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Science and spirit: Health care utilization in rural Jamaica

vom Eigen, Keith Alan, Ph.D.

Columbia University, 1992

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Science and Spirit:

Health Care Utilization

In Rural Jamaica

Keith Alan vom Eigen

Submitted in partial fulfillment of the
requirements for the degree
of Doctor of Philosophy
in the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY
1992

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ABSTRACT

Science and Spirit:

Health Care Utilization in Rural Jamaica

Keith Alan vom Eigen

This study uses an analysis of health care utilization in a rural community in eastern Jamaica, to evaluate health care development in this Caribbean country and suggest new approaches which could improve the effectiveness of health development programs. To make sense of health-seeking strategies it is necessary to look first at the various components of the health care system and their interconnections with the cultural, social, economic, and political realms. This problem is approached through the use of Kleinman's tripartite model of health care systems, which focuses on three interconnecting sectors. Within the popular sector, the realm of self-medication and family based care, there are a variety of options which people use in the early stages of illness. The professional biomedical sector, which includes the government health services and private doctors, plays a vital role when illness does not respond to self-treatment. However, structural inefficiencies and economic barriers limit access to biomedical treatment, especially for the poorest individuals. The folk sector is comprised of a variety of alternatives, public and private, ranging from church-based faith healing to several types of folk practitioners and the African-derived Kumina cult. Spiritual beliefs, which have taken shape through the evolution of Jamaican folk religion, continue to exert a profound influence on health care decision-making. Patterns which

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emerge from the analysis of numerous cases suggest that health-seeking strategies can be better understood when analyzed not as choices between systems, but as steps in a complex iterative process of coping with an illness. The relative balance among the various factors affecting health care decisions changes at different stages of the process. The preponderance of chronic illness in rural Jamaica means that many people cycle continually through the illness and the health-seeking process. There has been a dearth of creative planning aimed at addressing chronic illness, which has become the most important health problem in Jamaica. To better respond to the changing needs of the population, planners and administrators must look for more effective methods of managing chronic illness, including strategies for prevention and treatment.

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CHAPTER ONE

INTRODUCTION

INTRODUCTION

Throughout the world, massive efforts are being made to improve the quality of life in areas where disease, poor standards of living, and limited access to basic health care are producing untold human suffering. Over the years, anthropologists have been involved in these projects in several capacities, both in providing insight and direction for development planning and in the implementation of specific programs. In turn Anthropology has benefitted significantly from involvement in these efforts. "Experiments" in planned change have given us new insight into social and cultural processes, and have stimulated the development of new theoretical perspectives on cultural change. These experiences have also prompted anthropologists to question and redefine their role in our society and in the progress of the world as a whole.

The study on which this dissertation is based is born of this double-sided history of anthropological involvement in practical issues. It is, on the one hand, an effort to apply an anthropological perspective to examination of the basic struggles of life in a disadvantaged area, in order to evaluate current development strategies and suggest new strategies for reaching development goals. On the other hand, it is an effort to utilize a focus on pragmatic issues to enhance our ethnographic data base, as well as to contribute to the development of theoretical approaches to the study of health care systems.

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The heart of this study is an analysis of patterns of utilization of health care options in a rural community in eastern Jamaica. The basic premise is that examination of health-seeking strategies provides a method for evaluating the effectiveness of the health care system in meeting both the "felt needs" and the "real needs" of those it is presumed to be helping (Foster 1984:850; Goodenough 1963; Nichter 1978). However, the anthropological experience has taught us that an understanding of health-seeking strategies is impossible without a more comprehensive view of the social, cultural, and historical milieu in which these are formulated, as well as an appreciation of the structure and functioning of the health care system as a whole. Much of this study and the analysis presented here are devoted to examination of these contextual variables.

This analysis takes as its cornerstone the "holistic" perspective of Anthropology which considers cultures in their totality as well their parts. Specific aspects of a culture, such as its health care system, cannot be fully appreciated or understood when looked at apart from the overall social/cultural system. Indeed, singling out a particular subsector for analysis in isolation artificially reifies it as an autonomous functional entity and consequently produces a distorted view of its structure, function, and meaning (Comaroff 1983). Each part of the social/cultural system is interconnected with the rest such that changes in one produce changes in all the others, and in the system as a whole (Radcliffe-Brown 1965[1952]:6-7). This perspective, I would argue, has been the central and most useful contribution of Anthropology to development planning.

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Although struggles in present day Jamaica parallel similar struggles going on throughout the world, it must be kept in mind throughout that there are enough unique features about Jamaica to make uncritical extrapolation of lessons learned here to other areas risky at best. However, examination of the Jamaican situation, when taken in proper perspective, can produce some insights that are of value in a more general and theoretical sense, and that may be of use in other settings.

ANTHROPOLOGICAL PERSPECTIVES ON DEVELOPMENT AND HEALTH CARE SYSTEMS

Anthropological approaches to the study of health care systems have evolved considerably over the past few decades, during which time Medical Anthropology has grown from the avocation of a few to an independent sub-discipline in its own right. Throughout its short but animated history, Medical Anthropology has been driven by theoretical trends which have reflected not only intellectual developments in its parent discipline, but also societal concerns and priorities. It is in its essence an "applied" discipline, as its objects of study -- illness and healing -- represent the core of the constant human "battle against dissolution" (Murphy 1987:223). It is not surprising, then, that the ferment of activity around the issues of illness and health care which has taken place in recent decades should be reflected not only in the growth and maturation of Medical Anthropology as a distinct field, but in its orientations and themes as well (Hunter 1985).

During the 1950s, with the attention of the world turned to rebuilding from the ashes of World War II, another world -- a Third

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one -- was discovered. With the proliferation of newly independent former colonies, came attempts to confer upon these impoverished and "backward" lands the benefits of "modernization." Early public health efforts to introduce sanitation, modern biomedical technologies and other health promoting measures into these societies met with a surprising amount of resistance. The organizers of these well-intentioned, but often disastrous, programs realized that in order to promote the acceptance of these measures they needed to know more about the people they were so clumsily trying to help. Anthropologists who were called in to help grease the wheels of progress turned to the study of "cultural barriers" that seemed to be preventing transmission of "modern" elements to "traditional" cultures (e.g. Foster 1955,1984; Paul 1955; Adams 1955). While anthropologists have long been interested in the transmission and diffusion of cultural elements (e.g. Kroeber 1931), as well as in the process of cultural change that comes about through culture contact (i.e. "acculturation") (e.g. Herskovits 1958[1938]; Redfield, Linton and Herskovits 1935), this involvement of Anthropology in the promotion of change marked the birth of both "Applied Anthropology" and the practically oriented side of Medical Anthropology.

Through their focus on the clash between "modern" and "traditional" these early applied/medical anthropologists highlighted the logic and mechanisms of resistance to biomedical hegemony. What had been illogical to the agents of change became sensible in the light of cultural analysis (e.g. Wellin 1955) and examination of the actual, often negative, consequences of development programs (e.g. Hughes and Hunter 1970). The goals and contributions of these anthropologists

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arose out of their role in determining methods of more effectively promoting health care development, while at the same time making health development more responsive to the needs and views of those it was meant to serve.

The dualistic conceptualization of health care systems in terms of an opposition between "traditional" and "modern" forms of health care focused on explaining the process of change as a result of the interaction of these two types of systems (Paul 1955; Wellin 1977:52-4). Ethnographic work based on this concept reinforced the adversarial model. Health care systems around the world were portrayed as traditional systems under siege by Biomedicine. Anthropologists for the most part concentrated on the traditional side of the equation and studied the impact of modern medicine on indigenous cultures (Landy 1977[1974]). Some of these studies focused specifically on how people adapted to and utilized the changing systems, and how this affected the nature of the changes taking place (Erasmus 1952; Gould 1965).

Through continual ethnographic and applied work around the globe, Medical Anthropologists became more sophisticated in their ideas and techniques. They gradually came to realize that the traditional/modern dichotomy was in many respects misleading, and as a model was unable to account for much of the data that was being generated. They began to recognize that there was often a great deal of differentiation and variation within both traditional and biomedical sectors. Often several different traditional forms with different meanings and uses were found to coexist in a state of "medical pluralism" (e.g. C.M. Leslie 1976,1977[1976]). At the same time, the stereotypes of traditional

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systems were called into question by studies which highlighted their internal variation and adaptiveness (Press 1977[1971]). What were thought to be homogeneous, unchanging systems were actually in a constant process of internal and syncretic flux. In many cases, elements of Biomedicine were found to be incorporated enthusiastically by traditional practitioners. It came to be recognized that all medical systems, including are own, are pluralistic in nature (Stoner 1986; Kleinman 1988:262-3; Holohan 1987; C.M. Leslie 1980).

The growing appreciation for the vitality and flexibility of indigenous ideologies and health care systems was parallelled in the international development arena by new approaches to promoting social change. During the 1950s and 60s the Community Development (CD) movement emerged as a dominant development philosophy. This model was heavily influenced by the experience of agricultural extension workers in the USA as well as by British Social Anthropology, which concentrated on studying communities as integrated social systems (Swezey and Honigman 1962). It was based on respect for the autonomy and values of the recipient population, and it emphasized the principles of self-help, self-respect, and self-determination in the belief that lasting and acceptable change could only come through the initiative of those who were to be affected by it. It took communities, conceived of as integrated wholes, as the unit of development planning and action, and sought to involve the recipients in both of these activities. Change was ideally to involve all facets of community life because improving living standards in the community depended on coordinated changes in

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infrastructure, education, economic opportunities, health care, etc. (Swezey and Honigman 1962; Dunham 1963; Van Willigen 1976; Foster 1982).

Since its ascension in the 50s and 60s, the CD approach has had its own failures and problems. It has been criticized for the paternalism inherent in the idea of the "induction of felt needs," its emphasis of non-material over material progress, its imposition of a foreign ideology, the oft mistaken assumption of a cooperative spirit and motivated community leaders, and the fallacy of assuming that the "community" was always the relevant social unit (Erasmus 1968). However, its principles did become pivotal in the thinking of international development agencies, and continue to be so today. This approach to development was also picked up by those working for the improvement of health conditions in underdeveloped countries, with some notable successes (e.g Behrhorst 1975; Horton 1987) as well as failures (e.g. Paul and Demarest 1984, Crandon 1983).

The Community Development philosophy was particularly influential on the evolution of the Primary Health Care (PHC) movement, a model of health care development based on the same principles as CD. The PHC model was developed during the early 1970s out of a search by agencies such as the World Health Organization (WHO) and UNICEF for new ways of promoting health care and improving health standards in underdeveloped countries in the face of scarce resources. Like CD, the orientation of PHC initiatives has been based on broad participation, universal accessibility, community orientation, low cost strategies, and integration with overall development (Foster 1982). PHC represented a reaction to previous approaches which promoted centralized, urban-

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oriented, hospital-based services which catered to the elite, while even basic care was denied to the poor and rural masses. It has sought to concentrate attention on provision of basic services such as maternal and child health and immunizations; redistribution of funding from the center to the periphery; opening access to all; utilization of local resources and manpower to minimize costs; decentralization of the planning and delivery of health care to the community level; and integration of health care programs with broader based strategies to improve nutrition, water supplies, and standards of living (Bennett 1979; Foster 1982). These strategies and goals were codified by the famous WHO/UNICEF Alma Ata Conference of 1978, which in the heady optimism of the day sounded the rallying cry of "Health for All by the Year 2000," the now familiar slogan of the PHC movement (WHO 1978).

At this same time new directions in health care systems modeling were evolving in Medical Anthropology, and these both reflected and influenced the progression of the PHC movement (e.g. Press 1980; Kleinman 1978a, 1978b, 1980; Janzen 1978a). These models, which were refinements of the medical pluralism perspective, began to take a more comprehensive, objective, and meaning-centered view of health care systems in order to provide a framework through which they could be systematically studied and compared, and to offer new insights into the health care development process. Kleinman's model is notable in this regard (Kleinman 1978a, 1978b, 1980).[1] This model explicitly recognizes the major role that low-level family-based care and

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[1]See Chapter 4, pp. 91 - 96 for a more thorough explanation of this model, which forms the basis of this analysis of the health care system in eastern St. Thomas, Jamaica.

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prevention (the "popular sector") plays in health care systems. It highlights the manner in which the meaning of illness is embodied in strategies of utilization, which in turn define the interrelationships among the different sectors of the health care system (Kleinman 1980:179-202). Such an approach is on common ground with the ideology of PHC because it recognizes the importance of low-level self- and family-directed health care, and the influence of health-seeking strategies on the social and cultural construction of health care systems.

The optimism of the early declarations of the PHC movement has been muffled somewhat by the gradual realization that in most countries the shifts in power and resources necessary for the implementation of comprehensive Primary Health Care measures have not materialized (Mburu 1981). As a result, some health development planners have turned to a strategy that involves a more focused attack on specific health problems in the interest of using resources as efficiently as possible (Walsh and Warren 1979). There has been a lively debate in recent years between those who favor targeting resources on key areas, so-called Selective Primary Health Care (SPHC), and those that favor the traditional comprehensive PHC model (CPHC) (Warren 1988; Walsh 1988; Newell 1988).

During the 1970s and 80s as anthropologists began to look more carefully at the global forces that hinder health development, and that have been responsible in large part for creating the existing inequities, an important theoretical trend arose in Medical Anthropology which focused on the political economy of health care systems. This school, which has become known as Critical Medical Anthropology (CMA),

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grew out of a reaction against perspectives that see medical systems as autonomous and detached from the larger political and economic forces that shape social change around the globe (Frankenberg 1980; Morsy 1979; Singer 1990). It has extended health systems modeling beyond the strictly local context to include interconnections with larger world systems. By adding a needed political economy perspective to the study of medical systems, CMA has reinforced the view that health inequities are not merely epidemiological problems, but rather are products of economic exploitation and class conflict. Thus solutions to these problems require more fundamental changes than mere public health interventions.

The philosophy and methods of CMA closely parallel those of earlier theoretical trends in the field of Development Economics, in particular Dependency Theory and World Systems Theory (e.g. Palma 1978; Baran 1958[1952]; Frank 1967; Wallerstein 1976[1974]; See Morgan 1987). Like these earlier schools of analysis, CMA is intellectually, politically, and morally appealing. However, it has yet to come to terms with the major shortcomings that caused Dependency Theory to fall out of favor in Economics, limiting its impact on Development Planning. By asserting that the cause of all health problems lies in the exploitative political/economic relations of the world system, CMA can logically offer no solution to these problems short of total overhaul of the entrenched inequitable international system. In other words, the solution to the world's (and local) health problems logically must lie in a restructuring of the international order, presumably through world socialist revolution (Morgan 1987). While some might consider this a

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real goal, to most it clearly is no less a utopian idea than the expectation that the developed world might volunteer to give a large share of its wealth to the underdeveloped countries, submitting graciously to a "New International Economic Order" (Cline 1979). Thus in pragmatic terms CMA has little to offer to development planners who must function in the real world of material limitations and political maneuvering, making the most of scarce resources to address practical problems.

UTILIZATION OF HEALTH CARE OPTIONS

The study of health behavior, including the utilization of health care alternatives, has been a central issue in Public Health, and other fields such as Medical Geography, for many years (e.g. Kasl and Cobb 1966). Much of the energy of public health programs in fact goes into efforts to change such behaviors. It is not possible to review this vast subject here. Instead, some observations will be made on its relevance to health care systems modeling in Medical Anthropology, for this is one area in which the issues of health care decision-making and utilization have an added significance. Research on health behavior gives us information about the health-related activities and conceptual categories of individuals, and at the same time provides valuable insight into the structure of the health care systems themselves. But, perhaps more importantly, it is essential to the construction and revision of theoretical models of health care systems and health behavior. Utilization studies aid in evaluating the utility and accuracy of the theoretical constructs from which they are generated.

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Thus they enable further progress in theory building and, consequently, in ethnographic research as well.

As health care systems modeling has evolved, utilization studies have parallelled theoretical developments. Health care choices were of obvious interest to the early applied/medical anthropologists whose goal was to help promote the acceptance of public health programs. Questions of utilization came down to inquiries about factors which influenced the use of either "traditional" or "modern" alternatives (Erasmus 1952; Gould 1965). Studies along these lines in turn contributed to an enhanced interest in the logical and conceptual categories through which native peoples interpret illness (e.g. Nurge 1977[1958]).

In addition to those studies which looked at choices between conflicting traditional and modern (or native and Western) treatment systems (e.g. Romanucci-Ross 1977[1969], Finkler 1981; Beals 1976), some took a broader view of pluralistic medical systems and looked at choices among a variety of traditional and biomedical options (e.g. Janzen 1978b; Colson 1971; Press 1977[1971]; Coreil 1983a,1983b; Amarasingham 1980; Cosminsky and Scrimshaw 1980). One general conclusion that can be drawn from looking at a number of these studies is that health-seeking strategies vary considerably among these different societies. This lends support to the view that health care systems must be considered as distinctive localized systems, and to the need for caution in extrapolating from one system to another (Kleinman 1980).

Kleinman's model of health care systems, which is used in this study, brought with it an enhanced appreciation of the popular sector of health care and the importance of meaning in the illness experience (See

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Chapter 4, pp. 91 - 96). In his own work, Kleinman has added this perspective to the study of health-seeking through his attention to the health care that goes on outside of the specialist sectors (1980:179-202), and others have built on this viewpoint (e.g. Coreil 1983a,1983b). Such an approach can give fresh insight into the structure of health care systems, as it is through their utilization that such systems are socially and culturally constructed (and reconstructed). As Stoner suggests, "definition and delineation of separate medical systems within societies is perhaps less valuable for development of an understanding of health-seeking behavior and health care decision making than the clear and focused study of the actual health care alternatives that people use in times of illness." (Stoner 1986:44).

Previous studies of health-seeking strategies have for the most part examined them as choices between two (or more) alternatives and analyzed the factors influencing such decisions. Some (e.g. Finkler 1981, Long 1973) have taken a slightly different tack by looking retrospectively at patients presenting in different settings and comparing their characteristics in order to make conclusions about factors influencing use of the different alternatives. A few, like Kleinman (1980), have taken a more useful, long term, progressive perspective and analyzed strategies as a linear or branching series of discrete events, thus introducing the notion of process to the study of health-seeking strategies (Chrisman 1977). In this paper I take this perspective a bit further by examining the health-seeking process as not merely linear, but as a cyclical, recursive, self-reflexive process in

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which the meaning of an illness and the salience of different factors is constantly shifting and being transformed as the illness progresses.

THE RESEARCH PROBLEM

The main purpose of this study is to examine health-seeking processes in rural Jamaica and use this information to evaluate the effectiveness of efforts to improve health standards in this area. Such an approach can also provide suggestions as to how the effectiveness of these programs can be improved. The health care system which has evolved in the island over the past three hundred years includes a large segment of services and facilities provided by the government. A large proportion of the budget of the Ministry of Health and Environmental Control in Jamaica goes towards providing public primary care services to those who are unable to afford medical care on their own. While limited studies have been conducted in the past to look at the utilization of government services, there have to date been no studies of health-seeking in rural Jamaica which have looked comprehensively at the various health care alternatives which are available and, more importantly, at the process through which decisions about using these different alternatives are made. While such knowledge is of great importance in designing a system which is responsive to the needs of those it is meant to serve (Nichter 1978; Kleinman 1978b), so far planners have had to rely on stereotypes and anecdotal information. Through a comprehensive analysis of the health care system and interpretation of patterns of health care utilization in a rural area in the parish of St. Thomas, this study provides valuable insight into the

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motivations and incentives behind health-seeking strategies in rural Jamaica (cf. Kleinman 1978b). While looking critically at the health care system, this study also represents an attempt to generate data which will be of use to planners in enhancing the responsiveness and effectiveness of primary care for the rural poor.

This analysis is pursued not in a spirit of criticism, but rather in the hope of providing a new and forward-looking perspective on health care development in the Caribbean. As part of this endeavor, ethnographic and public health work that has been done previously in the island will be examined, and the findings of this study will be used to contribute to theoretical and practical approaches to the problem of health care development, as well as to the study of health care systems in Medical Anthropology. Through this process I also hope to make a contribution to the ethnography of Jamaican culture and the study of cultural transformations in the Caribbean.

Jamaica is no new-comer to the idea of health care development and the ideals of the Primary Health Care movement. As will be seen in chapters to come, public health efforts have a long and fruitful history in Jamaica. However, through its progress, and through changing social, economic and epidemiological conditions, challenges are arising that call for creative new approaches. Past experiences around the world have shown that cookbook application of good ideas can be disastrous (e.g. Paul and Demarest 1984; Crandon 1983). In order to be effective, appropriate, and efficient, planning must take into consideration local needs and circumstances, and take heed of changes occurring in these.

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Only through comprehensive and balanced research can these trends be followed and responded to.

In reformulating its health policies and planning for the future, the Jamaican government in 1977 embraced the PHC model and the related tactics being formulated by WHO and UNICEF as its main strategy for achieving the nation's health care goals (Carr 1984:26). Since then, policies have been further refined and reformulated in the face of political, ideological, and economic factors. However, as we shall see, deep-seated organizational problems, bureaucratic inertia, and lack of responsiveness to local needs have perpetuated and recreated inefficiencies in the delivery of health services. When needs are great and resources scarce, efficiency becomes an issue of central importance. This study directly addresses the issue of local needs and looks at ways in which these could be more effectively met.

Previous studies of health-seeking strategies in Jamaica have been of limited value for this purpose because of their restricted scope and lack of appreciation for the complexities of the health-seeking process. For example, Long (1973) used a statistical discriminant analysis to look retrospectively at different characteristics of healers' and doctors'[2] patients in an attempt to determine which factors had the

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[2]Throughout this paper the term "doctor" is used in preference to "physician" to refer to biomedical practitioners. "Doctor" is the term used popularly in Jamaica specifically to refer to a biomedical specialists, while the word "physician" has meanings in the Jamaican context that might lead to some confusion. For example, healers often refer to themselves as "physicians," and spiritual healing in particular is referred to as "physician-work." One of the most popular hymns used in religious healing services is "The Great Physician," which refers to Jesus in his healing capacity. "Doctor," on the other hand, does not have this double connotation. "Healer" as used here refers specifically to folk (continued...)

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strongest influence on decisions to use one or the other type of practitioner. However, he mistakenly assumed that the traditional/modern dichotomy was a useful one in the Jamaican setting and thus misjudged the nature of the decision-making process. He also failed to take into consideration the important area of self-medication. Several questions arise as a result. Are choices between doctors and healers really an important aspect of the decision-making process? Is the traditional/modern dichotomy of any real relevance in the Jamaican situation? How significant is this issue to health development?

Mitchell (1980) in a study of the role of pharmacists in the Jamaican health care system takes a more balanced perspective on the issue. However, her analysis is also overly simplistic. She focuses primarily on one type of treatment (self-medication) and thus neglects the importance of the folk-healing sector. By trying to explain health-seeking in terms of a single variable (class), she also distorts the complexities of the process. Here again we are left with several questions. What is the importance of self-medication in the health-seeking process, and what role does the pharmacist play in this regard? What is the role of class in influencing health-seeking strategies, and how does it interact with other factors?

In a recent study of spatial patterns of health care usage in the Kingston Metropolitan Area (an urban setting), geographers Bailey and Phillips (1990) attempt to analyze factors affecting health care utilization by comparing behavior in neighborhoods of differing "social

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[2](...continued)
practitioners, since again this is its meaning in popular Jamaican usage.

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status." While their conclusions are supported by quantitative data, they are not very informative (e.g. that people without cars spend more time travelling in trying to get health care; and that wealthier people go to private doctors more frequently than the poor). They claim that their methodology provides some control over other variables, but in fact by using location as their main independent variable they lump together a variety of factors (economic, education, cultural orientation, etc.) and thus are only able to speculate on the specific roles that each of these plays. They also totally ignore the folk and popular sectors of the health care system, thus distorting the interpretation of their findings. As a result their work obscures more than it reveals.

This paper represents an attempt to go beyond the shortcomings of these previous studies. By working from the traditional holistic perspective of Anthropology I hope to disentangle the intricate web of factors -- historical, political, ecological, economic, social, cultural, symbolic, and personal -- which have come together to shape and animate the Jamaican health care system. The relevance of such a perspective for health care development planning will become more evident as the analysis unfolds.

I take on this daunting task systematically. The following chapter (Chapter 2) is a brief overview of the methodology used in collecting the data on which this paper is based.

Chapter 3 begins with of a review of the historical, economic, and political factors which have shaped society and culture in eastern St. Thomas, Jamaica, the region of interest in this study. The second part

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of the chapter is an introduction to the community of Albion which is the focal point for the description and analysis which follow.

Chapter 4 outlines the organizational basis of the study, specifically Kleinman's (1978a,1980) model of health care systems. It then focuses on the popular sector of the health care system, the realm of self-medication and non-specialist treatment.

Chapter 5 describes the professional sector of the health care system, the public and private biomedical alternatives in the area, looking both at its history and its current structure.

Chapter 6 is a fairly comprehensive historical review of the development of folk religion and folk healing in Jamaica. In this chapter an attempt is made to draw together and critique previous writings on this topic and synthesize them in light of my own findings. This also demonstrates clearly the intricate interconnection of folk healing traditions with other elements of Jamaican culture.

In Chapter 7 a description of the local folk healing sector is presented. Along with findings of previous studies this is used to analyze the structure of folk healing patterns and their trajectories over time.

Chapter 8 begins with an examination of illness incidence in Albion, and continues with an analysis of health-seeking patterns. Health care decisions are interpreted as stages in a complex iterative process in which the influence of different factors and criteria varies according to the individual's position within this process.

In Chapter 9, the Conclusion, the results of the various segments of the paper are drawn together and their significance for health care

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planning in Jamaica, as well as their implications for the study of health care systems and Jamaican ethnography, are discussed.

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CHAPTER TWO

RESEARCH METHODS

This study is based on fieldwork conducted in Jamaica from July 1987 to September 1988, a period of approximately 15 months. Data were collected using a variety of techniques including informal and open-ended interviews, structured interviews, participant-observation, a household census and survey, library and archival research, and use of statistical resources.

The first six weeks of the study were spent in Kingston. During this time research was conducted in the libraries of the University of the West Indies (UWI) and the National Library at the Institute of Jamaica (IOJ). To aid in the selection of an appropriate research site, authorities were consulted at the University of the West Indies at Mona (UWI), the Ministry of Health and Environmental Control (MOHEC), the Pan American Health Organization (PAHO), the Caribbean Food and Nutrition Institute (CFNI), the Caribbean Institute of Mass Communication (CARIMAC), the University Hospital of the West Indies (UHWI), as well as the Institute of Social and Economic Research (ISER) at UWI, to which I was affiliated as a research fellow. During this period contacts were also established in St. Thomas, the parish which was chosen as the site for the study.

I set up residence in Morant Bay, the parish capital of St. Thomas, in early September 1987. During the next two months contacts were made with private doctors in Morant Bay, public health administrators, and three of the church-based healers in the eastern

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part of the parish. Personnel and patients were interviewed in the various health care settings in the eastern area, and several districts were visited in the process of selecting a community on which to focus more intensively. Observations were also made at healing services and other functions at the healers' churches, and the healers were interviewed concerning their lives and work.

The district of Albion was selected as the site for a community study, for reasons which will be more fully discussed in the next chapter. At this time (October-November, 1987) I began preliminary work on the census/survey of households in Albion, and through field testing and revisions developed the interview schedule that was used for the remainder of the survey (See Appendix, pp. 534-537). This census/survey focused on demographic variables, employment, education, migration, living conditions, land ownership, health care practices and elicitation of illness episodes. I also attended a Kumina ceremony and conducted informal interviews with residents of Albion.

In November, 1987 I moved to Albion where I lived for the remainder of the research period (10 months). Much of December was spent working with Brother John, the resident healer in Albion, interviewing him and his assistants, interviewing patients, observing clinical interactions, and "hanging around" his Revival church and his office in between these activities. (I found that this type of research requires a great deal of patience.) Trips were also made with Brother John to each of his branch churches in St. Thomas and Portland. In addition, during this time I collected case histories from sick

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individuals and participated in community activities (Kuminas, Dead-Yards, Funerals, etc.).

After a few weeks vacation in January, I shifted my attention to practitioners outside the district. I located and interviewed seven other healers in the area, including three Science Men (See Chapters 6 and 7). Public healing work was observed with five of these other healers (for a total of eight of the ten healers), and when possible the healers who did private healing were observed in their nonpublic clinical interactions. However, because of the sensitivity of this issue both with clients and the healers, this was possible only with the three healers with whom I had the closest rapport, and even then were limited in number. During the spring of 1988 I interviewed all of the doctors working in the eastern part of the parish, both public and private (eleven in all), about their backgrounds and work. I also spent time observing clinical interactions with all but one of these doctors. More time was also spent observing and interviewing in the public clinics.

During the summer of 1988, my research assistant (Meg Harvey) conducted the bulk of the household survey interviews. The results of this survey are discussed at relevant points throughout this paper. During this time I spent more concentrated periods of time interviewing patients, gathering case histories, and observing interactions in three settings: a private doctor's office, a public clinic, and a healer's private practice. Followup visits and interviews with patients at their homes enabled a longer term perspective on their illnesses and

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treatments in a more neutral setting. Our research activities were completed by mid-September 1988.

In sum, this variety of techniques enabled us to collect data balanced by the different perspectives through which it was obtained. In addition it provided an appropriate mix of qualitative and quantitative information.

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CHAPTER THREE

THE RESEARCH SETTING

INTRODUCTION

In order to understand the functioning of the health care system in rural Jamaica, it is essential to first have an appreciation of the context in which it operates. The purpose of this chapter is to provide an overview of the economic, cultural and social environment in rural eastern Jamaica, and more specifically in the eastern part of the parish of St. Thomas, where the study was conducted. In the case of St. Thomas, the area's history as a center of the plantation system has exerted an enormous influence on the lives of its people, and on the course of its development. In a discussion of the plantation system and its cultural consequences, its role in shaping the political and economic structure of the area will be our primary focus. Through this mechanism it has had a pervasive influence on Jamaican culture and on Jamaicans' adaptations to difficult circumstances. The resulting attitudes and approaches to life are major determinants of how poor rural Jamaicans utilize health care alternatives, and consequently they play a major role in the cultural and social construction of the health care system.

The second half of the chapter is a description of the community of Albion, in which were based the aspects of the study which focused on illness behavior and health care utilization. It provides a summary of living conditions, class structure, economic strategies, the social

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system, and cultural patterns in a typical community in rural eastern Jamaica.

In the rapidly changing society of Jamaica, older cultural forms are being altered in the face of modernization, though the rapidity of this change is variable in different parts of the island. Since folk healing is felt to be declining in many areas of the island, in choosing a location for this research project I wanted to be sure of finding a place where folk healers were still very active. My learned informants in Kingston mentioned a variety of locales where they knew of some healing activity, but the one parish that all pointed to as having a strong tradition of healing was St. Thomas. To Kingstonians, St. Thomas is known as a "science parish," notorious for the practice of "Obeah" (sorcery) and healing. It is said that people from St. Thomas are feared by other Jamaicans because it is assumed that they have access to all sorts of potent magic.

ST. THOMAS

Situated at the southeastern tip of the island, the parish of St. Thomas is a legacy of the forces that have shaped Jamaican development (and underdevelopment) over the past three hundred years. Belying its proximity to the commercial center of the island, it remains one of the least developed and poorest areas of Jamaica. It is one of the few regions in the island where one can still catch a glimpse of the "Old Jamaica," untrammeled by tourist hordes. This relative "backwardness" is not the result of a poverty of resources, but rather the reverse. A rich environment has paradoxically fostered the persistence of timeworn

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forms of economic exploitation and, consequently, a tenacity of traditional forms of cultural adaptation. This is not to say that life in St. Thomas has not changed over the years, or that its people have not desired change, but rather that natural and cultural buffers have blunted the rapidity and magnitude of these changes in comparison with other parts of the island.

The area which comprises St. Thomas today was originally two separate parishes -- St. David in the western half and St. Thomas-In-The-East -- which were consolidated around 1870 (Black 1973: 127). Within the parish there are conspicuous variations of topography and climate. The section west of the Yallahs River, formerly St. David, is relatively dry and not well suited to plantation agriculture (Kaplan 1976:16). Closer to Kingston, this area has been subject to a greater suburbanizing influence from the urban center and has benefitted from the expansion of commercial activity from the Kingston Metropolitan Area. While poor, and still heavily dependent on subsistence agriculture, this western part of St. Thomas has been drawn more closely into the modern economy. In contrast, St. Thomas-In-The-East remains firmly embedded in the plantation economy that has shaped Jamaican culture and society since the British capture of the island in the mid-seventeenth century.

The Plantation System

The persistence of plantation agriculture in eastern St. Thomas is the result of geographic, climatic and historical factors. The volcanic origin of Jamaica has left it with a central backbone of jagged peaks

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surrounded by fertile coastal plains. In St. Thomas these productive flatlands extend from the southern and eastern coastal areas towards the interior along the Blue Mt. Valley and the Plantain Garden River Valley. There they are thwarted by the steep slopes of the Blue and John Crow Mountain ranges along the border with Portland to the north. The mountains wring a plentiful rainfall out of the moist Trade Winds brushing over the island from the northeast. While western St. Thomas lies in the rain shadow of the Blue Mountains, the precipitation in eastern St. Thomas is plentiful, exceeding 60 inches per year. This, along with rich alluvial soils, make eastern St. Thomas an ideal area for growing sugar cane (Statistical Institute of Jamaica 1986).

The earliest settlers in the area were a group of 1,600 colonists from St. Kitts and Nevis who arrived in St. Thomas-in-the-East in 1656 to set up sugar plantations on the British model, which had been successful on those other islands. They settled at Stokes Hall (named after their leader, Luke Stokes) in the eastern end of the parish. But nature exacted a toll -- 2/3 were wiped out in the first year, probably the victims of diseases borne by mosquitoes from the Great Morass, a large swamp at the eastern tip of the island (Black 1973:32). The survivors, however, persevered in their task and before long the prime flat land was covered with fields of sugar cane tended and processed by gangs of slaves imported from Africa.

Exploitation of Caribbean sugar lands brought great wealth to British colonial estate owners and the shipping companies which carried out a "triangular trade" in slaves, sugar, and manufactured goods between Africa, the Caribbean and England. The capital they accumulated

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provided a major boost for the Industrial Revolution in England (see Williams 1970: 140-155). The bulk of the Jamaican population during this period, of course, consisted of African slaves who had been brought in to work the plantations. The remainder was made up of a sufficient number of Europeans or locally born "creoles" to administer the estates and keep the slaves in line. Many of the owners, eschewing the difficult environment and isolation of island life, left the management of their estates to agents and reaped their profits from a safe and familiar haven across the waters. By the 1830s there were 67 sugar plantations on the plains of St. Thomas, about a third of which had absentee landowners. In addition, there were about 20 "pens" (mostly cattle ranches) on the flat lands, and in the more mountainous areas a hundred or so (114) smaller coffee estates (Thornton 1980:117).

By the end of the eighteenth century, however, the gleam of Caribbean sugar wealth had already begun to tarnish. Increased worldwide competition in the industry (especially from Brazilian and Indian sugar, and European beet sugar) had sharply curtailed the profitability of the West Indian sugar plantations (Williams 1970:281-92). Abolition of the British slave trade in 1807, and emancipation of the slaves in 1838, further increased the costs of sugar production. During the nineteenth century the more marginal plantations throughout the island were forced by their burden of debt and diminishing profits to subdivide their property and sell out to smaller scale cultivators. The decline of the large estates was more precipitous in the less productive hilly areas such as St. Andrew, where large scale agriculture was more difficult. Following Emancipation, there was a great demand

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for land by the freed slaves who had little inclination to continue their labor in the cane fields and who had been evicted from the estate lands where they had formerly grown provisions. However, the fertile lowland plains were largely unavailable to them. They had little choice but to settle in the steep, rocky, erosion-prone, mountainous areas. Even so, the number of small landowners more than tripled in the two years following Emancipation, and continued to increased dramatically throughout the nineteenth century (Thornton 1980:104). In addition, many ex-slaves squatted on waste land that was of little interest to the landowners, further swelling the ranks of small farmers.

The largest, flattest and most fertile plantations, however, were able to survive this onslaught of unfavorable economic and labor conditions. They did so to a large extent by limiting the scale of their production and diversifying. Many of the large plantations of St. Thomas shifted to growing coconuts, cocoa, and especially bananas, which became increasingly important export crops toward the end of the nineteenth century. The large landowners, reluctant to sell land to small farmers and thus reduce their own labor force, instead let much of it go to bush (Thornton 1980:151,188-91). The tensions that arose out of the frustrations of land-hungry peasants living in abject poverty in the midst of underutilized fertile land soon led in St. Thomas to one of the most important upheavals in Jamaican history.

The Morant Bay Rebellion

For the estates, labor was a critical problem during this period. There were few freed slaves who would choose, except by necessity, to

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work in the cane fields for low wages. The plantation owners and agents, who controlled the island government, used a variety of measures to insure the continued exploitation of poor black laborers. The laboring class was systematically and intentionally denied access to "Crown Land:" unused estate land, and land which had been forfeited to the state for tax default. Taxes were disproportionately levied on the poor to force them into wage labor and prevent the accumulation of savings which would enable land purchases. The economic downturn and a series of natural disasters in the mid-nineteenth century led to an increase in unemployment, rampant inflation, and wage reductions. The importation of thousands of indentured laborers from Africa, India, China and Madeira from the 1830s to 1860s compounded this problem. These conditions produced crushing poverty among the working class. To add to their misery the lower class also had to endure epidemics, floods, droughts, and judicial injustices meted out by the planters, who were also the local magistrates and justices of the peace (Robotham 1981:27-67).

In October of 1865 the frustrations and tensions that had been building among the lower class exploded in St. Thomas-In-The-East. Sparked by a miscarriage of justice against a poor black man, a mob led by Paul Bogle, a local preacher and activist, marched on Morant Bay to demand redress. When fired upon by the local militia they rioted, killed several government officials, and burned the courthouse. They took over Morant Bay and Bath and managed to control much of the parish for several days. When word reached Kingston, Governor Eyre sent troops by ship and overland through the Blue Mountains to Morant Bay. In

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cooperation with Maroons[3] recruited from the hills, the troops brutally crushed the rebellion. Afterwards they went on a rampage of retaliation against the blacks in the area. Nearly 450 people, many innocent, were killed, 600 were flogged, and more than a thousand homes were burned. (Black 1973:116-126; Lowenthal 1972:64) Paul Bogle and George William Gordon,[4] a political leader of the area who had been fighting for reforms but who was not directly involved in the revolt, were hanged with several compatriots at the courthouse.

After the crisis had ended a colonial inquiry sent from Britain documented the scandalous abuses that had been going on, as well as the mismanagement of the crisis. One result was the return of Jamaica to Crown Colony status, which gave the British government more direct control of the island government. This, however, secured the planters' dominant position since it meant that the ex-slaves would not be able to wrest control of the island from the greatly outnumbered whites (Augier 1966; Lowenthal 1972:64). What the whites had feared most, and what they managed to avoid, was a Haitian-style revolution.

Despite the exposure of previous abuses, and some efforts to correct them, little was done following the rebellion to improve the lot of the poor. Onerous economic and social conditions prevailed through

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[3]Early slaves that escaped from plantations and set up insular communities in the inland mountains became known as Maroons. They, and their descendants, were so successful in defending themselves against the colonial powers that they were granted political autonomy in a negotiated settlement in 1739 (Black 1973:53-4). A few Maroon communities are still active in Portland and some of the western parishes (e.g. see Cohen 1973).

[4]Following Independence in 1962 Bogle and Gordon were among those designated as National Heroes, and today they are considered great patriots.

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the second half of the nineteenth century (Augier 1966:33-40; Thornton 1980). Continued depression in the sugar markets prompted more plantations to turn to other crops such as bananas and cocoa, which became leading export crops. By the 1920s bananas, which could be grown profitably by small farmers as well, had become the leading export (Kaplan 1976:73). While plantations throughout the island were divided up, most of those in the fertile river valleys and coastal areas of St. Thomas managed to stay intact. Towards the end of the nineteenth century Crown Lands became available for purchase by small farmers. Some of the lower class were able to save money for land, and many others went abroad to work temporarily (e.g. to Panama) where they were able to earn enough to buy small plots on their return. The general pattern which emerged was the division of marginal, unsuccessful estates and increasing numbers of small landowners, though these were concentrated mainly in the marginal hilly areas. The small farmers grew subsistence crops but also produced some crops such as bananas, coffee and logwood for the export market (Thornton 1980:171-202).

Plantation Economy

Despite the decentralizing trends in the agrarian economy during the late nineteenth century, the plantation system continued to play a pivotal role in economic and political developments in the island. Diversification to other plantation crops such as bananas prolonged and reinforced the vulnerability of the plantation-based, export-oriented economy. During periods of stagnation in the sugar markets, many of the plantation lands were shifted into banana production. Although banana

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production enabled more small farmers to participate in this export market and enhance their position, it also helped large plantations weather cyclical market downturns and avoid dissolution. However, bananas eventually proved to be just as unreliable as sugar. The banana industry was periodically devastated by blights, hurricanes and other natural disasters, the two World Wars, and market collapses, preventing any long-term accumulation of capital or stability in the agricultural export sector (Black 1973:131-4). Market forces which should have wiped out plantation production in favor of a more diversified manufacturing economy were prevented from effecting change by colonial policies which propped up plantation markets in times of difficulty.[5]

The inherent rigidity of the plantation system repeatedly frustrated attempts to break out of the cycle of vulnerability and dependence it had created. Caribbean economies were effectively locked into mercantilist relations with the outside world by colonial policies, which into the twentieth century systematically impeded development of more dynamic economic forms through artificial support of plantation exports (e.g. price supports for sugar), direct discouragement of manufacturing and processing within the island, removal of profits from the country, and disincentives for local reinvestment of accumulated capital (Lowenthal 1972:238; Beckford 1972). During this period, greater capital investment in mechanized agriculture was needed in order to maintain competitiveness, and this resulted in a steady shift of

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[5]For example, the World Wars stepped up worldwide demand for sugar but wrecked the markets for perishable bananas. During World War Two the British government paid for the banana crops which could not be delivered, an act of "generosity" which at the cost of preventing long-term structural changes, maintained short-term stability.

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plantations from private ownership to control by multinational vertically integrated corporations. The waning of colonial power during the twentieth century was offset by an increasing control by these multinational corporations, which continued colonialist market relations by using Jamaica as a source of raw materials and profit with no effort to encourage local economic development through forward or backward linkages (Beckford 1972).

Ironically, much of the political transformation of the island which led to decolonialization was directly tied in with the economic stagnation and structural rigidity resulting from the plantation economy. Small banana producers banded together in 1929 to form the Jamaican Banana Producers Association which enabled small farmers for the first time to exert some political influence. More important were the labor organizations which created a mass movement pushing for decolonialization and independence during the 1930s and '40s. This movement shaped the political structures which continue to dominate island politics even today (Black 1973:140-5).

During the 1940s and '50s the discovery and development of mineral resources in the island, particularly bauxite (aluminum ore), promised a possible means for breaking the cycle of dependency. However, plans developed for exploitation of these resources parallelled the plantation model, with control in the hands of multinational corporations which exported raw materials, extracted profit, and failed to forge links with the Jamaican economy (Girvan 1967,1971; Manley 1982:44-7). When the inevitable decline of world aluminum markets came in the 1970s, the hoped for bonanza again turned to bust.

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There has been a great desire in Jamaica, especially at times when socialist-leaning political forces have come into power, to extricate the economy from the clutches of the plantation system which is felt to be an obstacle to independent economic development (Goldsmith 1981; Best 1968; Beckford 1972). In the 1970s the socialist government of Michael Manley made attempts to break these bonds of dependency through nationalization of some plantations and mining concerns. Unfortunately, their efforts resulted in a trading dependence on multinationals for dependence on international lending agencies, especially the IMF. Today the massive foreign debt of Jamaica makes restructuring of the export-oriented sectors impossible because of the continual short-term need for hard currency to finance the debt and maintain the inflow of vital resources (e.g. oil). Thus there has been a tendency to continue encouragement of the export of raw materials, since other export sectors have been unable to develop sufficient marketable surpluses. The result is a continuing cycle of low investment and stagnation in other sectors.

The plantation system has managed to stay intact in St. Thomas up to the present day because of the relative productivity of the parish's land. As in other parts of the island, the trend in St. Thomas has been towards corporate and multiple ownership of plantations, and away from individual absentee ownership. The persistence of plantation agriculture in St. Thomas is significant here because it has had, and continues to have, a marked influence on economic, social, political and cultural structures in the area. For individuals, the most immediate effect is on employment opportunities. Those who do not have sufficient land to farm for profit have few alternatives to arduous but low-paying

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agricultural labor on a plantation. Aside from a tire factory in Morant Bay which employs mainly skilled workers, there are virtually no other large employers in the area besides the plantations. Plantation owners in St. Thomas have been known to use their political influence to block other forms of development in the parish, e.g. the tourist industry, which might threaten their pool of cheap labor (Dreher 1982:20). Even for those people who have enough land to grow food for subsistence, plantation labor is one of the few sources of cash available.

Estate work does not necessarily mean field labor; packers, skilled workers and supervisors are needed as well. Some supervisory positions can be attained by locals who have done well in school and are able to move themselves up in the ranks. The higher management positions go to those who have the advantage of higher education. These men usually come from other parishes or even from abroad; locals have little chance of attaining such a position. Those trained in a trade, e.g. electricians, mechanics, etc., can get better jobs than unskilled laborers, but work is often scarce.

Of course there are some other jobs available in the area to those with some special training, e.g. schoolteachers, nurses, busdrivers, government administrators, etc. For those who are able to accumulate some capital, e.g by doing farm labor in the USA, purchase of a car for use as a taxi may provide a steady income. But for most people these jobs are only dreams.

Another alternative to farm labor is the ubiquitous Jamaican vocation known as "higglering," which in its origin is another remnant of the plantation system. This informal marketing system began shortly

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after plantations were introduced as a way to induce slaves to produce their own food. Slaves on the estates were given small plots on which to grow provisions and were allowed on Sundays to take the surplus to sell at local markets to earn some cash (Mintz and Hall 1960:4-5). This practice evolved after Emancipation into a customary system in which higglers, primarily middle-aged women, would collect and pool the meager surplus produce from the households around them and travel to sell it at the local or regional weekend market (Katzin 1959).

This system still functions, but has in recent years been expanded and elaborated on by enterprising small-scale capitalists. In rural districts of St. Thomas, local women (and some men) buy bags of coconuts, bananas, etc. from nearby estates which they take, along with household surplus production, to Kingston by truck for resale. More ambitious urban higglers now travel regularly to foreign lands such as Panama and Miami to purchase cheap goods which are imported and resold at a profit. These innovative traders have earned themselves the official sobriquet of "Informal Commercial Importer". In St. Thomas this spirit is manifested on a smaller scale. The streets of Morant Bay, once relatively quiet, are now clogged with vendors selling everything from clothing to goldfish. The competition is fierce, however, and only those with desirable goods (e.g. shoes) purchased abroad can make a handy profit. Those who have a travel visa or relatives abroad willing to send goods are at a great advantage. Most others are unable to make more than a few dollars selling their candy and cigarettes.

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For the majority of young people in the rural areas there is little chance for advancement. A few are able to do well enough in school to get to University and obtain a decent job in Kingston or perhaps a chance to emigrate. Those in better off families of course have a distinct advantage here. Others, if lucky, may be able to do temporary farm labor in the USA or obtain some training in a trade. Manual labor on estates, difficult and degrading work, is an unattractive option, but the only one open to many of the people. Estate labor is associated with its own difficulties. Employment, especially on the sugar estates, is often seasonal, so that one can count on a steady cash flow for only part of the year. Often workers are hired only as they are needed, for specific tasks such as "bushing" or "building" grass (cutting grass around coconut trees). While some workers are able to maintain a fairly steady flow of such jobs, most are able to find only sporadic work.

The most common response to this is the classic Jamaican adaptation described by Comitas as "Occupational Multiplicity" (Comitas 1973[1964]). Because work opportunities are too limited for most people to rely on any single job or occupation, most will work in a variety of jobs, basically doing whatever happens to be available at the moment. When asked about their work, most people of working age will say that they just do whatever job they can get. A young man may profess to be at once carpenter, mason, plumber, and cultivator. This usually means that while he has had no formal training in a trade, he has had some experience in a variety of jobs, and is willing to do whatever is available.

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In the past, a major employer in the area was a shipping wharf at Friendship, a deep water port east of Morant Bay. Up until the 1970s this was the main point of exit for bananas and sugar produced in the area. In the old days when the ships were loaded by hand, anyone who was strong and willing could obtain work carrying the bunches of bananas up the gangplanks into the ship. Although the work was physically exhausting, it was available and paid better than field labor. Since the port was closed in the mid-70s, bananas have been taken by truck to Port Antonio in Portland from whence they are shipped. What were once loading docks and warehouses at Friendship Wharf are now just bare foundations. The wood and zinc buildings were stripped away long ago by scavengers looking for materials to patch their rickety houses. In 1988, as elections neared, the government announced a "study" to look into the possibility of re-opening the port (Henry 1988; Daily Gleaner 2/19/88). But now that the elections are over it is unlikely that anything will come of this.

Because of the shortage of regular work, many families must rely on household subsistence cultivation for the bulk of their diet, especially in the rural areas. While many people have access to land, it is often "family land"[6] to which they have only some communal

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[6]"Family Land" in Jamaica refers to land that has been inherited jointly by all descendants of the original owner. When a landowner dies without bequeathing it expressly to a certain person, it customarily passes to the corporate ownership of his spouse and descendants. In practice only a few will make use of the land at any one time, but any of the beneficiaries have rights to live on it and share in the production of its trees. And if they move away they have the right to return there at any time, providing a sort of insurance for hard times (Clarke 1971; Blustain 1981). In the past it was thought that this led to fragmentation of the land, but in fact the reverse is true. The custom maintains the (continued...)

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rights. Those who do not own or have access to land are unable to cultivate their own staples and must either buy them at a market, or buy or beg them from neighbors. A variety of starchy crops are grown as subsistence crops (bananas, ackees, plantain, breadfruit, coconuts, yams, etc.) and form the bulk of "poor man' food". Those who have secure long term rights to land will plant fruit trees and benefit from the produce of these (avocado pears, oranges, jackfruit, papaws, mangos, etc.). Many who have some capital and a place for grazing will raise goats or, if especially well endowed with capital, perhaps a cow or two. While a surplus of any of these may be sold in the market, some crops (e.g. pimento, cocoa, nutmeg) are grown primarily for sale, since only small amounts will be consumed by the household. Because of the importance of this subsistence production much of the economic activity in the area goes unrecorded and is difficult to quantify.

Social Impact of the Plantation System

The ramifications of the plantation system have also had a marked impact on the social structure of Jamaica. The settlement patterns of the island were a direct result of the needs of early sugar estates. In the early days this meant large numbers of African slaves and enough Europeans to supervise and keep them under control. Later on a class of

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[6](...continued)
piece of land as a whole while allotting its benefits to those family members who are most in need of it and who are willing to stay and cultivate it (Blustain 1981: 55-6). Of course, this does not always work smoothly in practice, and disputes over rights sometimes arise. Family land also has important symbolic significance as land ownership in Jamaica has traditionally been the key to social prestige and political participation (Besson 1979).

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locally born "creoles", often of mixed race, arose and took over the middle rungs on the social ladder. The result was a race/class hierarchy with a small number of whites on top, a larger group of mixed race in the middle, and the multitude of blacks at the bottom (Smith 1961; Braithwaite 1960). The group at the top was the smallest, but also had the greatest power and access to resources. Those at the bottom were the poorest and most vulnerable. Prior to Emancipation these distinctions were codified in the laws of slavery, but even after the slaves were freed the pyramid was maintained by economic and political means. Not only were these classes differentiated by their relative power and wealth, but they also developed such distinct cultural and social systems that the overall structure has been described as a "plural society" (Smith 1960).

While this social structure has persisted to the present, it has been modified in a number of ways. Following Emancipation, the need for labor led to the importation of indentured laborers from Africa, India and China. East Indian laborers settled throughout the island, but their descendants have exerted less cultural influence in parishes like St. Thomas, where their numbers are low, than in areas such as St. Mary and Westmoreland, where they are more numerous, or other Caribbean islands such as Trinidad where they form a large segment of the population. Other immigrants such as Jews, Chinese and Syrians have played an important role in the society, but these groups are relatively small. Their success in business has moved them into the upper classes, and they have tended to maintain a separation from other groups. As a

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result, their influence on the culture of the masses in Jamaica has been limited (Lowenthal 1972).

After Independence in 1962 many of the whites left the island and the size of the white population has continued to shrink, decreasing from 0.7% of the population in 1970 to 0.2% in 1982 (Statistical Institute of Jamaica 1986:25). Since Independence there has also been some increase in social mobility. Today it is not uncommon to see dark-skinned men of humble background at the top positions in society, thus blurring a bit the once sharp lines of race and class. The system of stratification has become less closely linked to skin color than it was in the past. This period has also seen the rise of a larger middle class, which Gordon calls the "commercial-industrial bourgeoisie." (Gordon 1986).

However, the gap between the highest and lowest levels of society, in terms of access to resources, has actually widened. Few of the new opportunities have reached the rural poor. Upward mobility has improved, however statistically the number who are able to advance, while significant in relation to the size of the upper strata, is still minuscule in relation to the number of poor. This creates a paradoxical situation in which, because of some increase in opportunities for upward mobility, the culture of lower class Jamaica is having a visible effect on the upper classes, while at the same the lower class individual has very little chance to advance, and gaps in wealth continue to widen (Gordon 1986). The rural poor have the least opportunities. "Rural small farmers and agricultural laborers are by far the most disadvantaged groups in society in terms of access to the highest levels

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of the middle strata, despite all the postwar social policies of improving rural conditions." (Gordon 1986:49)

In St. Thomas, color/class stratification remains intact to a large extent. The large laboring class is overwhelmingly dark-skinned, while the professionals, estate owners and managers are mostly lighter-skinned. Opportunities for advancement up the social scale, e.g. through advanced education, exist mainly outside of the parish in urban centers such as Kingston. While efforts have been made by the government to provide more chances for advancement, for example by increasing the number of high school places available, those from the poorest families continue at a great disadvantage. Even when education is free, there is often insufficient money to pay for the keys to the door of learning: a uniform, shoes, and bus fare. Uneducated parents are less likely to insist on regular attendance by their children, and the broken homes, single parent households and lack of security among the poor are hardly conducive to discipline and hard work in school. Better off parents are able to send their children to private schools, and provide a more stable environment for them at home.

The history of the settlement of St. Thomas has had a strong influence on cultural developments in the area. Slaves brought in to work the sugar estates came from a variety of tribal backgrounds. Intermixture of the different tribal groups and the strictures of slavery made it next to impossible for the slaves to maintain much of their African culture. Under the watchful, and fearful, eye of the slaveowner the only aspects of African tradition that persisted were those that were non-threatening or that could be passed on relatively

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clandestinely, such as certain religious beliefs and practices (See Chapter 6) (Curtin 1955:29; Simpson 1978). Even these have failed to survive in much of the island. Although African culture has provided the basis for much of the later cultural development of Jamaica, in most parts of the island the only clear obvious African survivals appear in old folk tales, in beliefs about the spirit world, and in words originating in African languages.

In St. Thomas and a few other areas, however, historical circumstances have enabled pockets of African culture to survive in a much more intact form. When Emancipation came in 1838, few of the freed slaves were willing to continue to work for their former masters. Most preferred to scratch out an existence from subsistence farming in the hills. Desperate for other sources of labor the planters devised schemes for importing indentured laborers. At that time a large number of Africans freed from Spanish and Portuguese ships were being held in refugee camps in Sierra Leone and St. Helena. Between 1841 and 1865 recruiters were able to convince, and/or coerce, a large number of these displaced Africans to come to Jamaica to work as indentured laborers on the estates. These free Africans were settled primarily in two areas: St. Thomas-in-the-East, and Westmoreland at the western end of the island. In both of these areas, and in some of the highland Maroon (See p.32) settlements which resisted European influence, some aspects of African culture have persisted much more strongly than in other parts of the island (Schuler 1980).

The free Africans who were settled in St. Thomas (more than 1200 in all) came primarily from the Congo area in Central Africa. They

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managed to form a relatively cohesive and stable group and their presence had a great influence on the culture of this part of Jamaica (Schuler 1980). The most visible example of this is the Kumina cult which, despite having lost some of its intensity and numbers, is still quite active in the area. This and other aspects of Central African culture were not only passed by the free Africans to their descendants, but also were a strong influence others living in the area. (See Chapters 7 and 8 for a more complete discussion of the Kumina cult.)

The plantation system has also had a profound effect on political developments in Jamaica. Throughout most of its history the government of Jamaica was under the direct control of wealthy plantation owners, which insured that the interests of plantation agriculture took precedence over most others, and that political activity revolved around this. At several points some of the most significant political developments resulted out of struggle against these entrenched interests. In the late 1930s economic woes and poor working conditions led to massive labor unrest. Sugar estate and other plantation workers were among the most vocal and militant of the protesters. The main leader who emerged to represent the poor rural workers was Alexander Bustamante. He founded the Bustamante Industrial Trade Union (BITU) and its political offshoot, the Jamaica Labour Party (JLP). His efforts on behalf of the downtrodden masses were a major factor in shaping the post-war political landscape in Jamaica. Bustamante became the first prime minister in 1962. Since then the JLP has alternated in power with its rival, the People's National Party (PNP) (Eaton 1975).

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Politics in Jamaica are based on partisanship, patronage and extreme personal party loyalty, sometimes to the point of violence. The benefits that come to local party supporters when their party is in power (usually in the form of public works projects, jobs and favors) insures their continued allegiance. Indeed, party loyalists depend on, and feel entitled to, such patronage in exchange for their votes and support. Often it is the only way their communities can get access to scarce social resources. Failure of such patronage results in widespread resentment. The complaint is often heard in the home districts that the politicians never show up to help people until election time rolls around and they come searching for votes (Eaton 1975:125; Foner 1973:118-120).

St. Thomas is no exception to this pattern. Some of Bustamante's earliest organizing efforts in the 1930s were among plantation workers in St. Thomas, and the parish has remained a bastion of Jamaica Labour Party (JLP) support since then (Eaton 1975:38,61,79,88-89). The JLP ruled the country throughout the 1980s up until the election in February 1989, and was in power during the research period. The People's National Party (PNP) took a majority in Parliament in the 1989 election, and more recently has consolidated its control of local governments as well. During the research period the Member of Parliament (MP) for eastern St. Thomas held a powerful and highly visible cabinet position as Minister of Public Utilities and Transport in the JLP government of Edward Seaga, and was regularly voted in national polls as one of the most popular politicians in the party. Yet in his constituency there were complaints among the rank and file about his failure to bring many

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new benefits to his parish. Not surprisingly, during the buildup to the most recent election he announced some large public works projects to be undertaken in the parish: improvements to the telephone system and a major water project at the eastern end of the parish, as well as a "study" to determine the feasibility of reopening Friendship Wharf (Daily Gleaner 1987,1988). He was one of the few JLP MPs (Members of Parliament) who retained his seat in the 1989 election.

THE COMMUNITY STUDY

In planning this project I felt that the best way to come to an understanding of the impact of illness on the lives of rural Jamaicans, their strategies for coping with illness, and how they use the treatment alternatives available to them would be to investigate these issues in a single rural community. In the proper setting this would also would enable me to gather ethnographic data on folk healing practices and religious organizations involved in healing, as well as to look at how these fit into people's lives on a day to day basis. While I was not attempting to do a detailed "community study" per se, I felt that in order to fully appreciate health related beliefs and behavior it would be important to see how they relate to and are influenced by economic variables, social structure and cultural activities.

Several criteria were used in selecting a site for this aspect of the study. I wanted to find a community whose boundaries were fairly well delimited, and of a size that would be manageable with the time and resources available. It should be a place where people have access to both folk healing and biomedical treatment, but in a location where

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travel and distance would not introduce a strong bias for the use of either system over the other. And it should provide an environment in which ethnographic information on the folk healing system could be readily gathered. Albion, the community in which I conducted this part of the study, proved to be an excellent choice.

Jamaican Communities

Within Jamaica there is a great deal of variation in rural community organization. Community types in St. Thomas range from the small urban agglomeration of Morant Bay, the parish capital, and the surrounding residential suburban housing developments, to the isolated and impoverished settlements in the hills. Foner (1973) has discussed five "ideal types" of Jamaican communities: small towns, sugar estates, settlements bordering sugar estates, remote hill communities, and more prosperous villages populated largely by farmers. Examples of all of these can be found in St. Thomas. We could perhaps add to this categorization the suburban housing developments, publicly or privately financed, which provide housing to the middle and upper class workers in the more prosperous towns. Each of these types has its own characteristics.

The towns are the centers of economic and administrative activities. They contain regional markets, supermarkets, hardware and appliance stores, banks, pharmacies, hospitals, government offices, and the offices of doctors and lawyers. They also are commercial centers, being the site of shipping ports, factories and businesses. Morant Bay, the parish capital of St. Thomas, is a good example of such a town. It

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is the epicenter of the former St. Thomas-in-the-East, i.e. the part of the parish east of the Yallahs River. The main market of the parish is located here and nearly all public transportation in the area is routed through the town. Taxis and minibuses take people to and from numerous districts throughout the parish, while longer trips, e.g. to Kingston, are made on the larger minibuses which line up alongside the market. If one does not own a car - and few do - the only other means of travel to and from Kingston is the "country bus," a huge, hulking, groaning, crawling, but reasonably dependable monster that snakes along the coastal road from Kingston to Port Antonio at the northeastern tip of the island. In order to make the journey to Kingston from the eastern part of the parish, if one does not take the slow country bus, it is necessary to somehow get to Morant Bay and scramble there for a spot on one of the crowded minibuses.

Sugar estates, the second type of community, are really seasonal communities as they attract large numbers of workers during the crop season from January to July when work is available. During the "dead season" only those workers who are needed for maintenance tasks on the estate are retained. Thus their "inhabitants" tend to be mobile male laborers from other areas or parishes who are not permanent settlers. (Foner 1973:5).

Settlements bordering sugar estates are made up to a great extent of workers who have come from other areas to labor on the estates and subsequently settled permanently nearby. They are also dependent primarily on the estates for work and subject to the same yearly boom/depression cycle of the sugar industry. During crop season they

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are relatively prosperous, but in the dead season the workers must turn to subsistence farming and sporadic work from other sources to survive (Dreher 1977: 92). There are several such communities, some quite large, adjacent to the sugar estates at the eastern end of St. Thomas.

Foner's fourth type, *remote hill communities*, are common in St. Thomas. In the past these hamlets were quite isolated and lacked paved roads, electricity, telephones and water supply systems. However with modernization these amenities have become increasingly available even in the more remote areas. Their inhabitants tend to be linked by ties of kinship and they are relatively closed to outsiders (Smith 1965[1956]:184). Lack of employment opportunities force those with access to land to gear their efforts towards subsistence agriculture with hopefully some surplus production that can be marketed locally or sold to higglers. The landless often eke out a hand-to-mouth existence and are forced to look for work on nearby sugar, banana, coconut or cocoa plantations. Those who are too old, too young, or too sick to work have an even tougher time surviving and often live in crushing poverty, dependent on neighbors and relatives for food and assistance.

The final type is the more prosperous *community of small and medium farms*. In these, people have land on which they grow crops for export as well as their own use. They are less dependent on neighboring estates for work and have greater access to modern amenities such as electricity, telephones, water systems and schools.

Of course, few communities will fit perfectly into any of these ideal types; most combine characteristics of several. But these prototypes exemplify the variation one sees in Jamaican settlements. In

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her discussion of the "ganja (marijuana) complex" in three St. Thomas communities, Dreher (1982) presents a useful example of how these ideal types are manifested in reality in the parish. One of the communities she discusses is adjacent to a sugar estate. It is fully caught up in the plantation economy and is relatively open. Another, far removed in the hills, relies heavily on subsistence farming and is much more closed. The third lies somewhere between these extremes with a mixture of characteristics of both of these types (Dreher 1982).

Use of the term "community" is actually somewhat problematic in the Jamaican context. Our usual concept of communities as easily definable, functional, corporate units often just does not fit here. This is a result of both historic settlement patterns and the structure of the political system. Settlements tend to follow a pattern of what M.G. Smith has termed "ribbon development" (Smith 1965[1956]:178). Houses are found strewn along the roads and paths which are the arteries of rural commerce and transit. "Communities" often blend imperceptibly into each other with no clear boundaries between them. The dearth of village councils or political organizations means that other factors such as kinship networks, and informal social groups provide the main foci of community orientation, and the primary forces for social cohesion. Local official politics is actually based at the parish level and political leaders are chosen on the basis of political regions which encompass several communities or residential districts (Foner 1973:8). As a result, individual communities have little political salience.

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Nevertheless the idea of the community as a corporate entity is not totally foreign here. Some districts[7] are often delimited by natural boundaries and transportation access. There are some organizations that function at the community level and serve as unifying forces, e.g. cricket clubs. Kinship ties, economic relationships, and land tenure patterns also are important factors in people's identification with a particular community.

Albion

Branching off of the main coastal road, which runs from Morant Bay eastward toward the tip of the island, are occasional small roads which at first sight appear to be just service roads leading into the backlands of the large banana and coconut plantations nearby. Some are, but others lead into sleepy hamlets wedged unexpectedly into the hills amidst the expansive stretches of swaying coconut palms. Sometimes the only clue to the presence of one of these villages is the small group of people standing at the intersection with the main with their market bags waiting for the next minibus to appear.

One of these roads leads, after a steady uphill mile along a picturesque ridge overlooking a large stand of coconut, into the district of Albion[8]. The access road was paved long ago, but now shows

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[7]"District" is the word used by rural Jamaicans for a community. "As used by rural folk... the term "district" normally refers to a distinct community, members of which recognize certain bonds among themselves which do not extend to other groups nearby." (Smith 1965[1956]:178)

[8]To protect the anonymity of informants all names used for individuals and research sites (except for the larger towns such as Kingston and Morant Bay) are fictional. For the purposes of the descriptions to (continued...)

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signs of steady deterioration due to years of neglect. At the other end of the district the road eventually connects up again with the main, after winding through some uninhabited estate land (See Map 1). When the road was in better condition buses and taxis passed regularly through Albion, and this was actually the main route to the east. But now the district is more isolated. Few drivers are willing to take the risk of driving through the damaged back road anymore, and the main route in and out is too long to be profitable for commercial vehicles. Even those minibus drivers with a license supposedly requiring them to provide service to the district avoid it in favor of the more profitable route on the main. The only way to catch a ride to town nowadays is to walk down to the main road and wait at the corner for a passing minibus.

Albion consists of a collection of houses scattered along this access road as well as the smaller unpaved side roads and footpaths sprouting from it. These roads and paths run mainly along ridges separated by steep and verdant gullies. The boundaries of Albion are actually fairly well delimited by natural boundaries and the surrounding estate lands. Despite its lack of any real corporate organization, its relative isolation as an island of activity in this sea of silent coconut palms has endowed it with a real sense of community. Those who live are implicitly bonded to one another by this insularity. Not that life in Albion is always harmonious - far from it. But unlike many districts in Jamaica, in Albion a person knows who his neighbors are, he know who lives in the district and who is a stranger, and he knows where

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[8](...continued)
follow, the "ethnographic present" is considered to be the period from mid 1987 to mid 1988.

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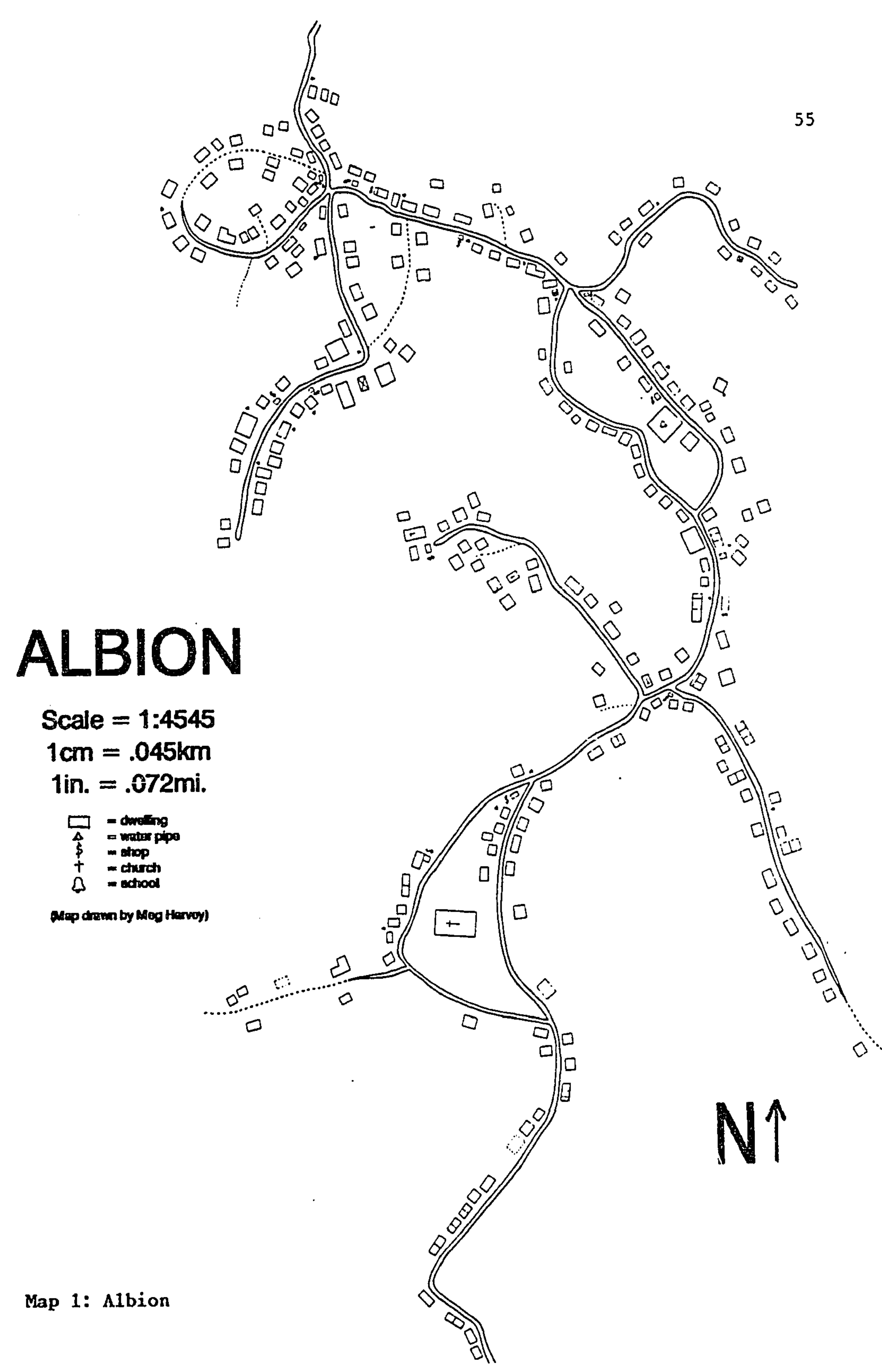

Map 1: Albion

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Albion begins and where it ends.

None of my informants in Albion was able to give a complete account of the district's origins. However, from information I've been able to piece together from various sources its beginnings as a district appear to be quite early. The oldest residents remember that Albion was at one time an estate in its own right. An old estate map made in 1838 (Anonymous 1838) shows the western boundary of the Albion estate and a small group of dwellings at the site of the present day village. These probably housed the estate workers and slaves. Cane was processed on the estate with a cattle powered mill (Map of Jamaica 1804). Another map (Anonymous n.d.) shows Albion as a tract of "281 acres, chiefly sold in lots. Estate of D. Ewart." Apparently the estate was broken up at a fairly early date, a victim of the difficult markets, labor problems and poor economic conditions at that time. The old deed for the property where I resided in Albion listed the land as having been formerly part of the Albion Estate. An acre on a steep hillside cut by a gully, it was sold originally in 1840. It appears that the poorer hilly land of the estate was sold to small farmers for residential and cultivation purposes and today this land continues to be quite fragmented. The better farming areas of the estate were bought in sections by neighboring estates or as medium size farms. Some of the better off residents now cultivate larger sections of land on the outskirts of the district, which have remained relatively intact.

Although commercial activity has declined in Albion since it was bypassed by the main flow of traffic, it continues to be a lively community. It is in fact one of the most populous districts in the

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parish. Our detailed census at the time of the study (1987-1988) showed the community population to be 848 people living in 260 households, and from previous figures it appears that it has remained relatively stable for at least the past 20 years.[9] The age-sex distribution reflects the pattern of a high birth rate with out-migration of young men and women (see Figure 1: Age-Sex Distribution in Albion). About half (387[46.2%]) of the population is under age 20, and in this age group the numbers of boys and girls are fairly even (F=200[51.7%],M=187[48.3%])). In the 20-and-over age group (450[53.8%]) there is a slight predominance of women (F=246[54.7%]; M=204[45.3%]), which suggests that the outmigration of men after age 20 may be more frequent than that of women, that women may have a greater tendency to return after moving away, and/or that the mortality rate of women may be lower than that of men.

Nearly all the residents of Albion are of African descent although there are a few families of East Indian or mixed ancestry. Most are descended from slaves, but the active participation of some of the families in the Kumina cult suggests that they probably have some free African ancestors. A few people were reportedly of Maroon descent, however they were fully assimilated and in no way distinguishable from their neighbors. There were no whites (other than the researchers), or

[9] Official census figures from 1982 show the population of the enumeration districts which include parts of Albion to be 950 (E57, E62, E63, E64, E73). In 1970 the figures had been slightly higher at 959, though the enumeration districts were slightly different (SE17, E36, E37, E38). These figures are larger than ours, which might suggest a decline in population. However, a closer examination shows that the enumeration districts do not correspond completely with the actual community boundaries and include territory that would not be considered part of Albion proper. Thus they probably overestimate the actual community population somewhat.

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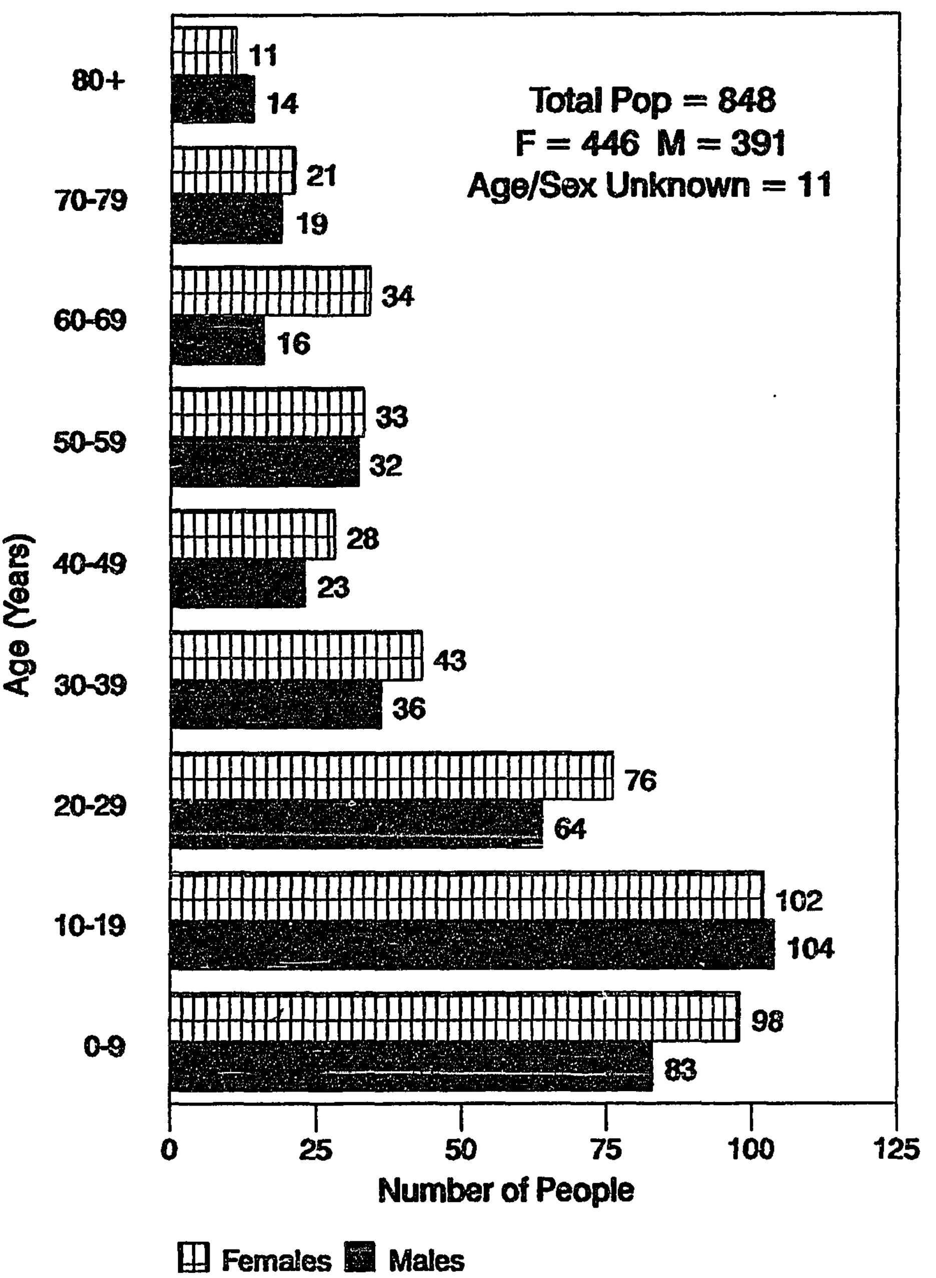

Figure 1: Age-Sex Distribution in Albion

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members of other ethnic groups, living in the district during the research period.

In its structure and activity Albion is typical of other inland communities in this area (see Dreher 1973:10-18; Smith 1965[1956]:179-181). Houses are arranged primarily along the roads and lanes that provide access to the different neighborhood groupings. These "neighborhoods" may be named for the road that services them (e.g. Mango Lane) or geographical features (e.g. Big Hill). They are made up of clusters of households which are often linked by kinship ties, which may reflect a common origin of the land, or in some cases joint tenancy on "family land." While most of these neighborhoods are mixed in terms of wealth and status, better off families have bought or inherited land close to the main road and it is here that one finds the concrete and tile houses which are the symbols of affluence. On the other hand, the poorest families tend to live in crowded, broken down shacks in areas without good access to the main road or water sources. These poorer neighborhoods can be found only by following narrow muddy paths off of the main roads.

There are seven general shops which supply the people of the district with staples and a variety of other goods such as simple over-the-counter medicines. Most also have a small rumshop attached. Aside from these there are several smaller stands run by individuals out of their households which sell cakes, biscuits, candy, cigarettes, and other small items. Just about any household with a refrigerator will sell ice, cold drinks and maybe ice cream to neighbors. On an even smaller scale is the person with a small amount of capital who will

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purchase a carton of cigarettes and sell them in small numbers to people in the neighborhood. In addition, some women will sell home-made products such as coconut oil, "chocolate" (cocoa), or coconut candies. There is also a small "butcher shop" which is silent except for one morning a week when the butcher, who lives outside the district, slaughters a pig and sells meat to whomever can afford it.

Albion has its own "All-Age" school which includes grades 1 through 9. Most of the children in the district attend this through grade 6, at which point they go off to high school or other secondary schools, depending on their exam results. Those who do poorly on the exams may stay through to grade 9, at which point their education will end. The principal of the school is a native of Albion, and lives in a government owned house next to the school. Most of the other teachers live outside the district and commute in daily. There is also a "Basic School" (pre-school) held at the Baptist Church where very young children (age 4-5) get their earliest education.

Albion has its own "type 1" Health Center[10], located in 2 rooms rented in the Baptist Church. This is run by a nurse-midwife who is there 4-5 days a week. It offers basic preventive and low-level treatment services (ante and postnatal clinics, blood pressure monitoring, dressing changes, well-baby clinics, nutrition counselling, treatment of minor illnesses, etc.). A Community Health Aide assists in the clinics and makes home visits to children and some elderly in the

[10]Type 1 community based health centers constitute the most basic level of the Primary Health Care System. See Chapter 4 for a complete discussion of the Primary Health Care system and the role of Type 1 centers in this.

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district. The health center also serves as an informal social center for friends of the nurse who gather there to chat during the afternoons.

Water for the district comes from a spring located on the outskirts of the district at the site where the sugar mill once stood. In the past the quality of this water was questionable, but about 10 years ago a new tank was built and a diesel pump installed. Water is chlorinated at the site and pumped up the hill to 6 standpipes on the main roads. Some households (28/260) were able to afford to have pipes installed in their yards, or connected with their indoor plumbing. Most, however, must carry water from the pipes to their homes, often a considerable distance. Water carrying is usually done by children. Having a diesel, rather than electric, pump means security of the water supply during a power failure, however it has a number of disadvantages as well. The pump is only turned on for an hour in the morning and an hour in the evening, which means that people must twice a day be ready to drop everything to go stand in line for water when it begins to flow. If they are away from home for some reason, they don't get water. The pump in Albion has also proved to be quite unreliable, and breaks down frequently. At one point it was out of service for about a month, and during this time water had to be trucked in from outside the district, which made it more difficult than ever to get water.

There are three churches in Albion. The Baptist Church is the largest and oldest, situated on a hill in the center of the district. There is no resident pastor. Services are run by a minister who comes in from another district one Sunday each month, and at other times by church elders. It is the most established and "respectable" of the

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three churches. The Seventh Day Adventist church is housed in a small but neatly constructed wooden building at the corner of Cotton Tree Lane. The pastor for this church also occasionally comes in from another district to do services, and at other times services are run by the members. The Seventh Day Adventists could also be considered an established or "nominal" church (see Wedenoja 1978:135). The third church is the Mt. Olive Galilee Revival Church located at the end of Cotton Tree Lane. Bishop Smith (Brother John), the preacher for this church has a house in another district, but lives primarily next to the church in Albion, which serves as his base of operations. He conducts the healing services on Tuesday nights, and sometimes the Sunday services as well (when not visiting another of his churches). He has 6 other churches in St. Thomas and Portland, and spends a good deal travelling to them for services or special events. (See Chapter 7 for a more complete description of healing activities at this church.)

While it is difficult at first to appreciate the social stratification of families and individuals in Albion, it is clear that there are disparities in wealth, prestige and influence, and that these have an effect on the social interaction of its members. The schema of 5 socioeconomic levels (I, IIa, IIb, IIIa, IIIb) that Dreher uses in her analysis of 3 other communities in St. Thomas is useful for looking at the social hierarchy in Albion (Dreher 1982: 10-32). These levels constitute a hierarchy of socioeconomic status. However, the lines separating them are often not clearcut and they really represent ideal types that blend into one another at the margins.

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Level I, consisting of wealthy, politically powerful estate owners or executive expatriates is not really represented in Albion. The closest to this might be Mr. Williams, the owner of Friendship Estate which borders the southeastern edge of the district. A number of Albionites work as laborers on his property, and his land serves as a favored site for praedial larceny, but he lives in another district several miles away and does not play a direct role in Albion's affairs.

Level II consists of the wealthiest members of the community. Families at this level live in large concrete and tile, or sturdy wooden, houses with modern amenities such as electricity, indoor plumbing, television, and stereo equipment. A few have a car or truck as well.[11] The households tend to be composed of a married couple with their children, and sometimes parents. The children attend school regularly and are often sent to Kingston, or one of the better local high schools, for secondary education. They may go on to University or professional school, and quite often migrate to Kingston or abroad. Religious affiliation is usually with the Anglican Church in another district, or may be with the local Baptist Church. They tend to hold high status positions as nurses, teachers, government administrators, or supervisors on one of the large estates nearby. Often more than one member of the household is employed, adding to the family income. Some of the local shopkeepers have been successful enough to be able to maintain such a lifestyle, and additionally there are a few households

[11]There were 4 cars, 2 trucks, 3 vans, and 8 motorcycles recorded in the district, though not all of these were in working order.

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with sufficient land (20-30 acres) to farm profitably. About 14% of the households in Albion could be considered as belonging to this level.

Dreher's categorization distinguishes between level IIa, who have personal and social connections mainly outside of the local community, and IIb who have their closest connections within the community (Dreher 1982). In Albion, just about all of the level II households could be classified as IIb, with primarily local ties and influence. Although there are a few people who have moved into the community to work as supervisors on nearby estates, this is unusual. Most people moving to the area for such a job will try to find a place in a more comfortable and convenient location. Thus the families at this level, though comparatively successful, have mostly originated locally and maintain local ties.

There are several routes by which level II members attain their status. Some are born into it and derive their wealth, especially land, from previous generations. Children from those families have a great advantage in obtaining the education necessary for a high status and high paying job. But there are other ways as well. Some achieve their status gradually after years of work, saving, and step-by-step home improvement. A number of the households in this category, then, consist of older couples with their children who have been able to advance their position from humble beginnings. Some people from less well off families have been able to migrate abroad and make their fortunes in places (e.g. the USA, England, Canada) where pay levels for even the lowest status jobs are much higher than in Jamaica. Some of these return to Albion for retirement after making sufficient money to buy

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land and build a house. Money sent back to Jamaica from emigres abroad makes up an extremely important part of the Jamaican economy and this is especially true in Albion. Remittances from a family member abroad, especially if they are investing in improving the house for retirement use, can enable a family to raise its standard of living considerably. Many Jamaicans who migrated abroad in the 1940s, '50s and '60s are now returning to build their retirement homes where they grew up and have land rights. Even temporary work abroad, for example farm labor in the USA, has enabled a few to acquire sufficient capital to make a start in business. Purchase of a taxi or van can provide a job and steady income for a man and, if his wife also works, enable them to live relatively well.

The monthly income of households at this level ranges from about J$1000 to J$5000[12] (US$180 - 909) and varies considerably depending on how many household members are working in what sorts of jobs, and also on the amount of remittances received. Income is relatively stable since the jobs occupied by people at this level are usually regular and secure.

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[12]All monetary values are given in Jamaican dollars (J$) which at the time of the study was worth about US$0.18. (US$1 = J$5.50). Prices for most goods in Jamaica, especially imports and processed foods, tend to be equivalent (after conversion) to US prices and often a bit higher. On the other hand, locally manufactured goods are slightly cheaper and some staples such as rice and flour are subsidized by the government and are thus sold at somewhat lower prices than the US equivalent. Surplus produce is sold locally fairly cheaply (e.g. a bunch, i.e. about 6 hands, of green bananas might be sold for about J$3) but in the marketplace, where produce brought in from other areas is sold by higglers, the prices are much higher (e.g. J$5 for a single hand). Obviously, then, the wages of a laborer (about J$50-150/wk.) does not have much purchasing power outside of the local subsistence economy. As one informant put it when speaking about a supermarket in Morant Bay, "Plenty people dem cyan [can't] even set foot in dere."

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The great majority (about 86%) of the households in Albion fall into level III, the poorest section of Jamaican society. There is enough differentiation within this class to distinguish level IIIa from level IIIb (Dreher 1982). People in level IIIa, about 31% of the households in Albion, generally live in small wooden houses, often time-worn, but neatly kept. A few have electricity, but most use kerosene lamps for light. They get their water by carrying it from the nearest standpipe, have a pit latrine out back and cook on kerosene stoves or charcoal fires. They usually own, or have family rights to the land on which they live, and they may have other small pieces of family or bought land which they cultivate or rent out. Some rent pieces of land for the purpose of cultivation.

Some have steady employment, e.g. as laborers on nearby estates, but most work a variety of irregular jobs, following by necessity a strategy of "occupational multiplicity" (Comitas 1973 [1964]). The men often have had some experience in doing various jobs from field labor to carpentry and masonry, and they will take advantage of whatever opportunities present themselves. Some are sufficiently skilled to be able to work independently as a tailor or furniture maker, though the demand for this work is often very irregular. Women in this group will usually work as domestics, field laborers or workers in the estate processing factories, or as higglers.

Higglering is actually the most common occupation for women in this group. A number of local women, and some men as well, will go into Kingston each week with local produce to sell in the weekend market. Some of what they sell is surplus obtained from people in the district,

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but more frequently, bags of coconuts are purchased cheaply from local estates and sold in town for a profit. On a good weekend a higgler might make J$200 or even more, but usually the profit is somewhat less than this. Every Wednesday night a large truck comes into the district to load up the bags of local produce and coconuts to be brought into town. The owners ride along with them or may take the bus and meet the shipment in town. Smaller loads are taken down to the main road on hand carts operated by boys to be taken into town on the country bus.

Income[13] at this level is very difficult to estimate accurately because it is quite irregular, depending on whether work is available. During the cane crop season a steady income can be obtained by working on a sugar estate, but in the "dead" season this disappears. The banana, cacao and coconut estates provide more regular employment for some, but pay less. A laborer on one of these estates might make $J50-150 (US$9-30) per week, depending on the type of work. Some of the luckier ones have been able to obtain regular jobs at Consolidated Banana Estate to the east, a joint government/private (multinational corporate) effort that is now one of the largest employers in the area. Information from the household census shows that household income at

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[13]In our household census we asked for information about income and as might be expected these data were the most difficult to obtain. Many people are wary about providing such information, and people generally like to keep it away from the government and nosy neighbors. As Dreher discusses (1982:16-17), most rural Jamaicans make an effort not to display any gains in wealth for fear of inviting envy or the requests of needy relatives. Even those who were willing to provide the information had difficulty in estimating their monthly household income because it is often irregular, and the person interviewed often did not know the incomes of all the other family members.

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this level (IIIa) is about J$400 to J$1000 (US$70-180) per month, and again varies with the number of members working.

