Healing in the African Diaspora Communities of Boston

Linda L. Barnes, Kenneth Fox, Eugene Adams, Janice Desir, Martin Epson, Melissa Hackman, Breai Mason, and Chioma Nnaji

Why the African Diaspora in Boston as a Focus?

The United States has, historically, constructed understandings of race in ways that have systematically devalued the lives of African-descended peoples. As the work of womanist theologian Emilie Townes illustrates all too clearly, one of the sites in which this troubled relationship has repeatedly surfaced is in the world of biomedical practice.[1] Racism in medical care traces back to the days of slavery in the United States, when slaves who attempted to escape were defined as mentally ill and suffering from "dresomania," the impulse to run away. In our own time, the evidence in both the medical and news-based literature shows that black patients and white patients often do not receive the same standard of care.[2] Racial ethnic minority status results in cradle-to-grave inequities that cannot be separated from corresponding inequities in the distribution of income.[3] Poverty and the effects of institutionalized racism thus become embodied.

The African-descended population in Boston, as in other larger American cities, is no longer a homogeneous one. It now includes immigrants from other former slave-holding countries such as Haiti, Puerto Rico, Cuba, Santo Domingo, and Brazil, as well as immigrants from countries such as Nigeria, Ghana, Cameroon, Sierra Leone, and Cape Verde and refugees from wars in such African countries as Somalia, Ethiopia, and Eritrea. Broadly speaking, therefore, many of the African diaspora peoples have entered the American context as a result of variations on violent and traumatic uprooting, albeit due to different historical circumstances. The newer groups find themselves subjected to inequalities resulting from the historic experience of African Americans in the United States, exacerbated by inequalities experienced earlier in their home countries in relation to the global economy. In addition, the presence of multiple generations introduces issues of differing degrees of acculturation. The convergence of these groups contributes to a diversity that is recent enough for the relationships among them still to be very much in flux.

For the groups descended from former slaves, the resulting religious traditions represent the blending of different African traditions with the types of spirituality practiced by the slaveholders. Islam also has a well-established presence in the United States. The boundaries between these traditions have been fluid and permeable. But, as Karen McCarthy Brown has observed, "African religious retentions in the New World, like Christian borrowings, are neither random nor fragmentary, but systematic and thoroughly understandable in terms of history and circumstance."[4] For these groups and for recent immigrants from Africa, religious traditions have represented powerful resources in the maintaining of identity.

The different groups have retained traditional healing systems to different degrees. Over time, their application has been influenced and transformed by dominant cultures on the one hand and, more recently, by the unprecedented interaction among groups on the other. The outcomes are new syntheses and integrated forms. These different systems are best understood under the broad umbrella of "healing" and must be seen in light of efforts to address conditions not only of body, mind, and spirit, but also of identity.

Of the multiple approaches to healing used by the African diaspora groups, a significantly high proportion are religious in nature. Indeed, whether stated directly or not, the underlying epistemology of many such systems is religious. The multiple approaches to healing also function as dynamic styles of meaning-making, as survival tools, and as the means of resistance and rectification.

In this connection it is important, when studying these traditions, not to fall into the New Age tendency to romanticize the healing practices of the diaspora groups for two reasons. First, this can result in the plundering of these practices, with no sense of accountability to their originators. This has, for example, frequently been the outcome of New

Age appropriations of Native American practices. Second, such an orientation also lends itself to overlooking the harsh realities of economic inequality, health status inequities, and barriers in access to and participation in the biomedical health care system. It is essential, therefore, to explore how these healing strategies, at least in part, represent efforts to offset these other disparities. It is also important to look at how the particular experiences of suffering reflect the embodiment of larger-scale socioeconomic forces such as residential, educational, and occupational segregation, institutional racism, and economic exploitation and disenfranchisement.

