Therefore, for some protecting the family secret is necessary, and for others, distancing themselves from the family is the only option altogether. For example, I spoke to two different families who had different responses. These two families have suffered different levels of persecution. I was directed to speak to these families by people in the community who felt that they could offer me a perspective to which I had yet to be exposed – the direct personal suffering of those affected by the illness of leprosy. The first family admitted the accusation, but explained

the rumor and what the truth was. It was no secret that people were jealous of them. The mother was accused of having leprosy, but when it was confirmed that she did not, people suggested that it was her obeah that cured her. Having the status of an obeah family worked in their favor from that point on. The second family was guarded and informed me that their surname was very common, and that there was no relation to the accusations of a leprous past, or the people of that surname that were leprous. I was also informed that by speaking to me, they were running an enormous risk. I politely kept my distance from them so as not to give anyone the wrong impression.

Chapter Summary:

This chapter has identified the historical location where the discharged patients resided. It also describes specific individuals who are mentioned in both the fictional account written by S.B. Jones-Hendrickson and the historical record, which is made up of Hansen Home documents and the oral histories that I collected. The legacy of leprosy left by these persons truly has shaped the history of leprosy in St. Kitts. In the concluding chapter, I discuss the legacy of leprosy weaving together the major themes from the many stories I collected in this research.

# Part IV: Conclusion

THE LAZARETTO, ST. KITTS.

### ANTIGUA LEPROUS BAKERS.

On Friday last a leper of disgusting appearance with tubercles on his face &c., was arrested by Inspector Thom and made to re-embark on board the sloop in which he had arrived from Antigua. The man stated that he was a baker which trade he had carried on in St. John's, Antigua, for many years. He of course disputed that he was a leper and said that he was suffering from a "heat of the blood." He was examined by a medical man in Basseterre who certified that he was a leper. Sir William Haynes Smith does not hanker after St. Kitts food; but we hope he appreciates the Antigua bread.

We congratulate Mr. Thom on his energetic action in this case, and we would like to see his night constables assist him in carrying out the law more than they do. We have been informed by gentlemen in Basseterre that they have been accosted in the streets at night by mendicant lepers.

—:o:—

### A LEPROUS FRUIT SELLER

The District Magistrate committed to the Leper Asylum, about a week ago, a leper who had been brought before him on some other charge, but who in the course of examination was discovered to be a fruit seller.




The Beggars' Opera at the Leeward Islands Music Hall.

*Governor Smith in his favourite rôle as Captain Macheath.*

"If laws were made for such as me
As well as them of low degree
I'd surely swing
On Tyburn tree."

# Chapter 10: Conclusions and Final Thoughts

This chapter revisits the research objectives, discusses the results of the research, and states some final thoughts about leprosy and how a shared history can help build a stronger relationship between St. Kitts and Nevis.

Objectives:

In 2000, I set out to research the cultural history of the former leprosarium Hansen Home. I achieved my objective by examining the archival materials from the National Archives and St. Christopher Heritage Society. I also made an outline of all the documents recovered from Hansen Home in addition to talking to people about their role with regards to Hansen Home and its patients. I returned in 2002 to find out why I had been repeatedly told that leprosy was not contagious, or "it's not catching." Through ethnographic interviewing, I collected more data about leprosy and the local knowledge of leprosy.

Results:

From the data collected, I described the culture within Hansen Home, its day-to-day routine and rules. I presented stories told from the vantage points of government reports, laws, newspapers, Hansen Home staff and volunteers, and from relatives of former Hansen Home patients. The stories came from a diverse pool of contributors, and, therefore, created a comprehensive presentation of this material. Details are presented about the culture within Hansen Home; although the patients did not have a direct voice, their collective story is also shared.

As a product of understanding the phenomenon of "it's not catching," I was exposed to a local knowledge of disease and illness. This local knowledge is complex, as it rests in medical pluralism. Kittitians employ both biomedical and ethnomedical theories and practices in their methods of healing. Therefore, their local knowledge of leprosy is shaped by both biomedical and ethnomedical influences. The local knowledge of leprosy is imbedded in rich layers of sociocultural context, rich in historical specificity whose details vary over time. Leprosy is not contagious in St. Kitts if examined at a specific points in time, particularly now in St. Kitts and in probably the last thirty years or so. However, leprosy was indeed contagious in the historical context of 1890 through at least the 1940s when attitudes began to shift. Because of the impact of medical treatments and the attitudes and actions of medical doctors, people began to change their understanding of leprosy.