An essential part of households' strategy for survival at this level is subsistence cultivation. They grow a variety of crops (e.g. coconuts, bananas, yams, etc.) and may have some fruit trees as well. The surplus is sold to neighbors or higglers. Few attempt to farm on a large scale, because cultivation is done by hand and a larger scale effort requires greater investments and the hiring of labor. Many raise goats or chickens as an added source of protein and income. Those over 60 are eligible for a government old-age pension of about J$110-120 ($20-22) per month, or sometimes a pension from a former place of employment. More importantly, remittances from abroad enable some aging parents to maintain a standard of living that would not be possible otherwise. Mothers with young children are able to get some government assistance in the form of foodstamps (J$15/month).

Children from this level attend the All-Age School in Albion and if talented and hard-working enough to pass the Common Entrance Exam[14] may go on to High School in Morant Bay. The cost of private high schools is prohibitive for these IIIa families. Others will attend the other local Secondary or Technical schools, and those unable to find places will continue in the All-Age school to age 16. Attendance is not always regular and some will drop out when they reach age 16, having

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[14]Each year the government provides high school places to children (usually 11 years old) who score highest on a standardized exam, the Common Entrance Exam. In 1987 there were 9,000 free places in high schools awarded among the 46,000 who took the test (Sunday Gleaner 1987). Others, depending on their scores, are eligible to attend other types of secondary schools or technical schools. The lowest sector will continue in the all-age schools through grade 9.

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finished their mandatory education. At this level, education is an important means of upward mobility and those trying to advance will work hard to get their children through school. However, most families in this level are unable to provide the support or encouragement needed to promote success in school, and few of their children are actually able to advance themselves through education.

Family patterns at this level follow the general pattern for lower-class Jamaica that has been analyzed in great detail by others (See Clarke 1966[1957]; Cohen 1971; Davenport 1961; Smith 1966). Unions tend to be consensual and serial, though older couples or particularly devout Christians may get married. These households tend to be headed by women (when a man is not present) and it is not unusual for a woman to have children by several different "babyfathers," which results in very complex kinship relations in the community. Women begin to have children at a young age and a household may contain several grandchildren as well. It is not uncommon for a young mother in poor circumstances to send her children to her mother to be cared for if the mother has a more secure living situation.

Families in this level usually attend the Albion Baptist, Seventh Day Adventist, or Revival Zion churches, though they may be affiliated with other churches outside the district, e.g. Pentecostal or Catholic. Some of the families are participants in the Kumina cult, hosting Kumina ritual dances at their homes on special occasions, and most of the others will attend these ceremonies as social events.

Level IIIb is the poorest and the most numerous level, comprising about 55% of the households in Albion. In culture and background they

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are similar to level IIIa, but have less income and access to resources. Consequently they lead a more uncomfortable and precarious existence. Some are reduced to this level by illness, disability or old age, which prevents employment as well as self-help through subsistence cultivation. A significant proportion are large families headed by women who have no steady source of income. Many of these households are landless and live in a rented room, while some others build a flimsy one-room shack on rented or family land. Those who do not own land outright may have some rights to family land in Albion or in another area. Those who rent a room usually do not have rights to use the house plot for cultivation and, unless they have some other land, are unable to grow food for subsistence.

People at this level are primarily dependent on labor on neighboring plantations for income. Such field labor is back-breaking, irregular and usually short-term. And it is unavailable to those who are not able-bodied. Some get food stamps, pensions or remittances, but these are not enough to raise them above their bleak existence. Women who must stay at home to mind their families may boil coconut oil or do laundry for some extra income. Most would look for work if they had a reasonable chance of finding a job, but many have given up the search and do not actively seek employment.

Unemployment is a major problem in Albion. Of the able bodied working age population (age 20-65, not in school), 37% did not have gainful employment in the week before they were interviewed. Most of these (76%) stated that they had looked for work or would work if employment was available. So the unemployment rate, calculated as the

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portion of the total work force which wants work but is not working, was 28.3%. (The national rate for Jamaica at that time was about 20% [Planning Institute of Jamaica 1988].) Although less measurable statistically, underemployment is an even more widespread problem. Of those listed as employed, 33% were "self-employed," meaning for the most part only part-time work or small-scale work at home. In addition, a large proportion of those employed by someone else were working part-time or in a temporary position.

Many of the households in level IIIb are headed by women with no partner to assist in supporting and raising the children. Some may get some help from the babyfather(s) outside the household, but this is typically unreliable. Teenage pregnancy is very common in Albion (as in the rest of Jamaica) especially in the lower levels of society. Girls often begin having children at 15 or 16 (or even younger) and there is still social pressure on them to start at a young age.[15] Of the 54 girls in Albion age 15 to 20, 14 (26%) already had at least one child, and this rate was higher in level IIIb. There was also one 14-year-old mother. Early pregnancy is one of the most important factors which lock these families into a cycle of poverty as it prevents the young women from getting further education or training, and keeps them from getting a start in the labor market. Unable to support her children on her own,

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[15]A teenage girl who does not start having babies may be called derogatorily a "mule" by her peers, and knowledge of and access to contraception is poor. Contraception is available at the government family planning clinics, but typically the young women do not get involved with these until they have already had a few children. The traditional pressures for large families and the attitude among men that gives prestige for promiscuity and prolificacy are still very strong in lower class Jamaican culture. Despite government family planning campaigns, contraception is still often threatening to a man's self-image.

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if a young girl does not receive support from the babyfather(s) she will usually live with her mother's family, though she may go off to work and leave the kids with her mother. As she gets older she may move off on her own and rent a house or, if lucky, form a stable relationship or inherit some land. A woman with young children to care for is limited to work that can be done at home such as boiling coconut oil, making chocolate or doing laundry.[16]

Living conditions for these families can be quite miserable. The typical IIIb household lives in a broken down, often rented, wooden shack with none of the modern amenities except perhaps a transistor radio (which usually can't be used due of a lack of batteries). Those who have a piece of family land to live on may patch together a shanty of discarded bits of zinc,[17] boards, bamboo, and plastic sheeting. Wattle and daub, nog, or woven bamboo are sometimes used by poor people in making a house, but are less commonly seen today than they were in the past.[18] The walls inside are papered with old newspapers,

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[16]Recently the local Home Economics extension worker has attempted to give Albion women other means of income through lessons in needlework and cooking, and through organization of cooperative goat and chicken rearing projects. However, participation has been poor presumably because most of the poor young women see little opportunity for economic advancement in these activities and are already locked psychologically into a cycle of poverty and resignation. Their skepticism is not unjustified. For example, the goat rearing project was jeopardized by the theft of some of the first offspring.

[17]Sheets of corrugated galvanized steel, known as "zinc", are used as roofing material on practically all buildings in Jamaica. Houses of the well-to-do have sheets of painted zinc, or aluminum, in good condition, while those of the poor have partially rusted, recycled sheets that may leak badly.

[18]Wattle and daub = small branches woven together and plastered with mud. Nog = A wooden frame filled out with stones and mud.

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magazines or wrapping paper to cover holes and prevent curious neighborhood boys from peeping in. Cooking is done with wood gathered from nearby bush land and for light at night they use kerosene lamps made from old tin cans. Toilet facilities consist of a hole dug in the ground, with perhaps a board across it to keep children from falling in. Their diet consists mainly of starches, (breadfruit, yams, green bananas, flour, rice), coconut oil, and occasionally a can of sardines or mackerel for protein.

The usual family pattern among these households is a matrifocal one. A household typically consists of a woman and her children, and depending on the stage of the family life cycle, her mother or grandchildren. Single parent households are more common at this level partly because the difficulties of such a situation predispose them to poverty and hinder advancement. Some households in this level also have a man present, though marriage is uncommon. As a couple gets older and their relationship more stable they may get married. Marriage in this level is the sign of a mature relationship rather than a young one. Some of the children may be those of the current partner, though often there are children by other fathers as well.

Children of these households have poor attendance at school, often because they are unable to afford a school uniform, shoes or bus money. Their poor background and lack of family support puts them at a disadvantage in the competitive educational system. Many are unable to get a free place in high school and terminate their education by the age of 16. Without success in the educational system, the major avenue for upward mobility, their chances for advancement are bleak.

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Field labor is difficult and low-paying work -- not an attractive prospect for young men and women leaving school. Unless they can get one of the better jobs on the estate (e.g. as a tractor sideman) they will often live at home with their family and try to get into some other line of work, perhaps as a domestic helper or security guard in Kingston. In the meantime they will do occasional odd jobs, or they will earn some cash by stealing coconuts at night from a neighboring estate and selling them in Kingston.[19] Some of the younger kids will make some cash by transporting goods up and down the access road to the main on pushcarts constructed of assorted scrap materials.

Level IIIb members for the most part attend the Mount Olive Galilee Revival Church which makes this one of the most active, though poorest, churches in the district. They are also active participants in Kumina events, which for some are religious rituals, but for most are primarily social activities.

While this system of hierarchical levels is an important factor ordering social relations, it should not be seen as a system of rigid, clearly delineated categories. Rather, the groupings blend imperceptibly into one another. There is also some fluidity and

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[19]It is understandably difficult to get information on the economy of illegal activities such as praedial larceny or ganja (marijuana) growing, and I did not specifically investigate these activities. It is unclear how important they are in the economy of the area, but the ganja trade at least seems to be less active here than in some other parts of the island. It is doubtful that these activities have more than a minor impact, at least for the average person. Recent campaigns against the ganja trade have reduced its profitability. Praedial larceny can have a significant impact, especially in influencing the willingness of farmers to invest in certain crops or animals. However, it usually is perpetrated against estates outside the district or against people considered to be outsiders. (See Smith 1965[1956]:184. For a discussion of ganja in Jamaica see Dreher 1982, and Rubin and Comitas 1973.)

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mobility within this hierarchy, as life circumstances enable a family to improve their position or, conversely, push them into a more desperate condition.

In most Jamaican communities social mixing of the higher levels with the lower is limited, and those in levels I or IIa will usually have most of their contacts outside of the district with other people of the same status. This is to some extent true in Albion, however there are actually few families of the highest social rank in the district. Almost everyone is in the lower three levels (IIb, IIIa, IIIb) and there is considerable social interaction among these. There are many kinship links among these levels, which automatically bring them together for many social functions. Children of the different levels play and grow up together in "posses" (friendship groups), and continue their friendships into adulthood (cf. Smith 1965[1956]:182). Thus there is a balance between forces uniting the people of Albion with those that separate them.

Despite the sense of cohesion and belonging that Albionites share, there is little formal organization of the community. There is no community-wide organization, leader or purpose that brings the whole community together at any one time. The largest active community organizations are the three churches. Their main activities are their religious services, but they do have some groups organized within the church membership, e.g. youth fellowship groups. Some of their fund-raising events draw a larger cross-section of the community, such as the annual week-long "convention" at the Revival church. Funerals and other

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funerary customs such as "Nine Nights"[20] may also draw a large cross-section as they activate the complex and pervasive network of kinship and friendship ties in the community. There are smaller informal groups that will come together to, for example, share cultivation tasks cooperatively or reciprocally. But large communal work groups are rare. The only large working party I observed was a group of about 20-30 friends and relatives who got together to help a man move his small two-room house. Another popular informal organization is "partners," a small cooperative rotating savings/credit scheme.[21] There are a few voluntary organizations in the district, such as the cricket club, which owns the ball-field, but they are not very visible or active.

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[20]Nine Nights is a Jamaican custom in which, for the nine nights following a death, friends and relatives hold a vigil in the yard of the deceased. In Albion today this is often referred to as a "dead-yard" and in practice is held between the time of death and the burial, which may be shorter or longer than the traditional nine nights. The attitude of those gathered is actually festive and everyone is welcome. Most of the activities take place in the evening, and there is much cooking, feasting, drinking, singing, conversation, and playing of dominoes. Later in the evening prayers and hymns may be led by the preacher or one of the church leaders. Drumming may also take place if the family is active in Kumina. The custom of Nine Nights performs useful functions on several different levels. The most important overt function is to keep the spirit of the dead from troubling the family until the body is safely interred. More practically it brings relatives, neighbors and friends together to provide solace, company, and assistance (e.g. in cooking and housework) to the family of the bereaved. It enables friends of the deceased to pay their respects to the family and thus reconstruct social ties sundered by the death. It is a dramatic demonstration of the status and position of an individual within the community, the more prestigious and popular drawing larger crowds. Attendance at a dead-yard also reflects social and class groupings within the community (cf. Smith 1965[1956]:184).

[21]In "partners" a group of about 8-10 people will each contribute a weekly set amount (perhaps J$50-100) to the fund. In an order drawn by lots, one person each week will be given the total amount contributed by the others, thus enabling each to obtain a large lump sum which can be used for some special purpose such as home improvement, purchase of livestock, investment in goods to sell, etc.

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Entertainment in Albion, aside from that mentioned already, is limited. There are a few rum shops where small groups may gather at the end of a day, but most people do not frequent these. There is one "club" where young people gather on weekends to drink, dance, and grind to the throbbing beat of popular "dance hall" music. Occasionally an enterprising individual will sponsor, in hopes of making a profit, a dance or "session" with a hired "sound system," drinks and food. Kumina ceremonies are also popular and entertaining social events. While a few people are caught up in the religious and ritual aspects of the event, most are more interested in socializing, drinking, singing, and watching the dancers as they are possessed by ancestral spirits.

Insular Jamaican hill communities such as Albion are relatively closed to outsiders and characterized by multiplex social relations. An individual fills several roles in relations with another -- kinsman, fellow church member, neighbor, customer, supplier, etc. (cf. Dreher 1982:17). In this tightly knit community relationships are vigorous and little escapes the close scrutiny of one's neighbors. The routine and drudgery of country life are spiced up with gossip and intrigue. Basically, everyone knows everybody else's business, and makes a point of doing so. News and gossip travel through the district very rapidly. This aspect of life in a rural village makes it uncomfortable for some. Sometimes this is a factor in the desire to move off to Kingston or abroad where one can live a relatively freer and less scrutinized lifestyle.

Close contact in a situation of scarcity also breeds many conflicts -- some overt and some unspoken -- within the community.

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Rural Jamaicans generally approach life with an "image of limited good" (Foster 1965). Advances by one person or household are seen to be at the expense of others. Outsiders who have recently moved to the district are looked on with suspicion and sometimes treated with a degree of hostility. When a person or family does have some amount of success, for example in getting a decent job, others are envious. Indeed this envy, and the malicious thoughts that go with it, are anticipated. To prevent this, people will intentionally downplay any good fortune or success they may have. As one informant explained to me, many people will "live poor" out of "habit" even when they get some money (cf. Dreher 1982:16-18).

Conversely, misfortune is often suspected to be the work of envious neighbors. Sometimes this is a reality, for example when praedial larceny wipes out expected earnings. More often the misfortune, e.g. illness or bad luck in business, is seen to be the result of spiritual forces marshalled by one's enemies through "Obeah" (sorcery). But suspicions of sorcery, while very commonly held privately, are rarely voiced openly for fear of inciting even worse consequences. Instead they are dealt with quietly by a visit to a "Science Man" who can counteract the magic. This is an important issue with respect to illness beliefs and treatment, and will be discussed more fully in the following chapters.

SUMMARY AND COMMENTS

The plantation system developed and persisted in Jamaica as the result of a variety of historical, ecological, political, and economic

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factors. Its effects in shaping the social structure and culture of the island have been profound. Though plantation agriculture is less dominant today than it has been in the past, Jamaica continues to be dependent upon, and constrained by it. This mode of production still dominates economic and social relations in certain ecologically suitable regions of the island, such as St. Thomas, where it has been able to survive relatively intact. Not only did it shape local developments through its own requirements and ramifications, but it also tied the local economy intimately to trends in the worldwide system of economic and political relations. In St. Thomas we plainly see the end result of a pattern of sustained colonial exploitation in which European centers of trade were enriched at the expense of peripheral lands.

The class system which arose through this process as the by-product of plantation agriculture recreated these exploitative relations within the social pyramid of the island. A small class of white European landowners reaped the benefits of the labor of a much more numerous class of African laborers, while a class of brown, mixed-race middlemen was able to prosper to a lesser extent by brokering these relations. Perseverance of the plantation system was thus dependent on the creation and propagation of a large class of disempowered, unskilled, poor, laborers. In the early days this was accomplished through the physical coercion of African slaves. Later on, control was maintained through economic and political means, which proved to be just as effective. Poor blacks were systematically held back through low wages, high prices, taxation, and restriction of access to land, education, alternative employment, and political power. But in the

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effort to maximize profitability while insuring an adequate labor supply, post-slavery plantation production entailed a more delicate balance between reward and deprivation. At a few critical junctures, this balance fractured, resulting in social convulsions such as occurred in the 1865 Morant Bay Rebellion and the 1938 Labor Riots.

In the post-colonial era, this class structure has become less rigidified and less color-coded. Individual planters have to a great extent been replaced by large multinational corporations, the government, and even international lending agencies such as the IMF, as the objects of dependency and the purveyors of power. These changes, however, have had only indirect impact on poor rural Jamaicans, who for the most part have been unable to extricate themselves from their situation of minimal choice and opportunity. Their options continue to be manual labor in the plantation fields, abject poverty, or perhaps for a lucky few, emigration.

The district of Albion represents the typical marginalized Jamaican community. It is neither closely enough tied in with the local plantations to benefit from their prosperity, nor separate enough to be independent of them. Its poverty fuels the profitability of the plantations since its people have little choice but to work for minimal wages. It represents the large underutilized labor pool that is a necessary pre-condition for the survival of plantations, not just because of the workers it supplies, but also because it creates an excess demand for employment which enables the estates to keep wages low. The multinationals obviously have an interest in maintaining this pool, and the government, now that it has become involved in the

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plantation business through nationalization of plantations and joint ventures, ironically has a similar unstated interest.

The plantation system has been central in the evolution of lower class culture in Jamaica, because of both the constraints it has imposed and the reactions it has provoked. Jamaicans have, from the earliest days of plantation life, developed a variety of social, cultural and psychological coping mechanisms which have enabled them to deal with the difficult conditions of poverty, insecurity, frustration, and disempowerment in which they exist. While not always adaptive in a positive sense, especially in the changing context of the modern world, these continue to dominate the lower class orientation to life (cf. Kerr 1952). And, as we shall see, they play an important role in the social and cultural construction of the Jamaican health care system.

While rural Jamaicans differ significantly from classical Old World peasants in their history and political/economic roles (Comitas 1973[1964]), they endure under many of the same pressures and constraints. Not surprisingly, they have developed adaptive strategies and a mindset that in many ways is similar to that of the stereotypical peasant, to the extent that Mintz (1974; 1985) defines them as a "reconstituted peasantry." For example, in their farming practices they operate under many of the principles of "peasant economy" as described originally by Chayanov (1966[1933]) and later by Sahlins (1972), producing mainly for subsistence using family labor, avoiding of the use of cash and credit, and avoiding risky strategies whenever possible (Edwards 1961,1965; Goldsmith 1981:15). The conditions in which they live foster a constant sense of insecurity, which in turn promotes

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competition, suspicion and envy among neighbors. This is the essence of what Foster (1965) calls the "Image of Limited Good," in which benefits to one are felt to come at the expense of others in a zero-sum game (Cohen 1971[1955]). (See p.77) This mindset, as will be seen in later chapters, has been pivotal in both the evolution of the health care system, especially folk healing, and in the current patterns of utilization of health care options.

In modern times, with the increasing fluidity of the class/color hierarchy, the potential for upward mobility is becoming more and more salient in lower class culture, even though when it comes to individuals the actual chances of this are quite small (Gordon 1986). Choices among health care alternatives, like other publicly disclosed consumption patterns, make a statement about one's position in society and one's aspirations for social advancement (Brodwin 1989). Thus health-seeking decisions may be influenced by a prestige factor, with the individuals involved using the opportunity to make a public statement about their self-image and public persona (cf. Mitchell 1980). Mass marketing and the mass media play a significant role here, as they are used to define the image of the middle or upper class and to sell products such as over-the-counter medications by associating them with an upwardly mobile lifestyle. As elsewhere, American consumerism has come to be regarded as the epitome of the desired lifestyle, and imported goods and medicines continue to be high prestige and alluring items.

Another prominent feature of rural Jamaicans' strategies of adaptation is an ambivalent attitude towards authority, which is characterized by a combination of dependence and hostility. Because of

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the very real disempowerment which has been their lot, poor Jamaicans have come to look to powerful others to give them access to benefits that are otherwise unattainable. In the days of slavery the object of this dependence was of course the slaveowner, who was responsible for ensuring that their basic needs were met. The British Crown also came to be seen as a protective patron whose power and authority superseded even that of the plantocracy. It was appealed to especially in situations of conflict with the planters (See Chapter 6, p.226), an attitude which continued into the twentieth century. In more recent times this fealty has been shifted to wealthy or influential figures, and even to bureaucracies, but primarily to politicians, who are expected to look after their constituents in a most paternalistic fashion. This paternalism and authoritarianism is cultivated by politicians as a means of securing the support and votes of the masses. During the 1972 national election, for example, Michael Manley, the current Prime Minister, was portrayed as "Joshua," brandishing his "rod of correction"[22] (Elkins 1975:241). Even Manley, however, could not match the dictatorial style of the master politician-as-father-figure, Alexander "Moses" Bustamante, the first Prime Minister of free Jamaica. Known to his followers as "the Chief," he demanded a blind and devoted trust from them, and in turn promised to work tirelessly on their behalf. He parlayed this image into the most successful political career in the island's history (Elkins 1975; Kerr 1952:156-64). As will be seen in later chapters, this same paternalistic/authoritarian style

[22]This rod, which was rumored to have magical powers, was actually a walking stick presented to Manley by Emperor Haile Selassie I of Ethiopia during Manley's visit to that country (Elkins 1975:241).

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is also used to great advantage by religious leaders and healers (e.g. see Chapter 6, p.233).

The corollary to this authoritarian paternalism on the part of patrons is the submissiveness and deference that their lower class clients are culturally expected to show to them. This is part of the more general pattern in which lower class people are expected to behave deferentially to those of higher position. In a face-to-face encounter with someone of high status this is manifested by passivity, avoidance of eye contact, reluctance to state opinions, docility, flattery, cowering, self-deprecation, etc. on the part of the low status person. More commonly even, it is expressed through avoidance of such encounters altogether. This behavioral and personality complex has been described by Whitehead as the "buccra-massa"[23] (Whitehead 1984). Among Whitehead's informants, "buccra-massa" was used to refer to the degrading submissiveness that one was expected to show in encounters with higher status people. He found that many people avoided this situation whenever possible, relying instead on "brokers" who were able to "buck-the-massa" (i.e. deal with high status people on their own terms) to act on their behalf in such encounters.

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[23]"Buccra" (or buckra, backra) is a term going back to the early days of slavery and is apparently derived from the Efik (Ibo) term *mbakára* meaning "white man" or "one who surrounds or governs." In Jamaican patois it came to be used to refer to white people, anything associated with white people, masters, or anyone of high rank. And it was sometimes used as a term of respectful address equivalent to "boss" or "master" (Cassidy and LePage 1967:18). "Buccra-massa" in its literal sense means "white master," though in some areas it is apparently also used to make a metalinguistic comment on the social relationship itself. I did not hear the term being used in St. Thomas, though I would not rule out the possibility. Nevertheless, this same social and behavioral complex is present there.

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The other side of this ambivalence is a resistance to external control and a hostility towards authority which, however, is often expressed in a passive/aggressive manner. This also has deep roots in lower class Jamaican culture. Patterson, for example, in his classic work on Jamaican slave society (Patterson 1967) discusses the "Quashee[24] personality," which by the eighteenth century was widely accepted among Europeans as the stereotypical slave personality, not only in Jamaica, but in other slave owning areas of the New World as well. This style seemed to be brought out most clearly in the slaves' interactions with whites and was characterized by evasiveness, feigned ignorance, submissiveness, deviousness, apathy, laziness, flattery, compulsive lying, distrustfulness, conservatism, and a childlike irresponsibility and happy-go-lucky nature. Behind this "fool-ish" exterior, however, the slave was a calculating and clever manipulator who used these traits and his keen sense of the foibles of others to best advantage. In their interactions with whites, this social style rarely failed to produce the frustration and exasperation which were no doubt, whether consciously or unconsciously, its intended consequence (Patterson 1967:174-81). This personality style had its darker side as well. Grudges were clung to, and vengefulness expressed when the situation allowed it. When placed in a position of authority over others, the slave often took out his rage on those he controlled. The slaves who worked as "drivers" of the field slaves could be capricious

[24]The term "Quashee" derives from the Twi word for Sunday, which in early slave society was commonly used as a male name among slaves. The early slaves followed the African practice of naming children after the day on which they were born, and each term had variations for male and female (Patterson 1967; Long 1774, II:427).

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in their cruelty to their subordinates (Patterson 1967:62-3,100). When possible, for example during rebellions and uprisings, this aggression was taken out directly on the whites. Needless to say, the planters did everything in their power to see that such opportunities did not arise.

These characteristics of cleverness, deviousness and trickery are also celebrated in popular mythology, most notably in "Anansi" stories, folk tales which are more than just children's stories. The hero of these tales is inevitably Anansi, the spider and trickster, who seems to be derived directly from African folklore. Anansi is not necessarily a lovable character, but rather is admired and celebrated for his skill in judging the character of others and manipulating them cleverly in order to win with wit over brute strength in satisfying his own greedy desires.

These cultural personality characteristics persist in modern Jamaica, albeit in an attenuated form, no doubt because lower class Jamaicans have never been able to extricate themselves from the position of powerlessness into which they were placed by slavery. Whitehead found the passive/aggressive "buccra-massa" style being used frequently as a means of covert defiance, in much the same manner as the Quashee personality described by Patterson was used by early slaves (Whitehead 1984; Patterson 1967). The "Samfie-man" (con-man) is an extreme example of the use of trickery and deceit as a means of controlling others for one's own benefit. However, the attributes of dependence, submissiveness, repressed hostility, and covert defiance, in various mixtures, remain important components in Jamaicans' encounters with individuals and institutions of authority. Obviously, such cultural

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attitudes have important implications for health care issues, especially in clinical situations in which encounters between people of differing status take place, e.g. between doctors and lower class patients (cf. Mitchell 1980). However, as we shall see in the following chapters, practitioner/patient relations involve more than a simple intimidation and avoidance, as has been argued by others (e.g. Mitchell 1980). The very nature of therapeutic interactions insures that the issues of power and control will be played out on several other levels as well.

It is not hard to understand why the matter of control should be a crucial factor in reactions to illness, and in health-seeking behavior. Illness represents the ultimate threat to bodily integrity and self-determination, the most basic requirements for survival and full participation in social life. Most actions taken to address illness represent efforts to restore the individual's control over the body, and psychologically this seems to be a core feature of both the illness experience and the healing process (Cassell 1985[1976]; Stoeckle and Barsky 1980). In most illnesses, especially minor ones, the individual may reassert control through labeling, explanation, self-medication, magic or other self-directed treatment options. In more serious illnesses, when self-treatment fails, the sick person must turn to a specialist who can act as the patient's agent in restoring control. Here, however, a delicate balance is entered into, with the ever-present possibility that the specialist may usurp control rather than act as the agent of the patient. When complex social status issues are involved, the situation is even more tricky. The danger is that while curing the physical disease of the patient, the specialist may in fact inhibit the

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psychological process of healing by denying to the patient the sought-after sense of self-determination (cf. Young 1982).

In the Jamaican setting, the relationships of patients with doctors and healers are complicated by the issues of authority and power which are such central elements of Jamaicans' cultural and psychological identity. These factors exert a significant influence on how people make use of the different health care alternatives that are available to them. They also have important implications for the planning of appropriate and constructive health care development. Approaches which fail to take account of these deeply rooted issues, and which are based primarily on externally derived "recipes" for development, are unlikely to be able to effectively meet the needs of the Jamaican people (Whitehead 1984).

In the next chapter we begin exploring the health care system and its social and cultural significance. We start by focusing specifically on the means by which rural Jamaicans deal with minor illness through self and family-based treatment.

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CHAPTER FOUR

THE HEALTH CARE SYSTEM I:

THE POPULAR SECTOR

INTRODUCTION

The preceding has provided a framework in which we can begin to appreciate the circumstances in which poor rural Jamaicans live out their day to day lives. We now zoom in more closely on the aspects of Jamaican life concerned directly with illness and health care. In doing so we take another step in the contextualization of Jamaicans' illness experiences and health-seeking strategies.

In one sense this is an orderly march from the general to the specific, a step on the path from a sweeping perspective on the social, cultural, economic and historical milieu to a more restricted focus on the day-to-day realities of personal experience. From this perspective each layer we peel from the proverbial onion appears to be conditioned by the one which surrounds it. However, we must not lose sight of the fact that each layer is shaped from within as well as without. Social "systems" are constructed out of individual actions as well as by the broader material and social setting in which they develop. Or more precisely, we can say that such systems arise, and are shaped and reshaped continually through the complex dialectical interactions of individuals with each other, and with their environment writ large. Social systems constitute the setting for human activity by presenting individuals with various possibilities and constraints for action, while

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at the same time emerging and evolving through the cumulative actions of the members of the society (cf. Murphy 1971:94-5).

It is also important to keep in mind that cultural and social "systems" are conceptual models we create in order to make sense out of a chaotic and ever changing world. While the regularities and patterns they objectify do in fact exist in a very real sense, the models we generate may distort our understanding of reality through oversimplification and neglect of the variability, diversity, and change inherent in social life (Murphy 1971:110; Pelto and Pelto 1975). We also must be aware of, and avoid as far as possible, our tendency to "reify" our models, to treat them as "things" in themselves, apart from the phenomena they were created to explain (Murphy 1971:43-5).

With this in mind, we turn to an analysis of the health care system in eastern St. Thomas, using a model which separates it into its constituent elements and then reassembles it by demonstrating the connections among them. My purpose here is two-fold. In discussing this system I hope to illustrate how the historical, economic, social, and cultural variables discussed in the previous chapter are manifested within the world of illness, suffering, and the attempt to alleviate these. But at the same time I aim to provide an understanding of the context in which individual decisions about illness and health-seeking are made, and to show how this context shapes and is shaped by individual actions. Thus we can look at the health care system as the link and mediator between illness on the one hand and the social system on the other. From this perspective we can examine how the forces and conflicts that shape the dynamics of the larger social and cultural

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systems are played out in the misfortunes of everyday life. On the other hand, the health care system itself is but one aspect of the overall social and cultural systems, and indeed plays an important role in shaping these more comprehensive processes. So exploration of the health care system's attributes and functions can give us further insight into Jamaican culture as a whole as well.

A MODEL OF HEALTH CARE SYSTEMS

Kleinman's model for the analysis and cross-cultural comparison of health care systems (Kleinman 1978a, 1980:24-60) serves as a useful framework for this investigation. While acknowledging that comprehensive "external" social and cultural forces and institutions (e.g. political factors, economic systems, etc.) exert an important influence in shaping health care systems, he explicitly focuses on them as **local** systems (cf. C.M. Leslie 1980). This is because these systems are integrated "social realities" which are "created by a collective view and shared pattern of usage operating on a local level," even though they are shaped within the constraints imposed by external variables, and even though they may be "seen and used somewhat differently by different social groups, families, and individuals" (Kleinman 1980:39). In other words his approach conceptualizes the health care system from the perspective of the people who use it on a day to day basis. It springs from an interest in the same questions that concern us here: How do people understand an illness? How do they perceive, explain and label their symptoms? What is the social role of

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a sick person? What treatment options are available to people? How do they use these alternatives and what factors influence their decisions?

The model proposed by Kleinman looks at health care systems as comprised of three interdigitating "sectors", which he terms the popular, professional, and folk sectors (see Figure 2). While on the surface it may seem that this segmentation is complex and artificial, or even ethnocentric, in fact this separation is based on only two simple distinguishing features, the relevance of which is universal. The popular sector is distinguished from the other two by the lack of specialist involvement in therapeutic activities. The other two, specialist, sectors are in turn are distinguished from each other by the criterion of professionalization. It must be emphasized that while a crude use of the model implies that these different sectors are separate and self-contained, the model itself acknowledges their interconnections. These intersections are represented in the diagram (Figure 2) by the areas of overlap between the circles. In short, the model does not assert that all health care systems have the same structure, nor that this is the only model that might be used to examine such systems. Rather, it is merely an analytical tool that is useful for breaking such systems into manageable and meaningful components for the purposes of analysis and comparison.

Unlike many approaches to studying medical systems, Kleinman's model explicitly acknowledges and highlights the central role played by informal and familial networks in dealing with illness in all cultures. The "popular sector" is "the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care

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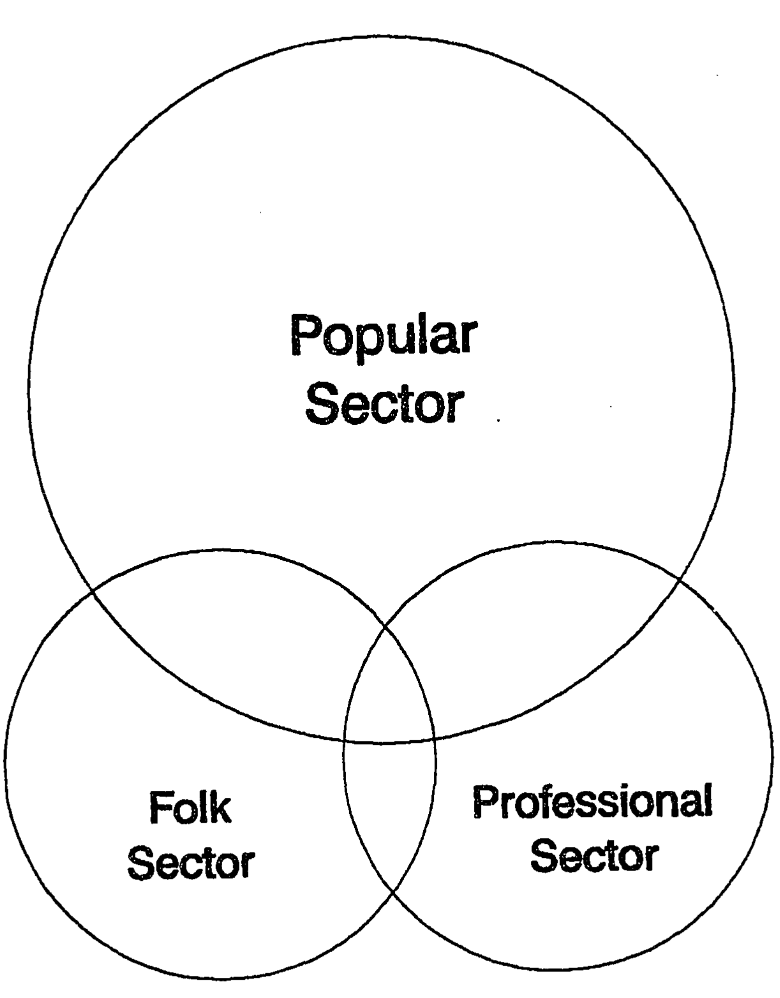

Figure 2: Kleinman's Model of Health Care Systems (Adapted from Kleinman 1980:50)

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activities are initiated." What separates it and distinguishes it from the other sectors is really the distinction between specialists and non-specialists. The popular sector is made up of the health care beliefs and practices which take place within the context of the family, usually prior to the consultation of an expert in either the folk or professional sector. The care in the popular sector may be directed by the affected individual, the family, extended kin groups, concerned friends, or other such "therapy management groups" (Janzen 1978;1987).

While often ignored or downplayed by medical professionals, the bulk of illness experience, diagnosis and treatment actually occurs within this sector (Kleinman 1980:50). It is within this realm that illness is first encountered, labeled and explained, and it is to this sector which the sick person returns following utilization of treatment options in one of the other specialist-oriented sectors. Kleinman points out that much of the health related activity in the popular sector is actually concerned with prevention and health maintenance rather than treatment (Kleinman 1980:51-3).

The "professional sector" is comprised of the "organized healing professions" (Kleinman 1980:53). Usually this is synonymous with "Western Medicine" or "Biomedicine", but in some countries such as China and India there are indigenous systems of treatment which have been systematized and professionalized. The professional sector is often dominant over other sectors in its power and control over social resources. In many societies, including our own, biomedical practitioners serve as "gatekeepers" who control access to resources and legitimize social roles and statuses. In this way the professional

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sector may serve as a primary means of social control (Stone 1979; Zola 1972). It plays a central role in strategies of health-seeking for illnesses too serious or severe to be brought under control in the popular sector, though severity is only one of the factors which influence people to seek help in the professional domain (e.g. Mechanic 1972, 1983). The professional sector includes a variety of different institutional structures controlled or dominated by doctors, e.g. private medical clinics, public clinics, hospitals, pharmacies, etc. It also may include a variety of non-biomedical subsectors such as chiropractic, osteopathy, homeopathy, etc.

The "folk sector" consists of non-organized, non-professionalized healing specialists. This category is less easily defined than the professional sector as it is much more variable, fluid and mixed. In its various components it overlaps both the popular and professional sectors. This is the realm of many of the "traditional" healing practices found in cultures around the world, although in a few settings (e.g. China, India) traditional practices have been systematized to the point of professionalization (C.M. Leslie 1977[1976]). And while long-standing traditions often provide the basis of folk healing practices, many systems of folk healing have developed through innovation and syncretic blending of diverse elements from a variety of cultural origins. This is certainly the case in Jamaica and in many other New World settings. Kleinman points out that the folk sector includes both "sacred" and "secular" practices, though these overlap to a great extent. It also is the realm that has historically been of greatest

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interest to anthropologists, especially with respect to healing rituals and shamanistic healers.

By singling out these three sectors, Kleinman's model predisposes us towards emphasizing their distinctiveness and separateness. However, although these three sectors can be neatly defined conceptually, in reality they overlap considerably and blend into one another. While we can easily distinguish a folk healer from a doctor, it may be less clear whether the use of an antibiotic by the former constitutes a folk or biomedical practice. But as Stoner (1986) points out, it is not really crucial to make this distinction. "The labeling of healing methods as 'traditional' or 'modern' becomes less important than the development of an understanding of the contextual, metamedical nature of the illness experience, the healing process, and the decision to utilize one health care resource over another." (Stoner 1986:47). Thus the intersection and boundedness of the various sectors of the health care system are functions of how they are utilized by people on a day to day basis. Through an analysis of patterns of utilization, we can get a clearer idea of how the different domains interconnect, and consequently how the system functions as a whole.

In looking at the health care system of eastern St. Thomas we will take such an approach in considering how illness is defined and experienced, what alternatives for treatment are available, how people make decisions about the use of the different options and how these choices are worked out in patterns of health-seeking. For the sake of clarity this large task is broken down into several more manageable perspectives. In this chapter we will look at one of the three sectors

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to begin describing and analyzing the different alternatives that are available to sick people. In the following chapters we will look at the other sectors, and then more specifically at the patterns of utilization of treatment options, and the factors which influence these.

While it is tempting to try to describe a "Jamaican Health Care System" I will refrain from doing so here. In keeping with Kleinman's focus on health care systems as local systems which are interwoven with the intricate web of local cultural, social, and economic relations, we will restrict our focus here to analyzing the health care options available to people in eastern St. Thomas. This region is of course not isolated. It shares most of its cultural background with the rest of the island, and it is tied in with regional and national referral networks. Many of the issues to be discussed here will be generalizable to much if not all of Jamaica. However, we have seen in the preceding chapter that this region is sufficiently unique to make such generalization hazardous without careful investigation in other parts of the island.

THE POPULAR SECTOR

As is true elsewhere, the popular sector of health care in St. Thomas is the most important in several senses. It is within this sector that illnesses are first experienced, labeled and treated. The majority of illness episodes are handled within it, and it serves as the entry and exit point for the other sectors (Kleinman 1980:50-52). In Jamaica and other Third World settings the popular domain of health care has an additional significance because of economic and social barriers

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that restrict movement into other sectors. Of course this is especially true for the poorest levels of society. Jamaicans are essentially pragmatic in their approach to illness. They do have a variety of strong beliefs about illness causation, to which at times they may adhere doggedly. And there are a variety of factors which influence their health care choices. However, when illness is especially severe or persistent, they will usually try whatever they think might work, even if goes against their normal belief system. Thus one finds that sick people pursue a variety of strategies, sometimes several simultaneously, and they certainly are willing to experiment when confronting common illnesses.

When illness strikes it has its most immediate and most important impact within the family unit. Although the description in the preceding chapter of family patterns in Albion may have given the impression that kin ties are loose and fragmented, this is not really the case. While teenage motherhood, serial mating patterns, and one-parent households have produced a diffuse and complex kinship structure in the community, family units are actually surprisingly strong and cohesive. This cohesiveness often depends on maternal ties, and many of the families, especially in the lower levels, are headed by women (Clarke 1966 [1957]). While men, when present, often take a dominant role, it is typically women, and maternal relations, which provide the stability and structure of family life.

When a child gets sick, the responsibility for making decisions about what to do lies primarily with the parents, especially the mother. The degree of input by the father will depend on his relationship with

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the mother and his position (or presence) in the household. Fathers tend to have greater authority and input in families at the higher socioeconomic levels. Grandparents may in some circumstances exert a controlling authority in such decisions, especially when the mother is young and still resident within her mother's household.

Older individuals generally make their own decisions about how to handle an illness, though they may receive, and even seek out, input from family members, friends, or other social contacts. Diffuse kinship and friendship networks serve as a very important avenue for the sharing of information about sickness and treatment alternatives. Illness is a frequent topic of casual conversation among relatives and neighbors, and each person will use his own experience and knowledge to offer advice.

There are five main types of self-treatment used in the popular sector of health care: Bush medicines, over-the-counter non-prescription medications (OTCs), "home remedies" (non-herbal substances whose primary use is non-medicinal, e.g. kerosene), religion, and magic. People do not make sharp distinctions among these different types of treatment, and they are often used interchangeably and in combination. Bush tonics, for example, often include in addition to roots and herbs, substances such as rum, wine, stout, and over-the-counter vitamin tonics. These different types of self-treatment have an equivalent significance in the minds of those who use them because they all serve the same purpose. They all provide the individual with an affordable means of exerting control over an illness without the cost and surrender of autonomy that comes with consultation of an expert. This is especially important for lower class rural Jamaicans who are intimidated

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by doctors and the bureaucracy associated with the biomedical sector. More importantly, a visit to a private doctor or healer represents a severe financial burden to poor people. In many cases these economic factors outweigh any effect that inter-class tensions might have.

While the different types of self-medication serve equivalent purposes and are sometimes used interchangeably, they each have a different meaning and set of symbolic referents. Bush remedies, for example are seen as products of nature and thus as gifts of divine creation. Because they are "natural" they are felt to work in harmony with the human body and spirit. In creating these bushes, God instilled each with a special essence that goes beyond mere chemical constituents. Along with this essence goes a sense of purpose; each plant has a special use or uses for which God designed it as a "gift" to man. Men have only to discover this purpose through divine revelation or through experimentation. For example, the cure for an intractable illness which has resisted other treatments, may be revealed to the sufferer or a healer in a dream. Each successful treatment with a particular bush serves as a proof that God has indeed given it special powers, and thus provides a reminder not only of God's authority, but also of his concern for man. At the same time it refutes man's presumptuous desires to exert his control over nature. In this sense it enables the individual to challenge the imperious arrogance of doctors. Every case in which a bush remedy works where Biomedicine has failed becomes a victory for Nature, God, and Tradition.

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Over-the-counter medications, on the other hand, serve as examples of man's ability to exert control over nature, the body, and disease through Science and Technology. They represent, albeit in an attenuated form, the extraordinary power of modern Biomedicine. Indeed, many of these OTCs may be first encountered in a medical clinic where they are often dispensed, or may be first used on the recommendation of a doctor. At the same time they allow the layman to have access to this power for his own purposes.

Other types of self-treatment not included in these two categories can be grouped collectively as "home remedies". This would include treatments such as the use of kerosene and camphor as a liniment, and the wearing of a copper bracelet for arthritis. This category lies in the range between the other two and carries the connotations of discovery, innovation, and mystery. These treatments are neither of the Natural/Divine realm, nor of the Science/Technology realm, but rather represent the power and ingenuity of the common man to experiment and discover in everyday objects, substances and activities, uncommon and special purposes. This realm provides a link between the other two as it has elements of both Nature and Tradition as well as Technology. Some home remedies, for example foods such as honey, molasses, or carrots are products of nature, but as foods also belong in the realm of man and ordinary life. On the other hand, some of the crude drugs used in home remedies such as camphor or "red lotion" (potassium permanganate), link the home with the technological world.

Religion is a core institution of Jamaican society and, as might be expected, plays an important role in the popular health care sector.

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Most religious healing actually takes place under the auspices of specialists, but sometimes it may be used within the popular sector as well. Individuals often turn to their faith when they are sick and a few use this as their primary, or only, form of treatment. The use of religion in the popular sector ranges from simple prayers, to visits by a group of concerned fellow church members who may call on a sick person to offer prayers and support. This, in some cases, shades into specialist practice, and an individual who devotes much of his or her time to this may find themselves consulted as an expert. Indeed, as we shall see in later chapters, many healers get their start in this way.

Magic is sometimes used by laymen as a form of treatment, however this is utilized much less frequently than the other forms we have been discussing. The practice of magic by lay individuals echoes the magical practice of experts in the same way that OTCs echo biomedical practice by doctors. The use of magic by individuals ranges from the wearing of magical charms or amulets, to the performance of rituals. This blends into magical expert practice, and as an individual increases his use of magic, he may find himself in the role of expert with "patients" who come to him for assistance.

Bush Medicine

"Bush"[25] or herbal medicines are the most important and most widely used treatments in the popular sector. Bush medicines are also

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[25]In Jamaican patois the word "bush" is used to refer to any plant other than a tree. In a different, but related, sense it also means forested land, or land off of the main road where cultivation is done. When used in this way it has the added connotation of "wildness" (Cf. Cassidy and LePage 1967).

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used extensively by folk specialists, who are considered to have a more detailed and specialized knowledge of their use. As we shall see, folk healers' use of bush medicines differs somewhat from how they are used in the popular sector. However, for the most part bush treatments are considered to be in the public domain of knowledge and it is within this domain that they are most commonly utilized. The use of bush medicines, in the popular sector, does not require any special abilities or experience other than a knowledge of what bushes to use for what sicknesses, and how to prepare them. If one knows where to obtain the appropriate bushes they can usually be picked freely, or perhaps, if available only on private land, with the owners permission. Bush treatments are generally not sold, although one might find less common herbs or roots, or readymade bush tonics, for sale in the regional market or pharmacy. Some people use a ready-mixed herbal purgative that can be purchased in shops or pharmacies. Thus bush remedies constitute a free (or very cheap) and widely accessible form of treatment. This, along with their reputation for effectiveness, explains their popularity among rural Jamaicans as a first line of resort when dealing with illness.

We have little historical information on the development of popular herbal medicine in Jamaica. Early observers were more impressed with the dramatic displays of ritual specialists and with the activities of sorcerers or "obeah men" than with popular bush medicine. They did not take an interest in the popular ethnopharmacology of the slaves. The early reports that did give information on plants of Jamaica did so primarily from a botanic or economic perspective (e.g. Sloane 1707).

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Presumably a knowledge of bush remedies arrived in the island with slaves brought from Africa. Among those brought in were various healing specialists with an extensive knowledge of African herbal medicine, and it is likely that many other slaves had at least some basic knowledge of herbs. Although they were in a new environment, they were familiar with at least some of the plants. Through trial and error, and other logical processes, they were able to determine uses for many other botanical species. Presumably this information then spread by word of mouth, and some species came to be widely used. It is also likely that European folk traditions of herbal treatments were brought in by colonists, but we have little concrete evidence concerning this.

Interest in studying the popular use of herb medicines has increased in the 20th century and there have been several works on this subject in Jamaica (e.g. Beckwith 1927; Davis and Persaud 1970; Ayensu 1981). In addition, several other researchers have obtained information on bush medicines as part of more comprehensive studies of health care (e.g. Long 1973; Cohen 1973; Mitchell 1980). In the 1950s G.F. Asprey and Phyllis Thornton, botanists at the University of the West Indies in Kingston, investigated the popular/folk use of bush medicines and compiled botanical and pharmacological information on this in a series of articles published in the West Indian Medical Journal (Asprey and Thornton 1953, 1954, 1955a, 1955b). Although they give little information about their research methods, they apparently collected samples of herbs, which they identified, as well as data from informants and other sources on the medicinal use of the plants. They listed 250 different species of medicinal plants used for 36 different complaints,

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though less than half of these species could be confirmed to be still actively in use at that time. Nevertheless their work demonstrates the great variety and popularity of bush medicines.

We have some knowledge of the pharmacological constituents of these plants, though few clinical studies have been done to test their actual efficacy in treatment of the ailments for which they are used. When such studies are done, they generally focus on purified constituents and thus fail to duplicate use among the general public. There is now great interest among Caribbean governments in the development of drugs from native plants, both to reduce dependence on imported pharmaceuticals and as a source of foreign exchange (Daily Gleaner 6/14/88). Two researchers at the University of the West Indies in Kingston were recently awarded the Order of Merit, the highest national honor, for the development of "Canasol", a drug extracted from "ganja" (marijuana, Cannabis Sativa) which is useful in the treatment of glaucoma (Daily Gleaner 10/20/87). There is continuing interest in investigating other bushes which might be of use in treating other diseases such as hypertension (e.g. Skyers 1990).

Among the general population, information about bush remedies is exchanged primarily by word of mouth. When someone is sick, it is quite common for relatives, friends, or neighbors to stop by and make suggestions about what bushes might be helpful to try. They may have used a bush treatment for a similar ailment, or may have heard of someone else who did. These suggestions are taken seriously, especially if the illness is persistent or unresponsive to other therapy. Even strangers avidly exchange information on bush medicine. Illness is a

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common topic of conversation among older Jamaicans, and in such conversations the talk inevitably turns to what bushes might help certain ailments (cf. Mitchell 1980:33-35). While riding in a country bus from Port Antonio to St. Thomas I overheard such a conversation. A middle aged woman and man who had just met were discussing their medical problems. Upon hearing of her companion's "pressure" (hypertension) the woman recommended that he try making a tea with soursop leaf (Annona Muricata). Another woman sitting across the aisle chimed in with her own suggestions about how to prepare it.

As might be expected, older people generally have the most extensive knowledge of herbal treatments. This can be attributed to their greater experience, more "traditional" upbringing, and greater concern about health issues as the inevitable ailments of increasing age creep up on them. Within the family it is typically the grandmother or grandfather who has the greatest knowledge of herbs and directs the use of them by family members. I frequently heard complaints that knowledge of bush medicine was dying out because the young people do not take an active interest in it and are more caught up in "modern" ways of life. Certainly young people do not have as much occasion to use bush treatments, and with the greater availability of biomedical treatment, there is less need to rely on them exclusively. Another important factor is that some of the locally available over-the-counter medications (e.g. analgesics) are more effective than bush medications. However, even the young people are familiar with bushes that are used for common ailments, such as colds, and make frequent use of them.

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While it is true that the older generation has greater knowledge of bush medicines than the younger one, this does not necessarily mean that the knowledge is disappearing. Older folks, as I've mentioned, have a greater preoccupation with illness than the young, mostly because of their increasing confrontation with it. Thus it is likely that as a person grows older their interest in and knowledge of bush medicines will expand. We can expect that many of the young people of today will become more familiar with bush medicines as they age and use them more frequently.

If knowledge of bush medicine as a whole is decreasing, it may also reflect the changing epidemiologic patterns in the island. Many of the illnesses that were treated with bush medications in the past, e.g. diseases of childhood, have decreased in their frequency, and it is not surprising that knowledge of bush remedies for them would also be declining in importance. At the same time chronic diseases of older age groups, such as heart disease, have increased in prevalence and the use of bushes for treatment of these remains quite popular. Because these diseases are associated with older age, it is not surprising that knowledge of bush remedies would be greatest in the elderly. But this does not mean that such knowledge is dying out, it may just reflect a shift of the illness decision making peak from young mothers to elderly people. Young people's knowledge of bush medicine is greatest for those bushes used most frequently in treating problems typical of their own age group. In any case, with the interest that rural people show in bush medicines and the amount of information that is exchanged about

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them, it seems likely that they will remain an important therapeutic option at least in the foreseeable future.

There is no overall systematized, unified herbal pharmacopeia in Jamaica, however some generally accepted patterns of usage exist. There is a great deal of variation, but particular bushes, especially the most popular ones, come to be associated with specific uses. For example, some bushes are used by almost everyone for a particular sickness (e.g. Leaf of Life [Bryophyllum Pinnatum] for the common cold). On the other hand, one may find a bush being used for a great variety of illnesses, and at the same time different people will use different sets of bushes (though sometimes overlapping) for treating the same illness. This variation is not surprising given the nature of information exchange and the amount of individual experimentation that goes on. One finds the greatest consistency in treatments for the most common ailments e.g. common colds, hypertension, etc. Despite all the diversity, there is no doubt a process of cultural selection going on that over the centuries has led to a uniformity in the use of some herbs. We might hypothesize that the herbs used most widely, frequently and consistently are the ones most likely to have a clinically demonstrable efficacy. There have in fact been recent research efforts to test the efficacy of certain of these treatments (e.g. coconut water and lime juice for hypertension) using controlled clinical epidemiological methods (e.g. Skyers 1990).

In a household survey of Albion, considerable information was collected on the knowledge and use of bush medicines for a variety of complaints. While the instrument used (See Appendix, pp. 534-546) was not designed to exhaustively investigate community use and knowledge of

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bush medicines, it did provide an abundance of such information. In agreement with past studies (Asprey and Thornton 1953,1954,1955a,1955b; Mitchell 1980; Cohen 1973) we found that the common cold was the ailment most commonly treated with bush medicines and the one for which the largest assortment of bushes was used,[26] though a smaller number of these was used with the greatest consistency. This is most likely a result of the prevalence of the illness, its mildness, its self-limited nature, and the symptomatic relief that may be obtained pharmacologically (e.g. decongestant action, etc.). The bushes most commonly used in the treatment of colds are Leaf-of-Life (Bryophyllum Pinnatum), Grow-stake (Gliricidia Sepium), Jack-in-the-Bush (Eupatorium Odoratum), Ram-goat Dash Along (Turnera Ulmifola), Aralia (Aralia Guilfoylei), and Marigold (Bidens Reptans). These and other bushes used for colds are known collectively as "cold bush." They are usually prepared as teas.

Other common ailments which are frequently treated with bush medicines include headache, fever, "runnin' belly" (diarrhea), "nerves," and "pressure".[27] For these common ailments the "bushes of choice" are

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[26]Over forty different bushes were reported as treatments for colds.

[27]"Pressure" or "high blood pressure" is a folk redefinition of the biomedical disease category of "hypertension". In lay conceptualization of the disorder, a variety of symptoms are commonly believed to be associated with it. Although biomedical theories of hypertension downplay or deny the existence and importance of such symptoms, Jamaicans frequently judge the presence and severity of the illness according to symptomatology. The common perception among Jamaicans is that heat, stress, upset, or exertion causes the blood pressure to rise and that this in turn causes fatigue, weakness, dizziness, lightheadedness, headache, and a feeling of heat in the head. Thus, whenever an individual who has been diagnosed rightly or wrongly (the diagnosis may be erroneously based on a single blood pressure reading) as suffering from high blood pressure (continued...)

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shared common knowledge, so that children learn about them during the process of socialization. They learn what bushes are appropriate for what ailments as they are given bush remedies by their parents and grandparents. With less common ailments, information exchange is more specialized.

Bushes are also used preventively, usually in the form of "bush tonics" which are felt to boost one's strength, vitality, sexual vigor, and resistance to disease. Bush tonics usually are made up of a combination of bushes, primarily roots, and the tonic is sometimes called colloquially "roots."[28] Bushes used frequently in the tonics include Irish Moss (Gracilaria sp.), China Root (Smilax Balbisiana), Strong Back Root (Morinda Royoc) and Ganja (Cannabis Sativa). Some bush tonics, especially "roots," are very much gender oriented, and are felt to enhance a man's sexual abilities and performance. Other tonics, e.g. ganja tea, are for more general use and are sometimes given to children.

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[27](...continued) experiences any of these symptoms, it is explained as due to an exacerbation of the disease. In addition to anti-hypertensives obtained at clinics, people often use bush medications to treat these symptoms, and these are usually felt to act by cooling or relaxing the body (cf. Mitchell 1980:30,35-6). (For an analysis of similar folk conceptions of hypertension in American culture see Blumhagen 1980, 1982; Nations et. al. 1985.)

[28]In traditional Jamaican patois the term "roots" has the connotation of earthiness and masculine virility, thus it is a fitting name for bush tonic. In addition, the word has in recent years taken on a new significance through its popularization by the Rastafarian movement. For the Ras Tafari cult "roots" signifies their connection with Africa, and thus is of vital importance in their ideology. In their characteristic fusion of life and language, some Rasta groups support themselves by making and selling "roots" bush tonics. The term, however, does not have the same significance that it does in American Black folk culture in which "roots" and "rootwork" are used in reference to sorcery and magic (Snow 1978:78,90).

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Bush treatments are prepared in a variety of ways and may be used internally or externally. The most common form of use is a tea made by boiling or steeping the bush (or bushes) in water. In fact, to "boil bush" is an expression commonly used to refer to the use of herbal treatments in general. Aside from the drinking of bush teas, bushes may be applied externally in a prepared or natural form. For example a whole cowfoot leaf (Piper Umbullatum) may be tied on the head to provide relief from a headache, and a pepper leaf (Capsicum spp.) may be applied to "draw" a boil. Others are used to dress wounds. Bushes may be boiled, usually in combinations, to make an infusion which is used as a "bush bath". This form of treatment, as we shall see, is used most commonly by healing specialists.

Over-the-Counter (OTC) Medications

Another important form of self-treatment is the use of medicines which can be bought over-the-counter without prescriptions at pharmacies or at local shops. Most of these are biomedical treatments which are considered to be safe for general use without a doctor's approval. This category also includes what we might call "patent medicines", treatments which participate in the symbolism of biomedicine, and which may at one time have been within the biomedical realm, but the usage of which now falls outside the scope of current biomedical practice. These patent medicines provide a connection between the traditional and scientific, and consequently between the popular and biomedical sectors.

Unlike many developing countries, Jamaica has a fairly strict and effective system of pharmaceutical classification and control. Although

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its rules are less restrictive than those of the USA, this system exerts tight control over the sale of drugs. In Jamaica, drugs are grouped into four "lists." List 4 consists of antibiotics, narcotics, and other potentially dangerous drugs. A doctor's prescription is required for dispensation of these. Drugs in list 3, which includes 75% of all those listed, may contain small amounts of list 4 drugs, and can only be sold in pharmacies, but are deemed safe for dispensation without a prescription. List 2 includes worm medicines, cough medicines, vitamins, and contraceptives. These may be sold in shops or supermarkets as well as pharmacies. List 1 includes "vitamins, tonics, antacids, liniments, aspirin, and laxatives" (Mitchell 1980:42) and these also may be sold in shops. Thus most pharmaceuticals (Lists 1,2,3) could be considered OTCs, though many are available only in pharmacies. (Mitchell 1980:41-2)

Also within the realm of OTC medications are what Mitchell (1980:43) calls "crude drugs." These are basic substances in the form of leaves, tinctures, minerals, compounds or oils which were originally used by pharmacists and doctors in the preparation of medicines. Examples of these would be epsom salts, frankincense, myrrh, potassium permanganate (used in solution as "red lotion"), peppermint oil, camphor, etc. These substances are relatively cheap and are sometimes used for self-medication, often in combination with bushes or in home remedies. Many of these crude drugs are not far removed from being products of nature, yet they are processed and converted into "man-made" substances. Thus, like patent medicines, they have characteristics of several different realms. Consequently, they provide a link between

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Bush Medicine and Biomedicine, and between the popular, folk and professional sectors.

Most of the OTCs used in Albion are purchased at one of the small general shops in the district. This means that the overwhelming majority of OTCs purchased by Albionites are of the cheapest and simplest types. Most people, especially those of the lowest socio-economic levels, can not afford the more complex, sophisticated, or imported OTCs which are expensive and available only at a pharmacy. Access to the only pharmacies in the area (there are 2 in Morant Bay) is also limited by the distance and travel time involved. The majority are intimidated by the choices of OTCs available in a pharmacy, and would be unsure of what to ask for or purchase. Occasionally the pharmacist will be consulted for information about medications,[29] but most people would not venture into a pharmacy except to get a medication prescribed by a doctor. If they are going to invest a significant sum in treating a disease, many prefer to spend it by consulting a private doctor and obtaining a prescription medication. If an illness is not bothersome or serious enough to induce a trip to a private or public clinic doctor,

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[29]Mitchell (1980) provides a more in-depth analysis of the role of pharmacies and pharmacists in the Jamaican health care system. Some Jamaican pharmacists will take on a diagnostic role as well as an informative one. People will sometimes prefer to consult a pharmacist as opposed to a doctor, because the business relationship with the former allows the customer to maintain control over the interaction, something which is not possible with doctors. The two pharmacists in Morant Bay, however, do not usually provide services beyond the provision of information, and as members of the middle class are not much less intimidating to lower class Albionites than are the doctors. Also, because of the expense, most Albionites rarely use more than small amounts of the cheapest and most widely available OTCs, which can be purchased in the local shops.

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then it is likely that bush medicines or cheap OTCs will be deemed sufficient for its treatment.

The OTCs which are stocked by the local shops include simple analgesic preparations (e.g. Panadol [Acetaminophen], Phensic, Cafenol), cold medicines (e.g. Contac, Comtrex), cough syrups (e.g. Vick's 44), liniments, laxatives, etc. Thus the OTCs available reflect the needs of the community. The most common and mildest illnesses (e.g. headache, arthritic pains, minor cuts, colds) are the ones most commonly self-treated with OTCs. Imported and expensive OTCs are beyond the means of those who provide the shops with most of their business.

Like bush medicines, OTCs are used as a first resort for treatment because of their low cost and availability. They also provide a means of exerting personal control over illness. In her research, Mitchell (1980) found that OTC medications, as opposed to bush medications, were used more frequently by those in urban vs. rural areas, by those of higher social status, and by younger people. Because of their connection with Biomedicine and the metropolitan world they represent a "higher status" choice of treatment, and thus constitute a means of expressing social mobility and a progressive self-image. Mass media advertising is playing an important role in this regard. Many analgesics, cold medicines, tonics, and vitamins are portrayed on television and radio in a way that identifies them with young, upwardly mobile, middle class figures. Some of our informants did in fact report trying a certain medication because they had heard about it on radio or television. Mitchell sees OTCs as supplanting bush medicines, and

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assuming an increasingly important role in self-medication (Mitchell 1980:49-51,141-167).

While this may be true to a certain extent, I found that in a rural area like Albion, bush medicines are generally favored over OTCs, and their use seems to be continuing at a high level. There are several factors which explain their continuing popularity and suggest that the use of bush medicines will continue to be an important medical alternative well into the future. The most important of these is cost. OTCs are by far more expensive than bush medicines, and people of lower socioeconomic status are unable to afford any but the simplest and cheapest ones (e.g. analgesic preparations). Imported medicines and those only available in pharmacies are beyond the means of most lower class Albionites. It is cheaper for them to go to a public medical clinic and get free prescription drugs than to buy most OTCs. Some people will go to the local Health Center to get free, or very cheap, cold medicines, analgesics, or antacids (when they are in stock). With the persistent and worsening depressed state of the Jamaican economy, it is unlikely that OTCs will be much more accessible to poor rural Jamaicans in the near future.

"Home Remedies"

Not all medications used in the popular sector of the health care system fall neatly into the bush/OTC dichotomy. There are, in fact, a number of substances which fall into neither category, but which are used in an equivalent fashion. These substances share some of the characteristics of each group, and thus provide a link between them.

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Their use demonstrates that while different types of medication have different symbolic connotations, the symbolic aspects are secondary to questions of efficacy in the minds of those who use them. Thus the bush/OTC dichotomy is in some respects a false one. In reality people move easily among these different realms and use them concurrently and in combination, their main goal being relief rather than any sort of conceptual consistency.

These treatments share some aspects of the "natural" world of bushes in that they are commonly available, very cheap or free, and devoid of any connection (at least currently) with the biomedical establishment. Yet they are man-made (or heavily processed), and thus share the connotations of artificiality and technology. They are "popular" both in their widespread use and in the manner in which their usefulness is discovered. Knowledge of their medical efficacy is rooted in discovery by the layman during their everyday use within the family rather than in declaration from a higher authority. On the spectrum of popular treatments these remedies are linked most closely with "crude medicines" and bush medicines, and sometimes incorporate, or are used in combination with, these.

The best example of such a home remedy is kerosene oil. In addition to its physical and chemical properties, its ubiquitous presence in the homes of the poor as the only source of nighttime lighting probably led to its use for a variety of unrelated purposes. It is now quite commonly used in a mixture with camphor (a crude drug) or various bushes, as a liniment in the treatment of osteoarthritic joint pain, a widespread problem. It is also taken internally for a

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variety of stomach ailments, though I was told that this is in its "burned" form. Other treatments in this category would include copper bracelets used for treating arthritis, rum which is used in a slew of popular treatments, and foods such as honey, salt, and coconut oil.

Religion

Although healing is quite common within the realm of religion in Jamaica, religious healing usually takes place under the aegis of a specialist, and thus would fall within the folk sector of the health care system. However one sometimes finds religion being used for healing in a popular sense. Religion and religious groups are core features of Jamaican culture, and also provide important coping mechanisms for individuals threatened by disease and suffering. While the social and cultural significance of religious healing will be discussed more fully in a later section, here a case example will best illustrate how faith may serve as a means of coping with personal suffering.

Olive Johnson is a 69 year old woman who has been living in Albion since 1961. She shares a small but relatively comfortable concrete and tile home with her daughter and several grandchildren. They live on the main road close to the Baptist church on land that was left to her by her common-law husband when he died a few years ago. Though their origins were humble, through hard work and pious living the family was able to attain some measure of security. Their attitudes and living standards are now more typical of the lower middle class (level IIB) than of the poorest levels of Albion society. They have electricity, a

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television and a standpipe in their yard -- luxuries by Albion standards. Miss Olive's children and grandchildren have been ambitious and successful, reflecting the stable environment and encouragement she was able to offer them while they were growing up. Her daughter May, who lives with her, is a nurse at the King George Hospital in Morant Bay. A son, who lives on his own, owns a popular local "sound system".

Miss Olive is a deeply religious woman. She is a member of the Baptist church and is very active in the congregation. One day she told me the story of an event which both enhanced her religious convictions as well as set a precedent for her orientation to the health care system. When she was about 15 she stepped on a fishbone which punctured her left great toe, which subsequently became infected. At that time she had already developed a strong faith in the healing power of God, and in her prayers she asked Him to help her. The toe, however, worsened and turned black. Her family and friends, concerned about her health, gave her a continual stream of advice about what to do for the toe, but she remained committed in her reliance on God to help her. As it worsened they begged her to go to a doctor, but she refused. With her prayers going unanswered she began to have some doubts. But she said she felt too "ashamed" to go to a doctor -- she refused to give up her faith.

One night she went to bed after praying very hard for God to heal her. During that night she received what she calls a "spiritual injection" from God. She woke up feeling completely transformed. Soon after this her toe began to get better and eventually healed. Since then, with her faith solidified through this dramatic cure, she has

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relied only on prayer when she gets sick. She refuses to see a doctor or to use any bush or OTC medicines. Fortunately, she has managed to stay relatively healthy throughout her life, further proof to her of God's beneficence. Other family member's use both bush and biomedical treatments, and she does not interfere with her children's treatment decisions for their own children. However, for her, only prayer will suffice.

While this story emphasizes the personal, self-oriented aspects of religious healing there are also important communal factors involved. While the Baptist church does not conduct public healing services per se, they view healing as one gift that the pious can receive through their relationship with God, and prayer is the means through which this is sought. But prayer is not strictly a personal enterprise. Through prayer, one can intercede with God on behalf of another, and communal prayer focused on an individual is more powerful in soliciting divine assistance than the prayers of isolated individuals. It is not uncommon during a church service for the congregation to be asked to focus their prayers to help a particular person who is sick or suffering. In addition, small groups of church brethren may visit a sick person's home to conduct a brief service and offer their prayers. Miss Olive's use of prayer to heal herself also extends to helping others. She frequently lends her spiritual assistance to those who are sick, and she is a regular participant in visiting prayer groups.

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Magic

Occult practices or "Science" are also commonly used to treat illnesses, but as with faith healing, almost always fall under the scope of an expert practitioner. On rare occasions, though, such an approach may be used in a limited way by an individual who has some experience with magical techniques. The most common example of this would be the use of charms or amulets for protection. However, these are difficult to obtain in Jamaica and if the individual has not had the opportunity to travel abroad they must be obtained through a specialist who has obtained them "from foreign." Candles are also used frequently in occult practice and may be obtained locally, but more specialized knowledge is needed in order to use them properly.

By and large, though, it is not common for a lay person to resort to magical techniques on their own. In order to be successful in such a task, it is felt that considerable skill, experience, and knowledge are needed. Attempts by "amateurs" to influence the spirit world are thought to be quite dangerous since a novice does not have the skill to control the powers that may be unleashed. Thus there are few who are willing to risk it. Those who take time to learn the proper techniques of course become more skilled, but then are likely to be functioning in the capacity of a healing expert or at least an assistant.

It is possible to purchase Over-the-Counter magical powders, oils, incense, etc. at some pharmacies, though these are usually used under the direction of an expert healer and one must go to Kingston to find pharmacies that sell them. However, it may be that some people who are unable to afford the services of a healer will try to use these on their

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own for various purposes. I did not see any examples of this, but since such usage would be relatively clandestine, it would be very difficult to rule out this possibility.

SUMMARY AND COMMENTS

Kleinman's tripartite model of health care systems is a useful tool for looking at health care alternatives and utilization strategies, and also for making comparisons among health care systems in different cultures. Its categorization of alternatives in terms of two simple distinguishing features (use of specialists, professionalization) not only makes sense from the observer's perspective but, as will be seen more clearly in later chapters, also seems to accurately reflect the basic conceptual criteria used by rural Jamaicans in making health care decisions. In the analysis of the health care system of eastern St. Thomas, use of this model enables us to make sense of the complexity of health care activities, and to clarify the system's underlying structure and order. The simplicity and flexibility of the model helps us avoid the distortion that would be introduced by a procrustean imposition of a more rigid and foreign model.

The first major criterion distinguishing the three different sectors -- popular, professional, and folk -is the social context in which the health care activity is taking place, or more specifically, whether someone in a specialist role is involved in the treatment. The crucial distinctive feature which sets the popular sector apart from the other two is that the health care activity involves the sick individual, and possibly his or her family or friends, but does not involve a health

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care specialist or "expert".[30] When a specialist is consulted, usually because treatment within the popular sector has failed to produce the desired result, one of the other sectors is entered into. The main distinctive feature separating the folk and professional sectors is the criterion of "professionalization."[31]

Use of the tripartite model and the concepts of specialization and professionalization as principal distinguishing features in this analysis is consistent with the manner in which health care options are perceived and used on a day to day basis by rural Jamaicans. While a detailed analysis of patterns of utilization will be deferred until

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[30]Of course, the matter of how a "health care specialist" is to be defined is a crucial question here. For our purposes it will suffice to take a common sense approach and define a health care specialist as a person with a generally recognized special skill, knowledge, and experience with regard to health care, and whose social role involves an explicit focus on the diagnosis and treatment of the illnesses of others, though not necessarily a complete or full-time occupation with this. That such a definition is less than completely precise reflects how the different sectors of the health care system can overlap and shade into one another; their boundaries are blurred rather than sharp.

[31]The concept of professionalization is more difficult to define than it is to illustrate; it is easy for us to appreciate the difference between a doctor and a folk healer. For our purposes here the key features which distinguish the professionalized sector from the folk are its formal, explicit, established, and codified structural organization; its standardized criteria for training and accreditation; its shared base of knowledge and practice; and its relatively standardized fee schedule. Of course, where there are different and competing subsectors within the professional sector (e.g. Biomedicine, Chiropractic, Homeopathy, etc.) the standards of knowledge, training, organization, practice and fees will differ among them. In the Jamaican setting this is not a factor because of the dominance of Biomedicine. The folk sector, on the other hand, while not without structure or shared ideas, is characterized by an implicit and informal rather than explicit and standardized organization, a lack of formal standards for training or practice, and a great deal more heterogeneity among practitioners. Again the boundary between folk and professional is not necessarily clear and precise, though in the Jamaican setting, and perhaps in other cultures where Biomedicine dominates the professional sector, it is not a difficult distinction to make.

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Chapter 8, suffice it to say here that Albionites in their conceptions and practice implicitly make clear distinctions among these different sectors and use them for different purposes at different stages of the health seeking process.

Each of these sectors can be further broken down and analyzed in terms of its components, structural features, and functions. It is at this level that comparisons between different health care systems are most revealing, and that we find the unique features of each system being played out. We have seen in this chapter that within the popular sector can be found several different categories of treatments (bush, OTCs, home remedies, magic, religion). The boundaries between these categories are again not always precise and clear, as we see, for example in the links created among them by treatments such as "crude medicines." And for many purposes the different categories are used interchangeably. They are, however distinguishable in terms of their symbolic connotations, their social significance, and their reputed efficacy for treatment of various types of illness. Thus a variety of factors come into play when choices among them are being made.

Although many different factors come into play in health care decisions, Jamaicans are essentially pragmatic in their choices among different options. Few are so ideologically committed to any particular treatment, or so logically inflexible that they would be unwilling to try just about anything that they think might work. Perceived efficacy, however, is itself a complex matter and is highly dependent on other individual factors such as previous experience, education, social status, age, exposure to marketing campaigns, etc. Lay evaluation of

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efficacy rarely follows scientific logic. Few people, Jamaicans or otherwise, think in terms of clinical epidemiological concepts. As Malinowski pointed out many years ago, "...in human memory the testimony of a positive case always overshadows the negative one. One gain easily outweighs several losses." (Malinowski 1954[1925]:82). Thus perceived efficacy often diverges from that which might be determined statistically, and numerous factors come into play in its formulation. In a situation in which illnesses are generally mild and self-limited, such as is found in the settings in which popular treatments are used, it is even more fluid, and more open to influence from other factors.

Another crucial factor in the choice of treatments is cost which, because of the poverty of Albionites and other Jamaicans, exerts rigid constraints on the avenues that can be pursued. The importance of this factor, however, is also subject to influence depending on the severity of the illness, previous experience, resources available, etc. The symbolic connotations of the different options, as defined by tradition, personal experience, or the mass media, also play a role, especially when self-identity and public projection of one's social status are at stake. This tends to be most relevant when an individual or family is in the process of trying to redefine their social position, for example in trying to advance from the lower to middle class. It is less important for those firmly rooted in either class.

One feature that all of these popular categories share, and which is central to their inclusion in the popular realm, is that they each represent a first line of defense against the loss of self-control that is threatened by illness. They enable the individual to maintain

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control of his or her body, and to correct an aberrant condition using one's own knowledge, skills, and experience. Treatment within the popular sector symbolizes and promotes feelings of self-reliance, independence, and in some cases, for example when bushes are used, a freedom from even the constraints imposed by poverty. These are powerful motivations, especially in Jamaica where issues of control and power are so vital in shaping culture and personalities. Jamaicans do not relinquish control lightly. One young man I knew in Albion went so far as to self-treat a toothache by using a red-hot file to burn out the nerve in the tooth. He explained that he did this because he couldn't afford to go to a dentist, but it was quite evident as he described the incident that he was proud of the bravery and resourcefulness he had shown in treating himself. And he said he would do it again if the need arose -- for him it worked.

The decision to consult a specialist is a complex one. While it offers the possibility of regaining control of an illness that has not responded adequately to self-treatment, it also carries with it the threat of a loss of autonomy and the intimidation that comes in interactions with higher status people. It is in such situations that the conflicts inherent in the ambivalent attitudes that lower class Jamaicans have towards authority come to the fore. When possible, Albionites prefer to avoid facing these conflicts and stay within the popular realm of treatment. Not surprisingly, denial is sometimes used for this purpose. Ideological commitment to a popular sector treatment may persist in the face of worsening disease when it is critical to the

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maintenance of self-identity. The case of Olive Johnson (See p.117) is an example of how this can influence decision making.

These issues, of course, are not unique to rural Jamaica, but because of the particular social and cultural developments which have taken place here, they are of particular salience in this setting. In addition, they have important implications for the design of appropriate and effective health care development strategies. As will be seen in later chapters, Albionites often avoid using government health care services, even when they are provided at little or no cost. This diminishes the efficacy not only of treatment services, but even more so of preventive services. The effectiveness of development planning in this setting could be enhanced if it was able to make use of such cultural information in order to help overcome cultural and social barriers to efficient utilization of services and resources (cf. Whitehead 1984).

We now turn our attention to another part of the health care system: the professional sector. When an illness becomes too severe or debilitating to be handled within the popular sector, it is the professional sector which becomes the next choice for most Albionites.

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CHAPTER FIVE

THE HEALTH CARE SYSTEM II:

THE PROFESSIONAL SECTOR

INTRODUCTION

In Jamaica the professional sector of the health care system is synonymous with "Biomedicine", the scientific medical system of Western culture. While in some societies there are other professionalized systems (e.g. chiropractic, osteopathy, homeopathy, etc.) that coexist or compete with Biomedicine, in rural Jamaica this is not the case. In Kingston one may find other types of practitioners, but in rural St. Thomas there is no room economically for any competition. The health care marketplace in St. Thomas is insufficient to support alternative professional systems. We often think of Biomedicine in terms of doctors and hospitals, however as we shall see, the biomedical system in St. Thomas encompasses much more than this. Before looking at biomedical alternatives that are available to people in St. Thomas it will be helpful to first get some idea of how the system has developed in Jamaica.

THE HISTORY OF BIOMEDICINE IN JAMAICA

In many parts of the developing world, the cultural position of Biomedicine is that of a foreign system imposed by a colonial power in opposition to well-integrated traditional indigenous systems. However, because of the unique history of this area, the situation in Jamaica and most of the Caribbean is somewhat different. The cultural destruction

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brought about by the hardships, disconnection, and restrictions of slavery meant that indigenous African health care systems had been destroyed, or at least stripped to their bare essentials, and that the new and renascent forms which were to emerge had to evolve under tight constraints.[32] A primordial form of Biomedicine was introduced to island culture at the same time that this redevelopment of traditional forms was going on, with the result that over the next two centuries the two systems developed more or less in parallel, with interchange and sharing of elements in both directions. Consequently, biomedical and traditional health care systems in Jamaica are perhaps more complementary and less competitive than is the case in many other colonial settings. In addition, foreign influence on both systems has further blurred the distinction between "traditional" and "modern." Both the folk and biomedical sectors are created out of a mixture of traditional, modern, syncretic, imported and novel features. Their sociological and cultural distinctiveness is related more to issues of class, cultural origin, and social and cultural functions than to conflicts between "traditional" and "modern" (cf. Stoner 1986; Coreil 1983; Amarasingham 1980).

European medicine was, as I have mentioned, introduced with the early colonization of the island. There are direct continuities in terms of underlying ideology, knowledge base, and methods between this old form of medicine and modern Biomedicine. However, the Western

[32]The early, truly indigenous culture of Jamaica was wiped out by the Spanish prior to English settlement through the genocide of the island's native Arawak population. Arawak culture, including its medical system, consequently had little or no influence on the later cultural developments in the island.

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Medicine of the seventeenth, eighteenth, and nineteenth centuries was quite different from current forms. It was only semi-professionalized, and in fact was essentially a folk system. Although fundamental knowledge of anatomy and physiology had begun to develop by that time, and the basic scientific orientation of the field was present already, in practice the old system of medicine had more in common with folk medical systems than with the Biomedicine of today. The humoral theory of disease, which explained sickness as resulting from an imbalance of fundamental bodily "humours" (melancholy, phlegm, blood, choler) was the basis of "Physic" through the seventeenth century, and persisted much longer in common belief and practice (Foster 1987:357,384; Nuland 1988:155,305). Treatments aimed at correcting these imbalances were crude, and often traumatic. Purging, bloodletting, blistering, and cauterization were used in various combinations for most ailments. The pharmacopeia of the day included some dangerous drugs such as mercurials, as well as more benign herbal treatments and some genuinely useful drugs such as opiates (Craton 1978:127-131). A doctor's success usually depended more on the placebo effect and the resiliency of the body than on pharmacological or instrumental effectiveness.

As might be expected, this form of treatment was relatively powerless against the tropical and epidemic diseases which plagued Jamaica throughout most of its history. During the seventeenth, eighteenth, and nineteenth centuries the most important causes of morbidity and mortality were infectious diseases such as yaws, malaria, cholera (after the slavery period), typhoid, dengue fever, yellow fever, dysentery, pneumonia, tuberculosis, measles, smallpox, hookworm, guinea

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worm, and other parasitic diseases. The rates of mortality were highest for newcomers, Europeans as well as Africans. Africans were, at least in part, chosen to work the plantations because of their hardiness in a tropical climate, and because of their resistance the various diseases which had decimated the native populations, as well as to tropical diseases such as malaria (Harris 1964; Rout 1976:22-6). Nevertheless, mortality rates for captured slaves were very high. About 30% died between the time of capture and arrival in Jamaica (Craton 1978:414). And during the period of "seasoning" the new arrivals had a much higher mortality rate than creoles (Craton 1978:121).

European arrivals also died at an alarming rate from exposure to diseases for which they had no resistance. As mentioned earlier (see Chapter 3, p.28) 2/3 of the first settlers in St. Thomas died in the first year (Black 1973:32). The mortality rate for English soldiers in the garrison at Spanish Town (1817-1836) was 12% per year, one of the highest in the world at that time for this type of outpost (Craton 1978:122,412). The crowded and unsanitary conditions in the urban area of Spanish Town (the capital at that time) predisposed to malaria and dysentery, with a consequent high death rate among whites and slaves living there (Craton 1978:122). A satirical cartoon from 1800 depicts the typical decline and demise of "Johnny New-come" who falls prey to "The Yellow Claw of Febris" (Holland 1984[1800]).

The plantation slaves were spared these unhealthy conditions but had other problems to contend with -- overwork, malnutrition, injuries, and corporal punishment. Infant/childhood mortality of slaves was very high throughout the island due to unsanitary conditions, tetanus, and

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childhood diseases. Although hard data is scarce, 30% of those born on one plantation were recorded as dying in their first five years of life during the period from 1792-1838 (Craton 1978:121). During the period from 1803 to 1816 there were a series of epidemics of smallpox, yellow fever, and typhoid which pushed the overall annual death rate to about 127/1000 (Marchione 1977:69; Carley 1943:1). From 1817 to 1829 the death rate among the slaves was about 32.7/1000 (Marchione 1977:69; Eisner 1961:131-2).

When slaves fell sick they often were denied access even to what medical treatment was available at the time. It was not until the Consolidated Slave Act of 1792 that provision of medical care for slaves and keeping of death records was required (Marchione 1977:69; Carley 1943:1). However, most plantations contracted with "doctors" on a per capita basis to care for sick slaves. The practitioners were paid an annual set fee per head to make a weekly visit to the plantation, as well as emergency visits when necessary (Curtin 1955:48). Sick slaves were treated in the plantation "hothouse" (i.e. hospital), and those with contagious diseases such as yaws were consigned to isolation hothouses. The interest of the slaveowner was of course primarily economic. A sick slave was unable to work, and it was worth paying a doctor to get them back on their feet, whether they were ready for it or not. The main goal was to maximize production, and the slaves represented a capital investment that on the one hand needed maintenance care, but on the other had to be utilized to the limits of endurance in order to optimize returns. In this sense the doctor had a role analogous to a "horse doctor." As Craton puts it:

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> Masters and doctors alike were disposed by their "interest" and ignorance to minimize slave ailments. Owners and overseers were determined to keep all but the dying at work and to trim the costs of medical treatment. To their eyes, a successful doctor was one who satisfied these requirements. Paid a per capita fee, plantation doctors were positively rewarded for cursory treatment and encouraged to ignore failure and simulate success. Faced by a level of general health that condemned the plantation system by which they lived, or was beyond their care or ken, doctors tended to disguise the inadequacy of their treatments and the ignorance of their diagnoses with accusation of malingering, self-inflicted injury, and "natural" unhealthiness stemming from the slaves' racial origins. In this they perpetuated the malign ignorance of Dr. Thomas Trapham who in 1679 attributed the high incidence of yaws among blacks to the alleged fact that they were an "animal people," subject to an "unhappy jumble of the rational with the brutal Nature"... (Craton 1978:127; Trapham 1679)

Positions as plantation doctors, which could be relatively lucrative, were usually obtained through connections with plantation attorneys. Consequently, the men who filled them were typically not of the highest quality. While most could at least claim some British training, there was no real regulation as to their training or experience (Curtin 1955:48). When a doctor was available, he was often more dangerous to the patient than the disease itself. With his leeches, purgatives, emetics and caustics, he could kill as well as cure, and could rarely offer effective treatment for the most common diseases of that era (Patterson 1967:99-100,102-3; Gardner 1971[1873]:180,390).

Following the abolition of slavery, the freed slaves were denied even this cursory medical care. Planters had no incentive to provide

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treatment for their workers,[33] and few of the freedmen had enough income to pay for treatment on their own. Thus few doctors remained in the rural areas and many left the island altogether. By the 1860's the number of doctors in the island had fallen to a fourth of what it had been at the time of Emancipation (Curtin 1955:160). There were fewer doctors in the island in 1900 than there had been in 1800 (Craton 1978:119). In 1830 there were 200 doctors in the island and the per capita ratio (1:1,855 people) was higher than it is today (1987 - 1:7,117) (Marchione 1977:69; Planning Institute of Jamaica 1988:20.14). By 1846 there were only 139 doctors, and by the 1850s there were not much more than 50 (1:8,822) (Marchione 1977: Eisner 1961:339-40).

At the same time, health conditions worsened for the rural population. With the decline in the sugar industry throughout the nineteenth century real wages were declining and prices were rising. As discussed in Chapter 3 (p.30), the planters actively sought to insure a supply of labour by impoverishing the working classes through low wages, high prices, restriction of land ownership, and oppressive taxation (Robotham 1981: 27-67). Nutrition was poor and, with worsening conditions, starvation and malnutrition were rampant throughout the island (Robotham 1981:72). Living conditions were unsanitary, and many of the poor were not even able to clothe themselves. As might be

[33]Planters were still required to provide medical care to their indentured laborers. Although they often cited this as a benefit to recruit indentured workers, the evidence indicates that the level of care provided was minimal. In the 1860s there were 3 doctors covering 16 estates in St. Thomas, which they did in addition to their regular practices. The estates each employed from 13 to 42 indentured African immigrants. With poor roads and long distances impeding travel, the care available to these workers was neither good nor accessible (Schuler 1980:60-1).

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expected, it was "the children who bore the brunt of this deprivation." (Robotham 1981:73). Diseases such as leprosy, yaws, and syphilis increased in their incidence (Robotham 1981:72). More than thirty thousand died in the cholera epidemic of 1850-1, and a smallpox epidemic which followed exacted a similar toll[34] (Curtin 1955:160; Campbell 1976:266). Tropical and parasitic diseases continued to cause an even more severe degree of death and suffering. About 8% of the population died between 1850 and 1854, mostly from these causes (Eisner 1961:136; Marchione 1977:70).

The Assembly government of the island did take some measures to stem the flow of doctors out of the island, passing the Dispensary Act in 1846 "which provided small stipends to physicians and encouraged them to set up prepayment systems," and the Medical Charities Act of 1851 which "divided the country into service areas with a dispensary and doctor in charge for the benefit of poor peasants" (Marchione 1977:70). But the legislators were unwilling to commit sufficient funds to public health or provide free care to the indigent, preferring to spend their funds on schemes to increase immigration of new workers (Curtin 1955:160-1; Campbell 1976:315-8). In 1862 Edward Jordon, the mulatto Minister of Health declared "...it is no more the duty of government to provide medical men, than it is to provide butchers and bakers....I hold

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[34]The deaths which occurred might have been prevented if contemporary standard medical care had been available to the masses. "Variolation" (inoculation with smallpox itself) had been introduced to England from Turkey by Lady Mary Wortley Montagu by 1717, and was used by a few progressive slave doctors by the mid eighteenth century. (John Quier used it in 1768.) Jenner's method of cowpox inoculation had gained widespread acceptance in England after 1800. However, this form of prevention was not made available to the Jamaican masses until 1865, after the epidemic (Craton 1978:129; Marchione 1977:72).

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that it is the duty of every man to provide himself with medical aid, as well as food." (Quoted in Campbell 1976:316). That year a petition for medical assistance by the peasants of St. Andrew was met with indifference by the government (Campbell 1976:315-6).

The physical suffering of the poor added to the frustrations which culminated in the Morant Bay Rebellion in St. Thomas in 1865 (see Chapter 3, p.30). George William Gordon's protest of an incident, in which a sick man had been locked up in the Morant Bay jail because there were no medical facilities available to treat him, became a major issue in the conflict leading up to the rebellion (Black 1973:127). While the Crown Colony government, which was instituted after the mishandling of the rebellion, was hardly a champion of the poor, it did promote a more equitable and prudent use of the island's resources. Direct control by the British government enabled reform movements in Europe to have a more immediate impact on Jamaica than might otherwise have been the case.

The most notable figure in this regard was Sir John Peter Grant who arrived in Jamaica in 1866 to take over the governorship from the disgraced John Eyre who had been overly zealous in putting down the rebellion. Grant had been an able administrator in India and during his tenure as governor (1866-1874) he was able to bring about a number of significant reforms in Jamaica. Among other things, Grant redrew parish boundaries and reformed parochial government, overhauled the judicial system, reorganized the police force, cut formal ties with the Anglican church, improved transportation, encouraged development of the banana industry, relocated the capital from Spanish Town to Kingston, and made improvements in the educational system (Black 1973:127-30).