A Preliminary View

Religiously rooted, non-biomedical approaches to healing are as pervasive in the African diaspora communities as they have proved to be in the other religious and cultural communities of Boston. However, such approaches have received relatively little attention in the scholarly or medical literature, or in the popular media, apart from stigmatizing reports. Literature searches related to understandings of, and approaches to, healing used by each of the diaspora groups show that, although the practices of some Haitian and Cuban communities in the United States have been better documented, there is virtually no pertinent material available about the practices of newer immigrant groups.

In other cases—as with African Americans—much of the literature is dated. A good deal of it pertains to regions in the country other than our own. Little of it includes critical social analysis. Only a few examples locate the material within the context of religious studies.[5] Nevertheless, these sources point to older African American practices that may have various contemporary forms in urban centers in the United States at the turn of the twenty-first century. A focus-group discussion held at Boston Medical Center, for example, revealed that the use of "roots" referred to in 1970s articles about the American South might, in some newer versions, continue to be practiced in Boston. The literature indicates that the African American churches have also played a crucial role in shaping their members' understandings of healing.[6] Discussions with local pastors support that this is the case in Boston as well, although the particulars remain to be researched. (The literature also suggests some of the important limitations of church involvement.)[7]

Popular African American periodicals (*Essence* and *Ebony*) contribute to informing the public imagination about approaches to healing, particularly among women. Here, one sees crossovers from the mainstream press and its representations of complementary and alternative therapies, such as aromatherapy, massage, herbs, yoga, and Chinese martial arts, such as *tai ji*. What differentiates these representations from those in the mainstream press is the added Africentric dimension. The International Association of Black Yoga Teachers, for example, offered an opportunity to journey to Cuba and practice yoga there; in addition to Chinese forms, another of the martial arts represented is *capoeira*, a Brazilian form descended from practices originally brought by enslaved Angolans. Reviews of books in community bookstores suggest the same kinds of mixtures. On the one hand, there are the popular books one would find in mainstream health food stores and in New Age bookstore sections on health and spirituality. On the other hand, there are also books on naturopathy and on natural health from an African American perspective, as well as books on meditation for African American women, side by side with other sources tracing practices to Egypt and other parts of Africa.

Anecdotal evidence from discussions with families at Boston Medical Center suggests that herbs are used with good results by various groups, as is meditation in relation to health conditions such as sickle-cell disease (SCD), which particularly afflicts African-descended peoples. Religion figures largely in families' understanding of health. As one counselor who assists families with children with SCD observed, "It doesn't seem to matter which religious tradition a family belongs to, whether Christianity or Islam, these families all talk about a connection between faith, health, and the family's ability to cope."

A pilot study focusing on Dudley Square—one of the hubs of the African diaspora communities in Boston—illustrates the richness of current active practices. In this one city square, in addition to multiple chiropractors, a market run by African immigrants also sells herbs. Above an Afro-Caribbean market, one finds Botánica Aché, which not only sells herbs but also the oils for ritual baths and the figures and ritual objects related to the African-descended religious and healing tradition of Santería. Up the street, Korngold Pharmacy sells both regular pharmaceutical products and herbs, including the kinds of herbs sold at mainstream health food stores (e.g., ginseng, Saint-John's-wort, garlic, ginkgo biloba, and echinacea). At the Tea House of the Almighty, one finds a palm and tarot card reader who sells products related to root work.

The square also supports a bookstore carrying Africentric health-related books; street vendors

belonging to the Nuwabian Nation, a religious group whose practices represent a synthesis of elements from Christianity, Islam, Africentric representations of Egypt, and theories of extraterrestrials, and who sell both health-related books and oils for healing baths; and a plethora of churches that offer healing services. Clearly, the religious and the therapeutic do not divide along neat lines in most of these examples.

Work in Progress

The research team of the Boston Healing Landscape Project is currently studying both tradition-specific practices and cross-tradition practices related to particular illnesses or themes. We expect to publish the results of these studies in an expanded edition of this volume. The following descriptions suggest the range of the work in progress, and the kinds of practices found in Boston's African diaspora.

