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Research paper

The use of herbal remedies to promote general wellbeing by individuals of African-Caribbean origin in England

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ABSTRACT

Within the Caribbean community there is a tradition of using herbal remedies to maintain general health and wellbeing, for both everyday common ailments and chronic conditions such as hypertension. This paper presents an account of an ethnographic study which aimed to describe and illuminate Caribbean hypertensive patients' use of herbal remedies. The design was informed by the focused ethnographic approach of Muecke, and van Maanen's adjectival approach. There were three phases: phase one, focus groups; phase two, semi-structured interviews; and phase three, further interviews using vignettes derived from the preliminary data. Thirty-six participants were recruited through general practice surgeries in two UK cities. All were of Caribbean origin. Data were managed with the aid of Atlas/ti qualitative data software package and analysed using Roper and Shapira's framework for analysis of ethnographic data. Findings were grouped into four major themes: the use of herbal remedies and how this was learned from family members; specific herbal remedies for hypertension; the need for caution in using herbal remedies; and where herbal remedies were obtained. The findings demonstrated that participants had a propensity towards self-care and medication with herbal remedies, complementary to or in place of Western medicines. They used these remedies as an empowerment strategy to gain control over their treatment and condition but did not always reveal this to professionals. In the light of these findings from practitioners it is concluded that it may be useful for professionals working in primary care to acknowledge the possible use of herbal remedies and improve their cultural competence in helping patients manage their hypertension.

Keywords: African-Caribbean, chronic illness, herbal remedies, hypertension

Introduction

Hypertension is a major health issue globally for ethnic minority individuals, as is evident from the experience of minority and indigenous populations in both North America (Anand *et al*, 1993; Hajjar *et al*, 2003) and Australasia (Hoy *et al*, 1999; Leonard *et al*, 2002). Other migrant communities such as South Koreans in Western societies also demonstrate a high prevalence of hypertension, when compared to the host community (Kim *et al*, 2000). Hypertension exists among minority communities around the world irrespective of culture and ethnicity, suggesting the possible influence of environmental and structural factors on morbidity. This paper draws on a much larger study which aimed to establish the meaning and consequences of hypertension for members of the Caribbean community living in the UK in presenting an account of Caribbean people's use of herbal remedies with particular reference to the management of their hypertension.

Use of the term African-Caribbean

It should be noted that, in this study, the term African-Caribbean has been used to refer to individuals who have ancestral links to Africa via the Caribbean, and that additionally participants were afforded the opportunity to self-assign ethnicity (Nazroo, 1997; Bradby, 2003). Communities of Caribbean origin in England often adopt the term African-Caribbean to describe community groups and associations. In consideration of this, it can be speculated that the term reflects a group acceptance of the term as existing within a social reality, and such usage demonstrates that the term has meaning and validity for the group (Modood *et al*, 2003). The huge variation in culture, traditions, and languages between and within the Caribbean islands is acknowledged.

African-Caribbean people living in the UK

The period following the Second World War in Britain was characterised by a period of economic growth and prosperity (Kushnick, 1998; Alibhai-Brown, 1999). The labour shortages present in Britain at the time preceded government policy and strategy that focused on facilitating individuals of the British Commonwealth, including the Caribbean Islands, to migrate to Britain as a solution to the labour shortages. The work available was largely unattractive to the indigenous population, often being in public services such as transport, the National Health Service and the textile industry (Kushnick, 1998). While the British government recognised the need for an immigrant workforce, the context in which this occurred is important when considering the health status of the African-Caribbean population today, as economic and social status are major determinants of health. The social variation in health status that African-Caribbean people experience is not simply a manifestation of cultural difference, but a result of the unique coalescence of factors such as migration, cultural adaptation, structural issues such as prevailing ideologies, the effects of racism and racialisation, and the intersection of social class and economic issues (Karlsen and Nazroo, 2002a,b; Nazroo, 2003). In the 2001 UK census, 1% of the total population described themselves as 'black Caribbean' (National Statistics Online, 2006).

