The Holistic Complementary Structure of Western Bio-Medicine and Traditional Healing and Achieving Complete Health

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The Holistic Complementary Structure of Western Bio-medicine and Traditional Healing

and Achieving Complete Health

by:

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A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts
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Date of Approval:
August 9, 2011

Keywords:
birth weight, culture, wellness, environmental insult, social determinants

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Dedication

I dedicate this thesis to my mother and father Roselyn Oubre and Darrel Oubre Sr., Grandmother Catherine Marie Landry (May You Rest In Peace) and Grandmother Gloria Oubre. Thank you for always, “knockin’ some sense” in me! This was not an easy journey, and I am grateful for the advice and encouragement through all the opposition.

“The flower that blooms in adversity is the most rare and beautiful of all.” ~ From the Disney Film Mulan 1998~
Acknowledgements

I would like to acknowledge Dr. Dawood Sultan, Dr. Deborah Plant, Dr. Deanna Wathington and Dr. Monica Hayes for cultivating my knowledge in holistic healing and exposing me to the multifaceted depth of health. Thank you all.
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Abstract

Achieving complete health requires a deep understanding of complementary cultural competency sensitivity between physician and patient. This may include but is not limited to access to preventative health care resources, access to health educational resources and access to cultural healing resources, for example, shamans, Ayurvedic physicians, and herbal healers. Advocates of cultural competency emphasize great importance on knowledge of the patients’ cultural background; however, the transcendence of this knowledge can be explained further through complementary cultural competency sensitivity. This is when the cultures of the physician and patient complement each other in terms of understanding what is in the patients’ best interest in the overall goal of healing and complete health for the patient. The explanation of this concept revolves around the idea that health is not just found within body wellness physically, but also mentally and emotionally. The tragedies of poor health outcomes we face have psychological repercussions with a significant social determinant that biomedical medication cannot and should not solve. The purpose of research includes theoretical discussions that address questions of: What roles do Evidence Based Results play for Medical Anthropologists? How will having knowledge of socioeconomic status, cultural practices and determinants of environmental insult and structural violence as experienced by the individual patient influence the facilitation of the process of creating a positive health outcome for the patient? How should “End of Life” issues be
addressed? How does language influence health? Does a positive dialogue between health professionals and patients contribute to better health outcomes? The Research will emphasize the idea that Ethnomedicine (traditional medicine) and Western Bio-medicine complement each other within the model of complementary cultural competency sensitivity. The Holistic Complementary Structure of Western Bio-medicine and Traditional Healing is a multifaceted mean by which the manifestations of complete and positive health results occur. The methods of research used in the research include ethnographic interview content discussions, primary and secondary literature sources, and research of bio-statistical data. The interview discussions consist of dialogue with Medical Anthropologists, a Nurse Practitioner, a Global Health Studies Ph.D. professor and an Africana Studies Ph.D. professor. In order to prove the hypothesis, explanations through examples of Ethnomedicine (traditional medicine) and Western Bio-medicine working together, show how the combination of the two modalities along with the factors of complementary cultural competency sensitivity between patient and physician contribute to positive health outcomes.
Chapter 1: Introduction

Typically, in the United States, health is all too often thought of as merely the absence of disease. However, complete health extends beyond the parameters of this type of thinking. Complete health is defined in holistic terms to mean the stability and wellness of the mental, physical and cultural aspects of a person (Weissman, 2005; Baer and Singer, 2007). By combining the practices of indigenous Ethnomedicine (traditional healing) with the technological advances of western Biomedicine, physicians, traditional healers and medical anthropologists who use such a holistic approach all have a better chance of understanding, sustaining or recovering a patient’s complete health.

Traditional medical techniques and western Biomedicine are more efficient when combined because the care in which a person receives then becomes all encompassing, thereby addressing the person mentally, culturally and physically. Traditional healing techniques for example, Ayurvedic medicine, yoga and meditations also have potential to fill in the gaps of health compliancy where western medicine cannot penetrate such as motivation, self-assurance, self-affirmation and consistency. The ways in which a patient is medically addressed mentally, physically and culturally could include exploration of the patient’s traditions and disease knowledge, perceptions or experiences. Also important to consider are the patient’s religious practices and socioeconomic status variables. Because cultural medical traditions play a significant role in an individual’s
mental and physical health, it is important to explore them through research which could possibly result in holistic understandings of health and healing.