Spiritual Beliefs and Religious and Cultural Practices of Haitian Women in Relation to Maternity

Haitian communities are now to be found in such major cities in the United States as Miami, New York City, and Boston. For this reason, elements of Haitian lifestyle, beliefs, and values can be observed in a variety of different areas. One of these is the influence of religious pluralism. The Haitian community is characterized by different religious systems, each of which is present in cities like Boston. Such traditions not only provide Haitians with spiritual and emotional support; they also influence perceptions and choices within this population on a wide range of issues. These issues include persons' views concerning health care and strategies for pursuing health in ways that both involve biomedical care and go outside its framework to involve complementary therapies. Rarely do Haitian patients discuss such therapies with their caregivers.

This use of culturally grounded complementary and alternative medicines is related to a complex interaction of beliefs, values, perceptions, and religious and cultural orientations toward health and life. The use of these practices is especially seen among women, who are twice as likely as are men to be regular users of alternative medicines. People of African descent (whether Caribbeans or West Africans) are also likely to use alternative medicines.[8] Correspondingly, ethnic women, as primary caregivers, employ a variety of therapies in the treatment of ill family members and in their own personal care, including physical attention, spiritual comfort, and folk remedies.[9]

Existing research pertaining to Haitian women is sparse at best. One study provides an overview of cultural issues in relation to Haitian women, but without a focus on beliefs and practices involved in family planning, pregnancy, childbirth, and the infancy of the baby.[10] Another study examines the culture-bound syndrome of *pedisyon* (perdition), or "arrested pregnancy syndrome," culturally understood as a factor contributing to the mortality of Haitian women.[11] There is additional data on medical and social variables leading to maternal mortality.[12] Neither of these two studies, however, addresses the experiences of women themselves. One study of fertility rites among Haitian women provides useful information, but is so dated that new data is needed. Moreover, the study addresses the experiences of women in Haiti, and not that of immigrant women.[13] Nursing literature has examined cultural issues pertaining to childbearing Haitian refugee women, concluding that these women express similar concerns as their American counterparts. However, the study appears not to have focused on the kinds of beliefs and practices of interest to us. In addition, the data pertain to new refugees and not to women who may have lived in the United States for decades or who may be second-generation Haitian Americans.[14] Another study examines cultural and programmatic barriers to modern contraceptive methods, but does not include traditional practices used in family planning.[15] Finally, one study explores reasons for a decline in breast-feeding among Haitian women who have emigrated to the United States. This data is useful in presenting some of the attitudes specifically pertaining to infant feeding preferences.[16] None of the studies looks at the influence of religious or spiritual traditions and their role in Haitian women's worldviews.

This project seeks to examine how different religious traditions and/or denominations present in Haitian communities inform Haitian women's approaches to maternal and infant practices, beginning with family planning and continuing through pregnancy, delivery, and the first year of the child's life. The project will assist the medical community in learning more about the relationship between religious worldviews and pregnancy, childbirth, and maternity in the experience of Haitian women, especially since these variables often overlap. We anticipate that the study will provide data on common practices and traditions and/or medications or herbal remedies used by Haitian women during this time, as well as providing clinicians with a broad view of the Haitian woman's outlook on pregnancy and maternal practices during her baby's infancy.

The findings will contribute to more culturally

sensitive health care for pregnant women of Haitian descent. It will also address concerns that perplex the medical community about pregnancy among this population. Such questions include why Haitian women tend to become dehydrated during their pregnancies, what practices and traditions they follow during pregnancy, and why they tend to sing rather than scream or shout during the birthing process.

As is increasingly well known in the medical community, failure to adopt transcultural perspectives affects patients' compliance with prescribed regimens and their clinic attendance. Also, it results in the inability to develop culturally appropriate health education programs and culture-specific care.[17] So, through creating a context in which Haitian women can talk openly about practices and orientations that are most meaningful to them in the context of bearing children, we expect to gain knowledge of cultural healing traditions and remedies among Haitian women that will help clinicians provide care that is deeply informed by cultural perspectives. We also expect to show a range of perspectives within the Haitian context, so that we avoid the risk of suggesting a one-size-fits-all model.