The devaluation of persons with leprosy has unfortunately not changed as the stigma continues. Although there is no longer anyone with this disease in St. Kitts, rumors and accusations against families who were thought to have the disease still exist. In addition, accusations concerning the origin of leprosy also have not changed. The belief that leprosy did not come from Kittitians, but from Nevis and other outsiders persists. Accusations against obeah, the "leper," and the Other share a common theme of marked identity. Sandy Pointers identify themselves as the victims of an invasion of colonialism where the leprosarium was forced upon their city. Leprosy came from outsiders, who were either non-Sandy Pointers, or non-Kittitians. Most often, Nevisians were implicated. These stories reveal an underlying rivalry between Sandy Pointers and other Kittitians, and Kittitians and Nevisians. Historically, Kittitians viewed Nevis as

forced upon them through colonial policy. As such, this island rivalry is expressed through accusations of obeah. Kittitians have Othered Nevisians and have largely implicated them in the origins of leprosy in St. Kitts. They have also Othered folks with leprosy, by identifying them as outsiders who brought this disease to St. Kitts.

Final Thoughts:

Both St. Kitts and Nevis have distinct island identity and history. Despite their respective uniqueness, they share together a common nation-state identity, which continues to be negotiated. This union, while initially wrought with animosity and frustration, is becoming stronger. This country continues to build on its past and strive toward a promising, united future.

A major contributing factor in the strength of this union is the collective public health agenda that has a history of success. An effective health care delivery system is critical to the eradication of disease. In St. Kitts and Nevis, leprosy has been eradicated. The same can be said for malaria, filariasis, and schistosomiasis, to name a few diseases. Although *Mycobacterium leprae*, the bacterium responsible for leprosy, is no longer plaguing the people of St. Kitts and Nevis, leprosy has left a legacy of stigma and blame.

Leprosy is an Old World disease that is successful in crowded, malnourished, unsanitary populations. It is particularly successful in locations where the health care delivery system is underdeveloped and unsuccessful. Leprosy, like many other diseases, such as small pox, was brought to the Americas. Through migration, leprosy was able to find a home in St. Kitts, Nevis and the wider Caribbean. The fear of leprosy and the spread of leprosy led to the establishment of the leprosarium at Charles Fort, Sandy Point

in 1890. This was in response to the public health crisis that was also affecting the wider Caribbean, the United States, and South America. The Americas responded to the epidemic of leprosy by establishing leprosariums. However, it was not the leprosariums alone that made these successful; it was their overall quality of care provided not only to those with leprosy, but to the entire population.

Addressing the public by creating sanitary conditions, reducing malnutrition, and providing housing and better living conditions all contributed to the eradication of leprosy in St. Kitts and Nevis. The segregation of patients in Hansen Home was the first step in that process. The process of creating sanitary conditions, reducing malnutrition, and providing housing and better living conditions came slowly and was largely implemented in the 1930s and 1940s social security programs of St. Kitts and Nevis, which developed public latrines, baths, standpipes, and public health centres (Payne, 2001:3). Achieving good public health paved a path for the eradication of many diseases.

Despite the eradication of the disease, leprosy, as the illness, remains. The illness is the social stigma and suffering that is still associated with the labels "cocobay" and "leper." These labels contribute to the legacy of leprosy as being one that continues to create fear. Some people refused to talk or be seen with me due to the reputation I had for wanting to ask questions about leprosy. This fear comes from this legacy of stigma. It has taken some people years to escape the label "cocobay," despite not ever having the disease leprosy. This label has been transferred to people who may or may not have had a family member with the disease. Biomedical research has proven that leprosy is not hereditary. However, this does not prevent people from labeling an entire family as "cocobay" for generations to come.

