Traditional Health Systems and Public Policy

Proceedings of an International Workshop, Ottawa, Canada, 2–4 March 1994

Edited by
Anwar Islam and
Rosina Wiltshire
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The Caribbean Experience  
Jeanette Bell

The Caribbean consists of islands and territories ranging from Central America in the north, sweeping south wards to the mainland territory of Guyana, South America and the chain of islands in between. The region includes a range of ethnic and cultural influences and a variety of language speaking groups such as English, French, Spanish, Dutch as well as Creole languages. Very little remains of the indigenous peoples who originate in the region. They were the first victims of diseases and enslavement that resulted from the contact with Europeans. Although the region is diverse and complex, there are some similarities between territories yet each possesses its own uniqueness that arises from the bringing together of people from the contrasting cultures of Africa, Europe and Asia. This presentation will focus primarily on the realities of the English speaking territories and how the effect of colonization influenced on the knowledge and practices of the colonized peoples of the region.

The most common experience of all territories has been the colonization. We were, and in some cases still remain, colonies of Europe and/or North America. It was under the colonial administration that the issues of power, control and the development of our formal systems of health care began to take place. The Chief medical Officer was part of colonial administrative system and it was the western medical model of health care that was introduced and gained dominance, i.e., the concept of disease, causality, signs and symptoms treatment, the provision of institutional based services and the "medicalization" or "professionalization" of health care was part and parcel of the system. While this system from Europe gained dominance other non-traditional systems of health care were marginalized, dismissed and made illegal by the colonial state.

Orlando Patterson in his work, "The Sociology of Slavery" describes the patterns that developed in Jamaican society in relation to the structure and functioning of plantation society, the political system, the social organization of life and work on the plantation as well as the cultural dimensions. He writes:

"Among the skilled slaves are included the boilerman, carpenters, smiths, coopers, masons, doctors, nurses and midwives. On Orange River estates in 1823 among the slave population of field negroes, carpenters, blacksmiths... were two doctors, one doctress and two midwives. Mothers in Jamaica came from both the African and Creole groups thus we should expect that many of the rites and taboos relating to birth and..."
early infancy in Africa would have been practised by African mothers".

Patterson goes on to make the distinction between Obeah (bad medicine) and Myalism (good medicine). Obeah is described as a type of Sorcery, largely harmful which was performed at the paid request of clients by use of charms, poisons and shadow-catching and approximates to West African bad medicine. Whereas in Myalism, proponents were aware of the teachings of Obeah men but used them for good rather than evil. Myalism was not individually practised but organized more as a cult with a unique dance ritual approximates and to West African good medicine. Its practice involved the use of herbs or narcotics. Most slaves would only allow themselves to be treated by black doctors.

Resistance to slavery and oppression was also a part of the struggle. During the seventeenth and eighteenth centuries in Jamaica where the most documentation exists, a series of laws were enacted to prevent rebellions. These laws were passed in 1684, 1696, 1717, 1744, 1781 and 1826 expanding or adding new dimensions to the systems of social control. The laws were aimed at prohibiting the assembling of slaves, the beating of drums, groups, and the use of poisons. It was in the assemblies that the religious tribal dances were accompanied by the use of drums which were perceived by the planters as a preliminary to uprising and rebellions. The laws gave powers to plantation owners, their family members and overseer to regularly search, confiscate and burn weapons or potential weapons of slaves. By 1696, this category of weapons was expanded to include poison that any person could be regarded as guilty of murder for using a poison. Part of the systems of social control included the preventing of meetings on Sundays and holidays. In 1717, powers were expanded to prevent the visiting of any "strange negroes" from assembling on any plantation. In 1744, "any crime of compassing and imagining the death of any white person by any slave or slaves" was deemed a crime as high as the crime of murder.

It is clear that in the minds of the planters and the legislators that the boundaries between the practice of myalism, obeah, various African Cultural forms such as, drumming, gatherings and uprisings were very indistinct and were viewed as threats to the social order. As a result these practices would have gone underground. Much of the documentation was written by the British and reflects their perspectives on African cultural forms within a context of struggle of maintain a social system in which the interests of planters and the administrators of the colonial state were diametrically opposed to those of the large slave population.

What is significant is the fact that in West African culture (Ashanti and Dahoman) there was an understanding of the interconnection between mind, body and spirit, that a healing process would include prayer, incantations, the laying on of hands,
the use of herbs, baths and potions. This interconnection of mind, body and spirit has not been strong in western orthodox medicine and is only gradually being recognized in some circles. Despite the holistic environment, some of this traditional knowledge has survived, I believe, that this is so because of the central role women played in the practice of midwifery, and the care of children which gave them a space in which to function and to apply their knowledge of healing. This knowledge was passed on from one generation to another, from mother to daughter or through a form of apprenticeship based on interest and aptitude. The midwives were customarily women of the district or community who had gained their skills in a very practical way. The limited knowledge of principles of hygiene and asepsis combined with virtually no ante-natal preparation and often poor physical and nutritional states of mothers took their toll in terms of high maternal and infant mortality rates. It is probably these factors that raised the concern of the medical profession.

A study carried out by the International Confederation of Midwives in the 1970s showed that in Haiti, midwives delivered as many as 80 percent of births. In Jamaica, during the same time 25 percent of the deliveries in the rural areas were being done by midwives while in Barbados, 96.9 percent of births took place in hospitals and medical institutions. The level of poverty, size of the territories, the contrasting conditions in urban and rural areas may help to explain some of these disparities.

Emerging from the riots and unrest of the 1930s a new nationalist leadership generated power, committed to the social development of the region. This leadership emerged from the beginnings of the labour movement in the British Caribbean, education and health were the sectors earmarked for improvement and development. The health strategies used varied in the territories. In Guyana for example, the knowledge and skills of traditional midwives were upgraded and they were incorporated into an overall comprehensive health care scheme. In Jamaica, although the practice was quite prevalent they were not officially recognized, while in Barbados, it was made illegal. Women were therefore increasingly loosing ground in this area of work. The institutionalization of health care brought its own problems - there was shortage of beds, overcrowding of wards and the importation of ideas and methods adopted in European countries meant a reliance on extensive and expensive equipment reducing the possibilities for the development of health care at a more domiciliary and community level.

Only in recent times, and particularly in the context of our worsening economic situation where imported medicines and treatments are becoming more expensive are we beginning to recognizes the value and contribution that traditional knowledge of medicines have and can play. We also recognize the benefits and limitations of some orthodox approaches, that they have been particularly successful in addressing the infectious diseases that
were once prevalent in our region, but have had serious limitations in addressing the non-communicable diseases that we now face. We have also awakened to the fact that many of the expensive medicines we buy are in some cases based on the traditional knowledge of our own herbs and as well as other people's for which the pharmaceutical companies have gained license. Our historic struggle for the right to practice our knowledge and skills has not been unlike the struggles in Britain and North America of other women healers who in Europe were burned at the stake for witchcraft or the battle that midwives lost in North America against the male obstetricians. At the crux of the matter, is the use of power by influential groups to marginalise and outlaw the practices of others based on belief systems.

In the search of rediscovery, we have recognized not only that orthodox medicine has contributed to the significant decline of infectious diseases but also the limitations of compartmentalising knowledge of health. We need the benefit of what other systems and ideas have to offer, and hope that this rekindled interest in alternative systems will not lead to the further exploitation of our knowledge and environments.