Botánicas *of Boston: Community Healing Centers*

The use of herbal therapies by mainstream patient populations has been documented by D. M. Eisenberg et al. in national studies of Americans' uses of complementary and alternative medicine (CAM). Indeed, of the versions of CAM studied, the use of herbal medicine ranked second in relation to the other therapies. Yet, such studies also acknowledge that their findings do not provide "a sufficiently large database to provide precise estimates of the patterns of alternative therapy use among African Americans, Hispanic Americans, Asian Americans, or other minority groups." The Eisenberg team encourages the development of parallel studies, "modified to include therapies unique to minority populations and translated when appropriate," to make it possible to compare patterns across ethnic groups.[18]

The very populations referred to constitute a majority of the patient groups at Boston Medical Center. Anecdotal comments from the pediatrics clinical staff suggest widespread use of herbal therapies in these communities, along with other culturally based practices. Yet, again, families rarely discuss their use of such therapies with clinicians. Visits throughout the communities of Roxbury, Dorchester, and Jamaica Plain quickly reveal the pervasive presence of a category of healing centers where herbs and other culturally specific CAM therapies are sold. These centers, or *botánicas*, are generally connected with the traditions of Espiritismo and/or Santería. The clientele of the *botánicas* includes African Americans, Afro-Caribbeans, Brazilians, and some of the African immigrant groups (particularly those from West Africa).

Despite the popularity of these healing centers in the communities they serve, biomedical clinicians generally have little knowledge about the kinds of therapies dispensed by the *botánicas*. This study will first map the locations and sizes of the *botánicas* of Boston. It will then catalogue the herbal products sold, along with other products related to CAM therapies. Finally, based on published sources on herbs used in some of the African diasporic traditions, it will compare the data found in Boston with data related to countries of origin, to determine patterns of transmission of knowledge and practice.

Gay, Lesbian, Bisexual, Transgendered (GLBT) Adolescents and Young Adults in African Diaspora Communities: Spirituality, Identity, and the Impact of HIV/AIDS

HIV/AIDS is one of the leading causes of death for people of the African diaspora. According to the Centers for Disease Control and Prevention (CDC),[19] of the estimated forty thousand new HIV infections reported each year, more than 50 percent occur among people of Afro-Caribbean descent. Latinos make up 13 percent of the population of the United States, but account for 19 percent of new HIV infections each year. Latinos have three times the infection rate of non-white Hispanics.[20]

Most data generated by the CDC and HIV groups like Balm in Gilead[21] report that one in fifty black men and one in 160 black women is HIV positive. AIDS is the number one cause of death for African Americans between the ages of twenty-five and forty-four. HIV rates are even higher in the black gay/lesbian/bisexual/transgender community. A recent article in the *Boston Globe* entitled "Seeking a Haven from Isolation: Black Gay Men Face Soaring HIV Rate and Find Little Comfort" estimates that three in ten young gay, bisexual, and/or transgendered black men in the Boston area may be HIV positive.[22] If this group were a country, only Botswana would have a higher infection rate.[23]

Black men, according to federal studies, are better informed about HIV than their white counterparts. Yet, HIV rates continue to rise in the black gay community and to drop in the white gay community.

The reasons are open to debate. According to the *Boston Globe* article about gay men of color in Boston:

> as with white gay men, they may have been lulled into complacency by the more effective HIV drugs now available, some speculate. Perhaps longstanding prejudice against gays in the black community, where most gay blacks still live, continues to force many to keep their relationships covert, making it harder to sustain a monogamous lifestyle. But these are simply guesses.[24]

This study explores the intersections between non-normative sexualities, religion, and healing, in particular around HIV. Research focusing on sexuality and religion is important because faith is an important resource in healing. Homophobic traditions or those that allow GLBT people in their midst, but silence them, do harm, physically, mentally, and spiritually.[25] This affects a person's whole being and a person's ability to live well, especially when the individual's life is further shaped by a chronic illness that leads to premature death.