African-Caribbean people and hypertension

According to the British Hypertensive Society (2000), hypertension is the persistent elevation of diastolic blood pressure. Factors that contribute to the development of hypertension include obesity, smoking, high levels of alcohol consumption, lack of physical activity, socio-economic status and ethnicity (Cooper and Rotimi, 1997; Cooper *et al*, 1997; Cappuccio *et al*, 1998a,b; World Health Organization (WHO), 2000). While the condition is extremely common, there is evidence that many of the associated risk factors are modifiable (Cappuccio, 1997; Cappuccio *et al*, 1998a,b; Ramsay *et al*, 1999a,b; WHO, 2000). The early detection and treatment of hypertension are hindered by the fact that often the condition can be symptomless (Raleigh, 1997).

The prevalence of hypertension is strongly associated with an increased incidence of cardiovascular events, regarded as a risk factor for stroke (Morgan, 1995; Raleigh, 1997) and coronary heart disease (WHO, 2000), and resultant increases in mortality and morbidity. There is increasing evidence of the role of hypertension in end-stage renal disease (ESRD) among patients from all backgrounds, including those who belong to minority ethnic communities (Kaplan, 1994; Raleigh, 1997; Laville and Gueffier, 2000). Both South Asian and African-Caribbean populations are said to experience the sequelae of ESRD at three to four times the rate for the white population in the UK (Raleigh, 1997). A similar pattern is observed in African-American populations (Suthanthiran *et al*, 2000). As the cause of hypertension is unknown in 95% of patients, contemporary medicine may have limited success in reversing the consequent organ damage in the cardiovascular and renal systems (Brown, 1997).

Explanatory models of health and illness/lay perspectives and health beliefs

Kleinman (1988), in seminal work, conceptualised explanatory models (EMs) of illness. An EM is the patient's subjective view of illness, and refers to the unique and individual insight in respect of interpretations and understanding of the illness. Specifically an EM maps out the following dimensions of illness in terms of the:

- aetiology or cause of the condition
- timing and mode of onset
- pathophysiological processes involved
- natural history and severity of the illness
- appropriate treatment for the condition (Helman, 2001).

Kleinman (1988) regards EMs as idiosyncratic and multifactoral, arising from a range of personality and socio-economic factors. In this sense EMs are dynamic and contextually bound but are regarded as 'not identical to general beliefs about illness that are held by society' (Helman, 2001). Hodgson (2000) argues

that cultures interpreting and understanding illness hold clusters of EMs, although no empirical data are presented to support this assertion. Clustering of EMs did occur in this study as commonality existed between participants but an earlier study (Blumhagen, 1980) suggests that only individual EMs are possible. In this respect the findings of this study elaborate and expand understandings of EMs in evidencing clustering in respect of the use of herbal remedies. Both practitioners and patients hold EMs that may not be synonymous with biomedical explanations (Helman, 2001). This paper presents evidence in relation to the final dimension of Kleinman's model: participants' conceptualisations of appropriate treatments for their condition.

Use of herbal remedies in chronic illness

Phytotherapy, or herbal remedies, has been used globally and in the UK for the treatment of ailments and chronic conditions for many centuries (Little and Parsons, 2003). The use of herbal remedies within the general population forms a component of what is known as complementary and alternative medicine (CAM; Eisenberg *et al*, 2000). The Royal Pharmaceutical Society has predicted that 'retail sales of herbal and homeopathic preparations and aromatherapy essential oils will total £126m ($176m) by 2002' (Roach, 2000).

It is clear that some sections of the general population are strong supporters and users of herbal remedies. Their widespread use within the general population has prompted calls for stricter regulations (Roach, 2000) and randomised controlled trials to establish both the efficacy of herbal remedies (Little and Parsons, 2003; Little *et al*, 2003) and the extent to which these remedies create placebo effects. Some observers have noted the increased use of complementary therapies, especially plant and herbal remedies, in the management of chronic diseases such as osteoarthritis, rheumatoid arthritis (Little and Parsons, 2003; Little *et al*, 2003) and dysmenorrhoea (Proctor and Murphy, 2003), and clearly individuals, especially those experiencing chronic illnesses, value herbal remedies.

Study aim

The overall aim of the study was to establish the meaning and consequences of hypertension for individuals of African-Caribbean origin and their perceptions of primary healthcare services. In this paper we discuss participants' use of herbal remedies, as it became evident during the progress of the research that the general use of herbal remedies was prevalent within the African-Caribbean community. This paper presents the study findings that specifically relate to the use of herbal remedies for chronic illnesses by African-Caribbean people in England.