Chapter Overview

Through the research, ways in which western medicine and traditional forms of healing addressing the physical, mental and emotional aspects of complete health will show the potential of how well the complementary structure of Western Bio-medicine and Traditional Healing can help in achieving Complete Health. The chapter entitled: “Spirituality, Linguistics and Health: Analysis of Linguistic Data in Capoeira Songs” examines the importance of Axé in the Afro-Brasilian marital art Capoeira and the importance of positive energy flow encircled in the roda (ring or circle) and how it is linked to Candomblé, camaraderie and positive health outcomes. The next chapter, “The Impact of Western Medicine: Pharmaceutical Medicine In the AIDS “Industry” explores the way in which pharmaceutical industries shape the health of entire countries in particular sub-Saharan Africa in HIV/AIDS antiretroviral treatment. Along with that exploration, a discussion on intellectual property rights and how patents should be valued is included. The following chapter, “Environmental Insult and Low Birth Weight” tackles the issue of high low weight rates among blacks in the diaspora. This chapter discusses how race, Environmental Insult, Structural Violence and the negative side of Social Determinants of Health can negatively influence the health of an individual. The chapter titled, “End of Life Issues” examines the process of passing away by which an individual experiences. This chapter also discusses how death affects the family of a loved one as
well as physicians administering health care to the dying individual before passing away mentally and emotionally. Finally, conclusions on the importance of understanding background cultural information, the useful infusion of traditional healing in western medical practices and the attention placed on emotional and mental healing define the complementary structure of complete health. The methods of research used in this study include ethnographic interview content discussions, primary and secondary literature sources, and bio-statistical data. The interview discussions consist of dialogue with Medical Anthropologists, a Nurse Practitioner, a Global Health Studies Ph.D. professor and an Africana Studies Ph.D. professor. All have expertise which is individually relevant to the understanding of a holistic approach to health. After completing discussions, examining the literature sources and the bio-statistical data, a meaningful conclusion concerning the complementary structure of Western Bio-medicine and traditional healing in achieving complete health can be drawn.

As defined in a previous paragraph, complete health involves the stability and wellness of both mind and body (Weissman, 2005; Baer and Singer, 2007). Holistic medicine generally describes the type of medical care a patient can receive that involves positive, “health care through the integration of all aspects of well-being: physical, mental, emotional, spiritual, environmental and social.” (Baer and Singer, 2007) Traditional healing describes methods by which indigenous physicians use to treat their patients (Baer and Singer, 2007). Other terms that will be explored in this study include personalized medicine, biomedicine, illness and disease. Personalized medicine is defined as treatment that should be as individual as the patient’s health issue (Singer and Baer, 2007). As defined by the National Cancer Institute, Biomedicine is the system in which
medical doctors and other healthcare professionals such as pharmacists, nurses and therapists treat symptoms and disease using drugs, radiation or surgery (www.cancer.gov). Biomedicine is also known as Western medicine and the two terms will be used interchangeably in this thesis. Although illness and disease are usually used synonymously, each term has its own definition. Baer and Singer note that the difference between illness and disease has a lot to do with the cultural interpretive perspective used in medical anthropology. Illness may be defined as bodily signs of physical and/or emotional discomfort (Baer and Singer, 2007; Weissman, 2005). Disease is a condition of physical discomfort diagnosed by a professional healer, such as a physician of Biomedicine. The purpose of disease diagnosis is to allow physicians the ability to classify patients in order to better understand why people get sick (Baer and Singer, 2007). These diseases are then codified into the International Classification of Diseases.

In this study, I will argue that there are negative issues that arise when adhering to a single healing system. Some of the major problems with single healing systems include ignoring important aspects of complete health: the patient’s mental stability and peace and the importance of an individual’s culture. Another problem is the delay of healing (Weissman, 2005). Not a single means of healing can achieve complete health. This implies that the system of healing should necessarily be holistic. Human beings are complex and their complexity is often the cause for stressful, unknown or time-consuming single healing practices.

Ignoring the patient’s mental stability and peace and the importance of culture adversely influences achieving complete health. Healing systems should have
individualized factors that are specifically tailored to address specific aspects of an individual’s life. This is necessitated by the fact that culturally specific aspects of an individual’s life often influence the way an individual responds to any type of treatment (Baer and Singer, 2007). This notion is best understood when comparing it to our biochemical structure. Just like the substrate can only have a specific enzyme, the pathway through which healing occurs is specific to the individual. An enzyme will not only be blocked if trying to fit into the wrong substrate, but even when the proper substrate is introduced to the proper enzyme, there is a specific way in which they fit each other. There is some give on both parts in order for the substrate to lock into the enzyme. Once that event occurs, a pathway of all types of biochemical reactions occur, thereby making the body function in the way it is naturally supposed to function (Campbell, Reece and Mitchell, 1999). It is important to realize that this interaction is vital for life. In fact, it is even responsible for creating life. Without biochemical reactions, our bodies will not work and life will cease. These interactions are extremely powerful and all are attributed to proper energy flow within the body in perfect balance with each other (Campbell, Reece and Mitchell, 1999; Weissman, 2005). Likewise, the holistic approach involves continuous give and take on the part of all individuals involved (healers, patients) as well as the methods used in order to properly address illness and disease conditions.