Working in the GLBT community of color in Boston, we are investigating how different religious traditions present in the larger African diaspora community (for example, African American Christian churches and traditional African religions like Ifa, Yoruba traditions from Nigeria, Santería from Cuba, and Candomble from Brazil) help both to heal and to wound young people with regard to sexuality, identity, and disease.

We are working with GLBT adolescents and young people of color for three reasons. First, the white gay community frequently ignores GLBT people of color in research and activism around issues of health, because of racism.[26] We hope to address this lack of attention. Second, because of ways in which some religious traditions associate homosexuality or non-normative sexuality with sin, deviance, and disease, people of African descent are often isolated in their own communities, as well as in the larger mainstream culture.[27] African Americans who are GLBT frequently live in their communities of birth; thus, there is much at stake in being public about one's sexual orientation. Historically, African American churches have had trouble in dealing with issues of homosexuality. Traditional African religions are also frequently homophobic.[28] We hope to generate data that will illustrate some of the consequences—both positive and negative—of these attitudes in the lives of GLBT young adults of color. Third, we are focusing on adolescents and young adults because they are frequently seen by physicians and researchers as irresponsible, and thus unreliable as subjects in drug trials.[29] This perception can result in exclusion from such studies. We expect to gather data concerning the perceptions of GLBT young adults of color regarding themselves and their identities.

None of these factors is static. Religious traditions are changing, for example, as HIV/AIDS rates continue to rise and homosexuality becomes more public. People who seek healing often combine Western medicine with therapies related to religious traditions in the diaspora communities.[30] People may go to a hospital clinic to get their T-cell count and a checkup, but they may also go to a diviner before taking their medication to see if it will work for them. Ritual baths for cleansings, altar-making for the Day of the Dead and International World AIDS Day, and the pursuit of ancestral guidance are some of the ways in which religious traditions have become resources for healing.[31]

In an article entitled "Spiritual Emergencies and Psycho-Spiritual Treatment Strategies among Gay/Homosexual Latinos with HIV Disease,"[32] Chief Alade of the North American Yoruba Society writes: "AIDS has contributed to the change in Afro-Caribbean healing practices in the United States. And so has the increased visibility of gays and lesbians in our communities." African American Christian churches are also changing, in order to deal with issues of sexuality and HIV infection. Black churches in Boston had a week of prayer for the healing of AIDS in early March of this year.[33] There is also an organization called Balm in Gilead that deals specifically with the Black churches and their responses to people with HIV/AIDS.[34]

In this study of the experience of GLBT people of color from the African diaspora, we will focus on how religions in the communities served by Boston Medical Center may prove to be both resources for healing and sources of heartache. The potential significance of the results is multiple. First, our preliminary research suggests that more extensive data will bring to the attention of the white GLBT community ways in which their outreach has often ignored GLBT people of color. The data will serve as a new source of information for the white GLBT community, who see their HIV rates decreasing, as HIV rates rise for people of color. Second, the study will inform some of the religious groups in the minority communities about ways in which homophobia and/or silencing of GLBT people of color can contribute to a reduced quality of spirituality and life. Third, we hope that the medical community will benefit from our findings. An understanding of the

intersections between cultural identity, spirituality, and the pursuit of health through the use of complementary therapies on the part of GLBT adolescents and young adults of color will help doctors ask patients different questions and be better informed about the possible complementary and alternative practices their patients may be using. As HIV rates soar, prevention and treatment must be context specific.