Methodology

The research used a focused ethnographic approach (Muecke, 1994) to explore perceptions of illness (Hudelson *et al*, 1995; Gillibrand and Flynn, 2001). Spradley (1979) states that 'ethnography is a fundamental tool for understanding "multicultural" societies of the modern world'. As used in this study, an ethnographic approach provided a method of accessing health beliefs and behaviours (Savage, 2000). The approach adopted was not of the classical genre but what van Maanen (1995) describes as adjectival. Adjectival ethnography differs from the classical genre, which uses participant observation as the principal data collection tool, by relying heavily on the ethnographic interview for data collection (Higginbottom, 2006).

An important dimension of ethnography is that of reflexivity. Defined by Denzin and Lincoln (1998), reflexivity refers to a process by which 'researchers are obliged to delineate clearly the interactions that have occurred among themselves, their methodologies, and the settings and actors studied'. Reflexivity is therefore focused on making explicit and transparent the effect of the researcher, methodology and tools of data collection on both the research process and findings. In this study, this was achieved via a narrative journal which enabled a critical deconstruction of self-identity and ethnicity, and evaluation of the impact these dimensions had on both the progression of the research and the study participants (Higginbottom, 2006).

Data collection

Data were collected in three phases (see Table 1):

- Phase 1 consisted of two focus group interviews, with a total of ten participants, which provided the opportunity to obtain a broad and preliminary scope of the areas of the investigation
- Phase 2 comprised 21 semi-structured interviews with 21 participants which lasted approximately 45 min to 1 hour 30 min, and which were used to explore in-depth the key issues that emerged in Phase 1
- Phase 3 was built on the seminal work of Greenhalgh *et al* (1998), and involved the use of

Table 1 Methods used for data collection

Data collection tool	Number
Focus group interviews	2 (5 participants in each)
Semi-structured interviews	21
Vignette interviews	5
Total	36

vignettes derived from data from the semi-structured interviews to encourage five participants to comment on the experience of the person in the vignette rather than giving a personal perspective that they might otherwise be reluctant to share. While fictitious in nature, the vignettes embraced many of the key concepts highlighted by participants in Phase II. The vignettes were tape recorded and played to each participant at the start of the interview. All the focus groups and interviews were conducted by the first author and tape recorded.

Rigour and robustness were achieved in this research by the application of established principles outlined by Murphy *et al* (1998) and Guba and Lincoln (1989) – confirmability, transferability, dependability, and credibility. The use of an explicit and transparent methodological framework and a reflective approach was essential. The credibility of the findings was further assured by the confirmation of the salience of the findings by the consumer research advisory group comprising an individual who was a former chair of local African-Caribbean association, two carers of individuals with hypertension, one individual with hypertension, and a community member.

Sample

Approval to conduct the study was obtained from the two local research ethics committees in the study locations. Twenty-seven general practice surgeries in two cities with high populations of African-Caribbean patients were contacted by letter, which contained a brief explanation of the study. A sample letter was provided for the practices, which was then customised to meet local requirements. Practices were then contacted by telephone to ascertain their willingness to participate in the study. An honorarium of £100 was paid to practices that required some compensation. A total of 13 practices in both cities were recruited. Three other practices agreed to participate following initial contact, but later withdrew.

Participants were accessed through general practitioner (GP) surgeries and community groups and associations in two English cities. Community groups and associations were also used to achieve maximum phenomena variation (Murphy *et al*, 1998). Purposive and snowballing samplings were used to generate the study sample. Thirty-six people of African-Caribbean origin (see Table 2) participated, all of whom had been diagnosed with hypertension. There were 36 participants comprising 20 women and 16 men between 37 and 82 years of age (median age 59.5. years). Two participants were born in England, three migrated from the Caribbean as young children, and the remainder did so during the first wave of migration which took place between the late 1950s and early 1960s. Participants had been living in England for between 20 and 47 years; the majority had lived there for 40 years or more. Thus, most had spent more time in England than in their birth country. Most participants either held or had retired from working-class jobs such as joiner, builder, grinder or cutlery worker. Six people held professional roles in statutory services such as a teacher, nurse, midwife, social worker and youth worker.

Participants were given the opportunity to self-assign their ethnicity (Nazroo, 1997; see Table 3).