The second major problem of adhering to a single healing system is the delaying of healing and not achieving complete health. This may be better understood through doctor and patient interaction and the bias that some doctors may have to their own health system. If a doctor only prescribes the typical medications used in biomedicine, their
patient may never get the experience of having alternative ways available to address a problem in their health that drugs cannot help heal. When an individual is hurt, pain killers, are often the first thing that is prescribed. However, once the medication wears off, and the pain persists. The body has now made it known that there is an underlying problem that needs to be addressed by a different modality (Weissman, 2005). This idea lends itself well to the previously mentioned idea that patient specific treatment to specific health needs achieves complete health. Again, without exploring and including other health alternatives like herbal remedies, Ayurvedic methods, prevention programs and healthy diet and exercise to address specific health needs, an ill individual may have shortcomings on their way to wellness or a delay in healing.

Another example of doctor and patient interaction delaying complete health in a single healing system is found in the authority relationship between the doctor and the patient. The authority relationship typically reflected in the practice of not questioning the doctor can have serious effects on the psyche of an individual (Baer and Singer, 2007). Doctors are usually seen as the authority on the causes of illness or disease, while the patient is typically socialized into not questioning them. If a doctor does not expose his or her patient to alternative health systems, that individual may only receive advice from the doctor’s perspective. This is problematic because an alternative health system may be more beneficial to the patient. To solve this problem, new types of medical care practitioners and careers should be developed.

The recent attention placed on physicians having knowledge of different cultures possibly having a positive direct effect on health also highlights the need for more
individuals in the medical field with linguistic and cultural competencies (Baer and Singer, 2007; Smedley, et al., 2003). In other words, recognizing the need for medical anthropologists and traditional healers working in hospitals signifies a move in a positive direction. Also there is a need for doctors trained in western biomedicine to practice in areas populated and run by indigenous people where traditional spiritual methods are typically used. This step also lightens the burden of responsibility and distributes it to everyone so that all involved may recognize each other as legitimate sources of restoring and maintaining complete health.

The last major problem with adhering to a single healing system applies particularly to the western biomedical system. This problem can be defined as the increasing risk of medical intervention (Fam Pract Manag. 2000 May;7(5):59-60). This happens when a patient is exposed to an initial treatment to help the patient deal with the stress of the illness. But, at the same time that initial treatment has risks of its own along with the chance of that patient needing more treatment to offset any type of negative feedback the body gives as a reaction to the initial treatment. For example, this is very common for women in labor (Eberhard and Geissbühler, 2000). Traditionally, a woman is more comfortable and more effective in giving birth in the squatting position or water birth where gravity or weightlessness takes a lot of the birthing load off of the mother (Eberhard and Geissbühler, 2000). In the United States, most births occur in a hospital bed with the mother lying down and she has to give birth to the newborn via pelvic contractions and force. As a result of this position, childbirth can be more painful which is why some women opt for an epidural anesthesia to ease the pain. In essence, childbirth could be prolonged because of this intervention. Essentially the woman may have a loss
of sensation or loss of pain via loss of transmission signals through nerves within the spinal cord (Eberhard and Geissbühler, 2000; Campbell, Reece and Mitchell, 1999).

The concept of complete health is also inherently linked to the idea that cultural competency has to be discussed in the medical field. Baer and Singer state, “Healing requires a legitimated, credible, and culturally appropriate system” (Baer and Singer, 2007). This statement means that without knowledge of a patient’s cultural background, the system in which the person is treated loses the potential for effectiveness. The healing system of an individual should be as specific as the individual. Some health care systems should and are already subscribing to this idea. In Unequal Treatment, the practice of Evidence Based Treatment (EBT) is mentioned as a primary way of ensuring that patients receive the care which they need in order to fully heal (Smedley, et al., 2003). In EBT, doctors and clinicians are made aware of cultural and medical practices in communities where there is a high concentration of a particular ethnic group, race or nationality. By using EBT, a trusting relationship between the doctor and patient can be established and which may create a possibility for a better health outcome. EBT is a great start. It is also effective in improving health care systems. This type of cultural competency program can also be modified to fit any type of culture or ethnicity or race because it is based on the notion that care is administered on the foundation of knowing the individual’s holistic needs. The patient is taken care of mentally, physically and spiritually. The ideal outcome of this type of approach would increase the probability of the patient having little confusion, ill feelings, or worries about their condition (Singer and Baer, 2007; Smedley, et al., 2003).
According to cultural anthropologist Pamela Erickson, Ethnomedicine discusses the general principles that are the groundwork for all medical systems, theories on disease causation, the relationship between geographic location and disease, the idea of holistic medicine, and the question of why western biomedicine has gained superiority in the medical community. She also breaks down regionally the traditional medical techniques used worldwide. Ethnomedicine takes a textbook approach to discussing traditional medicine and biomedicine, concluding that a balance between the two would better serve patients worldwide (Erickson, 2008). Furthermore, excellent health is not just about medicine and getting rid of pain, instead it is about taking care of a human being physically, mentally and emotionally. Erickson states, “just as we can have disease without illness, and illness without disease, we can have curing without healing and healing without curing” (Erickson, 2008). Obviously, Erickson proposes a multidimensional approach to studying health. Once the dimensions of health are determined, ways of improving the community can begin.