The legacy of leprosy has produced a culture of blame that is defined by accusations associated with the origin of leprosy in St. Kitts. Outsiders or non-Kittitians are implicated in the origin of leprosy. More specifically, Nevisians are often identified as those who brought leprosy to St. Kitts. Nevisians are also implicated in the use of obeah, seen as an agent to transmit leprosy. Nevisians are an easy target for blame given the history of accusations against Nevis for a number of St. Kitts' alleged problems. Othering has become a way to assign blame for this disease and for any misfortune. However, the origin of leprosy cannot be simply reduced to blaming a neighboring island; it must be viewed in the historical context of the disease itself.

Although Nevis is implicated in the origin of leprosy in St. Kitts, it must be noted that leprosy came to the Caribbean through migration. Leprosy may have been in St. Kitts prior to being present in Nevis, since St. Kitts was the first non-Spanish colony in the Caribbean. Nonetheless, the accusations against Nevisians for bringing leprosy to St. Kitts are an unfortunate event that appears to be politically motivated. This political motivation is not one sided, but really a product of a larger issue of historical conflicts between St. Kitts and Nevis that risk eroding the united agenda of two islands, one nation.

Leprosy is very treatable if not curable today. The legacy is also treatable. Those who have lived with the stigma through family association are in need of healing. The need for healing is not healing from leprosy but from society's reaction to leprosy. This is true for anyone who lives with this disease or with the illness legacy it leaves behind. In terms of St. Kitts and Nevis, the legacy of leprosy is all that is left with regards to the current status of leprosy in this nation, yet this legacy is very powerful. Accusations of

leprosy are devastating not only to the persons in question, but to their family, community, and nation. The Federation of St. Kitts and Nevis should be proud of their history and of how these islanders have succeeded in eradicating a serious public health danger. In time, perhaps St. Kitts and Nevis can set the example of how to eradicate leprosy's legacy of social suffering through embracing its successes and identifying what can be done in the future to free its citizenry from the last remnants of a culture of blame and stigmatization.

The objectification of the patient is an unfortunate legacy of leprosy. As Mother Teresa once said, "the biggest disease today is not leprosy or tuberculosis, but rather the feeling of being unwanted." The L-Word is globally defined among those who work against leprosy and with the patients of this disease as a slur. No other disease, except perhaps HIV/AIDS, carries global social consequences comparable to those associated with the "leper" label. No other disease has the historical depth to which such consequence can be traced. In St. Kitts, the word "cocobay" carries the same weight.

This stigma is a global and historical one found wherever leprosy is or has been. The stigma creates a "leper" identity, which overrides preexisting identities of those who are afflicted with this disease. I have illustrated how thriving individuals who lived lives as tailors, as teachers, as cooks were reduced to the label "cocobay." These individuals were once respected and treated with dignity. As a consequence of leprosy, this dignity was stolen. The global society has positioned these individuals in this subordinate status while continuing to use the L-word. St. Kitts is just one example of how people with leprosy are stigmatized, but St. Kitts is also an example of how attitudes towards leprosy can change and how the legacy of leprosy can be shaped and reshaped.

As a result of this work, I hope that answers are found regarding leprosy in St. Kitts and Nevis. The ethnohistory of Hansen Home is important because it is part of the history of St. Kitts and Nevis. Both Kittitians and Nevisians, along with people from other islands, lived there for more than 100 years. The stories about leprosy that have been presented here reflect a gradual shift in thinking and talking about leprosy. Accusations of obeah reveal a complex local knowledge of leprosy. The healing strategies and the medical pluralism used in St. Kitts is a lesson in how a poor, young country can defeat disease through the use of an effective health care delivery system, which was firmly grounded in a combination of biomedical and ethnomedical knowledge.

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# Appendix

# Appendix A

Appendix A: Informed Consent Form (2002)

**INFORMED CONSENT FORM**

A Local Knowledge of Cocobear: An Historical and Ethnographic Analysis of Leprosy and the Leprosarium Hansen Home at Charles Fort, St. Kitts, West Indies

You are invited to participate in a research study. The purpose of this study is to collect information on how Kittitians make sense of disease. My specific objective is to identify ideas about leprosy (Hansen s Disease) and/or cocobear. I expect to find that Kittitians have historically displayed an ethic of care based on their perceptions of disease, which probably persist today. Beyond exploring this question, I will also investigate Kittitians reflections on the historical and cultural significance of Hansen Home. The benefit of this research will be a contribution to the cultural history of Hansen Home and the development of a humanistic account of Kittitians experience with Hansen s Disease. It may also inform future developments regarding the Hansen Home - Charles Fort site location.