Table 2 Place of birth of participants and their parents

Place of birth	Number	Parents' place of birth	Number
Jamaica	31	Jamaica	33
Guyana	1	Guyana	1
Barbados	1	Barbados	1
Dominica	1	Dominica	1
Leeds, UK	1		
Wolverhampton, UK	1		

Table 3 Participants' self-assigned ethnicity

Self-assigned ethnicity	Number
Jamaican	15
Black British	7
African-Caribbean	4
Afro-Caribbean	4
West Indian	2
West Indian/British	1
Black	1
Caribbean	1
Black/West Indian	1

Self-assignation is discussed in detail in other publications (Gerrish, 2000; Modood *et al*, 2002; Higginbottom, 2004). The birth place of the participants' parents and grandparents as well as religious affiliations were elicited to give a more comprehensive view of the participants' ethnicity. Participants selected a range of terms to describe themselves, e.g. Jamaican, Afro-Caribbean, Black British, British, West Indian, African-Caribbean, Jamaican/British, Black West Indian, and West Indian/British. It was notable that midlife participants tended to describe themselves as Afro-Caribbean or African-Caribbean. Most of the participants had origins in the Caribbean island of Jamaica, but three originated from Guyana, Dominica and Barbados, respectively. Detailed information was collected on the place of birth of the participant, their parents and grandparents. Religious affiliations were also recorded to obtain a comprehensive insight into their ethnic background.

Participants' use of language

It is important to point out the differences in speech patterns between some participants of African-Caribbean origin who were Jamaican born and spoke English, and Standard English speakers who were born in the UK. These differences may present challenges for the reader in comprehending the meaning of their statements. Many older African-Caribbean people speak Patois (Higginbottom and Serrant-Green, 2005) which is also referred to as Jamaican. While Patois is not regarded as a different language, as many of the words are derived from English, Jamaican Patois may present challenges. Difficulties may arise for Standard English speakers as Patois is derived from both West African and European languages. As such, it is characterised by a unique syntax, morphology and grammatical expression (Scott, 1998). Furthermore, participants often switched between speaking Standard English and Patois. In some instances this was integrated with an English regional accent, such as a Yorkshire accent. It was important that participants were able to express themselves freely and fluently in their preferred idiom (Higginbottom and Serrant-Green, 2005), and so translation was needed when participants spoke solely in Patois. However, the Standard English often spoken by participants was used with the grammatical expression and syntax of Patois, and was easily interpreted, but the syntax of African-Caribbean speech made the group conversations during the focus group interviews much harder to transcribe and interpret within the context of the meanings of the speakers. It was for this reason that the co-moderator of the focus group interview was a Patois speaker. The co-moderator assisted with the translation of occasional words and translated one interview.

Data analysis

The process of qualitative data analysis is characterised by identification and classification of data, and progresses to abstract generalisations, explaining patterns of assessment within the professional group. The process described below is not linear, but undulating and convoluted. This characterises the iterative process (Silverman, 2000) associated with qualitative research, as preliminary interpretations are challenged and data are revisited in the light of further data collections and new insights into the data. In this study data analysis was informed by Roper and Shapira (2000) who provided a series of steps (see Box 1).

Data were managed with the aid of Atlas/ti qualitative software for data analysis. Analysis of qualitative data is dependent on immersion by the researcher in the data collected, in order to establish familiarity with the data. This demands frequent reading and systematic review of the transcripts. The initial process commenced with checking the written transcript against the audiotaped version, to correct any inaccuracies. As the analysis progressed, it became evident that re-listening to tapes in addition to familiarisation with

Box 1 Steps in analysis (after Roper and Shapira, 2000)

- Coding for descriptive labels
- Sorting for patterns
- Identification of outliers or negative case
- Generalising: constructs and theories
- Memoing: reflective remarks

transcripts was an essential component of the process of analysis. Nuances and inflections of speech cannot be captured in a transcript. Reliance on the transcript alone creates a deficit that may considerably lessen understanding of the meaning of the words and viewpoints articulated. Once familiarisation with the data had occurred, the data were assigned to the software Atlas/ti in order for the coding process to begin. Codes were assigned to words, sentences or paragraphs, line by line. Each code was defined (using the comment facility of Atlas/ti) and later combined to form abstract categories, themes or domains. Atlas/ti enables the generation of code lists from datasets and across datasets. It is also possible to generate a list of new codes that occurred 'today' or from a specific dataset. This dimension proved to be extremely useful in establishing when analytical saturation of the data had occurred, e.g. when no new codes or themes emerged from the data.