Describing health in holistic terms (Baer and Singer, 2007) allows society to carefully examine not only the obvious reasons for why certain situations occur in healthcare, but also opens up the door to look at seemingly unconventional reasons affecting healthcare. Erickson touches on that notion, but she fails to explore it in greater especially where she discussed “What Causes Disease?” (Erickson, 2008). While reviewing Erickson’s work, I would constantly ask the question, “how does this relate to health disparities?” This is where the book, lacks in social relevancy. Erickson does a great job of explaining how health must be seen as multidimensional by using examples from other cultures worldwide, but the only way to make that knowledge useful is to
translate it into social awareness and practice. How can acknowledging that there are social, political and economic causes for disparities and disease ultimately improve the health of a society? Perhaps Erickson did not mention this topic in detail for fear of falling into an ecological fallacy, or perhaps she purposefully did not further discuss this topic so that the reader would draw their own inferences about those particular causes.

Clearly, Ethnomedicine focuses on other medical techniques besides biomedicine as a way to help, cure or heal patients. In the chapter, *The Geography of Disease Causation*, Erickson systematically lists cultures, giving a little historical background, and discussing each culture’s own medical techniques. One important aspect of looking at disease causation geographically is culture-bound syndromes. Define culture-bound syndrome here. Therefore, Erickson’s major concern is that traditional medicine and western biomedicine should complement one another. She is obviously also interested in simultaneously discussing pathways to further interface the two brands of medicine as well as further exploration of the topic.

Michael R. Zimmerman’s article “Paleopathology and the Study of Ancient Remains” discusses the main purpose of paleopathology while providing examples of how ancient diseases affected past civilizations. The article emphasizes the idea that uncovering ancient diseases can actually be a window to the general health status of a population. We not only are able to find out what actually killed this person, but how that particular person lived, and what other factors of their culture were influenced by this infectious disease. This holds great importance because it marks the point when we stop looking at a person from a past culture as an artifact, or an ailment, but actually as a real
person who experienced the pain and sufferings of infectious diseases just as people do today. The main findings in this article discuss the general meaning of congenital defects, traumatic injury, infectious diseases, metabolic and nutritional disorders, degenerative diseases, circulatory abnormalities, cancer, and dental paleopathology while also giving clear examples of each type. The article makes it possible to understand the links between the diseases that people suffered and such variables as diet and lifestyle. To me, they were not just unfortunate. The people studied were responding to the environment in which lived. If certain foods are not available, then the benefits that the particular foods offer are not received. The contribution this article brings to the medical anthropology community is that health is determined by the environment in which individuals live and that environment may affect food access as well as a variety of social, political, and economic issues. When first reading this article, one may think that it is mainly about scientific evidence of ancient diseases, but after looking at it again, the article holds other implications about health and disease across different civilizations. One interesting point Zimmerman brought up in his article is the fact that patients today actually show signs of symptoms, whereas ancient remains only show the final manifestation of a disease (Zimmerman, 2004). Information like symptoms is crucial in diagnosing any disease. This is a great example of how studying ancient remains can influence the way we study disease today.

Despite the great amount of valuable information in this article, two shortcomings made it a little difficult to understand. The first is the scientific terminology. I understand that when discussing diseases, having a scientific background is a must, but a little more clarification with the terms would have made the read a little more understandable. The
second shortcoming ties into the first shortcoming whereby without providing an easily readable text, the general public may not be able to fully grasp the depth to which the article extends. Overall, it was well written. Given the fact that the subject matter at first glance may not be socially relevant, the article still provides insight into all cultures. Zimmerman’s final statement that “paleopathology adds a critical dimension to our study of human history and evolution in relation to the environment” explains the actual importance of paleopathology not in just scientific terms, but also in how we as humans study each other and how we respond to our surroundings throughout the course of history.