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During Grant's term great strides were also made in improving access to health care. He established the Public Medical Service, upgraded vaccination programs, tightened quarantine regulations and improved water supplies and other public utilities. The Public Health Law, which still serves as the organizational basis of the government health services, was passed in 1867:

> A Central Board of Health as well as local parish boards was established. The 14 parishes were divided into sanitary districts and taxes were levied for sanitary control, quarantine, and food inspection. Thirty-five Government districts were created and District Medical Officers were appointed at salaries of 200 to 300 pounds sterling per annum. In addition, 11 estate hospitals were taken over by the government (Carley 1943:2). District Medical Officers were expected to supplement their incomes with private practice. Physicians, however, were not readily attracted to this service. It wasn't until 1880, when the first ticket system was devised that persons unable to afford medical care were identified and given tickets for free or low cost service (Eisner 1961:341). (Quote from Marchione 1977:72-3)

Although these measures did improve access to medical services for the poor, they did not have a great impact on indices of health status, such as the infant mortality rate, for a number of years. According to Marchione's calculations the IMR did not begin to drop significantly until the 1920s. These efforts did, however, help prevent additional serious epidemics from occurring and provided a framework for later developments. Further measures were taken over the next several decades to add to these advances (Marchione 1977:74). Quinine, used in treating and preventing malaria, was subsidized. The 1910 Yaws Notification Law was aimed at inducing victims of this disease to obtain treatment (Marchione 1977:73-4).

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While the groundwork for the public health system was laid in the nineteenth century, the greatest improvements in health status took place after 1920. The Rockefeller Foundation, which was involved in Jamaica from 1918 to 1937, played a major role in instituting these improvements. The foundation had successfully reduced hookworm infection in the southern USA through sanitation and curative measures, and later extended these efforts to a number of plantation-based societies around the world, including Jamaica. Their work in Jamaica focused initially on hookworm control and was coordinated with local Boards of Health, which provided sanitation measures. Hookworm was brought under control by the 1930s. The Rockefeller Foundation later extended its work to efforts to control other infectious diseases such as malaria, tuberculosis and yaws. Other accomplishments included the introduction of school hygiene clinics which provided an important forum for health education, the initiation of a malaria survey and control program, the establishment of the Tuberculosis Commission and the Yaws Commission which surveyed incidence and provided treatment, and the startup of a course for sanitary inspectors (Marchione 1977:74-5).

The Rockefeller Foundation's work also influenced the development of the structure of services at the local level which emerged through the implementation of these programs. Public health units made up of a Medical Officer of Health, a public health nurse, and a team of sanitary inspectors were formed to carry out the preventive aspects of the efforts. While this type of organization assured attention to preventive aspects of public health measures, by separating the curative

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from the preventive services it had some negative consequences as well. As Marchione puts it:

> The separation of public health and curative (therapeutic) medicine characteristic of metropolitan countries had been transferred to Jamaica along with the improvements in public health. This division has plagued efforts at comprehensive health care delivery ever since. (Marchione 1977:75-6).

Measures of health status did improve dramatically between the 1920s and 1940s despite the lack of modern antibiotics and pesticides. The Infant Mortality Rate had been fairly steady at about 175 per 1,000 up until the early 1920s, but dropped to about 90/1000 by 1945 (Marchione 1977:71; Cumper 1983:1988-89). Life expectancy during this period improved from 37 to 53 years (Cumper 1983:1989). Between 1921 and 1948, the number of physicians working in the island increased from about 140 (57 in government service) to about 235 (130 in government service) which represents an increase from about 1 doctor per 6,129 people (.16 per 1,000) to about 1 per 5167 (.18 per thousand) (Cumper 1983: 1988-9; Marchione 1977:76; Eisner 1961:341).

While public health measures and improved treatment access were instrumental in improving health status, several other societal factors had a major influence as well. The poorer classes had made improvements in their standard of living due in part to the growth of the banana industry which was able to accommodate small farmers. Along with better clothing, nutrition, and transportation, improved levels of education fostered a greater public understanding of health issues and an increased utilization of biomedical resources (Cumper 1983:1989). Even the economic downturn and resultant labor unrest in the 1930s paradoxically improved health standards because it led to demands by

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workers for greater access to health care. The ticket system for indigent health care was expanded in 1933, and during the 1930s and 40s the number of dispensaries and other outpatient facilities more than doubled. Attendance at these clinics rose dramatically during the 1930s, especially in the rural areas where the number of out-patient visits rose seven-fold (Marchione 1977:77-8).

After 1945 measures of health status in Jamaica continued to improve. By 1970 the Infant Mortality Rate had dropped to 32 per 1000 and life expectancy had risen to 68 years. Government per capita expenditure on health rose four-fold in real terms between 1945 and 1970. Hospital capacity increased and the number of doctors in the island increased to 457 (307 in government service) or 1 per 4,090 (.24 per 1000) (Cumper 1983:1988-90). The effectiveness of Biomedicine as a whole, of course, improved dramatically during this period, due especially to the introduction of antibiotics. Public health measures also improved in their effectiveness with new vaccines, a better understanding of nutrition, improved water supplies and sanitation, and pesticides which enabled better mosquito control. Establishment of Maternal and Child Health (MCH) clinics at the health centers (85 by 1945) and the increased rate of hospital births reduced maternal and infant mortality significantly (Cumper 1983:1990-1).

By 1970 the epidemiological picture in Jamaica had altered dramatically. Malaria and hookworm had been virtually wiped out, and the other infectious diseases which had been leading killers were significantly reduced.

> No more than half of the eight most important causes of death in 1945 were in the top eight after 1960....The rising

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> relative importance of cancer, and cerebral vascular problems attested to the reduction of infectious diseases by the application of modern medicine and the rising standard of living -- especially of the upper classes. (Marchione 1977:81).

In 1948 a medical school and nursing school were opened at the new University College of the West Indies (later U.W.I.) in Kingston under the auspices of the University of London, as a regional effort to increase the number of health care workers in the island and in other British West Indian territories. A new hospital was also opened at the University to serve as a teaching, research and tertiary care center. The first graduates of the medical school entered the work force in the mid 1950s and the school has continued to graduate about 40 Jamaican doctors per year since the 1960s.[35] While this did improve manpower in the health services, an unfortunate result of the structure of the medical curriculum, which was based on the British model, was that a large proportion of the graduates went on to specialist training rather than going into general practice as had been expected, and many emigrated to higher paying opportunities in England and the USA (Ragbeer 1974:113-15). While changes made in the curriculum to incorporate more social and community medicine, preventive medicine, and public health have steered more graduates toward general practice in rural areas, the

[35]The University of the West Indies is a cooperative university of several Caribbean countries and a significant number of the medical graduates are from these other countries. For example in 1973-4 out of a total enrollment of 556 (including all five classes), 221 (39.7%) of the enrolled students were Jamaican, 168 (30.2%) were from Trinidad and Tobago, and the rest (167, 30%) were from other countries (Ragbeer 1974:122). Current admissions and enrollment are basically the same, as they are based on a quota system.

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profession continues to be specialty-oriented and high rates of emigration continue to be a serious problem (Marchione 1977:93).

During the 1970s the socialist government of Michael Manley placed a high priority on health care and other social services. Thus despite a collapsing economy, "Government expenditure on health services per capita in real terms... was at least 30% higher in 1980 than in 1970, and total real inputs may have almost doubled over the period." (Cumper 1983:1992). Most of the increases came in capital investment and increases in service by health centers and Casualty Departments (Emergency Rooms) (Cumper 1983:1992).

An important innovation of the Manley years was the initiation of the Community Health Aide program, based on the "barefoot doctor" model used in China, and other Primary Health Care programs. The CHA program trained 1200 local women in the provision of basic health care, and the dissemination of health and nutrition information. It focused on community based work and home visits for those unable to make it to health centers (van Schaik 1989:2; Dept. of Social and Preventive Medicine 1976; Ennever and Standard 1982). While the CHA program did provide valuable outreach services, its impact was hindered by organizational problems, political patronage and foreign influence[36] (Marchione 1977:366-8).

Nevertheless, despite decreased living standards, shortages of goods and the exodus of professionals in the 1970s, health status measurements continued to improve during the decade. The Infant

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[36]Implementation of the program was supervised by a U.S. medical school, medical students from the U.S. participated as part of their training, and CHAs were used for distribution of U.S. food surplus.

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Mortality Rate declined to about 26.5 per 1,000 by 1978 (McCaw 1985:8).[37] Mortality patterns continued to show a decline in the importance of infectious diseases, and a relative increase in mortality due to chronic and degenerative diseases such heart disease, cerebrovascular disease (strokes), hypertension, cancer and diabetes, a pattern typical of the more developed countries of the world. These five conditions were the leading killers by 1979. The only infectious diseases still in the top ten by that time were diarrheal disease and pneumonia, both of which had shown continual declines (McCaw 1985:6,80).

The system of government health services which emerged by 1980 had evolved through a process of accretion over the years. While it had responded to changing circumstances, it had maintained some built-in inefficiencies as well. Primary Health Care was by that time organized into a three level system incorporating about 370 health centers, which provided preventive (immunizations, ante- and post-natal care, maternal and child care, family planning, etc.), home visits and basic curative services. Public health services (e.g. sanitation, food inspection, etc.), as well as the health centers, in each parish fell under the auspices of the parish Medical Officer for Health, though lines of authority were complicated by the fact that some of the sanitation workers were employed by the local Parish Councils (parish governments).

Secondary and tertiary health services were provided by 29 public and 6 private hospitals distributed around the island, each parish having its own general hospital, with the rest concentrated in the

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[37]Statistics for later years show a further decline in the IMR to 9.6 by 1982, however data for years after 1978 are considered unreliable because of underreporting, and problems in data collection (McCaw 1985:8).

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Kingston/St. Andrew area. At the parish level these services were under the direction of the Senior Medical Officer, who ran the hospitals and supervised the work of District Medical Officers who worked at health centers and clinics. This separation of the "Health" and "Medical" sectors, and the complex chain of command in the Ministry of Health, not surprisingly created problems of coordination and inefficiency in the provision of services. In addition, the control of some of the personnel by the Parish Councils introduced the further complications of political maneuvering and problems of coordination (Marchione 1977:90-92).

When the conservative administration of Edward Seaga took power in 1980 it introduced a number of austerity measures aimed at getting the collapsing economy under control. The worldwide recession in the early 1980s further worsened matters, however, and it wasn't until the late 1980s that national economic conditions began to improve again. Expenditure on health was decreased according to the policy of reducing government's role in providing social services. Real per capita expenditure on health was cut nearly in half between 1980 (1980J$96.35) and 1985 (1980J$54) but began to climb again after this (Cumper 1983:1988; Planning Institute of Jamaica 1988:20.1).

During the early 1980s the level of services provided was cut back considerably, especially in the rural areas, and health facilities deteriorated. One casualty of this era was the Community Health Aide Program which in 1983 was reduced in number of personnel by one-half to two-thirds. The remaining CHAs were needed to help out in the clinics, which drastically reduced their ability to provide community based

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health services and home visits (van Schaik 1989:4). Through a process of "rationalization," services at many of the hospitals and health centers were cut or consolidated during the 1980s. The basic structure of the government health services continued as described above, although the removal of Parish Council involvement in health care[38] did simplify the bureaucratic organization somewhat.

With the economic improvements of the late 1980s, Seaga's government felt it could afford to invest more in health services and in September 1987 (in the face of an impending election campaign) announced plans to upgrade the Primary Health Care system with some outside assistance from USAID and the World Bank. There were also plans made to improve several hospitals, privatize hospital management, increase family planning services, and improve laboratory facilities (Daily Gleaner 9/23/87). However, a devastating hurricane in September of 1988 and the election defeat of the Seaga government by Manley's PNP in February 1989, left uncertain the sort of changes that will take place in the health care system over the next few years. Given Manley's ideological orientation there is likely to be a return to an emphasis on Primary Health Care and community based services, though economic conditions may continue to limit improvements.

One problem that is likely to continue to plague the health care system in Jamaica is that of maintaining adequate levels of manpower. Personnel shortages have forced cutbacks in service in many locales (Daily Gleaner 9/17/87, 8/28/88; Rawlins 1988). Emigration of health

[38]Seaga's government stripped the Parish Councils, many of which were controlled by the opposition political party, of much of their power.

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workers has long been a problem. Between 1962 and 1972, 2,900 nurses were lost to emigration, mostly to the USA (Marchione 1977:94). But the steady stream of doctors and nurses leaving the country during the 1960s and 70s has turned into a torrent in the 1980s and 90s.

Especially acute is the problem of continued nurse emigration. The reasons for this are mainly economic. Nurses in Jamaica are poorly paid in relation to other professionals. Unlike doctors, they are unable to supplement their incomes by "moonlighting" in the private sector. The starting salary for a nurse in government service in 1987-8 was under J$15,000 ($2727) per year. With the possibility of earning ten times that in the USA, and with American employment agencies actively recruiting nurses in Jamaica to replenish shortages in the USA, it is not hard to understand why they are leaving in droves. During four months in 1988, 250 nurses sought verification of their school transcripts as part of the emigration process (Rawlins 1988).

This creates a dilemma for Jamaica. By educating nurses at public expense who then emigrate, it is in essence subsidizing health care in the developed countries. To meet its own shortage it must educate more nurses, but these added expenses detract from its ability to pay nurses an adequate salary and improve working conditions, which might induce more to stay in the country. Clearly it is a losing battle, and there were some publicly vented suspicions that the government had resorted to collusion with the US government to restrict visas for nurses, though this was officially denied (Daily Gleaner 11/18/87, 7/19/88; Weekend Star 11/20/87).

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THE BIOMEDICAL SYSTEM IN ST. THOMAS

The biomedical services available in St. Thomas can be divided into two main categories: those provided by the government and those provide by private physicians. While these two parts of the system do cooperate to some extent, they function independently for the most part, and they will be described separately here. These options will be described from a patient's point rather than an administrator's, by concentrating on the services provided, the personnel involved, and the operation of the system on a day to day basis, rather than on their organization and bureaucracy.

Government Health Services

St. Thomas, like the rest of Jamaica is divided into health districts for the delivery of Primary Care services. There are four health districts in St. Thomas, two in the east and two in the west, each of which includes approximately 20,000 people (based on 1982 census figures). These in turn are each broken down into 4 to 7 smaller districts (18 total), each of which is served by a health center (Planning Institute of Jamaica 1988:20.5]). There are three types of health centers, and the three levels constitute a hierarchical referral system (at least in theory). In addition each of the centers serves as a primary care site for a separate catchment area.

Type 1 centers are the simplest, and offer preventive and screening services, and some simple treatment measures. They theoretically serve a population catchment area of about 2,000 people (average 2,149), though the actual population of these areas ranges from

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530 to 4,500 people. Staffing and scheduling at these centers varies somewhat depending on demand and available staff, but basically they are run by a single nurse-midwife with the assistance of a CHA or two. When necessary, referrals are made to a higher level center or to the hospital.

Albion's health center is a Type 1 center and serves as a good example of how these function. The catchment area for the Albion Health Center supposedly is the smallest in the parish at 530, however the actual population of the district, as we have seen, is about 848, 60% higher than the official figure.[39] The Albion Health Center is staffed by Nurse Comfort, a nurse-midwife, and Miss Morrison, a Community Health Aide. Nurse Comfort is in the clinic 4 days per week[40], and Miss Morrison helps out in the clinic except on the one day per week on which she does home visits. The clinic is open from about 9 or 10 in the morning till about 4 or 5 in the afternoon.[41] Services offered include

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[39]The population divisions used to create these health districts are based on census districts. Unfortunately, the census enumeration districts do not coincide very well with actual community boundaries, and this makes it difficult to use them to allocate services on a community basis. Workers in the health centers were generally aware of these discrepancies, through community surveys that were done during times of better staffing, and through the ongoing household visits of Public Health Inspectors.

[40]Later on during the research period services at the Albion Health Center were cut back because Nurse Comfort was needed 2 days per week at the Midway Health Center (a Type 2 Health Center) because of staffing shortages there. So the Albion Health Center was then open only 3 days per week.

[41]Nurse Comfort lives about 15 miles away and because of the poor public transportation in the area it takes her about an hour to travel each way to and from work. It was not unusual that problems in getting transport would force her to open at a later time. Towards the end of the research period Nurse Comfort moved closer to the district, but still had a difficult commute.

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a Prenatal Clinic (1/month), Family Planning Clinic (1/week), Child Welfare Clinic (2/month), Hypertension and Diabetes Screening (1/week), and Dressing Changes (4/wk). The special clinics take up about half the day and for the rest of the time Nurse Comfort and Miss Morrison are available on a less formal basis. Nurse Comfort went to England for midwifery training, and occasionally does home deliveries. But almost all deliveries are now done in the parish hospital and it had been some time since she has done one in the district. Since she lives an hour's commute away, and transportation does not run after 9:00PM, it would be difficult for her to be readily available for deliveries in the district.

Nurse Comfort is from another part of the parish, but has been working in the district for 6 years and is well liked in the community. She is a young (about 30), enthusiastic, jovial, and outgoing person and is known to everyone in the district. She has formed close friendships with a number of the young women in the area and participates in their home economics group as well as in other community activities. She loves working in the district because she finds the people so friendly and appreciative (despite Albion's reputation to outsiders as a superstitious and unfriendly district). She prefers it to working in the larger health centers where politics and personality clashes can get in the way. She does complain of the lack of support she gets from the government; materials, equipment, and medications are always in short supply. The most distressing part of the job for her, though, is her low salary. After taxes she takes home only J$992 ($180) per month, and with a daughter to support is barely able to make ends meet. Because of

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this she has plans to apply for a visa to emigrate to the USA, but has not gotten around to it yet. She did express some trepidation about the bureaucratic process she would have to go through to do this, and it seems this is the only thing holding her back.

Miss Morrison, the Community Health Aide, grew up in Albion and is well known in the community. She also is young and friendly, though somewhat less enthusiastic about her work. Dissatisfaction with her job comes especially from her low pay, about J$800 ($145) per month gross, but also results from her limited role in the clinic, lack of opportunities for advancement, and lack of concern by government administrators (cf. van Schaik 1989).

The AHC is located in two rooms rented by the government in the Baptist church. Facilities and equipment are minimal. There are a few tables and chairs, a filebox for records, cabinets for storing the few drugs they have on hand, and a scale for weighing babies. The clinic has no running water or electricity. Water must be fetched from a standpipe down the road. The only medications available in the health center are simple drugs (cough syrup, worm medicine, Panadol (Acetaminophen), antacid, etc.), and those needed for family planning (birth control pills, Depo-Provera for injection). Others have to be obtained from the higher level health center or hospital, though sometimes if Nurse Comfort knows that someone is coming up to the district (e.g. the Public Health Inspector) she will ask them to pick up a prescription for one of her patients.

Afternoons at the clinic are typically slow, with people occasionally coming in to be seen for a minor illness or to pick up some

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medicine. The Health Center actually has come to serve as a social center as well as clinic. The afternoons usually find Nurse Comfort and Miss Morrison on the veranda outside the clinic talking with their friends, and a few others who have come by for medical reasons. Sometimes young mothers will stay for a while after their visit to socialize, and others will come by just to chat. This gives the clinic an informal and friendly atmosphere, which seems to make people in the area more willing to use it for minor problems. Nurse Comfort is on good terms with Brother John (Bishop Smith), the preacher/healer at the Mt. Olive Galilee Revival church, and has attended a number of his healing services. This facilitates the process of referral for medical care when he has a patient he is unable to manage.

Most of Nurse Comfort's work is preventive, and during the various clinics, she puts a lot of effort into health education. For example, when a mother brings a baby in for a checkup, she will attend not only to the child's progress, but will talk with the mother about nutrition, care of the child, what to expect developmentally, and how to handle behavioral problems. While she can treat minor illnesses and injuries (e.g. a child's cold or minor cut), more serious cases must be referred to one of the other health centers or to King George Hospital in Morant Bay. Patients with more serious problems will generally be sent to a health center where a doctor is having a clinic that day, or if necessary, directly to the hospital.

The next higher level health center to which patients are sent is the Type 2 center at Midway. This center serves a catchment area of

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about 6,000 people,[42] which is adjacent to the Albion catchment area. It is located in a large cement and tile building which contains 2 consultation rooms, a large lobby/waiting area, an office for the head nurse, pharmacy and records areas, supply rooms, and a meeting room (which doubles as an office for the Public Health Inspector). Attached to the health center is a small house occupied by the Staff Nurse who is available for emergencies after hours. The staff at the Midway Health Center includes a Public Health Nurse (Mrs. Billings) who has midwifery and public health training and who runs the clinic, the Staff Nurse (Nurse King), a Public Health Inspector (Mr. Bentley), three Community Health Aides, and a few other support staff (porters and cleaners).

This health center provides the same basic preventive services as are available at Albion, with more frequent clinics, and a few extra services as well. In addition to the Family Planning Clinic (6/month), Child Health Clinic (6/month), and Prenatal Clinic (1/week), the doctor from the adjacent Health District of Gateland comes to do a Doctor's Clinic once per week (on Thursdays),[43] and the Nurse-Practitioner from Gateland does the same (Mondays). There is also a Hypertension/Diabetes

[42]The official figure, based on census data is 6,014, but a survey done by Community Health Aides in 1984 recorded a population of 5,489 being served.

[43]Due to staffing problems, the areas covered by government doctors (District Medical Officers) do not coincide exactly with the Health Districts. For example, Dr. Mung, the DMO based at the Hounslow Polyclinic (formerly Hounslow Hospital), which serves as the Type 3 Health Center in the Gateland Health District, conducts clinics there three times per week. In addition he does one clinic per week at the Type 2 Health Center in Benton (also in the Gateland Health District), and one clinic per week at Midway (Morant Bay Health District).

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clinic (1/week) run by Nurse King.[44] The clinics at Midway are of course attended by a larger number of people than those at Albion because of the greater population served. During a doctor's clinic 50-60 people might be seen in a morning.

The Hypertension/Diabetes clinics have been a very important addition to the services offered by the Primary Care system. These ailments and their complications and associated conditions (heart disease, strokes, etc.) are very prevalent in Jamaica and constitute 4 of the nations's top 5 killers (Planning Institute of Jamaica 1988:20.3). When a person is diagnosed with one of these problems they can, if they desire, be assigned to one of the clinics, depending on where space is available. For example, many people from Albion have been assigned to the clinic at Hounslow Polyclinic (in a different Health District) because there were no more slots open at Midway. (Fortunately it is about the same distance from Albion as Midway.) The patients are scheduled for visits once every 2 months, though they sometimes come in sooner if they are experiencing symptoms they associate with their condition (e.g. headaches, dizziness, faintness, weakness, vision problems, etc.). Usually they are seen by the staff nurse who will check their blood pressure and/or urine sugar, and renew

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[44]This clinic differs from the screening done at Albion in that the Midway Health Center usually has medications to give out for Hypertension and Diabetes, whereas these are not usually available at Albion. People in Albion who have a need for this type of care must travel to Midway or to Hounslow Polyclinic which has a similar clinic. At times, when the medications are in short supply at Midway, the patients may be sent to the parish hospital to pick them up (which costs them J$2 more for transportation and a J$5 fee for the medicine).

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their prescription. They will also be seen occasionally by the doctor, or sooner if a problem arises.

Child health and immunization programs have been very successful in reducing infant and childhood mortality nationally. Expectant mothers are now routinely recruited into the system during pregnancy (though sometimes too late for good prenatal care), and after the birth their participation is maintained through the Child Health clinics which monitor growth, nutrition, and immunization status of the child. Immunization programs have been successful enough to increase the rate of immunization (nationally in the target population) to higher than 80% for DTP, Polio and BCG (TB) by 1987, from around 50% in 1984. Measles vaccination in 1987 was still low at 44.5%, but had improved from 16% in 1984 (Planning Institute of Jamaica 1988:20.7). Immunization rates in St. Thomas were similar to national rates during this period (Health Information Unit, MOHEC 1988). It is not possible to compare Albion's rates with these because most of the mothers in Albion take their babies to the Midway Health Center for most of their immunizations, as Nurse Comfort is not equipped to do all of them.

Measures of children's nutritional status nationally were still not ideal in 1987 (77.1% Normal or above; 21% Gomez I; 3.3% Gomez II; .3% Gomez III) but had improved significantly since 1985 (60.5% Normal; 31.9% Gomez I; 6.6 Gomez II; 1% Gomez III) (Planning Institute of Jamaica 1988:20.9; McCaw 1985:62). Food stamps are given to pregnant women mothers of young children (J$20 per 2 months) which can be used for the purchase of corn meal and milk (though some shopkeepers will violate this restriction). Nurse Comfort at Albion uses the food stamps

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as a way to increase attendance at immunization clinics, by scheduling them for the same day as the food stamp distribution.

Mr. Bentley, the Public Health Inspector who oversees the eastern part of the Morant Bay Health District is based at the Midway Health Center. He is a Grade 1 PHI, but because of staff shortages must perform some of the duties of a Grade 2 Inspector.[45] His work entails periodic inspections of homes (about twice yearly) and shops, gathering of statistical data, health education talks, organizing groups for special purposes (e.g. waste disposal), restaurant inspections, inspection of animals before slaughter, and organizing educational workshops and the annual examination for food handlers.

He began working for the Parish Council about 5 years ago (when it was still involved in Public Health staffing) and received on-the-job training at that time. After working for about a year, he went the West Indian School of Public Health for two years of training. Since he had been working for the Parish Council, they continued to pay him his salary while he was in school. (Tuition is paid by the government.) Because of the assistance he received he was "bonded" to work for the

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[45]There are five levels of Public Health Inspector whose duties are fairly well defined, but in practice their actual activities may deviate somewhat from this. The PHIs are under the supervision of the parish Medical Officer for Health (MOH):

Grade 1: General inspections, inspections of homes, food establishments, and sanitation facilities. Keeps records of inspections.

Grade 2: Inspection of food places (restaurants, street vendors, marketplaces, dairies, food processing plants, etc.) including more detailed inspection of sanitation and food hygiene.

Grade 3: Supervises inspections for a Health District.

Grade 4: Supervises inspections for the parish, oversees the Grade 3s.

Grade 5: Chief Health Inspector for the parish. Does mainly administrative work.

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government for three years, and has one year remaining in his obligation.

Mr. Bentley is young (25), bright, and interested in his work, but has a number of complaints about his job, the main one being his low salary (J$800 [$145] per month gross; or J$575 [$105] after taxes). Because of the seniority system, advancement in the ranks is very slow. The Ministry provides no vehicle for him, and he is unable to afford one, so he must travel by taxi (for which he is reimbursed) or by bike, both of which are very slow. He has been discouraged by the lack of interest in health issues among the local people. An effort to organize a community health committee in Midway had recently fallen through due to lack of interest. He also complained of government funding cutbacks which have created staffing problems and forced the curtailment of some important projects such as mosquito control.[46] He would like to leave his job when his commitment is up, but he doesn't know what he'll do after that.

Although funding shortages prevent the Ministry of Health from paying health workers better, one way they compensate for this to some extent is by granting generous leave time. Mr. Bentley, for example, each year gets 35 days of vacation leave, 14 days sick leave, and 14 days "departmental leave." He had accumulated enough time so that he was recently able to take four months off. This is not uncommon, as a

[46]There used to be a special team in the parish for this. Mosquito control efforts in Jamaica are now mostly centered on surveillance and spraying at the two international airports to curb the introduction of harmful species from abroad (Planning Institute of Jamaica 1988:20.10-11). There are, however, species present in the island which are capable of carrying malaria and yellow fever, and there are occasional outbreaks of dengue fever.

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number of the nursing staff at the various health centers also took long leave periods during the research period. This, of course creates further staffing problems, as the duties of absent staff must be taken over by someone else, and personnel sometimes must be shifted from one health center to another to compensate, which creates discontinuity and organizational confusion.

When a patient must be referred from the Midway Health Center for more intensive treatment, e.g. if a doctor is not available on that day or if they require hospitalization, they generally are sent to King George Hospital, the parish hospital in Morant Bay. Theoretically they might be sent to the next higher level health center, the Type 3 Morant Bay Health Center, located next to the hospital. Type 3 Health Centers are supposed to have a doctor available at all times, but this may be accomplished by locating them next to a hospital. In Morant Bay the doctor does not do any clinics at the health center itself, but rather the hospital has a regular walk-in Outpatient/Casualty clinic. So patients in need of further attention will be sent to the Casualty department from any of the health centers.

Otherwise the Type 3 Morant Bay Health Center is similar in staffing and services to the Type 2 Center at Midway. However, because it serves a larger catchment population (12,749), and provides part-time staff for some of the smaller Type I centers, it has a somewhat larger team. It provides Child Health Clinics (1/wk.), Prenatal Clinics (1/wk.), Post-natal Clinics (2/mo.), and Family Planning Clinics (1 or more/wk.). The schedule differs in that there are no Hypertension/Diabetes, Doctor's, or Nurse-Practitioner's Clinics.

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Instead these take place at the nearby hospital, which leaves more time for scheduling preventive clinics. As in the other Health Centers I visited, most of the activity takes place in the mornings, and by the afternoon things can be quite slow. (The official hours are 8:00AM to 4:00PM.) People in need of curative attention go to the hospital Casualty Department rather than to the health center.

Thus the hospital provides a substantial proportion of the outpatient curative service which is an important aspect of primary care. In fact, in 1987 the number of curative outpatient visits to King George's Hospital (25,168 Casualty + 5,734 Outpatient = 30,902 Total) was very large in comparison to the number of visits to all the health centers in the parish combined (57,248) (Health Information Unit, MOHEC 1988). When one considers that the latter number includes 14,795 routine visits to health centers for Hypertension/Diabetes clinics (which are handled by nurses) as well as visits for dressing changes and minor problems, it is apparent that the hospital provides a very large proportion of the curative primary care in the parish, and manages most of the difficult and serious cases. Yet, ironically, King George's Hospital is not considered by the government to be part of the Primary Health Care System of St. Thomas, and in fact is run through a totally separate chain of command and channel for funding. This, as one might expect introduces a maldistribution of resources and a number of inefficiencies into the system.

The King George Hospital was built in 1954 with assistance from the British Colonial Development and Welfare Office to replace the overcrowded old hospital which was damaged in the 1951 hurricane. It is

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designated a Type C Hospital and has 164 beds (58 General Medicine, 58 General Surgery, 30 Pediatrics, and 18 Obstetrics). The average occupancy rate in 1987 was 72.7%, though this was higher for some services (e.g. Pediatrics 156%) than for others (e.g. Surgery 49%) (Health Information Unit, MOHEC 1988). The hospital is run by three doctors, two of whom are a husband-wife UN Volunteer team from Burma. Other personnel at the hospital include 43 Registered Nurses, 32 Assistant Nurses, 1 Pharmacist, 1 Pharmacist Technician, 2 Clerks, and a number of Porters and maintenance personnel.

The head of the hospital is Dr. Panjit, the Senior Medical Officer (SMO) for St. Thomas, who trained as a surgeon in India and who has been working in Jamaica since 1981. When he first came to Jamaica, Dr. Panjit worked at the UWI hospital for two years before joining the government service. He ran the Hounslow Hospital for about a year, at which point it was "rationalized" (i.e. downgraded) to a "polyclinic" with no surgical service. He then began working at King George Hospital, but continued to hold clinics at Hounslow Hospital 2 days per week. In 1986 he took over the SMO position from Dr. Lewis who resigned after many years as SMO. In addition to running the hospital, Dr. Panjit has a private practice that he conducts 3 afternoons per week, plus Saturday mornings. He spends much of the rest of his time in the Operating Theatre, doing Ward Rounds, and when he has time, helping out in the Outpatient/Casualty Clinic.

Dr. Khuen is a UN Volunteer from Burma who works in the hospital with Dr. Panjit as Assistant Medical Officer. He has been working at the hospital for just over two years, having extended his original two-

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year term to four. At the hospital he takes care of most of the inpatient ward work and does surgery with Dr. Panjit. One of his reasons for coming to Jamaica was to have the opportunity to get some specialist training experience, which is difficult to get in his own country. While in Jamaica he can pursue a certification in Surgery through the British examination system. Dr. Khuen's wife, Dr. Tingsa, works part-time at the hospital, primarily running the Outpatient/Casualty clinics. She also spends a good portion of her time taking care of the household and the couple's six year old son.

Regular Outpatient clinics are held three days per week (Monday, Wednesday, Friday), but on other days the doctors will see emergency cases in the Casualty department. There are also regular clinics for pre- and post- surgical evaluations, and medical followups. The hospital also provides some more specialized clinics (Sexually Transmitted Diseases Clinic, Mental Health Clinic, Hypertension/Diabetes Clinic, Dental Clinic), which are run by outside staff, on a less frequent basis (usually once per week). Facilities at the hospital are simple, and the doctors complain of a chronic shortage of materials and poor equipment. For example, the ECG machine broke eight years ago and was never repaired, so patients must be sent elsewhere to get ECGs done.

Although the hospital provides care for all types of patients, it has a surgical orientation because of the training and interests of the doctors that run it. Because of its limited facilities and staff, the hospital is unable to provide the specialized care that some patients need. Patients who need more intensive or specialized treatment than can be provided by the hospital may be sent to one of the larger and

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better equipped hospitals in Kingston. The hospital has two recently acquired ambulances for transporting patients (Daily Gleaner 2/19/88). In addition to being used for patient transfers, the ambulances are available for transporting patients to the hospital in emergencies, but the lack of telephones in many areas puts this service out of the reach of most.

The curative outpatient service that the hospital provides is one of its most important functions, and is the service that is most frequently used by people in the area. On clinic days, people begin to arrive at the hospital several hours before the clinic is scheduled to begin (e.g. 4 or 5 AM) so they can be seen as quickly as possible once the doctor arrives. Clinics start usually at about 9 or 10 AM, depending on when Dr. Tingsa arrives. On an average day, 150 or more patients might be seen, and Dr. Khuen or Dr. Panjit help out Dr. Tingsa in the afternoons if they have time. Because the demands on the doctors are not always predictable there are frequent alterations in the clinic schedule, and sometimes patients don't find out until after they arrive whether a clinic will be held and what time it will start. Understandably the patients get upset at this, but there is nothing they can do about it.

With so many patients to be seen, the doctors must practice a sort of "assembly line medicine." The time that each patient spends with the doctor is quite short (2-3 minutes on average). With little time for extensive questioning or examination, treatment is usually empirical. The doctor prescribes a medication for what she feels is the most likely

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cause of the problem, and if the patient is not helped they hopefully will return, or perhaps go to a private doctor.

Treatment in this clinic is not free. Patients (except those brought in by the Police) are charged from J$10 - J$20 ($1.80 - $3.60), depending on the tests and medications that are ordered.[47] While the fees and the short time spent with the doctor deter some people, most see some advantages in coming to the hospital clinic. The hospital has laboratory and other services (e.g. X-Rays) that are not available at the health centers, and that would otherwise require an expensive visit to a private doctor, and perhaps even a trip to Kingston. Also, the amount one must pay for medications is much less than they would cost at a private pharmacy. If a patient is sick enough for hospitalization they must be seen by one of the hospital doctors anyway, since private doctors can not admit patients directly to the hospital. And the availability of surgeons and operating facilities make it the most logical place to go if one has a traumatic injury. If specialist care is to be obtained at one of the public hospitals in Kingston, the patient must be referred there by the hospital doctor. So the people who attend the clinic are those who live nearby and use it as their primary curative clinic, and those with serious problems who come by referral from a health center or, more frequently, by "self-referral."

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[47]Since 1985 the Ministry of Health has been charging fees at hospitals to help cover part of the costs of care. Patients unable to pay can theoretically have the fees waived, however in practice these charges do deter some people from seeking treatment. About half the fees are returned by the Ministry to the hospitals to help pay for maintenance, expenses and improvements (Daily Gleaner 6/10/88).

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Up until 1984 when it was "rationalized" to a Polyclinic, the Hounslow Hospital, which is 12 miles away at the eastern end of the parish, also provided inpatient care for a smaller number of patients (35 beds) and surgical services. It serves primarily the people of the districts bordering the large sugar, banana, and coconut estates in the east, but patients come from some more distant districts as well (e.g. Albion). As a Polyclinic, the facility is supposed to provide 24-hour coverage by the nursing staff and doctor for whatever emergency cases might be brought in.[48] In addition there is a small maternity service which is used primarily for "observation," and some uncomplicated deliveries. Most of the former hospital space, including two medical wings and the operating theatre, are not being used.

The Polyclinic also serves as a Type 3 Health Center which provides preventive services similar to those at the Morant Bay Health Center and the Midway Health Center. There are also staff nurses available 24 hours per day to provide emergency care if needed. Dr. Mung and some of the nurses live on the compound so they are available if necessary. Outpatient curative clinics are held five days per week. Dr. Mung has clinics on Monday, Tuesday and Wednesday, and there is also a Nurse-Practitioner (Miss Jones) at the Polyclinic who has clinics on Wednesday, Thursday, and Friday. On the days when they don't have clinics at Hounslow, Dr. Mung and Miss Jones conduct weekly clinics at two Type 2 health centers (Midway and Benton).

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[48]After leaving Jamaica I learned that in February 1989 the hours of operation were cut back to 8:00AM to 4:00PM due to a shortage of nursing staff.

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Dr. Mung, the District Medical Officer who runs the Hounslow Polyclinic, is another UN Volunteer from Burma who arrived in Jamaica recently. In Burma he ran a community hospital but has had some experience in surgery, and as a TB control team leader as well. Like his friends Drs. Khuen and Tingsa, whom he knew in Burma, he came to Jamaica to work as a volunteer to help people in need, but also for the experience of living in another country and to have the opportunity to do some specialty training. His wife, who is also a doctor in Burma, was not allowed by the government to leave, so he is in Jamaica without his wife and family.[49]

Dr. Mung's duties at the polyclinic entail mostly outpatient work. Because they are not set up for inpatient treatment, they are not supposed to keep a patient for observation for more than 24 hours. Serious cases will be sent to King George's Hospital in the polyclinic's ambulance.

Outpatient clinics at the Hounslow Polyclinic are quite busy, but the doctor and nurse-practitioner do not have to see as many patients each day as do the doctors at King George Hospital. They see about 50 or 60 patients in a day, so on average they are able to spend about 6 or 7 minutes with each patient, including transition time. However this still does not leave much time for talking with or examining the patient. And usually there are distractions, such as emergency cases

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[49]The unpopular totalitarian military government in Burma controls government doctors closely and it is difficult to leave the public service. Drs. Khuen and Tingsa were not employed by the Burmese government so they had an easier time getting out of the country together. Dr. Mung's wife and family were eventually able to join him about a year later.

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that come in, which detract from the time they can spend with clinic patients. On days when both Dr. Mung and Miss Jones are working, patients will be divided up between them, with the more serious cases being seen by Dr. Mung. (Patients are screened by a nurse before seeing the doctor or nurse-practitioner.) In theory, the Nurse-Practitioner should be consulting with the doctor about her cases, especially the difficult ones, but this does not happen much in practice, especially because the two are working in the same clinic only on Wednesdays. In addition to her general clinics, Miss Jones, the Nurse-Practitioner, also runs the weekly STD clinic at King George's Hospital.

Private Doctors

In addition to the four government doctors (2 full-time, 2 part-time) in eastern St. Thomas, there are seven private doctors in this part of the parish, not including Dr. Panjit who has a part-time private practice in addition to being Senior Medical Officer at the hospital.[50] All of these doctors have their practices based in Morant Bay, the capital and market center of eastern St. Thomas. Three of the private doctors spend only part of their time in Morant Bay. One (Dr. Stewart) has a practice two days per week at Bog River in Portland, and two of the others (Dr. Adams and Dr. Webster) share two practices, one in St. Thomas and one in Kingston, and divide their time between each. In addition to his practice in Morant Bay, Dr. Panjit also has a clinic on Saturday mornings in Ipswich, near Hounslow. For the most part, though,

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[50]There is an additional doctor in the western part of the parish who works part-time in government health centers and part-time in private practice.

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if one wants to see a doctor in eastern St. Thomas, it is necessary to go to Morant Bay.[51]

Most of the doctors are relatively young, in their 30s and 40s, but a couple are older. Dr. Lewis, for example, is in his sixties and is planning to retire soon. He was Senior Medical Officer at the hospital for many years, having resigned from that position two years ago, but maintained a private practice as well during that time. Though a surgeon by training, he also has an MPH, and has worked in public health programs as well as in medical practice. His private practice, like the rest, is a general practice, though people with surgical problems will go to him preferentially. Because of his strong personality and many years of work in the area, Dr. Lewis is probably the best known and most highly respected of all the local doctors.

Contrary to what others have written about doctors in Jamaica (e.g. Mitchell 1980), and what many assume, the doctors in St. Thomas do not come from "upper class" backgrounds.[52] Most come from middle class families (Level IIa or IIb in our classification scheme), with parents who were teachers, civil servants, small businessmen, etc. What their families did share was an ambitious attitude and a high value on

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[51]Rather than travel to Morant Bay, many patients in the western part of the parish who want to see a private doctor will go to Kingston, which is within easy travel distance, and where there are a large number of private doctors, as well as the large and specialized public hospitals.

[52]This may have been more true in the past when medical school had to paid for by the student's family or by a scholarship to a school abroad. During the Manley administration medical school tuition was paid for by the government, which opened up the profession to many who would have not been able to afford it otherwise. The Seaga administration, however, reintroduced a fee for medical students in the form of a "cess" of about J$6,000 ($1,091) per year. This may have the effect of restricting medical education to students from more wealthy families.

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education. Many of the doctors have siblings who also have assumed high status, respected positions in society. Although by the nature of their current positions they could be considered as upper or upper middle class, there is not as much social distance between them and their patients as one might assume (cf. Mitchell 1980). However, their origins outside the parish, their experience abroad, their advanced education, and their connections to the urban center, do distance them socially from their patients and sometimes this can introduce problems in communication and understanding.

Unlike the government doctors, all of the private Morant Bay doctors (except of course Dr. Panjit, the SMO) are Jamaicans. None is originally from St. Thomas, though two, Dr. Stewart and Dr. Young, grew up in nearby Portland. All but Dr. Stewart, who went to high school in Portland, were able to attend one of the better high schools in Kingston because they had performed well in primary school. While a couple started medical school right after high school,[53] some worked at other jobs for a while before starting. And some started in the Natural Sciences program at UWI before beginning their medical education.

Dr. Lewis is the only one of the doctors in the parish who trained abroad in England. The rest graduated from the Medical School at the University of the West Indies in Kingston. Most, after graduating from medical school, did an internship at one or more of the large public hospitals in Kingston. Medical training at UWI, since its break from the University of London, has been more oriented towards the training of

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[53]Medical education in Jamaica is based on the British model in which pre-medical and medical training take place in a single five-year program. A Bachelor's degree is not required for admission.

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general practitioners, and gives the students good experience in several fields. Internship training usually involves experience in a variety of specialties: Internal Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, etc. Most of the Morant Bay doctors did a year of internship with experience in several fields before starting practice.

Although all of the doctors have general practices, some have a particular interest in one area. For example, Dr. Bradley is especially interested in Obstetrics and Gynecology and his practice is weighted somewhat towards this.[54] Dr. Panjit and Dr. Lewis, the two surgeons, see many surgical patients, but have general practices with a variety of other types of cases as well.

Although their primary training has been in Jamaica, a few of the doctors have had some education abroad. Dr. Young spent three years training in General Practice in England. Dr. Webster took time off during medical school to obtain an MSc in Physiology at a US school (on scholarship), and after finishing his training, and practicing for a couple of years in Morant Bay, went to New York for a one-year fellowship in Human Sexuality. On Saturdays he practices Sex Therapy at one of the larger private medical groups in Kingston. Dr. Stewart obtained his BA at a New York university before starting medical school. And Dr. Lewis attended medical school in England (on a scholarship), and did some of his surgical training there, in addition to obtaining an MPH in the USA later on.

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[54]Dr. Bradley was planning to go to the US for residency training in this field and finally was accepted into a U.S. Obstetrics/Gynecology program. Toward the end of the research period he left Jamaica to start this, and his practice was taken over by a doctor from Kingston.

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There are two pathways by which the doctors came to practice in St. Thomas. A couple, Dr. Bradley and Dr. Webster, took over already established practices in Morant Bay when their predecessor retired or emigrated. Most, however, began working in the parish as government doctors, either as Assistant Medical Officer at King George Hospital or as District Medical Officer in one of the outlying Medical Districts. The most important constraint in starting off in practice is of course financial. Most new graduates do not have the resources to buy a private practice or start their own. The government health service, in which one is allowed to practice privately part-time, enables one to get some experience, while establishing a base of patients. Thus it is common for young doctors to spend a couple of years working for the government before going into private practice. Some, like Dr. Young, incur an obligation to work in the government service to pay off their student loans. Dr. Young spent a year as AMO at the hospital, then two years as DMO for western St. Thomas before going completely into private practice. Like several of the others, he started his private practice while a government doctor which gave him an established base of patients when he moved into full-time private practice.

While government service can be an attractive option for new doctors, the financial aspects of it and the poor working conditions make it difficult for the government to keep them in the service. Junior doctors make about J$15,000 ($2,727) per year, and much of this goes to taxes. While private practice on the side increases one's earnings, it is not difficult to see why few opt to stay on for more than a few years. In addition to the poor pay, working conditions are

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frustrating, with chronic shortages of support staff, drugs and equipment.

Starting up a practice from scratch is a difficult proposition in Jamaica, though more so in Kingston than in the rural areas. Although he had worked as a DMO and MOH in Portland, and had a small practice in Portland already, Dr. Stewart decided to shift to Morant Bay to open an additional private practice. Things were slow at first but gradually picked up, especially after he moved his office to a central location in town where he now shares office space with Dr. Panjit. (They have alternating schedules, so only one is in the office at time.) Dr. Young, on the other hand, after returning from his three years in England, attempted to start up a practice in Kingston, where the number of doctors competing for patients is much greater. After a frustratingly slow six months he returned to Morant Bay to practice.

None of the doctors lives in Morant Bay, though several of them did when they first began their practices. All but Dr. Lewis, who lives in a rural district 15 miles away, live in Kingston and commute an hour or more to Morant Bay to work. Most prefer to live in Kingston primarily because their children can attend better schools there and it is a more culturally active area. Dr. Carter, for example, lived in Morant Bay for more than ten years before moving to Kingston when his children were old enough for school. Before going into private practice he worked full-time as AMO at the hospital for a couple of years, then for two more years part-time while he established his private practice. Since moving to Kingston he has started another smaller practice there, and plans to eventually shift all of his work there.

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Practice in a rural area comes with a number of advantages and disadvantages. Fees tend to be lower than in Kingston, because the area is generally poorer and patients can't afford to pay as much. On the other hand it is easier to start a practice in such an area, the patient demand being greater in relation to the number of doctors. One problem that the doctors complain of is the difficulty they have in referring patients for specialty care. There are no specialists in the area, so patients must be sent to Kingston for this, which is a difficult and expensive trip for most people. It is also difficult to get special lab tests or diagnostic procedures done, although there are now three private labs in Morant Bay (actually collection centers for labs based in Kingston) which can do most basic tests. Before this, patients were sent to the hospital for lab tests, but the hospital lab will no longer do tests for private patients. Patients are still sent to the hospital to have X-Rays done, since there are no private facilities available in the area.

Some of the doctors also complain about the management of the hospital because they feel that the SMO sometimes is a bit authoritarian in his control of it. They can send a patient to the hospital for admission, but it is up to the doctors there to decide whether the patient will be admitted or sent home with medications. Private doctors do not admit patients directly and once the patient is in the hospital, their care is taken over by the hospital doctors. Occasionally conflicts arise because of disagreements between the private doctor and the hospital doctor over who needs to be admitted.

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Another problem is the lack of communication among the different doctors. Patients in St. Thomas, as we will see in the Chapter 8, often "doctor shop," moving among several different doctors. This may be a matter of convenience, depending on who has office hours that day, or who has the shortest waiting line. Or it may be due to a desire to get another opinion on a problem if one doctor did not treat it successfully the first time. In any case this makes it very difficult to provide continuity of care since the doctors each keep separate records and only rarely discuss individual patients with one another.

But despite these problems, and the inconvenience of the commute, the doctors find it pleasant to work in St. Thomas. The atmosphere is more relaxed and personal, as compared to the businesslike attitude and skeptical patients one finds in Kingston. Rural people tend to be trusting and somewhat more reliable than those in the city. Though fees are lower, people are more conscientious about paying them. If they can't pay all at once they will return to pay the rest when they are able. While patients tend to be less well educated and more "superstitious", they are more respectful and trusting of the doctor, and often will bring the doctor gifts of fruit or other produce.

All of the private practices in Morant Bay are organized in the same basic way. Patients are seen on a first-come first-served basis. Those who don't want to spend a long time waiting will try to get there early. Patients are given a number by a secretary or assistant, and are seen by the doctor in that order, though sometimes exceptions are made if a person has to catch a bus, or if there is an emergency. This system often makes a trip to the doctor a day-long affair, especially if

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one must travel from a distant point in the parish. It is not hard to understand why some will go to the doctor with the shortest lines. The doctors apparently feel that the patients would not be reliable enough to come at a scheduled appointment time, and this system makes it a bit easier to see a doctor at the time that one becomes sick, which is when most people will consult them. However, it does detract from the continuity of care. The doctor may tell a patient to return on a specific day for a test result or followup visit, but they are not given an appointment and must wait with everyone else.

The doctors' offices generally have a waiting area, a clerical area for records, and one or two consultation rooms. Some of the doctors also dispense drugs to their patients, and a few have pharmacy rooms with windows for this purpose. There are few distractions to occupy the patients while they are waiting. Some will chat with friends that have accompanied them, or with others in the room, and there are sometimes lively conversations about medical topics or local gossip. There is some health related information exchanged here, but the most frequent sounds are the sighs of those frustrated by the long wait. One doctor, Dr. Bradley, has installed a TV and VCR in his waiting room which provides a welcome distraction, and fills the window with errant schoolchildren who must be shooed away by the staff.

Because their patient load is smaller, the private doctors are able to spend more time with each patient than the clinic doctors (around 10-15 minutes on average), and it is this extra and more careful attention that induces most patients to seek out a private doctor, despite their higher fees. Many patients will use the health centers

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for routine services, but if they have a serious problem will go to a private doctor. Some of the private patients have health insurance, which pays all or most of the fee. Usually this is obtained through work at one of the larger businesses, or for the government (e.g. teachers, civil servants). But the poor and unemployed generally must pay cash, and thus a visit to a private doctor is not taken lightly.

A few of the doctors have special arrangements with local businesses to see their workers. Dr. Bradley, for example, spends Friday afternoons seeing workers at the local Goodyear plant (the largest factory in the area). Dr. Stewart sees patients from the Consolidated Banana Estate, the large plantation in the eastern end of the parish. Most businesses, however, provide health benefits to their workers in the form of insurance plans.

The cost of going to a private doctor in Morant Bay varies somewhat. The Medical Association of Jamaica (the national organization of doctors) recommends a fee of J$50 ($9.10),[55] though in St. Thomas, as in other rural areas, the fees charged are usually J$10 -15 less than this. Most will charge J$30 ($5.45) or J$35 ($6.36) for a visit, but will vary this somewhat according to the patient's ability to pay. Children are generally charged less (e.g. J$20 ($3.64)). The cost of drugs can add considerably to the cost of the visit, but if the doctor sells the medications himself it may be a bit cheaper. Some will charge a single fee which includes the drugs. There are two pharmacies in town at which prescriptions can be filled, but the doctors know that many patients will neglect to fill them completely because of the high cost.

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[55]This was increased from J$40 ($7.27) during the research period.

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So one reason for charging a single fee, or dispensing the drugs in the office, is to insure that the patient gets the medications they need. If the patient needs a test done they will be sent to one of the private labs, and this will add to the cost of the visit. The charge for this, of course, varies considerably according to the type of test done.

Dr. Lewis is the most expensive doctor to visit. He charges J$60 ($10.90) for a visit, or J$80 ($15.54) including drugs. His almost legendary reputation in the area, however, keeps his waiting room full. Dr. Young, on the other hand, tries to charge as little as possible, and thus is even busier than Dr. Lewis. A dedicated and very religious person, he feels an obligation to provide service at an affordable price, and he includes the cost of drugs in his average J$40 ($7.27) fee. He realizes that he is unable to spend as much time with each patient, but he prefers this to making it more expensive for them. And the patients seem to agree. He has a very good reputation in the area and is one of the most popular doctors among people in Albion.

All of the doctors will adjust or waive their fees for someone who is unable to pay, but since almost everyone can plead poverty, the threshold for this is fairly high. Some of the doctors also spend time doing charity work. Dr. Young, for example, spends one day per week working in ghetto areas in Kingston and also spends an afternoon each week seeing patients at the St. Thomas Infirmary (the "poor house").[56] Dr. Stewart helps out at the hospital clinic once a week. And Dr. Lewis

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[56]Normally this should be the responsibility of the AMO, but since no one had been going there, Dr. Young took it upon himself to do so.

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will not infrequently perform surgery at no charge for those unable to pay.[57] He never charges for emergency surgery.

While private doctors are able to spend more time with their patients than the clinic doctors, they still feel severe time constraints on what they are able to do. This is especially true of Dr. Young who tries to see as many patients as possible, and spends less time with each (around 10 minutes), in order to keep the cost per patient down. Their interviews and examinations are very problem-directed, and some patients will not be examined if the doctor feels it isn't necessary. However, a patient who is not examined is usually a disgruntled one because they feel the doctor has not paid sufficient attention to them, and they may make another visit to a different doctor. This is also true of prescriptions. Most patients expect to come away with something when they leave the doctor and may feel cheated if they are not given a prescription. Sometimes the doctors will do a quick exam and prescribe something just to allay the patient's concerns.

Most of the doctors feel that a significant number of patients (30-50%) come to them for problems that are primarily psychosocial rather than physical, and that they need reassurance and counseling more than medications. However, as Dr. Lewis explained, "Never tell a patient that nothing's wrong with them." To do so is to insult them. They go to the doctor because they feel they are sick and expect a careful evaluation and some treatment. And because it is less time consuming and complicated than trying to provide psychological

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[57]One time when I went to see him at the hospital he had just removed a 15 lb. ovarian cyst from a woman whose illness was obvious when he saw her on the street. He performed this surgery at no charge.

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counseling, the doctors generally concentrate on the physical side of their patient's problems while perhaps adding some reassurance. This of course goes along with their training and the orientation of Biomedicine. Only one of the doctors, Dr. Webster, has had formal training in counseling techniques. Even he feels it is too time consuming to make much use of in his general practice, though he does do some counseling in his Saturday Sex Therapy work in Kingston.

Other Biomedical Options

Some of the larger businesses in the area have health care facilities for their workers and their families. For the most part these are small clinics staffed by nurses who deal with minor problems. Patients with more serious problems will be referred to a private doctor with whom the company has an established relationship, or to the hospital if it is likely that they will need hospitalization. Some of the clinics will have a doctor come in one afternoon per week, as Dr. Bradley does at the Goodyear plant. Nowadays, however, it is more common for the company to arrange for coverage of its workers with an insurance plan. The employees are then are able to visit a doctor at their own discretion, though there is usually some co-payment required (e.g. J$10 [$1.82] per visit), and there may be a limit on the benefits they can receive in a certain time period.

I have not mentioned dental care, as it was not an issue that was specifically focused on in the study. However I will say a few words about it here. Dental health in Jamaica is, to put it mildly, horrendous. There is basically no preventive care, and with a high

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sugar/starch diet, children develop caries and periodontal disease quite early. For example a study in 1984 showed that by the age of 15 the average Jamaican had 10 "decayed, missing or filled permanent teeth" (McCaw 1985:65). One can practically omit "filled" from this definition, because the great majority are unable to afford such care. Poor people in Albion rely to a great extent of self-treatment or no treatment at all.[58] Most professional dental care performed is in the form of extractions and denture making.

Dental health does not seem to be a very high priority for the people or the Ministry of Health. Prevention is minimal. There is a dental clinic once per week at the hospital, and as might be expected, their main work is extractions. There is one private dentist in Morant Bay, but because of the cost it would be rare for the average person to go to him, except when there is an acute problem such as an abscess that can't be handled by self treatment. There are also a couple of private "dental hygienists" in Morant Bay, but I did not investigate their practices, and they seem to be peripheral to the overall system.

SUMMARY AND COMMENTS

The professional sector of the health care system of eastern St. Thomas is for all intents and purposes synonymous with Biomedicine. Nevertheless, within this sector there are several different alternatives to which Albionites can turn for "specialist" care. Each of these entails a different cost -- economically and psychologically --

[58]For example, one informant described to me how he cured a toothache by heating a small file until it was red hot and touching it to the tooth, which killed the nerve. (See Chapter 4, p.125)

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and each offers a different set of benefits. An appreciation of the historical development of Biomedicine in the Jamaican context is essential for an understanding of the current structure and operation of the professional sector.

The history of Biomedicine in Jamaica is as old as the European settlement of the island. The earliest doctors, in addition to their role in caring for the elite, were employed to oversee the treatment of slaves when they fell sick. By all indications, they were not very successful at either of these tasks. They were, however, paid well for their efforts and the planters at least seemed convinced that their services were beneficial. Just as he depended on the planter's profits, in his medical treatment of the slaves the doctor shared the planter's motivations. With a high mortality rate, especially among new arrivals, the slaves were in essence "perishable goods," subject to rapid depreciation. In order to obtain the maximal return for his capital investment, the planter had to get as much work as possible out of the slave during his productive life span. The estate owner also had an obligation to maintain the slave if he lived beyond the point where he was fit to work. Thus the planter had an incentive to favor short term over long term interests when it came to the health of the slaves. The doctor's main task was to keep the slaves working, and to please the planter he would do what was necessary to achieve this.

When slavery ended in 1838 so did the planter's incentive to provide medical care for his workers. When a laborer fell ill he could be replaced by another. The hardships of the masses forced them to continue laboring on the estates. They did what they could to avoid

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plantation labor, but sometimes they had no choice if they wanted to survive. But the gains to be had in providing medical care for the Jamaican masses had dried up, and the doctors left the island in droves, a pattern which continues today. Biomedicine did not begin to contribute significantly to the improvement of health standards of the masses until the twentieth century, and then it was mainly through public health efforts.

One of the most important endeavors in this regard was the work of the Rockefeller Foundation during the 1920s and 30s in bringing hookworm, malaria, tuberculosis and yaws under control. While the importance of this contribution must not be understated, it should be kept in mind that the interests of the foundation were not purely humanitarian. One of the primary motivations behind their medical efforts in tropical areas around the world was to enhance the exploitability of these areas for plantation agriculture by improving the quality of their labor force. As Morgan (1990) explains in discussing similar work by the Rockefeller Foundation and the United Fruit Company in Costa Rica:

> Both organizations saw disease control as the key to improved economic opportunity. Their reports are filled with images of 'conquering the tropics' and making the jungles fit for economic exploitation. Improved health was seen as a means to this end rather than as an end in itself. ...Medical service was considered a sound business investment instead of a humanitarian charity.... (Morgan 1990:213)

Public health campaigns by the Rockefeller Foundation and the British colonial government in the early twentieth century not only began to improve health standards among the Jamaican populace, but they also laid the organizational foundation which continues to shape the

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government health services up to the present day. While effective for its original purposes, this structural framework has been less conducive to more recent strategic orientations. The earlier public health campaigns were based on a top-down, almost military, approach (cf. Morgan:1990). Their organizational legacy has made it more difficult to fulfill some important objectives of the current Primary Health Care strategy, such as increased community participation in health care planning, and integration of community-based indigenous health care resources into the Primary Health Care system (cf. Morgan 1990; World Health Organization 1978). Another impediment to effective health care development which has been perpetuated by the current bureaucratic structure is its inheritance of the separation between "health" (public health/preventive) services and "medical" (curative/treatment) services in terms of administration and funding. This outdated and counterproductive segmentation maintains inefficiencies in the coordination of these types of services in the Primary Care system, and visibly affects public perceptions about the role of the government in providing global health care.

What is the proper role for the government in the provision of health care in a developing country such as Jamaica? And what is the best means for organizing, implementing and allocating such services? Such questions are obviously as much political as they are medical. And the answers to them are tempered as much by considerations of economy, efficiency, and political expediency as they are by humanitarian and practical concerns. Jamaica's orientation towards the provision of Primary Health Care (PHC) has shifted with the periodical realignments

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in the political landscape. During the Manley administration of the 1970s the WHO Primary Health Care model was accepted as the most suitable paradigm for meeting the needs of the country, and significant investments were made in improving "community-based" health care through programs such as the Community Health Aide program. The Seaga administration of the 1980s continued the basic format of the PHC model, but cut funding for many of the programs and introduced user fees as a means of meeting budget constraints imposed by the disastrous state of the island's economy. Unfortunately these measures not only cut costs, but effectively reduced access to medical care by the poor.

Both administrations, however, accepted the premise that it is within the proper role of the government to provide basic health care and preventive services to the most needy segment of the general population, viz. those who are unable to afford private medical care. This inevitably brings up the issue of rationing, implicitly or explicitly, because there are simply not enough resources to pay for adequate care for all of the poor -- far from it. In the process of planning for Primary Health Care, priorities must be set to guide allocation of resources. In Jamaica decisions were made which led to the concentration of resources on particular demographic groups, particularly on pregnant women, infants and young children, and to a focus on preventive services, such as immunization, rather than on curative services.. The latter were considered to be more properly within the domain of the secondary and tertiary level sector, which includes hospitals and specialized clinics and which is funded and administered separately from the Primary Health Care system.

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Such a strategy seems to make sense from a utilitarian perspective. It is reasonable to assume that it is more cost-effective to allocate resources to prevention of diseases rather than treatment of them, and to concentrate services on infants and young children. The potential contribution of the young to the future of society is greater than that of the old, who are at or near the end of their productive lives. Also, in many developing countries children are the most numerous, and most rapidly increasing, sector of the population, as well as the group that suffers most from poverty. It is not surprising, then, that the Primary Health Care initiative, as developed by WHO and UNICEF and adopted officially by Jamaica, is geared towards concentrating resources on the youngest age groups (World Health Organization 1978; Carr 1984:26). This strategy grew out of the experiences of health development planning in Third World countries where infant and child mortality from preventable and curable causes is rampant, where poverty is the most important cause of sickness, and where even basic health care services are unavailable to many. The majority of special world-wide campaigns organized by WHO and UNICEF, such as the Diarrheal Diseases Control Program (CDD), the Expanded Program on Immunization (EPI), and the Child Survival Campaign, are targeted towards children (Basch 1990; Coreil and Mull 1988).

We must, however, look more critically at the question of whether this approach is the most appropriate for Jamaica. There are a variety of other considerations which must be taken into account in making such a determination. Even though Jamaica can still be considered an underdeveloped country with widespread poverty, poor housing conditions,

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high unemployment, etc. it is significantly better off as far as health standards go than most Third World countries. We saw, for example, in this chapter (See p. 142) that the current patterns of morbidity and mortality in Jamaica are, because of the relative success of public health programs over the past 70 years, more like those of the developed/industrialized countries, than those of most of the underdeveloped countries of the "South." The biggest killers in Jamaica are chronic and degenerative diseases (heart disease, strokes, cancer, etc.) of adults rather than infectious and environmental diseases (diarrhea, malnutrition, parasitic diseases, etc.) of children. In addition, population statistics show that there has been a slowing of the growth of the youngest age groups, which constituted a smaller segment of the population in 1982 than they did in 1970 (Planning Institute of Jamaica 1988:15.3-4). Apparently the Family Planning campaign, which showed increases in utilization of its services over the decade, has been having its intended consequences, the crude birth rate declining from 28.0 births/1000 population in 1979 to 22.2 in 1987 (Planning Institute of Jamaica 1988:20.8,15.1). In short, Jamaica is different from many other underdeveloped countries in that it has already progressed far along the course of the "epidemiologic transition" from infectious diseases to chronic and degenerative diseases, a pattern which has been noted in a number of other developing countries as well (Omran 1971,1983; Olshansky and Ault 1986; Bobadilla et. al. 1989). Thus many of the assumptions about population and disease patterns on which the prevailing models of health development are based do not really hold for Jamaica.

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There are other aspects of the thinking of international development planners which contribute to the inadequacy of their paradigms in the Jamaican context. One methodological problem which seems to have crept in surreptitiously is the overreliance on certain statistical indicators of epidemiological patterns, such as the Infant Mortality Rate (IMR) and mortality rates in general. The IMR is relatively easy to measure and ordinarily correlates well with overall health status. It has become the most widely used measure of general health status of a population:

> The infant mortality rate has often been cited as the most sensitive indicator summarizing in a single number both a general level of "development" and the state of health of a population. On the one hand, high rates of infant deaths are presumed to reflect underlying inadequacies in socioeconomic and hygienic conditions that promote life-threatening illness in the very young. On the other, there is a common impression that many sick infants could be salvaged through appropriate medical intervention. Thus "guilty" governments are subjected to the double-barreled criticism of first failing to prevent infant illness and then failing again to provide adequate help when needed. (Basch 1990:134)

IMRs of different countries are used as a means of comparing their level of development and the adequacy of their health care systems. In a sort of international competition, the ramifications of which are as much political as they are humanitarian, countries vie to have the lowest rates of Infant Mortality.

While it is a useful statistical measurement, there is a risk in overreliance on the IMR as an indicator of health status and in reification of the concept of Infant Mortality such that it is detached from the variables it was originally taken to represent and made an end in itself. Programs aimed selectively at reducing infant mortality

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(e.g. through prenatal care, supplemental feeding programs, immunization, etc.) may improve standards of infant health while leaving untouched other age groups and other factors affecting the overall health of the population. While better infant health is of course a laudable goal in itself, if it used as a general indicator it may mask, and leave unaddressed, other serious health problems and thus lead to distortions in overall health planning.

As a whole, mortality figures are a crude indicator of health status because they leave unmeasured the toll of suffering produced by diseases which are manifested primarily through prolonged morbidity, such as many of the chronic and non-fatal diseases. As overall conditions and health care are improved and chronic illnesses come to occupy a larger proportion of the spectrum of illness, mortality rates become an even less reliable indicator. But because of the difficulty of designing alternative indices (e.g. of functional status) and applying them to large populations, it is unlikely that they will be able to replace mortality rates as realistic indicators of health status. The IMR, though not without its own sources of statistical error, is relatively easy to measure since it relies solely on registration data (birth,death) and unlike other mortality rates does not require gathering of census data. In countries with low data-gathering capabilities it is sometimes the only feasible indicator.

There are other factors aside from their humanitarian appeal which makes child health programs attractive for planners. The causes of mortality in the youngest age groups in underdeveloped countries are primarily infectious in nature. Thus programs to address them can

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produce measurable results relatively cheaply in a short period of time through preventive (sanitation, immunization) and curative measures (antibiotics). Chronic illnesses of adults tend to be less curable, more difficult to manage and treat, and preventable only in a long-term scenario. Results are less visible and less rapid. Not surprisingly, chronic illnesses are less attractive as targets for health campaigns which must demonstrate rapid and tangible results in order to maintain their political and financial support.

Other derivatives of the international Primary Health Care framework which have been incorporated into Jamaican health care planning are the notions of "decentralization" of services, "community participation," and the use of "community health workers." These elements are tied in with the philosophy that Primary Health Care should be "community-based," which itself is derived from the Community Development (CD) approach to planning (Foster 1982) (See Chapter 1, pp. 6-8). The idea that decentralization is a fundamental component of effective and appropriate Primary Health Care comes from the experience of large countries such as China and India where huge expanses of rural territory often go unserved because health care is unavailable outside of urban areas. This obviously is a very different geographical situation from that found in Jamaica and similar small countries.

In Jamaica the goals of "community-based" care and decentralization have been addressed by creation of a network of small health centers scattered in rural areas. Unfortunately, there have been limited resources available to staff and maintain these centers. The result has been a system of widely scattered low level health centers

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which are not equipped to offer more than a minimal level of service on a limited schedule, with the consequence that the people of the area generally bypass them to go to facilities where they know more services are available. Although transportation is poor in Jamaica, it is a small country. People are generally willing to travel ten miles to a hospital when they are sick rather than waste time at a local low level health center. The people of Albion and other similar communities were never consulted about what their ideas of "community-based" health care are, or whether they might be willing to travel a greater distance if more services were provided. And of course distance is a relative matter. In many locations it takes the same time, money and effort to travel to a low level clinic as it does to the hospital. The importance of distance as an obstacle to health care access would certainly diminish if better transportation were available.

Although the idea of "community participation," has been a central feature of PHC planning around the world, it has proved an elusive goal because of political and economic realities in the developing world (PAHO 1984; Morgan 1990; Paul and Demarest 1984; Crandon 1983). In Jamaica the means chosen for expanding community participation has been the creation of "Community Health Committees" in each district or town. However, the effectiveness of these committees in achieving real community participation has been illusory. Imposed from above, the committees are essentially vehicles for enhancing community cooperation with programs that originate in the central administration, and in some cases for raising funds locally to help support government facilities and projects. They are usually initiated and controlled by government

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health service staff. The health committees evoke little interest among the population as they are for the most part given little opportunity for real input into the planning or allocation of services, and they have little power. They tend to recreate existing power inequalities already present in the community, and thus the disenfranchised have little incentive to participate. (PAHO 1984:65-9) The health workers responsible for setting up and working with these committees are frustrated by the apathy they must confront, though they could hardly expect anything different. Efforts to set up community health committees in eastern St. Thomas have typically met with little success for these very reasons (e.g. See p.155). Albion has no community health committee, and it is unlikely to form one in the foreseeable future.

The community health worker model, which has come to be closely associated with the PHC strategy, is based on the example of the "Barefoot Doctors" in China which during the 1970s stirred up considerable interest in the health development field (e.g. Sidel and Sidel 1974; New 1977[1975]) as a potential solution to health personnel problems in areas of very poor access to care. In some countries the use of such workers has yielded considerable benefits (e.g. Behrhorst 1975). In Jamaica the Community Health Aide Program met with a variety of problems during its initial stages (Marchione 1977, 1984), and was sharply cut back by the Seaga administration in 1983 (van Schaik 1989). In spite of this, the CHA has come to be an accepted member of the PHC team, and fulfills important functions (Ennever et. al. 1988), although poor pay and lack of advancement opportunities have detracted from their level of commitment. But the position of the CHA in Jamaica has drifted

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away from that of the community intermediary. In the current situation the CHAs spend most of their time working in the health centers rather than working in the community. And in their community work they follow the priorities of the health centers, spending most of their time seeing children and pregnant mothers for followups and routine assessments. For example, of the 754 home visits that Miss Morrison, the CHA in Albion, made in 1987, 620 (82.2%) were for Child Care Nutrition Assessment (586, 77.7%) and Maternal Visits (34, 4.5%), while only 48 (6.4%) were Geriatrics Visits. (7 [.9%] were Communicable Disease Followups, and 79 [10.5%] were classified as "Other").

So the commitment to "community-based" health care is far from being realized in any meaningful sense (cf. PAHO 1984). The ideas and desires of common people with respect to health care are neither solicited, nor in most cases are they heeded when they are made known through public activity. In September of 1987, the people of Port Antonio in Portland literally had to demonstrate in the streets of Kingston to have a particularly abusive, barbarous and negligent doctor, who was running the Port Antonio Hospital, removed from his position. Protests against the cutbacks in service at the Hounslow Hospital, and many other facilities around the country, during the program of "rationalization" went unheeded. Political patronage comes into play even in the selection of CHAs, who are supposed to be liaisons with the community (Marchione 1977,1980). While some are members of the communities they serve, they are chosen by outsiders rather than by the community. It is hardly surprising that it is difficult to drum up interest in Community Health Councils. People know from experience that

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the main concerns of the government are to further its political goals and cut costs whenever possible. When services were reduced through "rationalization," the promised upgrading of other facilities never happened. The only logical response is to resist changes whenever they are planned or, conversely, to do nothing since resistance seldom works. Rural Jamaicans have become resigned to the idea that the government is neither willing nor able to provide the sort of health care services that they really want.

In addition to an ideological adherence to doctrines of the international Primary Health Care movement, there are a variety of other considerations which have affected the setting of priorities by health care planners in Jamaica. The main limiting factor is of course cost, and this constraint has become even more stringent during the sustained economic crisis which began in the 1970s and has continued since. The government is unable to pay health care personnel high enough salaries to keep them from going into private practice or prevent them from emigrating at an ever increasing rate. Doctors can be retained only if they are allowed to spend much of their time in private practice. There are fewer alternatives for nurses, who continue to leave in droves, with the result that many facilities are reducing services because they are short of staff. We have seen that in St. Thomas the government is relying heavily on UN Volunteers to provide doctors for the hospitals and clinics. Three of the five government doctors in the parish are volunteers from Burma. Is it not surprising that the Ministry of Health, in setting priorities for Primary Care, would emphasize programs (e.g. immunization and family planning) that can be administered in

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discrete "packages" to large numbers of people by low level personnel at low cost, rather than measures to prevent and treat chronic diseases, which require greater participation by higher level personnel in a framework of continuity and long-term management.

Like people everywhere, rural Jamaicans are most interested in seeking health care at the time when they fall sick. They feel no need to see a doctor or visit a health center when they are well. Seeing a doctor is a relative luxury, so they do it only when it is really necessary. But when they do get sick, they resent having to wait for hours to get a cursory perusal in the health center assembly line. Health center doctors have neither the time nor the energy to investigate their case thoroughly or give them the information they desire. They prefer to go to a private doctor, where waiting time is shorter (though still considerable), but where they feel they are given more personal attention. But few can afford this easily. The cost of more intensive treatment, such as surgery, is also prohibitive for many people, which forces them to endure large hernias, tumors, cataracts, valvular and coronary heart disease, ulcers, indwelling catheters, etc. with no hope of relief. It is no comfort to them if the government targets its efforts on preventive measures for children since the effects of these programs, though quite real, are not evident. What they see, and feel, are the effects of preventable and treatable chronic illnesses which go without effective treatment.

This of course is a classic case of the conflict between "felt needs" and "real needs" which is a central problem in any social planning. It comes down to the fact that the goals and incentives of

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individuals are different from those of the society taken as a whole. In health care this problem is especially obtrusive because of the clash between the viewpoints of policymakers, who think in terms of social goals and resources, and those of doctors, who must deal with individual cases on a day to day basis (Weinstein and Stason 1977; Detsky and Naglie In Press). There is no easy solution to this dilemma. In the planning of the Jamaican Primary Health Care System the emphasis has been placed on strategies which appear to be most cost-effective from a societal perspective. But a sick person, and the doctor who is treating them, have only the current sickness to contend with.

Poor rural Jamaicans feel slighted and frustrated by a system in which they are often unable to obtain adequate treatment for their ailments. They perceive, rightly of course, that theirs is a two-tier health care system. They are beholden to a second-rate system, while only the well-to-do are able to afford the higher quality care of the private system (cf. Crandon 1983). But with the limited resources available to the government Primary Health Care system and the high demand for services, there is no way that everyone could be satisfied. When faced with decisions about how to allocate resources, the choice has been made to provide what is needed for targeted programs (specifically preventive programs for infants and children) and to use the rest for other services. The result is a sort of "rationing by inconvenience" (Grumet 1989) as well as rationing on a first-come, first-served basis. Because of limitations of staff and supplies, health centers are able to provide only a certain amount of desired services such as doctor's clinics, hypertension/diabetes clinics,

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casualty services, etc. The high demand for these means that many patients must be seen in an assembly-line fashion, that some people must be turned away, that waiting times are long,[59] and that when drug supplies run out people must buy medications on their own or go to another facility.

While rationing of one sort or another is necessary under such a system the current approach is an inefficient means of addressing this. One major error is that by artificially segregating "preventive" and "curative" services and by focusing resources on a particular age group, many preventable and treatable diseases go without attention. The chronic and degenerative diseases, which are now the most common causes of mortality and morbidity in the country and which promise to become even more prevalent in the future, could in fact be reduced if preventive measures were targeted at a more general population. There are currently few efforts being made to stop the rising level of tobacco smoking in Jamaica, which is a well known cause of heart disease, strokes and cancer.[60] The economic clout of Jamaican and foreign tobacco companies keeps advertising of cigarettes prominent in the mass

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[59]A recent study done in 44 government health centers in Jamaica showed that the average waiting time for medical patients was 3 hours and 53 minutes, and that the average time spent with a doctor was 7 minutes (Desai et. al. 1989).

[60]The impact of tobacco use on the health of people living in underdeveloped countries is becoming an increasingly more serious problem as smoking rates rise in these countries even as it is dropping in the more developed countries. To develop new markets, tobacco companies are turning to Third World countries where they can have great political and economic influence, and where people are largely ignorant of the effects of smoking on health. International health agencies are now beginning to pay more attention to this issue which threatens to undo many of the health gains which are being made by these countries (e.g. Roemer 1986; Stebbins 1990; WHO 1983; Nath 1986; Muller 1983; Taylor 1989)

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media. Sporting events sponsored by tobacco companies, such as the "Craven A" football (soccer) tournament, are given a high public profile.

Similarly, few efforts are being made to alter the Jamaican diet, which is liberal in its use of animal fats and coconut oil, both of which have been shown to cause heart disease (e.g. Blankenhorn et. al. 1990; Council on Scientific Affairs, AMA 1990). Hypertension/diabetes clinics in the health centers function mainly to free the clinic doctor from seeing these patients for routine visits and to enable patients to obtain medications at a lower cost than they would have to pay at a pharmacy. While these clinics are providing a valuable service, recent studies have shown that in their current form they have not been very successful in providing control of these diseases (Morrison and Bennett 1988). There are currently no programs to screen the general population for these very common problems, although people can have their blood pressure checked in health centers if they make the effort.

One possible means of addressing these problems, aside from a greater allocation of resources to health care overall, would be to design a less fragmented system in which prevention and treatment could take place together in an integrated format rather than being artificially separated. A system that was more centralized on, for example, the parish or half-parish level might be able to provide a more efficient organization of services. A team consisting of several nurse-practitioners with supervision by a doctor, who could handle difficult cases, would be able to see more patients more efficiently than they can when working individually, scattered over a large area (Dr. Ronald

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Lampart, personal communication). As will be seen in Chapter 8, Albionites frequently bypass the health center referral system and go to the Casualty Department at the King George Hospital in Morant Bay for primary care. Improved transportation could make access to a central center from any part of the parish relatively easy. Programs of prevention should be applied to the population as a whole rather than limited to certain age groups, and specific efforts should be made through screening, primary prevention, and secondary prevention to target the main killers of Jamaicans: heart disease, cancer, strokes, etc. Areas which have neglected in the past such as Dental and Mental Health also need to become higher priorities. A more equitable and efficient system of rationing, which does not undermine the goals of the system should also be devised. Of course, programs that are working well now, such as the Maternal/Child, Family Planning, and STD clinics, must be continued in order to consolidate and maintain the progress that has been made already. But if further advances are to be made, health development planning in Jamaica must look more towards Jamaica's special situation, its particular needs, and how these will be evolving in the future.

The obstacles to such change are many. Most importantly, resources are scarce, though perhaps with improvement in the economy the public-service oriented Manley government might be willing to make greater investments in health care. It is likely that any change in the status quo will be met with political opposition from the general public, which has little confidence that the government has any interest other than cutting back services. And of course government

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bureaucracies have entrenched interests and ideological orientations that would make any major restructuring of the system a formidable task. One factor that could decrease strain on the public system would be national advances in employment, income and overall development which would shift many people into the private health care sector.

Rural Jamaicans continue to be extremely doctor-oriented in their approach to medical care. When an illness has not responded to self-medication, and a decision has been made to seek the help of a health care specialist, it is almost always a doctor who is turned to next. Doctors are considered to be very powerful individuals, and many people place an almost blind trust in them. But this trust has its limits, and the relationship between patients and doctors is much more complex than this. A sick person turns to a doctor in order to regain control, through the agency of the doctor, of a situation that has gotten out of hand. The doctor must first of all be powerful enough to meet the challenge, and must be willing to use his power in the patient's behalf. At the same time he must not threaten to usurp the self-determination and autonomy of the patient. In order to be successful in this role the doctor must be able to convey this dual character to the patient. This requires a delicate balance in clinical interactions.

Although most doctors do not come from an "upper class" background, their role does give them considerable authority and high status, especially in relations with lower class patients. The nature of the biomedical culture, combined with time constraints, is not conducive to giving patients much power or autonomy in their interactions with doctors. The ambivalent feelings that Jamaicans hold

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toward authority figures (See Chapter 3) have an important influence on the doctor-patient relationship in this context. Lower class Jamaicans bristle at the submissiveness expected of them in their relations with high status persons, and to a great extent avoid such interactions when possible. On the other hand they learn through their enculturation and personal experience that in order to obtain desired benefits they must build alliances with powerful and influential individuals.

From the perspective of rural Jamaicans, a doctor's power comes through his or her ability to effectively use the corpus of information, principles, and practice which constitutes Biomedicine. To some extent doctors in St. Thomas are seen by lower class Jamaicans as equivalent and interchangeable. Theoretically, two different doctors should, when treating a particular patient, come up with the same diagnosis and plan of treatment. Doctors share in this common basis of knowledge, however their ability to use it successfully depends on personal characteristics as well. Among the personal characteristics which influence a doctor's abilities are intelligence, experience, patience, competence and concern, and a patient's evaluation of the doctor's ability rests to a certain extent on his success in conveying these to the patient. The ultimate assessment of a doctor's ability, however, rests on the final outcome of the treatment. Patients regularly withhold their judgement until they have pursued a course of treatment and find out whether it makes them feel better or worse. Few patients are aware of or understand the empirical nature of most of the treatment that is prescribed, so the early results of treatment are critical in influencing further treatment decisions. Confidence may be built up

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over time, however, and after several successful treatments a lack of success may be tolerated for a time. Patients regularly "test" doctors in whom their trust is equivocal by going to another doctor to see if he makes the same diagnosis and prescription for treatment.[61] Their confidence in particular doctors, and in Biomedicine as a whole, is understandably shaken when a treatment makes them feel worse, or when they are given different diagnoses and treatments by different doctors.

Doctors also inspire trust in their patients when they can convey their competence through their own self-confidence. Authoritarianism is positively valued by patients as long as it is justified by the doctor's abilities and experience, and as long as the patient is convinced of the doctor's concern about their well-being. Some of the most authoritarian of the doctors in Morant Bay, such as Dr. Lewis, are also the most experienced and the most respected. But more than this, the successful doctor must be sensitive enough to know when a patient needs to be autonomous and given the opportunity to participate and exert self-control in the relationship. Some doctors are more effective at this than others and this is one factor which influences a doctor's popularity among patients.

In entering relationships with doctors, lower class patients bring with them their ambivalent attitudes towards authority. The doctor must tread a fine line to gain the patient's acceptance. He should be powerful, and express this through his self-confidence and strong,

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[61]This is done without informing either doctor that they are going to someone else. The lack of sharing of information among doctors not only makes consistency in evaluations difficult, but also makes accurate diagnosis problematic because important historical information may not be known, or may be withheld by the patient.

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authoritative manner. At the same time he must cultivate the trust of the patient by demonstrating his willingness to act in their interests. By doing so he can enhance the patient's sense of control over the situation, while avoiding the threat of usurpation of control that threatens to further reduce the patient's sense of autonomy in the situation, and which will elicit resistance on the side of the patient. Patients will resist a loss of control in the relationship and this will be expressed through non-compliance, going to another doctor, or abandonment of biomedical treatment altogether.

Of course, these conditions are not always met, and the relationship between doctor and patient is not always as positive as it might be. In this regard the private doctors have a great advantage over those who work in the public clinics. Time constraints and patient load make it difficult for the clinic doctors to elicit a patient's worries or demonstrate concern for them. Over time they often abandon even attempts to express this to patients. Their diagnoses and prescriptions are based on shallow information, often gathered by a screening nurse, and they feel too pressed to spend much time communicating with patients. Most of their treatments are empirical, and to them it makes sense that if their initial assessment is flawed the patient can always return for a re-evaluation. From the patient's perspective, of course, this does not build confidence in the doctor. The doctor's superficial evaluation creates suspicions about the level of their concern for the patient, and their dictatorial pronouncements, without explanation or discussion, threaten the patient's sense of self-control. For the patients, the assembly-line method of practice does

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not work. They regularly reveal their lack of confidence in the health center doctors, and overwhelmingly express through word and deed their preference for private over clinic doctors.

In St. Thomas the clinic doctors are primarily foreigners while the private doctors are all Jamaicans. Although relations with doctors of other ethnic backgrounds follow the same general rules as those with any doctors, the issue of ethnicity, must be taken into account here as well. The Burmese UN volunteers are defined by most of their patients as "Chinese" doctors. Chinese Jamaicans, while representing a small proportion of the total population,[62] have a fairly well-defined niche in Jamaican society. The Chinese in Jamaica have come to occupy positions as merchants and businessmen, and are generally accorded a fairly high social status, analogous to those of mixed-race who have come to occupy positions of power and prestige. In St. Thomas, for example, the two large supermarkets in Morant Bay and several other large businesses are owned by Chinese Jamaicans. On the other hand there is some hostility towards this group as they represent "outsiders" who have become wealthy and powerful in Jamaica, presumably at the expense of Jamaicans.

In doctor-patient relationships, however, this does not seem to have much effect. Chinese Jamaican doctors are considered to be of middle to upper class in their background, and in their current position are analogous to other doctors. For example, one of the private doctors in Morant Bay, Dr. Young, is of Chinese descent, and this seems to have

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[62] In the 1982 census figures, 0.2% of the population was classified as Chinese (Statistical Institute of Jamaica 1986b:25).

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no obvious effect on his clientele. He is one of the most respected and frequently used doctors among Albionites, both because of his reputation as a skilled clinician and because of the low fees he charges, which is also seen as a demonstration of his concern for patients. In informal discussions among Albionites about the local doctors, Dr. Young's ethnic background was rarely mentioned, nor did it seem to have an effect on assessments of his abilities or character, though it was occasionally used as a means of identifying him ("the Chinese doctor").

When ethnic difficulties arise between the Burmese doctors and their clinic patients, it is more frequently related to problems in communication than anything else. Understandably, the Burmese doctors sometimes have difficulty with Jamaican patois, and a communication gap may arise and go undetected, to surface as a conflict later on. When a large gap exists and the two parties are having difficulty understanding each other, a nurse may be called in to "translate." While this is not an ideal solution, it helps to smooth over the cracks in communication that can arise.

One important factor that patients frequently cite as a reason for their preference for private doctors over the clinic doctors is that private doctors, in addition to thoroughly "sounding" the patient, take more time to explain to them what is wrong. In the assembly-line of the public clinic the doctor may merely hand them a prescription without ever explaining what the problem is. Of course, this may be because the doctor is not really sure of the diagnosis, and wants to try an empirical treatment without out admitting the uncertainty. More often, though, it is because of the time pressures in the clinic and the

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assumption by the doctor that the patient would not really understand anyway. But doctors who fail in their communication with patients may not realize the importance of such an explanation. Understanding and explanation are a powerful means of reasserting control over an illness. Sometimes the uncertainty and worry that accompany an illness can be distressing as the physical symptoms, and a thoughtful explanation may go a long way in dissipating these.

Having an explanation for a puzzling illness is important for the social functioning of an individual as well as for their state of mind. Illness is a significant mode of social interaction in rural Jamaica, as it redefines the individual's place within the family and larger society. It alters one's social as well as personal identity. While explanations for an illness are generated by all concerned from its moment of onset, to have a doctor's explanation provides both a validation of the illness and a means of understanding its mechanism and its prognosis. When one returns from a visit to a doctor without any better understanding of the illness, there is frustration and a continuing unpleasant uncertainty all around. Relationships continue in a state of unstable flux; they are not able to solidify in a new orientation. The individual remains in his or her undifferentiated state of liminality, not knowing what to expect, out of control (cf. Murphy et. al. 1988).

Even when they do take time to explain to patients what is wrong with them, doctors are at a disadvantage with respect to other, non-biomedical, practitioners in that they are unable to tell a patient *why* they got sick. Biomedical reasoning contains no teleological anchor.

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While it can explain how and illness happened in terms of a probable causal chain of events, and may be able to dissect these mechanisms in great detail, it lacks a means of linking an illness to the social, cultural, and moral world of the patient -- the world in which they actually live -- in an ultimate sense. Other types of Jamaican practitioners, as we shall see in the following chapters, do not lack this capability. Their ability to reach the patient where their heart is, at the place of their hopes and fears, is one reason why folk healers have flourished in Jamaica over the past three hundred years, and why they continue to flourish today.

To understand the nature of folk healing in Jamaica, and to begin to understand its place in the system of healing activities, we must try to appreciate the spiritual side of Jamaican culture, for this is where its power lies. To penetrate the foundations of spirituality in Jamaica, and its significance in the process of healing, we must trace back its roots to the earliest days of settlement in Jamaica, and beyond.

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CHAPTER SIX

THE HEALTH CARE SYSTEM III:

THE HISTORY OF JAMAICAN RELIGION AND FOLK HEALING

INTRODUCTION

Folk healing in Jamaica is widespread and encompasses a variety of groups, practitioners and activities. In every part of the island an assortment of alternative healers can be found. However, despite its pervasiveness, folk healing remains to a large extent a clandestine practice. The mixed feelings one finds with respect to folk healing are a reflection of the Jamaican cultural identity which is divided between allegiance to traditional folk culture and metropolitan/colonial values. Like other aspects of the culture of the lower classes, folk healing has long been an embarrassment to those who seek to emulate British and American culture. And yet it addresses such basic needs of the masses that it has continued to flourish despite official repression.