There are no foreseeable risks from participating in this research. Participation is strictly voluntary and you may withdraw at any time. Most interviews will be audio taped, but if you do not wish to be audio taped you will not be excluded from the study. You may decline to participate at any time without penalty. If you withdraw from the study before data collection is complete, your data will be returned to you or destroyed. Audio taped interviews will be erased; however; if you wish to maintain the tape, then it will be available to you upon the completion of my thesis.

Your identity will be kept confidential. Field notes and audiotapes will be stored securely and available only to my advisor, Dr. Faye V. Harrison at the University of Tennessee, and myself. My thesis and any future articles will maintain this confidence. Pseudonyms will replace your real name to protect your anonymity. Audiotape transcripts will be censored by removing all identifiers. A professional transcriptionist may be hired to transcribe the audiotapes. This professional will adhere to the same confidence secured in this contract. All consent forms will be stored for 3 years in a locked file cabinet under my name; this file cabinet is located in 521 South Stadium Hall Department of Anthropology, University of Tennessee.

During May and June of 2002, you may contact me (Nancy R. Anderson) at Trinity Inn, where you may leave a message, or through the National Archivist, Ms Viki O Flaharity, at Government Headquarters, Church Street Basseterre. If you have further questions about the study or its procedures after August, you may contact my advisor, Faye V. Harrison, or me at 250 South Stadium Hall, University of Tennessee, Knoxville, TN 37996-0720; phone 865-974-4408. If you have questions about your rights as a participant, contact Research Compliance Services of the Office of Research at 865-974-3466 at any time.

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**CONSENT**

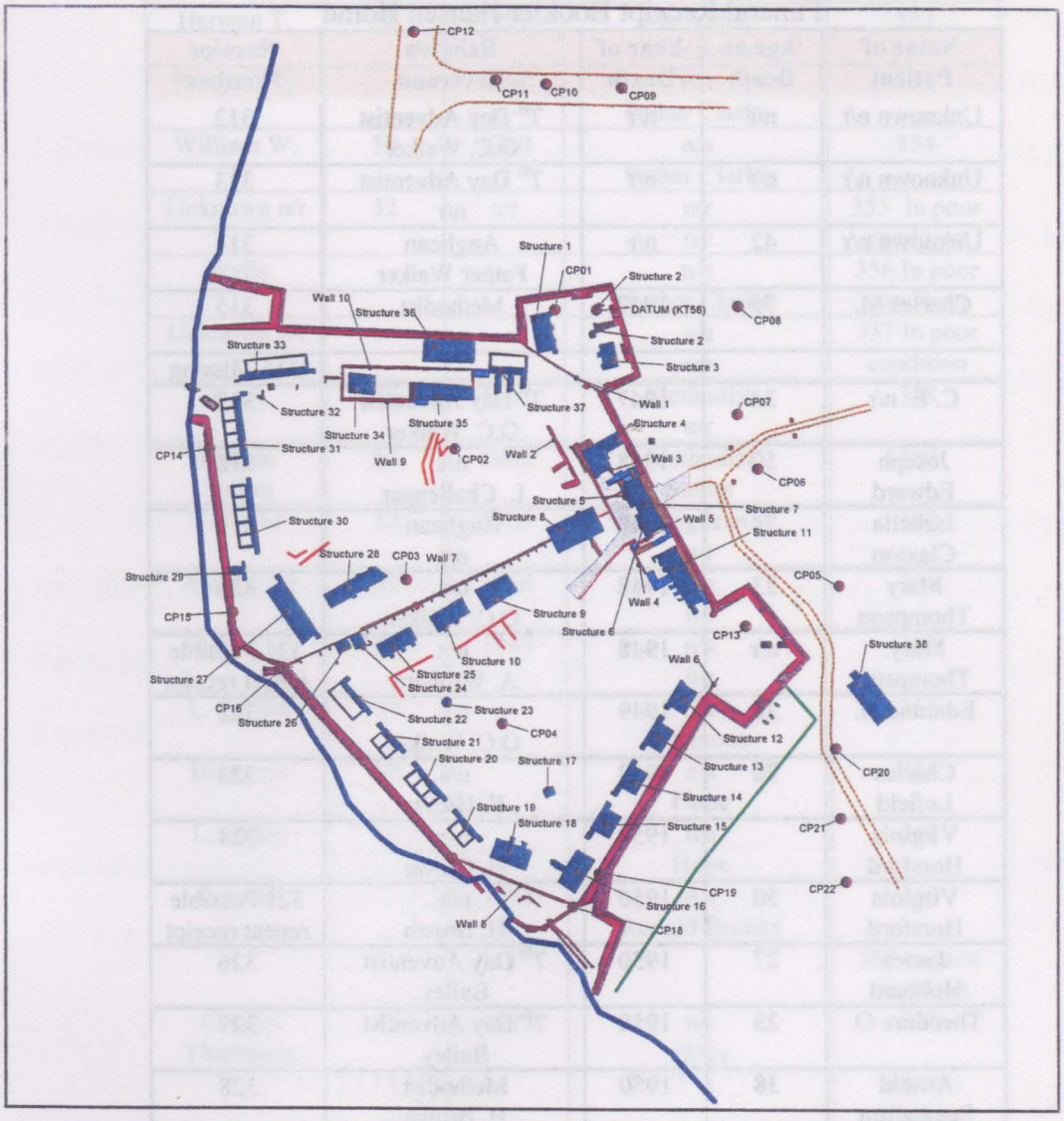
I have read the above information and my questions have been adequately answered; therefore I agree to participate in this study. I have received a copy of this form.