In conclusion, the complementary structure of a healing system that combines both western biomedicine and traditional healing may be the way in which complete health is achieved. Cultural traditions are unquestionably included in indigenous healing practices, while the recognition of cultural traditions is somewhat lacking in western medicine. Given available evidence, it makes sense that the combination of western medicine and traditional healing would create a realistic and effective way for individuals to heal properly. If we apply the concept of personalized medicine and patient specific treatment to healing systems, a better understanding of how to go about administering correct healing techniques is likely to be reached. This is why it is necessary to know that not one healing system or modality to all patients with common illness or symptoms can be applied. Once an individual understands that combining and becoming sensitive to cultural influences and the imperative role it plays in our health, that individual is better equipped to help themself as well as others in maintaining and restoring complete health.
Chapter 2: Culture, Linguistics and Health: Analysis of Linguistic Data in Capoeira Angola Songs

The use of language as a tool to express camaraderie and positive energy can be associated with creating therapeutic healing to the individuals involved in using the language. The practice of the Afro-Brasilian martial art of Capoeira demonstrates this notion well. This chapter will discuss the important role of Brasilian capoeira songs in the game of capoeira as well as in holistic traditional healing. The two songs, Paranáué (named after the region of Brasil Paranáué) and Eu Ja Vivo Enjoado (I Am Already Bored) are examples of how the language in capoeira songs speak to the type of movement done in the roda, (the circle of people in which the two jogadors or players of the game play), and also the soul of a person. Matthias Rohrig Assunção states, “Yet capoeira is much more than music and dance: it is a holistic art that develops creativity and theatricality and offers its own path towards spirituality” (Assunção, 2005). Through oral tradition, the elements of brotherhood and sisterhood are also raised through the emphasis of black consciousness, which contribute to the notion of camaraderie between jogadors. This is all done through language. In other words, capoeira lyrics are used to not only to direct movement, but also to bring forth energy. The usage of metaphors, speaking roles, particularly in the use of call and response during the game all contribute to what is called Axé, which is energy. The proper practice of capoeira is supposed to
bring about good Axé and good Axé brings positive energy to one’s body. This may result in therapeutic qualities attributed to the jogadors of the game.

It is important to first mention that I have been a Capoerista (student of the martial art/religion/dance/game of capoeira) since 2006 and have also practiced capoeira in the city of Sao Luis in the state of Maranhão in Brasil. The experiences I have had involving capoeira has revealed to me the important role that language plays in the creation of good energy in the arena of wellness. This chapter begins with the definition of Axé and how it applies to the martial art of capoeira. Next, a brief presentation of historical background of the martial art will be mentioned because the context in which the game is played is grounded in its historical tradition. Because language is heavily involved in creating good Axé, and good Axé is linked to wellness, this chapter will then focus on how the use of language can be a significant factor in attaining good health. Catimbó the Northern Brasilian magical practice of healing is also associated with the practice of capoeira. In the discussion of the relationship between healing and language, the importance of metaphor usage and the power that specific speaking roles contain in the two capoeira songs, Paranáué and Eu Ja Vivo Enjoado will be mentioned. The discussion will be followed by the conclusion of how in capoeira, the use of different factors of language has the ability to create the energy of camaraderie, brotherhood and sisterhood and wellness, which is called Axé.

Axé can be defined as energy, but it also has other important elements that contribute to its makeup. The word Axé is defined as divine energy and has Yoruba roots associated with all things that are positive (Assunção, 2005). Language contributes
greatly to Axé. Speech is the vehicle by which this energy is transferred. Along with verbal transference of energy, the *bateria*, or orchestra for capoeira holds great importance to creating Axé, and the instruments are considered the heartbeat and soul of the bateria. It consists of the berimbau, atabaque, agogô, pandeiro and the reco-reco. Since Axé is a type of energy in Afro-Brasilian religion, it carries the potential to have an effect on the person or people to which it is directed. Axé applied to capoeira creates an energy rich environment of camaraderie, brotherhood and sisterhood, wholeness and wellness. This environment cannot be created without the exchange of dialogue and use of language; hence the importance of language in Axé.