Girls Becoming Women at the Margins: Hip-Hop Culture as a Factor in the Identity of African American Adolescent Girls and Young Women

In recent years, the medical community has grown increasingly interested in the role of religion and spirituality in the overall well-being of the whole person. Significant areas, however, have remained unaddressed. First, although the biomedical community has become more and more concerned with developing what is referred to as "culturally competent care"—care that is responsive to patients' cultural backgrounds—few programs in medicine and spirituality have examined the importance of particular religious traditions as integral parts of specific cultural systems, or how these multifaceted systems have a bearing on people's experience of health care in the United States. The tendency, instead, has been to favor an understanding of "spirituality" as a generic phenomenon. This tendency is often informed by unexamined biases emerging out of popular culture. Yet, in reality, every spiritual tradition has specific teachings, practices, and rituals to facilitate healing. The experience of spirituality is also contingent on the age of the individual.

Second, although the medical community has dedicated a growing attention to complementary and alternative medicine (CAM), little of this attention has been directed at such practices as they are specifically defined and used by immigrant and racial-ethnic minority groups in the United States. However, just as the religious landscape of the country has become increasingly complex, as has been shown by Harvard University's Pluralism Project, the landscape of healing practices has become equally pluralistic due to the same rich cultural diversity.

Moreover, much of the epidemiological literature on the use of CAM has focused on adult populations, although an emerging literature is beginning to look at CAM use in pediatric populations.[35] In 1999, a search of Medline, Embase, CISCOM, and Cochrane Library, together with a related review of over one hundred papers looking for surveys on CAM use by children below the age of eighteen years, yielded eleven surveys. Variations in the definitions of CAM used, in the study populations, in the periods of time represented, and in the methodologies made it difficult for the authors to draw firm conclusions. Nevertheless, the resulting data indicated that a large proportion of children use some form of CAM. Yet, one survey suggested that only about 50 percent of CAM users tell their physicians about it.[36] Even fewer studies have looked at the experience of older adolescents and young adults, and those that have looked at this experience have not focused on subjects in this age group in communities of color. Nor have these studies focused on the experience of young women in this age group.[37]

This study will examine intersections and relationships between the culture of hip-hop and 1) the formation of identity of young black women, 2) these young women's experience of spirituality, and 3) these young women's understanding of health and the pursuit of health. The background of this study lies in the historic presence of music in the black community as a means of spiritual strength and as a vehicle for identity formation and expression. Prominent scholars in the field of African American studies have addressed this issue as it relates to different periods in African American history. Al Raboteau, for example, has examined slave songs as a window into the consciousness of enslaved Africans in America. Cornel West identifies a progression from slave songs to gospel, the blues, and jazz as parallel movements chronicling the religious consciousness of African American people. Hip-hop is the latest movement on that chain.

By focusing on the hip-hop movement as a formative spiritual and cultural influence in the lives of older adolescent girls and young women of color in the Boston area, this project will illuminate the value systems and related behavior patterns of the study group. By examining what these young women do in the pursuit of health as they understand it, we will come to a clearer understanding of CAM in this context. By focusing on the generally overlooked, yet highly influential, aspect of hip-hop culture in these young women's lives, this study will enable practitioners working for the health and welfare of these communities to deepen and refine their understanding of this part of their patient population. Although the girls and young women may come from different cultures of origin, they come together in the culture of hip-hop.

We hope to learn how they understand and treat their bodies, minds, and spirits in the attempt to grow into womanhood, given the prescriptions of hip-hop culture. Do they, for example, identify a

connection between their involvement with hip-hop culture and music and spirituality and complementary healing practices? Specifically, attention will be paid to the use of language generally associated with religious and spiritual ideas and practices in their discussion of music and the culture surrounding it. We will be looking at the degree to which the young women describe themselves as feeling justified or motivated to action by messages in the lyrics or by other aspects of hip-hop. Such connections between the ethics promoted by hip-hop and life choices made by study subjects will provide pilot data on ways in which African-descended women between the ages of eighteen and twenty-two apply ideals espoused in hip-hop music to their own lives, whether in aid of their health or to its detriment.