Interviewee s signature_____
Date_____

I, Nancy R. Anderson, agree to maintain the confidence and anonymity of each interviewee.

Interviewer s signature_____
Date_____

# Appendix B




Cemetery Outline
Rock Alignments
Interior Structural Feature
Control Point (CP#)
Structure
Stairway
Test Unit
Sea Wall
Road
Gate Marker Monument
Fallen Defensive Wall
Drain Pipe
Open Drain
Sidewalk/Walkway
Wall
Base of Defensive Wall
Concrete Driveway and Walks
Burial Pit

10 0 10 20 30 40 Meters

Compiled and drawn by Todd M. Ahlman
University of Tennessee

# Appendix C

## Funeral Receipt Booklet Hansen Home

| Name of Patient | Age at Death | Year of Death | Religion Reverend | Receipt Number |
|---|---|---|---|---|
| Unknown n/r | n/r | n/r | 7th Day Adventist O.C. Walker | 312 |
| Unknown n/r | n/r | n/r | 7th Day Adventist n/r | 313 |
| Unknown n/r | 42 | n/r | Anglican Father Walker | 314 |
| Charles M. | 75 | 1947 | Methodist n/r | 315 |
| | | | | 316 Missing |
| C. B. n/r | 34 | 1947 | 7th Day Adventist O.C. Walker | 317 |
| Joseph Edward | 50 | 1948 | n/a L. Challenger | 318 |
| Isabella Claxton | 74 | 1948 | Anglican n/r | 319 |
| Mary Thompson | 23 | 1948 | n/a O.C. Walker | 320 |
| Mary. Thompson | n/r | 1948 | n/a A. Williams | 321 Possible repeat receipt |
| Edmund H. | 38 | 1949 | n/a O.C. Walker | 322 |
| Charles Lefield | 70 | 1949 | n/a H. Brown | 323 |
| Virginia Horsford | | 1950 | n/a H. Brown | 324 |
| Virginia Horsford | 50 | 1950 | n/a H. Brown | 325 Possible repeat receipt |
| James Hubbard | 27 | 1950 | 7th Day Adventist Bailey | 326 |
| Theodore O. | 23 | 1950 | 7th Day Adventist Bailey | 327 |
| Arnold Pemberton | 38 | 1950 | Methodist H. Brown | 328 |
| Emanuel Davis | 78 | 1951 | Methodist H. Roberts | 329 |
| Catherine M. | 51 | 1952 | Anglican Clarke | 330 |
| Sarah Allen | 46 | 1953 | n/a Thomas | 331 |
| | | | | 332 -346 Missing |
| L Herbert | | 1953 | n/a Hope | 347 |
| Geraldine S. | | 1955 | Methodist n/r | 348 |
| Alice L. | 69 | 1956 | n/a Payne | 349 |