With the use of Atlas/ti, the code relationships can also be constructed visually in graphical representations, and code hierarchies or typologies can also be illustrated. The coded data were examined to allow phenomena hidden or embedded in the data to become more explicit. Consideration was given to the relevance and significance that emergent findings held for the specific research questions and objectives. During this process, outliers or negative codes are identified that do not appear to fit into emergent patterns. The conclusion of this process is a narrative about each theme, illustrated with verbatim comments.

Findings

Findings were grouped into four major themes: the use of herbal remedies and how this was learned from family members, specific herbal remedies for high blood pressure, the need for caution in using herbal remedies, and obtaining herbal remedies. Each is discussed below. All participants have been given a pseudonym in order to maintain anonymity and confidentiality.

Use of herbal remedies

Over half of the participants used herbal remedies for general health and wellbeing, with a smaller number using herbal remedies specifically for hypertension. Some participants reported using herbal remedies only when it became clear to them that the author had knowledge of this practice within African-Caribbean communities in England. Herbs and bush teas commonly used by participants were Aloe vera, singer bible, cerasee, rosemary, bread fruit leaves and fever grass (Tables 4 and 5). Participants who did not use

Table 4 The types of herbal remedies reported in this study

Remedy	Used for
Aloe vera	High blood pressure, healing of wounds
Bissy	Stomach upset
Bread fruit plant leaves as an infusion	High blood pressure
Cerasee (cerrasee, serasee)	General health, blood cleanser
Cho-cho	High blood pressure
Coconut water, lime and lemon	High blood pressure
Fever grass as an infusion	High blood pressure
Hawthorn	High blood pressure
Lime juice, garlic	High blood pressure
Marijuana as an infusion	Asthma
Scorn the earth	High blood pressure
Singer bible (single bible or *Semper viva*)	High blood pressure
Tuna	High blood pressure
Any bitters	To lower blood pressure

Table 5 The use of herbal remedies and concordance with prescribed medication (main study sample semi-structured interviews)

	Non-concordant with medication	Herbal remedies/ self-care	Concordant with medication	Non-concordant with professional advice	Concordant with professional advice
Total	9	12	7	2	11

herbal remedies emphasised their preference for Western medicines.

Barbette (Interview 14) recollected her early introduction to herbal remedies in the form of purges and laxatives:

> 'It'time we have school holiday, we get a wash out before we go back to school, to prevent us from having fever and all them kind of things. Bellyache. Then we go back to school all fresh, because we have a wash out and your insides clean. You know, children eat this, that and the other. So, your inside clean to go back to school, when school re-open.'

Barbette's statement demonstrated use of herbal remedies as the social norm in the Caribbean, where it is embedded in the socialisation of children. Similarly, Loretta (Interview 17) described her own experience of receiving herbal remedies and purges as a child. Although not appreciative as a child, Loretta now believed that herbal remedies were indeed beneficial to health:

> L: 'They would say boil such and such a thing and give you, they have to, sort of, stand over you and watch you ... to see you drink it, because you never want to drink it. But, now I realise that there was benefits from it. I'm sure it was.'
>
> G: 'Yes. You think it was helping.'
>
> L: 'Yes, because, there was always, sort of, little, if you had a cold. They never say 'well, go to the doctor', or 'go to the chemist'. They just buy different things. For instance, my Father, as far as I understand, has never, ever seen a doctor till three months before he died. He kept good health, but any little thing, it was always some bush [herbal remedies/ plants] or other ... that was used.'

Some of the herbal remedies are referred to as *bitters* (Morgan, 1993), reflecting the actual taste of the substance. The unpleasant and bitter taste of some of the remedies was identified by Carmel (Interview 21):

> 'One thing I remember, when I was younger, very young and my Mum, I had a chest problem, cough and she scrap that single bible there ... And my Mother scrap it, you see, like this, she cut a piece off and she scrap all the ... She scrape the inside out. And mixed it up with milk. And give me to drink. And when I drank it down, they had to beat me to drink it.'