Contrary to the view of many doctors and nurses, as well as laymen, the folk healing sector in Jamaica functions for the most part in parallel with the professional, biomedical sector rather than in competition with it. One does find, of course, occasional cases in which there is a direct conflict between the two systems. But for the most part, in the manner in which the two are utilized, they fulfill complementary and parallel roles (cf. Coreil 1983; Stoner 1986). In fact they have evolved together over the past three hundred years, always in a somewhat tenuous and antagonistic balance, but each reflecting a different side of the Jamaican cultural personality, and

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each serving different needs. Biomedicine spoke to the Jamaican's longing for social and economic advancement through European refinement, and provided access to the powerful science and technology of the West. On the other hand, through folk healing, the Jamaican could strive to harness the mysterious and indomitable forces of the spirit world. The former promised order and social acceptability to the downtrodden, while the latter helped the powerless cope with the mysteries, fears, confusion, and sorrow of everyday life.

To make sense of the complex patterns of folk healing in Jamaica today, it is necessary to have some appreciation for the cultural streams from which it originates and which have shaped its evolution. In its earliest forms it derived from African shamanism, sorcery and religious cults. In addition to its own intrinsic path of development, it later on it was shaped by various Christian and syncretic movements and occult persuasions. What has resulted is, like many Caribbean cultural institutions, a fascinating blend of locally derived and imported elements, of the European and African, and of the traditional and modern.

Because of the intimate interconnection between Jamaican folk healing and religion, it is essential to come to an understanding of popular Jamaican religious forms, and their historical development, before the cultural framework and social meanings of current folk healing practices can be fully appreciated. It would not only be misleading to try deal with them separately, but well nigh impossible, since they are so closely intertwined and at times indistinguishable. Indeed, others who have written on popular religion in Jamaica

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invariably have ended up discussing folk healing at length (e.g. Moore 1953; Wedenoja 1978; Hogg 1964), while those who have concentrated on folk healing have had to pay just as close attention to religion (e.g. Long 1973). Before attempting to describe and analyze folk healing practices, then, we will turn first to a look at the history of Jamaican religious traditions and healing practices, focusing on their interconnections. In the following chapter we will concentrate on contemporary religious life and folk healing practices in St. Thomas.

THE HISTORY OF FOLK HEALING AND RELIGIOUS MOVEMENTS IN JAMAICA

The roots of healing practices and religion in Jamaica remain shrouded in the enforced silence of the slave and the indifference of his masters. The earliest planters cared little whether their slaves had a god (or gods), be it pagan or Christian, as long as their workers were in the fields from dawn to dusk. Fortunately, we do know something of the origins of those Africans who were torn from their homelands to toil in the steaming cane fields of Jamaica. Through our more extensive knowledge about the about the cultures from which they were so brutally ripped, and by piecing together contemporary accounts, we can infer a great deal about early slave culture.

African Precursors

Slaves that were brought into Jamaica from Africa during the three hundred years of active slave trading came from a wide variety of tribal groups, though the two main areas for obtaining slaves were the coast of Western Africa, and the Congo area in Central Africa. The main cultural

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groupings in these regions from which Jamaican slaves were drawn were the Akan tribes of the Gold Coast (Asante, Fante, Nziane, Agni and Brong); the Ewe and Nago of the Slave Coast; the Mandingo, Bambara, Serer, Fula, Wolof and Jula from Senegambia and Sierra Leone; the Yoruba, Edo, Igbo, Ibibio, and Ijo from the Bight of Biafra; and the Bantu (Kongo, Mongo, Kuba, Lunda, Luba, Warega, and Mangbetu-Azande) from the Congo and Angola (Alleyne 1988:42-57).

Needless to say, there was a great deal of cultural and linguistic variation among these widely scattered groups. One tactic used by planters to forestall organized resistance from the slaves was to take advantage of longstanding divisions and animosities among these different groups by mixing members of them together on their plantations. The plantations in turn were physically and socially isolated from one another, which further hindered slaves from communicating and organizing rebellions, the most feared complication of the imbalanced, flammable, social system of slavery.

The slaveowners developed simplistic stereotyped beliefs about the character and personality of members of these different groups, and these assumptions were actually used in setting the value of particular slaves and in allocating them for various tasks. "Eboes" (Ibos and related groups) were most numerous, but apparently were not highly valued as workers because of their purported passive, melancholic and suicide-prone nature. The "Coromantees" (from Gold Coast groups: Akan, Asante, etc.), also present in large numbers, on the other hand had the reputation among slaveowners for being "strong, intelligent, courageous and capable", and were often chosen to work as foremen. Their

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independent, proud, and aggressive nature supposedly enabled them to exert a strong influence on collective slave culture, but also inclined them toward rebellion. They were frequently noted, or presumed, to be the leaders of slave insurrections. Dahomeans (Ewe), known as "Papaws" or "Popos," were considered to be hard workers, while "Congoes" were thought to be less so. "Mandingoes" were highly regarded and were often chosen as domestic slaves (Hogg 1964:35-37). Whatever the actual validity of these stereotypes, that the planters held them demonstrates their awareness of cultural diversity among the slaves, and a concern for taking advantage of these differences to enhance the plantations' productivity and to prevent rebellions.

Within the society of the plantation there were other divisions as well. A hierarchical labor organization gave some individual slaves much more power and prestige than others, and those in higher status positions, e.g. drivers and boilers, sometimes used their power to take advantage of the others (Hogg 1964:47-8). In addition to the divisions between different tribal groups and within the labor hierarchy, there were distinctions between island-born slaves and new arrivals. As time went on an increasing proportion of the slaves were "creoles" who had been born in Jamaica and grown up in the world of the plantation. There were often tensions between these and newly arrived slaves, who were referred to pejoratively by the creoles as "salt-water Negroes" or "Guineybirds" (Patterson 1967:146; Long 1774,II:410).

Yet despite these divisive factors, there were unifying ties as well. The most important were the common experiences of transport and toil. All the slaves who survived the dreaded Middle Passage together

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on a ship formed a lifelong bond of affection and friendship. They were known as "shipmates" and their link was like that of brothers and sisters (Patterson 1967:150). During the "seasoning" process, newly arrived slaves were often quartered with and looked after by elderly members of their own ethnic group who had been there for some time. This served to integrate the new arrival into the system somewhat, though it sometimes led to abuses as well (Patterson 1967:152-3). Slaves who lived and worked together in time learned to communicate and cooperate. The years and generations of common suffering eventually wiped out the animosity and divisions among the different cultural groups.

Despite the diversity among the ethnic groups that were brought to Jamaica, they did share some cultural commonalities which helped them to develop a relatively unified culture in the new setting. Although it seems that some groups (e.g. the Akan) exerted a greater cultural influence than others, if only through sheer numbers, it was these shared "core" features which, not surprisingly, seem to have formed the basis of the new culture which emerged. In addition it seems that those cultural institutions which were subject to the least amount of suppression by the slaveowners were able to survive this period most intact.

For example, the world view of the African slaves enabled them to find meaning in the problems and tragedies of their lives. Life events were commonly felt to be under the influence of a variety of spirits, among which ancestral spirits were particularly important. As those closest to the corporeal world, the ancestral spirits were believed to

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have the greatest influence and interest in it. Those who had been wicked in life became naturally malevolent after death, and those ancestors whose needs were not met by their kinsmen through sacrifice and ritual could also do harm to the living. Those who were better cared for could provide luck and success in any endeavor.

Misfortune and illness were often believed to be the doing of malignant spirits which had turned against a person through the envy or vengeful black magic of a rival, through some ritual omission, or occasionally by accident, e.g. if a spirit was happened upon accidentally at night.[63] Thus the victim might well know, or at least suspect, what transgression or conflict had brought about the calamity. By consulting a diviner he could find out with more certainty what the problem was and take steps to correct it. From such a perspective, untoward events can be explained and understood in terms of the workings of the spirit world. Thus social and personal meaning can be assigned to everyday problems, and misfortune can be dealt with, and often reversed, through ritual action. Because meaningful action can be taken, there can be some sense of control achieved over the situation. Even if the problem can not be completely solved, this enhancement of the sense of control can be an important coping mechanism.

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[63]It is useful here to make note of the commonly made distinction between African "witchcraft" and "sorcery". The former is used to refer to the evil consequences caused through malicious thought or envy by a person harboring an inherently evil spirit which compels them to do harm. The latter refers to evil done through magic by a skilled specialist, who is otherwise a normal person (Hogg 1964:425).

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Religion of the Slaves

Transported with the slaves arriving in Jamaica from West and Central Africa were their spiritual beliefs and apparently a number of their ritual specialists as well. From the beginning the slaves appear to have continued their rich religious tradition, though of course the social and cultural fragmentation, and the strictures of life on the plantation, must have stripped away much of the elaborate ritual detail. We have few accounts from the earliest years of slavery (1655 - 1750s) but in general the different cultural groups appear to have continued in their own separate traditions and rites. During this period, ethnic identification was still an important factor, and tribal groups held collective gatherings which usually excluded others, but which sometimes included slaves of similar tribal origins from neighboring plantations. At this time the planters and overseers did not show much interest in the slaves' religious activities. They were concerned primarily with getting the work of the plantation done, and as long as the slaves worked when they were supposed to and stayed out of trouble the owners did not interfere with their "superstitions." The early plantation owners and overseers were not the most pious of men, and had little interest in "saving souls" or "Europeanizing" the slaves (Hogg 1964:45-6).

Although there is little information available on the religious beliefs of the slaves during this period, there are a few accounts which give us some idea of the type of ceremonies which were taking place. Not surprisingly the European observers were quite biased in their views of such rituals and sometimes equated them with "devil worship." The

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emotional intensity and unfamiliar behavior (e.g. possession, trance, dancing, singing, etc.) were in their eyes "licentious" and sinful. Religious ceremonies were usually held at night, on Saturdays, and at the Sunday markets. The holiday seasons ("crop-over" in August, Christmas and New Year's) allowed some free time for more elaborate ceremonies such as the Jonkonnu (often spelled "John Canoe") (Hogg 1964:57-8).

Not surprisingly, the most significant of these ceremonies were funeral rites. The appropriate treatment of the soul after death was, and still is, of utmost importance. The slaves believed that when they died their spirit would return to Africa. Indeed, several early chroniclers reported that this belief induced many of the slaves to commit suicide (Phillippo 1969[1843]:252-3; Patterson 1967:196-8,264-5; Leslie 1740:307-8). The slave looked forward to this return to his homeland, but depended on his kin and other survivors to perform the appropriate rites to release his spirit. Without the proper rites, a dead man's soul would be unable to assume its proper role as an ancestor, and would roam the earth terrorizing the living. Thus performance of the correct funeral rituals was not only a courtesy to one's departed friend or relative, but a practical means of protecting the living as well.

One of these observers, Charles Leslie, writing in the early eighteenth century, described an elaborate funeral which involved settlement of outstanding grievances and debts with the dead man, a ritual procession to the burial ground, animal sacrifice, a feast, singing to the accompaniment of drums and rattles, and much wailing

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(Leslie 1740:309-10). While ethnic divisions were still important in this period, Leslie reported that the slaves "have a kind of occasional Conformity, and join without Distinctions in their solemn Sacrifices and Gambols." (Leslie 1740:307). Thus by that time, familiarity and constant interchange seem to have enabled the slaves to form the beginnings of a more cohesive social and cultural system.

It is clear that the traditions of many different African societies contributed to the new culture which developed among the slaves in Jamaica, though it is impossible to trace with much certainty the origins of specific aspects of it. From studies of language and religious forms, and from the demographics of the slave population, it appears that Asante culture was one of the main sources of the new formation. There are some authors (e.g. Williams 1932, 1934) who claim an overwhelming dominance of Asante culture, because of the supposed "assertiveness" of the "Koromantis." However, it is more likely that many groups contributed, and that the forms which survived were those that were held in common by many of them, those that were best adapted to the new environment, and those that were not vigorously suppressed (Hogg 1964:56-7). And it seems that the cultural orientation of the West African groups was flexible and open enough to enable an integration of a variety of traditions (Alleyne 1988:87).

One aspect of African religious tradition which flourished in the new setting was the belief in the participation of ancestral spirits in current affairs, and the use of magic to influence them (Hogg 1964:57-8,60,63). The pressures and stresses of slave life, in combination with the regimentation which negated personal control over events, created a

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tendency to turn more and more to the spirit world for assistance in times of need. At the same time, disruption of traditional institutions, such as ancestor worship cults, removed the means of integrating these spirits into the social order. With the breakdown of tribal structure ancestral cults lost their clan orientation and became focused more on smaller family groups. Thus, individuals could count on the cooperation and assistance only from the ghosts of their own family, while those of other families, clans or tribes -- strangers -- constituted a threat. The world became a more dangerous place populated by unfriendly spirits (Hogg 1964:63).

Obeah

The practice of magic or sorcery,[64] which in the New World setting came to be known as "Obeah,"[65] was one institution which was

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[64]Again, the distinction between witchcraft and sorcery is an important one in this context. A witch, as conceived by Jamaicans and many African groups, is a person who contains a hidden evil spirit which causes them to prey on others. In Jamaica, witches were believed to slip out of their skins at night and suck the blood of their victims, causing illness and death. Babies were considered to be especially susceptible to this. (Williams 1934:169-72; Hogg 1964:425). Sorcerers, on the other hand were gifted, though otherwise normal, magical specialists, who used ritual and material means to deliberately influence spiritual forces to harm - or sometimes help - people. Africans and Jamaicans both recognize that sorcerers can have this dual purpose. In belief, the evil role is stressed, though in practice these specialists usually fulfilled a more positive role, i.e. as a "witch-doctor" or "medicine man". (Hogg 1964:425; Patterson 1967:183-4; Murdock 1980).

[65]The origins of this word, still in wide use in Jamaica and many other parts of the Anglophone Caribbean, are obscure. Williams traces the origins of the word to the Asante (Twi) word *obayifo* which means "sorcerer" or "witch" (Rattray 1916:47-8; Williams 1932:120; 1934:62). Patterson (1967:185-6) relates it to another Twi word, *obeye* which refers to the evil essence of witches. Cassidy and LePage (1967:326) suggest the Efik word *ubio* - "A thing or mixture of things put in the ground as a (continued...)

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able to continue among the slaves. The original "Obeah Man" was probably a fetish specialist who had continued in this role when brought as a slave to Jamaica. In Africa these specialists presided over a fetish in which a spirit had been induced to reside, and which was used to perform spiritual tasks (Hogg 1964:42,65). Some writers (e.g. Williams 1934; Alleyne 1988) have postulated that because the practice of magic and sorcery was done covertly and privately, it was able to continue relatively intact, while those more open religious practices and specialists (e.g. the Asante *okomfo* or "priest"), which were public and based on group participation, were suppressed. This may very well have been the case, though it is unlikely, as it has been argued, that this led to a great escalation in the use of sorcery for evil purposes. Rather it seems to have expanded the social role of the Obeah Man as a leader and influential member of society, and increased his positive social role more so than his negative one.

Although the *belief* in the evil doings of Obeah Men did become widespread in Jamaica during this period, many writers have failed to appreciate the differences between public perception and private deed, accepting at face value the reported increase in the use of sorcery (e.g. Williams 1934; Patterson 1967). Hogg, however, offers what seems to be a more realistic assessment of the situation. He realized from

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[65](...continued)
charm to cause sickness or death." By the time descriptions of Obeah practices were recorded in the late eighteenth century this term had come into widespread use. Its spread to other parts of the Caribbean may be a result of the transport of Obeah Men to other islands when they were apprehended (In the eighteenth century Obeah became a crime punishable by death or transport.) (Williams 1934:58). However it may also have been due to other modes of cultural communication and diffusion, or perhaps to common cultural antecedents.

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his own experience with modern Obeah Men that, although the common perception of them is that they perform mostly evil sorcery, the reality is far from this. In actuality they are consulted primarily for positive purposes, such as the treatment of illnesses or reversal of bad luck believed to be caused by evil spirits.

Because of this difference between reality and public perception, the growing belief in evil spirits and the expanding role of the Obeah Man seem to have become, in a sense, mutually reinforcing. The attribution of misfortune to evil spirits increased the demand for Obeah Men, the only specialists who were able to counteract evil spirits supposedly sent by another Obeah Man (or perhaps by the same Obeah Man on behalf of an enemy). This increased demand led to a proliferation of Obeah Men, which ironically created the perception that there was more evil sorcery being done than was actually the case. Consequently more people resorted to a belief in evil spirits as an explanation for misfortune, completing the cycle. The result was a gradually growing emphasis on the fear of ghosts and other evil spirits and a proliferation of magical specialists (Hogg 1964:63). This mechanism still plays an important role in helping to maintain the folk healing system.

The slaves in Jamaica came to place a very strong emphasis on the role of ghosts, or "duppies"[66] as they became known in patois, in the

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[66]The origin of this term is also obscure. Banbury (1895) claimed it was a derivative of "door peep", referring to something peeping in the door. One Science Man I worked with also gave this explanation. A more likely explanation is that it is derived from the Adangme word adope which refers to a type of ghost (Patterson 1967:204). Another possible origin is from the Kikongo word *n'dabi*, "one who has slept" (*laba*, "to sleep") (Schuler 1980:152).

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causation of illness and misfortune. If a dead person had not been given proper burial rites, a duppy might linger nearby and harm those who happened upon it. An ancestral spirit might help its living relatives if it was pleased and placated by them, or harm them if they had not kept up with ritual obligations. Duppies were also felt to be controllable by Obeah Men, who could command them in a variety of ways. Obeah Men worked primarily through spirit mediums, duppies over which they had gained control through a variety of rituals using the bones of a dead person, or sometimes rituals performed at a gravesite. The Obeah Man made sacrifices to the duppy in exchange for its assistance.

In addition to animal sacrifices, Obeah Men employed a variety of natural materials -- animal parts, grave dirt, herbs, etc. to make amulets, charms, and "Obeah bundles." A bundle of these magical objects could be used to secretly work evil by burying it in the path or yard of the intended victim. Alternatively a site could be protected from trespass by a more conspicuous placement of a talisman (Beckwith 1929). An Obeah Man could also reputedly harm a person by sending a duppy to attack him, or by capturing the victim's "shadow," or spiritual essence, and nailing it to a ceiba (silk-cotton) tree. Conversely, he could counteract an evil spell placed by another. In doing this the Obeah Man might dramatically remove the offending spirit in the form of a foreign body such as a nail, toad, broken glass, etc. by sucking it from the person's body, or by another "psychic surgery" technique (Patterson 1967:186-90). The Obeah Man was also reputed to be skilled in the use of herbal medicines, and for this reason was often employed in the estate "hothouse" or hospital, where he would treat "Negro diseases".

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Some of the slaves reportedly had so little trust in the white doctor that they would only allow themselves to be treated by the "black doctor," i.e. the Obeah Man or, as he was later called in this capacity, the "Myal Man" (Phillippo 1969 [1843]:263; Patterson 1967:191).

Thus we can see that the role of the Obeah Man was multifold. Although healing was among his most important duties, he could also offer protection from enemies, success in cultivation, a knowledge of the future through divination, and a means for the powerless to gain control over life events through magic. He also began to take on a role of social and political leadership among the slaves. This became apparent by the mid-eighteenth century during the investigation of a 1760 slave rebellion in the parish of St. Mary which became known as Tacky's Rebellion. It was found that an Obeah Man had been instrumental in recruiting and organizing the uprising. He had promised the participants that his magic would protect them from the bullets of the white man, and an oath of secrecy had been taken which involved ritual drinking of a potion containing grave dirt, gunpowder, and the blood of those involved (Phillippo 1969[1843]:248-9; Black 1973:57-8).

This revelation of the subversive aspects of Obeah sent a shockwave of alarm among the planters. They had formerly seen it as a bothersome superstition, but now recognized it as a politically and socially threatening practice. Obeah Men had already gained a reputation for being able to kill with magic (though usually this was attributed by the planters to suggestion or poisoning), and this disclosure of their role in the uprising convinced the planters of the necessity of suppressing their activities (Williams 1934:80,84-5;

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Gardner 1971 [1873]:190-1). Slaveowners naturally were alarmed about Obeah's capacity to threaten their property, as well as its potential for fomenting social unrest (Williams 1934:75).

Acting out of a fear of rebellion by the slaves, beginning in 1696 the Assembly had already passed a number of laws restricting public gatherings of slaves, especially from different plantations. This consequently hindered the celebration of traditional tribal festivals and religious rites (Williams 1934:69). Prohibited even (by 1717) were the use of drums and horns which the planters feared might be used for communication at a distance (Williams 1934:71).

With the discovery of the Obeah threat, in 1760 the Assembly took more stringent measures by passing the first anti-Obeah law, and it also passed a law which further restricted public gatherings. The former was later disallowed by the Crown, which held a veto power over the Assembly, but by 1781 an anti-Obeah law was approved which prohibited slaves from "pretending communication with the Devil and other evil spirits, whereby the weak and superstitious are deluded into a belief of their having full power to exempt them whilst under protection from any evils that might otherwise happen," and mandated "Death or Transportation" for any slave "who shall pretend to any supernatural power, and be detected in making use of any blood, feathers, parrot's beaks, dog's teeth, alligator's teeth, grave dirt, rum, eggshells, or any other materials relative to the practice of obeah or witchcraft...." (Williams 1934:78).

The outlawing of Obeah reinforced negative perceptions about the prevalence and nature of magical activities. By driving the practice

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further underground, it deepened the secrecy which surrounded it, and consequently enhanced the fear and mystery associated with it. Those Obeah Men who were known for their positive work distanced themselves from the negative connotations of their position by beginning to call themselves "healers" or "diviners," and they were referred to as such by their followers (Hogg 1964:98). There were some, however, who promoted their evil reputation as a means of convincing potential customers of their power.

Myalism

During the mid-eighteenth century a movement arose in Jamaica which became known as "Myalism"[67] The Myalists were organized into cult groups led by a Myal Man or Woman. These Myal leaders later came to be known for combatting duppies and the evil forces unleashed through Obeah. Some authors, such as Williams (1932, 1934) have argued that Obeah was strictly evil sorcery and that Myalism was a separate movement opposed to it, representing the re-emergence of a positive African cult based on the tradition of an organized "priesthood." However Hogg's assessment of the situation is probably more accurate. He argues that Myalism was an outgrowth of Obeah, but that it emphasized the positive aspects of it and organized it into a "public" movement. From this perspective the early close association of Obeah and Myalism is much

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[67]The origins of the word "myal" are not known. Cassidy and LePage (1967:313) suggest a derivation from the Hausa word *maye*, meaning: "1. sorcerer, wizard; 2. Intoxication,; 3. Return." The term "myal" today basically means "spirit" and is still used to refer to the spirit possession that takes place in Kumina rituals. To "catch a myal" in a Kumina means to become possessed by an ancestral spirit.

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easier to understand. Myal Men who led cult groups often at the same time functioned privately as Obeah Men, but in this seemingly contradictory role they were not necessarily infiltrators or hypocrites, as some have made them out to be (Williams 1934:59; cf. Hogg 1964:103). Rather they seem to have been fulfilling different functions in the two roles. Obeah practitioners and Myalists were united in their opposition to the slave system, and thus both had to remain secretive. This makes it difficult to determine the actual relationship between the two systems during this period (Hogg 1964:69-70; Gardner 1971[1873]:191).

Myalism in its earliest manifestations appears to have been used as a form of rebellion directed against the slave masters. The first indication of this aspect of the movement was the subversive use of a ritual "fetish oath" such as allegedly occurred during Tacky's rebellion. This type of oath had been used for many years for other purposes, e.g. as an "ordeal" for catching a thief (e.g. Leslie 1740:308), and was apparently an African survival. But it was only with the coordinated rebellious activity of the slaves that the "Myal society" became organized. Long's report in 1774 was the first reference in print:

> Not long since, some of these execrable wretches in Jamaica introduced what they called the Myal dance, and established a kind of society, into which they invited all they could. The lure hung out was, that every Negro, initiated into the Myal society, would be invulnerable by the white man, and although they might in appearance be slain, the Obeah man could, at his pleasure, restore the body to life. (Long 1774, II:416, quoted in Hogg 1964:72)

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The Myal dance of which Long speaks involved an initiation rite. During the ceremonial dance the initiate was given a potion[68] which purportedly induced a death-like state. He was later revived from this by the Obeah Man/Myal Man who, according to Phillippo, was usually called "Doctor" (Phillippo 1969[1843]:248). In this way the Obeah Man proved his powers of resuscitation of the dead, and the initiate was supposedly protected from the white man's weapons.

By the end of the eighteenth century, Myalism had become more organized and more clearly differentiated from Obeah, although many of the Myal Men and Women continued to do private magical "Obeah" type work. Myalism continued its role as a communal institution in opposition to the slavery system, while Obeah maintained its private orientation. The popularity of Myalism waned somewhat during the early 1800s but, as we shall see, it developed a new impetus later on (Hogg 1964:73-4).

Native Baptists, Myalists, and Independent Sects

It was not until the late eighteenth century that organized religious groups from Europe and America began to have much impact on the slaves. Up to this time the Anglican and Catholic churches, bastions of the white plantocracy, had made little effort to offer

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[68]The potion used was reportedly a cold infusion of the branched calalu (Solanum Nigrum) which is now known to contain the toxic glycoalkaloid solanine, a cholinesterase inhibitor which is also found in white potatoes (Asprey and Thornton 1954:23; Klaassen, et al. 1986:796). According to some reports the antidote used was lime juice and vinegar. Whether sufficient levels of this drug could be obtained to induce paralysis or coma, and whether this could then be counteracted by other herbal treatments is uncertain. Calalu is a commonly eaten vegetable green in Jamaica and, at least in its cooked form, is harmless.

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Salvation to the slave population, although some of those slaves in close contact with whites (e.g. house slaves) had picked up something of Christianity. The planters saw no need for spiritual education of the slaves, and in fact actively resisted the efforts of missionary groups who attempted this. They felt that education of any sort would be detrimental to the slaves as it would only raise their aspirations and make them more rebellious.

The first to have much success in spreading Christianity to the slave population were actually American blacks who came to Jamaica in the 1780s with Crown loyalists fleeing the aftermath of the American Revolution. The most influential of these were the George Lisle, a freed Baptist slave from Virginia who established an active congregation in Kingston, and Moses Baker, another black American who was a follower of Lisle. Baker set up his own mission in St. James and began taking his message to slaves in that area. While these men added some novel elements to their teaching, they were for the most part fairly orthodox in their views. However, a number of their followers, such as George Lewis, split off and formed their own groups which deviated much more widely from standard Baptist doctrine. In fact these splinter groups developed highly syncretic mixtures of Christian and African/Myalist elements. These "Native Baptist" groups, as they came to be known, were very successful, and spread throughout the island, developing into a distinct system of worship and communication network (Hogg 1964:81-2; Gardner 1971[1873]:343-5; Curtin 1955:32-5).

The leaders of Native Baptist congregations, who were known as "Daddies" or "Mammies," exerted an authoritarian control over their

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followers. They emphasized contact with the "spirit" over knowledge of the Bible. This was appealing to the mainly illiterate slaves who had grown up in the tradition charismatic African religion. These groups highlighted baptism by immersion, which came to be thought of as a magical rite that washed away sin, and they elevated John the Baptist over Christ. They relied on dreams, visions, and spirit possession (called "convince") for the core of their religious experience. These elements seem to have derived from African religious traditions, though they were superficially couched in Christian and Biblical terms. Many of their practices (such as fasting, the use of candles and fire) and beliefs (such as the claim to spiritual gifts such as divination, healing, prophecy, and interpreting and speaking in tongues) could be justified by Biblical references, but clearly departed from the teaching of sectarian missionaries. (Gardner 1971[1873]:357-8; Curtin 1955:33-5; Hogg 1964:109-114). They also "practiced a combination of faith healing and magical curing, anointing the patient's head with oil to the accompaniment of prayer and song by members of the group," a style very reminiscent of current practices (Hogg 1964:114; See Chapter 7).

> When any of the fraternity were confined to their beds by sickness, the minister, or father, as he was usually called, anointed them with oil, in imitation of the anointing of the Saviour by Mary Magdalene, before his crucifixion. The usual method of its application was by pouring it into the palm of the hand, and rubbing it on the head of the patient; the tata, or father, singing some ditty during the operation, being joined in loud chorus by all who assembled to witness the ceremony. (Phillippo 1969[1843]:272)

The Native Baptists had become firmly entrenched by the time missionaries from established sects (Moravians, Baptists, Wesleyan Methodists, Presbyterians, etc.) began to work earnestly in Jamaica. As

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part of their efforts to win converts among the slave population, some of the missionaries, such as the Baptists and the Wesleyans, took on an advocacy role for the slaves. This of course infuriated the planters, who retaliated by harassing the church groups and passing laws which prohibited preaching without a license (Gardner 1971[1873]:346-54). Some of the missionary groups such as the Methodists tried to avoid this conflict by concentrating on the free colored population in the urban areas. Others, such as the Presbyterians and Moravians, reacted by trying to maintain strict standards and tight control over their congregations. Complete acceptance of church doctrine had to be demonstrated before a person was allowed to become a member (Hogg 1964:82-4,87-8).

Still other missionary groups, such as the Baptists, concentrated more of their efforts on the slave groups, and were more interested in gaining as many converts as possible than in maintaining rigid controls. Consequently, acceptance of Christianity by members of these more flexible groups was often superficial. The converts frequently took Christian ideas and fit them into their own African/Myalist framework, producing yet another variety of syncretic mixture distinct from the Native Baptists. These missionary groups utilized what is known as the "class and leader" system, which had been developed in England by the Wesleyans and used also by the Native Baptists in Jamaica. Because the minister was unable to attend to all of the groups under his jurisdiction, "classes" were organized that were run primarily by slave "leaders" who conducted most of the activities, and reported on the conduct of the members. "Tickets" specifying the status of each

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participant were issued. The minister would visit periodically, but the leaders in practice had considerable autonomy. On the whole, these "Baptist Classes" were closer to the European/Christian sectarian end of the religious spectrum than were the Native Baptists. However some had a stronger African than Christian tendency, and many of these became so autonomous that they split from the Baptists and developed into independent groups under the control of the local leader (Schuler 1979b:68-9; Hogg 88-91,115-16).

The Baptist clergy and other missionaries persisted in their opposition to the slavery system, though they sought change through legislative means and lobbying of the British Parliament rather than through confrontation or demonstration. But they could not control the activities of all of their followers. Sam Sharpe,[69] a black Baptist Class leader in St. James, had been organizing slave resistance in the belief that the British King had already abolished slavery but that the planters were keeping this news from the slaves. In the winter of 1831-2, acting independently of the white missionaries, he organized a strike by the slaves. Unfortunately this movement soon got out of his hands and was taken over by a number of Native Baptist groups who turned it into an armed insurrection. This tragic course of events culminated in vicious reprisals against the slaves, as well as persecution of the missionaries who were suspected of instigation. The rebellion became known as the Baptist War, or Christmas Rebellion, but is known more frequently now as the Sam Sharpe Rebellion. This event bolstered

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[69]Since Independence Sam Sharpe has been elevated to the status of National Hero.

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abolitionist efforts in England, and Emancipation was granted in 1834. But "full freedom" did not come until 1838, following an "apprenticeship" period. (Alleyne 1988:90-1; Patterson 1967:280; Gardner 1971[1873]:270-86,361-5; Curtin 1955:83-9)

During the early nineteenth century the Myalists had emphasized their anti-white/anti-slavery orientation, but following Emancipation they became more and more caught up in anti-sorcery efforts. While the Myal leaders did continue their private "Obeah"-like work, which consisted primarily of healing and the counteraction of sorcery, they began to openly try to distinguish themselves from Obeah practitioners who were unaffiliated with cult groups.

Myal Men of this period developed a variety of ritual techniques used communally for counteracting Obeah and evil duppies. They became adept at ceremonially locating and digging up buried Obeah bundles. They supposedly had the power to cure "shadow loss", an affliction that had become near-epidemic, by locating the person's "shadow" (spirit), which had been captured and nailed to a silk-cotton tree by an evil sorcerer, and returning it to the owner. They were called upon to attend funerals to capture the shadow (duppy) of the deceased and "lay" it by putting it to rest in a small coffin so it could harm no one. They could also treat illness by removing an evil duppy which had invaded a person's body:

> Ghosts could, for reasons of their own or upon orders from sorcerers, enter the bodies of living persons to cause sickness and death. Techniques used to dislodge them varied considerably. Some Myalists held rites similar to those of shadow-catching, while others extracted snakes, pieces of glass, and other Obeah materials from their patients' bodies in a ceremony resembling the old Myal dance (Waddell, 1863:135-7, 189-91; De Lisser 1913:114-18; Phillippo 1843:248-9). (Quote from Hogg 1964:106)

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If there was an outbreak of misfortune in a community or region, such as a series of unexplained deaths, a Myalist group would be called in to catch and dispose of the duppies that had been causing the trouble. The captured duppies, and those of cult ancestors, were often subdued and put to work by the Myalists in their battle against evil sorcery. The established missionary church sects also preached against Obeah, though their methods and their opposition to all magical practices was of course quite different (Hogg 1964:98-107).

The Great Myal Procession and the Great Revival

Myalist activity experienced a revival following Emancipation (1838) and climaxed in the 1840s and 1850s in what has been called the Great Myal Procession (Hogg 1964:135). The center of this activity was in the northwestern parishes of Trelawny and St. James, but its influence was felt all over the island. During these years there was a great deal of hardship among the poor (See Chapter 3, p. 30), and difficulties were increasingly attributed to sorcery. The Myalists responded to this with increased anti-Obeah activity, even to the point of persecuting those Obeah practitioners whose work had been mainly positive. They attracted more followers and stepped up the intensity of their shadow-catching ceremonies. The Myal religion became a millennial movement not unlike the witch-finding cults that crop up periodically in West and Central African cultures in times of stress (cf. Mair 1969:66-9,172-7). The upsurge in anti-sorcery activity and the growing, mutually reinforcing, fear of ghosts and sorcery spiralled periodically into a veritable frenzy which spread out in waves across the island.

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Despite the illegality of Myalism, there were major surges of Myalist activity in 1841-2, 1846, 1848, 1852, 1857, and 1860. The excitement was picked up and carried on by various Christian groups as well, especially the Baptist Classes, who mixed more of the Myalist elements into their own practices (Hogg 1964:135-9: Curtin 1955:169-70).

The Myalists in turn had adopted some Christian symbolism by this time, and actually began to see themselves as a Christian movement of the highest order. "The Myal task, they preached, was to clear the land for Jesus Christ, who was coming among them..." (Schuler 1979b:72). However, even though they used Christian phraseology, their ideology and techniques were still fundamentally more in line with African traditions. They believed that, "all misfortune ... stemmed from malicious forces, embodied in the spirits of the dead. The Myal organization provided specialists -- doctors -- trained to identify the spirit causing the problem, exercise [sic] it, and prevent a recurrence. All problems were thought to stem from spiritual sources and required the performance of the appropriate ritual." (Schuler 1979b:67).

Although they now used the Holy Spirit and Angels in their work, and placed a greater emphasis on the issue of sin, the Myalists also continued to use spirits of the dead to aid them in their task:

> Through visions and glossolalia these spirits transmitted revelations from God, and by possessing their members enabled them to effect their cures (Waddell 1863: 188-94; Buchner 1854:140-2). The performances opened and closed with Christian hymns and prayers, but there the resemblance to church meetings ended. Participants sang and danced, and fell into violent trances which involved rapid spinning, tree climbing, self-flagellation, and other strange antics. Blood sacrifices, particularly of fowls, occurred at most ceremonies (Gardner 1909: 459-69; Banbury 1895:20-2). When Obeah men believed to be sorcerers were caught, they

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> received severe physical punishment. (Quote from Hogg 1964:137).

To the sectarian missionaries, whose influence was waning, this unorthodox religious activity was disheartening, as it represented a failure of their efforts. They took some encouragement, however, from the revivalist movement which swept through America and Britain in 1858-9. "They began to promote revivalism in Jamaica by increasing the intensity of their sermons, holding special meetings, and begging their followers to receive the Spirit of God." (Hogg 1964:139). The revivalist movement in Jamaica caught on first among the Moravians in St. Elizabeth in the fall of 1860, but rapidly spread to the rest of the island. Unlike the Myalist movements which preceded it, the Great Revival in Jamaica started out as a sectarian Christian movement. Only later, when it was picked up by the Native Baptists and Myalists, did it take on African/syncretist characteristics, much to the disappointment of the sectarian missionaries. As one put it:

> Like a mountain stream, clear and transparent as it springs from the rock, but which becomes foul and repulsive as impurities are mingled with it in its onward course, so with this most extraordinary movement. In many of the central districts of the island the hearts of thoughtful and good men were gladdened by what they witnessed in the changed lives and characters of people for whom they long seemed to have laboured in vain; but in too many districts there was much of wild extravagance and almost blasphemous fanaticism. This was especially the case where the native Baptists had any considerable influence. Among these, the manifestations occasioned by the influence of the Myalmen...were very common. (Gardner 1971[1873]:465)

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The Myalists and Native Baptists picked up this fervor and the "wild extravagances" became wilder as the movement progressed.[70] Although both of these groups maintained their belief systems, their reliance on charismatic elements intensified. "There were oral confessions, trances and dreams, 'prophesying,' spirit-seizure, wild dancing, flagellation, and mysterious sexual doings that were only hinted at in the missionary reports." (Curtin 1955:171). During this period of the Great Revival, both Native Baptists and Myalists started calling themselves Revivalists, and the distinctions between them blurred as the number and variety of local cult groups rapidly expanded. The growth of charismatic groups represented a loss for the missionaries, whose congregations dwindled after the fervor of 1861 had subsided (Curtin 1955:171-2).

The effects of the Great Revival are still being felt today. It provided the environment and impetus for the development of religious patterns which have evolved into the forms we find in present-day Jamaica. And it led to an amalgamation of Myalist, Native Baptist, and

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[70]Revivalists today still make clear reference to this period of 1860-1861 in which the fervor of the Revivalist movement intensified progressively. The terms "'60" and "'61" are used to designate the "level" one is "moving on" while possessed by the Holy Spirit. The '60 level is felt to be "God's level," the rightful place for Christians. On the other hand, '61 is believed to be the level on which duppies and evil spirits move. Those who seek possession by evil or non-Christian spirits are said to "jump '61." This latter term is usually used by Revivalists in reference to the practices of Pocomanians (See p. 237). But according to my informants, even strict Christian Revivalists are sometimes taken by the Holy Spirit to the '61 level so they can be taught "the difference between good and evil," and so they can be shown how to fight evil spirits. (A more detailed explanation of the origins of this terminology can be found in Hogg 1964:145.)

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sectarian Christian elements into what has become known as Revivalism, still one of the most active religious movements in Jamaica.

The years following the Great Revival saw a continued proliferation of independent Revivalist groups, each under the guidance of a charismatic leader. The more stable of these provided an axis of political leadership representing the interests and frustrations of the lower classes.[71] The Anglicans and Catholics, who had been closely associated with the upper classes, finally began to make some efforts to recruit members from the lower classes. There was also an influx of other missionary churches from abroad (e.g. Quakers, Seventh Day Adventists, Congregationists, Jehovah's Witnesses, etc.), though the most successful of these later arrivals were the Pentecostal churches (e.g. Church of God, Church of Christ) whose emotional orientation appealed to the lower classes and whose organization allowed for more local autonomy. Because of this they, like the Baptists, produced a number of splinter groups as local leaders incorporated African/Myalist elements and broke away with their congregations to become independent (Hogg 1964:145).

The propagation of new sects and cult groups fostered a competitive atmosphere in the world of Jamaican religion. The heads of these groups sought new ways to attract followers, for their prestige and influence were directly proportional to the size and loyalty of their congregation. One of the most successful means of attracting new members was to offer practical benefits in addition to spiritual

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[71]For example, Paul Bogle, the leader of the Morant Bay Rebellion (See Chapter 3, p. 30), was a Native Baptist preacher.

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inspiration. Although healing had been a part of lower class Jamaican religious experience since the earliest days of slavery, during the late 1800s and early 1900s it came to play a central, and sometimes dominating, role. Huge cult followings built up periodically around especially successful charismatic healers. Some of these healers used traditional methods taken from Obeah and Myalism while others developed new techniques (Hogg 1964:146).

In the 1870s and 80s a preacher/healer named Stewart, known popularly as the "Haddo Doctor", was the most popular Revivalist in Jamaica. He had a healing encampment ("balmyard") where he treated thousands primarily with spiritual healing techniques, though he also dispensed herbal teas to the sick (Elkins 1977:3-4).

By the turn of the century the most famous and influential Revivalist was a man named Alexander Bedward. His early life was undistinguished, but after receiving a vision while in Panama[72] he returned to Jamaica where he became one of the founding members of the newly-formed Jamaica Native Free Baptist Church. This sect, based in the poor Kingston neighborhood of August Town, was established in 1889 by H.E. Shakespeare Woods, "a black man from America who gained fame as a prophet while living in a cave." (Elkins 1977:4). As Wood's appointed successor, Bedward assumed leadership of what was a local group and turned it into a national movement with missionary outposts as far away as Central America (Hogg 1964:147). Bedwardism was anchored in the Revivalist tradition and in turn his movement had a great influence

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[72]Employment opportunities in Panama (on the railroad and canal projects) attracted large numbers of Jamaican workers from the 1860s to 1930s (Black 1973:134-5).

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on the development of modern Revivalist forms. His fame and following came primarily through his healing powers.

In 1891 he received another vision telling him that the waters of the nearby Hope River could be used for healing. His healing work began on a small scale, starting with a jar of water from the river over which he fasted and prayed, and which he then used to cure a woman who had been sick for many years. As others heard of this more and more sick people with every complaint imaginable came to him for help, and apparently he was successful with many of them. Soon after this he received a vision telling him to convert the whole of the Hope River into a healing stream. He began conducting healing services at the river every Wednesday morning, during which he "walked to the river with his followers, delivered a sermon to the multitude, and blessed the waters, inviting people to bathe, drink, and be cured" (Elkins 1977:11). These gatherings attracted crowds of up to 12,000 people and won him a large following among the lower classes (Elkins 1977:11).

The established churches and the authorities were alarmed by Bedward's anti-establishment preaching and the excitement he whipped up in the masses. He was arrested and tried for sedition, but acquitted on the grounds of "insanity". Soon he was back at the head of his flock. Assuming the title of Shepherd, over the next three decades he built his organization into the largest Revival sect in Jamaica. At its peak he claimed 7,000 followers island-wide, and had branches as far away as Cuba and Central America (Elkins 1977:11-15).

Bedward's downfall came when his zeal began to outstrip even his own spiritual gifts. He had at various times claimed to be the

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reincarnation of different prophets, such as Moses and John the Baptist. In 1920 he announced that he was the incarnation of Jesus Christ, and instructed his followers to call him "Lord." He told them that God was going to call him to Heaven and he set the date for his ascent as the last day of that year. Thousands gathered on the fateful day, many having quit their jobs and sold their possessions, intending to follow him. When the appointed time came and went without the expected miracle happening, he announced that God had decided to postpone his call so he could lead his flock for another 17 years. (Elkins 1977:15-16; Hogg 1964:149; Beckwith 1929:168-171) This aborted ascension damaged his reputation and popularity, but he maintained a loyal following.

After enduring continued harassment by the government, Bedward led a march of 700 people into Kingston in April 1921. Alarmed by the growing intensity of his movement the authorities arrested him and had him committed to the Lunatic Asylum, where he died in 1930, "reportedly patient and unassuming until the end." (Elkins 1977:17). Deprived of its leader, his movement dwindled, though a small group of committed followers carried on in August Town for many years afterwards (Hogg 1964:149).

There were a number of other charismatic preacher/healers who gained wide followings during the early twentieth century. At the turn of the century Charles "Warrior" Higgins, another Revivalist leader, treated patients with herbal tonics in his "Millennium Hospital" in Kingston (Elkins 1977:22). "Doctor" David Bell treated thousands at his balmyard in May Pen and later in the Kingston Shanty Town of Smith Village (Elkins 1977:42-46). In St. Elizabeth, Mother Forbes was known

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throughout Jamaica for her "balm" healing. After her death, her balmyard was kept up by her daughter, Mother Rita, who succeeded her as the most influential healer in the parish and who was active through the 1960s (Beckwith 1929:171-173; Long 1973:88-110).

Throughout this period there was a continuation of the general pattern of a plethora of independent groups connected loosely by shared patterns, irregular intercommunication, and common identification. There were many groups which arose, flourished, and then faded without leaving a record behind, so we must rely on snippets of information and extrapolation to trace the complex evolution of contemporary religious patterns. Even today it is difficult to construct a precise model of current patterns of religious organization because of the wide variations among groups, the mixing of different forms within individual groups, and the ambiguities in descriptive terms. Foreign influences at various points further complicate the picture.

Zion Revival ('60 Revival) and Pocomania

Around the turn of the century we can see the origins of the two Revivalist groups which became most widespread in later years: Zion Revival and "Pocomania."[73] Of the two, Zion Revival continued the

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[73]This term, like "Obeah" is extremely ambiguous, confused, and value-laden in popular use. It's origins are obscure. Some have traced it to the Spanish ("little madness") but this is probably incorrect. Beckwith (1929:176) refers to the group as "Pukkemerians" and suggests the term arises from the phrase "pick-them-here" which would refer to the finding of buried Obeah objects. Others have suggested that the word should be spelled "Pukumina" or "Pukkumina" which would suggest that it is a variation on "Kumina," (Alleyne 1988:96; Seaga 1969:2), and thus would give it an African origin (Cassidy 1961:235). There is no evidence currently available that could settle this matter one way or the other.
(continued...)

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overall long-term trend of Jamaican folk religion towards sectarian Christian patterns, while Pocomania remained closer to the Myalist/African tradition. They do however share a number of features with each other, and with preceding forms.

Pocomania seems to have had its primary origins in Myalist groups but it had some Native Baptist influences as well:

> The post-emancipation Myal procession was apparently directly ancestral to it, judging from similarities between the two. Members themselves trace Pocomania back to the Great Revival, and it was during the later, more esoteric phases of this movement that the cult acquired many of its modern characteristics. Its subsequent development by-passed the sectarian Bedwardite movement that influenced and lent prestige to Zion Revivalism. (Hogg 1964:154-5).

There is some evidence that Pocomania developed in the rural parish of St. Mary where it first came to public attention in 1909, and later spread to the neighboring parishes of St. Ann and St. Catherine (Elkins 1977:30-1). However, there is insufficient evidence to draw definite conclusions about this. According to newspaper reports of the day (1909), "At meetings members tore their hair, beat their breasts and indulged in 'weird' ejaculations. They also emitted a barking sound which reportedly distinguished the new religion from its predecessors." (Elkins 1977:30). While this description is obviously biased, it touches upon some of the essential elements of the Pocomania "style" of worship.

The central feature of Pocomania services is spirit possession. While this is found in Zion Revival as well, what distinguishes

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[73](...continued)
Here I use the spelling "Pocomania," mainly because this is how the term is pronounced by most Jamaicans. In popular usage the term is sometimes shortened to "Poco,'" which has a slightly more derogatory connotation.

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Pocomania from the latter is the types of spirits which manifest themselves through the cult members. In Pocomania the spirits called upon are primarily "Earthbound" spirits (especially "Fallen Angels," which are not considered evil in the Pocomanian pantheon), and "Ground" spirits, which are ghosts (usually of former cult members). These spirits are felt to be "closer" to humans and more responsive, and thus more useful, than the "Heavenly" spirits (The Triune God, Archangels, Angels and Saints). Zion Revivalists, on the other hand, typically deal only with the "Heavenly" and non-satanic "Earth" spirits (e.g. Apostles and Prophets). They consider the "Fallen Angels" and "Ground" spirits to be evil and useful only for purposes of sorcery (Seaga 1969:10-11).

It is not surprising, then, that Pocomania groups have gotten a reputation for "devil worship." Among most Jamaicans the term "Pocomania" has taken on a derogatory meaning, and Pocomania followers often deny that they are such, preferring to just call themselves Revivalists. This has further added to the confusion about what Pocomania really is, how it resembles or differs from Zion Revival, and the extent to which it is still practiced. Despite the stereotypes, "the general belief in a mythical cult of malevolent devil-worshipers" is unfounded. Like the practice of sorcery, it is more myth than reality. "The investigator can never find them, just as he can never meet real sorcerers." (Hogg 1964:157).

In order to attract members, Pocomanians adopted a dramatic and showy style which incorporated spectacles, parades, wild possession states, and flashy costumes. Some groups even began using the ghosts of other ethnic groups, e.g. East Indian, which attracted large crowds with

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their bright costumes and flamboyant dancing (Hogg 1964:157-8). In modern Jamaica, though, in which upward mobility is both more available and more sought after by the lower classes, this type of activity has become less attractive and less adaptive. Consequently, the popularity of Pocomanian cults has declined.

Pocomanian Revivalism today is primarily an urban phenomenon, with its focus in Kingston. It has virtually died out in most other areas (Hogg 1964:155), and can no longer be found in eastern St. Thomas. In his study of religious groups in St. Thomas in 1950-51, Joseph Moore reported that the Pocomanians in St. Thomas were in small, itinerant, "deviant"[74] groups and were dwindling in number. By the time of this study (1987-88), I was unable to locate any such groups in the research area, and was told by informants that there were none. I was told that one must now go to Kingston to find "'61" Revivalists (a term used as the equivalent of what we've been calling Pocomania); only "'60" Revivalism (Zion Revival) can be found now in St. Thomas (See Footnote 70). This is probably true for most of the rest of the island as well.

Zion Revival, as described by Hogg (1964), Seaga (1969), Moore (1953), Simpson (1956), and Moore and Simpson (1957-8), lies further towards the European/Christian sectarian end of the spectrum of religious practice, as opposed to Pocomania's more Myalist/African orientation. It appears to have been influenced by the "Holiness" movement which arose in the United States after the Civil War:

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[74]In his judgement of Pocomanians as deviant devil worshippers he was probably misled by value judgements made by informants, as discussed above (cf. Hogg 1964:157).

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> Combining ascetic denial and enthusiasm, it [the Holiness movement] reacted against the 'worldliness' of institutionalized religion. It stressed the desirability of achieving 'sanctification' -- interpreted as an instantaneous cleansing from sin through baptism with the Holy Spirit. The 'left wing' of the movement emphasized, in addition, divine healing, premillennialism and speaking in tongues. Some 'radical' Holiness preachers also believed in multiple baptisms, if needed. (Elkins 1977:26)

The Holiness movement, which later gave rise to Pentecostalism, was strongly influenced by men like John Alexander Dowie, an American preacher/faith healer who founded the Christian Catholic Church (popularly known as "Zion") in Chicago in 1896. The movement was brought to Jamaica when the Rev. Isaac Tate founded a branch of this church in Jamaica in 1901. He promulgated Dowie's brand of healing and charismatic religious experience. Other strong influences on Zion Revival were the Church of God, from Toronto, which arrived in 1904, and the Salvation Army which established itself in Jamaica during the period from 1887 to 92. All of these groups were strongly invested in faith healing (Elkins 1977:26-29).

Around this time there arose a group of itinerant revivalists who, apparently influenced by the Holiness people, began calling themselves "Zion." They are known to have been present in St. Catherine in 1905, but supposedly originated earlier in Manchester (Elkins 1977:30-31). This unorthodox group (they disavowed marriage, and baptized seven times) may have been the precursor to the itinerant "Revival Zion" bands that Moore found in St. Thomas in 1950 (Moore 1953:56-58), and the Revival groups that Hogg studied in St. Mary in 1955-56 (Hogg 1964:244-61). However, we have no clear proof of this.

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In 1906-7 there was another widespread revival movement in Jamaica which was strongly influenced by groups such as the Salvation Army. One of its main leaders was W. Raglan Phillips who left the Salvation Army to head the movement. He formed an organization called the "Revival League" and edited a newsletter called the Revival News (Elkins 1977:30). In addition to Bedwardism, this movement probably had a strong influence on what became the main stream of Revivalism in Jamaica: Zion Revival (a.k.a. Revival, or Revivalism). As a means of attracting more followers, these groups adopted some of the Salvation Army practices such as drumming,[75] holding street meetings, and some techniques of faith healing. It also borrowed from other sources as well. For example the use of colorful ceremonial turbans seems to have come from East Indian influence (Hogg 1964:153).

Revival, or Zion Revival, is similar to Pocomania in many ways, but differs in having a much more Christian and Biblical orientation. Thus it appears to be closer in its origins to the Native Baptist movement than to Myalism. Services are oriented around sermons, Bible readings, and Christian hymns. Zion Revivalists believe in a "Triune" God, but also acknowledge the existence of a variety of other spirits, both good and evil. Spirit possession is a desired state, but as mentioned above, only "Heavenly" spirits (primarily the Holy Ghost, but also Angels) and positive "Earthbound" spirits are welcome; other

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[75]While drumming in some cults, such as Kumina, is clearly African in origin, the drums and the style of drumming used in Zion Revival are more closely related to European and American styles, and were probably picked up from the Salvation Army. Nevertheless, while Revival drumming is technically probably not an African "survival," the widespread inclination among Jamaicans to use drumming in religious practice may be a derivative of African religious traditions.

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spirits that try to attend are driven off. The possessing spirit often becomes the guardian and teacher of the person involved, and during possession states individuals may go on a "spiritual journey" in which they are given special knowledge and "gifts". Revivalists believe that spiritual gifts are bestowed according to one's level of spiritual advancement. These gifts include Prophecy, Speaking in Tongues, Preaching, Interpretation, and Healing (Hogg 1964:244-61; Moore 1953:69-113; Seaga 1969; Simpson 1956; cf. Bible 1 Corinthians:12).

In Moore's day (the late 1940s and early 1950s) Zion Revivalists had a complex hierarchical organizational structure, used colorful costumes, constructed elaborate altars and "tables" for their services, and held services in a specially constructed "booth" rather than in a regular church building (cf. Moore 1953:69-113). Since the 1950s, all of these characteristics have changed considerably, all in the direction of moving to simpler forms, and towards the adoption of sectarian Christian practices. Revivalists now hold their services in a church building, use less elaborate ritual and symbolic forms, and have less complex possession behavior. The changes that have occurred seem to have been the response of these groups to changing social conditions, and thus can be seen as adaptations fostered by certain selective pressures. In particular, it seems that in order to maintain themselves by attracting new, especially young, members, these groups have had to adopt forms that are more "in tune" with the ambitions and self-image of young people growing up in an independent and modernizing Jamaica. In making these adaptations, Revivalism has managed to remain an active and

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vital movement, while Pocomania, which was not able to adapt as well, is dropping from the scene.

Yet many of the essential elements of old-time Revivalism have been preserved. Of these the most important is Healing. It has always been thought of as a very useful and practical benefit of Revival participation and it continues to be so today. Healing services are always the best attended, and many new recruits get their first exposure to Revival churches through these services. Children and babies, considered to be especially vulnerable to the influence of evil spirits, are frequently taken to Healing services, so they early on become accustomed to the activities of Revivalism. The spiritual gift of Healing is an important milestone in the spiritual development of a Revival leader, and it is necessary to have some healing skills if one is going to be able to successfully lead a church and attract followers. Thus virtually every Revival church has a Healer and conducts regular Healing services.

Today Zion Revival, or "'60" Revival[76], has continued to grow[77],

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[76]Moore (1953) used the term "Revival Zion" (as opposed to "Zion Revival") to refer to small itinerant bands in St. Thomas that held services at the roadside or in private yards. He considered them, like Pocomanians, to be an offshoot of the main Revival group that he found in St. Thomas. In my fieldwork I neither saw nor heard of any such bands, and they probably no longer exist. (Many congregations with regular places of worship will hold occasional street meetings to recruit new members.) Here I use the terms "Zion Revival" and "'60 Revival" to refer to the brand of Revivalism that persists in St. Thomas today. This is probably a direct descendant of the "Revival" that Moore studied in St. Thomas in 1950-51, and related to the "Zion Revival" that Hogg studied in St. Mary in 1955-6. Hogg (1964) and Seaga (1969) considered Revivalism as a whole to made up of two main branches: Zion Revival and Pocomania, and the '60 Revival of St. Thomas today is most closely akin to the former.

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and remains a vital force in the religious life of the Jamaican lower class. It is somewhat misleading to speak of it as one group or one style of worship, because it is in fact made up of a multitude of independent groups each with its own leader and idiosyncracies. Some of these in fact may mix elements from a variety of sources, e.g. Pentecostalism and Revivalism (cf. Dreher 1969). Some of these Revival churches may be linked together by membership in a common "body", such as when a successful local leader sets up branches in other districts, or when a local church affiliates with an international organization. But even in this case the local congregations have a great deal of autonomy.

Despite the overall picture of heterogeneity, however, there is also a surprising amount of consistency among these groups. The commonalities among them apparently emerge and are perpetuated through a remarkably vigorous network of formal and informal interaction among the different groups. There is constant visiting between the different congregations usually in the form of delegations sent to visit special functions (e.g. conventions, fund-raising events, special services, etc.) at other churches. While these visits are usually local, they may involve long journeys, especially if the leaders of the two churches

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[77](...continued)

[77]Because Revivalism is not considered an official denomination for census purposes, it is not known how many Revival adherents there are or how this number has changed over time. There has been a general societal trend, however, away from the conservative established denominations (e.g. Anglican, Methodist, Baptist, etc.) and towards the more charismatic denominations (Church of God, Pentecostal, etc.). It is likely that Revivalism has shared in this trend and gained adherents as a result (Stone:1988; Statistical Institute of Jamaica 1986b:26). It appears that many Revivalists will report their denomination to census takers as one of the more established churches so as not to admit to lower class status.

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have a friendly personal relationship. The visiting follows a reciprocating pattern. A group which visits the convention of another expects a return visit when they hold their own convention. It is a mark of prestige for a church leader to be able to attract a very large crowd of visitors, especially from far away, for a special event such as a convention, as it is a measure of his or her influence and renown (cf. Dreher 1969:170-1). Thus, by organizing frequent delegations to visit functions at other churches, a leader can assure himself or herself of a large number of visitors at important functions at their own church.

Kumina

Another major religious cult, peculiar to St. Thomas, in which healing plays an important role, is the Kumina[78] cult. This is an ancestor worship cult apparently derived from Central African (Kongo) cultures. The ideology, symbolism and rituals of this group are among the most clearly African survivals that can be found in Jamaica. Because of this, some have assumed that its origins must be as old as the earliest slave arrivals (e.g. Patterson 1967:200-1). There is, however, no clear evidence for this assertion. Rather, it was probably brought in by later immigrants. Kumina seems to have developed among the Central Africans who were brought into St. Thomas as indentured

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[78]Cassidy (1961:235) attributed the word Kumina (sometimes spelled Cumina) to a derivation from the Kimbundu (Angola) *kumona*, "to see, possession." Later he postulated an origin from the Twi root *kom*, meaning "frenzied dance" (Cassidy and LePage 1967:267). It may also be related to the Kikongo word *koma*, "to hammer," which might refer to drumming (MacGaffey 1986:159; Janzen and MacGaffey 1974:85). "Knock de drum" is the expression used informally by participants to refer to the Kumina ceremony.

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laborers during the 1840s to 1860s (after Emancipation). Its participants seem to be drawn primarily from the descendants of those Africans (Schuler 1980:70-2). It remained an ancestor cult and its cosmology, symbolism, and practices appear to have been derived directly from Kongo culture. Although it seems to have persisted relatively intact up until fairly recently, there apparently has been some cultural interchange with Myalist and Christian groups. For example, many of the spirits (zombies) in the Kumina pantheon are Biblical figures (Moore 1953:165).

The Kumina cult is based on a cosmology in which a hierarchical pantheon of spirits, known as *nzambi*[79] (or "zombies" as Moore spells it), takes an interest in and influences everyday events. Contact and communication with these spirits is accomplished through Kumina ceremonies, in which drums are used to call the spirits who then possess the dancers. The pantheon includes several levels of spirits. "Sky gods" are the most powerful, but are the least interested in human affairs. They come to Kumina ceremonies but usually do not possess dancers. "Earth bound gods" are unable to leave the earth. They may possess dancers and are sometimes used by Obeah Men in "private workings." The lowest in rank, and the most closely involved in human affairs, are the "ancestral zombies." These are ghosts of former cult members, all of whom come to possess dancers, and which may also be used

[79] *Nzambi* is a Kikongo word meaning "spirit," and is used to refer to all spirits in their pantheon, which corresponds closely to the Kumina pantheon (Schuler 1980:152; MacGaffey 1986:6,75; Janzen and MacGaffey 1974:14).

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by Obeah Men. Many of these were known to cult members when they were alive (Schuler 1980:72-3; Moore 1953:164-6).

Kumina adherents have a dual soul belief akin to that of African cultures, and other Jamaican groups. According to their belief, when a man dies his "spirit" (which includes his personality) goes to *Nzambi Mpungu*, the highest *nzambi*, but if the person has been possessed in life at a Kumina they can return to earth to participate in Kuminas and fulfill other purposes. The "shadow" on the other hand, lingers at the grave, which it may leave to cause trouble if proper burial rites have not been performed. Thus proper funeral rituals, and communication with dead ancestors through the Kumina ceremonies, are essential in Kumina belief and practice. Nzambis are not only able to help the living, but are able to cause trouble as well, for example if their needs are not met, or if the family behaves against their wishes. Thus a proper and reciprocal relationship with the dead is essential for success and prosperity (Schuler 1980:72-3).

Kumina rituals, then, are mainly focused on the transition of a dead person into the spirit world. Most frequently they are performed as memorial services for a recently deceased person, and at certain specified intervals after the death. For example, many ancestral spirits require their descendants to perform a yearly memorial Kumina.[80] Kuminas also take place at other important life transitions (birth, naming of a child, betrothal, marriage), at major holidays (Christmas, Emancipation Day, Independence Day, etc.), and sometimes for

[80]Many people from St. Thomas who have migrated abroad will return each year to hold such a Kumina, so as not to provoke the anger of their ancestors.

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specific tasks (e.g. healing, divination, sorcery, etc.) in which the assistance of the ancestral spirits is desired.

Moore found the Kumina cult to be extremely active in St. Thomas during his study (1950-1) (Moore 1953:114-5). There were at that time frequent and very large Kumina ceremonies given throughout St. Thomas. He was able to collect a wealth of data about the complex cosmology and ritual practices of this group (Moore 1953:114-179). Today the Kumina cult is still active, however, it appears to be much less so now than it was during the 1950s, at least in the Albion area.[81] The number of devout cult members seems to have dwindled, such that the Kuminas which are held today are less complex and elaborate than those that were held during Moore's time. For most people Kumina has come to be more of an entertaining diversion than a religious institution, yet in that regard it still fulfills some important social, familial, and personal functions. Thus while it is still a popular activity, its character appears to be changing steadily. The use of Kumina for healing will be discussed in more detail in later chapters.

Obeah and "Science"

The issue of Obeah was discussed earlier in this chapter. Because of its clandestine, secretive, and indeed illegal, nature, we have very little accurate information on how Obeah developed in the years following slavery. As discussed earlier (See p. 215), Obeah, considered as evil sorcery, has probably never been as widespread as is commonly

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[81]It is said that the Kumina cult is more active and intact in some other parts of the parish, e.g. in some of the districts to the north and northwest of Morant Bay, but I was not able to verify this.

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believed. There have been occasional cases where individual "Obeah Men" (or Women) have been caught and prosecuted[82], though the frequency of such arrests of course depends on the vigor with which anti-Obeah laws are being enforced at any one time. The laws are vague enough to allow prosecution for a variety of occult practices. There have been some cases reported in which individuals have admitted to using their magic to kill and injure (e.g. Williams 1934:126-7), though these reports are difficult to verify. Nevertheless, they are probably deviant examples, which stem from popular myths and which reinforce public fears of sorcery, much as the anti-Obeah laws themselves do.

In the years during and following slavery, "Obeah" came to take on a negative connotation, though the slaves continued to support some of its anti-white/anti-slavery functions. It was blamed by many for misfortunes of all sorts. Thus it is not surprising that practitioners interested mainly in healing and assisting people in their life problems, would disassociate themselves from the term "Obeah." And in many cases they would use their own work to oppose evil sorcery. This appears to have been the origin of the Myal Men and Women, who performed private magical services in addition to leading cults whose function was to a large extent focused on anti-Obeah activities. A positive practitioner who remained in strictly private practice might be known locally as a "Healer," or perhaps might still called "Obeah Man," though the local folk would know that they were not of an evil persuasion. The private/public practice of the Myalist type of practitioners has

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[82]For example, a number of cases are cited in Williams (1934:124-36). Many of these, however, are actually cases of healing performed by magical means and thus should not be considered as sorcery.

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continued up to the present day in the tradition of Revivalist healers, who in addition to their church activities often perform magical services in private.

The tradition of the strictly private, non-cult-connected practitioner has survived as well, though this institution has undergone some interesting changes. During the twentieth century a different style of practice, known as "Science" has developed and largely supplanted the traditional African Obeah. Science is based on European traditions of magic learned through the use of books imported (illegally) from the United States or Britain. In the past they were obtained most commonly from the DeLaurence company in Chicago, though nowadays books and materials are often brought back from bookstores and occult shops in New York and London as well. While the traditional African-derived Obeah practice typically involves the use of exotic natural materials and the invocation of spirits (duppies) to perform tasks, "Science" is based more on sympathetic magic and uses a variety of prepared materials (oils, powders, incenses, etc.). Both styles, however, make use of herbal treatments.

We know that the practice of Science had begun as early as the 1930s, and probably some time before this (Williams 1934:135 cites a case). Hogg, writing in 1961, reports that Science had by that time begun to replace Obeah in urban areas, while the latter had continued to hold sway in the more rural areas (Hogg 1961:1-5). Today it appears that the traditional African-style practice of Obeah has for the most part died out, though some aspects of it continue in the repertoire of the Science Men. "Science" today is utilized not just by the Science

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Men, but is actually one of the techniques used by many of the Revival/Balm healers in their private work.

Of course, adoption of a term like "Science" for such a practice has a number of advantages. Not the least of these is the removal of much of the stigma associated with the term "Obeah," which today is almost synonymous with evil sorcery. "Science" connotes a technologically advanced, tested, and effective system -- which fits in well with the public image desired by such practitioners. Nevertheless, because of its ancestral links with Obeah, and its similar potential for evil-doing, the term "Science" has also recently come to have negative connotations. Most practitioners prefer to be known as "healers" which has a more positive implication, and perhaps describes their actual role more accurately.

There are two other cult groups which are, or have been, present in St. Thomas, but I will only mention them briefly here because they do not figure significantly in the folk healing system of eastern St. Thomas today.

Convince

A group which Moore found to be active in St. Thomas in 1950 is the Convince cult (also known as Convince Flankey, or Fankee) (Moore 1953:58-60). At that time it was a much smaller, and more loosely organized, group than the Kumina cult, and it appears now to have dwindled, if not disappeared altogether, in eastern St. Thomas. I did not witness or hear of any Convince ceremonies being held near Albion during my research and I was told it was no longer present in the area.

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The little information we have on this group comes from Moore (1953), and Hogg (1960; 1964:262-75). The latter observed some ceremonies in St. Mary in 1956. This cult apparently was found only in St. Thomas, Portland and eastern St. Mary, and according to Hogg probably originated among the Maroons. However, we have no definitive evidence of its origins.

The term "convince" was used by early Native Baptists to refer to spirit possession (Gardner 1971[1873]:357). In the 1890s a group of Myalists in Hanover who claimed to be able to cure with blessed water and counter all Obeah called themselves the "Convinced Doctors" (Elkins 1977:4), but it is unclear whether they might have had any link with the eastern Convince cult. Most likely the Convince cult developed in the eastern end of the island through a combination of African, Myalist, and Maroon influences. On the traditional African/European Christian spectrum, Convince falls somewhere between Kumina, the most purely African, and Pocomania which is more Christian-influenced.

Convince resembles Kumina and Pocomania in that it attempts to communicate with, propitiate, and influence spirits of the dead (mostly former cult members) through spirit possession in special rituals. Adherents of the cult are known as Bongo Men, and they gather together periodically to hold Convince ceremonies. Each ceremony is hosted by an individual Bongo Man to enhance his power and status, and others attend out of reciprocity. Thus they are organized only loosely. Some of the ceremonies are performed for specific practical purposes, e.g. curing, setting a duppy on a thief, etc. (Hogg 1960:7-8).

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Convince ceremonies involve animal sacrifices, and much singing and dancing, but no drumming. The behavior of the possessing spirits in Convince is much more violent, vulgar, and sexually explicit than is found in Kumina or Pocomania. Thus the ceremonies are very entertaining, and that seems to be one of their main attractions and purposes (Hogg 1960:12-19). The "Bongo" spirits are very defiant, individualistic, and human-like in that they each have a particular personality, are mainly interested in self-satisfaction, and are capable of evil as well as good (Hogg 1960:6).

Their relationship with these spirits is very important to the Bongo Men them as it is their source of luck and power. The relationship is a reciprocal one. In return for ritual sacrifices and the use of the Bongo Man's body in ceremonial possession, "the ghosts in turn protect him, teach him spiritual secrets, bring him general good fortune, and aid him in working Obeah." (Hogg 1964:7). Most Bongo Men are also "Obeah Men" or "Scientists" and obtain their powers through their relationship with these spirits. Thus Convince plays, or at least did so at one time, an important role in the folk healing system as a source of healing power, and as an ideological system in which some folk practitioners work.

Ras Tafari

Ras Tafari is a cult system which, because of its association with popular music groups and its depiction in popular films, is perhaps the most familiar to outsiders. The Rastafarian system is more than just a cult or religion. It is really a complete cultural system including a

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distinct political ideology, dialect, cuisine, spiritual orientation, and way of life for its members. The Rastafarian movement is centered in Kingston. There are some communal Rasta settlements in St. Thomas, mainly in the western part of the parish. These communes are operated in an isolationist fashion, so they have little impact on the culture of the surrounding area. However, as a national movement Rastafarianism has had a significant impact both culturally and politically.

Rastafarianism characterizes itself as African, and its outward orientation is very much along those lines. In fact it began as a millennial movement among urban ghetto-dwellers seeking repatriation to the African homeland. Ironically, though, despite their African orientation, their religion shows little if any connection with the traditional African patterns that have survived in Jamaica (Hogg 1964:162). They actually show a greater influence from European Christianity and Judaism than from African religion.

The Rastafarian movement began in the ghettoes of Kingston in the 1930s among followers of Marcus Garvey who took literally his prophecy of a "Redeemer" to come in the form of a Black King to be crowned in Africa. Their Messiah is Ras Tafari (Haile Selassie I), the late Emperor of Ethiopia crowned in 1930. In their belief system he came to liberate them and bring them all back to Ethiopia, a vision which has so far been frustrated. They see themselves as the lost tribe of Israel, removed from their Ethiopian homeland and cast into Babylon by their oppressors. From the beginning they took a very anti-white, anti-government stance, which led to persecution of the movement's early leaders by the colonial government. They believe in the sacredness of

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the Bible, but use their own world-view for interpreting it. Among outsiders they are most notorious for their liberal use of ganja (marijuana) as a holy sacrament. (Smith, et. al. 1960; Barrett 1977; Hogg 1964:161-3).

In line with their belief in the purity of natural things, strict Rastafarians eat a vegetarian diet and use only herbs in medical treatment. In addition to ganja they use a variety of other bushes, and in this they basically follow along the lines of the popular use of bush medicines as described earlier.

SUMMARY AND COMMENTS

In order to make sense of the forms and functions of current styles of Jamaican folk healing we must have both an understanding of patterns of Jamaican popular religion, and an appreciation for how religion and folk healing have evolved together. While the history of religious movements in Jamaica is quite complex, there are some general themes and trends which can be discerned. These trajectories of change are a function of both the blend of cultural elements from which they have emanated, and of the selective forces which have channeled them. Examination of the paths these changes have taken reveals, through the impressions they have left, the social forces which have shaped and molded them. An appreciation for these long-term trends and an understanding of the forces behind them also enables us to make some realistic predictions about the courses these institutions are likely to take in the future.

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The two primary sources of popular religion in Jamaica were the religious traditions of Africa, and European Protestant Christianity. While both have contributed to the evolution of Jamaican religion since the earliest settlement of the island, the balance between them has fluctuated over time. During the first century of the plantation/slavery system in Jamaica, from the mid-seventeenth to the mid-eighteenth century, the slaves' religion was a derivative of the African traditions they brought with them from their homelands. The demographics and practical constraints of the slavery system prevented many elements of the African religions from being maintained in the new setting, whittling them to their bare essentials. Those elements which seem to have provided some answer to the social, psychological, and practical needs of the slaves, and which were not easily suppressed by the slaveowners, were maintained and passed on, even after importation of new slaves ended. Although some African traditions were maintained in a more intact form in isolated Maroon communities, these had a limited influence on the society as a whole because of the Maroons' isolation. Later immigration of free Africans during the mid-nineteenth century re-introduced more elaborate and more purely African religious practices (e.g. Kumina) into a few areas such as St. Thomas, and these did have a more profound influence locally.

Those beliefs, practices, and institutions which enabled the slaves to gain a sense of empowerment, in a reality of total disempowerment, were clung to and cultivated. Folk healing beliefs and activities were among those cultural features which added to this

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feeling of empowerment. This came as much through their close connection with religious expression as it did through the practical tasks of diagnosis and treatment of illness. Folk healing and religious activity were for many years the only options available to many people for countering the personal disempowerment brought about by illness or misfortune. The persistence of folk healing in the face of expanding access to other forms of medical care is a testament to the ability of folk healers to address the needs of Jamaicans in distress, and to adapt to rapid social and cultural changes.

While the instrumental efficacy of folk healing techniques is questionable, they offer the distressed individual a means of doing *something* which may be of help when other avenues have been closed. This in itself provides a valuable means of reducing fear and anxiety through enhanced personal control, even if this control may be illusory. In a "hopeless" situation the only other alternative would be resignation and despair. The need for such alternatives is evidenced by the persistence of pluralistic health care systems throughout the world (C.M. Leslie 1980).

Sorcery beliefs are a central part of this cultural system. While in some respects irrational and socially disruptive, such beliefs seem to provide the vulnerable with a powerful means of explaining misfortune, and a vehicle for exerting a personal influence over events. Their potential for causing social disruption is limited by the fact that sorcery accusations are rarely, if ever, made publicly. Sorcery beliefs and folk healing practices each create a need for the other, and

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in this sense have been mutually reinforcing. In the Jamaican context neither could continue to exist without the other.

In addition to addressing profound personal needs, folk healing and religious institutions have served as one of the main forums for social interaction in Jamaica, and as a mechanism for organizing popular social and political movements. Early slave rebellions were often organized and led by Obeah Men, who served as political leaders as well as healers and religious leaders. Later on, more formalized church organizations provided a conduit for organized resistance to slavery and, after Emancipation, to political, social and economic oppression. In recent times other institutions have arisen to take over much of this political role, but religious groups still constitute the principal social organizations in rural areas. Religious leaders and healers are still among the most important and influential leaders in the countryside, as well as in some urban areas.

European/American Christian missionaries did not begin to have much of an influence on slave culture until the late eighteenth century. The planters had no interest in providing education or religious training for their slaves as it supposedly threatened to make them more rebellious and defiant. At the same time, however, missionary groups began to appreciate the potential power and influence that conversion of the slave population represented, and the planters were eventually unable to resist the constant pressure from these groups.

Once these campaigns began, the different factions of missionaries competed with each other to win shares of the market of black souls in the island. Some emphasized gathering as many converts as possible,

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while others concentrated on more intensive indoctrination of smaller numbers. But none of the "established" churches was able to completely win over the hearts and minds of the Jamaican masses. The most successful in this respect were independent groups and spinoffs which answered the needs of the populace on their own terms, enabling them to maintain their spiritual and political autonomy. The slaves, and later the lower classes, always managed to take from Christianity the elements that suited their needs best, and always managed to maintain their independence and control over their religious institutions.

To the slaves, Christianity and its trappings represented one of the main sources of the power and authority of the European slaveowners. But they were willing to accept it only to the extent that it enabled them to share in this power, while resisting it when it threatened to usurp their self-determination. Thus they often adhered to their African traditions while becoming Christians on the surface, where it served them best. This was a never ending source of frustration to the missionaries, as it prevented them from ever gaining complete control over their fold. To a great extent it was out of this tension between power and resistance that syncretic groups arose and flourished, enabling lower class Jamaicans to keep their African traditions and spiritual autonomy while adopting as much of the European Christian heritage as suited their needs. Over the years the mixture of elements in Jamaican popular religion has gradually become more European/American and less African, the latter persisting mainly as underlying orientations and beliefs cloaked in Biblical and Christian symbolism.

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Changing conditions and needs have favored some styles of worship while others have faded, or are fading, away.

Christianity in its Protestant and Catholic forms has always been one of the gateways to the respectability, power, and prestige associated with the higher levels of society in Jamaica. The general trend away from African religious forms toward more European ones has to a large extent been a function of the yearning of the masses to participate in this privileged position. In recent times, the possibility of upward mobility has become a more realistic desire, with the result that syncretic religious forms are moving continually towards mainstream European/American Christian denominations. There continues to be, however, a powerful attraction for charismatic forms of worship, with the result that sects which offer emotionally intense experiences in combination with Christian cosmology and symbolism are currently the most rapidly growing groups (e.g. various forms of Pentecostalism).

The religious institutions which endure in Jamaica today range in a continuum from those with the strongest African and Myalist elements to those based more solidly on European Christianity.[83] While the more African forms have lost ground over time, the basic principles on which they were based (beliefs about the spirit world, use of spirit possession, healing, etc.) continue vigorously, sometimes veiled in Christian symbolism. Healing is one of the key elements which persists actively, attesting to its timeless appeal. Although modern Biomedicine

[83]The groups in St. Thomas would range as follows from the most African to the most European (Those probably not active currently in St. Thomas are in brackets[]): Kumina, [Convince], [Pocomania], Zion Revival, Various Independent Sects, Ras Tafari, Pentecostal, Established Churches (Anglican, Catholic, Baptist, Methodist, etc.).

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offers a technically more effective arsenal for fighting physical disease than ever before, access to these marvels is limited for many of those on the lower rungs of society. At the same time, the logistical and ideological realities of biomedical practice prevent doctors from meeting all of the psychological needs of their patients. For rural Jamaicans, there is still much that puzzles, much that threatens, and much that compromises their ability to influence their destiny. These problems constitute the fertile ground which enables folk healers to prosper despite the profound and constant societal changes that are occurring.

As we have seen, the fortunes of religious leaders/healers have hinged on their popularity among their lower class followers and clients. Throughout Jamaican history they have had to rapidly adapt to changing social conditions or risk losing their following. The prime examples of such adaptability are the popular practitioners of magic who have successfully maintained their social role while making the transition from African based Obeah, to the modern European derived "Science." They have managed to endure because they provide a means of exerting supernatural control over difficult situations -- not just illness, but social disputes, legal difficulties, and relationship problems as well. Of course, their clients must have some faith in them if they are to be effective. Their very existence and continued activity actually go a long way towards reinforcing the beliefs that create a demand for their services. But such a self-reinforcing cycle of belief, fear, and help-seeking would not continue if there were not some basic social and psychological forces driving it. At the most

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obvious level these forces revolve around the need felt by powerless individuals to be able to exert a greater control over their lives and their physical and social environment. The healers who are most successful at providing this sense of enhanced control through their interactional skills and practical results, whether real or illusory, are the ones who are most sought after, and the ones who prosper. By looking at the characteristics of successful healers we can come to a better understanding of the needs which they are both addressing and at the same time helping to perpetuate.

In the following chapter we take a closer look at some of the healers who are currently working in eastern St. Thomas, concentrating on the factors which have made these particular healers among the most successful and popular in the area. Jamaican folk healers are extremely individualistic in their training, their belief systems, and their methods. However, there are some characteristics which they share and which seem to be the basis for success of the most popular practitioners. Through an in depth examination of these healers and the characteristics which contribute to their success we can penetrate to the core of the forces which animate the system of folk healing in Jamaica. At the same time we can begin to develop a better insight into the factors which come into play when a person makes a decision to seek the assistance of a healing specialist.

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CHAPTER SEVEN

THE HEALTH CARE SYSTEM IV:

FOLK HEALING IN EASTERN ST. THOMAS

INTRODUCTION

The folk healing sector as it is currently organized in St. Thomas shows direct continuities with the evolution of Jamaican folk healing traditions as outlined in the preceding chapter. There are four main categories of healing (Faith Healing, Revival Healing (Balm), Science, and Kumina) used in St. Thomas, which represent continuance of traditional patterns to varying degrees. In this section we will look at each of these in turn, focusing particularly on how these alternatives function in the world of Albion and its environs.

In analyzing these categories of healing it should be kept in mind that they are "ideal types." As they are manifested in reality there are no clear lines separating them; there is a great deal of overlap. The rule among Jamaican healers is individuality, and it is not unusual for them to mix and match elements from several, seemingly incompatible, systems. The power and popularity of a healer is based on the demonstration of a special "gift" for healing expressed in personal powers and knowledge. Each healer uses those elements which are most successful for them, and usually develops techniques of their own as well. Thus it would be unusual for a healer to fit precisely into any particular mold. Nevertheless, with the benefit of the preceding historical background, we are able to discern these different categories

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and look at each separately, as well as analyze the ways in which they are combined in the work of individual healers.

FAITH HEALING

Pentecostalism, which was introduced in Jamaica around the turn of the century, has in recent years been one of the most rapidly expanding denominations, increasing from around 4% of the island's population in 1943 to about 23.6% by 1982 (Stone:1988; Statistical Institute of Jamaica 1986b:26; Wedenoja 1978:139-41). Pentecostalism appeals to many Jamaicans because it addresses both traditional and modern concerns. Because it is based on religious experience through personal contact with the Holy Spirit in charismatic possession states it meets the traditional Jamaican desire to benefit through maintaining contact with the spirit world. The difference is that contact is made only with the Holy Spirit rather than with Angels, duppies, or ancestral spirits. The intense Pentecostal religious experience is conceived and interpreted in strictly Christian terms. Because of this it benefits from the aura of respectability characteristic of the more established Christian sects, and it shares to a certain extent in their higher status. Consequently Pentecostalism serves as an attractive option to the more upwardly mobile elements of the lower class, and could be said to represent the general trend towards more Christian-oriented forms of worship among the population as a whole.

Pentecostal churches do practice folk healing, though usually it is integrated into their regular services rather than being the focus of special healing services. If a member is sick, they will be brought

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before the congregation during a regular service to receive the special prayers of the pastor and the congregation. Pentecostalists see illness, like other misfortunes, as being the fruit of human sin and weakness. In order to be delivered from sickness, one must live right and seek salvation through prayer and penance, which help to cleanse the soul. Healing is but one aspect of the benefits of salvation. One prays directly to God for healing, and it is God (or Jesus) alone who is able to offer healing power (cf. Wedenoja 1978:185-6).

While a powerful preacher can help effectively channel the prayers, it is God who does the healing. Thus mainstream Pentecostal preachers usually do not take on the healer's role per se, though there are some who become known as effective healers because they are especially adept at soliciting God's divine intervention in curing an illness (e.g. Hogg 1964:241-2). When they do adopt the role of a healer it is often because they syncretically mix herbalist, Revivalist, Science elements into their practices. Dreher (1969:36-60,77-135), for example, discusses at length the work of a Pentecostal preacher/Science Man in western St. Thomas. While he considers his church Pentecostal, and named it accordingly, it actually incorporates many Revivalist and Science elements. The preacher has intentionally opted for a Pentecostalist format because of the higher prestige it affords. His private healing as a "Science Man," however, would be considered outside of the Pentecostal realm. The idea of an individual presuming to be able to cure with magic is alien to the mainstream of Pentecostal doctrine. This healer is an example of the sort of mixing of elements that is used routinely by Jamaican healers.

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There are some evangelistic preachers, however, who have become so adept at channelling the healing powers of Jesus that they do take on the role of personally powerful healers. Mother Winslow, one of the healers discussed in this chapter, is an example of this type of practitioner. Certain renowned foreign evangelistic healers, such as Oral Roberts, serve as a model for this type of healer, and play into the traditional "foreign = better" equation. His prestige is of course also enhanced by his great preaching abilities and world-wide mass-media influence. Occasionally he or other evangelists will visit Jamaica, and their services are attended by a wide spectrum of Jamaicans. Such healers are felt to be so close to the source of divine healing power that denomination loses its importance. They are considered great healers by all classes and denominations. In their overall work they generally place a great emphasis on divine healing, as anyone who has seen them on US television knows, and this part of their mission is particularly appealing to the average person.

Oral Roberts travelled to Jamaica with his "Expect a Miracle" crusade in June 1988, and conducted several well-attended services in the National Stadium, including a special one-night Healing Service (Weekend Star 6/24/88). He has been well known in Jamaica for many years through his radio broadcasts and personal visits. I met several Jamaicans who claimed to have been healed by putting their hand on the radio during one of his healing broadcasts. There are no local Jamaican preachers who even approach the status of Oral Roberts though some, like the Rev. Herro Blair, have begun to develop large followings through their use of the mass media.

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"Faith Healing" as we have been discussing constitutes a primarily public form of healing. A more "private" aspect of this is the practice of visiting a sick person at home by a preacher or group of church members. These visits include prayers and hymns offered to assist in obtaining divine intervention in healing the illness, which may be quite serious if it has confined the sufferer to their bed. These visits are of course also of great social significance, as they demonstrate the personal concern of the pastor or friends of the victim, as well as the solidarity of the social institution (the church) to which they all belong. Thus they maintain the victim's membership and connections to the group in spite of their inability to participate in its activities.

There are also a few faith healers who see clients privately. In many cases this type of practice seems to develop spontaneously, rather than out of a conscious plan. As a healer's reputation builds, people will come to them at home, outside of services, to solicit their help. If the healer is willing, they may develop a busy private practice out of popular demand. This seems to have been the case with Mother Winslow, one of the most highly regarded healers in eastern St. Thomas.

Mother Winslow

One folk practitioner who could be considered essentially a private faith healer is Mother Winslow, who lives in the district of Seaside, between Midway and Morant Bay, about 6 miles from Albion. Mother Winslow is a small woman in her 70s, partially disabled by a stroke seven years ago which left her with a spastic paralysis of her left hand and a weakness of her left leg. Her handicap has slowed her

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down somewhat, but she still actively participates in church activities and continues her healing work. Her calm manner only briefly conceals her great energy and intensity. She claims to have borne 23 children, 12 of whom are still living. So there are always children and grandchildren around her. She is well known and highly respected in the area for her unwavering faith and charitable works, especially her healing.

Mother Winslow is an Evangelist (a high ranking officer) at the Seventh Day Church of God[84] which is nearby her home. She has been deeply involved in religious work since she was very young. As a child she attended the local Baptist church where her father was a deacon. She first received the Holy Ghost when she was eleven, and shortly after that received her gift of Healing. She awoke crying one night after having a bad dream ("vision") and became sick. She was unable to keep any food down, vomiting anything she tried to eat. Her mother took her to a doctor in Morant Bay, who told her that there was nothing wrong with her, but she continued to be sick. After eight days she had another "vision" in her sleep in which she was told to drink a tea made with Sea Cotton Leaf. When she did this she was cured.

Since then she has been able to heal people by laying her hands on them and praying. She also received the gift of Prophecy at about this time. Through visions (dreams) she is warned about dangerous situations to avoid and about misfortunes to come. While she uses this mostly in her own life, occasionally she will receive a "warning" about someone

[84]This is a spinoff of the Church of God (a Pentecostal sect) that follows the Seventh Day Adventist practice of celebrating the Sabbath on Saturday, which they consider the original Sabbath day.

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else and she will do her best to let them know. As a child she was frequently possessed by the Holy Ghost, even when not in church. She would sometimes wake in the middle of the night jumping and shouting in the Spirit, and would occasionally be seized by it while at school.

She has belonged to her current church for about 30 years. Her commitment to observe the Sabbath on Saturday, which she feels is plainly spelled out in the Bible (cf. Exodus 20.8), was affirmed through a vision. She will not mix with other churches, which she feels violate the true Sabbath. She says that most of her healing work takes place in the church services. However, many people also come to her at home to seek her help. In addition she will often go to fellow church members' homes to pray for those who are unable to come to church.

Mother Winslow believes that most illnesses are caused by natural factors. For example she attributes her own health problems to overwork and the bearing of too many children. However, she also recognizes that many people come to her for treatment of illnesses they believe to be caused by sorcery or duppies. She herself denies a belief in such causation. She admits that there are evil spirits in the world, but they are not duppies. These spirits are essentially Fallen Angels. They are capable of causing harm, and causing illness, but such a spirit can not injure a true believer. Likewise, sincere prayer and devotion can counteract a naturally caused illness as well a spiritually caused one. So the key to healing is faith in God. By acting as a middleman with Jesus, and by helping people to increase their faith, she believes that she can promote healing, whether the illness has a natural or spiritual origin. Jesus is all-powerful, and there is no sickness that

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He is incapable of curing. However the key is for the person to have faith in Jesus; without this her power is limited.

Mother Winslow sees no conflict between her healing work and a doctor's methods. She has little need to refer her clients to a doctor because usually they will have seen one before coming to her. However, she sometimes will make such a referral when she "sees" that the person is in serious trouble (e.g. in danger of dying) and they are not a true Christian, and thus incapable of receiving the full benefit of her efforts. There is no conflict in a person taking a doctor's medicine while being treated by her, and this would be desirable when the person does not have a strong faith. She feels that for a doctor's medicine to work one must have faith in it as well, but this of course is a different type of faith.