In order to discuss the martial art of Capoeira, background information on the religion of Candomblé is needed. The Bahian Afro-Brasilian religion of Candomblé is evidence of religious syncretism between Angolan culture and the enslaved Africans taken to Brasil. Assunção states that one of the strongest pieces of evidence of African cultural hallmarks expressed by enslaved Africans and even Afro-Brasilians today is the existence of the religion (Assunção, 2005). Scholars emphasize that African values, aesthetics and spirituality are important elements in Bahian culture. Because these elements are based on African culture, in particular, Candomblé proves to be an important cultural aspect of tradition. Despite the inhumane conditions of slavery, enslaved Africans still held close to their, “complex religious system equipped with the four complementary dimensions in languages derived from Yoruba, Fon or Kimbundu” (Assunção, 2005). These dimensions include, the worship of the gods (Orixás), the cult of the ancestors, divination and the most relative dimension to this thesis, healing (Assunção, 2005). Because of the healing quality of Candomblé infused into the practice
of Capoeira, this traditional form of healing can beneficial to an individual’s mental, emotional and physical health. The practice of Candomblé also contains specific representations in the art of Capoeira. This includes the beat of the Atabaque (drum) that is called the heartbeat of the roda. The drum in Candomblé assists in creating a hypnotic rhythm to allow a practitioner of the religion to spiritually connect with an Orixá. The energy flow and retention in the Capoeira roda also resemble formation techniques practiced in Candomblé. The gestures a capoeirista may do, for example, crossing himself or making other hand gestures used in the religion before entering the roda are also derived from Candomblé. Acknowledging the mestre or master before entering the roda is not only necessary, but also adds to the ritualistic importance of the practice of both Capoeira and Candomblé.

The historical background of capoeira is the most important element to why certain words and phrases are used in the creation of good Axé. Elements of religious syncretism in Candomblé such as, Pajelança (shamanism), the Pajé (shaman), Provo de Santo (people of the saints and practitioners of Candomblé) and Orixás all contribute to the mysticism and practice of the game. Assunção notes that there are three “powerful myths that have nourished the practitioner’s hunger for history” (Assunção, 2005). These myths include, the remote origins of capoeira, its invention by maroons in quilombos within northeastern Brasil, and the fighting techniques disguised as dance (Assunção, 2005). While each myth involves certain real aspects of capoeira history, it is important to note that the origins of these myths are due to, as Assunção describes as deliberate ignoring of the lack of evidence, no notice of contradictory evidence, or the deliberate acceptance of contradictory evidence used to conform to pre-conceived ideas (Assunção,
One example of these myths is based on myth number one, the remote origins of capoeira. Even though capoeira was used to boost national Brasilian ideology and pride among the population, Assunção points out that the most radical expression of the remote origins of capoeira is derived from the idea that capoeira was originally hallmark to the African Angolan indigenous population and was virtually “transplanted” and practiced unadulterated in northeast Brasil. Assunção quotes Nardi in his explanation, “It was more than four hundred years ago that the warriors of N’dongo (today known as Angola) faced the invading Portuguese Armies. In a bloody and bitter guerrilla war, the N’dongo warriors fought the Europeans using their native martial art of *kapwera* - the Bantu verb meaning, “to fight” (Assunção, 2005). Capoeira was developed by the enslaved Angolan people that were exploited in the Brasilian slave society. According to oral tradition, it was used as a defense strategy for slaves while on the plantations in the northeast region of Brasil (Wilson, 2001). Police records from the 1800’s reveal that capoeira was also used in gangs as a way to create disorder in the streets of Rio de Janeiro (Wilson, 2001). These disruptions were clear indicators of political and social instability (Wilson, 2001). Wilson mentions that towards the end of the 1800’s, capoeira was practiced by freedmen, lower class men and even by some middle class men in Rio de Janeiro. Because of the growing expansion of the practice, capoeira was seen as a threat to the ruling, white elite class of the Brasilian population and therefore had to be stopped. In 1890 an official decree was made, outlawing the practice of capoeira, but the oral tradition kept the clandestine practice alive in Recife, Salvador, and Rio de Janeiro among street merchants (Wilson, 2001). It was not until 1930 when *Mestre* (master) Bimba (Manoel dos Reis Machado) of Salvador began to develop another faction of capoeira known as Capoeira...
Regional (Wilson, 2001). While Capoeira Regional quickly spread throughout Brasil and even the world, Capoeira Angola (the original style practiced by the enslaved Angolan population of the northeast region of Brasil for example Salvador, Bahia) is still practiced today and both factions of capoeira are kept intact due to the upholding of its oral tradition. Since the history of capoeira is verbally expressed during the game, it also contributes to good Axé. The use of this oral tradition is one example of how the use of language in the description of history can facilitate the creation of an environment of good energy and wellness.