Participants' reflective biographical accounts provided insights into the health-related actions and behaviours of the African-Caribbean people in this study. These also allowed predictions about their responses to prescribed medications and possible continued reliance on herbal remedies alongside primary healthcare services and pharmacotherapeutics. Four participants who used herbal remedies described powerful 'significant events' to demonstrate to the researcher the effectiveness of their practices. Edgar (Interview 6) stated that:

> E: 'He go to this doctor, and, and he has a lot of land, and er, he go to his doctor and he spent so much money and he couldn't cure him. And this is what he says, right, I don't know. He said he met this man and this man tell to er, boil it [cannabis], drink it.'
>
> G: 'Cannabis?'
>
> E: 'Hmm. And he boil it, and he been drinking it, being he was a big man, he knew this drink couldn't get people [inaudible]. He boil it and he been drinking it. He say ''every time I got to the doctor, takes a sample and says er, 'so far you're not as bad as you were'' '. He said ''no''. And he, he'd been on with this thing for a couple of months. And when he went back to doctor one week, the doctor tell him ''I think you're alright now''.'

In contrast to the commonly held assumption in the UK that cannabis is a herb that is smoked, Edgar's description was of an infusion or bush tea which convinced Edgar of its medicinal value for asthma relief. Delbert (Interview 9) described the antipyretic effects of herbs:

> 'Once when I was about seven, I was telling someone this same story yesterday, I was at home with a fever. The fever was hot. Very hot, I was burning up. It was only me and Arncy [?] at home, and about 8 o'clock my mother filled up the big wash pan [tin bath] with water, put it outside in the evening dew and told me to stand in it. She brought cannymin [inaudible] I don't know if you know it? It's white. She told me to drink it.'

Significant events regarding the use of herbal remedies and their health-enhancing properties were not confined to older people who were raised in the Caribbean and migrated to England as adults. Two participants who were born and raised in England spoke of their belief in the efficacy of herbal remedies. Carlene

(Interview 16) was convinced after a holiday in Jamaica:

> C: 'I didn't before [value herbal remedies]. It's only when I went to Jamaica and I got bit. You know when you get bites. What do you call them? Mosquitoes and ants.'
>
> G: 'Yes.'
>
> C: 'And my Dad got the single bible and squeezed the juice and rub it on it.'
>
> G: 'Yes.'
>
> C: 'And it stopped it swelling up and scratching.'

These narratives demonstrate the intensity of participants' beliefs in the value of herbs. Their graphic descriptions suggest a detailed knowledge of using herbs, and potential difficulty by some participants in giving up herbal remedies in favour of prescribed Western medicines. Letting go of this belief and practice would involve a salient deconstruction and rejection of personal socialisation, creating dissonance in their value-belief system.

Specific herbal remedies for high blood pressure

A small number of participants took herbal remedies specifically for high blood pressure. Carmel, for example, took Aloe vera. Hyacinth, a younger participant, used a mixture of garlic, coconut water, lemon and lime. Hyacinth had decided not to take her prescribed medication, preferring to use this herbal remedy, which she believed had lowered her blood pressure. Hyacinth (Interview 19) had shared this information with her GP:

> H: 'Because I really don't believe in taking medicine I had a chat with my family back home on the telephone and they talk about, you know, coconut water and lime, lemon, lime. Those kind of things.'
>
> G: 'Yes. Is that good for high blood pressure?'
>
> H: 'Very, very good. Garlic. And I actually use, a whole month, I use garlic and a lot of garlic and onion for cooking with, erm, use lemon and lime hot in water, when I could get the coconut water, as well, mix with it and it's amazing. I went back the doctor, blood pressure was down. Really, really down. So, I thought it was down about the same point with the tablets as well.'

Hyacinth believed that the efficacy of this remedy was confirmed by her GP when he told her that her blood pressure was no longer elevated.

Caution with herbal remedies

Participants are aware of the dangers of taking herbal remedies. According to Carmel (Interview 20), one can overdose on herbal remedies in the same way that one can overdose using prescribed medications:

> C: 'These are very dangerous [points to plant in living room]. It's good, but you can't drink it too strong.'
>
> G: 'What is that?'
>
> C: 'The Aloe vera.'
>
> G: 'Oh, yes.'
>
> C: 'You can drink it, but you can't drink these things. You know these things, people ...'
>
> G: 'Well, how do you drink that one, then?'
>
> C: 'I, I boil ... Yes. A little tiny piece, because if you drank it too strong, that's what damage your kidney and your liver.'