The Seventh Day Church of God is relatively well-built in comparison to many other lower-class Jamaican churches, reflecting the means and dedication of its members. It is constructed of concrete, with a tile-pattern floor, aluminum and glass windows, and a new zinc roof. The church and the services are run by a male pastor, an elderly man of dignified bearing with a natural skill for preaching. But when it comes time for healing, Mother Winslow, in recognition of her abilities, is given the floor. The services last for four to five hours, and unlike most Revival churches, a great deal of time is spent in organized Bible study and instructive sermons. The mood of these services is much more staid than one finds in typical Revival services. While there is some lively singing, and moments when the Holy Ghost makes its presence known through possession, the worshipers spend most

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of the time at their seats in formalized prayer, "Pentecostal prayer,"[85] hymn singing, Bible study, and listening to the minister's sermon. This type of service is more typical of the upper-class established churches and represents a pattern which is considered more "respectable" and which is attractive to the upwardly mobile.

Healing takes place towards the end of the service. At the end of his sermon the minister asks everyone in need of healing to come forward (typically eight to ten people), where they kneel at the front of the church[86] on cushions laid out there by assistants. The pastor prays for healing while the people in the church sing hymns which continue throughout the healing. Mother Winslow then comes up to minister to the sick. She makes her way slowly from one supplicant to the next, laying her hands on each to heal them. Using her good right hand she touches each on the head, shoulders, back, legs, and abdomen, with more attention paid to whatever parts are in especial need of it. As she does this she recites prayers and rebukes the causative spirits to come out in the name of Jesus, admonishing them to leave and take the sickness with them. She spends only a minute or two working on each person, though she may go back and spend more time on those she senses to be in greater need. With some she will stop and ask questions about

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[85]"Pentecostal Prayer" consists of a period in which everyone simultaneously kneels and prays aloud individually. Most Revival churches have short periods of Pentecostal Prayer during a service, though this church in particular would do it for prolonged periods, e.g. up to a half an hour at a time.

[86]It is typical in Pentecostal services for those in need of spiritual reinforcement, or forgiveness, to come before the crowd, which prays for them collectively. This also takes place in healing during the services.

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their illness and offer them advice.[87] When Mother Winslow has finished ministering to the sick, they go back to their places, and after a closing prayer the service is brought to an end.

Although Mother Winslow assured me that most of her healing is done in church, each time I went to visit her I found several people waiting to see her for private consultation. The techniques that she uses in her home healing differ somewhat from those used in church. When a client comes privately she does a "reading" (divination) using a technique revealed to her in a vision, which appears to be unique to her. She chooses a book in her worn Bible using an alphabetical system according to the month and date of the client's birth. As she reads through the passage the Holy Ghost reveals to her, through the words and between the lines, information about the person (e.g. problems they are having, things about their personal lives, etc.), the nature of their illness, and the proper treatment of it. When this has been worked out she often prays with the person, recites psalms, and sings hymns with them.

Mother Winslow's treatments involve prayer, laying on of hands, and anointing with oil and/or consecrated water. She claims that she uses herbal treatments only on herself, but in practice I found that she sometimes will suggest herbal teas to her clients. The choice of bushes, like everything else, comes to her through divine inspiration particularly in the form of visions, for which she prays. The simplicity of her methods sets her apart from other Jamaican healers; as

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[87]For example, I heard her tell one woman that even though the doctor told her she was not pregnant and needed an operation, she really was pregnant and should not have any operation until after the baby is born.

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a corollary of her ideology complicated ritual becomes unimportant. She looks down upon healers who use elaborate rituals (e.g. Science) to heal, considering this deceitful and unnecessary.

Mother Winslow works as a faith healer, and makes no claim to magical influence over spirits. Consequently, most people who come to her are suffering from physical illness or perhaps in need of solace in facing a personal crisis, rather than seeking magical help for solving a practical personal problem. In this sense her role differs somewhat from most other private folk healers. She sees it as her spiritual duty to help others, so she does not charge for her services, although she does ask clients for donations for her church. Because of this she is seen as a genuinely holy person, which of course enhances her status as a healer. She is revered by those she helps, and admired by everyone in the community. Her practice is informal, and people come to her as they can find her. On a typical afternoon, there might be four or five people waiting on the bamboo bench outside her home to see her. Her hours are limited by her time at home and her energy. It is easiest for people to find her on a day when there is a service, and often they will come to her home for a private consultation after the healing at the church.

The type of folk healing done by Mother Winslow corresponds to the more European/Christian end of the religious spectrum, and seems to be influenced most heavily by American Pentecostal and Fundamentalist traditions. With the long-term trend of gradual movement towards more Western religious forms, the more recent rise of Pentecostalism, continuing urbanization, and increasing desires for upward mobility, it

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is likely that this type of healing practice will increase in its popularity among Jamaicans. Perhaps in the future we will see more healers of this type. At the current time, however, the Jamaican folk healing world is still dominated by other forms of healing, in particular religious Revival Healing (or Balm), its magical counterpart, Science, and various mixtures of these. These are discussed in the following sections.

REVIVAL HEALING

Most folk healing in Jamaica takes place in connection with Revivalist church groups. Unfortunately, previous studies of healing in Jamaica have failed to provide a good overview of the role of Revivalist healing within the overall health care system, and of the central position of healing within the Revivalist world. Most previous studies have focused on either the private healing work of Revivalists, seeing their religious function as a "front" (e.g. Dreher 1969) and as peripheral to their main role as private healers (e.g. Long 1973), or on their religious activity, considering the healing work as peripheral (e.g. Moore 1953; Hogg 1964). In order to fully appreciate the complexities of Revival healing it is important to look at both its religious and healing aspects together, as they are closely interconnected.

While there are many consistent aspects of Revival healing activities in different areas of Jamaica, from information provided by previous researchers (Long 1973; Wedenoja 1978; Moore 1953) it appears that there are some regional variations as well. For example, both Long

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(1973) and Wedenoja (1978) worked in the western part of the island in the parishes of St. Elizabeth and Manchester, respectively. They describe a system known as "Balm" which they see as closely linked with, though in some respects distinct from, Revivalism. Balm is a system of primarily private healing in which the healer (usually a woman), working at a healing center or "balmyard" (often associated with a church), uses her divinely inspired powers to diagnose the cause of an illness and provide appropriate, usually herbal, treatment. The two writers disagree on the basis of this system, however. Long sees it primarily as a system of herbal treatment (Long 1973), while Wedenoja stresses the shamanistic, ritualistic aspects of it (Wedenoja 1978).

The system of Balm in western Jamaica was probably heavily influenced by the individual styles of some of the historically most important healers in that area, in particular Mother Forbes in St. Elizabeth. Mother Forbes, who was visited by Martha Beckwith in the 1920s (Beckwith 1929:171-3), was the best known healer in the area in her day. Although she died in the 1920s, her influence continued into modern times through her daughter Mother Rita, who carried on her practice and who herself became widely known. Mother Rita was in fact one of the Balmists studied by Long in the late 1960s (Long 1973:88-110).

Revival Healing in St. Thomas seems to have developed with some different influences and taken a somewhat different tack. For instance, the word "Balm" is rarely used to refer to healing in St. Thomas, though people recognize and occasionally use the term "balmyard" to refer to a place of healing. Healers in St. Thomas are more likely to refer to

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themselves as a "physician"[88] than as a "balmist." Although there are common threads between the two areas, healing in eastern St. Thomas seems to have been more influenced by both Myalism and Science/Obeah. Thus many Revival Healers in this area use "Scientific" techniques as well as herbal treatments, and the separation between healers and Science Men is a less clear one (cf. Dreher 1969). In fact Revival healers in St. Thomas are both individualistic and highly eclectic in their methods.

This individualism would make it difficult to characterize Revival healing as a system, except for the common attribute that these healers all share, which is participation in and connection with a Revival church. And usually this participation is in the form of church leadership. There may be other types of healers (e.g. Science Men) who use similar diagnostic and treatment techniques to what Revival healers use in their private consultations. However, their work is fundamentally different because it lacks what really constitutes the core of Revival healing, viz. public healing rituals. While Revival Healers may devote as much, or more, time and energy to their private healing work, it is their public healing ceremonies which distinguish them from other healers. This becomes more apparent as one explores the intimate connection between Revivalism as a religious movement and healing.

[88]The use of the term "physician" is an interesting one, and one might speculate some relation to the term "metaphysician." However, a more likely source is from one of the most popular hymns used in Revival healing, "The Great Physician," which refers to the healing power of Jesus, and which is used in almost every healing service (cf. Dreher 1969:82).

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The central role that healing plays in Revivalism goes back to its origins in Myalism. As described earlier, the Myalists considered healing, through the counteraction of duppies and evil spirits, as one of their most important functions. They became known especially for their adversarial relationship with Obeah sorcery, and their protective social role as "shadow-catchers." In the subsequent development of Revivalism, healing constituted one of the main inducements used to attract members. The importance of healing has been perpetuated in present day Revivalist ideology.

The notion of spiritual "gifts" is critical to the ideology of Revivalism. As described in the Bible (1 Corinthians:12) there are several spiritual gifts obtainable through one's devotion to Jesus. These include Speaking in Tongues, Seeing, Prophecy, Teaching, and Healing. These gifts are powers conferred by Jesus through communion with the Holy Ghost, and they are felt to come as rewards or milestones on a long spiritual journey.[89] Each stage on this journey requires

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[89]The metaphor of a "journey" is in fact frequently used in Revivalism and Pocomania. Revivalists often speak of "travelling" or "moving" while they are having a "vision" or "in the Spirit." In addition, a key experience in the path of Revivalist enlightenment is a spiritual journey or trek. The process through which this takes place is referred to as "going down." Usually this occurs while a Revivalist is in church and possessed by the Holy Ghost. The individual literally "goes down," falling to the floor in a trance state. They lay there in the church in an unconscious, or semi-conscious, state for a long period of time during which their spiritual journey takes place. Reportedly they can remain in this state for several weeks at a time, with 21 days (or another symbolic number) being the typical duration. During this time they are cared for by other church members. Some people who had gone through this experience claimed that they had subsisted only on liquids or a minimal diet during this time. The individual travels through their "visions" to a mystical realm where on their journey the trials, teachings, battles, and experiences they encounter enable them to grow spiritually. While on this journey, the person will often establish a relationship with a spiritual
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hard work and sacrifice. While some natural ability is needed to obtain these gifts, they are primarily achieved through faith, clean living, devotion to God, service, and especially prayer and fasting. One must be very serious about serving God and work hard to receive them. Thus the number of gifts that a person has command over is an indication of his or her level of spiritual enlightenment and proximity to the divine.

Growth and advancement through the ranks of Revivalism depends on attainment of spiritual gifts. One cannot lay claim to a high level of enlightenment without being able to show that these gifts have been acquired. Without this one is unlikely to be successful in attracting followers to start or perpetuate a church group. Revival church groups tend to be organized around particularly inspiring individuals rather than as enduring, self-perpetuating institutions. They are constantly in flux as the leaders develop their skills, split and form new groups, move on, form alliances, etc. In order to attract new members and maintain interest in their church groups, Revival leaders must continually demonstrate their mastery of these gifts. Thus healing, and other practices through which they can do this, are routine organized

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[89](...continued)
guide (e.g. a saint or angel) who will continue to assist them throughout their lives. They may be given spiritual gifts (such as the gifts of Healing or Reading), taught specific healing or divining techniques, given special objects, hymns or prayers, or undertake battles with evil spirits. Although the particular Revival Healers discussed in this chapter did not report having such an experience of "going down," several others Revival Healers that I interviewed did.

Pocomanians take this metaphor of a spiritual journey even further. Pocomanian services often are themselves a communal expedition of this type. The Pocomania band travels together, with each participant filling a particular role in helping surmount obstacles on the journey according to their assigned office (e.g. Water Maid, Hunter, Searcher, Rambler, Warrior, Spyer, Ax Man, etc.) (Hogg 1964:300-25).

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activities of these groups. Most Revival churches have regular healing services, and many Revival leaders do private healing as well.

Healing is also important to the maintenance of Revival churches because of the income and new membership it brings in. Public healing services, when they attract large crowds, provide a source of contributions to church funds, and attract new members. Though individual donations are small, collectively they can be a significant source of support. Private healing can bring in much larger fees. Though most of this goes directly to the individual healer, their assistants and the community as a whole also benefit. In addition, some is used to support church facilities and activities; the prosperity of a healer will be usually be directly reflected in the condition and size of her or his church.

Revival churches attract the participation of much greater numbers of women than men. This is also true of other churches in Jamaica, however the tendency seems to be even more pronounced in Revivalist churches. Likewise, these churches are often headed by women, which is uncommon among the "established" churches. Men, nevertheless, occupy high positions in Revival churches out of proportion to their numbers. Women hold many positions of authority in Jamaica, but in this still largely conservative, male-dominated society, men have a distinct advantage in rising to these levels. Thus it is not unusual to find a church group composed mostly of women, but headed by a man and with several top male officers. Likewise, while many of the Revival healers are women, a disproportionate number are men.

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Revival churches not only provide an arena for religious expression and folk healing, but also serve a variety of other valuable social functions. They are a major focus for social interaction and cooperative activities for the lower class, and are an important nucleus for community organization. On the personal level they provide benefits which are perhaps even more significant. They give lower-class individuals, especially women, an opportunity to engage in literary (i.e. Bible) studies and discussion. They provide a forum for learning techniques of public-speaking and polishing one's self-presentation, thus enhancing self-confidence. They provide an outlet for artistic expression, especially musical, and entertainment. And perhaps most importantly they give otherwise powerless individuals the opportunity to hold offices with power and responsibility. Thus they enable members of a disadvantaged class to build prestige, self-esteem, self-confidence, and personal authority.

This is especially true of Revival leaders, who may become leading members of the community, or perhaps even nationally known, for their religious and healing work. In fact much of the organizational maneuvering of these churches is tied up with issues of ego and authority of the leaders. A prominent member or officer may split from a group and start one of their own if they feel they are not being given enough power or prestige. Likewise, church leaders often ally themselves with national or international church "bodies" (i.e. denominational organizations) as a way of gaining access to higher levels of authority, prestige, and funds. And they may maneuver from one church body to the next as new opportunities arise. The church

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bodies, for their part, are anxious to attract as many member churches as possible as a way of enhancing their own influence, and will often "bargain" with church leaders, for example by offering them prestigious titles (e.g. Bishop), positions on administrative councils, and trips to conventions abroad, as means of enticing them to join. The more members and churches a leader has control over, the greater his or her bargaining power will be with the church "bodies." Especially ambitious and influential leaders (Bedward is an example) may start national or international bodies of their own (cf. Dreher 1969). Thus, as we shall see, the career of a church leader/healer can be as much political as it is spiritual.

Mother Simpson

The hallmark of Revival healing is its primary emphasis on public healing rituals. There are some "purist" Revival healers who concentrate exclusively on this type of practice. Mother Simpson for example, who has a Revival Church in Midway, is well-known throughout the area as an effective healer. She conducts healing services in her church once a week on Monday afternoons. She told me that she does no healing outside of the church, though occasionally people will visit her at home for help or advice. If a sick person comes to her at home with a serious illness, she will send them to a doctor, though if it is only a minor problem she will pray with them and give them some advice, e.g. on popular bush treatments, or refer them to a doctor. In other words, outside of the church healing services, she acts more as a non-specialist member of the popular sector rather than as a healing

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specialist. The church also has a prayer group run by the church "missionaries" that will visit sick people in their homes to pray for, and with, them for healing.

Mother Simpson's spiritual involvement began at an early age. She was born in Portland in 1914, and as a youth followed an independent evangelist "preacher lady." She was baptized at the age of 16 and soon after that moved to Kingston to work. There she joined a Revival church whose preacher had a branch in St. Thomas. On a missionary trip to St. Thomas with this preacher she met a man who soon after this asked her to marry him. So in 1940 she married and moved to St. Thomas, where she has been ever since.

She continued her religious work in the 1940s by starting a youth fellowship and Bible study group in her new home. This organization expanded gradually and the members formed the nucleus of her own church group. She joined the AME Zion[90] organization in the 1960s. In the 1970s she also took over as leader at another church in Portland when the minister there died. She visits this church several times a month and sometimes will stay there for a week at a time.

Her inspiration to begin her healing work and build a new church in her backyard came to her in a "vision" she had in the 1950s. In this dream she found herself behind her house with a small boy whom she was raising. Three mangoes dropped to the ground, and when the boy picked one up he began having "fits" (i.e. a seizure). Someone handed her a

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[90]AME (African Methodist Episcopal) Zion is an international church body founded in 1796 in New York City, which is well represented in Jamaica, where it has numerous member churches. Healing is not a part of official church doctrine, but its member churches are given considerable autonomy. So this has never been an issue for Mother Simpson.

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small Bible and instructed her to touch the boy with it and say, "I rebuke you in the name of the Father, Son and Holy Ghost" (cf. Matthew 17.18; Mark 14.25; Luke 9.42). When she did this the boy was revived. After having this vision she began using a Bible in this manner to heal, and built her church on that same spot in her yard. This use of the Bible continues to be the core of her healing technique, though over the years she has been "led by the Spirit" to add other things, such as anointment with olive oil, to her repertoire. Although churches she was involved with during her younger days did engage in healing activities, she claims to have had no other training other than that which she has received through the Spirit.

Mother Simpson does not believe that duppies exist or that they can cause illness. There are, as the Bible shows us, evil Spirits in the world (viz. the Devil), but she does not attempt to theorize as to their role in causing specific illnesses. She does accept the idea that an illness can have a spiritual basis, for example if an individual defies the will of God. However, she dismisses the idea of evil sorcery causing sickness, and says that if there is evil at the root of an illness, she has no special gift for detecting it. To her it is a moot point because she is interested only in healing and not in assigning a cause to the illness. In this disinterest in ultimate causes she differs somewhat from other folk healers. In fact, in her healing she makes no special attempt to diagnose the illness. She just does what the Spirit guides her to do in treating it. She is confident that the Spirit knows exactly what to do, so it isn't important for us to try to analyze or understand it. Sometimes the cause of an illness will be

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revealed to her so that if the person needs to see a doctor she can refer them to one.

She has no qualms about sending her clients to a doctor because she sees her work as complementary to what a doctor does. A doctor treats physical illness, while she treats spiritual infirmities. Spiritual healing can enhance the effectiveness of biomedical treatment because a sickness of the spirit can be at the base of physical illness. She herself regularly uses biomedical treatment. She attends the local Hypertension/Diabetes Clinic in Midway for control of her high blood pressure, and also occasionally uses herbal or over-the-counter medications. The effectiveness of her healing work is not in question to her, though, because she regularly sees the positive results that it produces. In any case, she believes that faith is crucial to the effectiveness of treatment, whether by her or by the doctor. However, faith in God is most important.

Mother Simpson's Mt. Calvary AME Zion Church is located next to her home in Midway. In appearance it differs from many other Revival churches in that it is sturdily constructed of cement and tile and appears to have been completed some time ago, reflecting the enduring stability of her group. It is designed and decorated in a manner typical of Revival churches with a small chancel containing a multi-tiered, gauze-curtained altar, a central "healing table," and rows of benches in the main part of the church. The tiers of the altar contain candles, bottles of consecrated water, jars of "flowers"[91], crucifixes,

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[91]"Flowers" are actually cuttings of various plants, especially croton (Acalypha Wilkesiana), dragon's blood (Trimezia Martinicensis), and leaf-
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small bells, and other symbolic objects. The healing table, which is used throughout the service, is generally set with candles, bottles of consecrated water, a basin of consecrated water with herbs, jars of flowers, a Bible, and grapefruits and oranges. For the Monday afternoon service it contains additional items (e.g. a large bowl of water, additional fruits, white teacups) for use in the ceremony of "breaking the fast" which precedes the healing ritual. On a stand next to the table is a large bucket of flowers, which during the service may be picked up and carried by anyone who is led to do so by the Spirit as a way of expediting its arrival.

Healing services are held each Monday afternoon at the church. Like most Revival services, they are attended almost exclusively by women, although men will sometimes come for the healing. The service begins around 11:00 AM and follows a typical Revival format. It consists of relatively solemn hymns, readings, and prayers interspersed with more animated "testimonies and exhortations," energetic call-and-response preaching, and lively hymns accompanied by drumming and dancing throughout the church. This ecstatic behavior also includes Spirit

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[91](...continued) of-life (Bryophyllum Pinnatum), which are a constant feature of the decor of Revival churches. They are said to "call the messenger," i.e. facilitate the arrival of the Holy Ghost. In Mother Simpson's church these flowers are primarily symbolic and decorative, while in some other churches they are used more directly to facilitate possession states. Except leaf-of-life, which is widely used in and symbolic of healing, the significance of these species is not immediately apparent. The healers I interviewed downplayed any symbolic meaning other than this, and emphasized their use as decorations. Some informants suggested that these species are used primarily because they will grow and last for long periods in jars of water, so they do not have to be changed frequently.

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possession, often manifested by "trumping."[92] As in other Revival services, the intensity of the activity builds and then recedes repeatedly throughout the service. The service follows a general, though variable, format, which culminates in a spirited "sermon" by Mother Simpson. This is followed by the "Breaking fast" ritual.[93]

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[92]"Trumping" or "Laboring" is an interesting form of possession behavior found in Revival and Pocomania. It is done with a bent-over posture and consists of rhythmic stamping of the feet, along with a chopping motion made with the hands, and a groaning sound made during inhalation and/or exhalation. Typically the person will shuffle forwards and backwards, stamping the foot at a regular step, while maintaining a fairly constant location. The intensity of the laboring can vary considerably, as can the patterns used. To me these patterns seem to be highly variable and improvised, although I was told that there are specific rhythms that are used in '60 Revival, while '61 Revivalists (Pocomanians) have their own typical patterns. When "in the Spirit" two or more worshippers may gather facing each other (e.g. in a circle) and then move in unison with the same pattern of stamping, striking, and groaning towards and away from each other. This activity is said to be the way the "Spirit moves" during possession, but also seems to be a way of bringing on a possession state. (The hyperventilation which takes place and the rhythmic repetition may indeed help induce an altered state of consciousness.) In healing, however, it has a specific purpose in "beating down destruction" (i.e. the evil spirit) that is on the sick person. Like many other aspects of Revivalism, "laboring" has a Biblical justification. The groaning is said to be equivalent to the "groaning in the Spirit" that Jesus did when he raised Lazarus from the dead (John 11.33, 11.38). And the stamping of the feet and chopping with the hands is based on Ezekiel 6.11: "Thus saith the Lord God: Smite with thine hand, and stamp with thine foot, and say, Alas for all the evil abominations of the house of Israel! For they shall fall by the sword, by the famine, and by the pestilence." (Cf. Beckwith 1929:162; Hogg 1964:248-9,435,436; Seaga 1969:7-8; Moore 1953:69-70).

[93]Fasting and prayer are the two primary methods by which Revivalists can achieve spiritual enlightenment and advancement. The fast is undertaken each Monday from around 6:00AM until the ritual breaking of it (around 2:00PM). Not everyone participates in the fasting or the breaking of it each week. Generally it is done by those who are so inspired by a vision, a practical need, or desire for advancement in the faith. In the ritual, those who have fasted gather around the table and, after some readings and prayers, ceremonially partake of the water, as well biscuits and pieces of the grapefruits and oranges. After this is done, others in the church share in the water, biscuits and fruit.

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After completion of this ritual, the room is rearranged for the healing. The table is cleared except for items used in healing (e.g. the Bible, the glasses of water, candles, a jar of flowers, a grapefruit and an orange, a small pair of scissors, and the white basin with herbs). New candles are handed out to those who have come for healing, and these people move to the front benches. Sometimes a lit candle, grapefruit and glass of water are placed on the floor for the "patient" to step over on the way to the healing table. While this is going on Mother Simpson leaves the church and returns shortly having exchanged her blue dress and white turban for a red[94] dress and/or turban.

The healing is accompanied throughout by lively singing, drumming and dancing by the members, who also participate to some extent in the healing. The patients are led, after stepping over the candle on the floor three[95] times, one by one up to the healing table where Mother Simpson stands with two assistants. The techniques Mother Simpson then uses in the treatment follow a basic pattern, though there is considerable variation as well. Each patient gets an individualized treatment according to how the Spirit "moves" the healer. In general, the person's candle is lit and then handed back to them. Mother Simpson then takes the Bible and presses it in time with the music all over the person's body. She takes the candle from them and waves it over and around them (to cut off evil), and sometimes presses it on affected

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[94]Today in this area of Jamaica red is the color symbolic of healing (cf. Kerr 1952:122-3), which differs somewhat from the color symbolism which was reported by earlier writers (e.g. Moore 1953:90-91).

[95]Three is a highly symbolic and significant number for Revivalists and figures in many aspects of ritual.

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parts of their body. She then dips her hand in the basin with water and herbs and "washes" the person by rubbing the water over their face, arms, and sometimes chest or other areas. Next she rubs olive oil over the same areas and sometimes pours it directly on the head or in the mouth of the person. Sometimes juice from the grapefruit or orange is squeezed and rubbed on. The person is then spun around three times and led off.

Around this basic procedure there is a great deal of variation. Sometimes special prayers, psalms or hymns are used. Mother Simpson may lecture the person on changing the wickedness of their ways. Some people are seated in a chair, especially if treatment of their legs is needed. Mother Simpson may use the scissors to snip around the person, another method of "cutting off destruction," or brush them roughly from head to toe using a branch with leaves. Persons in need of special attention may be subjected to extended "laboring" (trumping) by several members who surround them and sometimes crawl through their legs. Other special techniques may also be used.

The treatment of each person takes on the average from four to six minutes, but this is also quite variable. Most people are treated for two to three minutes, but in each service there are three or four people who are given much more attention and effort than the rest, and their treatment may last up to twenty minutes. Mother Simpson generally treats about fifteen people in each service, though this varies as well. The cost for the treatment is minimal. A donation of J$1 ($.18) is required to pay for the cost of the candles, oil and other materials used.

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This mechanical description of the service does not do justice to the emotional intensity that may be reached during the healing. Mother Smith often addresses emotional and personal problems which are presented in the guise of physical illness. In each service there is usually at least one person who is singled out for moral admonishment. This usually is aimed at a man (preferably young, as everyone knows that young men generally lead profligate lives), who is subjected to lecturing and vigorous healing efforts. This is done not only in the spirit of scolding, but also in the form of an invitation to accept the mercy and purity of Christ. Thus it can be quite touching as well as morally instructive. For example, in one service a woman who had become ill after turning away from her "calling" to become a Water Mother (Revival Church Officer), and who was also troubled by a variety of personal problems, was able to publicly reveal her troubles and receive the sympathy and support of others in attendance. She was given some practical advice by Mother Simpson on how to correct the problems, and the emotional release she obtained from this catharsis and public support was quite obvious.

During the service Mother Simpson, who has a grandmotherly demeanor in private, becomes strict and authoritarian. She maintains close control over the tempo and flow of the service. On occasion she will stop the proceedings and scold her followers for not putting enough energy and effort into it, or for not observing the proper solemnity at appropriate points. In the healing part of the service she becomes even more domineering. In this high energy ritual her attention is focused completely on her work. If one of the assistants or members makes a

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mistake in procedure or breaks the tempo they might well receive a slap as well as a scolding.

Brother John

Bishop John Smith, known to most as "Brother John" is based in Albion and is the best known, and most popular, Revival healer in eastern St. Thomas. As a Revival leader he has been more ambitious than Mother Simpson. Over the years he has put together a network of seven churches in St. Thomas and Portland, and attained the title of Episcopate Bishop in the Galilee Revival Church,[96] an international body with branches in the US, Panama, and Jamaica. He is widely recognized not only for his vigorous church work and lively healing services, but even more so for his practice as a private healer in which he mixes elements of Revival healing, Science, and bush medicine. It is for this in fact that people come from all over Jamaica to see him.

Brother John is now in his late fifties. At six-foot-two with a booming voice he is an imposing figure. Though he has had little formal education and speaks with a thick patois, he comes across as intelligent and knowledgeable. But despite his charismatic presence, and capacity for explosive preaching, in private he is taciturn and would rather talk about his religious work than about himself. This perhaps adds to the aura of mystery which surrounds him.

As a healer Bishop Smith differs from Mother Simpson in that he does private as well as public healing. In his private work he makes extensive use of herbal treatments, which falls easily within the

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[96]This is a pseudonym.

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Revivalist "Balm" tradition, and which undoubtedly goes back to the earliest Myal healers. He also utilizes a variety of "Scientific" healing techniques which, properly speaking, are more peripheral to Revival tradition, and which are in fact illegal. But in practical terms such techniques are used widely in various forms, and to varying degrees, by many Revival healers throughout Jamaica. While on the surface these magical techniques may seem to be in contradiction with the belief system of Revivalism and the ideology of religious faith healing, in the work of individual healers they are incorporated into an overall system such that these apparent contradictions disappear or at least become irrelevant. Because of their illegality, magical techniques must be used with more discretion and in greater secrecy than regular faith healing, so they are hidden somewhat from open view. It is likely, though, that magical techniques have been used all along by Jamaican healers from the days of the Myalists, through the Great Revival, and up to modern times. In earlier days the techniques would have been more in line with African magical traditions (viz. "Obeah"), whereas today the symbolism of European sources, transmitted to Jamaica in the form of books and imported paraphernalia, has mixed syncretically with earlier forms.

The key to understanding Jamaican healers is to realize that their power is a personal attribute and is not completely derived from any particular system of healing. Thus individual healers have no problem drawing on several systems. For example, Brother John not only uses bush medicine, faith healing, and magic, but also incorporates some elements from Biomedicine, such as the use of a stethoscope in

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"sounding," and the use of antibiotics for treating some infections. People go to him not necessarily because he has a knowledge of these techniques, but rather because he has a special spiritual power that enables him to diagnose and choose treatments from whatever system is most appropriate. And, more importantly, he is able to use these techniques as means of channelling his own personal power. In fact, it would not be unusual for Brother John to come up with a treatment that he had never tried before (e.g. a certain bush for a particular ailment) and use it with complete confidence in its efficacy, because it had been "revealed" to him by his spiritual contact, the "Messenger." And the patient would also have complete confidence in it, perhaps even more than if he had used a more standardized treatment, because of its origin from a "higher source."

The spiritual guidance that Brother John uses in his healing, as well as in every aspect of his life, comes from the Holy Spirit which communicates with him in the form of a "Messenger." He does not have to go into any altered state of consciousness to contact this spirit -- it is with him all the time. It speaks to him with a voice to warn him of danger, or tell him about the future. It also enables him to see things that others can't. He is able to see duppies or other evil influences on a person. He is also able to sense symptoms and illnesses sympathetically in his body, and this enables him to intuitively make diagnoses. For example, once while he was conducting a healing service a man paralyzed from the waist down was brought into the room and Brother John reported that before he even saw the man he immediately felt a burning pain in his back and legs. This ability to "feel"

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illnesses can be risky as well. People coming to him for treatment must have the evil spirits "cut" off of them as much as possible before they come close to him. Otherwise he would absorb all of their illness and become sick himself. For this reason he is unable to go into a hospital for fear of being exposed to such a concentration of sickness and suffering that it might kill him.

Although he can treat natural as well as spiritual sicknesses, his type of healing is felt to be especially effective in counteracting illnesses caused by evil sorcery. He believes that such sorcery is rampant in Jamaica, and especially so in St. Thomas where "de people-dem wicked." (I.e. he believes that the local people resort frequently to sorcery.) The evil spirits that cause sickness are duppies that are either set on a person intentionally through sorcery, or that are brought on by other causes such as family discord. He makes no conceptual distinction between "duppies" and "demons," as a demon is essentially a duppy that has been turned evil by the devil.[97] Duppies can be manipulated by people through magic, though one must have the right "spirit" as well because the practice is a dangerous one. He professes to have the knowledge and character necessary to be able to control duppies, which of course carries with it the possibility of bidding them to do evil as well as good. One of Brother John's assistants, for example, was able to describe to me half a dozen different ways of killing someone magically. While Brother John claims

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[97]Not all duppies are evil. Everyone who dies releases a duppy spirit, but if the person had been a good Christian in life the duppy is peaceful and harmless, and can not be turned to doing evil.

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that he never uses magic to work evil,[98] one must have a knowledge of how these "operations" work so as to be able to counteract them properly. Likewise, while he doesn't participate in other spirit cults such as Kumina or Convince, he must understand how they work and how their spirits "move" so that he will know how to combat their effects if necessary.

He explains that his type of healing is different from what a doctor does. A doctor treats illness "from the inside" using drugs and injections. He, on the other hand, treats "from the outside" primarily using bush baths to heal spiritual sicknesses. It is quite obvious that a doctor is unable to handle some illnesses; they may be unable to explain the cause of an illness, or the treatment they prescribe may be ineffective. This failure of biomedical therapy is in itself an indication that there is evil involved, and without the proper treatment, e.g. by him, the person is not going to get well. Brother John is convinced that while most doctors concentrate only on natural sicknesses, some have the ability to "read" and treat spiritual illnesses as well, and use these abilities in a discrete manner. As an example he cites a Trinidadian doctor who used to practice in western

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[98]Definition of what constitutes "evil" magic is of course relative and is not always clearcut. For example, efforts to "tie" a lover (i.e. magically insure their commitment) are positive from the client's perspective, but may be evil from the perspective of the object. A person who acts to further their own interests magically (e.g. to get a promotion, to effect the return of stolen goods, etc.) may in some cases be doing it at the expense of another's interests, and in some eyes this may constitute sorcery. So the public perception of rampant sorcery is not entirely without justification, though its character is much less malignant and less clearcut than is generally supposed.

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St. Thomas. He reportedly kept a vial of rosewater on his desk which, whenever evil was about, would fill the room with its scent.

His treatment does not compete directly with Biomedicine and he often refers patients that he feels have a primarily naturally caused illness to a doctor. He feels that his methods are in some ways analogous to a doctor's. A doctor "sounds" a patient to find out what is wrong with them, while he sounds them in a different way, using different senses. However the two treatment regimens are not completely compatible. If his herbal treatments are to work properly the client must stop taking any doctor's medicine three days beforehand and then get a "washout" (with a purgative) before starting herbal treatment.

Brother John was born in Portland in 1930 to a very poor family, and spent his early life there with his parents and nine sisters living in a dirt-floor shack. His religious calling was evident from an early age. As a youngster he longed to be able to attend the local Anglican church, but his family was unable to afford proper clothes or shoes. So instead, the boy would make himself a seat of stones on the property next to the church where he could see what was going on in the service and follow along, imitating the minister's actions, much to the amusement of the parishioners. He first received the Holy Spirit at the age of ten at a religious meeting, and soon after that he began attending "Spiritualist" churches. He was Baptized in the Universal Church of God when he was fifteen. His enthusiasm was a bit too extreme for some of the other members, though. One night the Spirit came upon him so strongly that he smashed up the railing and rostrum of the

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church. Shortly thereafter he was forced to leave this church by the church leader, who felt he had a "fanatic spirit."

He continued his religious work on his own, holding street meetings throughout the area. During this time he also began his healing work. His gift for healing did not come to him suddenly or through a vision. He often went to pray for people who were sick and when doing this sometimes received a "Message" (i.e. a command from the Holy Ghost) to rub the person with a particular bush. He found that when he did this and prayed over the person they would often recover. His reputation as a healer soon grew throughout the area, and was enhanced even more when he performed some dramatic cures.

John also became widely known for his powers of Prophecy, which likewise came to him through the Spirit in the form of "Messages." On occasion an Angel would come to him and tell him to travel to a certain place to deliver a "warning," which invariably would concern the impending demise of a certain person or persons.[99] Like most prophets of doom he was not taken seriously at first. But when his predictions

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[99]Prophecy in Revivalism almost always involves the delivery of a message to warn someone who is about to die, or to warn people of some natural disaster to come. This contrasts with the situation in Pentecostal churches in which prophecies generally concern the coming of Christ. Revivalists with the gift of Prophecy will not uncommonly receive a vision telling them to go immediately to a place previously unknown to them to deliver the woeful message, much to the consternation of those concerned. The purpose of the Message is to get the person to accept Jesus and seek salvation before it is too late. Prophecy is one way in which a Revival leader displays his or her powers and level of enlightenment, and thus is one effective means of attracting followers. Prophets will claim that their messages always come true. But of course we have no way of evaluating these claims retrospectively, and any attempt to look at this phenomenon prospectively and objectively would be exceedingly difficult. The important point is that the leader's prophecies, and reputation for this, are accepted by their followers as a valid demonstration of Grace.

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concerning untimely deaths began to come true, people recognized that he had a true gift of Prophecy, and would "start to fret" whenever he came to "blow de Message."

Following a successful cure of a girl who had become "mad like a dog" in Carrington, a district in Portland, he was invited by a group of people in the district to come there to hold street meetings. At one of his first meetings there, he delivered a message of doom about a local woman who was going to die suddenly. When this prediction came true his popularity in the district mushroomed. Soon he opened a church there and over the next eight years he continued his preaching, healing, and prophesying, while his following continued to grow.

At the end of that period he received a Message to go to a district in St. Catherine to deliver a prophecy of doom for a sick couple there. But unlike most, these people sought his help in reforming their ways, and with prayer and his healing power they were able to escape their fate. Brother John thus gained a following in this district, and soon afterwards left his church in Portland to start one in St. Catherine. He spent about five years in St. Catherine, during which time he also opened another church in a nearby district.

In 1961, he received a Message to travel to the district of Albion in St. Thomas, which he had never heard of previously, to deliver a Message about a pregnant woman who was going to die in childbirth. He arrived unannounced and was met by several women who were surprised to see him, but glad because their local Revival church had declined and fallen into disrepair after their leader emigrated to England. The service Brother John held was well-attended and the people were anxious

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for him to stay, but he returned to St. Catherine the next day. Three days later he received a telegram telling him that his prophecy had come true. He returned to Albion the next Sunday with two more Messages, both of which were also fulfilled. The people again begged him to stay and this time he agreed. He has been in Albion ever since.

Over the next 27 years he reunited the former members of the church and built it back up into an active congregation. He has branched out into several other districts. He started, or formed affiliations with, six other churches in St. Thomas and Portland, and these have developed into a loyal network of support. Such a network of churches requires constant nurturing, and he spends much of his time traveling among them. Some depend on him to regularly conduct services (especially healing services) while others have a more highly developed leadership and are able to function more independently. Almost every night of the week he will be at one or another of these churches to conduct or participate in a service. With additional special events to attend at other unaffiliated churches his schedule is very full and he is constantly on the move. Since he has no car and must rely on public transportation, much of his time is taken up in travelling. But somehow he manages to spend time in Albion seeing private patients almost every day, to visit his mother in Portland once a week, and to spend a little time with his wife and family in Midway. When he is unable to be in Albion to see his private clients, e.g. when he is away on a trip abroad, Brother Thomas, his chief associate, fills in for him.

This account of Brother John's life is from his own perspective and naturally explains the course of his career in terms of what he sees

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as his divine mission. What is less apparent here are the personal conflicts, ambitions, and political maneuverings that have influenced his career. Not surprisingly, he is reluctant to discuss these matters. It is obvious, though, that they are important. Brother John has been attached to four different church "bodies" over the 27 years he has been in Albion, and these affiliations were engineered more on the basis of politics than by ideology. He originally belonged to the Faith Bible Baptist Church, which he left after about seven years. Then he joined the Jamaica Free Baptist Church, and was ordained as a minister by that organization. (He had been a Deacon up to that point.) He then joined AME Zion but decided to leave it when he found that the Jamaican ministers were not being allowed to advance to higher offices in the organization.

About ten years ago he switched to the Galilee Revival Church organization which held out greater prospects for advancement. Within that body he has come to occupy one of the highest positions in Jamaica. However, he recently became disenchanted with this organization, because of conflicts with his immediate superiors, and actually entered into negotiations with another group based in the USA and Jamaica. But in the end he elected to stay with Galilee when it became apparent that the new organization would not give him the power he desired, and when the deaths of the two highest officials in the Galilee organization brought him closer to the top of the leadership hierarchy in that body.

Brother John's ultimate ambition is to form his own international organization with branches in the USA and Jamaica, and with Albion as the future headquarters. To this end he has recently made several trips

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to New York and looked into the possibility of finding space and sufficient supporters to form a congregation in the USA.[100] This is difficult for a foreigner to do from scratch, however, and he has been looking for other US churches with which to affiliate, which would help him to get a foothold in New York.

During his years in Albion, Brother John has become an influential member of the community. Although his lower-class background, and the lower-class status of his parishioners, has limited his influence within the higher strata of the community, his power base is within the largest section of the community. While some think of him as an "Obeah Man" and refer to his church as the "Poco'" church, he is generally well-liked throughout the community and many come to him for help and advice. Although he spends more time in Albion than anywhere else, he actually owns a house in Midway where his wife and five children[101] live.

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[100]Brother John actually has a number of close connections in New York among people he has known in Jamaica and who have subsequently emigrated. Many of these are former clients of his private healing, and people from Albion or the vicinity. Reportedly he is kept quite busy when in New York by Jamaican immigrants who come to him for treatment or help with personal problems.

[101]The actual number of children that Brother John has sired is somewhat of a mystery. He has five legitimate children and another five illegitimate children that he admits to. However, the actual number appears to be somewhat higher than this. One of his sons informed me that he actually has about 35 children in various locations. In any case it appears that wherever he has gone, Brother John has found favor in the eyes of the ladies, outside of church as well as in. While such fruitfulness would no doubt be looked down upon, or even considered scandalous, among the upper classes or in the USA, male fecundity is positively valued, at least covertly, among the Jamaican lower class. Even so, it is unusual for a minister at any level to be so prolific. Nevertheless, his followers seem to have no trouble in ignoring this part of his character, and it does not seem to detract from his effectiveness as a church leader. It may even add to it, since it has given him a large family network which often serves as a valuable resource in his work.

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Brother John's Mt. Olive Galilee Church is by appearance not quite fit for status as an international religious center. The church itself is still under construction, as it has been for a number of years, and the other buildings in the compound are quite run down. This is a reflection of the relative poverty of the Albion area and the socioeconomic standing of Brother John's followers. The present cement church was begun only about seven years ago, after the previous wooden one was destroyed by Hurricane Allen in 1980 and after Brother John had arranged a more secure lease for the land.[102] The church has been built up of cement blocks and has been roofed with a combination of corrugated zinc and aluminum. While the church is still in need of windows and doors to fill the spaces waiting for them, it is constantly being improved bit by bit. During my stay in Albion the walls were rendered, the dirt floor was finally paved with cement, the rostrum and chancel were also paved, and a new wooden railing was constructed.

The compound could be called a "balmyard," as described by Long (1973), and it is occasionally referred to as such. However it differs in its layout in that, unlike the stereotypical balmyard, it is not surrounded by a fence and seems to have grown up haphazardly rather than according to a set plan. There is little symbolic accoutrement to

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[102]The construction of a church in Jamaica depends as much on the land tenure situation as it does on the resources of the congregation. If the land to be used is rented, the church will be made simply of wood, or even bamboo, so that it can be dismantled easily if the landowner "serves notice." A church will be constructed of concrete only if the land is owned by the church or leader, or else secured by a long-term lease. This rule also applies to houses in general. In the case of the Mt. Olive Church, Bishop Smith had obtained a twenty-year lease with an option to buy when it expires. In contrast, Mother Simpson's AME Zion church was built on her own land, behind her house.

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reveal that it is a balmyard, except for the red and white flags set up on long bamboo poles next to the church.[103] In front of the church there is a "seal" which consists of a tall round table upon which sit a white basin and four tall (rum) bottles, all full of consecrated water.[104] Brother John also keeps a few doves, which seem to have no other purpose beyond their obvious Biblical symbolism.

In addition to the church, there are three other buildings in the compound. As one approaches from the road, the first building seen is a small shop built by Brother John where staples and general supplies are sold. Beyond this is a small, battered, two-room house (the original house on the property) which is occupied by one of Brother John's sons, and a girl who does the cooking and helps mind the shop. It is in this building that Brother John does his private healing during the day. Behind this is a small shed where bush baths are given. Down the hill and behind the church is a shack with two rooms, one for Bishop Smith when he stays in Albion, and one for an assistant. Except for the shop, the buildings are in a state of general disrepair and do not give the impression of prosperity.

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[103]According to Bishop Smith the purpose of these flags is to inform anyone who may be passing that there is a healing church, or balmyard, there. This signal can be found in widespread use all over Jamaica.

[104]The purpose of the seal is to protect the church from evil spirits. Most of the people who come for healing are beset by evil spirits, and they may inadvertently bring this "destruction" along with them to the yard. Before the person can enter the church or yard the spirits must be chased off by having the person walk three times around the seal, and then "bannering" them with a red flag (waving it rapidly over and around them). During the private healing this is usually done by Brother John's assistant, Sister Rita. At public healing services at the church this is done by other church officers, and takes place more within the church rather than outside.

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Brother John conducts healing services at his church on Tuesday nights. The services differ in a number of ways from Mother Simpson's. They attract a larger attendance, especially for the healing. They make greater use of symbolic objects and actions. They are generally livelier and involve a greater degree and intensity of Spirit possession. And the organization of the healing itself is a bit different. However, the basic symbolism and structure of the service is similar, and a number of other commonalities are also recognizable.

One striking aspect of the Mt. Olive healing services is that they are imbued with a potent aura of mystery by the very fact that they are conducted in the dull light of homemade kerosene lamps (the church is not electrified) which are barely sufficient to keep the inky darkness at bay. The service begins at around seven and usually lasts till around midnight or even later. Most of the service is run by one the church officers and follows a pattern similar to Mother Simpson's with prayers, readings, testimonies and exhortations, slow hymns, and livelier ones with drumming and dancing throughout the church. And the intensity likewise rises and falls as the service progresses.

Brother John normally makes his entrance at around 8:00 or 9:00. He usually spends Tuesday afternoons in Kingston, and his return may be delayed by bottlenecks in transportation. In any case, his presence is not really needed for the early part of the service. For the healing service he wears red, as do most of the members, though his outfit varies. He usually wears a red shirt, sash and beret, but sometimes will appear in a long red robe. In any case he cuts a striking figure. During the early part of the service he generally sits quietly beside or

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behind the rostrum, though he may join in to try to liven things up at various points. Brother John is a master at controlling the tempo and emotion of the gathering. At a moment when the atmosphere is quite subdued he may get up and suddenly launch into a "lively chorus" which shortly has everyone in the place dancing, jumping, twitching, "laboring," and speaking in tongues. He can just as easily slow the tempo down, e.g. by going into a slow solo chant. Occasionally he will add an element of shock and melodrama, for example by picking up a coconut or full bottle of water and smashing it loudly on the floor.[105] His ability to control the tempo of a service is a major factor in his popularity as a Revival leader. The quality of a Revival service is judged according to how lively it is, and one is assured of a lively service when Bishop Smith is present. Other leaders and members use similar techniques, however Brother John has developed this skill to a high level.

When the preliminary part of the service (several readings, prayers, testimonies and exhortations, the collection, etc.) has been completed, the service is turned over to Brother John who then delivers his sermon, which may last for an hour or longer. The sermon is often presaged by more singing and dancing, and may be interrupted throughout

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[105] This is done to "cut destruction," (i.e. to subdue and ward off evil spirits), and whenever this occurs everyone in the room must stand up and spin around to "turn off the destruction," as a precaution against it seizing them. Because Brother John is able to see an evil spirit when it arrives in the church, his surprise attack on it with a machete, coconut or water bottle may startle those who are not able to see it. When an Angel or the Holy Spirit arrives, Brother John or one of the others may grab the bucket of flowers and carry it on their head to "greet the Messenger." And those who are seized by the Holy Ghost may suddenly start speaking in tongues, laboring, dancing or even pass out. Thus the entire service is like a dramatic, largely improvised performance.

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by such interludes, "as the Spirit moves." Brother John's sermons are usually morally instructive expositions on basic themes, such as the need to seek salvation right away because one never knows when death is around the corner. He varies the intensity of his delivery to raise and lower the energy in the room, building to a final climax. Each line is met with a hearty "praise the Lord" or "Amen" from the crowd. He often uses the format of expounding at length upon a Biblical passage which relates to the issue at hand. He will have an assistant read a line and then go into a lengthy exposition of it before going on to the next line. His sermons are illustrated with parables and stories, e.g. about people that he warned of coming death, but who waited until it was too late to repent.

When the sermon is finished an announcement is made that it is time for all those who have come for healing to line up outside the church. The healing table is set with a white basin containing a greenish "bush-bath" liquid, one or two vases of "flowers," a Bible, an oil lamp, four tall rum bottles filled with consecrated water and corked with a candle (one at each corner), a small bottle of olive oil and another of Florida Water[106], and two small saucers into which these latter two are later poured. While people are lining up outside, Brother John and his assistants and other officers gather around the table and, holding their hands in the air over it, sing a hymn and say a prayer asking for Jesus' help in the healing. When this is completed

[106]This is a perfumed toilet water containing alcohol, among other things, which Brother John uses in healing. Sometimes this is substituted with Kananga Water or another type of toilet water. These are widely available in supermarkets or pharmacies in the larger towns, though Brother John often purchases these materials during his trips abroad.

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Brother John takes a seat next to the table while one of the assistants (the flag-bearer) uses a red flag ("banner") to chase off the evil spirits by whipping it all around the church. As the healing is started, the crowd is led into a more lively "chorus," and the singing, dancing and drumming will continue throughout the process, though sometimes the tempo will be more slow and solemn.

Unlike Mother Simpson, Brother John uses an "assembly-line" arrangement in his healing ceremony. The "patients" re-enter the church one by one in a line and go through a series of "stations" before they come to Brother John who administers the main part of the healing. As they step through the door they are met by an assistant who "cuts" off the evil spirits using a white candle which is waved around them, and through their legs and over their heads. Usually there is also another assistant who uses a pair of scissors, snipping it around the person, likewise to cut off the evil. The person then proceeds to the healing table where Sister Rita (Leadress Jackson), Brother John's "bath lady," takes the J$1 ($.18) payment, and gives them a quick "bush bath" by taking some of the liquid from the basin and rubbing it on their face, arms, and sometimes legs. The patients then wait in a line next to the table until Brother John is ready to minister to them one by one.

Although they start off with the same basic pattern, the techniques used by Brother John in this healing are quite variable and subject to a great deal of improvisation. He has no explanation for this except to say that he just does "what the Spirit moves him" to do. While doing the healing he seems to be in a somewhat altered state of consciousness, or at least gives the impression of this, though his

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manner will vary considerably as well. He appears detached and often will pause and cock his head as if listening to some silent voice. At times he may go deeper into a possession state, and speak in tongues, labor, or menacingly fight off evil spirits. But I never saw him entranced or possessed to the point where he lost control of himself.

Usually he works from a seated position, though he may stand or dance around if he is so inspired. As each person steps up to him he dips one palm in the saucer of oil, and the other in the saucer of Florida Water, then rubs his hands together. He then pats and rubs this mixture over their arms, head, face, etc. At times he may slap them gently, or not so gently, with it. As he does this he pauses from time to time to "sound" the person (i.e. sense what is wrong with them) by placing his hands on, or holding, their head, chest, arm or other body part while he closes his eyes in concentration to get the Message and feel what is wrong. At times he will grimace as he feels the pain and suffering of the patient in his own body. If more thorough diagnosis is needed he may put his ear to the patient's chest or examine some other part of the body. Diagnosis thus seems to be much more important in the healing of Brother John than it is for Mother Simpson.

Most of the patients are given a rather rapid and cursory sounding, and when he is satisfied that nothing is seriously wrong they will be anointed and sent off to complete the process with a drink of consecrated water. With some, however, more effort is needed for diagnosis and treatment. During this process Brother John may question the person, or make comments to them about the cause of their illness, the necessary treatment, other problems in their life, or things or

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people they should watch out for in the future. If he perceives the problem to be especially serious, he may tell them to come back and see him privately the following day. Or he may tell them that they should go see a doctor because their illness is "temporal" rather than spiritual.[107]

The reading/anointing of each person by Brother John takes on the average about 2 minutes. However, some people, especially those he perceives as having a serious spiritual problem (e.g. an evil duppy on them) will be given a much more thorough treatment on the spot. In each service there are 3 or 4 people who are given this extra attention and their diagnosis/treatment might last anywhere up to a half hour or even longer. It is impossible to predict ahead of time which patients will receive this special intensive treatment, because it does not seem to be closely related to the severity or seriousness of the physical illness. An obviously acutely ill person has a better chance of getting a longer treatment, though it doesn't always turn out this way. And a seemingly well person might be labored over for a long period. It just depends on where Brother John sees the most threatening demons.

During one of these extended treatments just about anything can happen. Brother John leans toward the dramatic and make good use of shock value. For example, I have seen him pour Florida Water on a grapefruit, ignite it and then rub the resulting ball of blue flames over the patient's body. In a similar manner a ring of flames might be created on the ground surrounding the person. Sometimes a small fire

[107]Because of all the noise in the room it is not possible for onlookers to hear much of what is being said. Thus while this is a public service, there is an element of privacy involved as well.

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will be made on the floor with banana trash and the person be required to step over it. He might use a machete to chop at the air or a piece of furniture. Or he might smash a bottle or coconut on the ground. More commonly, though, less drastic methods are used. He and several assistants will often gather around the patient and "labor" over them for a considerable time. Or he might pick up the bucket of flowers and carry it to the doorway to "greet the Messenger." Whatever course the proceedings take, though, he is always fully in control of the tempo and intensity of the action. When he has finished working on a patient they will be spun around three times and then sent off to the corner of the room where an assistant will give them a glass of consecrated water to drink.

In an average healing service 20 to 30 people will be treated in an hour or hour and a half. But it can go on much longer than this if more people show up, and if there are some especially difficult cases to treat. When the last patient is finished with, Brother John must have whatever "destruction" has clung to him "cut" off by his assistants. The flag-bearer banners him vigorously. He also may be "cut" with the candle or scissors. Sister Rita rubs his arms and legs with her hands, and slaps his shoulders, and his sash is removed. He washes his hands with a sliced lime and water is which is poured over them by Sister Rita. Following this he leads a closing prayer.

The healing service is attended primarily by Albionites. People from outside the district will sometimes attend, but this is difficult for them unless they have a car, live in a nearby district, or have a place to stay in Albion. Public transportation stops running by about

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9:00PM and there is no other way to get around without a car or bike. Although women predominate, both males and females of all ages come for healing. A large proportion of those who come, though, are not acutely ill. Some people will come for healing if they are feeling a bit under the weather, if they have a chronic problem, if they feel vulnerable to some suspected sorcery, if they've had a bad dream, if they want some protection, or sometimes just for a "checkup." And some people come regularly for healing each week, just for a "boost." The healing seems to be especially popular for pregnant women and small children. These periods of life are considered to be especially vulnerable and spiritually dangerous. As one informant put it, "Duppy get you when you pregnant."

Although Brother John claims that his private healing is merely an extension of what he does in the church, there are some obvious differences between the two practice settings. In his private healing he does use some elements of the communal healing, but relies more on techniques of Science and herbalism in his treatments. It is his personal gift of Healing which enables him to draw on all of these realms. A key element in Brother John's healing is his ability to "read," or diagnose intuitively the cause of an illness, or other personal problem. This ability comes directly from his personal spiritual gift rather than from knowledge of any particular system.

Brother John's private healing is very informally organized. He does most of his work on Monday, Wednesday, and Friday as he tends to be away on other days, but he tells people they can come see him on any day but Tuesday, when he is usually in Kingston. Clients may arrive at any

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time, though most come in the morning. It is impossible to tell how many will show up on any day. On some days a dozen or more people will come, while on others only a few, or maybe none at all, will show up.

When a client arrives they are first instructed to walk around the seal in front of the church and to drop a coin into the basin. Sister Rita or another assistant then "banners" them to cut off any evil spirits that may have tagged along with them. If Brother John is not occupied at the moment they will then be sent up to the little house where his "office" is. Otherwise they will sit in the church, which serves as a waiting area. The "reading" is done in Brother John's "office" which also serves as a small bedroom. It contains a bed, on which a client or one of the assistants might sit, a few chairs, a small table in the corner, and a variety of bottles, packages, and equipment that constitute Brother John's therapeutic armament.

Brother John's basic "reading" technique is very simple. He just leans back in his chair, looks into the distance, and with an authoritative air proceeds to ask questions and make pronouncements about the person's problem and its causes.[108] He usually uses no other special divining techniques, and in this regard his private work is much less dramatic and spectacular than his public healing services. He does on occasion, though, make use of some special equipment which adds some aura of mystery and surprise. He sometimes uses a black ball which has

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[108]Actually, the "reading" entails a complex process of negotiation in which the patient gives some information, and Brother John deduces the rest. Other healers, such as Mother Winslow, use a similar process of negotiation, though their divination techniques are different. The nature of the negotiation process and how it is used in healing will be discussed more fully later.

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a little window in which messages appear according to how a small float inside surfaces.[109] He also has a deck of horoscope cards which he sometimes uses by literally reading the characteristics and fortune of the person involved. Brother John can also do a reading for a person who is not present, as long as a piece of clothing or other possession is provided. Clients will sometimes get a reading, or even a treatment, for a child, husband, etc. without their knowledge, presumably because the person would not have agreed to visit such a practitioner.

People come to Brother John with a great variety of problems. Generally they seek him out when they think they are having a problem due to the influence of some evil spirit on their lives. Such evil forces can manifest themselves through illness, but also in a variety of other ways as well, such as relationship problems, financial difficulties, bad luck, crop failure, legal troubles, etc. Some people come to obtain magical intervention for a problem that is not a direct result of evil sorcery, but over which they would like to be able to exert some additional control, such as a court case, an examination in school, a visa application, winning the affections of another, gaining the return of a stolen animal, etc. (In such situations, the use of magic is sometimes seen as a necessary response to the suspected use of magic by competitors.) In most cases, though, there are several problems or, more precisely, a variety of interrelated problems which

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[109]This is actually the children's toy known as "Eight Ball" which normally looks like an oversized #8 billiard ball. Inside is a jar filled with a black liquid and containing a polyhedron on each face of which is a vague "answer". When the ball is turned upside down the message appears at the jar's bottom which is exposed. Brother John's ball seems to have been damaged by heat as the ball had shrunken to a smaller size and the number 8 had disappeared. Functionally it was no different, though.

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all must be dealt with. For example one woman who came to Brother John for help was having problems with a business due to sorcery, but her health was also being affected because of the sorcery and the stress that the business problems produced. The treatment addressed both of these concerns by prescription of protective measures for both the business and the persons involved.

As he does the reading, Brother John scribbles notes in a small school exercise notebook. These remind him of the person, the problem, any further tasks he must do for them, the amount they pay him, etc. He also tears sheets out of the notebook to write charms and write instructions for clients.

The primary treatment modality that Brother John uses is the bush bath. The bath is made from an infusion of several herbs mixed with various other ingredients such as Florida water or rum. He uses a basic mixture made from five herbs[110] for most purposes, though will make up special baths for particular cases when they are needed. The bushes are gathered, soaked, and prepared by Sister Rita. She also administers them in the little shack behind the house, and is allowed to keep the proceeds of the baths. Brother John also uses bush tonics and teas for

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[110]An odd number of bushes is always used. In his basic bath Brother John usually uses Madam Fate (Hippobroma Longiflora), Gwacko Bush (Mikania spp.), Thyme (Coleus Aromaticus), Barsley (Ocimum Basilicum), and Chinkweed (Commicarpus Scandens?). Other bushes used frequently in the bath are Maroon Bush (Echites Umbellata), Fever Grass (Andropogon Citratus), John Charles (Hyptis Vertillicata), Jack-in-the-bush (Eupatorium Odoratum), and lime juice (Citrus Aurantiifolia). Sister Rita makes the bath and has some discretion over what goes into it. These are rubbed and crushed to release the juices, soaked in water, and then mixed with rum, Florida Water or Kananga Water. Finally, psalms are read over the mixture to consecrate it. (Psalm 20 is especially good for this because it is felt to counteract evil.)

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various purposes. All of the bushes used in the bath can be found nearby, but Brother John sometimes goes to a market or pharmacy to purchase roots, bushes, or other materials that he can't get locally, or he might get some of these during his trips abroad. Usually a complete treatment will require three or more bush baths, so return visits are usually necessary. If a special bath or tonic is prescribed, then a batch may be made especially for the person.

Bishop Smith explains that he knows what bushes to use in each case "through the Spirit," but it is clear that many of the treatments he uses are "standardized," i.e. he uses them routinely for particular ailments (cf. Seaga 1968:106). And he admits openly to learning about the use of herbs from a variety of sources. For example, one of his favorite books is Jethro Kloss's Back to Eden, a treatise on herbal medicine, water cures, diet, and other "natural treatments" written in the 1930s (Kloss 1984). He has several other books as well from which he gets information on the use of herbs. He also learns in much the same way that everyone else gets such information -- by word of mouth and through informal discussions. However, it is important for him to focus on the input of the Spirit, for it is this which gives him his status as a specialist and separates him from the knowledgeable amateur.

Brother John also gets much of his knowledge of "Scientific" methods from books. The "Scientist" is true to the connotations of that title, since attainment of specialized knowledge comes through study and personal inspiration rather than just being passed from one person to the next. Although personal contact, influence, and information sharing are important sources of such knowledge, it would be an admission of the

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inferiority of one's "gift" to acknowledge having learned the practice from another individual.[111] The books used to learn "Science" are felt to be the writings of especially gifted, mythical prophets of ancient times, and take on a status akin to "scripture."[112] Thus they are felt to be legitimate sources for knowledge.[113]

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[111]Such teaching does, however, take place through an informal "apprenticeship" and association as a healer's assistant. Brother John, for example, has a couple of assistants who are learning the craft through their association with him. And some other well-established healers in the area have had associations with him in the past, although the extent of these was not readily assessable.

[112]Hogg (1960:4-5), however, points out that these books are sometimes approached quite critically and a Science Man may systematically test the procedures included in a book. This is done not in the belief that the prescriptions are faulty, but under the assumption that the great magicians who wrote them were careful not to reveal all their secrets at once. In order to be able to write more books, and thus make more money, they included a number of procedures with little or no value along with the truly effective techniques. The Science Man thus must sort through the procedures himself to separate the effective from the worthless ones. I did not find this sort of skepticism on the part of Brother John or other Science Men that I worked with, although they did tend to each pick out from the books techniques that they felt to be especially useful, and which became their preferred methods.

[113]Since such books on magical techniques are illegal in Jamaica, they must be smuggled into the country, and once obtained they are kept hidden away. In the past most of the books came from the DeLaurence Company of Chicago, and Brother John obtained some of his collection from this source. (He also says he ordered some materials from them which he never received, probably because they were stopped by Customs.) In recent times other sources for such books and magical materials have arisen, mainly in the US and England. For example, there are several bookstores in Brooklyn, NY where such books and supplies can be purchased. Although Brother John was reluctant to admit to owning such books, I eventually got him to show them to me. His collection includes The Ancient Book of Formulas, Albertus Magnus, Magic Black and White, Napoleon's Book of Fate, The 8th, 9th, and 10th Books of Moses, and several books by Ann Riva (Golden Secrets of Mystical Oils, Powers of the Psalms, Magic with Incense and Powders, The Modern Herbal Spellbook, and Secrets of the Magical Seals). A number of other writers have mentioned the books they saw being used by the Scientists with whom they worked (Dreher 1969; Seaga 1968; Long 1973; Wedenoja 1978; Hogg 1960).

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Brother John uses a variety of rituals, objects and materials in his Scientific work. The materials he most commonly employs are oils, incense, powders, perfumes, and baths. Many of these come in pre-prepared form and are packaged with names like Compellance Powder, High John the Conqueror, Mystic Musk Oil, Confusion Powder, 4711 Cologne, Dead Man Drug, etc. He also makes extensive use of candles of different colors which are used in a variety of rituals. He has a supply of these materials which he brings back with him from his trips abroad. This enables him to sell them to his clients at a cheaper price than they would pay elsewhere (they are available more cheaply in the US than in Jamaica), while giving him some profit. If he does not have the necessary materials on hand he will instruct the client to purchase it at a particular pharmacy in downtown Kingston where these items are sold. He blends some of the materials himself and keeps them scattered on the table in his room behind the church in a jumble of unmarked bottles. He will have some of them on hand in a cardboard box under the table in his "office" but is constantly sending one of his sons or helpers down to his room to fetch others.[114]

In giving out these materials, Brother John must specify how they are to be used, and this frequently requires certain rituals that must

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[114]Brother John has a variety of assistants and helpers of various levels. In addition to Sister Rita, and Brother Thomas, who participate directly in the healing, he has several sons and a few younger boys who hang around the yard and help with more mundane tasks such as cooking, fixing up the yard, etc. He keeps the boys constantly on the move, sticking his head frequently out of the small window in his office to shout things like, "Errol, go down de bottom and fetch de square bottle wi' de lickle clear some'ting in it!" Of course when Errol returns it is usually with the wrong bottle and he must make several return trips before he returns with the correct one.

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be done by the person at home, e.g. scattering a powder around the house, preparation of a bath, burial of an object,[115] etc. He also says that he must sometimes privately perform special rituals for clients in order to enlist spiritual assistance, but since these are usually done when he is alone, it is not clear how often he actually carries them out. In addition to diagnosis, the private visits themselves primarily involve the preparation of materials for later rituals to be performed at home. Except for the bush baths, they do not involve much actual ceremony per se. Often special amulets or objects must be prepared,[116] but this is done very matter-of-factly without much formality or gravity. The materials used may include ordinary objects or ingredients (e.g. honey or condensed milk) which the client is instructed to bring with them. But in most cases the rituals required are completed primarily by the client at home.

Often the person is given an amulet or other such object to carry with them for protection from evil. These may be prepared by writing a psalm or spell, but often they take the form of special objects known as "Guards." Guards come in several different forms, but the most commonly

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[115]Brother John often instructs people in how to perform these tasks clandestinely such that they can be accomplished without attracting undue attention. It can be imagined what the consequences might be if a person was found burying an object in their own or an enemy's yard, as such behavior is equated with evil sorcery, i.e. Obeah. The performance of such counter-sorcery rituals is in fact misinterpreted by some as evidence that Obeah is still widely practiced.

[116]For example, the preparation of a "talisman" or "amulet" often involves the writing of a psalm or a spell on special paper (parchment) with special red ink (either with a new red ball point pent, or with a red ink called Saturn's Blood). Candles are prepared by anointing them with oil and engraving names, spells or psalms into the wax. Sometimes more specialized objects such as wax dolls are prepared.

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used are rings, or charms worn around the neck. The rings are specially constructed with a box-like compartment in which is placed a variety of special materials which might include herbs, quicksilver (mercury), written charms, or body materials (hair or fingernails)[117] (cf. Williams 1934:143). Sometimes special charms worn around the neck are used as guards, and these might have specialized powers according to the type of charm used. Another type of guard is known as a "drinking guard." For this the subject drinks a specially prepared mixture of materials. In general, though, the rings are used most frequently and are felt to be the most powerful.

It is difficult to make a general statement about the amount of time that Brother John spends with each private client because it is both extremely variable and difficult to measure. Frequently it will be influenced by the number of people waiting to see him, and the timing of other engagements that he has to attend to. A consultation is not infrequently broken into several sections with a person being seen, then bathed, then seen again. In the intervals other clients will be seen. Also it is not unusual for a client to get a reading first for themselves, then for a family member or two during the same visit. Not uncommonly a client will come accompanied by a friend or two, or perhaps several family members. These people might be seen first as a group,

[117]Science Men seem to be especially wary and secretive about revealing the contents of these rings, leading me to suspect that either some potentially embarrassing materials are used, or that the secrecy is important to preserve their effectiveness. Because of the hazards of their work, all Science Men, and healers who use these techniques, will wear at least one of these rings. And the wearing of such a ring by a person usually indicates that they have previously made use of the services of a Science Man, though they may be reluctant to admit this.

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then one at a time, then in various combinations of twos or threes. In general, though, it is clear that he is able to spend much more time with each client than a doctor is able to. On a first visit/reading he might spend anywhere from 15 minutes to an hour, depending on the complexity of the case. Return visits are shorter, and may consist of just a short visit to pick up some more medicine, or a short chat followed by a bush bath. The bush baths do not take long to complete -- 10 to 15 minutes on the average.

Treatment by a healer like Brother John can be quite expensive, even when compared to what a visit to a doctor costs. A diagnostic reading alone is fairly cheap -- Brother John charges J$5 ($.91) for this. However, treatment is more expensive and with all the materials and services involved it can cost as much as J$600-800 ($109-145), which understandably can be a heavy burden for a poor person. Bush baths cost from J$5 ($.91) to J$50 ($9.10) depending on how specialized they must be, and for a full treatment several may be required. A guard ring alone costs about J$350 ($64). Some people I spoke with have become disenchanted with Brother John because of the high fees he charges. One woman who had utilized his services in the past, felt that he had lost some of his powers because he had become "too greedy," and she now prefers to visit a Science Man who charges less. Nevertheless Brother John still has a large clientele who feel his services are valuable enough to pay these fees. It is clear that the earnings from this work are Brother John's main source of income, as he is not paid for his ministerial services. They have enabled him to buy a small house in

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Midway and an acre of land in Seaside on which he raises some crops to supplement his income.

Brother John's private clients come from a wider geographic area than those who come to the healing services in the church. In addition to clients from Albion, and other districts in St. Thomas and Portland, he also frequently gets visitors from Kingston and other parts of Jamaica. People from distant areas generally hear about him by word of mouth from friends or relatives who have used his services in the past. While it is of course difficult to make a trip across the island to see a healer, their reputation seems to be magnified by distance. The rigors of such a trip may be justified in especially severe or refractory cases that local healers have been unable to manage. Another reason for visiting a distant healer might be the wish to keep one's visit hidden from neighbors who might gossip about it if it is done locally.

While Brother John in his private healing role could be characterized as a Science Man, he is extremely sensitive about the use of this term. In private he acknowledges his "lickle [little] scientifical business." But because of its negative connotations he bristles when he hears the term "Science" used publicly in reference to his work. He sees himself primarily as a holy man, doing his best to help people who are in need. An example illustrates a typical reaction from him when he feels he's being slandered.

A conductor on one of the country buses plying the route between Morant Bay and Port Antonio, in an exploit in humor and mischievous wordplay, had decided to "rename" Albion Crossing (where the Albion

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access road meets the main road) as "Science Crossing," an obvious reference to Brother John and his work. He proceeded to announce the bus stop as "Science Crossing" each time it was passed, and demand his passengers use the same term by pretending not to recognize the real name. When word of this got back to Brother John he was irate. He paid a visit to the owner of the bus company, with whom he is on friendly terms, and the matter was soon resolved.

There are several other Revival healers active in eastern St. Thomas. In their practice styles they fall somewhere between the extremes represented by Mother Simpson and Brother John. In their public healing they generally use techniques similar to those employed by these two Revival leaders, though each has their individual variations. Some use techniques so similar to Brother John's, that it is hard to imagine that there has not been some sharing of methods, a common influence in the past, or that he has had a direct influence on them. This is quite obvious in the case of a Revival leader/healer like Sister Nancy who heads a Galilee church in Morant Bay under Bishop Smith's jurisdiction. They have had a long and amiable relationship and Brother John often attends and participates in her healing services.

Sister Nancy's services are similar to Brother John's in their structure, e.g. the use of the assembly line format, however she adds a few different techniques. For example she always begins by drawing a circle on the floor with chalk which she divides into four quadrants and then fills with "spirit writing."[118] The patients each stand within

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[118]This is writing, intelligible supposedly only to those who have the gift of Interpretation, which comes to her through the Spirit. It is the written equivalent to speaking in tongues (cf. Wedenoja 1978).

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the circle as they are being worked on by Sister Nancy, who uses techniques similar to Bishop Smith's. Sister Nancy's services are better attended (perhaps because she is in a more populous and accessible area) and also more lively than the Bishop's. Much of the energy and fervor of the services comes from a group of young assistants and officers who regularly reach extraordinarily frantic states of Spirit possession, which make the services exciting and entertaining. Sister Nancy also does private healing in a manner similar to Brother John's, but again with some variations. For example she use a glass of water as a sort of "crystal ball" in her divination (cf. Seaga 1968:102). At this stage her private clientele is less numerous, and her hours less regular. (To support herself and her family she also works a full-time job.) So she is known more for her public healing than her private work. But her popularity is bound to grow in the future, as she is building a loyal following.

SCIENCE

Most of the healers in St. Thomas, including those who rely extensively on Scientific techniques, are affiliated in one way or another with Revival churches. However, there are a few who practice independently of any church or other cult. These are the true Science Men. Their heritage can be traced back to the original Obeah Men (and Women), who throughout Jamaica's history have provided private magical services for the lower classes. As we have seen, the transition from Obeah to Science has taken place fairly recently, especially in the country areas (Hogg 1960). But it seems now that this transition, if

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not complete, is nearly so. All of the non-Revival magical practitioners I was able to locate in eastern St. Thomas rely primarily on Scientific methods rather than Obeah, though one can still occasionally see remnants of the older practices.

While gender is not an absolute determinant of healing styles, culturally defined gender roles are an important factor in the practice patterns of individual healers. Men are more likely to utilize Scientific methods and to practice as independent Science Men. Women on the other hand are more likely to practice as Revival or Balm healers in association with a church group. These patterns are based on culturally stereotyped gender roles which permeate lower class society and which can easily be seen in other social institutions such as the female-oriented lower-class family. In this setting the male is typically the independent, detached, mysterious, and threatening figure, while the female fills the motherly role of nurturing, stability, love and reliability. The church group, which like the family provides stability and "communitas" (cf. Turner 1969), is dominated by women, and it is no surprise that Revival leaders are referred to often as "Mother" or, if male, as "Father" or "Daddy."[119] (cf. Kerr 1952:69,91,135-6).

The Science Man, on the other hand is the aloof loner, without commitment or obligation to any group. Because of this, his power is at once mysterious, potent, and dangerous. It is because of these qualities that he is feared, while at the same time he is in great

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[119]This term goes back at least as far as the Native Baptist groups of the early 19th century whose leaders were called "Mammy" or "Daddy," and may have been used in earlier Myalist groups as well (Gardner 1971[1873]:357; Hogg 1964:109-10). Some of Brother John's followers use the term "Daddy" in addressing him.

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demand when a powerful intervention is needed. This was especially true of the old-time Obeah Man who was conceived of not only as a loner, but as a social deviant and crippled or physically deformed outcast (Williams 1932:195,197,217; 1934:93,100,123; Banbury 1895:7). A few healers, like Brother John, have managed to effectively combine both of these roles, and this is one factor in his great success.

Science Men do share a number of techniques with Revival healers; there is, as we have seen, considerable overlap between the two systems. The Scientific methods used by Revival healer "mixers" like Brother John are in their form and sources (books) basically the same as those used by Science Men. Likewise, Science Men make a similar use of herbal medicine and some religious symbolism (e.g. psalms). In their utilization of the different types of healers, people for the most part make distinctions according to the personal abilities of the healer rather than on the basis of their methods, although there is a tendency of the more strictly "Christian" to use church-based rather than independent healers.

One major difference between the two types of healers, though, is that Science Men practice without the group support and socially acceptable image that a Revival Church provides. This has implications for both their social role and style of practice. Although there are certain role expectations associated with Science Men, without an institutional or group identity they must rely more completely on their own character and social relationships to define their role within the community. The Science Men that I had contact with focused their attentions on helping people with illnesses and other problems, and I

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saw no evidence that they practiced any sort of black magic. (Like Brother John, they did have knowledge of such techniques, which they claimed to need in order to be able to counteract them.) Although some Science Men are socially marginal, their relations within the community are on the whole quite positive and they often are well-known and highly respected. As usual though, people who don't know them well often assume that they practice evil sorcery. However, despite constant efforts I was never able to find one of those "old and shrivelled" evil sorcerers (Williams 1934:123) that people fear so much.

Whatever their intentions, the reality of the Science Man's work is that it is essentially an illegal activity, and has been so for over two hundred years. They do not have the aura of respectability that a church leader can claim. In the past, prosecutions for "Obeah" were actually fairly commonplace, and fueled the public fears of sorcery (see Williams 1934:129-35). In recent years, however, these appear to have become less frequent, probably due at least in part to the current political climate.[120] Another factor is the usual tolerance by local police who often fear, and may even be clients of, Science Men (cf. Dreher 1969:82-3).

Because Science Men work on their own without public ceremonies, they rely more extensively on private rituals instead.

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[120] Edward Seaga, who was the Prime Minister of Jamaica during the research period, did some of the earliest and best research on folk healing and Revivalism in Jamaica. Trained as a sociologist, he conducted research primarily among Revival and Pocomania groups in West Kingston, and provided some insightful analyses of the practices and the social roles of healers and Revivalist cults (e.g. Seaga 1968, 1969). He continues to maintain contacts with Revivalists and healers, and has worked for the preservation and promotion of Jamaican traditions.

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Whereas the ceremonial performances of Brother John are carried out for the most part in his public healing services, a Science Man will often make use of elaborate private rituals to a much greater extent. In terms of drama and intensity some of these private ceremonies approach the public rituals which take place in Revival churches. But their intensity derives not from the connection and communitas that a public healing ceremony provides, but rather from the fear, danger and mystery that surrounds personal contact with unknown, powerful, and dangerous spirits.

The Professor

True Science Men are much less numerous and more difficult to locate in St. Thomas than are Revival healers. While Revival leaders try to keep a relatively high profile so as to enhance the popularity and success of their churches, the role of a Science Man requires greater discretion. But there are a few who have become well known because of their success in a long-standing practice. One of the best known Science Men in eastern St. Thomas is James Parker, who plies his trade in the district of Stratford, which is located a few miles to the west of Albion and to the north of Midway.

To most he is known as Mr. Parker or Mas' James, but his friends and regular clients often address him as "Professor" or just "Prof'."[121] He is a small man (about 5'5'') but his energy and booming

[121]This title, of course, seems quite appropriate for someone who deals in "Science" and might be supposed to have arisen relatively recently with the transition from Obeah to Science. Interestingly, though, this term has actually been used to refer to practitioners of Obeah since at least (continued...)

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voice more than compensate for his size. He is 66 but looks and acts like he is in his 50s. In his loquaciousness he is the opposite of Brother John. He controls every conversation with a steamroller of incessant philosophizing, lecturing, storytelling, and joking. With his wide ranging interests and knowledge he comes across as very intelligent, and he approaches life and the study of the Mystical Arts with common sense and pragmatism rather than ideological conviction.

He refers to his practice as "Occult Healing" or "Magical Healing" but points out that one could call it Science, Voodoo, or Tangoo -- "it all mean de same t'ing." He believes in a Universal Power or "Great Spirit" but maintains an independence from any particular religion. He thinks that Christ, or "the Nazarene" as he refers to him was, like Moses, Buddha, etc., a great prophet, but was otherwise just an ordinary man. He accepts many aspects of Christian philosophy, but thinks that some parts of it are pure nonsense. The ideas of "turning the other cheek," or "giving one's coat to a stranger" seem silly to him. Likewise, he feels that there are some parts of the Bible which are obviously falsified. For example, he explains that Joshua could never actually have stopped the sun, as is reported in the Bible. He was just a great astronomer, so he knew that an eclipse was about to happen, and used that knowledge to fool the people. He enjoys discussing topics such as the possibility of life in outer space, and the question of

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[121](...continued)
the 18th century. In 1794, Bryan Edwards, an historian of early Jamaica, wrote, "It is very difficult for the White proprietor to distinguish the *Obeah professor* from any other Negro upon his plantation." (Edwards 1794, quoted in Cassidy 1961:242, italics added).

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reincarnation. To most these would be rather arcane matters, but to him they are issues of immediate and practical cosmological significance.

He believes, or rather "knows" from his experience, that the world is populated with a variety of spirits both good and evil. Any of these can be contacted and harnessed to further human interests, but to do this takes a great deal of skill, training, and fortitude. And even with experience one must be very careful, since dealing with such spirits is very dangerous -- even a simple mistake can be fatal. In his work he deals with a spirit medium which he contacts and communicates with while in a trance state. This enables him to see things that only the spirits can reveal, and to enlist their help in influencing events.

He was born and grew up near the spot where he now practices. The house he works in belonged to his parents. But he spent a number of years away, living in Portland and St. Elizabeth before returning to St. Thomas about 20 years ago. He first became involved in occult practices through his work as a performer. As a young man he saw a travelling troupe of acrobats perform, and decided that he should be able to do these feats just as well. So he started learning acrobatic and magical tricks and soon was in a travelling show. He eventually met a young woman who had a talent as a spirit medium, and it was she who introduced him to the occult. They started doing a show together in which he would hypnotize her. She would go into a trance and then would be able to answer whatever questions the audience put to her.

The Professor didn't start doing any healing until he was in his 20s. The call to do healing work came to him as a spiritual gift through a vision (dream) which he got at a time when he was very sick.

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In this vision he found himself in the Coronation Market in Kingston, where he saw a white man, a black man, and a woman who told him, "We're going to heal people." The woman took him into a hospital where there were several sick girls, whom they fed pieces of breadfruit with butter. The woman told him he "must do these things for the people." She gave him a uniform and showed him the various plants, candles, objects, etc. that he was to use in healing. He told her no, he didn't want to do it, and tried to throw away the garment. But she told him, "The Master says you must do these things, and you will be smitten if you don't." So he felt he had no choice but to accept this calling. Following this vision he used the techniques to cure some people and had further visions which taught him more. Soon people started coming to him regularly for treatment. He has continued his healing since then, including during the years that he spent in other parishes.

He admits knowing the techniques for practicing evil magic but denies that he will carry out the evil deeds that people occasionally come to ask him to perform. He calls this sort of person "vicious and stupid," and wants nothing to do with them. But he does readily admit that he knows magic that will "get rid of somebody" (i.e. make them move away and leave him alone), and says he might use it against someone who is giving him trouble, e.g. not paying money that is owed to him.

He believes that illness can result from either spiritual or natural causes. He can treat the former effectively through his magic and with the aid of his spirit medium, and also says he can have some effect on the latter by using herbs, etc. But in general he believes a "natural" illness should be treated by a doctor. For example, a case of

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madness can be caused naturally (e.g. by overuse of the brain, use of ganja, etc.) or by spiritual forces. He is able to treat the latter, but a natural madness is not effectively treatable by his occult methods.[122]

The Professor believes that faith is a crucial element in the success of his treatment, or any other type of treatment for that matter. This is not an abstract faith in a higher power, but rather a faith in the effectiveness of the treatment, and a firm belief that it will work. Without this it is much more difficult to produce positive results. He consciously cultivates the faith of his clients with his own self-assurance, dramatic demonstrations of his powers, and reassurance when they express any doubts. He feels that he must carefully cultivate his relationships with his clients in order to win their trust and respect. He compares this to the "taming" of an animal, such as a cow, who will not obey or follow you unless you have built up a relationship of trust through compassionate but firm treatment. He feels that many biomedical doctors fail to cultivate such relationships, and thus hurt their chances of success in treating patients.

Mr. Parker has the busiest practice of any of the folk healers I worked with in St. Thomas. His clientele comes from all over Jamaica (and even from abroad), though primarily from St. Thomas, Portland, and Kingston. His office is hard to find, as it is off the main on a side

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[122]the Professor explains that a spiritual madness can sometimes be cured by tying the person up in a rope which has been used to hang someone. The best for this is a rope that has been used by a murderer to hang himself. He has never actually tried this technique himself but remembered reading it in one of his books. In general he usually doesn't attempt to treat cases of madness.

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road at the top of a steep hill (John Crow Hill). Only the determined are able to find the route, locate the road, and climb the hill. Many first time customers are brought by friends who have made use of his services in the past. People come to him for assistance with a wide variety of problems, from trouble with relationships to court cases, of which illness constitutes about a third to a half. Like Brother John's clients, they often come with several interrelated problems.

When a client reaches the top of the hill, invariably panting and covered with sweat, they are greeted by a worn sign outside the gate painted with an angel and the words, "Please say the Lord's prayer before you enter." After obeying this instruction, they enter the yard and take a seat on one of the hard benches, usually with a number of other clients, in the roofed, cement-floored waiting area (about 10' x 15') that Mr. Parker has constructed in front of the house. The house is a sturdy four-room wooden building. On the veranda and front walls of the house are painted pictures which serve as a reminder of the business at hand: two black snakes curled around the door frame, an angel with a sword and a torch, a man with a sword cutting off the head of a three-headed snake, a portrait of Christ, spiritualist benedictions ("Sanctous Spiritous," INRI), etc.[123] A radio on the small veranda next to the house blares with popular daytime talk shows.[124]

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[123]The paintings were done by a cousin of Mr. Parker who lives in Albion, and who paints many of the signs and murals commissioned by local rumshops, shops, night clubs, etc.

[124]It seems that the Professor uses this blasting radio as a means of enhancing the privacy of the activities going on within his office since it is very difficult for anyone sitting in the waiting area to hear what is going on in the office over this racket.

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The wait can be a long one unless the person has arrived very early, because there are usually five to ten or more people waiting at any one time, and it can take the Professor an hour or more to finish with each client. (Some of the people waiting may have just accompanied someone else, or may be there for just a quick return visit.) I have seen some people wait all day long, only to be turned away at the end of the day because there is no time left. When it gets especially crowded, Prof's son will hand out numbers to make sure people are seen on a first-come, first-served basis. (Sometimes exceptions are made for someone who has come from a very great distance, since their journey is too long for an early arrival, and they must leave in time to catch the bus back home.)

Mr. Parker no longer lives in the house where his office is located. With the income from his healing work, and remittances from his wife who is a nurse in England, he has built a large home near the beach in Seaside and commutes each day to his office to work. (His son does live in the Stratford house and looks after the planting and the animals.) In this large and comfortable house, which is still under construction, he says he has a special room, in which no one else is allowed. It is here that he does his studying, prepares for his daily work, and performs special rituals for his clients. And he keeps most of his mystical books here as well, for use in his studies and trials of magical techniques.

The Prof' arrives at his office each weekday morning at about 7:30 AM. He first changes into his uniform: a blue robe, green skullcap embroidered with special mystical words and adorned with a jewelled

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brooch, a chain around his neck, and a plaid cloth over his shoulder. His fingers are filled with a half dozen guard rings, and other special rings. He then spends an hour or so burning incense, reciting invocations and benedictions, burning candles, praying, etc. in order to contact his spirit medium and prepare for the day's work. By about 8:30 he is ready to see the first client, who has usually arrived by then. He works until about 5:00 PM, but may stay till 6:00 or 7:00 if he is involved in a long case.

He uses one of the front rooms off the veranda as his "office." In this room is a table covered with sheet metal, and adorned with a variety of objects (a menorah with candles of several colors, a small brass buddha, a brass crucifix, a couple of crystal balls, etc.) which he uses in his reading, healing, and other rituals. On a shelf is a collection of oils (mostly refined herbal oils such as jasmine, cinnamon, etc.) and magical powders.

In "reading" Mr. Parker uses a small crystal ball. He explains that it takes seven years of intense training to master the use this tool, which he learned how to do through his books. Because his eyes have become so sensitive he now wears sunglasses whenever he goes outside. (This adds to his distinctive appearance, as few Jamaicans wear sunglasses.) Before he does the reading he must go through an opening ritual which entails lighting candles, burning incense, making certain adjustments of other objects on the table, rubbing rum on his face and hands, and making an offering of rum to the "descendants" (i.e. ancestors). Throughout this process he recites a series of complex invocations and the client is required to contribute at certain key

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points, for example by stating their name. He explained to me that he is in a trance state as he does this, though outwardly his state of consciousness does not appear to change dramatically. When the ritual is completed he gazes into the crystal ball, covering it partially with his hands. As he gazes he pauses repeatedly to write down his findings in a school exercise book. This writing, which he calls "shorthand" or "Hebrew," was illegible to me. It looks like random scribbles. When he has filled up a page or more, and gotten all the information he needs, he closes the process by reciting more invocations to send the spirits away, putting the candles out and reversing the manipulations of the objects. He then literally reads from the paper the information for the client, viz. what is wrong and what must be done about it. Like Brother John, the Professor can do a reading for someone who is not present if a piece of clothing is brought, though in this case a slightly different ritual technique is used.

Treatment involves even more elaborate ceremony. Often this requires that the person bring several objects or materials with them when they come. Usually, after a reading is done and the proper ritual determined, the person is told to return on a different day with the requisite materials. This serves as a means of involving the client deeply in the preparation for their treatment, and insures a deep commitment to it -- those who have doubts will not return.

A variety of rituals are used in treatment, but there is one in particular which the Professor seems to use most frequently. The purpose of this rite, is to invoke the assistance of spirits in order to attain a particular "wish," whatever that may be, and to provide for the

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spiritual protection of the client from evil. It involves invocation of the spirits, communication of the wish to them, "building a talisman" to protect the subject (sometimes a guard ring is also prepared during this ceremony), the ritual preparation of protective garments (underwear), concoction of a magical bath solution to be used at home, and the preparation and provision of several other magical objects (candles, incense, magical gravel to be placed around the home, etc.) also to be used at home.

In some of these "operations" animal sacrifices are required, and this usually means a white cock. For especially severe cases a more powerful ceremony is needed, and a rabbit or other animal might be used instead. Following the ritual, the animal can be eaten, quite unceremoniously. (I recall some delicious lunches of rabbit stew which these occasions provided.)

Through a skilled utilization of intricate ceremonial actions, accompanied by elaborate invocations delivered in a penetrating, hammering rhythm, the Professor transports the subject to the world of the spirits, where they stand "naked" (in a figurative sense) before them, stripped of all pretense. The subject is left alone to state his case with the spirits while the Professor leaves the room to continue his management of the proceedings from the adjoining "altar room."[125] When the subject has finished communicating his wishes to the spirits,

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[125]When the Professor enters this room he can be heard through the door continuing with further invocations, and supposedly with special ritual acts. I later got a look at the "altar room" and found that it contained little except a small shelf with a few bottles on it. There was no special altar to be seen. Nevertheless this does not seem to detract from its real function.