Childhood Asthma in the African Diaspora Healing Systems

Asthma is an exploding epidemic of clinical medical and public health importance that affects an estimated fifteen million Americans, including nearly five million children in the United States. Asthma prevalence, morbidity, and mortality have substantially increased over the past fifteen years and continue to be a burden on the health care system.[38] Asthma has a disproportionately greater impact on low-income African American and Hispanic/Latino communities that suffer from urban underdevelopment or underdevelopment. Asthma is traditionally associated with genetic predisposition and environmental hazards. However, analytic frameworks from medical anthropology, medicine, public health, and religious studies have concluded that an individual's socioeconomic status (SES) has a direct relationship to the development, severity, treatment, and outcome of the disease. L. A. Smith and J. A. Finkelstein define SES as the "social factors such as income, education, place of residence, and occupation, which mediate the daily experiences of individuals and populations."[39] In communities with low SES, families typically have lower-paying jobs, more hazardous waste sites, fewer resources, limited health care, and less political representation. With these living conditions, the communities are prone to bear a disproportionate share of the burden of any illness, and of asthma in particular.

The trends for asthma in the Boston area, particularly Roxbury, Dorchester, and Mattapan, are similar to those in other urban areas in the United States. Asthma incidence rates in Roxbury and Dorchester are five times the state average.[40] These predominantly minority populations, many of them of African descent, are plagued with poor housing, the lack of accessible and quality health care, industrial pollution, and high exposure to diesel fuel exhaust from idling buses at sites like the Massachusetts Bay Transit Authority (MBTA) Bartlett Bus Depot on Washington Street.

Racially segregated, high-risk areas of concentrated poverty and environmental contamination did not develop overnight. The history of social inequality in Roxbury, Dorchester, and Mattapan built the foundation for current ecological, economic, and social conditions. In the early 1900s, Roxbury and Uphams Corner in Dorchester were thriving, with the opening of the Strand Theatre and the development of community businesses. Both were predominantly Irish and Italian Catholic communities. Because of the neighborhood burning in 1950, whites began to migrate to suburban areas. With them went community businesses, jobs, schools, government accountability, and development opportunities. African Americans and other people of African descent began to occupy the Dudley Street neighborhood. The racial demographics changed drastically, from 95 percent whites in 1950, to 79 percent in 1960, and to 45 percent in 1970, with correspondingly increased minority populations in this area.[41]

From 1930 to 1985, Boston's minority population experienced overwhelming structural violence through the effects of discriminatory real estate and bank investments. In particular, the U. S. Federal Housing Administration's (FHA) 1938 *Underwriting Manual* required real estate investigators to evaluate each property on the probability of "invasion" by certain racial and social groups. The manual suggested that, if such racial or social groups were present, neighborhoods would become unstable and decline in value. The Housing Act of 1949 introduced "urban renewal/urban removal." Through this act and the Boston Redevelopment Authority (BRA), city contractors demolished low-income neighborhoods in order to develop government buildings, expensive residential areas, hotels, and retail businesses. Instead of the resettlement of low-income families in a "decent home and a suitable living environment," these families were placed in public housing and poverty-stricken neighborhoods. If the land was renewed into a residential area, whites were given priority.

In the early 1960s, redlining,[42] blockbusting, and loan sharing became regular practices on the part of government and private lenders. These federal policies and regulations promoted racial discrimination as the key to "neighborhood stability and housing values." In the 1980s, a suspiciously high number of

arson cases forced low-income residents out of the area and allowed the city to receive insurance and tax deductions on rebuilding in the interest of "urban redevelopment." Roxbury was nicknamed the Arson Capital of the Nation. Local residents of the area attempted unsuccessfully to save seventy-five of the burned-out buildings for low-income housing and community activities. It was speculated that these buildings were burned out for the city's Southwest Corridor Project, which also relocated the MBTA Orange Line from Dudley Station. The denial of loans to qualified minority borrowers, "unexplainable" residential fires, and higher property taxes forced minorities to abandon their communities.