Participants indicated that tacit knowledge of herbalism was possessed by elders in the family and neighbours in Jamaica. After emigration, this source of information may no longer be available. The use of herbal remedies was not universal. Eight participants made very clear they did not take herbal remedies. By contrast, other participants believed that both herbal and Western medicines could be used effectively together.

Obtaining herbal remedies

Participants provided insights on how they obtained herbs and traditional remedies. Some participants grew their own herbs as houseplants. One participant reported that the term *single/singer bible* (Aloe vera) is derived from the Latin term *semper viva* (meaning long life). Ingesting its leaves or stems provided a specific remedy for high blood pressure. Participants frequently obtained supplies of herbs when visiting Jamaica on holiday, often getting enough supplies to last one or two years. As Carlene (Interview 16) commented:

> C: 'Yes. My Mum's going to Jamaica next month. And bringing some over for me.'
>
> G: 'Yes. So, what will she bring you?'
>
> C: 'Like, single bible, and a bush tea that you can drink. It's [more] bitter than cerasee. It's bitter for the blood.'

Carlton reported that his father often returned from holiday with a number of different herbs in a box. These were generally not labelled, creating some confusion as to which remedies were actually taken. If herbs or bushes could not be obtained on holiday, they could be purchased in some continental or Asian stores (as distinct from an English herbalist). However, participants stated they would not obtain herbs in this way because of the high cost, adding that they were of low quality, being 'old' or not freshly picked. Carlene reported that, in her location, a door-to-door

salesman sold herbs and a range of other products for African-Caribbean people in the neighbourhood. Some commonly used herbs such as cerasee were available as commercially produced products in herb tea sachets.

Discussion

Thorogood (1998) proposed that Jamaican health beliefs and concepts of health are derived from two cosmologies based on medieval theories of humours, and West African conceptualisations of the obstruction of bodily passages. Implicit in the latter view is the need to maintain clear body passages using purges and laxatives if necessary. Within this world view, the body is linked by one continuous passage from the mouth to the anus via the uterus and stomach (Helman, 2001). The use of herbal remedies in the Caribbean was informed by West African folk medicine, presumably by way of the tacit cultural knowledge held by those populations transported to the Caribbean by the transatlantic slave trade (Morgan, 1993; Thorogood, 1998).

Kleinman (1988) identified the three domains comprising healthcare systems: popular, professional and folk. The *popular* domain is a lay, non-professional sector in which between 70% and 90% of illness episodes are managed. It includes perceiving and experiencing symptoms, the assignation of labels, health-seeking behaviours, authorisation of a specific sick role, self-care and treatment. The family is the main provider of such care. The *professional* domain is organised by professionals sanctioned by society, usually through legislation. The *folk* domain is a non-professional, non-specialist sector embracing religious and secular healers, such as folk healers, shaman and herbalists. In the study reported here, participants used all three sectors of the healthcare system singly or simultaneously.

According to Mason *et al* (2002), 'people often turn to complementary treatments because of frustration with conventional medicine'. This frustration was evident from study participants who expressed dissatisfaction with the side-effects and perceived efficacy of antihypertensive therapies. Thus, participants in this study shared similarities with the general population, suggesting that use of herbal remedies is not simply a result of ethnocultural origin. Rather, it may typify the norms and values of other groups within society at large, especially those who experience chronic illness and perceive prescribed medications as having limited efficacy. Since most of the participants in this study had been residents in the UK for over 30 years, adoption of the values and norms of the host community may have occurred. However, there was one significant difference in that, in contrast to members of the general population who purchase herbal remedies from herbal stores and pharmacies (Roach, 2000), the study participants largely grew their own herbal treatments, or obtained dried plants from the Caribbean.