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he knocks three times on the door of the altar room and the Prof' returns to continue the proceedings. This ritual thus affords the client a great deal of privacy, as even the healer is not present for parts of it.[126]

Later in the ceremony the Professor mixes up a magical bath (to be used at home) in a small rum bottle. This performance is also quite impressive because the mixture produces a dazzling combination of colors and movement. The liquid contains slowly blending bright colors, as well as particles which mysteriously bob repetitively up and down from the bottom of the bottle to the surface (presumably due do an effervescent action), which adds to the drama of the ritual and provides further proof of the Professors powers.[127]

Following recitation of spells aimed at insuring the departure of the spirits, the client is given the materials to be used at home and is instructed in their use. This involves a complex ritual of candle lighting, incense burning, bathing, invocations, etc. which must be

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[126]Since the problem being addressed is often quite personal (e.g. legal or sexual), and there may at times even be attempts to elicit the help of the spirits to harm enemies (though I never saw this), the rituals are surrounded with an aura of secrecy and privacy. It is not surprising, then, that the presence of an observer is problematic. Access was consequently difficult, though I was fortunate enough to be allowed to observe several of these readings and ceremonies. I was not allowed to make tape recordings of any of them.

[127]The Professor also uses other techniques of simple chemistry to demonstrate his powers. For example he will sometimes mix a powder and liquid in a newspaper, which is then rolled up and dropped on the ground. This inexplicably starts smoking and then bursts into flames. The client is told to step over the smoldering paper and then put their left foot on it until it is out. Brother John used a similar "miracle" to demonstrate his magical powers to me. He mixed potassium permanganate and glycerine in a paper, which was then rolied tightly. As Psalm 75 was read repeatedly over it, it started smoking, then burning, whereupon he threw it to the ground.

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repeated over several days. This is a daunting proposition for many of the clients, a good proportion of whom are illiterate. Even I had to write the instructions down a few times to get them straight. (The Professor will write down instructions if the person desires.) No doubt the requirement that the person follow through with a complex ritual at home enhances their feeling of participation in the treatment, and hopefully their feeling of control over their problems.

Unlike Brother John, Mr. Parker does not give bush baths at his office, and his use of herbal treatments is less frequent. He does have a knowledge of herbal medicine, and sometimes prescribes herbal tonics or teas for his patients. However, in his occult healing he tends to use refined oils rather than actual bushes. His use of bushes actually seems to parallel their use in the popular sector, though he has more knowledge of them than the average person. In this way his employment of them differs slightly from that of Brother John who often uses bush baths as a means of cleansing a person spiritually.

Treatment by the Professor can cost as much as what Brother John charges. A reading alone costs J$10 ($1.82), and in minor cases the treatment may require a simple ritual at home using cheap materials. In more serious cases, though, the costs can run up to J$600-800 ($109-145) or even more, in addition to the cost of the materials. Like Brother John, the Professor is fairly relaxed about payment, and usually this is done in installments. Most people will pay the full amount eventually, since non-payment of a debt to a spiritually powerful, and dangerous, man is a risky proposition.

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KUMINA

As pointed out earlier (see p. 245) the Kumina cult is an African-derived ancestor "worship" cult peculiar to St. Thomas. Though less active now than it was during the 1950s, Kuminas are still held in Albion on a fairly regular basis. It is said that the cult is even more active is some other parts of the parish. Kumina ceremonies are usually held as memorial rites for dead ancestors, or at important life transitions (birth, death, marriage, etc). They may also be held for various practical purposes, including healing.[128] There was only one instance of a Kumina being held for healing purposes during my stay in Albion, though I did meet several other people who had used them for this purpose in the past.

Kuminas are usually held only by families which are involved in the cult, and these are mostly descendants of Central African indentured laborers who were brought to the parish in the mid-nineteenth century (see p. 45). It is usually these families that use them for healing purposes. But other people will attend as observers, or sometimes as participants. In some instances healing Kuminas will be held by other "non-Kumina" families, mainly in cases that have been refractory to

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[128]It is generally held that Kuminas can also be used to call the spirits to perform some evil deed, such as killing or harming someone. I found it hard to believe that a large number of people would be willing to participate in a ceremony with an evil intent. I was informed that the specialists who are running the Kumina can do this and use the zombies for their own purposes without letting the crowd of people attending know about it. Thus the crowd may participate as unwitting accomplices. Some people shun all Kuminas for this reason, but most are willing to go anyway since they feel they don't have direct control, and participate primarily as observers. Some claim that in a Kumina intended for evil purposes the "booth" will be decorated in red and white, so that one should be able to tell which ones to avoid by watching for this.

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biomedical treatment and other types of folk healing. The expense and organizational complexity of hosting a Kumina make it a method of final resort in most cases, except when it is prescribed specifically by a Science Man or other healer.

A Kumina is felt to be effective primarily for spiritually caused illnesses (cf. Schuler 1980:80). Lack of response to biomedical treatment is usually considered to be evidence of spiritual causation. If the illness also shows no response to other forms of folk healing, then it may be decided that it is caused by an ancestral spirit who is feeling neglected or slighted, and a divination may confirm this suspicion. In such cases a Kumina may be felt to be the most appropriate manner of addressing the desires of the ancestor. Some folk healers (mainly Science Men) will themselves suggest a Kumina as primary treatment if they feel the illness is caused by an ancestor in need of placation, especially if the patient is from a Kumina family. In addition there are some Science Men (or Obeah Men) who are deeply involved in Kumina and may use it as one of their primary modalities for treating difficult cases.[129]

Traditionally the holding of a Memorial Kumina entails the appointment of several officers, individuals experienced in the cult. Among these are the Mother of the Kumina who acts as the chief spiritual leader, the Queen and her attendants, and the Scientist or "Obeah Man"

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[129]Moore (1953), for example, described several "Scientists" or "Obeah Men" in St. Thomas who had facilities in their compounds for conducting private Kumina ceremonies with the purpose of invoking spirits for the performance of various tasks, including healing (Moore 1953:124-35). I did not see this, and cannot comment on whether it still occurs. However, there are Science Men/Kumina leaders who can be enlisted to organize and run Kumina services with various purposes at private homes.

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who looks after the technical aspects of the ceremony (Moore 1953:144-8; Schuler 1980:73-6). Other types of Kuminas, e.g. for weddings or betrothals, are less formally structured, and are usually organized by a family member experienced in the cult. For a healing Kumina, though, more professional help is usually sought, especially when the family has not had any previous experience in organizing a ceremony. Ownership of drums is also a factor here, since very few families in the district own them, and the attendance of someone who has the necessary equipment must be assured. The person who brings the drums is generally the one who runs the ceremony, and for this service a specialist often is paid.

The healing Kumina that I witnessed was conducted by a Science Man named Barker, who was originally from Albion, but who now lives in Stratford. This man also practices private "Scientific" healing at his home at the base of John Crow Hill on the same road which leads to James Parker's office. The sick woman for whom the Kumina was held explained to me that she invited him to run the Kumina because he was the only one she knew who owned drums. But Barker's participation may also have been related to his involvement in the case at an earlier point, when the woman's brother took some clothing of hers to him for a private "reading."

A Kumina is held in a specially constructed, though simple, "booth" consisting of a coconut thatched roof with bamboo supports over a dancing floor. The center post is of significance as a focal point for the attraction of the "zombie" (nzambi) spirits, and may be decorated specially. At the healing Kumina I attended the center post was wrapped with a white ribbon and a white candle was placed at its

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base. Ideally the booth will be lit with an electric bulb, though this is not always available.

In the Kumina ceremony two drums are used to call the spirits of the zombies (gods and ancestors) to come and possess the dancers, who dance around the drummers counter-clockwise in a circle. There is usually one bass drum (called a banda or kimbanda) on which a steady rhythm is played, and one higher pitched "playing drum" on which the more melodic and intricate rhythms are played.[130] There are several other simple rhythm instruments which can be played by the less experienced, such as "shakers" (rattles), a scraper, and "kyata" sticks (used to hit the wooden rim at the back end of the drum), which are used to accompany the drums. The dancers and bystanders clap and sing repetitive, call-and-response songs along with the drumming. Sacrifices of rum, wine, etc. are made to the spirits by spraying them from the mouth around the booth and at the periphery of the yard. The participants also partake liberally of the rum and other beverages provided.

The Kumina drumming begins at around 8:00PM or so (traditionally at sundown) and continues throughout the night until the next morning, though the smaller family-oriented ceremonies might break up earlier. The intensity of the activities waxes and wanes throughout the night.

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[130]The drummers are usually local people who have considerable experience with Kumina, though some may come from other districts as well to participate. It takes more skill to play the playing drum, and this honor will be reserved for the more experienced drummers. The drums are made of hollowed out logs with goatskin heads, and are tuned by banging the nails which fasten a wooden strip holding the head on. In preparation for the Kumina they are ritually rubbed with rum. The drummer sits astride the drum and uses his hands to hit the head.

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The spirits enter the drums where each is believed to actually play its trademark rhythm, such that individual spirits can be recognized as they arrive at the Kumina through the drums, according to their individual rhythms.[131] As they move around the circle, some of the dancers will be possessed one by one by zombie spirits. (This is referred to as "catching a myal.") The possession state is violent at first, and the person is often thrown to the ground thrashing. Assistants and other dancers will help keep these people under control so they don't hurt themselves or anyone else present. Gradually they become more controlled and assume the personality of the zombie, but must still be watched over. When a person is possessed, their behavior is unpredictable (though each particular zombie is considered to have a characteristic personality) and they are controlled by the whims of the spirit. They may dance in unusual (again, characteristic) postures, run into the bush or to the spirit's gravesite, try to climb trees, throw things, etc. Of course, this is all great entertainment for the crowd of bystanders, and many people attend just to watch the amusing and bizarre antics of the possessed dancers.

Except perhaps for some of the smaller ceremonies, there is almost always an animal sacrifice in a Kumina, and typically this takes place at midnight. Usually it is a goat that is killed, though a cock might be used at a small ceremony. The goat is first led around the circle and forced to drink rum as a means of acquainting it with the spirits.

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[131] As proof of this several people, including some not deeply involved in Kumina, related to me descriptions of very powerful Kuminas they had witnessed in which the drums were covered with a sheet, and continued to play on their own, with no drummer touching them.

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It is killed by cutting its throat, usually on the grave of the person being memorialized. Later the goat is curried and shared by the family and guests.

At the special healing Kumina I attended, a cock was killed over the sick woman who lay on the ground, after a 10-cent piece and some rum were forced down its throat. Blood was spattered on the woman and pieces of the chicken thrown as offerings to the zombies. Bottles of cream soda and stout were shaken and squirted all over the woman and other participants. Candles were also used to cut the evil spirits off of her. The dancers who became possessed focused all their attentions on the sick woman. Apparently the zombies who possessed them were spirits of her ancestors who had come to try to heal her. They clung to her, danced with her, and subjected her to a number of symbolic acts, the meaning of which was unclear, but the intent of which was apparently to heal her. She had buckets of water and bags of rice dumped over her head. She was carried around upside down and spun in the air. The zombies made her jump back and forth over a fire, after which her slip was taken from under her dress and burned almost completely in the fire. The burned slip was then soaked in a pail of water (about a quart) which the sick woman was required to drink. These activities went on for several hours.

Spirits in a Kumina are felt to act out their whims and desires according to their own rules. Acts which to humans don't seem to make much sense are meaningful to the zombies. Thus when possessed dancers appear to behave "irrationally" it is just because we don't understand their higher purposes. These symbolic acts by the zombies were

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considered to have a real magical purpose and no one questioned the meaning of them.

For the person who is the object of such a healing ceremony, the most salient reaction seems to be one of fear. It is essentially an ordeal. The person is never in any real danger, but the unpredictability and intensity of the experience gives it a shock quality, especially to someone who is not experienced in Kumina. It is impossible to generalize from observation of a single case, but from others I talked to this seemed to be a common reaction. A sixteen year old girl who had become hemiparetic (probably due to intracranial hemorrhage or other cerebrovascular accident during pregnancy) was treated with a similar ceremony. Later she was able to joke about how the goat was put around her neck and then killed, but it had obviously been a traumatic experience at the time. She reportedly vomited for several days afterwards.

Nevertheless, the experience of having a large number of people and several spirits all working to cure the individual makes it more than just a simple ordeal. There is some tenderness involved as well. At the healing Kumina I attended, one of the possessed women spent a considerable amount of time with her arm around the sick woman, talking with her and giving her advice from the spirit world. She also took her off alone to the back of the yard where they shared a drink of wine and made offerings to her ancestors. So there is a sense of connection with the spirit world established, especially with one's ancestors and dead loved ones.

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SUMMARY AND COMMENTS

Because of its complexity, folk healing as currently practiced in eastern St. Thomas is difficult to break down into simple discrete categories for the purposes of analysis. I have attempted in this chapter to deal with this problem by focusing on the major styles which, at least in a theoretical sense, are distinguishable as separate, coherent systems. These four "ideal types" (Faith Healing, Revival Healing, Science, and Kumina) illustrate the range of folk healing styles that are currently in use in this area.[132] In practice, it would be unusual to find any of these styles being used in a "pure" form by any particular healer. Many individual healers utilize a combination of two or more folk healing styles, and may also mix in elements of popular medicine (e.g. popular bush medicine) and Biomedicine. However, by defining these ideal types we are able to make some sense of the variety of patterns that are found, and analyze them on several different levels.

These four healing styles, like the religious forms with which they are closely connected, fall along a cultural spectrum ranging from traditional African/Myalist forms at one end to European/Christian-Protestant forms at the other. The position of each style on this axis

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[132]These categories do not necessarily exhaust all of the styles of folk healing that can be found in Jamaica. For example "Balm" healing, which is prevalent in some areas of the island, especially in western parishes such as St. Elizabeth and Manchester, is similar to Revival healing, but seems to have characteristics which distinguish it to some extent. Balm healers tend to rely more heavily on the use of bush medicines than the practitioners discussed here (cf. Wedenoja 1978, Long 1973).

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reflects its historical evolution, as well as the cultural orientation and social status of its adherents.[133]

Faith Healing, and Pentecostalism, with which is intimately connected, although actually of primarily American origin, is the most European/Christian of the healing styles that we have discussed here. Its outward symbolism is altogether Christian, and it is only in its core elements that we find what appear to be some African derivatives, such as the belief that illness may be caused by personalized spiritual forces (e.g. demons, duppies).[134] But it combines this concept syncretically with the more Christian/European notion that illness and

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[133]Although these different healing styles and religious forms can be characterized as being more African or Christian in orientation, it should be kept in mind that overall, at its core, and in its continuing popular usage, Jamaican folk healing is historically a cultural product of the slave/lower class. Thus all of these styles contain African elements to a greater or lesser degree. In fact, the extent to which healing is used within a particular religious mode seems to be an indicator its proximity to African derived religious forms. Folk/religious healing was disdained by the Protestant traditions that predominated historically in Jamaica, and it was only with the development of syncretic forms in the late eighteenth and early nineteenth centuries that folk healing became integrated with Christian elements. The more recent introduction from America of Pentecostalism, in which healing has a more accepted role, complicates the matter somewhat. However, these Pentecostal traditions have also been integrated syncretically with more purely Jamaican forms. Consequently, even among the most outwardly Christian forms, the prominence of healing activities seems to indicate a greater degree of influence by African culture than is found in denominations in which healing is not an important function, such as the "established churches" (e.g. Anglican, Catholic, etc.). Thus when we are discussing folk healing styles and their interconnections with popular religions (if in fact the two can be separated at all, cf. Comaroff 1983) it must be remembered that we are concentrating on lower-class Jamaican culture, and the more African end of the cultural spectrum.

[134]This is not to say that the idea of personalized spirits and demons as a cause of illness is totally foreign to European derived Protestant traditions. However, the manifestation of this concept in popular culture in Jamaica seems to be more closely related to African traditions, for example in the widely held popular belief in duppies as concerned ancestral spirits.

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other misfortunes are linked with moral and spiritual transgressions (i.e. sin). The belief that illness can be cured by appeal to an anthropomorphic deity (Jesus) also combines African and Christian elements.

Faith Healing is primarily a public activity, and it contains a strong implication that the personal matters of sickness and healing are tied up with moral responsibility to a community (one's fellow parishioners). But it can also have a private aspect as well, as we saw in the work of Mother Winslow, and as was illustrated earlier in the case of Olive Johnson (See Chapter 4, p. 117). Likewise, Pentecostal religious experience is primarily public, but also has some elements of privacy. While a Pentecostal congregation participates as a community in a service, the individual experiences the Holy Spirit personally: when one is possessed, the outside world dissolves.

Faith Healing is essentially religious, rather than magical, in nature in the sense that healing takes place through appeal to and worship of a supreme deity rather than through manipulation of spirits by instrumental means. The Faith Healer acts primarily as a conduit for this spiritual force rather than as a skillful manipulator of spirits or as a knowledgeable user of bushes or drugs. The power of a Faith Healer consists in the spiritual gift they have received which enables them to act as a channel for the power of the deity. In seeking the help of a Faith Healer, a sick person is attempting to reassert control of their own destiny by placing it in the hands of Jesus, whom their faith tells them they can trust to act in their best interests. While the Faith Healer has a great deal of power, it is based on their close connection

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with the deity. There is little risk that the healer will usurp control of the therapeutic relationship for their own purposes, or fail to act in their "patient's" best interest. A person must, at least in theory, have some degree of religious faith in order to seek the help of a Faith Healer and this necessarily carries with it a trust in the concern and good intentions of the healer. This trust is enhanced when a healer, such as Mother Winslow, refuses payment for her services, but rather asks only for a donation for the church. The Faith Healer is among the least threatening and most admired of any practitioner in the Jamaican setting.

But for those with a cultural orientation more closely tied in with the traditional African stream, healers who are able to communicate with and manipulate spirits that are "closer" to the human situation represent a more powerful option. In traditional African cosmology it is these "earthbound" spirits (e.g. ghosts of the dead) which are most concerned with human affairs, and which exert the most influence over day to day matters. They represent the greatest threat in terms of illness causation, and also the greatest hope for supernatural intervention when help is needed to cure an illness or counteract misfortune. It is generally assumed that only the most dedicated Christian can have a faith strong enough to enable them to receive the full benefit of Jesus's mercy. For the average person who has less faith and trust in Jesus, another type of healer with more personal power represents a more useful alternative.

In Revival healing the healer becomes a more significant part of the therapeutic equation. A Revival healer also depends on a spiritual

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gift for his or her power, but is more than just a channel for the power of Jesus. He or she learns to manipulate the power of the Holy Spirit through hard work and devoted study (See p. 277). In Revival healing, special objects and symbols play a much greater role than in Faith Healing. Revival healers must learn how to use these objects and manipulate their symbolic power effectively in order to be able to conduct a successful and spiritually charged service. Some of these objects can be used by anyone with sufficient knowledge and experience while others, such as Mother Simpson's Bible (See p. 283), are effective only in the hands of the individual to whom they are given by the Holy Spirit.

In the cosmology of Revivalism, illness is more of a personal affair than it is in Pentecostal Faith Healing. In Revivalism, sickness is more often ascribed to conflicts with the spirit world (whether through malfeasance or accident) rather than to a moral transgression with respect to the community, though the latter certainly happens. One can get sick through persecution by personalized "earth-bound" spirits, be they "duppies" or "demons." These spirits may become adversaries as the result of a personal conflict or slight (such as when the duppy of a relative becomes offended by the handling of their property), by conflicts within the surviving family, or by neglect of ritual responsibilities. In other cases, the spirit of a dead man may return to pursue conflicts unresolved during life. An evil spirit may also be "set" on a person through sorcery. Alternatively, this may happen just by chance, for example when a person is unlucky enough to accidentally "buck up on" (meet up with) a duppy roaming through the night. Thus, in

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Revivalist belief, moral culpability less frequently becomes an issue in the explanation and treatment of an illness.

Likewise, treatment of an illness through Revival healing is more of a personal and individualized affair, even though it usually occurs in the setting of public Revival healing services. In such services, the "patients" are treated literally in an "assembly line" fashion, with several stations that must be passed through before the main Healer is reached. Each person receives equivalent treatment at these stations (e.g. "cutting" with a candle or scissors, a "rubbing up" with bush bath, etc.), but this is considered to be preparatory to the real treatment which is done by the healer. Even when they reach the healer, the treatment for each seems quite similar (e.g. rubbing up with oil and Florida Water, etc.). Yet despite this apparent uniformity, individualization of treatment is an important element of Revival Healing.

In Revivalism, the concept of illness differs from that of Biomedicine in that diseases are not conceived of as discrete definable entities, each having a specific etiology and a specific mode of treatment. While "natural sicknesses" are felt to fit somewhat into this pattern, and consequently to be most effectively treated by a doctor, the types of illnesses that Revival healers are usually asked to treat are "spiritual sicknesses," which have a much more global manifestation and a less straightforward mode of treatment. This type of illness is thought to result not from a physiological derangement characteristic of a particular disease entity, but from a malignant constellation of spiritual forces unique to an individual. When a

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person is "dealt a blow" or has "destruction" cast upon them for whatever reason, the effect is a general spiritual trauma which can be manifested in a variety of ways. As part of an overall decline in one's ability to interact successfully with the world -- in relationships, financial matters, personal satisfaction, etc. -- any type or combination of physical illnesses might result. Treatment of the disease per se can only be a temporizing measure. Unless one gets to and uproots the spiritual cause of the problem, the inexorable decline will continue. Each problem or illness that a Revival healer is asked to address is the result of a unique combination of spiritual and personal factors, and thus must be approached in an individualized manner.

This individualization of treatment in Revival healing services is not obvious at first, but with continued observation it becomes more clear. Each "patient" is initially "sounded," "read," and "anointed" by the healer in a similar fashion, yet there is actually considerable variation in the patterns used. For example, the healer often concentrates on a particular part of the body, and varies the pattern of sounding, manipulation, and anointment for each person. But the individualization of treatment goes far beyond this. As mentioned earlier, there are typically several patients in each Healing Service who are judged to be in need of more than just the basic therapy. It is in the prolonged ministrations to these individuals that the individualization, spontaneity, and improvisation which form the basis of Revival healing become obvious.

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The actions of the healer and his or her assistants are believed to be controlled by the Holy Spirit, as it is the Spirit which gives them the ability to heal and which guides them in their work. Those who have reached the higher levels of spiritual development are in such close touch with the Holy Spirit that they are assumed to be possessed and controlled by it throughout the service. The healer and assistants must act "as the Spirit moves them" in order to deliver the proper combination of symbolic actions, hymns, and prayers which can break, or at least suppress, the power of the evil forces causing the problem. They must open themselves to the spontaneous influence of the Holy Ghost, though this must be done in harmony with the group as a whole. The result is a cyclical ebb and flow of spontaneous "ecstatic" symbolic activities such as "laboring" or "trumping," speaking in tongues, singing, dancing, and the use of special objects, which are aimed at "greeting" the Holy Spirit and destroying or fighting the evil spirits which are at the root of the person's problems.

It is the job of the healer to orchestrate the intensity and direction of these actions while avoiding anything that might detract from their spontaneity. To be effective, a Revival healer must be able to inspire energetic action among his or her followers, while at the same time maintaining control over the flow and energy of the proceedings. It is not surprising, then, that the most successful Revival healers are authoritarian, disciplinarian figures who are at the same time capable of projecting, and inspiring, great emotional fervor. As we have seen, healers such as Brother John and Mother Simpson have managed to develop these qualities to a high degree.

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The healer's authoritarianism inspires some degree of fear and unease in their clients, however this seems to add to rather than detract from their effectiveness. For example, Brother Watson is a member of one of Bishop Smith's Portland churches who occasionally comes to Albion to participate and assist in healing services. His actions during services are extreme in the sense that he manifests fervent possession behavior (speaking in tongues, trumping, "vomiting" out the evil spirits he absorbs, etc.) at a high pitch throughout most of the service. His behavior during the healing is especially dynamic, and those who attend find his manner of direct confrontation and accusation a bit threatening. But despite the fear he inspires (or perhaps because of it) people in Albion consider him to be a powerful healer. After one Mt. Olive service in which he participated, the district was abuzz with gossip about how he had confronted several individuals with information about their less than exemplary lifestyles. This demonstration of his ability to "read" the truth about people was taken as clear evidence of his spiritual power and healing capabilities. However, Brother Watson would not be as effective on his own, without the discipline provided by Bishop Smith. It takes a strong authority figure like Brother John to channel and direct this sort of "fanatic spirit."

A Revival service can be likened to a spiritual battleground with numerous forces, both positive and negative, vying for control of the participants and their souls. Much is done in the preparation and conduct of the service to exclude evil spirits and attract the good. Yet the essence of the service, and of the healing process itself, lies in the struggle between these opposing powers. An effective Revival

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leader is able to draw the participants together into a unified force assisting Jesus in the battle against evil and the Devil. This is especially true in healing services, where the main focus of the group is on the elimination of the demons, duppies, and evil spirits that are responsible for the afflictions of the sick. The healer and his or her assistants literally battle the evil spirits hanging over the sick as well as those that arrive unexpectedly during the service. Only those participants who are "in the Spirit" can see these demons and assist in the work. When a duppy arrives the healer must act quickly to ward it off with a symbolically aggressive act, such as chopping it with a machete, or cutting it down by smashing a coconut or bottle of consecrated water. The assistants participate in "beating down destruction" through "trumping" and "laboring" in which they "chop and stamp" the evil spirits. Occasionally the Angel of Death may enter or pass through the room, and the healer will ward this off by smashing a bottle of consecrated water. As the spirit flees, the gathered congregation must "turn the roll" (stand up and turn 360 degrees) to "turn off destruction" and prevent the spirit from affecting them.

Because Revivalists ostensibly rely on the spiritual power of Jesus to purify and heal, it appears somewhat paradoxical that they make such frequent use of paraphernalia and symbolic manipulations. These techniques appear to be more "magical" than "religious" in nature in that they are essentially instrumental means for influencing personalized spirits rather than a way of "worshiping" and soliciting help from a deity. To the healer, though, there is no dilemma here. Prayer, fasting, symbol, and ritual are all means to the same end. The

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spirit and power of Jesus can be invoked, and influenced, not only through prayer, but through direct instrumental actions. It is in this tendency towards "magical" manipulations, viz. the instrumental use of special objects and ritualistic (both improvised and stereotyped) actions to influence spiritual forces in order to attain material ends, that Revivalism's syncretic African roots are displayed most prominently. This, of course, is not to say that its Christian heritage has not contributed to its symbolic/magical ritual. However, this ritual is more closely linked with African cultural influences, such as traditional cults that aimed to influence events through appeasement and manipulation of ancestral spirits.

Although the private work of Revival healers is an extension of their public healing, it differs significantly in style. In their private healing work they make even greater use of magical and instrumental techniques, analogous to those that were used by the traditional "Obeah Man." In fact, their private consultation work is in many ways indistinguishable from that of contemporary private secular practitioners such as Science Men, who are directly descended from the old-time African healer/sorcerer Obeah Man. Bishop Smith, as we have seen, has in addition to his churches an active private practice in which he combines Science, Revivalism, herbal treatments, and crude biomedical techniques. One feature which tends to differentiate the private practice of Revival healers from that of Scientists is the more frequent use of herbs, especially in the form of bush baths. This, in fact, seems to be the essence of the healing style known as "Balm" in western Jamaica, a variant of Revival healing. Science Men, on the

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other hand, rely more heavily on purely magical techniques such as spells, candles, talismans, etc. The Professor, for example, has a knowledge of herbs and sometimes prescribes bush remedies, but more frequently uses refined herbal oils as ingredients in magical potions and as magically protective perfumes. I never saw him use a real bush bath. While Revival healers in St. Thomas use herbal remedies, they seem to lean more towards the use of Scientific techniques than do Revivalists in other parts of the island, perhaps because of the strong local tradition of Obeah and Science in St. Thomas.

As mentioned earlier, the eclectic and overlapping styles of individual practitioners makes it difficult to categorize them in more than rough terms or to talk about clearly demarcated systems of healing. Healers who do private work function independently as individuals rather than as representatives of neatly defined and integrated healing styles. And their personal power is the recognized basis for their legitimacy as healing specialists. They customarily dissociate themselves from other healers and develop exclusive techniques which emphasize their distinctiveness. This is especially true of Science Men. Revival healers will sometimes work together in public services, especially when they are affiliated through a church organization, and may sometimes even cooperate in private healing. For example, Brother John regularly attends and participates in the public healing services of Sister Nancy, his protégé, and in his private healing frequently worked with his close associate, Brother Thomas. As a general rule, however, private healing is an individualized affair, both in terms of the power of the healer and the nature of the interaction.

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The aura of individual power which is projected by Jamaican folk healers places them in an ambivalent position within the fabric of society. They may be respected as religious leaders and healers, or as influential members of the community, while at the same time being feared as sorcerers (or at least potential sorcerers). In fact, the ambiguous social presence which Jamaican folk healers generate has historically been a central feature of their role in the larger society (Hogg 1964:98), as well as an important determinant of their legitimacy as practitioners. A reputation for sorcery carries with it not only the elements of danger and fear, but also the connotation of great individual power. There have been cases in the past, for example, in which healers attempted to enhance their reputation for power by claiming to have carried out evil deeds through magical means (Williams 1934:124-43). While few contemporary healers would go this far, most either inadvertently or intentionally encourage this sort of double-sided perception through their authoritarian, sometimes even abusive, styles and the secrecy which surrounds their private work. For example, although Brother John tries to suppress some of the more malicious rumors about his practice of Science (e.g. See p. 320), it is well known that his work goes beyond simple Revival healing or herbal remedies. But the range of perceptions about his social position is evidenced by how he is referred to by different people. Depending on the personal orientation and past experience of the commenter, he was variously described to me as a "great healer" or as "the wickedest man in all of Jamaica." The vehemence with which sectarians denounce such healing work adds to its aura of power as well as its air of danger.

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This aura of danger is especially characteristic of independent practitioners such as Science Men who, unlike Revival healers who have public religious functions and roles, have no fixed and visible moral position within the community other than that which they cultivate personally. As a consequence, Science Men are typically considered more dangerous, as well as more powerful, than other types of healers, and the most successful will develop a regional or even an island-wide reputation. The trepidation with which clients approach encounters with such practitioners is understandable. A new client will usually arrive in the company of a friend or relative, hopefully one who is already familiar with the healer, for moral support. Children will typically be brought by a parent or grandparent, and the fear inspired in a child by such a visit not surprisingly goes a long way towards shaping life-long attitudes toward such practitioners.

The apprehension associated with a visit to a Science Man grows not only from their reputation but from the nature of the encounter as well. The setting is highly ritualized and often the practitioner is in a trance state while dealing with the client, creating the sense that one is making direct contact with the spirit world. This impression is reinforced by the dramatic elements introduced by the practitioner into the interaction: ceremonial acts, incomprehensible language and writing, dramatic pyrotechnic demonstrations, animal sacrifice, etc. Within this setting, control is entirely within the hands of the practitioner, who assumes an authoritarian, and occasionally even disciplinarian, manner towards the client. In order to participate in this encounter and reap

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its potential benefits, the client must give up any claim to control over the situation, at least temporarily.

This tradeoff, however, is in many ways less threatening than the loss of control that is associated with a visit to a doctor. The class differences that typically separate doctor and patient, and the social tension which this begets, are generally not factors in the Scientist/Client relationship because the Science Man and client both usually come from the lower levels of society, and have a similar lower class orientation. In addition, there are a number of techniques that these practitioners use in order to build a therapeutic alliance with a client. If he is in a trance state during the reading or treatment phases of the encounter, the Science Man may freely adopt a more congenial attitude when the encounter has finished, without endangering the aura of power he has created. For example, the Professor, while very domineering and distant during trance in a highly ritualized encounter, after a session will often joke and talk with his clients and share a drink with them, thus separating somewhat his personal from his professional identity. In essence, the client interacts with the frightening and powerful spirit world through the medium of the Science Man, while the practitioner himself is able to form a more friendly personal alliance with the client.

In addition, the prescribed treatments usually involve a very extensive participation by the client, such as the performance of rituals at home, so that the individual can feel that he or she is in more direct control of much of the treatment process. And the Professor rarely pushes a client directly into treatment on an initial visit.

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Once a reading is done, if further treatment is needed, he almost always tells the person to return at a later date, in order to give them the opportunity to back out if they wish, and to insure that only those who are seriously committed will pursue therapy. In combination, these techniques are very effective not only in convincing the client of the power of the healer, but in inspiring confidence and trust in him as well.

One advantage that healers have over doctors in forming therapeutic alliances is that they are able to explain to the client the ultimate cause of their problems in a way that fits in with their own experience, perceptions, and suspicions. Most people who go to a Science Man for help have, because of multiple previous treatment failures, already come to the conclusion that their illness is caused by spiritual forces, which they typically attribute to the work of a rival or enemy. They are usually convinced that someone has "cast a blow" against them, and often they have already formed clear suspicions about who the culprit is and why they have resorted to sorcery. The Science Man will frequently confirm these suspicions. And, as we have seen, the technique of "reading" is sufficiently flexible to allow the client to form many of their own interpretations. The healer can provide an explanation that may not exactly coincide with the client's own Explanatory Model, but which the client can nevertheless easily relate to, understand, and use in the re-interpretation of his or her social relationships.

A doctor, on the other hand, even if he or she has the time or inclination to explain matters to the patient, can at best present them

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with a biomedical model of the pathophysiology of the illness. Though some doctors try, this can rarely be done in terms that are consistent with the patient's everyday knowledge, understanding, and concerns, and almost never in a way that can assign an ultimate cause to the problem. The doctor can say something about how an illness has occurred and developed, and even what the underlying pathophysiologic etiology might be. However, he is not able to connect with the patient's moral world such that he can explain *why* the illness has afflicted a particular person at a particular time. The healer's advantage is that by interpreting an illness in terms that are meaningful to the patient, by explaining its ultimate moral and social cause, and by providing a means of confronting the problem at its root, he returns to them a sense of control over their body and their fate, of which they were robbed by the illness. The healer is able to empower the patient through the display of his own power, while the doctor often inadvertently disempowers in exercising his skills.

Kumina, of course, lies at the African end of the cultural spectrum. Over the years it has been influenced somewhat by other religious/cultural movements, however it seems to have retained its original form and content to a considerable extent. Although its vitality and popularity have waned in the past few decades, it remains an important element of cultural life in eastern St. Thomas. Kumina can not be analytically assigned to any specific cultural sub-category. It has important functions not only as a modality of healing, but as a religious complex, a belief system, a social institution, a network of kinship relations, a means of artistic/cultural expression, and even as

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a form of entertainment. Here we will concentrate on its healing functions, though to avoid distortions its other aspects must be kept in mind as well.

In comparison to other folk healing modalities, Kumina healing ceremonies are held relatively infrequently, and then usually only when other forms of treatment have been tried without success. However, they can be among the most powerful alternatives in terms of social and psychological impact. The meaning and significance of such ceremonies varies considerably, depending on an individual's previous involvement with Kumina, and their personal orientation. Although active Kumina adherents are a minority in Albion, everyone in the area is quite familiar with the ceremony because almost all have participated at one time or another, if only as spectators. Healing Kuminas are rarely held by families who are not active in the "cult," but this sometimes does happen. Kumina is regarded by even non-adherents as a powerful means of communication with and influence over spiritual forces, and there are occasions, as in our own case example (See pp. 338-344, 465-468), when a non-Kumina family will resort to this option when all else has failed.

Participation in a Kumina can be quite an intense experience. This is even more true of a healing Kumina, in which the attention of the visiting spirits, trancing participants, and onlookers, is focused almost entirely on a single individual: the sick person. In such a situation, the recipient of all this attention must completely give up control of the course of events and follow the dictates of the officiating Science/Obeah Man and the spirits which possess the participants. While a similar cession of control occurs in many other

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types of therapeutic interaction, the balance between trust and fear is especially delicate here because of the grisliness of the proceedings (e.g. animal sacrifice), but even more so because of the unpredictability of the spirits that enter and effectively take control of the Kumina. The Science Man/Obeah Man directs the preparation of the booth and materials, performs the necessary rituals, such as the animal sacrifice, and exerts at least some influence over which spirits are asked to join in the ritual. But despite his ostensible control over the ceremony, everyone participating knows that the spirits who arrive and possess the dancers do so of their own will because of their interest in the ceremony (e.g. because of a kinship relation) or because of their desire for appeasement and contact with the living. In the chaos of the moment they are chained by no man. It is as much as the Science Man and his assistants can manage to keep the possessed dancers from hurting themselves or others in the crowd through their frenetic activity.

The Kumina spirits, or zombies, that possess the dancers are "earth spirits," primarily ancestors of the participants. As such they still have quite human-like personalities, with a strong need for gratification of their desires, but without the inhibitions that corporeal existence entails. They show little of the restraint that the living must have in order to exist in society, and these "anti-social" qualities are not suppressible by the possessed dancers. In fact it is the vivid display of this normally unacceptable behavior which makes Kumina so entertaining for the spectators. Even for those who are not possessed, a Kumina ceremony is an occasion of considerable license.

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This disinhibition is expressed through excessive alcohol intake, smoking of marijuana, and the open display of aggression and sexuality to an extent that would ordinarily be embarrassing. Zombies (spirits/possessed dancers) characteristically manifest wild behavior -- running through the bush, rolling in the mud, climbing trees, demanding wine or rum, drinking the blood of the sacrificed goat, and making lewd gestures to other participants and spectators. For the sick person to place themselves at the whims of these spirits takes a fair amount of courage.

In a Kumina, although a Science Man is present and involved, the therapeutic interaction for the most part takes place directly between the sick person and the spirits. So there must be some degree of trust in their intentions and abilities. Fortunately, the spirits that do appear at a healing Kumina are generally those which have an interest in the matters at hand, and for this reason can be relied upon to help solve the problem. The Kumina represents a channel of communication between the spiritual and material worlds. The illness may in fact be seen as a sort of "message" to the living that the spirits want the Kumina performed either for the fulfillment of ritual obligations which have been neglected, or for a chance to communicate with and manifest themselves and their desires through the living. The spirits that show up are typically the ancestors which have been asking for appeasement, those who have a special interest in the sick person (such as a departed favorite grandparent), and perhaps some who are just out for some fun and frolic. The measures used and demanded by the spirits are not completely intelligible from the limited human perspective. However, as

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in a Revival service, there is an underlying assumption that the dramatic ritual acts demanded or performed by the spirits have a definite purpose and are efficacious. So there is an implicit trust hidden behind the apprehension of the participants. Although the sick person gives up control of the situation, it is ceded not to a human who might have ulterior motives or be unconcerned with the outcome, but rather directly to spirits who are by their nature both concerned and capable, even though somewhat unpredictable. So despite the fear and uncertainty, trust is an essential element of the equation.

While Kumina is now essentially a public ritual, in the past it seems to have had more of a dual private/public character similar to that which one currently finds in Revivalist healing. Moore, working in the Morant Bay area in the early 1950s, described the compounds of several Kumina leaders ("Obeah Men"), who also did "private workings" for clients (Moore 1953:124-5;133-4). Their compounds contained special chambers and booths for dancing and ritual activities. Their private work was based on the invocation and control of spirits for the performance of various tasks such as healing, though it could also be done for evil purposes. In this sense, these practitioners were analogous to the Obeah Men of the past, or Science Men and Revival healers of today, but used techniques based on Kumina rituals in place of, or in addition to, the more standard methods of Obeah or Science. That these Kumina leaders were called Obeah Men or Scientists also demonstrates this affinity. Moore does not offer a good description of what personnel were involved in these private workings, but apparently they included the practitioner and a small staff of assistants. These

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ceremonies, according to Moore's descriptions, involved drumming and the ritual invocation of spirits (Moore 1953:157-60).

It is unclear whether this type of "private working" still takes place in eastern St. Thomas. Today the Kumina cult is in general much less active, and less elaborate in its practices, than it was during Moore's day. Barker, the man who conducted the healing Kumina I witnessed in Albion (See pp. 338-344) is the only Kumina leader/Science Man that I met in the Albion area. He does in fact have a private practice as a Science Man. However his private work is more like that of an ordinary Science Man, with a primary reliance on herbs, oils, and basic magical techniques. He is relatively poor and his small house and yard are certainly not set up for the sort of private Kumina rituals that Moore describes. When he decides that a client needs a Kumina ceremony performed, it is done at the home of the client, rather than at his own yard. He denies using Kumina rituals to invoke spirits for evil purposes, but even if this were done it would have to be in a setting that afforded more privacy than is possible at his home. I am not able to say whether or not there are "private" Kumina practitioners in other parts of St. Thomas who continue to practice in the manner described by Moore, however I saw no evidence of it in the Albion area.

The variety of folk healing styles that can be found in St, Thomas is a reflection of the Jamaican cultural premise that spiritual healing power is essentially an individually attained talent. Individual practitioners must somehow distinguish themselves as having a unique and special gift in order to be seen as legitimate and to be taken seriously by those who are seeking help in the attempt to exert control over

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spiritual forces for medical or other reasons. The variety of styles available is also a function of the spectrum of cultural orientations of those who utilize these services. The choice of one or another type of practitioner is not only a matter of personal orientation, preferences, and past experience. It is also essentially a statement about one's position in the social hierarchy, the direction that one is headed, and one's level of commitment to certain cultural ideals. The use of public or private alternatives can be an indicator of the strength of one's attachment to the assumptions underlying them (cf. Brodwin 1989). But choice among treatment options is a much more complex and fluid process than these simple statements imply. In the next chapter we look at the spectrum of illness in Albion, a typical poor rural community, and the process through which selection of treatment alternatives takes place in the course of the illness experience.

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CHAPTER EIGHT

UTILIZATION OF HEALTH CARE ALTERNATIVES IN ALBION

INTRODUCTION

While the health care alternatives described in the previous chapters constitute the basic structural framework of the local health care system, it is the utilization of these options through day to day health-seeking decisions that animates it and drives its continual evolution. Such systems develop over time through the complex interactions among illness incidence, treatment alternatives, and health-seeking decisions, while at the same time being shaped by social, cultural, political and economic forces. This chapter takes a closer look at the interplay of these forces in rural Jamaica, specifically eastern St. Thomas. After considering the nature of illness in Albion, we will explore the strategies used by Albionites in seeking relief for their ailments, and the factors which influence these treatment decisions. And finally, we will examine how these health-seeking strategies shape and are shaped by the health care system as a whole.

ILLNESS IN ALBION

As discussed in Chapter 5 (See p. 142), national mortality patterns in Jamaica have shifted significantly away from infectious and parasitic diseases towards chronic and degenerative problems such as heart disease, cerebrovascular disease (strokes), hypertension, cancer, and diabetes, a pattern which is still more typical of developed

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countries than of third-world tropical countries (McCaw 1985:6,80). In fact the "epidemiological transition" into an era of chronic and degenerative diseases, along with low mortality and low fertility rates, is well under way in Jamaica.[135] That such a transition has occurred (and is occurring) in Jamaica is a testament to the success of Jamaican public health efforts during this century (Cumper 1983). As we shall see, the patterns of illness occurrence in Albion reflect these national trends. What these national mortality figures are unable to give us, however, is an understanding of morbidity -- the suffering and functional disability associated with non-fatal illnesses. In this study a survey of Albion households was used to collect accounts of illness episodes in order to obtain information about illness prevalence, morbidity, and patterns of health-seeking.

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[135]The notion of the "epidemiological transition," a concept parallel to the better known model of the "demographic transition," was introduced by Omran in 1971 (Omran 1971) as a means of analyzing the evolution of epidemiologic patterns on a worldwide basis. In short, his model asserts that disease patterns tend to follow a basic evolutionary pathway from an era of high mortality due to rampant infectious disease, "the age of pestilence and famine," through various transitional stages, and finally into the "age of degenerative and man-made diseases," in which mortality reaches a low, stable level and in which fertility is the main determinant of population growth (Omran 1971,1983). (Some have argued that an additional epidemiologic stage, "the age of delayed degenerative diseases," is now beginning to emerge [Olshansky and Ault 1986].) While most developed countries have progressed far along this continuum, much of the developing world still is mired in the grip of uncontrolled infectious disease. However there are some countries, such as Mexico, Jamaica, other Caribbean nations, and several southeast Asian countries, in which chronic and degenerative diseases now overshadow infectious diseases (Omran 1983:315-6; Litvak et. al. 1987; Bobadilla et. al. In Press). International Health Policy planners are just now beginning to address the major realignments in priorities and planning that will be required as more of the developing world begins to move through this transition (Bobadilla et. al. In Press; Jamison and Mosley 1991, In Press; Frenk et. al. 1989).

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In the household survey the respondents (mostly household heads) were asked to report on illnesses of household members that had occurred within a month prior to the interview date.[136] If the affected individual was present for the interview, they usually provided the information pertaining to their own illness, though in many cases the episodes were reported by someone other than the affected person (e.g. by the household head or another family member). The extreme variability among illness types and their time course makes quantification and comparison of the cases somewhat difficult. For example, for recent acute illnesses, health-seeking strategies could usually be recalled in detail, while individuals with long-standing chronic illnesses were often unable to give a complete account of all the health-seeking activity they had undertaken since the onset of the illness (though they could recall the most recent events). On the other hand, some illness accounts were complicated by numerous concurrent treatment strategies. For the purposes of the survey, questions focused on the current (or most recent) episode or exacerbation of a chronic condition. Respondents were usually able to provide reasonably full accounts of the illness course, health-seeking strategies, and recent problems.

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[136]Most of the interviews were conducted by Meg Harvey, my research assistant, during the period between early July and early September 1988. I conducted approximately 20 of the interviews from September to November 1987. Seasonal variation in illness incidence may have had some influence on the patterns of illness found, though without a much more detailed study it would not be possible to determine whether this had any effect on the findings. The Appendix (pp. 534-546) contains a copy of the interview schedule used.

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Definition of what constitutes an "illness" was left up to the informants, thus allowing for an "emic" interpretation of the question of whether anyone in the household had been "sick" in the past month. It is possible that varying interpretations of this question may have introduced some further inconsistencies into the definition and description of illness episodes. However these subjective differences are part and parcel of the cultural and personal experience of illness. Thus, this study does not pretend to a rigorous epidemiological analysis of the prevalence of any particular "disease" or "diseases." Rather it focuses on the subjective experience of illness and the effects that this has on interpersonal relationships and functional deficits in carrying out daily activities. Most important to us here is rural Jamaicans' subjective experience of illness and their strategies for coping with it.

In all, 139 illness accounts were obtained from the 260 households (which contained 848 individuals) in Albion or, on the average, about .5 per household. When these illness episodes are categorized roughly into chronic and acute types, one of the most striking findings is that chronic diseases are responsible for not only the majority of illness episodes, but also for the greatest morbidity. 60% (83/139) of the illness episodes recorded were chronic[137] in nature, while the remainder (56) could be considered acute illnesses.

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[137]For the purposes of categorization, a chronic illness is defined as an episode lasting longer than three months, or an illness of more recent onset that is expected to last indefinitely. While these criteria may seem rather arbitrary, there was in fact little difficulty in using them to distinguish illnesses which by "common-sense" could be considered acute or chronic in quality.

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When looked at as a whole, illness prevalence shows a bimodal distribution, with peaks in the youngest and oldest age groups. As might be expected, chronic illnesses were much more prevalent in the older age groups. Acute episodes were spread fairly evenly over the population, affecting both young and old. The absolute number of acute illness episodes was highest among the youngest age groups, but much of this excess can be explained as a result of demographic patterns, since the youngest age groups constitute a disproportionately large segment of the population. On a per capita basis, acute illnesses were only slightly more prevalent in the 0-9 age group than in the general population. The average age of those reporting chronic illnesses was 60.9 years, while the average age of those reporting acute episodes was 23.6, (which is close to the average age of the population: 28.6). Given the fact that the older age groups make up a relatively small segment of the population (only 26.2% of the population Albion population is older than 40) (See p. 57), and that chronic illnesses tend to be more incapacitating than the most of the self-limited acute episodes, it appears that on an individual basis the middle-aged and elderly shoulder the greatest burden of illness.

Figures 3 (Acute Episodes), 4 (Chronic Episodes), and 5 (Acute and Chronic Episodes) present this data in graphical form. In Figure 3 we see a peak of absolute acute illness prevalence in the youngest age groups (bar graph) but a relatively constant per capita prevalence, with small peaks in the 0-9 and 50-59 age groups (solid line). Figure 4 shows a low incidence of chronic illness (both absolute and relative) until the 40-49 age group, after which the prevalence increases rapidly.

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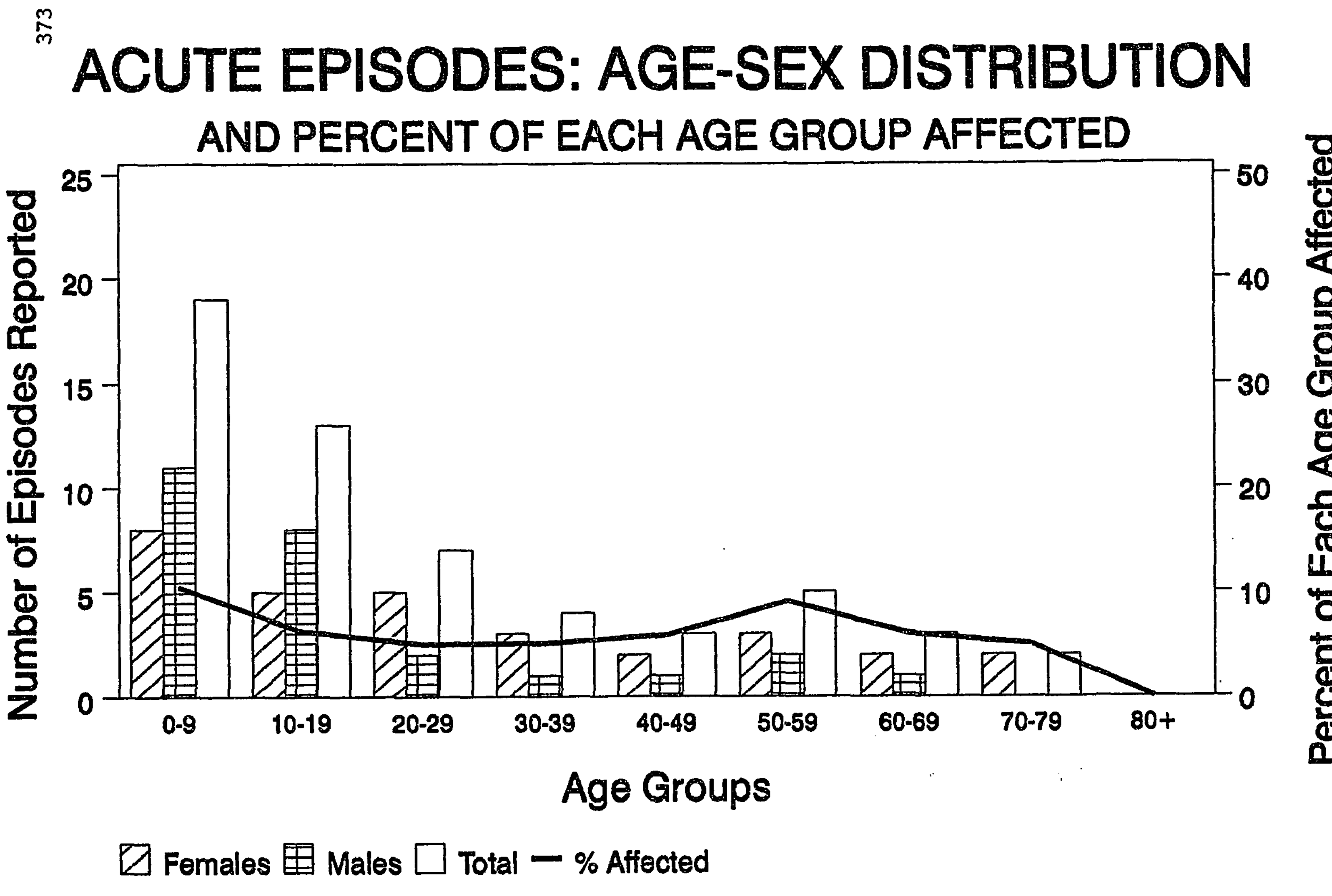

Figure 3: Acute Illness Episodes

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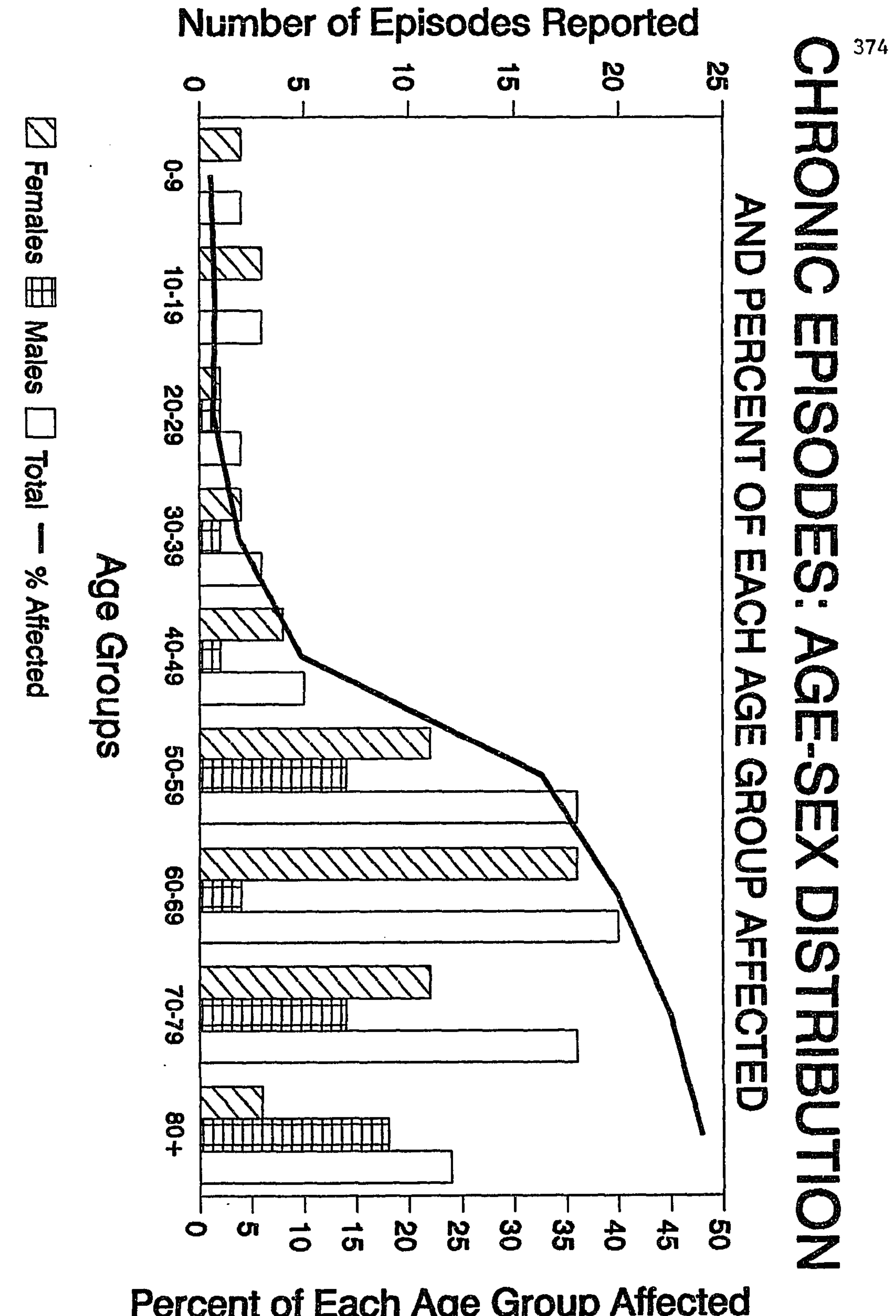

Figure 4: Chronic Illness Episodes

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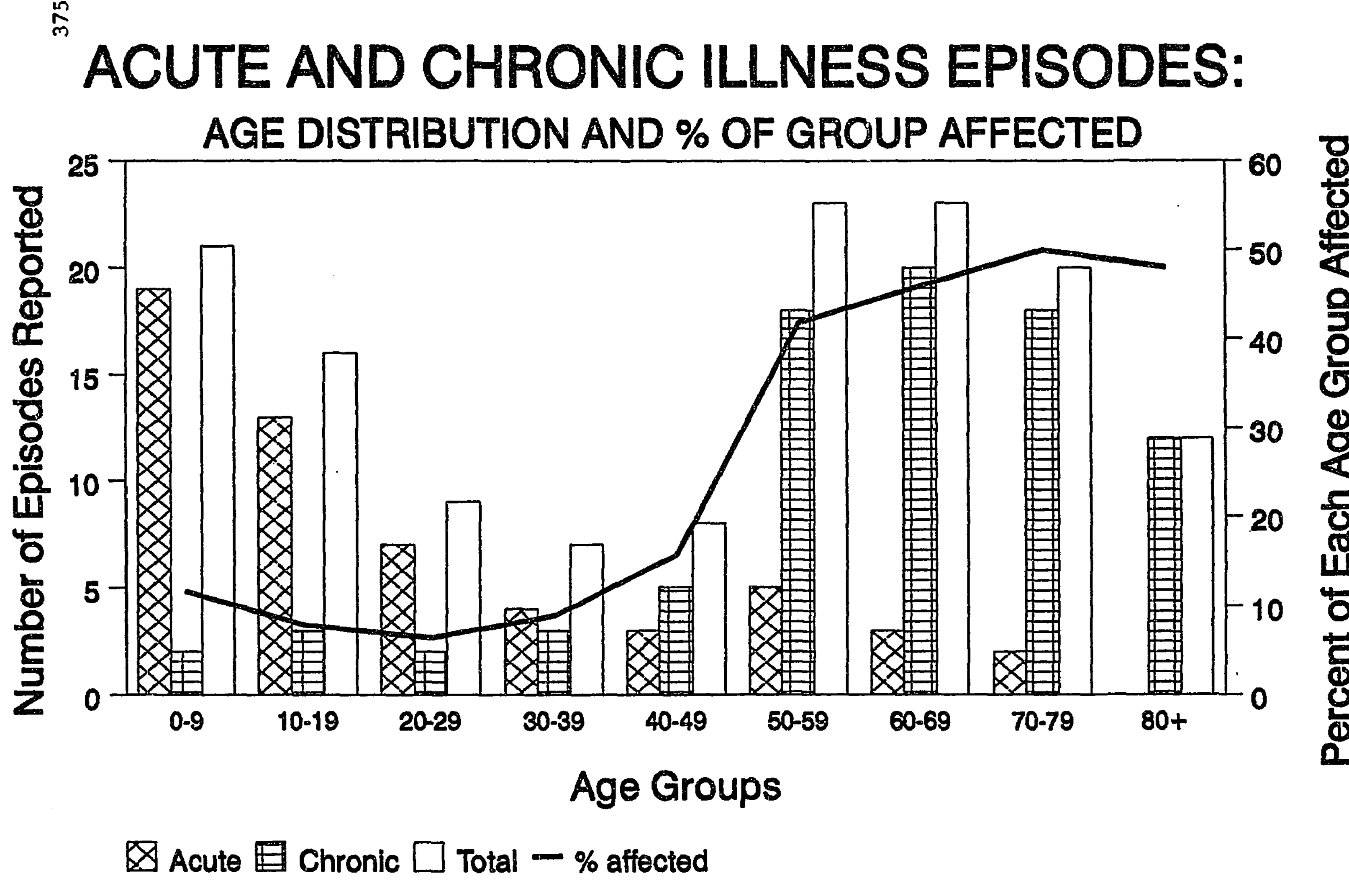

Figure 5: Acute and Chronic Illness Episodes

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Figure 5, which combines this data, again shows the peaks of absolute prevalence (bar graph) in the youngest (acute) and oldest (chronic) age groups. Per capita overall illness prevalence (solid line) shows a slight gradual decline after age 9, but then a rapid, nearly exponential increase from age 30 to 60, after which the rate of increase slows and reaches a plateau near 50%.

The chronic complaints most frequently reported in the collection of illness episodes were "joint pains" (primarily osteoarthritis), "pressure" (hypertension and its associated symptoms, see p. 109, fn. 27), "nerves" (weakness, shakiness, tremors, anxiety), blindness and vision disturbances (mostly due to cataracts or pterygia), gastrointestinal complaints (e.g. pain, "gas", bloating, etc.), fatigue and weakness, diabetes ("sugar") and its complications (e.g. infections, vision problems, neuropathies, poor circulation, kidney disease, etc.), asthma and chronic obstructive lung disease, heart disease and its symptoms (palpitations, shortness of breath, angina pectoris, peripheral edema), trauma-related chronic disability, neurologic residua of cerebrovascular disease (strokes), and various other complaints (e.g. musculo-skeletal pains, headaches, etc.). (Because of the stigma attached to psychiatric problems, these were probably under-reported, and may be reflected in some of the other categories above.) Many people are afflicted with several of these problems, which synergistically intensify their suffering and functional deficits. Typically these ailments have a waxing and waning though gradually worsening course, such that the resulting impairment fluctuates anywhere

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between the extremes of mild discomfort and total functional disability.[138] As we shall see, a variety of treatment alternatives are used in the constant attempt to mitigate the effects of illness, and some of these treatments are able to provide at least some temporary relief. However, except for the few surgically correctable diseases represented (e.g. cataracts) these illnesses are generally not curable, and are a constant, unwelcome, companion to the end.

The illnesses which fall into the acute category are quite different in character. Typically they are of variable severity, though usually mild and self-limited, and result either from infections or trauma. Most common are the viral syndromes including various upper respiratory tract infection symptoms ("cold," sore throat, cough, congestion, runny nose, etc.), "flu," fever, headache, nausea, vomiting, diarrhea, myalgias, etc. Bacterial infections (e.g. otitis, strep throat, dysentery, etc.) also occur, but with less frequency. Children are especially susceptible to these infectious illnesses, and it is usually for the very youngest (or very oldest) that they constitute a potentially lethal threat.[139] Diarrheal disease (of whatever cause) or meningitis, for example, can be fatal in young children if not treated promptly and appropriately, though for most they are self-limited.

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[138] I. e. the person is bedridden and unable to carry out any of their normal activities.

[139] Similar to other parts of the developing world, diarrheal disease and respiratory infections (pneumonia and influenza) are the leading causes of death among children from age one to four in Jamaica. And in children under one these are the second and third leading causes (next to perinatal mortality) (McCaw 1985:51). Children are also the most frequently affected by some of the chronic parasitic diseases, such as "worms" (usually ascariasis). Because these are often not recognized, we were not able to get good information on their true prevalence.

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Other age groups are of course also susceptible to these same ailments and get them frequently. Even in adults, and especially in the elderly, severe cases of common, acute illnesses can be temporarily debilitating, seriously compromising functional status, and in some complicated cases might even be fatal. However, in the great majority of cases these are temporary and short-lived. For most people they are minor, self-limited illnesses without residual sequelae. Other acute illnesses reported included injuries, rashes, conjunctivitis, otitis media, toothache, muscular strains, etc. as well as some more serious illnesses with an acute onset.

In all, 109 out of 260 households (42%) reported having at least one illness episode during the month prior to the interview.[140] This percentage seems relatively high in comparison to previous data available. For example, a 1981 survey showed that in rural areas 67.1% of households reported illness over the prior *twelve* months (McCaw 1985:54). It is difficult to compare these two surveys given the different time frames each utilized in data collection. However when it is kept in mind that many of the illnesses reported are chronic and of more than twelve months duration, and that acute episodes may occur multiple times in a household (e.g. repeated colds) these two figures may be reconcilable. In any case, it is clear that the cost of illness in Albion and other rural areas is high. Aside from minor, self-limited, acute illnesses the most common and most damaging are the sort

[140]This may have underestimated the actual occurrence to some extent since the respondent reporting for the household may not have been completely aware of the health status of all of its members, especially in large households.

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of chronic diseases we normally associate with developed countries rather than underdeveloped tropical countries, and the burden of these chronic illnesses falls primarily on the middle-aged to elderly. These patterns of illness occurrence of course have a significant impact on the manner in which people use the health care alternatives which are available to them.

UTILIZATION OF TREATMENT ALTERNATIVES

Previous efforts to interpret health-seeking patterns in Jamaica have fallen short of this goal for a variety of reasons. For example, Long's (1973) use of a statistical multivariate discriminant analysis to determine which factors correlated most closely with choices between folk healers and doctors, was hampered by the problems inherent in such a methodology. Such a "fishing expedition" approach (cf. Feinstein, et al. 1981) distorts the issue by increasing the likelihood of chance correlations, by confusing correlation with causality, by neglecting most of the process through which health-seeking decisions are made, and by attempting to reduce this complex process to a collection of simple variables. He failed to fully appreciate that health-seeking is a much more intricate process than just a choice between doctors and folk healers. Mitchell's (1980) analysis of the use of self-medication and pharmacies is more informative, but again is too limited in its focus, and too sweeping in its generalizations, to provide a good understanding of health-seeking decision-making among rural Jamaicans.

In the preceding chapters I have attempted to provide an overview of the sociocultural milieu and the health care system in eastern St.

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Thomas, including their historical evolution, with the goal of reaching a more complete and thus more enlightening view of the illness experience in this area. It would be difficult to make sense of health-seeking decisions without a holistic view of the cultural, social and historical environment, the basis of any anthropological analysis (cf. Comaroff 1987).

With the wide spectrum of illnesses that people in Albion encounter, the variation in their duration and course, and individual differences in socioeconomic status, education, income, previous experience, religious beliefs, personality, cultural orientation, social networks, etc., it is not surprising that there is considerable variation from case to case in how people utilize the treatment alternatives available to them. Consequently, it would be misleading to say that Albionites as a whole follow any one particular pattern in seeking relief from their ailments. However, by looking at large numbers of cases and talking to people about the factors involved in particular health-seeking decisions, it is possible to uncover the general principles that guide these decisions, and to determine the specific factors which play the greatest role at each of the different stages of the process.

There are numerous variables which influence people's health-seeking strategies: illness severity, the type of illness, financial constraints, previous experiences with illness and practitioners, conceptions of causation, social status, aspirations for upward mobility, interpersonal conflicts and alliances, social networks, cultural orientation, etc. Each of these factors may come into play at

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the different stages of the health-seeking process, and may affect decisions differently depending on the specific circumstances involved. If we are to make sense out of any of this, it is useful to break down the complex iterative process of health-seeking into more discrete units and stages.

Chrisman (1977), for example, provides a useful model of the "natural history of illness" which divides the process into a series of "steps" which are "conceptually differentiated as elements in the health-seeking process: symptom definition, illness-related shifts in role behavior, lay consultation and referral, treatment actions, and adherence." (Chrisman 1977:353) (See Figure 6). While this model can allow for repetition or skipping of various stages, it is essentially a linear model, and thus somewhat oversimplifies what often is a cyclical, multiplex process. And it is a model most readily applicable to simple, acute illnesses which have a well delineated outcome or resolution. It is less useful for analyzing cases of chronic disease, in which illness becomes a permanent, though not necessarily static, state without a well-defined endpoint other than death (cf. Kleinman 1988; Murphy 1987; Murphy, et. al. 1988).

This model, while not completely satisfying, can at least provide a useful starting point for orienting us in the analysis of the health-seeking process since it emphasizes the role of social and cultural factors in health care decision-making, and highlights the health-seeking activity which takes place within the popular sector. However, it is especially important for us to look carefully at the factors which influence health-seeking decisions in the more common and costly

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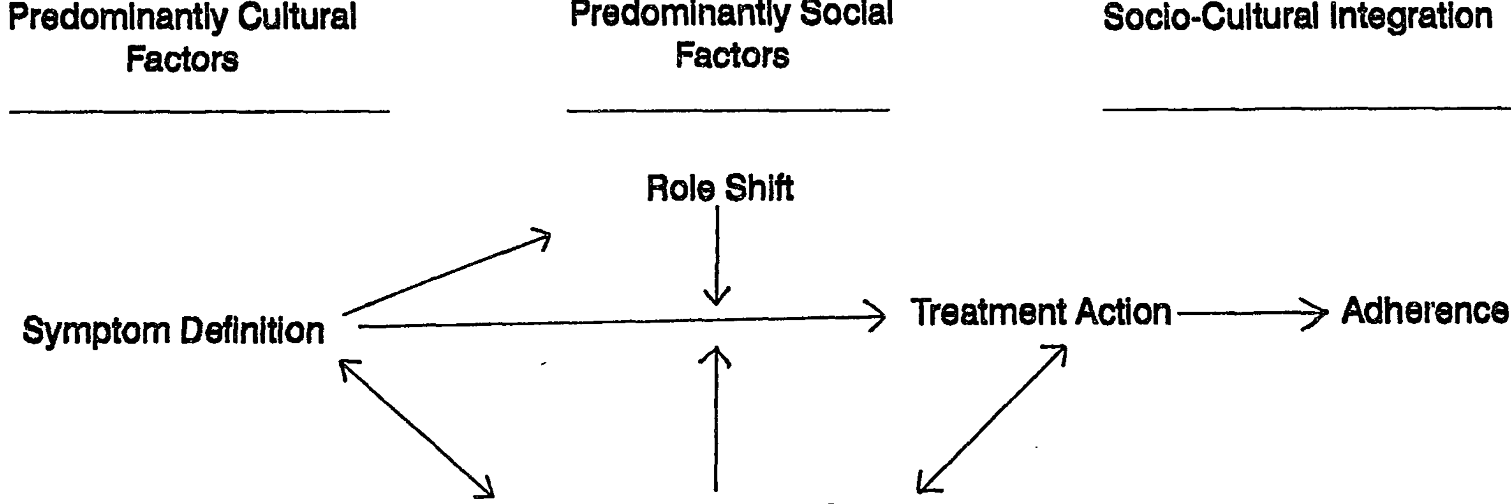

Chrisman's Model of the Health Seeking Process

(Chrisman 1977:354)

Figure 6: Chrisman's Model of the Health Seeking Process (from Chrisman 1977:354)

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framework of chronic illness, so we must build further on Chrisman's model. To do this we take a slightly different approach by breaking the process of health-seeking into four broader and more loosely defined "phases": Early Choices; Secondary Alternatives; Referrals and Further Choices; and Alternative Strategies. These phases of help seeking are by no means clearly demarcated or separated from one another. Nor are they always followed in the sequence presented here. However, as a series of broad categories they represent the shifts in frames of reference that occur in the course of a chronic illness, as treatment alternatives fail to meet expectations, and as meanings and identity are continually reformulated. As such, this process is built up out of frustration and despair, and out of the attempts made on personal, social, and cultural levels to come to terms with repeated failures in the "battle against dissolution" (Murphy 1987:223).

Early Choices

The first stage that Chrisman defines in the unfolding of an illness episode is "symptom definition": the recognition (or acknowledgement) of abnormal bodily function, and the attempt to evaluate, categorize, and sometimes explain it (Chrisman 1977:354-5). This process of evaluation involves the use of dynamic cognitive models developed from previous experience and shared knowledge.[141] The current symptoms are experienced, categorized, explained and acted upon

[141]Such cognitive models have been conceptualized in theoretical terms as "Illness Prototypes" (Bishop and Converse 1986; Young 1981, 1982), "Explanatory Models" (Kleinman, Eisenberg, and Good 1978; Kleinman 1980), and "Semantic Illness Networks" (Good 1977).

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according to these models, and in turn this process will serve to shape the cognitive model itself. For example, when someone develops symptoms of an upper respiratory tract infection it may be experienced as a "cold," with preconceived assumptions about which particular bodily signs, symptoms and events are connected with it. The individual and their family know from past experience and shared illness models what to call it, how to explain it, what it's course is likely to be, and how to go about treating it. They may connect specific events with it as causal factors, and its personal and social meaning is further delineated by the effects it has on functional capacities and interpersonal relationships. While individual models may differ, everyone has experienced such a common illness and knows what to expect from it. For a more unusual or threatening symptom constellation, the process of interpretation may be more complicated and variable, but it is basically equivalent.

For Albionites at this earliest stage of an illness, *severity* is the most salient feature affecting symptom definition and illness modeling, and consequently the initial choice among treatment options. The most basic decision that must be made once symptoms have arisen and been interpreted in the light of conceptual models of illness, is whether or not urgent specialist treatment is needed. For the most part in Albion this means deciding whether the sick person must go or be brought to the hospital, or if self-medication can be tried first. When a severe, potentially life-threatening, illness strikes, the choice almost invariably made by the affected person (or by their family or friends, if they are unable to make it for themselves), is to get to the

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hospital in Morant Bay. King George Hospital, is considered by everyone to be the place where the most intensive biomedical treatment is available, and consequently as the best place to go whenever a serious emergency strikes. While King George Hospital is not really well-equipped as an emergency care center, it is the most advanced and dependable source of treatment within reach. A doctor with surgical experience is usually available,[142] the nursing staff is present, and the hospital is better equipped than any of the other facilities in the area. The hospital also has two ambulances which if needed can be used to transport a patient to Kingston for more specialized or intensive care.

Illnesses that are felt to be best handled in this manner include critical injuries, sudden irreversible loss of consciousness, debilitating pain (e.g. in myocardial infarction or acute abdominal pain), incapacitating acute exacerbation of a preexisting condition (e.g. decompensated heart failure, asthma exacerbation), miscarriage, massive bleeding, etc. The handful of cases in the survey sample (5 out of 139) which were considered serious enough to require immediate attention at the hospital included acute injuries (motor vehicle accidents, falls, broken bones) and a stroke. (Some of these acute injuries were severe enough to result in chronic disabilities).

Unfortunately the poor transportation and communication systems in the area make reaching the hospital in an emergency a very difficult proposition, especially at night when no taxis or buses are running even

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[142]Dr. Panjit lives in a house on the hospital grounds and Dr. Khuen can be reached by phone in an emergency.

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on the main road. In such an emergency the only alternative is to find someone in the district who has a car (there are very few) and persuade them to make the trip. Usually this will entail a payment to the driver of J$20-30 ($3.60-5.45). Because I had a car and it became known that I was willing to help out in such emergencies, I was called upon to perform this service half a dozen times while I was living in the district.[143] And people were usually surprised when I refused to accept any payment. Transportation is sometimes not available, and the stricken individual may very well die in such circumstances.[144] During the study period, the Ministry of Health announced that the newly acquired ambulances would be available to pick people up in such emergencies. However this was not well publicized and few people were aware of it. In any case there was no phone in Albion, so it was not possible to call the hospital anyway.[145]

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[143]These cases included a young woman with a miscarriage, an elderly man in hypoglycemic coma, a boy with an acute abdomen, a middle-aged man with an MI, a woman with a badly cut foot, and a woman in labor. Unfortunately, my car was frequently out of commission, and there were a few other cases which occurred in which I was not able to provide transportation.

[144]During our last week in Albion, Brother Thomas, a good friend of ours and Brother John's chief associate (and frequent stand-in) in his private healing work, died of an apparent myocardial infarction ("heart attack") while we were trying to get him into my car to go to the hospital. He had suffered through the night with severe chest pains and shortness of breath before sending someone for me. We were unable to resuscitate him. It is uncertain whether he might have survived if had been able to get to the hospital earlier.

[145]Towards the end of the research period a phone (a public payphone) was finally installed in Albion, though like most such phones it was usually broken. About a month after the installation, all the phone lines in the parish and the rest of Jamaica were destroyed by Hurricane Gilbert. It reportedly took more than a year to finally restore service to the district.

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Fortunately the great majority of illnesses are not so severe that such action would be necessary. Most are at least "bearable," and in such cases a variety of other options are possible. Decisions about which of the alternative avenues to take is made usually within the household unit. When it comes to children it is usually the mother who makes decisions about how these options will be pursued, though the father or grandparents may have some input, especially if they live within the same household unit. Adults generally make decisions for themselves, but frequently a spouse or common-law partner will also have considerable influence.

Once it has been established that the situation is not life-threatening, and the symptoms have been recognized and at least tentatively categorized and labeled, then in many cases self-medication of one sort or another will be considered to be the most appropriate first line of treatment. Whether self-treatment is the first resort, however, will be influenced by other factors. Figures 7, 8, and 9 graphically present the initial choices of the survey sample, broken down by illness type and socio-economic level.[146] Overall, self-treatment was used about half of the time (45%). In acute illnesses, it was used initially about 2/3 of the time, regardless of SES (Socio-economic Status). For chronic illnesses, self-treatment was used less frequently (about 1/3 of the time overall), presumably because this option had been utilized in the past (though perhaps not recalled),

[146]It should be noted that in the pie graphs used, the units are "treatment choices." In most of the graphs this number exceeds the number of cases because in some cases two or more treatments were used concurrently.

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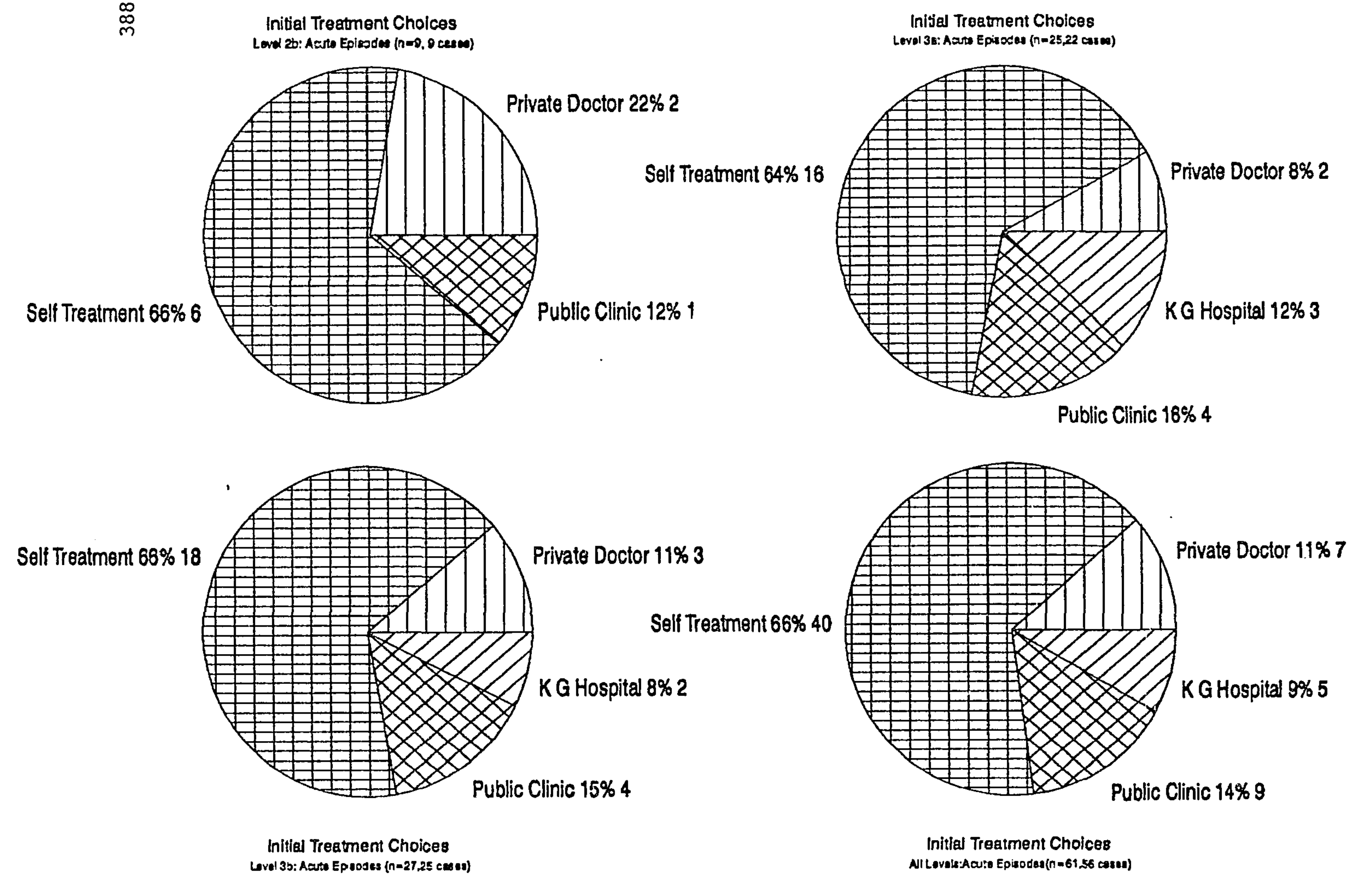

Figure 7: Initial Treatment Choices, Acute Episodes

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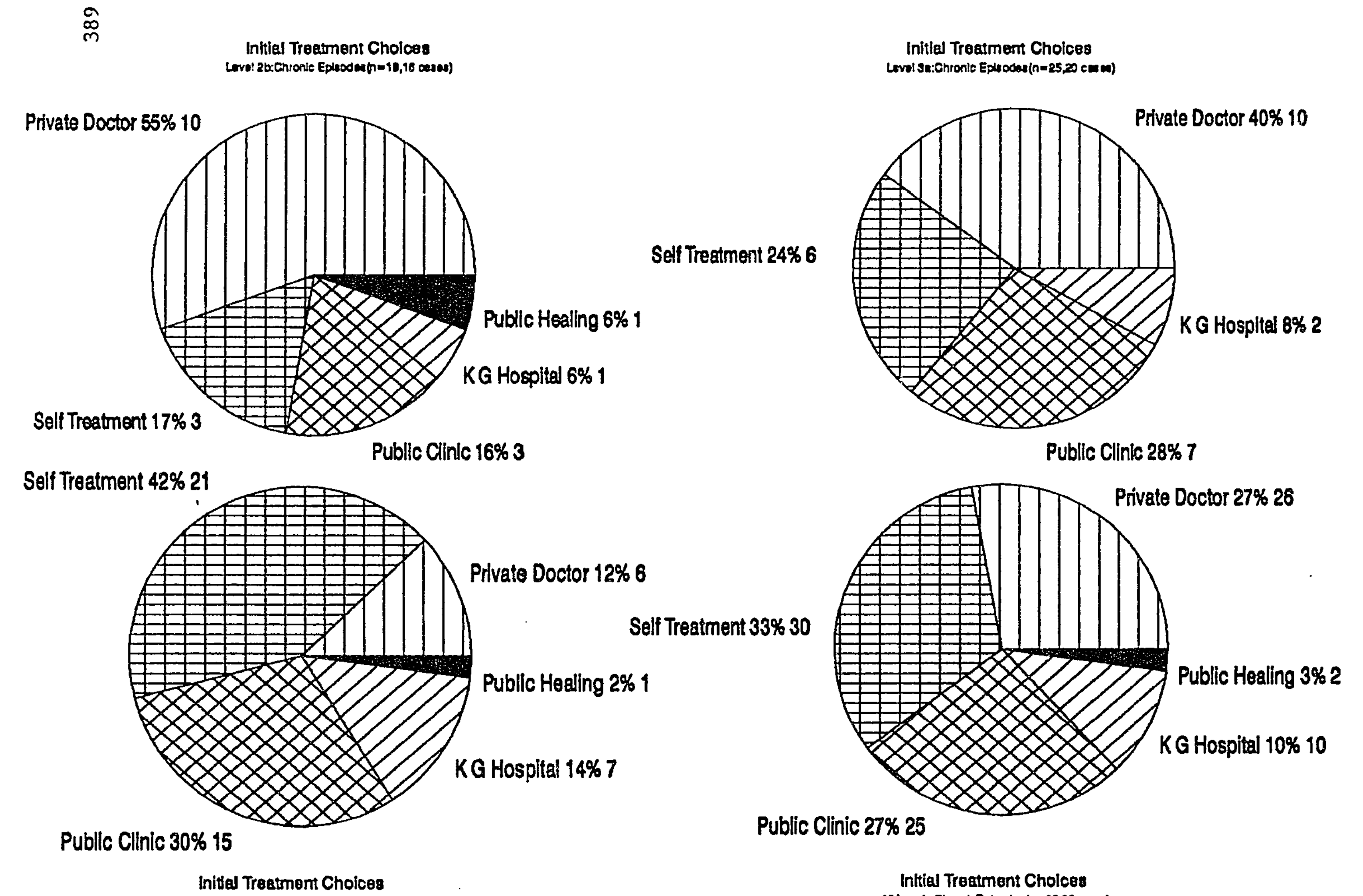

Figure 8: Initial Treatment Choices, Chronic Episodes

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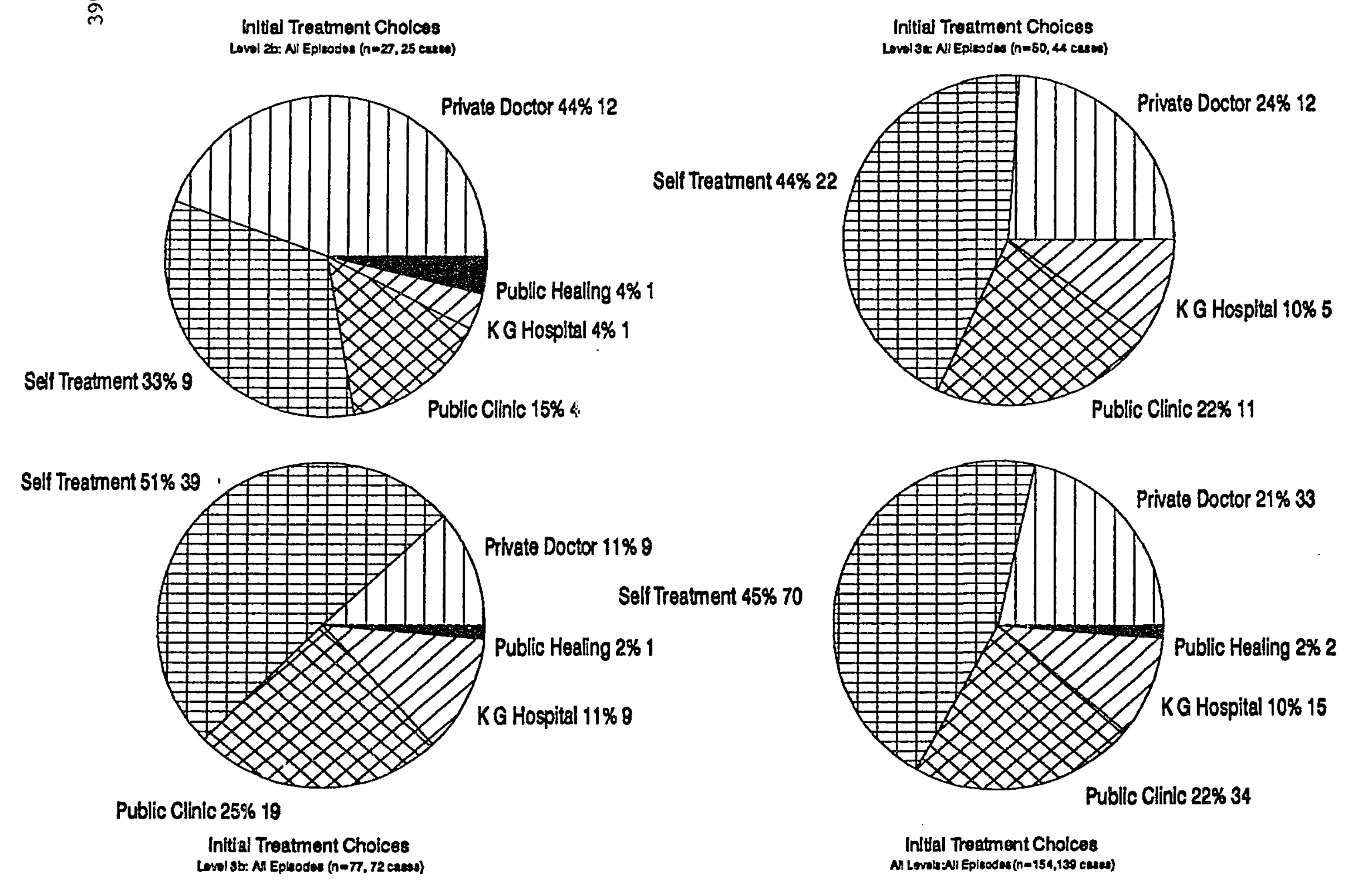

Figure 9: Initial Treatment Choices, All Episodes

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without good success. For chronic illnesses, self-treatment was used more frequently among the lower SES levels (42% for level 3b vs. 17% for level 2b), perhaps because of the higher cost of treatment in one of the specialist sectors.

At this point, various factors come into play in the choice among the various options for self-medication. As described in Chapter 4, the main self-medication alternatives are bush medicines, OTCs (over-the-counter medications, which here include "crude medicines") and "home remedies." There is some social meaning attached to the use of each of these different types of treatment and this becomes an important factor in the early choices among these options. For example, bush medications are seen by some as being old-fashioned and associated with "country" life, in contrast to OTCs which are considered more modern and representative of the lifestyle of the envied upper classes and the USA. On the other hand, bush medicines are also felt to be more "natural" and more spiritual in many ways.

Figures 10, 11, and 12 graphically show the choices among initial self-treatment choices by SES and illness type[147]. Overall (See Figure 12), choices between OTCs (41%) and bush treatments (44%) were fairly evenly split, with a smaller percentage of choices for home remedies (15%). Overall for chronic illnesses (See Figure 11), bush treatments (61%) seem to be favored over OTCs (27%), though this is true primarily for the lower SES groups. (Level 2b chose OTCs [60%] over bush treatments [20%].) On the other hand, for acute illnesses OTCs (49%)

[147]The small numbers of cases in some of the sub-groups make these data less reliable.