By the end of the 1980s, an estimated 840 vacant lots covered 177 acres of land within the Dudley Street neighborhood. Land became abundant in this part of Boston. Industries building new plants paid lower taxes and avoided labor unions. Land not purchased by industry became the property of the city, which allowed it to deteriorate into vacant lots or into dumping grounds for city garbage. The consequences of this denial of adequate jobs, housing, education, and political power, over a fifty-five-year period, were made manifest in the health care status of the current population.

One of the exacerbated health conditions that reflects these factors is the high incidence of asthma. Vacant lots and city garbage dumps are pools for asthma-inducing agents, such as cockroaches, rodents, and dust mites. Pollution from the industrial companies and the MBTA system ignites common asthma symptoms, such as wheezing, shortness of breath, and coughing. The most detrimental factor is the history of disinvestment, which limited the development of quality and accessible health care facilities and professionals for the Roxbury, Dorchester, and Mattapan minority populations. These populations include not only African Americans, but also other African-descended immigrants from the Caribbean, Brazil, and the African countries. Living in the Roxbury area, these groups are susceptible to the political, economic, social, and health burdens described above—particularly, the burden of asthma. Such factors also lead to higher incidences of childhood asthma.[43]

How do families make sense of and cope with an illness like asthma, particularly when it affects their children? What do they do in the pursuit of healing? Clearly, in many cases, parents take their children to biomedical physicians. But they also compose their own larger health care systems that may include different, culturally based, complementary and alternative approaches to healing. Each of these groups has its own approaches to healing that are rooted in culturally based versions of spirituality.[44] These healing systems inform perceptions of disease, health-seeking behaviors, and health outcome. The challenge among these populations is to contextualize asthma within traditional healing and spiritual systems and to determine ways to balance the healing practices of these systems with the therapies recommended by biomedicine.

In addressing asthma, both biomedicine and traditional African-descended systems aim to achieve a positive health outcome. Yet, despite some apparent similarities, there are also significant differences between the two systems. Traditional practitioners, for example, attempt to understand a given illness holistically, in the context of the patient's physical, psychological, spiritual, and social realities.[45] This orientation may seem to resemble the biopsychosocial approach in biomedicine. However, in many of the African-descended practices, practitioners are trained to interpret each symptom separately using diagnostic tools that include not only patient interviewing, but also dream interpretation and consultation with the spiritual realm through invoking and conferring with ancestors and deities.[46] The belief is that each of these vehicles will contribute to an understanding of why *this* person was afflicted, why with *this* disease, and why at *this* time.

Even greater differences exist between biomedical and traditional therapies. For example, the healing methods in many of the African-descended systems include performing rituals and sacrifices, using plant and animal products, wearing totemic objects, and avoiding certain behaviors. The specific methods to be used are prescribed through ancient traditions of divination.[47] The goal underlying the particular choice of healing methods is to maintain the patient's equilibrium with himself or herself, other people, the deities, the ancestors, and the environment, ultimately lifting up the patient's relationship with the Supreme God.

There is virtually no literature on how the African-descended traditions interpret and respond to childhood asthma. One study examined the use of drugs and various herbs by caretakers for preschool children in Ghana.[48] Another study looked at compliance on the part of Puerto Rican parents in insuring that their children used their asthma medications. This study found a correlation between compliance and acculturation to life in the United States.[49] Our team will gather preliminary data on cultural understandings of asthma within some of

the African diaspora healing systems, along with the range of healing methods prescribed, based on these perceptions.

Notes

1. Emilie M. Townes, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care* (New York: Continuum Press, 1998).

2. A. T. Geronimus, J. Bound, T. A. Waidmann et al., "Black-White Disparities in Health Care," *New England Journal of Medicine* 335 (1996): 1552–58; Rhonda Steward, "Dead on Arrival," *Emerge*, September 1999, 34–40.

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