The popularity of complementary and alternative medical (CAM) therapies presents new challenges (Eisenberg *et al*, 2000). It is worth noting that most of the participants in this study did not disclose their use of herbal remedies to healthcare practitioners. This is an important issue that needs to be addressed with increased use of plant and herbal remedies by the general population with chronic illness (Little *et al*, 2003; Little and Parsons, 2003; Proctor and Murphy, 2003). The overall findings of this study demonstrated that improved communication between practitioners and patients concerning their use of herbal remedies would improve management of their chronic conditions such as hypertension. The predominance of herbalism in Jamaica as a form of self-care is both a manifestation of lay and folk belief systems (Kleinman, 1988; Helman, 2001), and a pragmatic response to the limited provision of formal primary healthcare. In the past, ordinary Jamaicans could often not afford the services of a professionally qualified medical practitioner who was likely to be accessible only to people living in cities and towns. Many of the Jamaican people who migrated to the UK are rural and country folk who were less likely to be able to afford or subscribe to professional medical services in Jamaica.

It is important to view the use of herbalism within the context of social norms and practices within the Caribbean both past and present. Thorogood (1988) has identified the prominent role of Jamaican women in creating and using herbal remedies and bush teas for their family members. This study affirms the use of herbal remedies and the significant position of herbalism in the social mores and norms of Jamaican family life. A number of participants referred to the 'washouts' they received as children growing up in Jamaica, usually administered by mothers, in the form of an infusion known as 'bitters', in reference to its bitter taste. There were regular and ritualised cleansing events that usually occurred over a holiday, such as Christmas or Easter. The use of herbs as a form of self-care was a powerful dimension of informants' early socialisation; hence their belief in the efficacy and value of herbal remedies may not be readily abandoned after migration. Indeed, for many participants, the inherent value of herbalism was a 'taken for granted' dimension of life. The characteristic self-reliance of rural people in the Caribbean was viewed by participants as a positive attribute.

In the UK, most individuals of African-Caribbean origin are provided with care and management of their hypertension in primary care. Primary healthcare services

located in areas with high African-Caribbean populations would benefit from a greater emphasis on the provision of culturally sensitive care (Culley, 2001; Campinha-Bacote, 2002). An appreciation and understanding of the wider influences on health that African-Caribbean populations experience would also have potential benefits for the therapeutic encounter for other minority communities. This appreciation and understanding is most frequently expressed as cultural awareness, cultural knowledge, cultural skill, and cultural sensitivity (Campinha-Bacote, 2002). The notion of culturally congruent practice is problematic in that it is unrealistic to expect practitioners to have an in-depth insight into and knowledge of all groups they encounter. It is for this reason that our discussion has focused on the need for cultural sensitivity (Campinha-Bacote, 2002) in the assessment and monitoring of individuals of African-Caribbean origin who experience hypertension.

Conclusion

Kleinman (1988) conceptualised explanatory models of illness as the patient's subjective view of illness, interpretations and understanding of the illness experience. During nursing assessments it may be useful to elicit information regarding the explanatory model of health and illness within which the patient operates. Several models exist (Weinmann *et al*, 1996; Weiss, 1997; Lloyd *et al*, 1998) that can be integrated into nursing assessments. These models generally focus on questions that seek to establish the patient's perceptions regarding illness causation, and effective treatments of the condition. In this study, participants often failed to reveal their use of herbs to healthcare professionals who provided care and long-term management of their chronic illness. Discussions of this nature may facilitate patients' sharing with health professionals their self-care strategies, including herbal remedies.

Primary healthcare providers serving substantial populations of African-Caribbean people should audit their cultural competence by using tools such as the Inventory to Assess the Process of Cultural Competence among Health Care Professionals (IAPCC) (Campinha-Bacote, 1999, 2005). This tool is suitable for multidisciplinary primary healthcare teams. According to Campinha-Bacote (2002, 2005) cultural competence is a process requiring ongoing development.

Most participants, both first- and second-generation migrants, used traditional herbal remedies for health and wellbeing, with a small number using them specifically for high blood pressure (Higginbottom, 2004). The propensity of participants for self-care, and their resourcefulness, are significant findings, as many minor ailments with which patients present in GP surgeries could be treated by the individuals themselves (Roger *et al*, 1998; Brogan *et al*, 1998). During consultations it may be useful for primary healthcare professionals to acknowledge that other forms of treatment and care exist and may be accessed by their patients. Many participants in this study used herbal remedies, while a smaller number used private GPs. Almost all of them opted not to disclose use of herbal remedies to primary healthcare practitioners, for fear of retribution. Information concerning their use of different forms of care may enable primary healthcare professionals to provide more effective care and treatment plans for patients.

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