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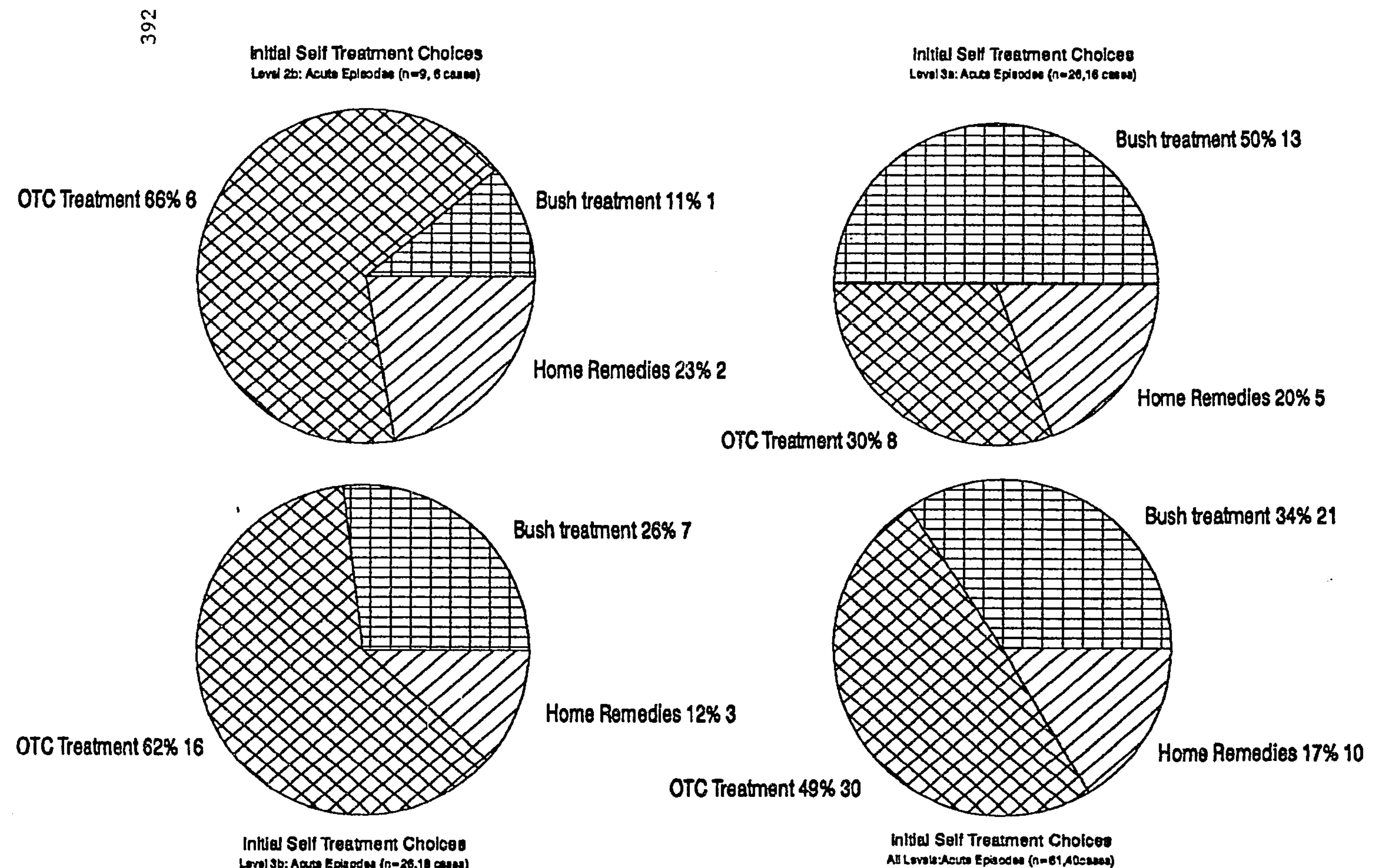

Figure 10: Initial Self-Treatment Choices, Acute Episodes

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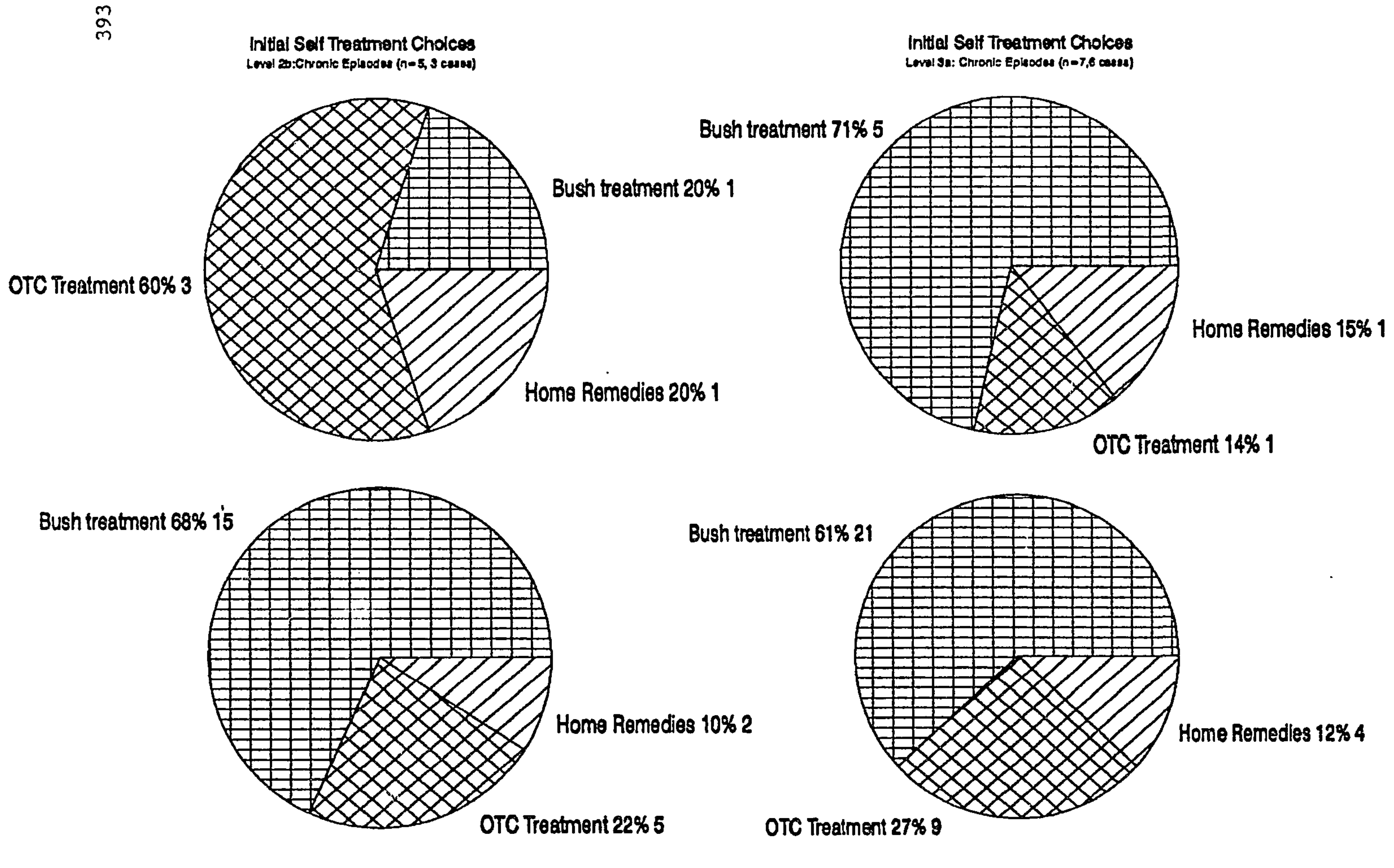

Figure 11: Initial Self-Treatment Choices, Chronic Episodes

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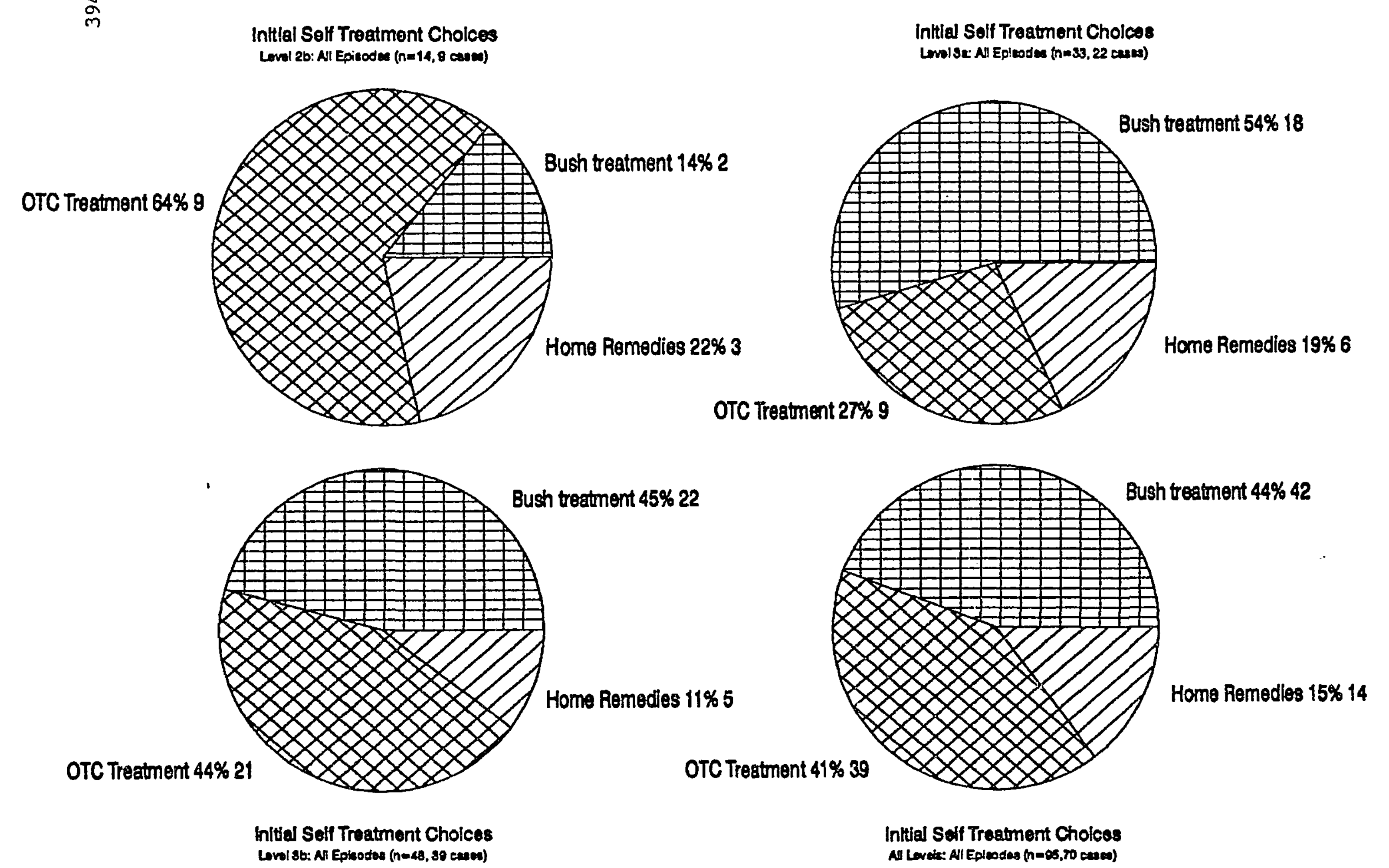

Figure 12: Initial Self-Treatment Choices, All Episodes

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were preferred over bush treatments (34%) overall, although the middle SES group did choose bush treatments more frequently (50% vs. 30%).

The highest SES group (level 2b) showed a preference overall for OTCs while the lower groups, were more inclined to use bush treatments, especially for chronic illnesses. The cost of the various treatments seems important, since the higher SES level groups can more easily afford the expensive OTCs, though there seem to be other factors at play as well. The higher overall use of bush treatments in the middle SES level (3a) compared to the other groups is a bit surprising, since we might expect that if this group had aspirations for upward mobility, they would emulate the higher SES level in their choices. This may be related to the general perception of bush treatments as being more economical, and perhaps to a greater influence of the advertising media over the poorest and least educated groups. In any case, it seems to go against the assumption that choice among self-treatment alternatives is a primary means of expressing an orientation towards upward mobility (Cf. Mitchell 1980).

From these results we can conclude that among the majority of the population in rural Jamaica bush treatments are still being widely used for a variety of ailments, and are seen as preferable to OTCs in many cases, especially for chronic illnesses. We can infer that in addition to illness type, choices among self-treatments are influenced by cost, cultural orientation, and probably other factors (e.g. education) which differentiate the various SES levels. It seems that choice among self-medication alternatives as a means of expressing social mobility, in

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practice plays only a secondary role.[148] While OTCs are used more by the highest SES group, this seems more a function of cost and education than a desire to express a prestigious social position, though we can not exclude that possibility with these data.

Common shared knowledge about efficacy, rather than ideological adherence to any particular type of treatment, seems to be a more important factor in choices among different types of self-medication for initial treatment, especially for the lower SES groups. The great majority of our household survey informants in Albion reported that they regularly use several different types of self-medication, and that they use these different types of treatment more or less interchangeably. The most important factor in choosing one over another is whether the treatment is generally considered to be effective for the particular ailment involved. A good example of this is the use of peppermint for gastric complaints. Peppermint can be used both in the form of an herbal tea, or as peppermint oil (a crude drug) mixed into hot water, and most people seem to use these interchangeably. Thus peppermint could be considered either as a bush remedy or as a store-bought medicine (OTC). To most people this distinction doesn't appear to make much difference.

For most minor ailments, there are both bush treatments and OTCs available, and there may in fact be several alternatives available in

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[148]It may play a more important role in other settings, such as the urban centers (e.g. Kingston), where social relationships are more heavily dependent on socio-economic status and class, than in communities such as Albion which are relatively homogeneous (almost everyone is poor) and where social relationships are more a function of kinship networks than of differences in social status.

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each category. Each may be used in different cases. However, for some specific ailments bush treatments may be generally preferred, while for others OTCs will be more commonly used. For example, in the treatment of colds or stomach aches bush treatments seem to be preferred as first line therapy. However, for fever and more generalized pain, OTCs are used more frequently (e.g. analgesic tablets, bay rum, liniments, etc.).

In Albion, bush medicines are overall the most widely used self-medications. They are generally free and easily available, so most people are at least willing to give them a try. In our household survey, only 26 households (10%) reported that they used no bush medications.[149] The main limiting factor in the use of bush treatments seems to be the lack of information about them. The overall knowledge of bush remedies seems to have slipped somewhat in recent years. Despite the ways in which this information is continually disseminated (See Chapter 4, p. 105), some people say they just don't know enough about them to choose which ones to use for particular ailments. Others are wary of using bushes because they are worried about their possible toxic effects, about which they feel they have inadequate information.[150] Although bushes are used especially frequently for chronic ailments (e.g. "pressure," "nerves," arthritis, etc.) they are

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[149]The real number is actually less than this since some of those who denied using bush medicines actually did report the use of specific remedies which could be considered bush treatments, such as the external application of lime juice.

[150]Some plants, of course, do have toxic properties. In recent years, revelations about the toxicities of some Jamaican plants that have been commonly used in bush tonics and teas (e.g. Periwinkle [Vinca Rosea], Crotolaria [Crotolaria Fulva], and ackee [Blighia Sapida]) have frightened some people about the use of bushes in general (See Davis and Persaud 1970).

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also widely used for some acute ailments. They are regularly used for the treatment of upper respiratory infections (URIs or "colds"), headaches, and digestive complaints, ailments for which they (anecdotally) seem to provide real symptomatic relief. For example, our informants reported over 40 different bushes that are used in the treatment of colds.

Over-the-Counter medications are also very popular in Albion, and are used by nearly everyone who can afford them. The most frequently used OTCs are analgesic tablets (for fever, headache, arthritis pains, bellyaches), cold remedies, liniments (for arthritis and muscular pains), cooling astringents (e.g. Bay Rum used for fever), skin creams, antacids, antiseptics, adhesive bandages, and tape (used for dressing wounds). These medications are usually purchased at one of the shops in the district in small quantities, e.g. 2 or 3 analgesic or cold tablets at a time. Because of the cost, most Albionites seldom use the fancier, more expensive, imported OTCs which are found in the pharmacies in Morant Bay. Contrary to what Mitchell (1980) has reported, Albionites only rarely consult pharmacists for advice on which OTCs to purchase. They rely more frequently on the advice of family members or friends who have had a good experience with a particular medication in the past. Advertising in the mass media, especially radio and television, also seems to be having a significant impact. A number of people reported buying a particular medication (usually a cold medication, such as Comtrex, or a pain reliever) they had decided to try after hearing about it from an ad.

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"Crude drugs" (included in the graphs under OTCs) such as camphor, castor oil, peppermint oil, cod liver oil, etc. and "home remedies" such as honey, rum, and kerosene, are widely used by all three SES levels. They are generally used in a similar manner to the other self-medications discussed. They also are attractive options because of their low cost and wide availability. For example, one of the most popular liniments used by the many arthritis sufferers in the district is made by dissolving camphor in kerosene or coconut oil.

Frequently, initial health-seeking strategies will involve consultation of a healing "specialist" (i.e. biomedical professional or folk healer), especially in chronic illnesses. The various biomedical alternatives (Health center public clinics, the hospital clinic, private doctors, etc.) were used much more often than folk healing specialists. Figures 7, 8, and 9 show that overall, biomedical specialists were used initially about 1/2 of the time (53%), while folk healing specialists were used only twice (3%). The tendency toward the use of biomedical choices generally increased with higher SES. For acute illnesses, biomedical alternatives were used about 1/3 (34%) of the time, and this proportion was similar for all SES levels. For chronic illnesses, the use of biomedical options was more frequent (64% overall), and these cases followed the trend of greater use of biomedicine among the higher SES levels. As mentioned above, the greater use of specialists for chronic illnesses probably reflects exhaustion of self-treatment options at some point in the past, though this might not have been reported, leading to some recall bias in these cases. (I.e. it was likely that those with chronic illnesses recalled fewer of the self-treatments they

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had initially used because of the time course differences from acute illnesses.)

Socio-economic Status seems to have played an even more significant role in determining which type of biomedical alternative would be pursued, and this was no doubt related to cost. Figures 7, 8, and 9 show clearly that private doctors were used much more frequently by those in level 2b, and progressively less frequently at lower SES levels. This is especially obvious for chronic illnesses (See Figure 8). Conversely, as might be expected, utilization of public facilities (health center clinics and the hospital clinic) was inversely proportionally to SES. Again this seems to be a direct function of cost, since poorer people are less able to afford a visit to a private doctor, which is generally preferred to the public alternatives. (This is discussed more fully below.)

All of the various public clinics were used by the survey sample, but there was a general preference for the higher level centers, especially for the more serious illnesses. A few people will go to the Albion Health Center to get some free cold medicine, antacid, etc. when they are feeling sick. The Health Center is also thought of as a place where one can go to have a minor injury assessed or a wound dressed. For the most part, though, it is not used very frequently as a source of curative care, even in the early stages of an illness. It's role is more in the realm of preventive care, for example in the well-child, family -planning, and immunization clinics. Many of those who do visit the Albion Health Center for curative purposes are young mothers with their children, who have become familiar with the Health Center through

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its ante- and post-natal care services, and well-child clinics. Even those who do make an effort to utilize the clinic are often disappointed because frequently it will be out of the medications they have come for. There is a chronic shortage of medications and supplies at the center.

Many people in the district actually think of the clinic as being primarily for children and young mothers, and as a result they are disinclined to seek treatment for their own ailments there. Some people who have become friendly with Nurse Comfort will go to her for advice or referral when they are sick. Many of the hypertensives in the district, will visit the Health Center to have their blood pressure checked when they start having symptoms and are concerned that their pressure might be rising. However, to get their medications they must attend a Hypertension/Diabetes Clinic at one of the higher level health centers. There were 1000 visits reported to the Albion Health Center for the year 1987 (excluding 754 home visits), and 448 (45%) of these were reported as "curative visits." Of these curative visits, 216 (48.2%) were for "trauma/injury" (mostly for minor first aid and dressing changes), 172 (38.4%) were for "hypertension" (i.e. blood pressure checks), 9 (2%) were for diabetes, 5 (1.1%) were for skin diseases, and the remaining 46 (10.3%) were for "other" reasons. Most of the home visits were for child care nutritional assessments, while a few were for curative followups and geriatric visits to the homebound elderly.

Another option that is used occasionally, though not as frequently as the public clinics, for the treatment of minor illnesses (and some major ones) is the public healing service which take place at Brother John's Mt. Olive Church each Tuesday night. The most frequent reason

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that people give for attending the service and going through the healing line is to "get a boost." In other words, if they are feeling a bit "low," or depressed, either from a bout with a mild acute illness, or a nagging chronic one, they will go through the healing ritual in order to be spiritually revitalized. The service does in fact seem to give many people a physical as well as a spiritual boost. I was quite surprised at one service when Mama Nancy, a 95 year old woman who suffers from chronic back pain (probably due to osteoporosis and arthritis), and normally walks only with difficulty hunched over with her cane, got up and started singing and dancing wildly without her cane.[151]

The healing service is also frequently used as a preventive measure by many people, especially during pregnancy. Growing fetuses and young children are considered to be very vulnerable to the effects of whatever evil spirits happen to be around, and because of this vulnerability pregnant women and new mothers with their babies are among the most frequent patrons at healing services.[152] Some people also use

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[151]Brother John spent some extra time working on Mama Nancy during this service. Pressing his hands to her chest and back he told her that there was something wrong with her heart because he could feel his own heart "burning" when he touched her. "If you go to doctor 'im a go tell you a t'ing!" When he asked if she had been to a doctor yet, she replied, "yes." After sitting for several moments in contemplation with his face in his hand, while he was receiving a "message" from the Messenger, he asked aloud if anyone had heard of something called "chiggernit" (chigger nut - Tournefortia Hirsutissima) to which Sister Rita replied that she knew it. Brother John told Mama Nancy that he would make her "something" (tonic) of it within a few days. Several months later Mama Nancy did go to see another doctor, who treated her with analgesics for back pain.

[152]Bush treatments are also frequently used preventively for small children, either as bush tea tonics (e.g. Ganja tea), or sometimes externally. For example, Asafoetida (Ferula Asafoetida) is often applied as a paste to a baby's scalp as a means of preventing "mole cold." ("mole" = anterior fontanelle)

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the services as a sort of "spiritual checkup" when they are ill or just "not feeling right." It is felt that, because of his powers of Reading, Brother John will be able to detect during the service any evil spirits that may be threatening them and recommend the necessary treatment. Sometimes such a problem can be effectively remedied in the service itself. Otherwise, some private healing work might be required. Brother John might also recommend that the person see a doctor, especially if they have an obvious and serious "temporal sickness" (See p. 402, fn. 151).

These different forms of self/family treatment and low-level specialist intervention are often used concurrently or serially. However, if adequate relief is not obtained, further measures will usually be considered and taken. The threshold for seeking further help varies from person to person, and is a function of the duration and severity (e.g. level of discomfort and functional disability) of the illness, the tolerance and inclinations of the affected person, and available resources. A moderately severe illness which does not respond to self-treatment will usually be taken for more specialized care fairly soon, especially if it doesn't fit into the regular cognitive framework of self-limited illnesses (e.g. colds, flu). A mild but unusually persistent illness will also be taken for further care in an effort to determine its source and to obtain relief from constant nagging discomfort, but the ill person may put up with it for a long time before taking further action.

When a new illness develops, self-treatment is most frequently the initial therapeutic measure taken. However, doctors, whether in private

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practice or in public clinics, are consulted surprisingly early in many illness episodes, sometimes before any self-treatment is tried. (This is especially true in exacerbations of chronic conditions -- See discussion above). The utilization of biomedical specialists as a first resort seems to depend primarily on the cost factor (i.e. those with more resources are more likely to go to a doctor first) and on the illness model (i.e. its meaning as negotiated within the relevant social network). If the Explanatory Model[153] which emerges characterizes the illness as "natural" and of low severity, then self-treatment will usually be attempted first. If it is characterized as being severe or potentially disabling then a biomedical specialist might be consulted despite the cost. Finally, if it is felt to be spiritually caused, a folk healer will probably be sought out.

Secondary Alternatives

If the illness fails to resolve after initial treatment efforts, a reinterpretation must take place. The symptoms, and any changes in them (e.g. improvement, worsening, or new symptom development) must be re-

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[153]The Explanatory Model concept, as developed and promulgated by Arthur Kleinman, integrates the cognitive, emotional and social aspects of illness with the physical, for both patient and practitioner. "Explanatory Models are the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process.... They offer explanations of sickness and treatment to guide choices among available therapies and to cast personal and social meaning on the experience of illness.... Structurally, we can distinguish five major questions that EMs seek to explain for illness episodes. These are: (1) etiology; (2) time and mode of onset of symptoms; (3) pathophysiology; (4) course of sickness (including both degree of severity and type of sick role - acute, chronic, impaired, etc.); and (5) treatment. EMs differ in the extent to which they attempt to answer some or all of these concerns." (Kleinman 1980:105).

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evaluated, the sick person's social position and role must be re-defined, and the illness model must be re-negotiated. Response to treatment serves as a means of testing the validity of the illness model. At the same time it is a way to judge the utility of the treatment, as well as the reliability and quality of the provider (especially when a specialist is involved). Thus the reinterpretation of the illness may involve major modifications of the illness model or, on the other hand, the illness model may change little while beliefs about the treatment and/or the provider are revamped instead. Not surprisingly then, when initial treatment fails, the criteria used in making health-seeking decisions, and the process through which these are made, can be altered considerably.

When this reinterpretation of the illness and the illness model takes place, the result is that care by a specialist becomes a much more attractive, and in some cases even essential, alternative. Failure of self-treatment usually is taken as a sign that the illness is too serious or complex to be handled by lay treatment. However, the failure of initial self-treatment usually does not yet incline the person to resort to an Explanatory Model involving spiritual causation. Instead, the model usually is modified to explain the illness as more complicated and tenacious, though still of naturalistic causation. Consequently, this reformulation leads to a greater utilization of biomedical specialists. There is especially a trend toward utilization of doctors, who are seen as more knowledgeable and skilled than other biomedical specialists (e.g. nurses, community health aides, etc.).

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This reorientation of preferences is demonstrated in Figures 13, 14, and 15, which depict Secondary Treatment Choices categorized by illness type and SES. Figure 15 shows that for secondary treatment, biomedical options (private doctors, public clinics) are the overwhelming favorite, being chosen 79% of the time overall, while self-treatment was used only 18% of the time. There were only a few cases in which folk healers were consulted as a second choice.

As we might expect, there were some differences in the treatments chosen for acute vs. chronic illnesses. For acute illnesses overall, self-treatment was again used more frequently than it was for chronic illnesses, though less than it had been initially. The numbers of acute cases, especially for level 2b, are too small to make accurate conclusions about differences among the SES levels, but it appears that all three used private doctors and the public clinics in roughly the same proportions. For chronic illnesses the use of private doctors and public clinics is more frequent, but the lowest SES group seemed to use self-treatment slightly more frequently than the others. Again, the numbers are too small to draw clear conclusions on this. The utilization of the public clinics was similar for all SES groups (about 35%) though the lower groups seem to have had a slightly greater tendency than the highest to bypass the triage system and go directly to the hospital and its clinic. The frequent use of private doctors (about 40% overall for all SES levels) is somewhat surprising, especially for those in the lowest SES group, who have a difficult time affording this.

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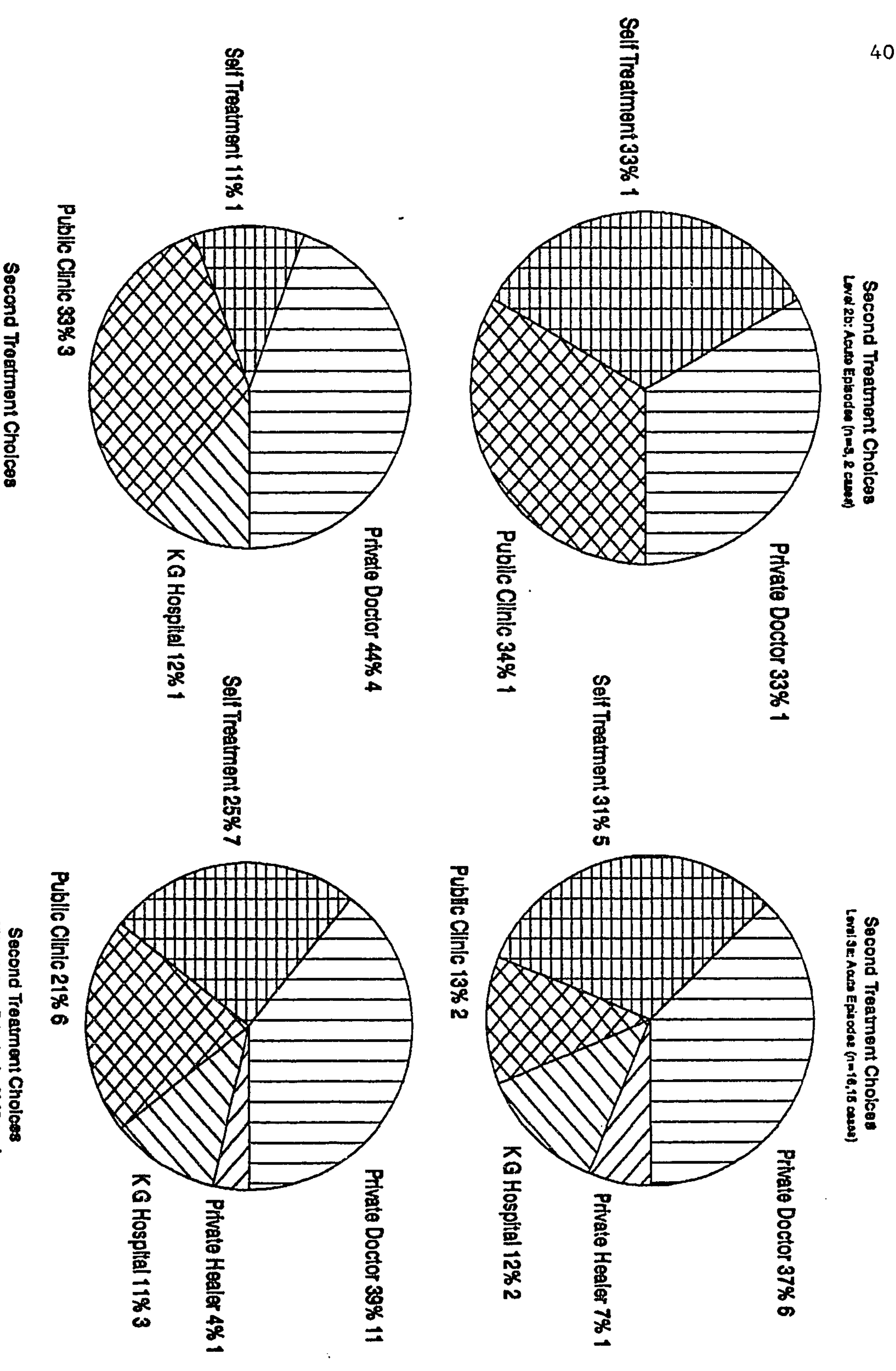

Figure 13: Secondary Treatment Choices, Acute Episodes

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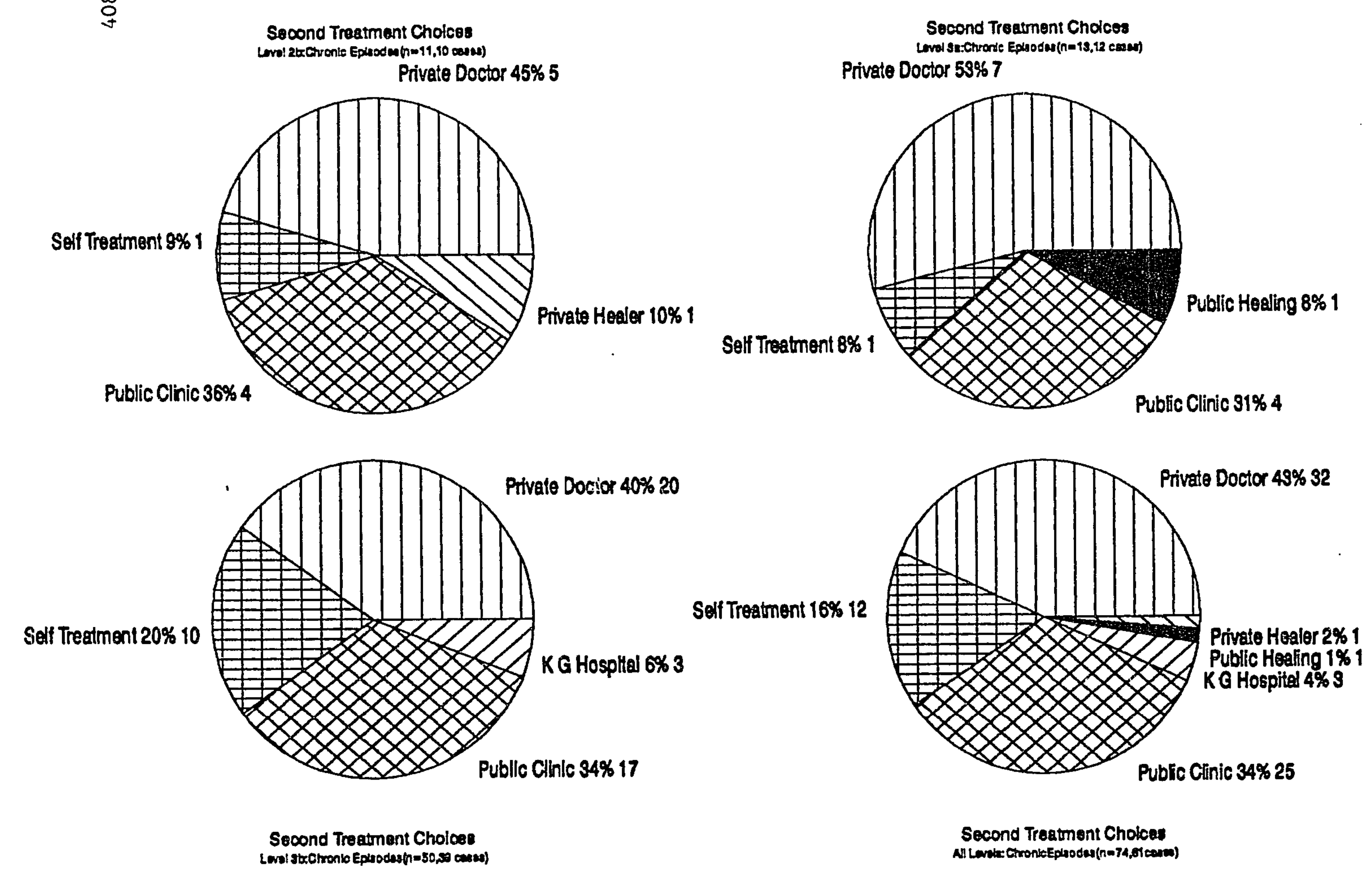

Figure 14: Secondary Treatment Choices, Chronic Episodes

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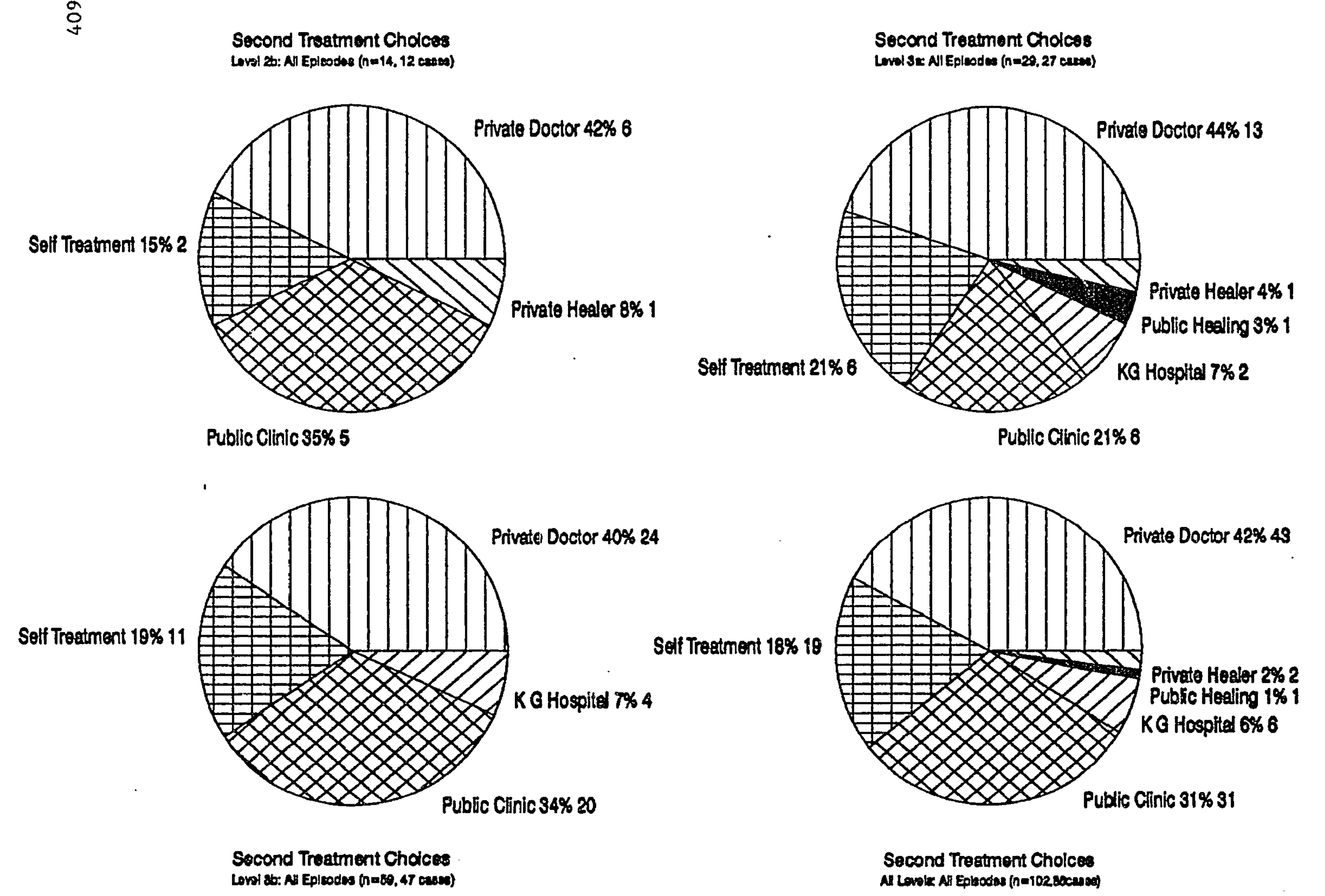

Figure 15: Secondary Treatment Choices, All Episodes

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Rural Jamaicans seem to be extremely doctor-oriented when it comes to secondary choices in health care. They learn from an early age that it is this biomedical specialist who is the expert at diagnosing and counteracting physical disease. So the desired choice of treatment when the simpler options have failed will almost invariably be a trip to a doctor, by whatever means possible. A visit to a doctor is also considered useful as a means of further investigating the etiology of an illness, not just because of what the doctor might say about this, but more so because a trial of biomedical treatment serves as a test of alternative explanations. A cure will effectively rule out a spiritual basis for the illness.

The most desirable choice for just about everyone is to go to a private doctor. Private doctors are considered to be better than the public clinic doctors because they will take time to examine ("sound"[154]) a patient, to make an accurate diagnosis, and also to explain to the patient what is wrong with them. It is felt that doctors in the public clinics (even though it might be the same doctor who would see the patient in a private setting at a different time of day) do not put as much effort into to their work, both because the patients are not paying them, and because they have more patients to see. Since the patients in a public clinic pay little or nothing for the services they

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[154]The term "sound" refers most specifically to the use of the stethoscope in examining a patient, but it is also used to refer more generally to the process of physical examination. The stethoscope, in Jamaican eyes, is a very powerful diagnostic tool, and it is assumed that a thorough examination is not possible without it. Thus, even if the person has a joint complaint, they will feel cheated if the doctor does not use his stethoscope on it. As mentioned previously (See p. 291) Brother John sometimes uses a stethoscope in diagnosis.

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receive, it is generally assumed that the doctor does not feel obligated to spend as much time with them or work as hard on their case. This perception is often supported by personal experience, as people find that when they are seen in the public clinics the doctor may ask only a few questions, and may then prescribe a medication without thoroughly "sounding" them or explaining to them what is wrong. They know that the public clinic doctor must see many more patients than a private doctor, and thus can spend little time with them. Consequently, if a person feels seriously threatened by their illness, either because of its severity, duration, or frightening symptoms, they will make every effort possible to muster the funds needed to go to a private doctor.

Those who have health insurance (usually through a job with the government or a large business) or a good income -- i.e. those in the upper levels of Albion society -- are able to afford the services of a private doctor, and prescribed medications, without much hardship. They may even have a regular "family" doctor, whom they see for checkups and routine care. Most people in Albion, however, are not in this position. There are many who are able to scrape up enough cash to see a doctor when it becomes really necessary, but the poorest, and those who must make repeated visits for chronic conditions, must rely more heavily on the free or cheap services provided by the health centers and the hospital.

The attitude of most rural Jamaicans towards doctors, especially private ones, is extremely deferential. The average person is intimidated in the presence of a doctor, and rarely would openly challenge a doctor's judgement or advice. This perspective is tied in

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with the two-fold attitude of deference and resistance that lower class Jamaicans have towards authority and authoritarian figures (See Chapter 3, p. 82; Chapter 5, p. 197), and seems to be more a function of the personal power differential than of class relations, though these two issues are not clearly separable. While the doctor and patient may not be far apart in terms of class origin, the doctor's profession elevates his social status. It is true that the deference seems to be similar to that shown to members of the upper classes, and that higher class patients do seem less intimidated. Nevertheless, the doctor is for the most part in firm control in his interactions with all of his patients, and most patients are too intimidated to ask questions or disagree with them during the encounter. However, patients are able to exert some control over their interactions with doctors in more subtle ways. It is the patient who has ultimate control over whether the prescribed medication will be purchased, or taken. And it is the patient who decides whether or not to return to that particular doctor.

The presence of several doctors in Morant Bay gives people an assortment to choose from. Since all practice on a first-come-first-served basis it is possible to see any particular doctor on most weekdays, provided one arrives early enough and is willing to wait. Although people speak generically about doctors as if they could do no wrong, they do make individual distinctions about their abilities, personalities and costs, and they make choices among them on this basis. Dr. Young, for example, is very popular among Albionites because he charges less than the other doctors while still providing good care. Dr. Lewis is the most expensive doctor in town, and the best known

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because he's been around the longest. Some people are willing to pay his higher fees, especially when they have an intractable problem, because they consider him to be the most competent as well.[155] Because he is a surgeon, he is able to do some procedures that other doctors can't. Thus patients assert some measure of control in their relationships with doctors by voting with their feet. If they are unhappy with a visit to a particular doctor, or if they are not pleased with the result of the treatment they received, they will very readily go to see someone else the next time.

As might be expected, this "doctor shopping" is often counter-productive. It is not unusual for a patient to see several different doctors for the same problem over a short period of time. Naturally, this creates difficulties in any efforts to maintain continuity of care. When a doctor sees a patient, he is often unaware of past diagnoses and treatments the patient may have received from other doctors, and patients are often unwilling or too embarrassed to talk about this because they think it may offend the doctor. Because each doctor keeps his own set of records, and there is little communication among the doctors in the area, information on the patient's past medical history is often missing from their records. And, probably most importantly, many patients are lost to followup after what are essentially "empirical" treatments, i.e. trial treatments, based on a tentative

[155]Some informants claim that Dr. Lewis has the ability to "read," i.e. to see when an illness is caused by evil spirits, and some told me that they had been told by Dr. Lewis to consult a healer because their illness was spiritual rather than natural in origin. This is unlikely, however, given Dr. Lewis's adamant position against folk healers, whom he considers dangerous quacks.

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diagnosis, given in the understanding that the patient will return for reevaluation if the desired result is not attained, or if further treatment is needed. In addition, there is the added burden for the patient of paying the fees of several different doctors for treatment of the same problem.

Despite their preferences, many people choose which doctor they will see on a particular day at least partly (and sometimes wholly) on the basis of convenience. They may arrive at the office of the doctor they intended to see, only to find his waiting room full, in which case they will go off to one who happens to have room on his schedule. Dr. Stewart, for example, having opened his practice in Morant Bay only recently, usually has a less full schedule than most of the other doctors, and people sometimes show up at his office because he is the only one who has time to see them that day. If they are pleased with their experience with him, they may return or even become a regular patient.

Many people in Albion are unable to afford to go to a private doctor even if they want to. For these people, access to a doctor's care can be had only through the government health services. Attending a government clinic is often an ordeal. Clinics are held only on specific days, so a sick person might have to wait several days to see a doctor. When there is a clinic, patients routinely wait several hours to be seen, and such a visit frequently takes up a whole day.[156] Many patients will arrive at the health center hours before the clinic is

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[156]In a recent study conducted in 44 Jamaican health centers, the average length of time a patient waited to see a doctor was 3 hrs. 53 mins. (Desai et. al. 1989).

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scheduled to begin in order to get at the head of the line, so they can be seen early. Such a strategy may actually reduce overall waiting time and it may increase the likelihood of being seen on that day, but it is not a feasible one for those who have to travel a considerable distance to the health center. Doctors' clinics are conducted only at the higher level health centers, so that some amount of travel is necessary for Albionites (and all others who don't live nearby) to reach them.

Theoretically, the referral network for the health centers begins at the local Type 1 health center. As discussed above, a sick person may initially go to see Nurse Comfort at the Albion Health Center, who will then, if necessary, send them on to one of the higher level centers or to the hospital. This approach, however, is the exception rather than the rule. Most people who feel they need to see a doctor (and are unable to afford a private doctor) will go directly to the hospital clinic, or to one of the higher level health centers where the government doctor or nurse-practitioner is holding their clinic that day. They know that if they take the time to go see Nurse Comfort first, they will arrive at the other clinic either too late to be seen, or else be put at the very end of the line, where they may have to wait for the rest of the day before being seen.

As explained in Chapter 4 (See p. 162), curative clinics in the eastern part of the parish are held at three different health centers on different days of the week. At the Hounslow Polyclinic to the east, a clinic is held daily, although Dr. Mung is there only on Monday through Wednesday. Nurse-Practitioner Jones is there from Wednesday to Friday, so on Wednesdays both are there seeing patients. The Midway Health

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Center offers clinics on Mondays (Miss Jones) and Fridays (Dr. Mung), and the Benton Health Center has clinics on Thursdays (Dr. Mung). On Tuesdays, Miss Jones conducts the STD clinic at King George Hospital. Outpatient clinics are held at the hospital on Monday, Wednesday and Friday by Dr. Tingsa, though the other doctors will sometimes help out. In addition, Hypertension/Diabetes clinics are held once a week at the higher level health centers. In these clinics, patients with these chronic problems are seen by a nurse and given a renewal of their medication.

When someone from Albion feels the need to see a doctor and can't afford a private visit, they will frequently go directly to the Hounslow Polyclinic or to King George Hospital rather than the Midway Health Center, which is supposed to be the next link in the chain of referral. Clinics are held more often at these other locations, and the pharmacies are better stocked. At Hounslow there is a clinic every weekday, and the doctor is often available (three days a week, plus most weekends if needed for an emergency). Clinics there are less crowded than at the hospital, so the doctor has more time for each patient. From Albion it is often easier to get to Hounslow than to either Morant Bay (which is further away) or to the Midway Health Center (which requires a change of taxi or bus).

On the other hand, the clinic at King George Hospital provides easier access to laboratory tests and x-ray studies, a better stocked pharmacy, and surgical services, all of which are based there. If a person feels they may need these services (e.g. for a bad cut or

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suspicion of a fracture) they will often just go straight to the hospital.

The Midway Health Center frequently runs short of medications. When a patient goes there to see the doctor or nurse-practitioner, they not infrequently will be sent to King George Hospital to buy the medication, which means a J$5 charge plus the extra travel expense and time. Thus it makes sense for people to start at the top of the referral pyramid rather than wasting time and expense working their way up through it. This is why the hospital out-patient clinics are always so crowded and why the referral system is so ineffective.

Some people show a preference for one of the clinic practitioners over another, although this may be expressed in negative rather than positive terms. If they have had a bad experience with a particular practitioner, they may be reluctant to return to see them. For example, one woman I spoke with had had an unpleasant encounter with Miss Jones (which seems to be related more to her manner than her clinical competence) and thereafter refused to go to the Hounslow clinic on the days when Miss Jones was working there for fear of being triaged to her. In general, though, this sort of conflict is unusual.

Thus when a sick person is making a decision about which of the government health facilities to go to, several factors come into play. Once severity, persistence of symptoms, discomfort, and worry have induced them to consult a doctor, and financial constraints have limited them to a choice among the government clinics, then accessibility of appropriate care, and convenience, come to the fore. But even though people make use of the government services this doesn't mean that they

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are satisfied with them. There are continual complaints among patients (and among staff as well) about the long waits, shortages of drugs, crowded clinics, short visits, lack of explanations given them, decaying facilities, etc. that plague the system. An especially sore point among people in eastern St. Thomas is the "rationalization" of Hounslow Hospital, which reduced the services available to them there, without delivering the promised added facilities and services at King George Hospital.

Patients usually have a high degree of satisfaction with their individual encounters with doctors, however rushed consultations and poor communication sometimes lead to anger and resentment. Time constraints and individual approaches are crucial factors here. Dr. Mung generally has a few more minutes to spend with each patient than does Dr. Tingsa, and this enables him to make a greater effort to explain things to patients and to avoid some of the misunderstandings that occur when there are communication gaps.

For example, at Hounslow I once saw Dr. Mung turn the anger of a man whose son had been injured in an auto accident, and who felt the boy had not been given sufficient attention by the staff, into respect and confidence by taking a few minutes to talk with him. By explaining to the distraught father the condition of the boy and the reasons for why he was being managed in a particular manner, and by addressing his worries, he was able to reassure the man and convince him that they did indeed care about the boy and were treating him appropriately. By contrast, the hurried assembly-line atmosphere at the King George Hospital clinic sometimes creates conflict out of simple

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misunderstandings. On one occasion there I spoke with an irate young man who had already seen the doctor and filled his prescriptions. He had come to the clinic because of back pain, and ended up with some tablets and a bottle of liquid medicine, which he recognized as stomach medications. He was very upset because he felt he had been completely misdiagnosed and treated incorrectly. In fact, he had been given some analgesic tablets and the antacid was merely to help alleviate whatever gastric side effects he might have. This was an unfortunate misunderstanding which could have been prevented with a simple explanation, which no one seemed to have time for.

Referrals and Further Choices

Although some illnesses, especially acute self-limited ones, will resolve with initial or secondary treatment, a certain portion will persist and require further efforts. This was true in 44 (32%) of the 139 cases in the survey sample.[157] 9 (16%) of the 56 acute cases, and 35 (42%) of the 83 chronic cases reported third treatment choices. The third treatment choices are shown graphically in Figures 16, 17, and 18, again broken down by type of illness and SES. Although the numbers of cases in some categories is too small to make many clearcut generalizations (e.g. there are no acute 2b cases), it appears that the mix of treatment choices is similar to that seen for secondary treatments. Overall, 36% of the choices involved private doctors, 36% were for the public clinics (and hospital), 24% were for self-treatment,

[157]These results are skewed to some extent by the time frame of the study. Some of the illnesses may have been too recent in onset to have reached this stage by the time of the interview.

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Third Treatment Choices
Level 2b: Acute Episodes (n=0, 0 cases)

No Cases

Third Treatment Choices
Level 3a:Acute Episodes(n=5, 5 cases)

Self Treatment 40% 2
Private Doctor 20% 1
Private Healer 20% 1
Public Clinic 20% 1

Private Doctor 50% 2
Self Treatment 25% 1
K G Hospital 25% 1

Third Treatment Choices
Level 3b: Acute Episodes (n=4, 4 cases)

Private Doctor 33% 3
Self Treatment 33% 3
Private Healer 12% 1
K G Hospital 11% 1
Public Clinic 11% 1

Third Treatment Choices
All Levels: Acute Episodes (n=9,9 cases)

Figure 16: Third Treatment Choices, Acute Episodes

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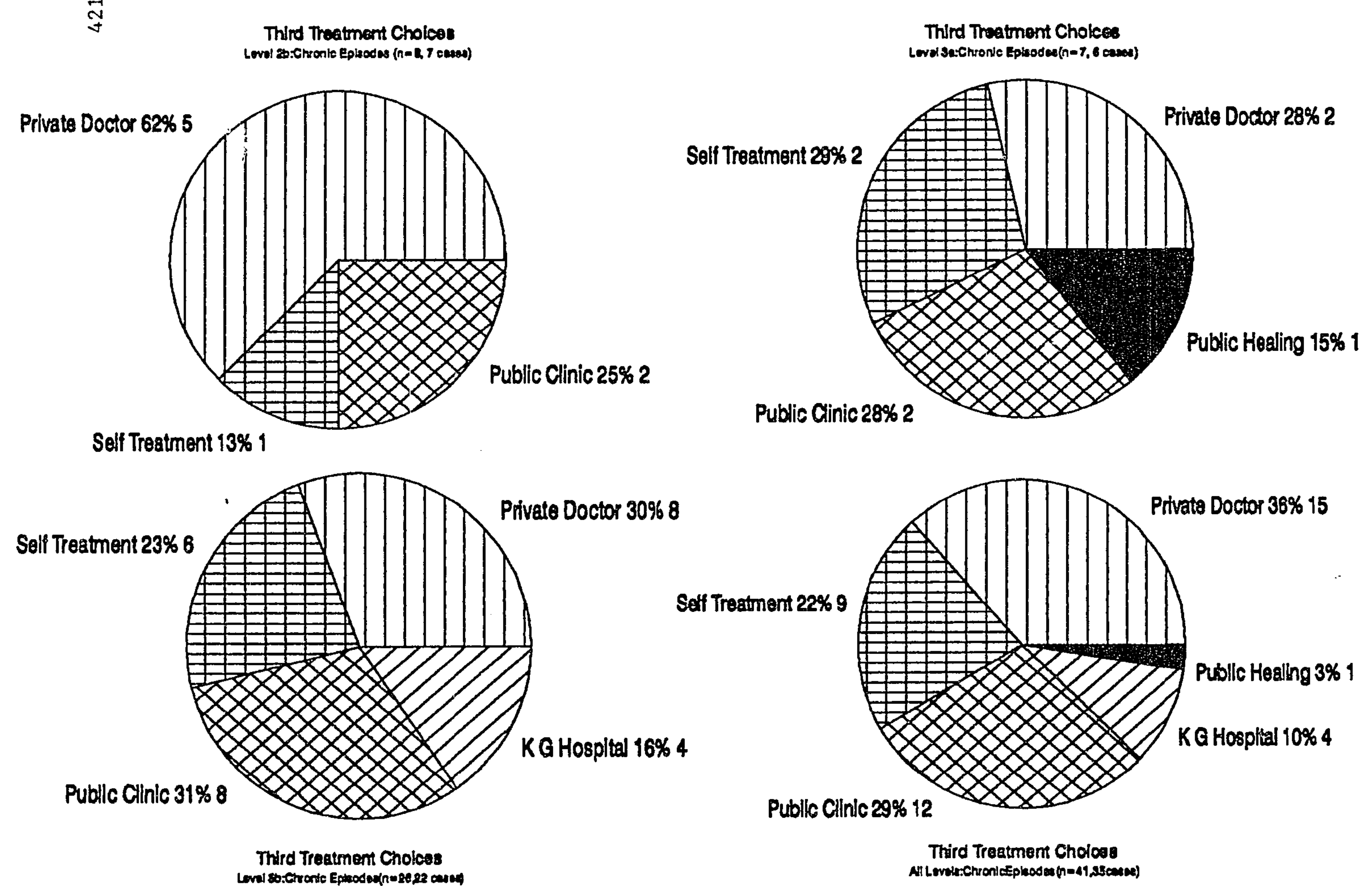

Figure 17: Third Treatment Choices, Chronic Episodes

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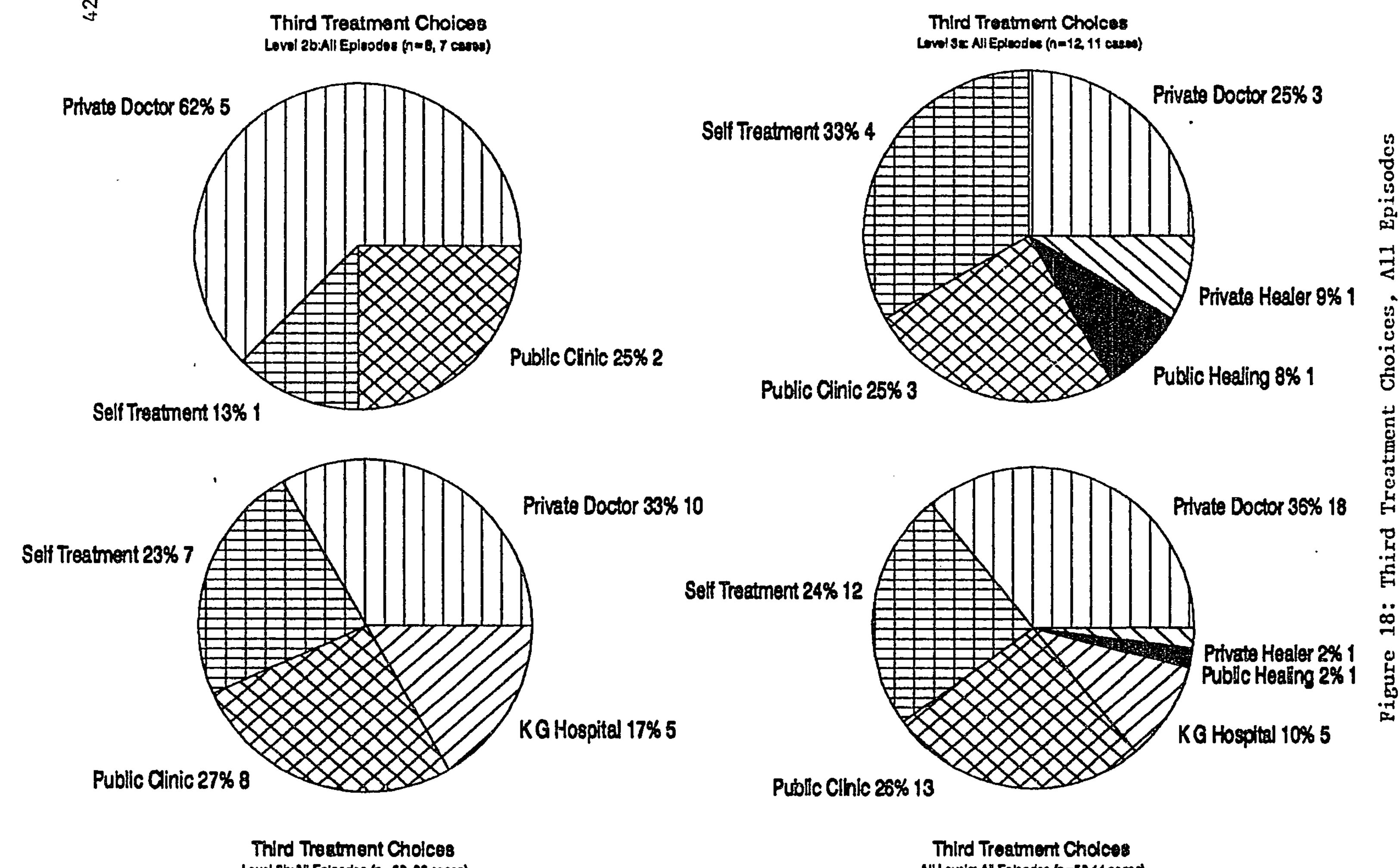

Figure 18: Third Treatment Choices, All Episodes

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and 4% involved folk healers. The lower SES groups increased their use of self-treatment slightly while the level 2b group used private doctors slightly more often. The slight increase in self-treatment might reflect some rejection of biomedical models in the illness reformulation or, more likely, the inhibitory effects of cost.

It is not surprising that we see similarities between the patterns of second and third treatment choice, given the limited time frame involved. Frequently biomedical treatment is structured such that repeat visits or referrals are needed, and judgements of treatment failure may be put off until several attempts are made. There is generally too much faith in biomedical therapy and the skill of doctors for this to be rejected too soon. Further major revisions of the Explanatory Model will in most cases not be made until several attempts at biomedical treatment have been made, even though the individual may lose confidence in a particular doctor after a few or even a single visit.

Some illnesses, especially acute infectious processes, or self-limited conditions, may respond adequately to self-medication or to simple treatment by either a private doctor or public clinic. In some cases, however, prolonged treatment, hospitalization, complex diagnostic studies, or services more specialized than those available locally may be needed to diagnose or manage the condition. Public clinic doctors have the option of referring patients to the public hospitals in Kingston, but for private doctors, referral of patients often poses more of a dilemma. Sometimes the patients are simply unable to afford the

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additional care needed and in such situations stopgap measures must be employed.

Referral in some cases may actually be done for the purpose of decreasing the financial burden to the patient, and this is less problematical. For example, patients are sometimes referred by private doctors to the public Hypertension/Diabetes clinics because they cannot afford regular visits to the doctor. Through attendance at these clinics, medications can be obtained more cheaply. Because none of the doctors has an electrocardiogram machine, and there is none at the hospital, patients are sometimes sent to the special Heart Foundation ECG clinics (which cost the patient J$40) for this basic diagnostic test.

On the other hand, patients may be unwilling or unable to comply with recommendations for intensive tests or expensive treatments. There are three private labs in Morant Bay (or rather collection stations for labs in Kingston) which are used by private doctors for diagnostic testing. Usually this involves simple blood tests or cultures of various sorts. But sometimes the doctor feels a more intensive test is needed and these are available only in Kingston, e.g. ultrasound scans and other specialized imaging techniques, complex biochemical tests, etc. Likewise the doctor may want to refer the patient to a medical or surgical specialist in Kingston for further evaluation and/or treatment. The cost of such a referral can run into the hundreds of dollars (J$), and is beyond the reach of many patients, especially those without insurance or a good income. Many must wait until they are able to save up enough money for the recommended test or treatment, learn to live

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with their discomfort, or try other alternatives. The decision to spend a large sum of money on such a referral is a difficult one for a poor person, especially if they don't have complete confidence in the referring doctor. Even the trip itself to Kingston is a gruelling ordeal (three hours on a hot, crammed minibus) and may be too much for a sick or elderly person to manage. And unless the person has relatives in Kingston to stay with, they have only a few hours to get anything accomplished because the buses returning to St. Thomas leave by early evening. Thus intended referrals are frequently not followed through with. This is a source of frustration not only for the patients, but also for the doctors, who feel unable to offer them much in the way of help.

Referral from the local hospital is usually to one of the large public hospitals in Kingston (e.g. Kingston Public Hospital (KPH), or the Bustamante Hospital for Children) or their specialty clinics. Hospitalized patients who need more intensive or specialized care than can be provided at King George Hospital will be transferred directly to Kingston by ambulance. Clinic patients will usually be referred only if they have an obvious specialty problem which the local clinic doctor is incapable of treating (e.g. cataracts), or if a more extensive diagnostic workup is needed and not available locally. All of these referrals must go through King George Hospital. So, for example, a patient at Dr. Mung's clinic at Hounslow Polyclinic, whom he feels should be seen at a specialty clinic at KPH, must first go to King George's Hospital to get a letter from the doctor there, which means another wait in line. (Dr. Mung also regularly sends patients to King

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George Hospital for simpler matters, for instance if they need an x-ray study done, or if they need to be hospitalized.)

Once a public patient is referred to a Kingston hospital, and manages to get there, they then come up against a confusing and impersonal bureaucracy at the Kingston hospital. They have to find the proper clinic, and then deal with erratic schedules, long waits, confusing paperwork, payment of various fees, etc. -- all of which can be perplexing and frustrating even for the stout-hearted. It is not hard to imagine how intimidating this is for a frail, elderly, disabled, illiterate, poor, rural farmer who has always tried to avoid the hustle and bustle of Kingston. Usually these referrals will require several return visits, all beset with the same bureaucratic hassles and logistical problems.

At the end of it all, the patient typically finds him- or herself placed at the end of a long waiting list for a surgical or other specialized procedure. They are informed that they will be notified by telegram when it is time for them to come in, and they return home to wait in uncertainty, perhaps indefinitely, with their problem unchanged and often unmanaged. And then there is the question of whether, or how, if they do ever receive the awaited telegram, they will be able to pay for the procedure. The Jamaican government health service now charges patients for surgical procedures and some other hospital costs.[158] While these are much lower than might be charged at a private facility and are, at least in theory, negotiable or waivable depending on the

[158]From 1985 to 1987, J$16 million was collected in this way, 50% of which was returned to the hospitals for maintenance, repairs and other expenses (Daily Gleaner 6/10/89).

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patient's financial status, in practice they can impose a significant burden on the patient, and they often deter patients from having treatable problems corrected.

These obstacles serve, both overtly and covertly, to effectively ration access to specialized care.[159] There are several otherwise able-bodied people in Albion who are severely or completely disabled because of correctable conditions for which they have been unable to obtain treatment. A common example of this sort of disability is blindness due to cataracts. In Jamaica where people receive a life-time of unprotected exposure to strong solar ultraviolet radiation,[160] cataracts are quite common, and can cause anything from mild visual impairment to complete blindness. I knew several people in Albion whose ability to work or take care of themselves had been seriously compromised by cataracts. Some had been on the waiting list for surgery for as long as two years, while others had been deemed too old for it.

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[159]Some specialized treatments are not available at all in Jamaica, which leaves the person who hasn't got the money to travel to Miami or New York for treatment out in the cold. In rare cases, a publicity-driven fund-raising campaign will enable an individual to receive intensive treatment abroad such as in the case of an eight year old boy who was flown to Canada for dialysis and a potential renal transplant in March 1988. His family had raised J$96,800 (Can$22,000) of the J$220,000 (Can$50,000) needed at the time he was accepted for dialysis. It was unclear where the rest of the money would come from (Daily Gleaner 3/11/88). A few children each year are also sent abroad for cardiac catheterization, for diagnostic evaluation of congenital and rheumatic heart disease, though many more could benefit from it. The catheterization equipment at the University Hospital has been out of service since November 1985 and public fundraising events have been held to try to raise money for new equipment (Daily Gleaner 10/1/87).

[160]Studies have shown that UV radiation is a causative factor in cataract formation (Taylor et. al. 1988; Lerman 1988). Sunglasses, which can give some protection against this sort of radiation, are rarely worn by Jamaicans.

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Other conditions can create similar problems. James Osbourne, a 56 year old poor cultivator/laborer in Albion, developed an oral tumor (presumably benign) which over a two year period grew to the size of a small orange (10cmx5cmx5cm) in his mouth, and was seriously impairing his ability to eat and speak. He also was greatly weakened constitutionally and found himself unable to keep up his small field of crops which he formerly cultivated for subsistence and for a small surplus which he could sell. Early on, when the tumor was still small, he was sent by Nurse Comfort to the Midway Health Center, and from there was sent by the nurse to King George Hospital. After taking some x-rays the doctor there referred him to the Kingston Public Hospital (KPH). He was seen at KPH by several different doctors on numerous occasions over the next two years. Three or four biopsies had been done but he was told they were inconclusive. On a couple of his visits to KPH he had been told to bring his clothes so he could be admitted, but as it turned out he was then sent home. In December 1987, on his last visit before our interview, he had been taken to see another doctor at the University Hospital who did another biopsy and took more x-rays. He was told that he would be sent a telegram to tell him when to return for a surgical procedure, though he had not heard anything by the time I spoke with him in September 1988. However, he had been told by a neighbor that 2 weeks previously an ambulance had come from King George Hospital to pick him up. But he was not at home, and missed them, so he wasn't sure what they had come for (No message was left). He had planned to go back to King George Hospital to talk with the doctors there about what was going on, but unfortunately Hurricane Gilbert hit that same day, tearing the

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roof off the hospital and effectively throwing everything into chaos. He was unsure of what he was going to do next.

Of course, most of the chronic illnesses that afflict Albionites are neither severe enough, unusual enough, nor curable enough to merit referral to Kingston. Typically these illnesses involve multiple symptoms, vary in their intensity and in the degree of disability they cause, and may respond only temporarily to biomedical treatment. The course of illnesses such as hypertension, heart disease, migraine, arthritis, or asthma involves a waxing and waning of symptoms and a continuous cycling through a variety of treatment alternatives. Illness models and health-seeking decisions and strategies at any particular time will reflect current severity, functional disability, resources available, what has been tried in the past, and previous successes and failures. Thus the health-seeking process in chronic illness is complex, continuous, and cyclical. It will vary according to the nature of the illness and the resources and orientation of the individual. Consequently, it is not really possible to describe a "typical" pattern of health-seeking for these persistent illnesses, or even for a particular type of chronic illness. What can be said is that over time the afflicted person will usually try several alternatives, and even when these fail may go back and try them again. As a general pattern, most people self-medicate most of the time, by whatever means, but when symptoms flare they seek out care at a clinic or doctor's office. There are, however, other options that some individuals will, in particular circumstances, make use of.

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Explanatory Models and Alternative Strategies

In the survey sample there were a only a few cases in which folk specialists were consulted (See Figures 7 through 18). Public healing was an initial choice in two chronic cases. For secondary treatment private healers were chosen in one acute and one chronic case, and public healing was chosen in one chronic case. For third treatment choices a private healer was used in one acute case, and public healing in one chronic case. These numbers are too small to draw definite conclusions on the use of these options, but it is interesting to see that folk healers were utilized by members of all three SES levels. Given these small numbers, in order to better understand the patterns of utilization of folk healing, we must look to information obtained through in-depth investigation of cases in which folk healers were consulted, and through discussions with the various folk healers and their clientele. One point that comes across from these sources is that the decision to consult a folk healer usually involves a significant investment in elaborating an illness model, which can come about through several different processes. Usually, however, it is the result of the sequential illness reformulations that occur in the course of a persistent illness.

Jamaicans for the most part do not seem to formulate elaborate Explanatory Models (See Footnote 153) for most of their illnesses, or at least they do not find it easy to talk about them. Nor do they expend much effort on devising or utilizing elaborate schemes for disease/illness classification. They face illness as a practical problem which needs to be controlled, rather than as an analytical

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puzzle to be pored over. In discussing illnesses with each other they tend to focus more on treatment choices than on etiological explanations. For short-lived illnesses, etiology is not very important. A mother may have a particular idea of why her child caught a cold, but this is a matter of uncertainty and what is most important is that the child get better. Many people express the feeling that they do not know enough about health matters to make judgements about diagnoses or causes. "That is up to the doctor," is a common response. In some circumstances, however, especially when an illness persists despite several efforts at what seem to be appropriate treatment choices, explanations of etiology take on a greater significance in decisions about health-seeking strategies. In addition to having a strong influence on treatment choice, these etiological theories also serve as a classificatory device which may affect all other aspects of the Explanatory Model.

The most common popular etiological explanations for illnesses involve "humoral" ideas. These are apparently derived from what were the accepted disease theories of the European Biomedicine introduced during the earliest days of colonialism, and which persisted in European popular theories well into the 19th century. They are similar to humoral theories still widespread in Latin America, though less elaborate (cf. Foster 1987). Most commonly, illnesses are ascribed to an importune exposure of the body to cold, wetness or dampness. This is thought to be especially harmful if it occurs when the body is hot, e.g. after exercise, or after being in the hot sun. This harmful chilling can take place in a variety of ways -- exposure to a draft, standing in

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front of an open refrigerator, playing in water, getting caught in the rain, etc. A variety of illnesses including colds, arthritis, and even corns, are often attributed to such exposure. Treatment might include hot teas, liniments and steam baths which are means of counteracting the chill with heat. On the other hand, some other conditions are attributed to overheating. High blood pressure (known as "pressure") is thought to be brought on or exacerbated by overheating through exercise or sun exposure and is treated with "cooling" remedies such as drinking lime juice and coconut water, or rubbing the head with a cooling lime. In another variation on the theme, herbal remedies for diabetes are often chosen for their bitter taste (e.g. Chamba Bitter - Phyllanthus Niruri) which is felt to counteract the "sweetness" of the "sugar."

Another popular etiological model involves the concept of "poisoning." Skin conditions, for example, are often ascribed to "poisoning of the blood." The most common popular category of this is "ptomaine poisoning"[161] which is a fairly commonly reported illness and which actually accords in a roundabout way with biomedical models. This disorder is thought to be caused by eating a "spoiled" tin of fish or beef, which "poisons the blood," producing an itchy rash. The popular sector method of self-treatment for this condition is to use a tea of "Bissy" (Kola Nut - Cola Acuminata) which is believed to counteract the poison. Some people will go to the doctor for treatment of this

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[161] "Ptomaine" is a relatively archaic medical term used to refer to a vague class of toxic bases formed through the bacterial decomposition of flesh or a body, and at one time was used to categorize poorly understood illnesses that were attributed to some sort of "food poisoning." (Dorland's Medical Dictionary 1985:1093). It probably entered the popular Jamaican vocabulary at some point in the past from this now outmoded biomedical usage.

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problem, especially in refractory cases, as biomedical treatments are also thought to be sometimes effective for it. Interestingly, some doctors will use this popular term in explaining to patients a diagnosis. One doctor I spoke with (Dr. Stewart) described the "ptomaine poisoning" syndrome as probably corresponding to a hypersensitivity (allergic) reaction to chemicals used in the canning process, which produces urticaria (hives). The popular use of the category, however, seems to include a wider range of disorders than just this.

In many other instances popular Explanatory Models, including concepts of etiology and appropriate treatment, parallel but differ in some respects from biomedical models. Popular illness terms and concepts such as "pressure," "nerves," "gas" (or "gas bag"), "cold," "open back," "sugar," "belly bottom pain," etc. correspond roughly to biomedical categories (Cf. Blumhagen 1980, 1982; Helman 1978).[162] For the most part, when a doctor diagnoses such a condition, the patient will accept and follow biomedical treatments. In some cases, though, when popular and professional models diverge, or when biomedical treatment fails in the patient's eyes to correct the condition, they fall back on popular self- or folk treatments, and become non-compliant with a doctor's advice. For example "pressure" (high blood pressure, hypertension) is popularly thought to be associated with particular symptoms (see Chapter 4, Footnote 27) and if these are not present the

[162]Most Jamaican doctors recognize the significance of popular terms such as "open back" and "translate" them into biomedical categories (in this case urinary tract infection). Understandably this is more difficult for foreign doctors.

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person will often stop taking prescribed medications under the assumption that the condition has been corrected or is inactive. They may also consider any measures (e.g. bushes) which seem to alleviate these symptoms to be effective treatment for the hypertension. When funds or patience are short, the person may rely solely on self-medication with detrimental long-term consequences (Ironically, in some cases the consequences may be positive because negative iatrogenic effects are avoided).

One Explanatory Model that assumes central importance in the course of some cases involves the attribution of the illness to spiritual causation.[163] As discussed previously (See pp. 210, 293) the attribution of illnesses to spiritual forces has been a central feature of illness models in Jamaica throughout its history. And as we have seen, these models have in turn been important factors in the shaping of Jamaican cultural institutions, especially in the realm of religion and folk medical practices.

It is hardly surprising that these beliefs appeared in Jamaica, since similar ideas (especially beliefs in "Spirit Aggression," see below) are ubiquitous in human cultures around the world (Murdock 1980:73). More significantly, such models are prominent in the African

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[163]See Stoeckle and Barsky (1980) for an analysis of "illness attributions," a concept derived from social psychology, which they use to refer to both "the cognitive processes by which an individual arrives at an explanatory belief and also to the explanation itself." (Stoeckle and Barsky 1980:224) They discuss the significance of attributions in "illness behaviors, coping responses, and emotional reactions," and stress their role in reducing anxiety and enhancing the sense of control of an ill person (Stoeckle and Barsky 1980:225). In addition they suggest that the elicitation of illness attributions can enhance the effectiveness of primary care doctors.

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cultures from which lower class Jamaican culture originated, and in those present-day cultures to which it is most closely linked, viz. African and other Afro-Caribbean cultures (e.g. Janzen 1978b:47; Coreil 1983:135; Borofsky 1968). The persistence of these beliefs is no doubt related at least in part to the adaptive functions they have served, and continue to serve, in enabling sick people to explain, understand, cope with, and obtain some measure of control over illness when other alternatives have failed.

The spirit world is as much a part of the everyday lives of poor rural Jamaicans today as it has ever been. Though perhaps their form has changed a bit, spirits still play an active role in practical affairs. Rural Jamaicans see and experience on a day to day basis the manifestation of both personalized (e.g. duppies) and impersonal (e.g. the Holy Ghost) spirits through possession states occurring in church or other ritual environments such as Kumina. They also may have, or hear about, more spontaneous contact in non-ritual environments. A family's ancestors are typically buried in their yard, and the family may be in regular contact with them through Kumina ceremonies or other more private rituals.[164] It is also generally accepted that even outside these ritualistic settings people may experience physical manifestations

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[164]It is customary for some families, even those which are not involved in the Kumina cult, to periodically make animal sacrifices (e.g. a goat) on the graves of their parents and other ancestors. This is often done on a yearly basis. Some individuals who have emigrated to other countries will perform such sacrifices during return visits, as a means of paying homage to and maintaining contact and favor with ancestral spirits. In this way family ties are maintained even after death. After it is killed the sacrificial animal is butchered to make a feast for relatives and friends, thus reinforcing current family and social networks as well.

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of ghosts either as apparitions or as "copis."[165] And they regularly experience and witness the work of evil spirits in causing misfortunes such as illnesses that doctors are unable to treat successfully. Thus there is a continuing need for ways to contact and elicit the assistance of spirits in order to obtain explanations for and to help manage life's problems. Specialists who are able to communicate with and influence the spirit world consequently continue to be in strong demand.

Spirits can cause problems, or provide assistance, in any aspect of one's life. The folk specialists who are able to pull strings in the spirit world act as "healers" in the broadest sense of the term. They are regularly consulted on matters which in addition to illness include misfortunes ranging from relationship problems, to personal disputes, to court cases, to theft. However, their most salient role lies in their ability to address illness, which is the most pernicious, and most feared, form of spiritual influence.

Jamaican beliefs in spiritual causation of illness fall roughly into two of the general classes outlined by Murdock (1980): "Theories of Animistic Causation," and "Theories of Magical Causation" (Murdock

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[165]A "copi" is analogous to what we would call a poltergeist. It is a ghost or spirit that takes possession of a house, usually with a variety of dramatic demonstrations of its presence (stone throwing, moving of furniture, noises, voices, etc.). Copis are relatively common occurrences in Jamaica, and have been described by several writers (e.g. Wedenoja 1978:373-431; Williams 1934:148-153,220-243). While frightening, a copi can have a sense of humor as well. In August 1987, a minor sensation was created by a duppy from Canada named Shirley who occupied a home in Kingston with the intention of forcing the owners to pay off a J$5,000 debt. Large crowds gathered at the scene, and it was reported that in addition to causing damage and creating a nuisance, "Shirley the Duppy" joined onlookers in singing lewd popular songs such as "Waa Punaany, "Wanga Gut," and "Sit Down 'Pon It" (Star 8/29/87). This incident inspired a record called "Duppy Come" by Peter Metro, which became quite popular on Jamaican radio shortly after the incident.

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1980: 19-22). The former class includes the categories "Soul Loss"[166] and "Spirit Aggression."[167] The latter class includes "Sorcery"[168] and "Witchcraft."[169] While Soul Loss (or "Shadow Loss") and Witchcraft were important beliefs in Jamaica in days gone by (see pp. 217,227; also Williams 1934:169-172), today they play a much less important role than beliefs in Sorcery and Spirit Aggression.

When an illness fails to respond to both self- and professional (biomedical) treatment, even after the afflicted person has cycled through these two sectors several times, a suspicion that the illness has a spiritual cause might well arise. "Natural" illnesses are supposed to respond to biomedical treatment, and if they don't there is something wrong. Any illness which falls outside the accepted sickness->treatment->resolution paradigm may be suspect. Thus chronic illnesses (with certain exceptions) are the most frequent candidates for such an explanation. There are a few categories of chronic illness, such as arthritis, "pressure", diabetes, etc. which because of their commonality and familiarity have come to be accepted as within the realm of natural

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[166]"Defined as the ascription of illness to the voluntary and more-than-temporary departure of the victim's soul from his body." (Murdock 1980:19)

[167]"Defined as the attribution of illness to the direct hostile, arbitrary, or punitive action of some malevolent or affronted supernatural being." (Murdock 1980:20)

[168]"Defined as the ascription of the impairment of health to the aggressive use of magical techniques by a human being, either independently or with the assistance of a specialized magician or shaman." (Murdock 1980:21)

[169]"Defined as the ascription of the impairment of health to the suspected voluntary or involuntary aggressive action of a special class of human beings believed to be endowed with a special power and propensity for evil." (Murdock 1980:21)

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causation, but even with these the questions "Why me?" or "Why now?" may need more of an explanation than can be offered by biomedical practitioners. Thus a point may come when a major reformulation of the illness model takes place, and such a reformulation involves a fundamental shift in etiological theories and the criteria used for making health-seeking decisions.

In addition to unusual persistence of symptoms, and non-resolution after biomedical treatment, there are also other factors which define the limits of plausibility of naturalistic explanations. If the symptoms experienced fall outside the realm of what would normally be expected according to popular Explanatory Models, especially if they are odd or bizarre, then supernatural causation may be suspected.[170] There are also certain patterns of insidious, vague, functionally disabling, constitutional symptoms which have come to be associated with spiritual illnesses. For example general malaise, fatigue, insomnia, nightmares, low energy, weight loss, inability to concentrate, anxiety, rashes, non-healing wounds or infections, hair loss, etc. might, if they persisted without a plausible natural explanation or response to biomedical treatment, be taken as indicators of spiritual interference. It is generally believed that when a sorcerer tries to kill someone he will attempt to bring about a slow, lingering death, so as to maximize

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[170]An example of this is a case of illness attributed to duppy contact in which a young woman felt a wave of heat come over her (a commonly reported feeling associated with contact with a duppy) and then became very ill with fevers, vomiting, and swelling and pain in her feet.

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suffering while not arousing suspicion.[171] It has been a source of consternation to many public health workers that the slowly progressive effects of malnutrition in children are not infrequently attributed to the work of a sorcerer or duppy. However, spirit-caused sicknesses can be acute in onset as well, especially if a person has a run-in with a ghost, in which case it is said "duppy lick [hit] 'im."

Sorcerers, or Obeah Men, are thought to cause illness by "setting a duppy" on a person through various magical techniques, which might involve rituals invoking the duppy, burying an object in the victim's yard or path, or putting something in their food. The act of harming someone through magical means is often referred to as "casting a blow." As discussed earlier (See pp. 215, 248) the belief that sorcery is a common cause of illness and death, and its use as a means of explaining misfortune and sickness in particular cases, is much more widespread than the actual practice of sorcery could possibly be.[172] The use of sorcery to cause harm is usually thought to be perpetrated by an enemy (or false friend) who is envious of the person because of their success, relationships, possessions, etc. Often it is attributed to a jealous mistress or former lover, or a competitor at work or school. Overt social conflicts and feuds, if coincident with illness or injury to one of the parties, will almost invariably arouse such suspicions. Or

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[171]Some early writers, convinced that sorcerers were indeed responsible for such lingering deaths, attributed them to the sorcerers' skillful use of poisons (Williams 1934:80,84-5; Gardner 1971 [1873]:190-1).

[172]This follows the pattern observed in most other cultures around the world (Murdock 1980:70).

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conversely, such social conflicts, even within families, may arise out of suspicions of sorcery.[173]

In addition to causing illness and death, Obeah/sorcery is also thought to be capable of damaging any other aspect of a person's life such as their relationships, financial status, success in school, farming, business, etc. Thus the attribution of an illness to sorcery automatically situates the illness within the matrix of one's social relationships as well as within the totality of one's life.

Duppies can also cause illness on their own through what Murdock (1980:20) calls "Spirit Aggression" without the intercession of a sorcerer. This may be by chance, for example if one happens to unexpectedly come upon a wandering duppy at night and be touched by it. Or it may be due to unlucky exposure to a duppy while burying or handling a dead body. Attack by a duppy may also be more purposeful, such as when an ancestral spirit decides to punish a descendant who has upset the family order through conflict, who has neglected ritual duties, or who has behaved in some other way against the wishes of the spirit.

The threshold for suspicion of spiritual causation varies from individual to individual and from case to case, but is related to factors such as social class, education, previous experience, cognitive belief systems, and social networks. Such suspicions are more common among the lower class, poor, and uneducated. Upper classes eschew such beliefs, at least outwardly, and the upwardly mobile person may disavow

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[173]Many people see this as the most negative effect of sorcery beliefs and those healers who encourage them.

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them to give the appearance of conformity to the ideals of his desired position. However, the increased penetration of the upper classes by individuals from lower class origins (despite a low degree of upward social mobility overall) has resulted in a spread of lower class values and practices to other levels of society (Gordon 1986) (See Chapter 3, p.43). Upwardly mobile individuals may in fact increase their use of healers and Science Men in order to enhance their progress, e.g. to assist in getting promotions or passing examinations. Thus it is not unusual to see relatively well-off individuals from Kingston among the clientele of any of healer, but especially of Science Men who are not only able to heal, and counteract evil, but who are able to magically promote success in other areas of life as well.

Social networks play an important role in influencing decisions to seek out the help of a healer. If an individual has regular contact with a healer, whether through family ties, social interaction or involvement in a church group, they are more likely to make use of that healer's services. For example, people who are acquainted with Brother John through his church work, utilize his services relatively frequently. The Professor's (James Parker) wife's family, who live in Albion, occasionally ask him to come to the district to "take care of some business" for them (i.e. to perform some magical tasks). Other clients have come to know these healers well through repeated association over the years, and now visit them regularly for whatever problems they have. And some others with long-standing connections visit only when in need. For example, one woman from Albion, who had emigrated to Canada but had returned to Jamaica for a visit, sought out

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the Professor for some magical assistance with a problem. She knew the Professor because he had been a drinking buddy of her father (now dead). Many people are referred to a particular healer through social contacts, either by family or friends. Most people who visit a Science Man or other type of healer, come with a friend or family member who is familiar with the healer, especially on a first visit. The companion acts as a guide to find the place, as a social broker to introduce the client to the healer, and as a provider of emotional support.

Past experience is another factor which may lower (or raise) an individual's threshold for seeking a healer's help. If a person has had a positive experience with a healer in the past -- especially if they have been cured of an illness that had resisted biomedical treatment -- they will be more likely to return to them. This will influence not only the decision of whether to consult a healer at all, but also the choice of a healer. And such an experience also has a strong influence on family members and other close social contacts.

Once a sick person has a suspicion that their illness might be due to supernatural factors, it is up to the healer to confirm or deny this. This can take place either in a public healing service or during a private visit. The former is cheaper, but only very limited information can be conveyed during such a service, and treatment is usually temporizing. If a spiritual illness is diagnosed during a service, Brother John will almost always suggest that the person return to see him in private later on. The lack of a diagnosis during a public service only decreases the likelihood of, but does not rule out, the presence of a supernatural illness. The spiritual "checkup" that a

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service provides may give enough further information to aid the person in their decision whether or not to see a healer privately, however it does not provide a definitive remedy. So a private "reading" may be desired, whatever the outcome of the service.

A private reading provides the definitive step in diagnosing a spiritual sickness. Once the decision is made to obtain a reading, the healer to be consulted must be selected. Some people, out of convenience and familiarity, will consult one of the local healers. The particular choice seems to depend primarily on social contacts, proximity, and reputation (i.e. opinions that other people hold of the healer). Thus many of Brother John's clients are from Albion or the surrounding districts, while the Professor attracts more clients from the Stratford and Midway areas.

On the other hand, there are some clear incentives that might incline someone to go to a more distant healer. Especially if local social conflicts are involved, many people do not want their neighbors and friends to know that they are consulting a healer, either because they do not want to be accused of Obeah, or because of how it might reflect on their social position. In such insular communities, gossiping is a major diversion, and there are few events of interest that happen without the entire district knowing about it in a very short time. Travel to a distant healer can help avoid some of this unwelcome attention.

In addition, the reputation of a healer seems to magnify and grow over long distances. Albionites, if they are not using one of the local healers, often go to Portland, which like St. Thomas has a reputation as

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a "science parish." It is relatively accessible, but far enough away to limit public knowledge of the trip. Alternatively, they may go to a healer in one of the more distant parishes. Distant healers are often considered to be more powerful, as well as more dangerous, than the local practitioners.[174] It is not surprising then, that a large proportion of both Brother John's and the Professor's patients come from other parishes, especially Kingston. Of course a danger involved in using a distant healer, if people do find out about it, is the immediate suspicion that the user is in fact working sorcery. It is assumed that the person must be trying to conceal something by visiting a faraway, presumably evil, practitioner.

Obtaining a reading is a relatively cheap (J$5-10, $.91-1.82) means of determining whether in fact an illness does have a spiritual component. The accuracy of a reading, and thus the caliber of a healer, will initially be judged primarily by the degree to which the healer is able to convince the client of their powers of discernment. The healer does this by telling the client things about themselves which they shouldn't by normal means be able to know, thus demonstrating their supernormal capabilities.

Healers can be quite convincing in their ability to know the "unknowable" and to the client and casual observer such interactions offer persuasive evidence of psychic abilities. However, more careful scrutiny reveals other explanations. Healers often know more about a

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[174]I was, in fact, told by several people that if one *really* wants to work sorcery that it is best to travel to Haiti where the sorcerers are much more powerful and more wicked than even the strongest Jamaican Obeah Man.

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client and their business than the client realizes, especially if they are local. It is difficult to keep any information private in a rural district, and healers generally have wide enough social networks that they are aware of goings on throughout the area. Visitors from afar present more of a challenge. Information about them can be obtained by the healer through careful observation and careful listening. Often clients will inadvertently disclose a great deal of information about themselves. And there are usually several assistants around who can overhear conversations and reveal useful information to the healer.