| | | | | |
|---|---|---|---|---|
| | | | | 350 Blank |
| Herman L. | 59 | 1957 | n/a<br>n/r | 351 |
| Herman T. | 38 | 1959 | Methodist<br>Dickenson | 352 |
| Percy Kelly | | 1954 | n/a<br>Father Clarke | 353 |
| William W. | 58 | 1960 | n/a<br>Father Clarke | 354 |
| Unknown n/r | 52 | n/r | n/r<br>n/r | 355 In poor condition |
| Wells | | | n/a<br>Father Clarke | 356 In poor condition |
| Unknown n/r | | | n/a<br>n/r | 357 In poor condition |
| B. n/r | 59 | 1961 | Methodist<br>n/r | 358 |
| Claude Sutton | 62 | 1962 | Methodist<br>Sutton | 359 |
| J. David | 52 | 1963 | Anglican<br>n/r | 360 |
| Audrey n/r | 32 | 1964 | n/a<br>n/r | 361 |
| Melvin M. | 55 | 1965 | n/a<br>n/r | 362 |
| L. Griffin | 50 | | n/a<br>Clemons | 363 |
| Blanc n/r | 80 | | n/a<br>Hope | 364 |
| L. Ottley | 60 | | n/a<br>Hope | 365 |
| Rose H. | | 1972 | n/a<br>Ronald Brooks | 366 |
| | | | | 367 In poor condition |
| Charles Thompson | 65 | 1973 | n/a<br>Hope | 368 |
| | | | | 369-373 Missing |
| Unknown n/r | 60 | 1977 | n/a<br>n/r | 374 |
| | | | | 375-376 Missing |
| L. Scarborough | 80 | 1977 | n/a<br>Hope | 377 |
| Alice L. | 60 | 1977 | n/a<br>n/r | 378 |
| Nicholas S | 68 | 1977 | n/a<br>n/r | 379 |
| Pearl Davis | 50 | | n/a<br>Albert | 380 |
| | | | | 381 Blank |
| Z. Walwyn | 61 | 1977 | n/a | 382 |

| | | | | |
|---|---|---|---|---|
| | | | Hope | |
| Joseph Stanley | 84 | 1978 | n/a Hope | 383 |
| Joseph Wilson | | 1995 | n/a Edward | 384 Out of sequence |
| | | | | 385 Blank |
| Benjamin Browne | | | Anglican Hodge | 386 |
| Unknown, n/r | 71 | 1979 | n/a Hope | 387 |
| Samuel Payne | 64 | 1981 | n/a n/r | 388 |
| W. Phillips outpatient | n/a | 1979 | n/a Hope | 389 |
| Lillian Isaac. | 67 | 1981 | n/a Hope | 390 |
| Joseph Sutton | 79 | 1982 | n/a n/r | 391 |
| Lillian Bartlett | 66 | 1983 | n/a Hope | 392 |
| Ellen Gaines | 78 | 1984 | n/a Hope | 393 |
| Samuel | 75 | 1986 | n/a n/r | 394 |
| M. Caine | 71 | 1991 | n/a n/r | 395 |
| Edwin William | | 1994 | n/a n/r | 396 |
| | | | | 397 -400 Blank |

*n/a refers to information not available, n/r refers to information not readable, Unknown refers to names that are not readable.

# Vita

Nancy Rebecca Anderson was born in Oak Ridge, Tennessee on 14 September, 1975. She went to Woodland Elementary School, Oak Ridge, Tennessee and to Kingston Elementary School, Kingston, Tennessee. She attended Cherokee Middle School, Kingston Tennessee and Northwest Middle School, Knoxville, Tennessee. She graduated with honors from West High School, Knoxville, Tennessee in 1993. From there, she went to the University of Tennessee, Knoxville and received a B.A. in anthropology with a minor in history in 1999 and a M.A. in anthropology in 2005.

Currently, Nancy is continuing her advanced studies of the Isshin-Ryu Martial Art. She is pursuing the degree Ni Dan; she received the degree of Sho Dan in 2004. Nancy plans to pursue a doctorate in Sports Sociology at the University of Tennessee, Knoxville.