The use of language in oral tradition is integral to preservation of heritage. In that preservation rests the possible secrets to how a certain atmosphere is created for a certain tradition to take place. For wellness to happen in an individual’s body, for example in the practice of capoeira, a certain atmosphere of good Axé has to be created. This is done completely orally with singing, and the music of the *bateria* (the band that at the head of the capoeira roda where the Mestre orchestrates the roda activity). Ahlers (2006) quotes Bourdieu in expounding on the importance that language has within oral tradition, particularity in the case of language being ebbed away due to a dominant language taking over. Ahlers (2006) quotes, “In such cases, the heritage language plays a particularly marked role as a form of cultural capital.” (Bourdieu, 1977, 1991) Without language, it would be extremely difficult for the transmission of good Axé to be diffused throughout the group of participants in the roda. The words and language in oral history carry the components to which good Axé needs to be effective.
The manifestation of good Axé and subsequently wellness brought about by reciting oral tradition and singing in the practice of capoeira is best exhibited in the lyrics of two popular capoeira songs, Paranáué and “Eu Ja Vivo Enjoado.” Both songs mention Deus (God) and the importance of the presence created while singing about Deus. The song “Paranáué” is not only about the Brazilian state Paraná that touches both Argentina and Paraguay and its large river with the same name, but it is also about the commonalities that Brasileiros (Brasilians) have in the capoeira culture. The chorus lyrics, “Paranáué, Paranáué, Paraná” sung over and over again are used throughout other capoeira songs. The version in the song mentioned in this chapter speaks about an individual going back to beautiful Paraná, the natural beauty of a woman and how Deus is the creator of all beauty. These lyrics have the power to create an environment of unity, which contributes also to good Axé. The other song, Eu Ja Vivo Enjoado is about the common feeling of wanting something more in life on earth. Participants sing about using the supernatural power of Deus to create a farm on the moon to escape the realities of living on earth. This song also carries a double meaning in the second half. The singer speaks of not believing what was mentioned prior and that it was just “talk” and that no man can eat without working for it. Again the common sentiments of wanting to escape certain conditions but in reality never being able to creates a bond between participants that can produce good Axé that has the ability to foster healing within one’s body. The unity of relating a common struggle between people has the potential of creating therapeutic qualities.

The importance of the role that the ancestors play in traditional and ritual healing is also expressed when singing capoeira songs. The Axé that the ancestors carry is still
felt among the participants who sing in capoeira rodas today. Paul Stoller discusses how the use of language is important to connecting the past in the present through stories. He states, “In the end it is the texture of the story that marks our contribution to the world, the contour of our stories that etches our traces in the world” (Stoller, 2008). This statement emphasizes the point that storytelling, whether it be through capoeira singing or oral tradition, it holds the capacity to live on through the energy it creates.

The element of charismatic imagination used in language associated with healing is expounded on by Thomas Csordas. Csordas (1997) explains the relationship between language and charisma:

“The Charismatic imagination is put into action in everyday life, in prayer, revelatory gifts, such as prophecy, and in ritual healing. Whether the specific images produced are conventional or original, the cultivation of this capacity is a moment of creativity in the Charismatic world and its use in specific settings constitutes moments of creativity for a sacred self.” (Csordas, 1997)

Here, Csordas states that the use of language has to have a charismatic quality in order to possibly contribute to ritualistic healing. Csordas also states that the, “force of ritual utterances diffuses “inward” as one makes the “decision” that is constitutes the divine word and experientially incorporates its meaning.” (Csordas, 1997) This may mean that when ritual sayings are uttered, the process of healing may begin within the initial speaker. This idea is best demonstrated in the call and response characteristic in the singing of capoeira songs in the roda. The Mestre sings the verse of a song and the other participants reply in the chorus. A conversational act happens where energy is transferred from person to person. Through the language used in the songs, the energy created can move freely about the environment. When the language of words associated with the
supernatural and healing are used, that same type of energy is created and is free to move about the environment, possibly into individuals in the same environment. The occurrence of good Axé moving freely about in an environment may lead to altered states of consciousness depending on the individual, their purpose and the situation.