The primary technique used in performing a convincing reading, however, is a subtle process of negotiation between the healer and client which both elicits and provides information. The healer will start with very general comments or questions, based on preliminary observations, and use the responses to close in on the problem and gauge the client's emotional reactions. Clients, anxious about their problems, often reveal more than they are asked to. At the outset, the healer will usually state the problem in very general terms, e.g. "you feelin' weak," or "somet'ing holdin' you back," and then proceed to narrow it down according to the patient's reactions. Another factor in the healer's favor is that when he makes an incorrect statement it is much less likely to be remembered by the client in evaluating the interaction, than is an uncannily accurate one. Thus through a skillful use of these techniques with a group of self-selected, willing, and anxious clients, healers can be remarkably successful in their assessments (cf. Dreher 1969:96,102-111; Davis, et. al. 1984). While some might argue that the use of such methods is tantamount to trickery,

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it is likely that many of the techniques are in fact utilized without conscious intention, and thus the healer may genuinely believe in the veracity of their psychic powers. There is no way to tell, of course, by observation whether healers might in fact have some paranormal abilities, however with the edge of Occam's Razor[175] we can put aside the need to invoke such explanations.

A healer will sometimes tell the client that their illness is not spiritually caused and in such a case will prescribe mainly herbal treatments or perhaps refer the patient to a doctor. But in most cases they will confirm what the patient suspects: that there is a malevolent force at the root of their problem. Usually this "blow" is attributed to sorcery that has been perpetrated by an enemy. There are some instances, however, when family discord is seen to be the main cause. Conflicts within a family, or a neglect of responsibilities to ancestral spirits, can bring on the wrath of the ghosts of dead relatives. For example, in one case the death of a teenage girl was attributed to family conflicts which had angered the ancestors, and which intensified when one family member resorted to sorcery against another.

Jamaican healers will rarely, if ever, explicitly reveal the name or identity of the person whom they determine has worked Obeah on the victim (Cf. Dreher 1969:105-8). The Professor, for example, explained that while he is able to ascertain through his powers of divination the identity of the villain, he never reveals this to the client because he is afraid that they might take matters into their own hands and harm or

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[175] "The principle of scientific thinking which states that the most simple adequate explanation of a thing is to be preferred to any more complex explanations." (Wolman 1973:260)

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kill the suspect. It is better, and more satisfying, for the victim to retaliate by counteracting the sorcery rather than through open conflict. In a reading, however, the healer will often give clues to the client and he may even provide a description of the perpetrator, while remaining sufficiently vague and non-committal to avoid obvious errors. For example he may indicate that it is a person at work, someone who lives nearby, a false friend, or a jealous lover. Most clients are able to put 2 and 2 together and draw a conclusion about the identity of the miscreant. Indeed, some arrive with suspicions already strongly formulated and merely seek to have them confirmed. Some are so confident of the perpetrator's identity that they will come away convinced that the healer revealed their name, even if the healer actually gave them only a vague clue.

Even though they may be convinced of the wrongdoer's identity, a victim will almost never make a public accusation of sorcery. Friendships may be abandoned, grudges held, and revenge sought, but direct confrontations are almost unheard of. Of course, the rumor mill grinds rapidly, and the supposed villain may hear second-hand about the victim's visit to a Science Man. If bad blood exists between them, the supposed villain may even take this as an indication that the victim is working obeah on *them*, in which case they will have to pay a visit to their own healer. Consultation of a healer may in fact represent a covert step taken in the course of a dispute as a means of avoiding open conflict. The best and most satisfying revenge in such a case is felt to be counteracting the spell with stronger magic, in which case the original spell will "turn back 'pon" the one who cast it. Proof of the

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efficacy of a counter-spell is manifest when the suspected wrongdoer himself falls ill or suffers some misfortune (Cf. Dreher 1969:113). Or at the very least, the victim's problems should begin to resolve. Attempting to influence events for one's own advantage is a risky business, especially if it involves harming another. Even when it doesn't, some people believe that an overreliance on magic can backfire and lead to illness, madness, or death.

Once the cause of an illness has been determined, the healer will inform the client of what treatment will be necessary, and what it will cost. Unfortunately, as we have seen, treatment by a healer can be extremely expensive, running into hundreds of Jamaican dollars. Even after the cure there may be a need for further protective measures, such as the wearing of a guard ring, which alone costs about J$350 ($65). Most healers are fairly liberal in their collection policies. They often will accept partial payment with the promise of the balance in installments.[176] Some healers will take financial hardship into consideration in setting their fees, and may treat a friend or relative for free.

Clearly at this juncture, though, cost and limitation of resources again become critical factors in the pursuit of health. Many people, even the poor, will somehow manage to come up with at least a down-payment for a healer's services. Once a person is convinced that the

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[176]Clients seem to be fairly conscientious in paying off these debts, though it may take them a long time. It is of course unwise to incur the wrath of a Science Man by cheating him. However, if the treatment is unsuccessful the chance of non-payment increases, as the client may feel justified in not paying, and the healer may be less determined to collect his fee.

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cause of their illness is sorcery, if they are unable to afford treatment they will feel condemned to suffer and perhaps perish at the hands of their enemies. There are a few alternatives that are available in such circumstances. The person may turn to a church and attend healing services, which provide some spiritual reinforcement and protection at a low cost. They may go to a different healer, such as a Revivalist, who can provide an alternative explanation, treat the problem more simply, or at least charge a bit less than a Science Man would. Another option is to turn to a healer such as Mother Winslow who charges little or nothing for her services. These measures, however, would be seen as stop-gap remedies, and only if there was a complete cure would their effectiveness be accepted.

Healers can be surprisingly successful in their efforts to cure illnesses that are brought to them. As might be expected, the cases that make it to their doorstep tend to be chronic in nature and resistant to biomedical treatment. Often a strong psychological or psychosomatic component is present as well. They not infrequently involve problems that to some might be considered "natural" changes that come with aging (aches, pains, weakness, etc.) but that have been endowed with special significance because of individual beliefs, life stresses, or social conflicts. Frequently cases of psychiatric illness (especially depression, anxiety disorders, psychoses, antisocial behavior, etc.) will end up at a healer, even though most healers will deny that they are able to successfully treat some of the more severe psychiatric/neurological disorders (e.g. epilepsy, psychosis). Some of Brother John's most dramatic cures, for example, have been of "madness."

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In some respects then, Jamaican folk healers function as folk psychiatrists. Biomedical options, especially the assembly-line treatment that one finds in the public clinics, are not well suited for managing most chronic or psychiatric disorders, which require long-term treatment and regular monitoring.

Aside from possible pharmacological effects of their herbal treatments (which are probably slight, especially when administered as baths), it is most likely "suggestion" and skillful psychosocial management which enable healers to have a beneficial effect on their clients. These can be effective even in cases where the illness is apparently quite physical in origin. For example, one woman I interviewed at the Professor's office, an elderly higgler from Kingston, was apparently suffering from osteoarthritis of the knees (a very common complaint among the elderly), and had been told such by a doctor. She had found that the analgesic tablets the doctor gave her provided only temporary relief from her joint pains. In her mind this treatment was a failure since it didn't cure her of the illness. Meanwhile, she had been in conflict with another higgler at the market, and began to suspect that this other woman was "doing somet'ing" to her (i.e. working sorcery) so as to cause the illness. She was brought by a friend to see the Professor, who confirmed her suspicions of sorcery and gave her the necessary treatment. Given my own biomedical model of osteoarthritis, I fully expected that she would be disappointed with the results. I was quite surprised when she returned two weeks later to thank the Professor for what had been a miraculous cure. Her pain had disappeared completely within a couple of days, and had not returned. Thus the

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efficacy of the healers' methods is self-evident to those who use them regularly.

Folk healers are of course not always successful. Their skill at managing failures is almost important as their skills in diagnosis and treatment. Most have developed techniques for managing failures which enable them to sustain their image of effectiveness, even in the face of disappointment, and to maintain the loyalty of their clients. If after treatment a client returns to the healer and reports that their condition has worsened or failed to improve, the healer will usually tell them that patience is needed, and that obtaining a complete cure may take a long time. Alternatively they may expound on the complicating factors or modify their original diagnosis or explanation. They may repeat the treatment or modify it, thus renewing the hopes of the patient that a cure may be possible and putting off the admission of failure. For example, one patient of Brother John's, who seemed to be suffering from a psychotic disorder (probably paranoid schizophrenia or schizoaffective disorder), had been coming to him several times a week for over two years. Even though he had shown little improvement, and was still tormented by duppies whenever he returned to his home, he was convinced that Brother John's treatments were helping him. Brother John was quite perplexed about what more to do for him, and some of his assistants even chided the man for "faking" his illness. Nevertheless, Brother John was always able to offer him some hope. In addition to trying to get him to see a doctor, giving him money for food, giving him bush baths, and treating him during healing services, he also let him

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sleep in the church occasionally so he wouldn't have to return to his duppy-infested home.

When treatment by a particular healer fails, even after several attempts, it is more common for the patient to use a strategy similar to the "doctor-shopping" pattern that characterizes the use of private doctors. A healer's power is an individual asset and the failure of one healer does not mean that a more powerful healer would not be able to succeed. Thus a person who is convinced of the spiritual basis of their illness may move from healer to healer looking for the one with the ability to handle their problem. Many of the clients I met had not only been to several doctors before consulting the healer, but had been to several other healers as well. Obviously this can become quite expensive, but the urgency of a spiritual sickness seems to inspire even greater commitment to finding a solution than does an illness which is naturally caused.

Even this may not provide a final solution to the problem. What happens when a person has exhausted all of these alternatives, and still is left with their illness? This is not an easy question to answer, since individual responses are so variable. But it is an important one to consider as the burden of chronic illness in the community grows. If sufficient resources are available, the person can continue to cycle through the process indefinitely. There is always a new bush that a friend has recommended, a different doctor to try, another healer to seek out. For many, however, resources are severely limited. They may come to a point when they must resign themselves to the suffering caused by the illness and accept it as their lot. Others fall between these

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extremes. They respond to flareups by re-entering the cycle of health-seeking, withdrawing from it temporarily when symptoms subside or when a lack of resources again limits their choices. Alternatively, an increase in resources may prompt a re-entry, as a long-delayed operation or visit to a practitioner is finally undertaken.

SUMMARY AND COMMENTS

The choice of treatment alternatives in Albion, as we have seen in this chapter, is rarely a simple matter. It would be a distortion to argue that any one factor is decisive in health-seeking decisions. Only a minority of illnesses follow a simple unilinear trajectory with a discrete starting and ending point. Most illnesses are complicated by an uncertainty about the cause and nature of the disease, unexpected turns in the illness course, and sub-optimal response to treatment. In any sickness there are a multitude of external and internal variables which shape assessments and choices: symbolic meanings associated with illnesses and treatment options, variability in previous experience and personal knowledge, advice from both lay and experienced others, limitations of finances and resources, availability of treatment alternatives, fear and uncertainty, unexpected outcomes, etc. In an acute, self-limited, short-lived, illness these complicating factors have less of an influence on choices and outcome. However, in a chronic or recurrent illness, they come to play a more and more prominent role as the illness progresses.

Unlike the "typical" underdeveloped country, Jamaica is already far along in its "epidemiological transition" to a state in which

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chronic and degenerative diseases -- diseases of the middle-aged and elderly -- are the most important sources of morbidity and mortality. Efforts to control infectious and childhood diseases in Jamaica have been successful enough such that even in poor rural areas such as Albion, their effects have been dramatic. This is not to say that acute and infectious diseases have disappeared -- far from it. However, we have seen that in Albion the great majority of acute illnesses are self-limited, and are not associated with a high morbidity or mortality, except perhaps among the most vulnerable (infants and the very old). On the other hand, chronic and degenerative diseases exact an ever larger toll in terms of functional disability, mortality, and economic cost.

One of the most important results of this epidemiological transition has been an alteration in the pattern of illness trajectories, and a consequent changing demand for health care services. Sanitation, immunization and antibiotics, the mainstays of the biomedical management of diseases most prevalent in an "Age of Pestilence and Famine" (Omran 1971:517-8), are no longer sufficient to cope with the changing patterns of illness in Jamaica. Even standard preventive public health measures such as improvements in sanitation and water supplies lose some of their urgency in a society where salmonella outbreaks are uncommon, but where heart disease kills thousands yearly. While some adaptations have been made to address these changing patterns, there is still a large gap between the supply of and demand for appropriate health care services.

The transition to chronic and recurrent illnesses has meant that more and more people in Jamaica are spending more of their lives cycling

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through the health-seeking process and oscillating among the various treatment alternatives that are available. In such a situation, a linear or even branching model of the health-seeking process is misleading. Chrisman's linear model (1977) (See p. 381, and Figure 6), for example, overlooks the crucial events that occur after a treatment alternative has been pursued and the therapy has been adhered to (or not adhered to) -- namely an assessment of outcome, a reassessment of symptoms, a realignment of the individual's position on the sick/well axis and in the social system, and a reformulation of the illness model.

In reality, after a treatment option has been tried there is generally a re-evaluation of symptoms. If they have sufficiently resolved, the individual is able to return to the ranks of the "well." If not, the illness is reinterpreted in light of changes which have occurred in symptoms, social relationships, and illness prototypes, and the cycle continues. Addition of these steps to Chrisman's scheme transforms the process from a linear one to a cyclical one with no necessary endpoint. Figure 19 gives a simple schematic representation of this reinterpretation of his model of the health-seeking process. This sort of dynamic, open-ended, cyclical model is more consistent with the realities of health-seeking, especially with respect to chronic illness. Although it has its own deficiencies, it does give us a framework in which we can begin to reconceptualize the health-seeking process.

Central to the reinterpretation of the illness experience and patterns of health-seeking is a better understanding of the factors which influence health care choices at each stage of the health-seeking

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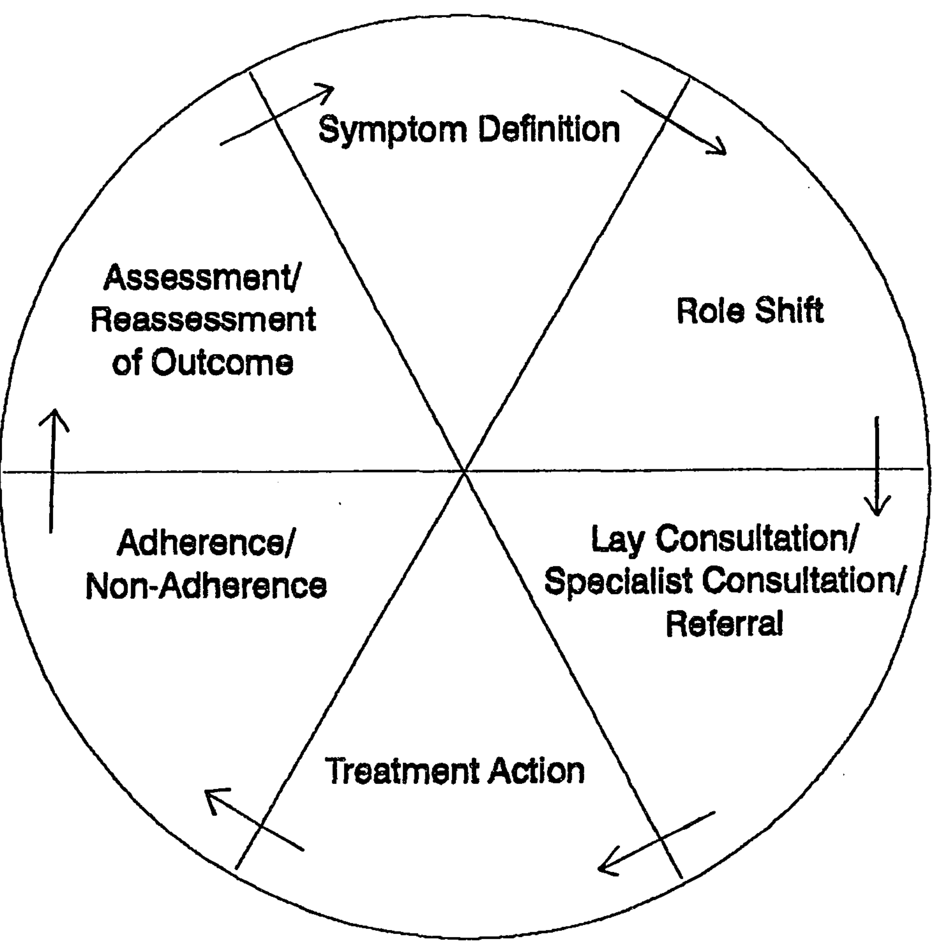

A Cyclical Model of Health-Seeking

Figure 19: A Cyclical Model of Health-Seeking

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process. We have looked at the basic principles of health-seeking in the setting of Albion by breaking the process crudely into four basic phases (Early Choices, Secondary Alternatives, Referrals/Further Choices, and Alternative Strategies). Each of these phases roughly corresponds to one or more turns through the cycle of health-seeking, and each phase seems to take place primarily in one of the three sectors (Public, Professional, Folk) of the health care system. We have, in fact, discerned a general pattern in which the sequence of treatment cycles usually begins with self-treatment or treatment within the family (popular sector), proceeds to primary biomedical treatment, then to secondary and tertiary biomedical care (professional sector), and then finally may move into the realm of folk healing (folk sector). However, it would be a distortion to characterize this progression as a "hierarchy of resort" (cf. Romanucci-Ross 1977 [1969]), since an individual may simultaneously seek treatment in two or more sectors at the same time, and movement can (and frequently does) occur from one phase or sector to another in either direction.

In fact, any of the available alternatives could be a reasonable choice in any phase of the process, depending on the constellation of factors operative at any particular moment. In this chapter I have attempted to provide an outline of the criteria which come into play in various situations in the different phases of the health-seeking process. This process is variable, and it is not always possible to predict which factors will be the dominant considerations at any particular time. The important point, though, is the realization that at different phases of the process the relevance and influence of

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various factors with respect to each other change continually as symptoms evolve and are reassessed, as meanings and relationships are transformed, and as even "constants" such as costs and access to various alternatives are altered and reinterpreted.

At the outset of the first phase of the health-seeking process, severity is the most crucial and determinative factor. The extent to which an illness is perceived to threaten life and bodily integrity, i.e. the degree to which control over one's physical and social "self" has been lost, will determine whether care is sought immediately in the secondary professional (biomedical) sector, or whether an attempt will be made to manage the illness within the popular sector. If the latter course is chosen, a variety of options is available, and other factors come into play in making a choice among these. Explanatory Models and Illness Prototypes enable a classification of the illness according to etiological theories and popular illness categories. Because different illnesses are believed to respond differently to the various popular sector treatments available, this assessment may be decisive in determining which popular option (e.g. bush, OTC, etc.) will be pursued. At this point finances are frequently not yet a critical factor, as most of the alternatives within the popular sector are roughly equivalent in cost. However, in a country with such wide differences in material wealth, cost is never totally without significance, and in fact can account to some extent for the continued popularity of bush treatments.

At this stage of the process, personal orientation and class values may steer choices in one direction or another, depending on the individual's self-image and goals for upward mobility. The choice of a

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treatment alternative makes a public and personal statement of class identification. In a rural community such as Albion the social distance between upper and lower segments of the community is relatively small, and common roots in "country" living make choices such as "bush medicine" legitimate even for members of the higher strata. However, we would expect that the "upwardly mobile" would strive to define their social image by using treatments associated with upper class lifestyle (e.g. private doctors and OTCs) more frequently. On the other hand, to those secure in their position (whether high or low) a choice inconsistent with one's social position should be less of a threat to self or social identity. Thus we can hypothesize that it should be the middle group which would put greater effort into emulating upper class values.

The survey data show mixed results on this question. The group we could expect to be most consciously striving for advancement (level 3a, the middle group) did use private doctors more frequently than the lower group (though less so than the upper group), but they also showed a higher use of bush treatments, and less use of OTCs, than the other groups. So our data is really insufficient to make a judgement on this hypothesis. It may in fact be the members of the highest local group (level 2b, which in fact is more of a middle group on a national basis) who are more conscious of presenting a high status image. The fact that the lowest group (3b) showed a relatively high use of OTCs, despite their poverty, might be evidence of the impact of mass marketing among the least educated. However, the data we have available are again insufficient for making such a judgement. And of course there are other

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complicating factors, such as cost and the fact that the various treatment alternatives have other, less contrived, symbolic meanings (e.g. with respect to metaphysical issues of causation and control), which influence decisions.

Because most illnesses treated within the popular sector are minor, decisions about the various alternatives usually need not be made on an urgent basis. The time frame in which the process takes place can be rather prolonged. However, when an illness fails to respond or becomes more debilitating despite several attempts at treatment, a shift is made to the next phase: Secondary Choices. This typically signifies a shift to the use of specialists in either the folk or professional sectors. In most cases biomedical care of one sort or another is sought first, but some people will consult a healer initially or simultaneously. Cost plays an important role at this juncture. It seems to be the main determinant of whether the sick person will use public or private treatment alternatives (whether folk or biomedical).

Within the professional (biomedical) sector private doctors are preferred if resources permit, although choice among the various private doctors is usually not considered crucial. Cost, convenience, and previous experience are the deciding factors here. Within the public biomedical domain (i.e. the government health service), treatment by a doctor is preferred to that by a nurse or nurse-practitioner, and sick people will often go to a high level health center or a regional hospital as a first choice because of the annoyance and frustration of going through the regular referral system, and the desire to see a doctor. A balance is reached by "rationing through inconvenience" (cf.

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Grumet 1989); overcrowding at the tertiary facility eventually turns many towards the local clinics and the private sector, and deters others from seeking help at all.

In the same way, within the folk sector cost is a crucial factor in the choice between private and public folk healing alternatives, though suspected severity of the problem (and the anxiety associated with this), and perceived efficacy also come into play. However, choice of a specific practitioner for private folk healing is much more critical, because folk practitioners rely on personal power, as compared to doctors whose power is based on a shared system of knowledge and skills.

Once the sick person has entered the biomedical specialist sphere, and initial measures have been unsuccessful, they (and their decision-making networks) must to some extent relinquish their control over the health-seeking process in order to move on to the phase of "Referral and Further Choices." At this level the selection of further diagnostic and treatment options comes under the influence of the "specialist," with the ill person exerting mainly a "veto" power. Cost again becomes a central consideration here, although choices also may be limited by the nationwide shortage of modern equipment and highly trained medical and surgical specialty doctors. This is especially true in the public domain, to which most people with a difficult problem must eventually turn (unless they are wealthy), since most hospitals are government owned.

Folk healers also make referrals on occasion. Most healers will send those they suspect as having serious organic illnesses to a doctor,

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and sometimes a referral will be made to another healer. For example, Sister Nancy will sometimes send difficult cases to Brother John. But for the most part, healers primarily make "self-referrals," suggesting continued and more intensive treatment rather than sending the person to a doctor or another healer.

Many problems are handled successfully by the time this phase is reached. However, after a combination of passes through these options, some will eventually reach the phase I have termed "Alternative Strategies." This phase is generally entered when a building frustration with previous treatment failures prompts a recourse to alternatives which enable and promote a fundamental shift in Explanatory Models of the illness. Earlier (e.g. popular or biomedical) explanations, even after several modifications, may become untenable in the face of repeated treatment failures, and this shift in EMs allows a new and "fresh" approach to the problem. Typically this means a move from the professional (biomedical) sector into the realm of folk healing, though the reverse can also occur.

Within the folk sector, new mechanisms of legitimation come into play, which enable healers to interface fundamentally with their clients' EMs and Illness Prototypes, while at the same time making an intimate connection with their emotional vulnerabilities. Practitioners in the folk sector are able to offer satisfying explanations not only for the failure of previous attempts at treatment, but for their own treatment failures as well, and are able to do so without calling their own legitimacy into question. Cycles through this phase become self-legitimating rather than self-contradicting. This self-legitimization

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comes not through the denial of failure, but through a focus on the potential for success in future attempts.

In this phase of the health-seeking process, cost is again a limiting factor, though less than one might expect given the high cost of utilizing a private folk practitioner. In fact, this high cost may become a factor promoting continuation within this sector rather than a reason for leaving it. The manner in which most healers collect payments from their customers establishes a bond of debt and expectation. Although healers ask for a high fee, they will often tailor the charge to the circumstances of the client, and by doing so make the client feel indebted to the healer. At other times the fee is set so high that both the healer and the client know that it is unlikely to ever be fully repaid. The period for repayment is often long and open-ended; the client pays as much as he is able, whenever he is able to. Entrance into this relationship places a burden on the healer as well. He is expected to solve the problem successfully for the fee which is charged. As many sessions and treatments as are needed to accomplish this are usually covered under the one fee. A client will not feel obligated to pay the full amount until results are seen, and once a down-payment is made, the burden of producing results falls on the healer.

In contrast, a doctor will usually charge his patients for each visit separately whether results are achieved or not, and delayed payment is frowned upon (though by necessity sometimes resorted to). This can lead to disappointment and skepticism when the problem is not solved after the first visit.

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Having fleshed out this cyclical model of health-seeking, it may be worthwhile now to try to go beyond it. It must admitted that, as outlined so far, this model of health-seeking is not much more than a variation on the unilinear theme. The main difference between this formulation and Chrisman's model is that the illness trajectory is characterized not solely as a linear or branching process but as a "cycle" with an iterative progression through stages of assessment/reassessment, action, and reconfiguration of meanings and relationships. At this point, the necessity of adding a third dimension to the model becomes apparent, because we can see that in reality the cycle is not merely repetitious, but depends on a continual evolution and transformation of meaning and circumstances. In this sense the process can be characterized not just as a "circular" cycle, as suggested by Figure 19, but more realistically as a "spiral", with the added dimension of continual reinterpretation and reassessment over time. Addition of the third dimension creates a "spiral" trajectory "winding" through the various "phases" of help-seeking and the different sectors of the health care system.

However, even this refinement of the model falls short of complete consistency with what we see happening in real cases of chronic illness. To better explain real behavior we must add yet another dimension to the model. One aspect of health-seeking activity which makes it difficult to interpret is the fact that individuals often move not on a single "spiral" path, but on several intersecting trajectories at the same time. Not infrequently we find what appears to be a concurrent utilization of several different illness models and lines of logic.

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Without recognizing that people may make use of several different Explanatory Models at the same or, to put it another way, that Explanatory Models are frequently multilinear, internally inconsistent and riddled with uncertainties, it is difficult, or impossible, to understand why an individual might make use of several seemingly contradictory modes of treatment at the same time.

The inconsistencies and contradictions that characterize human culture, thought and behavior complicate our efforts to provide coherent analyses of them, but are seldom of as much concern to the "actors" as they are to the observer. In illness, it seems, the space for inconsistency becomes even wider. However, what may be seen as laxity of thought, may in reality be what enables people to cope with the pressures and disasters of everyday life, by empowering them to hold on to hope in the face of failure, and by facilitating denial and other defense mechanisms. We see clear illustrations of this apparent inconsistency in the cases we have looked at throughout this work.

A good example of how a sick person can follow a multilinear health-seeking trajectory with no apparent sense of self-inconsistency can be seen in the case of Mary Watson, a 29 year old Albion woman who works as a school teacher in a nearby district. While at work one day in November 1987 she came down with a persistent, mysterious illness characterized by severe headaches, extreme fatigue, trembling, hot and cold flushes, amenorrhea[177], and galactorrhea.[178] She was so debilitated by this illness that she was unable to work. Fearful that

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[177]Lack of menstruation.

[178]Abnormal production of milk.

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she might have a brain tumor, she visited numerous private doctors[179] over the next several months, most of whom attributed her complaints to "nerves" or anemia and treated her unsuccessfully with vitamins and tranquilizers.

Concurrently during the same period she made use of several over-the-counter medications, tried a variety of bush teas recommended by friends and neighbors, attended healing services at the local Revival church, went to Brother John for private treatment, and was treated "at a distance" by another healer (Barker) when her brother brought some of her clothes to him. In desperation, she resorted to holding a healing Kumina,[180] despite the fact that her family had never been involved in the Kumina cult. Although it seemed to temporarily ease her symptoms a bit, even this ceremony was unsuccessful in curing her. She was eventually referred to a couple of private medical specialists in Kingston who seemed to have a better understanding of her illness, but who were no more successful in treating her because of problems in scheduling, the logistics of travelling, and the cost of medications. She finally obtained some relief under treatment by Dr. Lewis in Morant Bay, though her problem had not completely resolved by the time I left Jamaica. Throughout her illness she maintained a suspicion (reinforced by both of the folk healers she consulted) that her illness had been caused by the sorcery of a co-worker. At the same time she also held onto the hope that her illness might be cured by finding the "right"

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[179]As a government employee, she was fortunate enough to have medical insurance which, up to a certain limit, covered her medical visits and prescriptions.

[180]This is the healing Kumina described in Chapter 7, pp. 338-344.

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bush treatment.[181] Despite her formal education and her relatively high status position in the community, she was quite easily able to maintain an Explanatory Model of her illness which included several tentative lines of reasoning which were seemingly inconsistent not only with her education and social position, but also with each other.[182]

From one perspective this type of health-seeking strategy might seem like a "shotgun" approach, with a more or less random grasping at any possibility that might offer relief. However, each of the treatment options that Mary resorted to in her efforts to obtain some remedy for her affliction entails its own set of assumptions, explanations, symbolic meanings, and expectations. Utilization of a particular option requires some degree of acceptance of, or at least openness to, the logic and explanations tied up with it. In other words, for an individual to be able to maintain a hope that a particular treatment option might help them, their Explanatory Model must be able to accommodate the basic assumptions underlying it. Mary sought treatment from doctors for a suspected "brain tumor," while at the same time maintaining a suspicion of having been dealt "a blow" by a jealous co-

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[181]Her father years before had been afflicted with an equally mysterious, intransigent, and debilitating illness. None of the numerous treatment options he tried was able to help him until one night he dreamt of an angel giving him a particular bush. When he went out and gathered some of this herb, and self-administered it as a tea, he was rapidly cured. Mary held out a hope that she might have a similar revelatory experience.

[182]Ironically, the actual cause of her illness was probably close to her original suspicion. It was most likely the manifestation of a pituitary microadenoma, a small hormone-secreting tumor which can be dangerous, but which can often be treated successfully with medications. (This is my own impression from her symptoms and the description she gave of her treatment. I did not discuss her case with the doctors or specialty consultants.)

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worker, and holding on to a belief that the illness might be "divinely" caused and treatable by finding the "right" bush. All of these possibilities entail very different models of causation and treatment. But she was somehow able to integrate these seemingly contradictory modes of explanation into her Explanatory Model. Simultaneous utilization of several options demonstrates that Explanatory Models are often so flexible that they are able to include several apparently contradictory lines of reasoning. In fact, the typical EM is loose, malleable, and multilinear, rather than tight, rigid, and logically consistent. As such it is able to accommodate inconsistent sets of assumptions and logic, and only rarely do these inconsistencies create any sort of dilemma.

Patterns of health-seeking are of interest to us here not only because of what they reveal about the personal illness experience, but also because of what they tell us about the effectiveness of efforts to provide adequate health care to the rural poor in Jamaica. Clearly in Albion there is a wide gap between the demand for biomedical care and its availability. That such a gap exists in a poor country is hardly a surprise, though it need not be a cause for despair. By looking closely at this gap we can get some ideas about what changes in the system, within the limits imposed by the overall availability of resources, might make it more responsive to people's needs as well as more effective in meeting them. Knowledge of how health care alternatives are used gives us a good idea of what aspects of the current system are working, and what parts could be improved with a better targeting of available resources.

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Jamaica's "epidemiological transition," and the way in which this is played out in the burden of illness and disability which besets the lives of the rural poor, is the most significant development which must be addressed in rethinking health planning in Jamaica. The hallmark of this transition is the emergence of chronic and degenerative diseases as the most important source of morbidity and mortality not only among those who can afford adequate care, but among the poor as well. While infectious and childhood diseases have certainly not disappeared, the relative success of years of work aimed at reducing these has made it increasingly difficult for the preventive and curative services as currently constituted to meet the changing needs of the population.

It might be assumed that an argument for greater attention to these chronic and degenerative diseases implies a bias towards expensive, temporary, and only marginally effective treatments, and that it advocates redistribution of resources to centralized urban hospitals, away from community based primary care and prevention. But this is not the case. To have any chance of success and to be cost-effective, efforts to reduce the burden of chronic disease will need to focus as much, if not more so, on prevention and public health initiatives as have campaigns against infectious tropical diseases. Both primary and secondary preventive efforts, in principal not unlike those used in previous campaigns, will be necessary for success. It remains to be seen whether the current "community based" health care structure will be the best format for this. Planning for effective prevention of chronic illnesses and their sequelae will necessitate a rethinking of organizational strategies. The task will be just as complex and

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formidable because it must be aimed at altering deep-rooted behaviors, and at times may come up against powerful vested interests.

Tobacco use, for example, is one of the most costly and potentially devastating problems that developing countries will be facing in the coming years and decades. As smoking declines in the more developed countries, multinational tobacco corporations are increasingly turning to the developing world to expand their markets. Indications are that their efforts are meeting with relative success. Cigarette consumption is growing rapidly in Third World countries, as are its health consequences, and its negative economic and environmental impacts. However, the importance of tobacco as both a generator of government revenue and as a cornerstone of the small-scale informal marketing system in developing countries blinds regulators to the overall long-term costs and makes control of cigarette consumption a low priority (Stebbins 1990; Stanley In Press; Muller 1983; Taylor 1989; Barry 1991). Such is the case in Jamaica where cigarettes put extra cash into the pockets of small scale entrepreneurs who sell them by the "stick," and where tobacco companies define their image through attractive (and misleading) mass advertizing and sponsorship of major sporting events. Although the consequences are already being seen in high rates of heart and lung disease, the targeting of young people for promotional marketing promises even more devastation in years to come.

Control of smoking, obesity, hypertension, diet, diabetes, and other known risk factors for chronic diseases has the potential to significantly reduce the physical and economic costs of these diseases, as is demonstrated in falling rates of heart disease in recent years in

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the USA. But to have an impact on these and other risk factors, the traditional public health strategies (e.g. immunization, insect control, improved sanitation and water supplies, etc.) must be reoriented to approaches that are more effective at altering unhealthy behaviors.

But prevention alone is not sufficient to control chronic diseases. The nature of chronic illness is such that primary prevention must be supplemented by screening, education, secondary prevention, treatment, and perhaps most importantly, continuity of illness management. Ideally these should all be coordinated and integrated into a single system. The biomedical options available to Albionites are, as we have seen, poorly suited to promote either prevention or continuous care. The Hypertension/Diabetes clinics at the higher level health centers are obviously a very important step in the right direction. But while they provide some degree of continuity, they are limited in their effectiveness due to a lack of openings, frequent shortages of medications and supplies, poor monitoring techniques, infrequent visits with physicians, poor compliance, low rates of participation, and the difficulties that elderly folks have in getting to the clinics because of the poor transportation system. Only the most highly motivated patients attend these clinics regularly. Most people fall through the cracks in the system, and only return for treatment when the more serious consequences arise.

Because of their high case load and limited staff, the functions of these Hypertension/Diabetes clinics are very limited. They provide little in the way of education, except informally, on the control of risk factors (e.g. diet, exercise, smoking cessation, etc.). The

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patients enrolled in these clinics are not encouraged to learn about and participate in the control of their illness. Rather, they are treated paternalistically and are expected to become blindly dependent on the staff for monitoring and treatment. In reality, many patients surreptitiously take control of their illness through self-medication and non-compliance.[183] The interest that patients have in managing their illness becomes a force that the staff must struggle against rather than a catalyst for enhancing control of the illness.[184] A mistrust of the reliability of clients is demonstrated from the outset in all biomedical settings by the ubiquitous practice of operating on a first-come, first-served basis rather than by giving out scheduled appointments. The overworked, frustrated and dissatisfied staff are

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[183]A good example of the problems this can cause is the case of Johnson Clark, a 74 year old supervisor on a small coconut estate adjacent to Albion. Mr. Clark, although quite fit-appearing, is both diabetic and hypertensive. He had been attending the Hypertension/Diabetes Clinic at Midway regularly for a couple of years, and had a strong interest in getting control of his illness. (He actually came to me to ask for dietary advice since this had not been provided to him in the clinic.) His outlook changed after one day when he lapsed into a hypoglycemic coma. Despite the scare, and an initial concern about a possible stroke, in the hospital he had a rapid and uneventful recovery. However, he came away convinced, probably rightly so, that his medications had caused the problem. So he stopped taking them and resorted to using a bush tea, which he claimed made him feel a lot better. Whether his abandonment of the clinic is a good choice for him or not, in this case we can see how problems of communication and trust that arise routinely complicate the management of chronic illness. Usually this has detrimental consequences.

[184]Studies have shown that control of chronic illnesses is enhanced when patients play an active role in monitoring and managing the disease (e.g. McLean and Pietroni 1990; de Weerdt, et. al. 1990). That there is much room for improvement on the current paternalistic approach to chronic illness management in Jamaican clinics is demonstrated by a study at a diabetic clinic at the University Hospital in Kingston which showed generally poor success rates in controlling diabetes, despite better monitoring than most rural clinics are able to provide (Morrison and Bennett 1988).

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able to provide little personal attention to individual clients. And of course these clinics can offer nothing in the way of primary prevention, since by definition their patients are already afflicted with a chronic illness, often in an advanced state with secondary complications, by the time they enroll.

For the rest of the population, there is even less opportunity for continuity of care. The public clinic system functions like a "casualty department" with an emphasis on acute problem-solving and with little opportunity for followup. Treatment is empirical, but there is no way to reliably monitor results, unless the patient gets so sick that they must return. The system of "rationing by inconvenience" (cf. Grumet 1989) insures that it is mainly those who can't afford private care who will use the clinics, and then only when they can no longer tolerate the sickness. The elderly, especially, have a hard time handling the stress of going to a clinic. As a result, patients often wait until a problem has reached an advanced state before getting help, which makes treatment more difficult and more expensive.

Even for those who are able to go to private doctors, continuity is difficult to maintain. Most people are unable to afford regular visits to a private doctor, and go only when they have a severe illness. And many jump around to different doctors, so again there is poor followup of empiric treatments, and a fractionation of medical records. A doctor treating a patient is frequently unable to get any information on what other treatments might have been tried by other doctors, or used by the patient at home (e.g. bushes, OTCs, or home remedies). The result of this fragmentation of medical care is costly inefficiency.

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Patients are often evaluated and treated for the same problem by several different physicians, which results in wasted time and money, and less than adequate treatment success. Frustration, disappointment, and physical suffering are the fruits of this inefficiency.

Solutions to these problems are of course limited by the scarcity of resources available for health services. A central issue that must always be kept in mind is how the finite resources available can be allocated in a such a way that insures efficiency while providing the most health benefits possible for those who are in need. This of course is the key question which must be addressed in any setting, and to which, even in wealthy countries, there is never a perfect answer. In poor countries, where needs are greater and resources scarcer, the question is particularly critical. Facing this question means making decisions and setting priorities about whom is to be served, what problems are to be focused on, and what measures will be used to address them. In the past, the delivery of effective and affordable health services has been hampered by the uncritical application of models introduced by colonial (and later neo-colonial) powers. Over the past few decades there has been a move towards models more appropriate for the health problems of the Third World, e.g. the Primary Health Care (PHC), and Selective Primary Health Care (SPHC) models. However the essential issue lies not in which particular model should be applied world-wide, but rather in how planners in specific settings can make choices that are appropriate and effective for the unique epidemiological, social, cultural and political environment in that nation or region. Unfortunately, there can be as much waste and

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inefficiency in the uncritical, superficial, and dogmatic application of the PHC model now in fashion as there was associated with earlier colonialist models.

In the following chapter, the Conclusion, we will discuss the problems which have arisen in efforts to improve access to health care in rural Jamaica, and how the PHC model, as applied in Jamaica, has failed to provide an adequate solution to these problems. It will be shown that a more flexible, and adaptive approach, which takes account of local problems, constraints and resources, might enable the provision of better and more appropriate services and facilitate a more efficient use of resources. In addition I will venture to make some concrete suggestions about how this might be accomplished in the Jamaican setting.

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CHAPTER NINE

CONCLUSION

The health care system which has evolved in eastern Jamaica is the product of three hundred years of complex interactions among a multitude of forces and constraints. As we have seen, it is not possible to understand the structure or functioning of this system in any meaningful way without some grasp of its interconnections with other aspects of Jamaican society and culture, and without an appreciation of how these have influenced its development. To focus on only one of these factors would produce a distorted picture of the system and a misleading assessment of its costs, benefits, and potential for change.

We have seen, for example, the profound effects of the history and political economy of Jamaican underdevelopment, especially the perpetuation of the plantation economy, on the evolution of a society marked by great disparities in access to power and resources. The continuation of this socio-economic system, itself a product of ecological conditions and worldwide political/economic relations, has depended historically on restricting access of the masses to land and other resources. On the other hand, self-destruction of the system is averted by simultaneous allowance of sufficient access to resources to muffle social unrest and maintain the labor force.

Disenfranchised and disempowered by an exploitative socio-economic system, poor Jamaicans reassert control over their bodies and illnesses through a variety of traditional and not so traditional methods. This takes place primarily in the popular sector of the health care system,

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which is the realm of self-medication, and non-specialist, family-based treatment. Each of the alternatives within this sector has specific symbolic connotations with regard to cosmology, cultural meaning, and social relations. But while questions of class orientation and identification play some role in the selection of these alternatives, the most important factors influencing health-seeking strategies at this level are subjective evaluation of efficacy and cost. The primary goal of sick people is relief from their suffering, and they will do whatever they can, within the constraints imposed by poverty, to accomplish this. Symbolic meaning plays second fiddle to questions of efficacy.

When treatment within the popular sector fails, for most rural Jamaicans the biomedical alternatives become the most relevant. The development of the professional sector over time has resulted in a two-tiered system in which cost becomes an even more critical factor in making choices. Issues of political economy have figured particularly importantly in the evolution of this sector. The early development of what has become the public health system was dependent on foreign institutions (e.g. the Rockefeller Foundation, the British government) whose interests were as much attuned to the need for maintenance of a viable labor force for tropical enterprises as to the need for improved health as a value in itself (see Morgan 1990). After being taken over by the newly independent Jamaican government, public health efforts went beyond the earlier capitalist-inspired initiatives in both their scope and objectives. They were now beholden to the public at large, which had the capacity to exercise some control over them through democratic political processes. However the vertical top-down structure which had

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been laid down by the earlier campaigns, and the bureaucratic separation of "health" and "medicine" (i.e. preventive vs. curative) had sufficient inertia to persist relatively intact.

The poor masses, once dependent on plantation owners for whatever medical care they might get, are now dependent for the most part directly on the government services for health care. The government, which must deal with the political realities of the situation but which is also constrained by economic stagnation and a large foreign debt burden, in turn uses health care as a means of defusing public dissatisfaction by preserving at least a minimum of access. Without the means to provide adequate health care to all it rations, or in less inflammatory terminology, "rationalizes," health care through subtle, and not so subtle, techniques such as limitation of facilities and personnel, scheduling, user fees, co-payments, and bureaucratic obfuscation (cf. Grumet 1989; Desai et. al. 1989).

The development of private biomedical care in St. Thomas has also been subject to exogenous forces. With the abolition of slavery, there was a mass exodus of doctors from the island, since the freed slaves were not able to pay as much for their own medical treatment as their previous owners had been. Since that time the private medical domain has been slowly rebuilt, mainly as a result of public inititative, however, the sirens of economic reality continue to draw Jamaican doctors and nurses away from the people they were trained to serve. The ongoing "brain drain" puts tremendous strain on efforts to develop the island's human resources. The "medical colonialism" which has characterized Jamaican doctors' connections with the developed world has

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also detracted from the appropriateness of local medical training, and made it more difficult to gear training to the needs of the general population.

Doctors and hospitals are generally considered to be the most powerful options for the treatment of illnesses felt to be "natural" in causation. In exchange for the enhanced levels of control that can be exerted over the illness through the agency of the doctor, the patient must give up a measure of autonomy and self-control. But despite the authority that the doctor maintains within the consultation room, outside of its walls patients still exert ultimate control over their treatment through the choice between compliance or noncompliance with recommended treatments, return to or continuance of self-medication, and "doctor shopping." However, despite what Mitchell (1980) has argued, sick people in Jamaica seem more than willing to make this tradeoff. The demand for biomedical care is much greater than can be supplied by the current system, even in the private sector, which is much more expensive to utilize than the public system. Even the poorest people in rural Jamaica use private doctors surprisingly frequently.

The third realm of treatment, the folk sector, is made up of a variety of practitioners and institutions ranging in a continuum from churches and faith healers to Science Men and Kumina. While these alternatives are not organized into a formal structure, they do constitute an informal system which is held together by some shared basic assumptions. They share a common foundation in their theories of causation, in particular beliefs about the role of spirits in causing both illness and misfortune. In this they spring from and reflect

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popular modes of understanding and explanation passed down through generations from the original African slaves, and enriched by later arrivals. Although these modes of understanding and coping with misfortune have been altered over the years in their outward manifestations, in their core they have persisted at least in part because they provide an arena in which both personal misfortune and social conflict can be worked out without a direct disruption of the social fabric.

Folk healers also provide a place to turn to when other measures have failed to bring about a resolution to an illness. When this point is reached, an illness may join the class of misfortunes attributed to spiritual causes. Practitioners and groups which offer influence over the spirit world provide not only hope, but another viable alternative through which the sufferer can attempt to regain control over an unmanageable situation. Like doctors, they act as surrogates of control for their clients, but their role differs in that they are acting as intercessors with a higher force, rather than as skilled practitioners of a formalized treatment system. While their relationships with their patients are asymmetric and authoritarian to a similar degree, they are nevertheless able to form more of an alliance with their patients because of their role as brokers with the spirit world. A doctor can appeal to no higher authority, while a healer's power depends on his or her ability to do so.

Thus the overall flow of patients tends to be from the popular sector to the professional to the folk, with those cases which resolve dropping out along the way. However, to reduce the health-seeking

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process to such a rudimentary paradigm is a gross oversimplification of a complex process. When we examine more closely the trajectories of individual cases we see that the process is quite often cyclical, iterative, and multi-dimensional rather than linear as the overall flow might imply. A multitude of factors and criteria come into play along the way, and at each stage of the process the meaning and salience of each of these are transformed. Thus it is not possible to understand health-seeking decisions and strategies without looking more carefully at each of the steps and cycles within this process.

Kleinman's tripartite model has served as a useful framework for organizing this analysis of the health care system in eastern St. Thomas. The categories it provides us with do in fact seem to correspond with those which are most relevant to Jamaicans. But if we apply it unthinkingly it can lead us into distortions as well as clarifications. While the model does allow for overlap and interchange, by defining the three sectors as separate entities, we are led into emphasizing their differences and separateness rather than their areas of fusion and interconnection. In reality they each blend together. Furthest apart are folk healers and doctors, but even here there are areas of overlap. I have mentioned the use of biomedical techniques and paraphernalia (e.g. the stethoscope, antibiotics) by some of the folk healers (especially Brother John), as well as the referrals that folk healers will often make to doctors. And some doctors take on healer-like roles either through their overt religious commitment, or their supposed ability (in the eyes of patients) to "read" the presence of a

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spiritual influence.[185] In addition there are some personnel who are able to participate in both domains.[186]

The boundaries which the popular sector shares with both the folk and professional sectors are less distinct and involve even more overlap and interchange. The popular use of OTCs shades gradually into the professional realm, as the very same medications may be recommended or supplied by doctors and health centers. At the edges of the professional sector are a number of lower level workers, e.g. community health aides, nurses, and even porters, who have closer connections than doctors with the popular realm. Each of these participates in lay referral networks within the popular sector in their own interactions with family and friends outside of their work, and some serve as brokers with the professional realm.

Likewise, bush treatments and even some simple rituals are used in the popular as well as folk sector. Their use in the popular sector may at times even approach the manner in which they are utilized by healers. For example, I came across several cases in which an individual who had been sick with an intractable illness had a bush treatment revealed to them in a dream, which when used resolved the problem (or at least the cure was attributed to this). Healers also participate informally in

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[185]There have in fact been some organized efforts in Jamaica to bring together the religious and biomedical realms of healing in a single cooperative setting (See Griffith 1982,1983). However, this is uncommon. For the most part this integration occurs in the personal orientation of the individual doctor, of which Dr. Young is a good example (See Chapter 5, p. 174).

[186]For example one of the nurses at King George Hospital is himself a Revival minister. Although he does not act as a folk healer per se, he does participate in healing services and is on very friendly terms with Revival healers and church leaders in the area.

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lay information and referral networks. The treatments they prescribe on a formal basis may be continued, modified, or shared with others through the mechanisms of information exchange and decision-making in the popular sector.

Another shortcoming of Kleinman's tripartite structural model is its lack of a robust means of analyzing the patterns of movement among the different sectors. As Stoner (1986) suggests, this issue is perhaps the most fertile ground for efforts to improve our models of the structure and function of health care systems. Analysis of how health care options are utilized enables us to go beyond the concentration on structure to develop a better appreciation for process, for it is here that the meaning and adaptiveness of a system are played out. This is an especially important area to explore in the Jamaican setting because of the preponderance of chronic illness, which means that many people are constantly moving through the health-seeking process. Illness becomes a lifestyle rather than a discrete event (Kleinman 1988). Simple linear models of illness episodes, which grow out of the biomedical paradigm of acute illness (illness->treatment->resolution), can not do justice to the complexity that characterizes chronic and recurrent illnesses. Here I have tried to go beyond a two-dimensional linear or branching model by emphasizing the cyclical and multidimensional nature of the process in the Jamaican setting, and by focusing on the shifting meanings and contingencies that influence the trajectories of individual cases.

This project was undertaken in the hope that it would yield some information that could be of practical use not only in improving health

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care planning in Jamaica in particular, but that might be useful in other settings as well. The lessons to be learned from the Jamaican experience can provide useful insights for health care planning in general, and especially for the field of international health development. What have we discovered in this exploration that can be of use in this regard?

Jamaica finds itself today in the position of having great unmet health care needs in a setting of scarce resources. This is nothing unusual, for in every country this is the situation to a greater or lesser degree. Everywhere choices must be made about the proportion of social resources to devote to health care, and how this should be distributed. Priorities must be set in order to achieve maximal benefits for the expenditure. In practice this is rarely simply a rational and detached process of planning. Neither are these choices always in the hands of the planners. Political, social, and ideological factors often play a pivotal role in these decisions. Nevertheless, there is room in the world of health care policy making for informed and logical planning. This really is what the Primary Health Care (PHC) movement is all about. It arose and has thrived because it represents a creative way of setting priorities in health care planning. It directly addresses the conditions of rampant disease and poverty found in the Third World in a utilitarian effort to provide maximal improvements in health for the greatest number at the lowest cost (Cf. Weinstein and Stason 1977; Green and Barker 1988).

The strength of the Primary Health Care movement lies in its questioning of old established ideas and methods. It was founded and

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has flourished on the premise that health care development planning must be based on an understanding of, and appreciation for, local problems and needs. Setting priorities that are relevant to local needs, determined through community input, is one of the cornerstones of PHC. The PHC philosophy has gained widespread acceptance because it was shown that previous doctrines of health care planning were neither cost-effective nor responsive to local needs. Yet there is the danger that in becoming an orthodoxy in its own right, the PHC model can lose its adaptability and responsiveness. A flexible method of planning can become rigid and unresponsive if applied superficially, uncritically, and without regard to local realities. The question of what constitutes the most efficient and productive way to allocate scarce resources must be continually reassessed in each setting.

Jamaica is currently in the situation, unusual in most of the developing world (though not in the Caribbean), of having already succeeded to a considerable degree in accomplishing some of its goals in health development. Through a variety of programs (some in the spirit of PHC and some not) it has been able to eliminate or bring under control many of the infectious diseases that were the most prevalent causes of mortality and morbidity for most of its history. Today, as we have seen, the epidemiological picture has been shifted from infectious diseases towards chronic and degenerative diseases -- from the afflictions of the young to those of the middle-aged and elderly. However the structure, ideology, and direction of the government services have failed to respond adequately to these changes.

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We find, for example, that the organization of government health services is still split along a faulty dichotomy between "public health" and "medical care" (cf. Marchione 1977:76). While perhaps appropriate at one time, this vestige of the old vertically organized, top-down, targeted campaigns now stands as an obstacle to achieving an equitable and efficient allocation of health care resources. This organizational rift is parallelled by an ideology in which Primary Health Care is (if not officially, then informally) equated with "prevention," whereas "curative" care is considered as rightly belonging to the realm of Secondary or Tertiary (i.e. hospital-based) care. This is not to say that curative services are not offered in the government health centers, the backbone of the Primary Health Care system in Jamaica, but generally they are given a back seat. In these settings the great majority of services offered are preventive services for those who are well, and this is where most of the attention for health planning and setting of targets is focused. Thus the system fails to address the "felt needs" of local people, viz. the desire to be treated by a doctor when they feel sick. In fact, many people consider the government services to be irrelevant to their real needs. Only in the higher level health centers and hospital are government doctors available, and then only intermittently. Access here is limited by the overwhelming demand. Coordination of the services that are available is hindered by inefficient bureaucratic structures. In St. Thomas, as we have seen, a large proportion if not the majority of primary care in the parish takes place in the King George Hospital clinic, and thus by dint of bureaucratic definition comes under a separate administrative and

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funding structure from the same type of care that is given in doctors' clinics at the local health centers.

This artificial split produces inefficiencies in other areas as well. For example, trained midwives, such as Nurse Comfort in Albion, are placed at low level health centers where they end up providing only basic preventive services and some minimal curative care. While ideologically appealing, this effort to provide "community based" obstetrical care ends up cheating the community because the skills of the nurse-midwife are not fully utilized. Almost all deliveries in St. Thomas are now done at King George Hospital.[187] Women are encouraged to give birth in the safer environment of the hospital; a complication during a home birth could be disastrous given the poor transportation system. As a result the midwives in the health centers rarely if ever do deliveries, while those working in the hospital may do half a dozen in one night. Prenatal and postnatal care are dispensed under one system, while the delivery of the baby takes place under a separate staff and administrative structure. In addition to bureaucratic inefficiencies, the result is that the talents and training of many personnel are underutilized, while others are overutilized.

Other inefficiencies can be found in the operation of the health centers themselves. Despite the constant high demand for health care, the pace of activity at the health centers is quite variable. At times they are overrun, while at others they lay idle. Once the busy morning

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[187]For St. Thomas as a whole the percentage of home deliveries in 1987 was 9.4%. For Jamaica as a whole the figure was 7.8%. During 1987 there were no home deliveries in Albion (Health Information Unit, MOHEC 1987).

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clinics are finished, the pace of activity in the health centers generally becomes quite leisurely in the afternoons. And some of the personnel end up spending a large proportion of their time unproductively.[188] This is quite apparent in Albion where in the afternoons the health center becomes as much a social center as a clinic. The ebb and flow of activity in the health centers reflects the divergence between the public demand for services and those which are provided.

While the Jamaican Primary Health Care services are ostensibly based on the idea of providing decentralized community-based services, and the ideals of the PHC movement call for community involvement in planning,[189] in reality there is little input at the local level. Decisions are made centrally and local desires have little impact on policy.[190] In the planning process conflicts between "felt needs" and

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[188] A study in 1987 showed that health center personnel spent up to 60% of their working time "unproductively." This figure varied considerably among different personnel categories, but was highest for lower level ancillary workers, and lowest for Public Health Nurses (health center administrators). Doctors and dentists were also found to spend a large proportion of their time "unproductively," but this was primarily because the time they spent outside of the clinic in their private practices was counted as "non-productive." When present in the clinics they were found to work quite steadily. (Desai and McCaw 1987)

[189] Clear statements of this goal can be found in WHO/PAHO and Jamaican government policy statements (e.g. PAHO 1980; MOH 1978).

[190] This is not totally the fault of the government. In many districts, including Albion, the efforts by Public Health Inspectors to help organize community health councils have been futile. Unfortunately the rural poor have a long history of disempowerment, and this has left them jaded and skeptical of any chance of having meaningful input into government affairs. Consequently, it is nearly impossible to muster interest in such schemes. And, to be fair, Albionites are not unjustified in their apathy, as past experience has given them little reason to believe they might be taken seriously. For example, strong community opposition to the "rationalization" scheme had no effect on the plan.

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"real needs" must be resolved, are these are usually settled in favor of the latter, without the input of the target population. Priorities are generally set based on what the planners feel are the most important targets to meet. In health care planning there is a preference for preventive services, which are most cost effective from a planner's perspective, despite the higher popular demand for curative services. Unfortunately there is less attention paid to how these different types of services might be integrated more effectively together, to enhance the overall impact of each.

In Jamaica most people see little purpose in going to a clinic when they are feeling well. Often special incentives, such as the distribution of food stamps, are needed to enhance attendance at health maintenance and prevention clinics for pregnant women and babies. On the other hand there is a great unmet public demand for curative services, especially those provided by doctors. The Jamaican Primary Health Care system has explicitly emphasized preventive measures, primarily because of cost-effectiveness and the difficulty in retaining doctors. However other factors have come into play as well. Not the least of these is the mistaken assumption of many in the PHC movement which equates curative services with hospitals and expensive, elite-biased health care.

In the past, with a preponderance of infectious diseases these two categories could be distinguished relatively easily. For example, it was not difficult to see that measures such as mosquito eradication, immunization, provision of clean water, etc. were clearly more cost-effective than treatment of the diseases which would otherwise occur.

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However the situation is changing today. With chronic and degenerative diseases like diabetes, hypertension, heart disease, and cancer, which have now become the major causes of morbidity and mortality, the distinction between prevention and cure becomes less clearcut, and less relevant. Are blood pressure or blood sugar screening and monitoring preventive or curative interventions? In the Jamaican Primary Health Care system there is a tendency to view screening or care for illnesses such as diabetes or hypertension as "curative," while the actual goal is to prevent their complications. At issue here, though, is not whether a particular condition comes under one heading or the other, but whether effective methods can be developed for dealing with the problems at hand.

To its credit the government health service has attempted to focus some attention on some of the more prevalent chronic illnesses through programs such as the Hypertension/Diabetes clinics. The first of these clinics was actually started in St. Thomas at King George Hospital by Dr. Lewis in 1972. They were found to be helpful and are now used all over the island. While they have provided a mechanism for long term management, their potential contribution is far from being reached. The demand for these clinics is very high, and some have to divert patients to more distant health centers because of a full roster. The patients who make use of them are among the most conscientious (more often women than men), while the less cautious easily fall through the cracks. However, even for the more observant patients adherence to treatment is always a problem. Folk models of hypertension erroneously include the idea that high blood pressure is usually accompanied by symptoms (See

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Chapter 4, p. 109, fn. 27) so that many people take their medications and attend the clinic only when they are having such symptoms. The more resistant and independent patients never go to the clinics. No doubt there are many people with high blood pressure who are unaware of it because they would not think of having it checked unless they started having symptoms. Long term control, then, is difficult to achieve. Many of the newer and more advanced (and more expensive) medications (e.g. ACE inhibitors, calcium channel blockers) are not available because of cost, while some of those which are used (e.g. reserpine) have serious side effects, which also can hinder compliance.

Control of diabetes is fraught with additional obstacles. The only means available in the health centers for monitoring blood sugar is urine testing. This method is relatively insensitive and inaccurate in detecting elevated levels of blood sugar, especially if not done in a very standardized and controlled manner. Again, many patients with diabetes will take medications only when symptomatic, and may rely on bush teas instead of prescribed medications. Patient education, which is crucial for enhancing informed participation, is woefully deficient. One study showed that even in the much more carefully regulated environment of the diabetes clinic at the University Hospital, compliance and blood sugar control were uniformly poor among clinic patients (Morrison and Bennett 1988). In a rural setting, where one must struggle to not fall between the cracks, adequate control and continuing care are of course all that much more difficult. Sequelae of these chronic diseases are quite common and are responsible for a very large proportion of deaths and disability.

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Obviously the control of chronic diseases is one area in which there is great potential for improvement. If it is to continue to address vital needs, the government health care service will have to step up efforts to deal not only with hypertension and diabetes, but with a number of other chronic diseases as well which are poorly handled under the current system (e.g. asthma, arthritis, cataracts, kidney disease, cancer, rheumatic diseases, etc.). The idea that providing continuing care for these diseases is "curative," and thus not important to focus on in a Primary Health Care system, must be overcome. Treatment in the early stages is actually often more cost-effective than delayed treatment. Many of the methods which are useful in controlling these diseases are in fact "secondary" preventive measures, and more effective steps could be taken through community based programs to detect and manage them. Efforts should be made to increase screening, to educate people about these diseases, to promote preventive measures (e.g. diet and behavioral changes), and to make treatment and management more easily accessible. For example, some of the most important preventible causes of these diseases, such as smoking and diet,[191] have as yet to be addressed by the Primary Health Care system.

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[191]The Jamaican diet is high in oils and fats, especially coconut oil, which has been shown to be associated with increased rates of atherosclerosis (e.g. Blankenhorn et. al. 1990). Also, smoking is very widespread even though the poor can not afford as many cigarettes as they would like. Cigarettes are advertised widely in the mass media, and tobacco companies often get publicity by sponsoring sporting events. As in many developing countries, tobacco in Jamaica is becoming an increasingly costly health hazard (Taylor 1989; Nath 1986; Muller 1983; Stebbins 1990; Stanley In Press; Barry 1991). And it promises to get much worse if living standards improve and the poor are able to afford a greater consumption of tobacco.

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Another ideological stumbling block that must be overcome is the mentality that programs aimed at improving the health of adults and the elderly is somehow not in line with the goals of the PHC philosophy. It is not hard to see how this has become part of PHC thinking worldwide. In most developing countries it is indeed children who are bearing the brunt of malnutrition, epidemic diseases, and high mortality rates. Targeting health care development programs towards them has been widely accepted among planners as the most efficient use of resources for both the present and the future well-being of these societies. The Infant Mortality Rate (IMR) is a widely used indicator not just of the health of infants, but of overall "unmet health needs and unfavorable environmental factors" (Mausner and Kramer 1985). Since it is a relatively easy variable to measure (e.g. through birth and death records), and a fairly good indicator of the overall living conditions and health status of a population, it is not surprising that it has become the universal standard for comparing health conditions in different countries and regions. A worldwide "competition" to lower these rates has arisen and IMR statistics are used as criteria for decisions on allocation of social resources. However, while programs aimed at improving obstetrical and infant care may lead to better health standards for children and pregnant mothers, and thus a lower IMR, this approach may not have much effect on the health status of the rest of the population. Over the time the IMR may consequently become a less reliable, and even deceptive, indicator of overall health status. A single-minded focus on decreasing the IMR and improving child health, may lead to a neglect of unmet needs of the rest of the population.

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Most of the Primary Health Care programs in Jamaica are geared towards improving the health of infants and small children through a variety of measures such as immunization, pre- and post-natal care, child health clinics, growth monitoring, food stamps, Oral Rehydration Therapy (ORT) programs, family planning, etc. The criteria that are used for evaluating the performance of the health centers focus specifically on meeting the target goals of these programs (e.g. high levels of child immunization, growth monitoring, participation in family planning programs, and prenatal care coverage.[192]) These programs and goals continue to be the main targets in planning despite the epidemiological changes that are taking place. Strong efforts are made to increase the attendance at family planning and maternal and child preventive clinics, while subtle deterrents discourage attendance at chronic disease clinics.

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[192]The collection of information for monitoring performance of the government services clearly reflects, and probably reinforces, the biases that characterize health planning. For example the Health Information Unit of MOHEC collects data on the performance of health centers and organizes this data into a number of standardized tables which it uses for statistical and evaluative purposes. Almost all of the tables focus on aspects of programs which are aimed at reducing the infant mortality rate. They report on several specific issues and programs such as: the effectiveness of reaching clients for early prenatal care (Table 8B); the quality of antenatal care and the nutritional status of pregnant women (Table 9B); the percentage of mothers receiving postnatal care (Table 10B); the effectiveness of postnatal family planning and the breastfeeding campaign (Table 11B); the coverage of the target population of children in child health clinics (Table 12B); the coverage of the target population by growth monitoring (Table 13B); the effectiveness of the campaign to achieve complete immunization of all children (Tables 14B,15B); the effectiveness of family planning programs in enhancing the use of contraception by the target population (Tables 18B,19B,20B), etc. However, "curative" visits are tabulated only by the number of cases under specific diagnoses (Table 22B). There are no targets set, for instance, for the inclusion of hypertensives or diabetics in longitudinal clinics, and there are no figures available for evaluating performance in meeting such a goal.

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Even if child health is to remain the primary focus for health care planners, it needs to be more fully appreciated that the health of children is tied up with the overall health of the community, and not just with levels of immunization and peri-natal care. For example, the nutritional and health status of children depends as well on the education of mothers, employment levels, agricultural productiveness, and the well-being of care providers. Many of those who are disabled or killed by chronic diseases are the same individuals (e.g. grandparents) who are responsible for supporting and raising small children, so that the well-being of children does in fact suffer directly and indirectly because of these illnesses. I am not arguing that resources should be diverted away from the baby and child oriented programs, as these have been productive, successful, and cost effective. But rather, I am suggesting that if the goal of "health for all by the year 2000" is to be approached, further planning must also take into account the illnesses which nationwide have become the most prevalent causes of death and suffering. In this regard the situation in Jamaica can serve as an important lesson to other developing countries on the need for flexibility in planning as specific targets are neared, and as the epidemiological situation changes over time in response to public health efforts. Most developing countries have not reached this stage yet, but they would do well to consider these lessons if they do expect to have success in long-term integrated health development.

Another of the basic tenets of the PHC philosophy is the incorporation of traditional non-biomedical practitioners into social health programs. In Jamaica this would include folk healers such as

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those discussed in this paper. Other types of healers such as "nanas" (traditional midwives) have succumbed to official suppression and have almost completely disappeared, supplanted by the government health services. While I was in Jamaica the public health director (the Medical Officer for Health) for the parish of St. Thomas expressed an interest in incorporating folk healers into a program aimed at increasing the availability of Oral Rehydration Therapy. I agreed to assist in this by acting as a liaison with healers, who all expressed to me a willingness to participate. Unfortunately, this program did not get off the ground while I was in the field because of delays in training personnel and in obtaining materials. I was a bit surprised to find some of the nurses, e.g. Nurse Comfort, resistant to the idea, as they often have good relations with the local healers and understand their importance in the community. As I found out, this resistance came not from a bias against healers, but rather because the project would require them to do extra work and travelling, without any further pay or assistance with transportation. They feel they are already working hard enough for what they are being paid, and since they can not afford to buy a car with their current salary and the government is unable to supply vehicles, they have no means of transportation except public minibuses and taxis.

It is uncertain whether healers would have a significant effect in such a program since most people do not consult them until a doctor has been seen already. However, because of their prominence in the community as a source of health information, and the fact that babies are often taken to them for both preventive and curative treatment, I

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felt it would be appropriate to try to involve them in the program. It also might be useful to include other prominent community members such as teachers, elders, church leaders, justices of the peace, etc. as these individuals also serve as important sources of health related information in the community. In any case, the success of such an effort would depend on a committed participation of health care personnel, and it did not seem that this was happening with the ORT program.

It is doubtful whether folk healers would be able to take any more prominent role in the health services than this sort of peripheral one, in large part because of the very negative feelings that doctors and many other members of the biomedical sector have towards them. As it is, the hospital is off-limits to healers, except when they come as ordinary visitors. Patients who might want to make use of a healer's services are not allowed to do so while in the hospital. Occasionally this results in a patient leaving the hospital against the advice of the staff so they can consult a healer, with predictably negative results. Sick people would benefit if communication between healers and the biomedical system could somehow be improved, but this seems unlikely to happen in the current climate of distrust and antipathy between the two sectors. Although some people in the Primary Health Care system are interested in improving communication with folk healers, there are no plans to involve them any more closely than this. Nor would it necessarily be desirable to do so. As Kleinman (1978b:82-6) has pointed out, most folk practitioners do not wish to be integrated into the biomedical system any more than doctors want them to be. Cooptation of

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folk healers by the biomedical system might very well undermine their ability to function as a viable alternative source of care.

Another aspect of the PHC ideology which is sometimes applied uncritically is the goal of decentralization. In Jamaica this has taken the form of setting up multiple low level health centers which attempt to provide community based services. In the proper circumstances, community based facilities can be an effective means of delivering care. However in the reality of rural Jamaica, these centers are limited to a few communities, and the ones in operation are poorly equipped and can provide only the most basic services (preventive clinics, first aid dressing, cold medications, etc.). As a result, people often circumvent the referral network which has been set up to regulate use of the various levels of the Primary Health Care system. When they are sick they want to see a doctor and they know where to find one. They end up going directly to a high level health center or the parish hospital, which means that the doctor ends up taking care of problems that could be handled by lower level staff if there was a better coordination of the different levels of the system.

Jamaican government health policy documents (e.g. MOH 1978) clearly state the goal of basing Primary Health Care on "democratic" values and "community participation" in health care planning. This objective is derived directly from PAHO/WHO formulations of the ideals, philosophy, and framework of Primary Health Care (e.g. PAHO 1980, 1984). In Jamaica the goal of community participation was to be met by the formulation of Community Health Committees which would participate in setting health goals, helping to raise funds, assisting in implementing

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programs, etc. (MOH 1978:31-8). Just as efforts at "Community Development" have failed in rural Jamaica, attempts to organize health committees in this setting have met with little success (e.g. PAHO 1984:65-69). This is hardly surprising if one has an understanding of the sociological framework of rural Jamaica and its communities (See Chapter 3). Failure of this aspect of the program in Jamaica is a clear demonstration of how a rigid and foreign conception of what "communities" are (or should be), and how community leadership and decision-making should be organized, even if based on "democratic principles," can lead to obstruction and friction when applied uncritically. It also shows how even idealistic philosophies and strategies can be subverted by entrenched bureaucratic and social systems (cf. Paul and Demarest 1984). As a result, in the Jamaican setting PHC has become a rigid and hierarchical system which is poorly responsive to local needs or concerns.

The goal of decentralization is important for large countries where great distances can separate people from health care, but is less critical for a small island nation like Jamaica. In the different settings "decentralization" can have very different meanings. In the parish of St. Thomas, for example, one is never more than a half hour to an hour (depending on transport availability) away from Morant Bay, the parish capital, where the hospital is located. Rather than try to "decentralize" by spreading resources over numerous low level health centers in the parish, which are "community-based" in theory only, a more efficient and realistic solution might be to concentrate resources in one or two more centralized locations, for example at the hospital

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and at the Hounslow Polyclinic. Several nurse practitioners working in a central location under the direction of a doctor would be able to take care of large numbers of routine cases while diverting the more complicated ones to the doctor. Such a team would be able to more efficiently handle a large volume of patients than when these personnel are spread out over several outlying health centers, as is the case currently, and would probably be able to provide better continuity of care. The staff sould probably find this more rewarding as well. If transportation for patients was somehow subsidized or made more convenient, they would have relatively easy access to such a center. They already travel readily to private doctors or the hospital in Morant Bay when in need of treatment. Such creative, though ideologically distasteful, solutions might actually harmonize better with existing bureaucratic structures and social realities, and thus might more effectively address many of the needs unmet by the current system.

There are some indications that planners are beginning to think along these lines. For example the program of "rationalization" of the health care system was aimed at reducing duplication of services. In St. Thomas the plan was to reduce services at Hounslow Hospital and increase them at King George Hospital. Unfortunately, this move seemed to end up serving as a facade for cutting services overall. The cuts at Hounslow did take place, but the promised improvements at King George Hospital never materialized. Public confidence suffered as a result, and it is likely that further efforts to restructure the system will meet with stronger political resistance from a distrustful public.

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The most important component of the Primary Health Care philosophy is the need for integrated development, and this has as yet to be fulfilled in Jamaica. Health standards can not be improved beyond a certain point unless living standards in general are advanced through economic development, better education, increased employment, improvements in infrastructure, and progress towards meeting other basic social needs. Health care development is an all-encompassing effort intimately tied in with development of every other aspect of society. Given current economic constraints and prospects this goal is unlikely to be reached at any time in the near future. It would be unwise to hold one's breath waiting for "health for all by the year 2000" in Jamaica, or anywhere else for that matter. However, there is still room for optimism. Great strides have already been made, and the wise and creative use of available resources can bring further advances. Resourcefulness is one asset that Jamaica has in abundance.

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APPENDICES

Appendix A: Interview Schedule for Household Census/Survey

(HHS.4 6/21) 1

Time:___:___.___ Date:___/___/___ Respondent:______ Household#____

* Introduce self, explain study, confidentiality, etc.

1. Record Household members' information on index card:
   1. Name (& Pet Name)
   2. Sex
   3. Age
   4. Relationship to Head: (How ... related to (head)?)
   5. Birthplace: (Where ... born and grow?) - District and Parish
   6. Date of arrival in Arcadia (most recent): (When ... move to Arcadia?)
   7. Previous Location: (Where ... live before moving here?)
   8. Education: (How high ... reach in school?)
   9. Economic situation: What ... did during the past week? Worked? Looked for work? Wanted work and was available? Kept house? Went to school? or something else?

a. Worked for others	e. Wanted work and avail but didn't seek actively	h. Retired
b. Worked for self		i. Disabled
c. Seeking first job	f. Kept house (home duties)	j. Other________
d. Others seeking work	g. Student	k. No answer

   10. Occupation (What type of work ... normally does?)____________

* * * * *

2. Anyone who live here been sick in the past month?
   Yes - Go to HSQ.4. How many HSQ.4's used?____
   No - Go to item 3.

3. What you do if somebody here get sick?
   What you do for a cold?
   What you do for a fever?
   What you do for a bellyache?
   What you do for other types of pain?
   What you do for a cut?
   What you do for a serious sickness?

4. Who decide what to do when somebody get sick?

5. You ever boil, or use, any bush for sickness? What bushes? For what sicknesses? Any others?
   For a cold?
   For a fever?
   For pressure?
   For headache?

6. You buy any tablets or medicine in a shop or pharmacy, beside what the doctor prescribe?
   Y N What you buy? For what sicknesses?

7. You use any of the health centres, like the Arcadia HC, the Port Morant HC, the Hampton Court HC, or the Hospital at Lyssons? Y N Which ones? For what type of problems?

8. You ever go to a private doctor? Y N Which ones? For what type of problems?

9. You ever go to any healer? Y N Which ones? For what type of problems?
   You just go to healing service, or you go privately?
   What healers you know about?

10. You go to any church? Y N Which one? You join there? Y N

11. Where you carry your water from?

a. Public standpipe. Location_______	e. Private catchment, no pipe
b. Public pipe into dwelling	f. Public tank
c. Public pipe in yard	g. Other__________
d. Private pipe (well, catch) into house	h. Not stated

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(HHS.4 6/21) 2

12. What type of toilet you have here? You share it or it's your own?
    1. Pit latrine
    2. Flush, w/ septic tank
    3. Flush, linked to sewer
    4. Other___________
    5. Not stated

    a. Not shared
    b. Shared
    c. None
    d. Not stated

13. How you get your light?
    a. Kerosene 2. Electricity c. Other_______________ d. Not stated

14. What type of fuel you use for cooking?
    a. Kerosene b. Wood/Charcoal c. Gas d. Electricity e. Other/None _______

15. You own or rent this house?
    a. Owned by HH member
    b. Leased (Signed)
    c. Private rented (unsigned)
    d. Rent free (consent)
    e. Squat (no consent)
    f. Gov't rented
    g. Other___________
    h. Not stated

If rented: Who own the house?________________ How much you pay for rent? $____/mo.

16. How much land you have here with the house? You own or rent the land?

17. You own, or rent, or use any other land? Y N Where? How much?

18. You do any planting? Y N
    You sell anything you grow, or it just for your own use?
    a. Just for household use
    b. HH use and sell surplus
    c. Farm labor for others
    d. Farm supvsn for others
    e. Farm for profit, no emps
    f. Farms for profit, hires employees
    g. Other _____________
    h. Not stated

19. How you get money? Anybody who live here working? Anyone on a pension or get food stamps? Anybody send money from abroad?

20. How much money come in for the household in a month (week, year)?

21. You have a radio? Y N It working? Y N

22. You have a TV? Y N It working? Y N

23. You have any vehicle? Y N What type, yr? _________ It working? Y N

24. How many rooms you have here, not including any kitchen, bathroom or veranda? _______

25. What the house made from? (Material of walls.)
    a. Board (even)
    b. Board (Uneven)
    c. Cement (Concrete)
    d. Cement and board
    e. Zinc
    f. Nog
    g. Bamboo
    h. Wattle
    i. Wattle and daub
    j. Brick
    k. Brick and board
    l. Stone
    m. Other ____________

26. What you have on the roof? (Roof material) a. Zinc b. Other______________

27. What type of windows you have?
    a. Open (hole)
    b. Open w/ shutter(s)
    c. Sash w/ glass
    d. Sash w/ glass & other
    e. Glass louver
    f. Wood louver
    g. Other_________

28. Paint:
    1. New
    2. Good
    3. Worn
    4. Very worn

    a. Complete
    b. Incomplete (> 50%)
    c. Partial (< 50%)
    d. Unpainted, No finish

29. What type of floor you have? (Floor material)
    a. Cement
    b. Tile
    c. Board
    d. Earth or stone
    e. Other___________

30. How big the house? (Draw diagram if necessary)
    a. Estimated dimensions___________________
    b. Number of levels_______

Time finished:____:____.____

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Appendix B: Interview Schedule for Recording Illness Episodes

(HSQ.4 6/23) 1 Date:__/__/__ Time:____:____.___

Household#_____ Sick Person_____ Reported By:_____

1. What the problem was (is)? (Name, Sx, Development, Probe pertinent sx)

2. When it start?

3. What happen first? How it start? How it develop?

4. What you think cause this sickness?

5. Why you think it start just when it did?

6. (You) ever get this sickness before? It steady or it comes and goes?
   (Time frame, Chronicity, etc.)

7. The sickness affect (your) normal activities, like working, caring the house or yard, going to school, etc.? How much? (You) can do everything you normally do, or (you) unable to do some things, or (you) just have to stay in bed?
   a. Not at all
   b. Mild - Can do all or almost all activities, but not at full capacity
   c. Moderate - Unable to do some important activities
   d. Total - Bedridden, unable to do any of normal activities

8. Thinking back, what the very first thing was (you) did about the sickness? (You) ask anyone about it? (You) boil any bush? (You) go to a health centre? (You) go to a doctor? You go for healing, or what?

9. (If to another person) What he/she did about it? What he/she tell you?

10. What happen next? It work? (You) get better or worse?

11. What you think is the reason this happen?

12. You remember how much it cost? (Visit $____; Med, tests, etc. $____)

13. It was you decide to do this, or someone else? Who?

14. Why (you) decide to do this?

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(HSQ.4 6/23) 2

15. What you did about
    it next?

16. (If another person)
    What he/she did?

    What he/she
    tell you?

17. What happen?
    It work?
    It get better
    or worse?

18. What you think
    is the reason
    this happen?

19. How much it cost?

20. It was you decide,
    or somebody else?

21. Why (you) decide
    to do this?

22. How the sickness work? What the sickness do to you?

23. What you 'fraid of most about this sickness?

24. What you think going to happen with it? You think it will get better or worse?

25. The sickness cause any problem for you? What type of problem?

26. What type of treatment you think (you) should get?

27. What result you hope to get from the treatment?

Time finished:____:____.____

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Appendix C: Self-Treatments Used in Albion for Some Specific Ailments[193]

COLDS

Bush Treatments[194]

Asafoetida [Ferula asafoetida][195] (Used on scalp)
Aurelia [Aralia guilfoylei]
Batchelor's Button [Hyptis capitatis]
Christmas Bush (?Same as Jack-in-the-Bush)
Coconut Oil [Cocos nucifera]
Cotton Leaf [Gossypium spp.]
Cowfoot Leaf [Piper umbellatum]
Dam Blood [?]
Dog Blood [Rivina humilis]
Donkey Weed [Stylosanthes hamata]
Double Horse Whip (=Vervine, vervain) [Stachytarpheta jamaicensis]
Duppy-Gone Bush [?]
Fever Grass [Cymbopogon citratus]
Fitweed (=Spirit Weed) [Eryngium foetidum]
Five-finger [?]
Ganja [Cannabis sativa]
Garlic Oil [Allium sativum] (Used with honey)
Grow Stake [Gliricidia sepium]
Honey and Lime
Jack-in-the-Bush [Eupatorium macrophyllum]
John Crow Bush [?Abrus precatorius]
John Charles [Hyptis verticillata]
Know You [Ipomoea dissecta]
Leaf of Life, Tree of Life [Bryophyllum pinnatum]
Lime Leaf [Citrus aurantifolia]
Love Grass [?Cuscuta spp.]
Maidenhair [Adiantum tenerum]
Man-to-Man [?]
Marigold [Bidens reptans, ?Wedelia gracilis]
Maroon Bush [?Echites umbelatta]
Mott(?) Grass [?]
Never Dead [?]

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[193]These are self-treatments that survey respondents reported using. It by no means represents a complete pharmacopoeia.

[194]Most of these are used as teas. They are frequently used in combinations, and sometimes are mixed with non-herbal ingredients.

[195]Most of these scientific identifications are based on Asprey and Thornton, 1954-55. The bushes reported were not identified directly by the author.

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Pear Leaf, Avacado Pear [Persea americana]
Pepper Elder [?Peperomia pellucida]
Periwinkle [Vinca rosea]
Piaba [Hyptic pectinata]
Pimento Leaf [Pimenta officinalis]
Pop-Me-Not Bush [?]
Pudding Wiss or Wys (Withe) [Cissus cycoides]
Ramgoat Dashalong [Turnera ulmifolia]
Ramgoat Regular (?Same as ramgoat dashalong)
Rat Ears [Boerhavia scandens]
Rose
Search-My(Me)-Heart [Rytidophyllum tomentosum]
Sour Orange [Citrus vulgaris] (Used with sugar; burnt and used with honey)
Spanish Needle [Bidens pilosa]
Susumba (Berries or leaf) [Solanum mammosum or torvum] (Juice used with coconut oil)
Trumpet [Cecropia peltata]

Home Remedies

Honey
Rum

Over-the-Counter Medications

Bell's Cough Syrup
Cafenol
Cod Liver Oil
Comtrex
Contac
Eucalyptus Oil
Ferrol
Other cough syrups
Phensic
Vick's Inhaler
Vick's Vapo-rub
Vick's Formula 44

FEVER

Bush Treatments[196]

Bamboo Leaf [Bambusa vulgaris]
Barsley [Ocimum basilicum]

[196] Most of these are applied externally.

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Basil
Chamba Bitter [Phyllanthus niruri]
Chiggernut [Tournefortia hirsutissima]
Coffee (Used with white rum) [Caffea arabica]
Fever Grass
Fitweed (Used with lime)
Ganja (Boiled and used with Dragon stout)
Guinea grass [Panicum maximum]
Lime Juice (Mixed with alcohol and rubbed on)
Lime Leaf
Madam Fate [Isotoma longiflora]
Mastwood [?]
Mott(?) Grass
Rat Ears
Sinklebible [Aloe vulgaris]
Vervine (=Double Horse Whip)

Home Remedies

Bay Rum
Black Coffee and White Rum
Cold water
Honey (Mixed with aloe and egg white)
Dragon Stout (Used with ganja tea)
Lime Juice and Rum

Over-the-Counter Medications

Bay Rum
Cafenol
Phensic
Rubbing Alcohol

BELLYACHE

Bush Treatments

~~Black Mint [Mentha viridis]~~
Cerrassee [Momordica charantia]
Chamba Bitter
Colon Mint, Cullen Mint, Colic Mint [Lippia geminata] (Used for vomiting)
Ginger [Zingiber oficinale] (As tea or in rum)
Guaco Bush [Mikania spp.]
Guava [Psidium guajava] (Buds chewed)
John Charles
Lime
Mango [Mangifera india]

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Orange Peel [Citrus aurantium] (Also used for vomiting)
Pepper Elder
Peppermint [Micromeria viminia]
Piaba Leaf
Pimento
Pomegranate Skin [Punica granatum]
Search-Me-Heart
Semicontract [Chenopodium ambrosioides] (Used for worms)
Sinklebible (Aloe)
Wild Cinnamon Bark [Cinnamonum zeylanicum]

Home Remedies

Gin
Gizzard
Lime
Salt (Used with lime or gin)
Urine (Drink own urine)

Over-the-Counter Medications

Andrews Powders (For gas)
Antacids
Epsom Salts (Also used for "washout")
Gelusil
"Hans Juice" (For gas)
Milk of Magnesia (Also used for constipation)
Pepto Bismol (Also used for gas)
Sulphur Bitters
Tyrox (Used for worms)

WOUNDS (CUTS)

Bush Treatments

Ackee or "Young Ackee" [Blighia sapida] (Used with kerosene, especially for nail puncture wound)
Bastard Seed (?Bastard Cedar) [?Guazuma ulmifolia] (Chewed to make paste)
Bissy [Cola Acuminata] (Used with kerosene)
Chocolate or "Young Chocolate" (Cocoa used as paste)
Coconut Oil
Fresh Cut Juice [Dianthera pectoralis]
Green Banana [Musa sapientum] (Scraped and Mixed with kerosene)
Match-Me-Not [?] (Bark chewed or mixed with oil to make a paste)
Nutmeg [Myristica fragrans]
Sin(?) Leaf [?]
Sinklebible root [Aloe vulgaris]
Tree of Life Juice

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Home Remedies

"Antidote" (A type of stone from a river)
Kerosene oil

Over-the-Counter Medications

AB Lotion
"Black Dressing"
Camphor (Dissolved in oil)
Elastoplast
"MB Pill" (Ground up and sprinkled on cut)
Mercurochrome
Peroxide
Purple violet lotion (?Mercurochrome)
Sulfur ("Rock sulfur" in coconut oil)
Tape, Gauze and other dressings
"Yellow Lotion" (Acriflavine)

HEADACHE

Bush Treatments [197]

Banana Leaf (Young banana "heart" leaf)
Barsil (?Barsley)
Bontouch Leaf (?Bonduc) [?Caesalpinia bonduc or bonducella]
Breadfruit Leaf [Artocarpus incisa]
Chocho Leaf [Sechium Edule]
Cowfoot Leaf
Guinea Hen Root [Petiveria allicea] (Ground and mixed with rum, applied to head)
Hogmeat Wiss or Wys (Withe) (?Hog weed) [?Physalis angulata] (Vine tied on head, sometimes with 3 knots)
Jumbo Chocho Leaf
Lime Juice
Trumpet Leaf
Tuna Leaf [Opuntia tuna]
(White) Oil Nut Leaf (Castor oil plant) [Ricinus communis]
Wild Slip (Tied on head)

Over-the-Counter Medications

Aspirin

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Cafenol
Excedrin
Other Analgesic Tablet Preparations
Panadol (=Paracetamol, acetaminophen)
Phensic
Smelling Salts

PAIN/ARTHRITIS

Bush Treatments

Breadfruit Sap
Coconut Oil (Often used with camphor)
Garlic
Ginger
Jack-in-the-Bush
Lime Juice
Marigold
Nutmeg
Piaba Bush
Pimento
Sinklebible (Aloe)
Tuna

Home Remedies

Coconut Oil
Dragon Stout
Kerosene Oil
Olive Oil
Rum

Over-the-Counter Medications

Arsan(?) Ointment
Aspirin
Ben Gay
Cafenol
Camphor (Usually dissolved in coconut oil or kerosene)
Cepadol
Dewitt's Tablets
Fiery Jack Ointment
Granny White's Liniment
Indian Balm Oil
Magnesia (?Milk of...)
Menthol
Mentholated Spirits
Oxiden

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Panadol (=Paracetamol, acetaminophen)
Phensic
Radian Ointment
Saltphysic
Sloan's Liniment
Tedrol
Tiger Balm
Wintergreen Oil
Zan Buk(?) Ointment

HYPERTENSION ("PRESSURE")

Bush Treatments

Almond
Banana Leaf
Breadfruit Leaf
Coconut Water (Used with lime juice)
Cowfoot Leaf (Tied on head)
God Bush [Oryctanthus occidentalis]
King-of-Forest [?]
Lime Juice (Used with coconut water)
Naseberry Leaf [Sapota Achras]
Nattle (Natta) Leaf [?]
Poor Man (?)Train (?Friend) [Stylosanthes viscosa]
Soursop Leaf [Annona muricata]
Spanish Leaf [?]
Trumpet Leaf
Violet Leaf (Tied on head)
White Chocho Juice

NERVES

Bush Treatments

Carrots
Lime
Marigold
Soursop Leaf

Home Remedies

Cod Liver Oil
Honey
Milk

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Over-the-Counter Medications

Chase's Nerve Food

TONICS

Bush Treatments

China Root, Chainey Root
Ganja
Search-Me-Heart
Strong Back

Home Remedies

Dragon Stout (Sometimes used with Milk)

Over-the-Counter Medications

Ferrol

DIABETES ("SUGAR")

Bush Treatments

Chamba Bitter
Donkeyweed

MISCELLANEOUS DISORDERS

Bush Treatments

Bissy, Kola Nut (Cola Acuminata) (Used for "ptomaine poisoning," rash)
Duppy-Gone [?] (Used for menstrual disorders)
English Plantain [Plantago major] (Used for cataracts, other eye problems)
Madam Chase (Used for menstrual cramps)
Marigold (Used for menstrual cramps)
Semicontract [Chenopodium ambrosioides] (Used for worms)

Over-the-Counter Medications

Theophylline Tablets (Used for asthma)
Tyrox (Used for worms)
Whitfield's Ointment (Used for liver spots)

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Over-the-Counter Medications

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