In shamanistic healing, the words, tone, pitch and rhythm in which these words are spoken all produce the environment for energy to be created. With the high concentration of energy, it is possible for an individual to actually have an altered mental state of consciousness. (Sidky, 2009) explores this concept in shamanic healing in Nepal. Although shamanic healing in Nepal may differ significantly from shamanic practices in capoeira in Brasil, there is the common link of a transcendence of the mind through Axé. The shamans in Nepal use this transcendence to become a vessel through which supernatural powers can flow in order to allow healing to occur. Just as illness or disease may appear in an individual’s mind, body and spirit, therapeutic changes must take place in the same areas (Sidky, 2009). In order for shamans in Nepal to become effective in healing, Sidky notes that a shaman must be a state of ecstasy or trance. This is achieved by singing or reciting oral rituals. Here, language again plays an important role in the creation of positive spiritual energy. It is important to understand that spirituality contains the potential and the power to alter health outcomes because belief in the supernatural has been used as a driving force in the world for healing in almost every form of indigenous medicinal practice. In other words, it is imperative to know that when spirituality is applied to a believing patient, their chances of achieving complete health in mind, body and spirit may increase.
By creating the environment of camaraderie, brotherhood and sisterhood through singing, and instrument playing, Axé can be diffused through the group of people. Healing takes place when that energy is internalized by the individual. This is how language contributes to healing; the words we say carry positive and negative energy depending on the word, and if words of love, camaraderie and respect are continually recited, positive energy will flow creating an environment of healing, especially emotionally.
Chapter 3: The Impact of Western Medicine: Pharmaceutical Medicine In the AIDS

“Industry”

The socio-cultural aspects of HIV/AIDS entail many different facets. From the many stigmas one has to experience while having the illness, to the political battles that have to be fought in order to get treatment, to the fight to have good health as a human right, HIV/AIDS touches on all arenas politically, socially and economically. By having a mixed approach to treatment for example, making culture and the life of an individual more important that profits and asking about the individual’s life struggles with chronic diseases, patients need to feel as if treatment is penetrating through all aspects of their life mentally, emotionally, and physically. HIV/AIDS in particular, is presumed as a death sentence in some areas because the availability of medical attention is scarce or impossible to receive. A mixed approach to healing will allow patients to receive the help that they need emotionally and physically. To overlook the importance of the mental and emotional status of a sick individual would be detrimental to their health. This is why a multi focal approach to health is necessary. This chapter will discuss in particular, the economic aspect of the HIV/AIDS pandemic. Pharmaceutical companies have seen this pandemic as an opportunity to profit at the expense of others, in the name of capitalism. Anti-retroviral treatments are only offered at unrealistic price rates and obviously cannot be mass distributed within a country, particularly in Sub-Saharan Africa, without government assistance. Issues of personal political interest intersecting with availability
of resources create the perfect breeding ground for HIV/AIDS to spread. As a result, other countries such as Brasil and India have created and exported generic drugs for treatment. Problems occur when U.S. pharmaceutical companies hold patents on drugs for about 20 years; thereby making the company the sole creator of the drug, drug pricing and distribution. This clearly forms a monopoly, where the poor suffer. Bob Huff, editor of *Gay Men’s Health Crisis: Treatment Issues* makes a statement about this problem in his article, *Paying for Life: The Issues Behind Drug Pricing*. Huff States, “Drug pricing, critics say, is driven by greed and by the monopoly protection allowed by patents. The true cost of high drug prices, they say, is measured in lives lost” (Huff, 2003). This statement gives the real impact pharmaceutical companies make on human life.

This chapter will begin with a discussion of the three most common pharmaceutical companies in the U.S. and their impact on world health concerning HIV/AIDS treatment. Next, a discussion on what exactly Brasil and India are doing to circumvent big companies that hold the patents to antiretroviral medicines will be made. Then, the question of how can research and development thrive while keeping costs down will be addressed along with the topic of intellectual property rights and how long patents should be valued. Next, issues of drug production in Brasil and India and how it affects the health of HIV/AIDS patients will be discussed. It is also important to note that writers such as Susan Hunter, Helen Epstein, Stephanie Nolen and Paul Farmer have all contributed to the broadening of perspectives when addressing ethical and economic aspects of the HIV/AIDS pandemic. This portion of the chapter is most important because it reveals the true impact greed and capitalism uncontrolled has on populations worldwide. These writers force their readers to feel for the people who otherwise have
been far removed from the general public in the United States. We must all understand that we are all affected either directly or indirectly because of this issue. This chapter will conclude with possible solutions to at least lighten the burden of the HIV/AIDS problem and possible ways to implement them.

The top three leaders in pharmaceutical sales; Pfizer, GlaxoSmithKline and Novartis all exceeded the annual $USD 35,000,000 mark in 2008 (IMS Health, 2008). Figure: 3.1 reveals how much money is made in sales annually in the top 15 pharmaceutical industries worldwide. It is also important to mention that the top two companies; Pfizer and GlaxoSmithKline merged in April of 2009 to create a larger company and just prior to that merger in April, Pfizer bought pharmaceutical company Wyeth in January of 2009 for $USD 68 Billion (www.nytimes.com). Obviously, the mergers Pfizer created are slowly monopolizing the Anti-retroviral treatment market. This is only one case in particular where personal profit has been feeding the giant Pfizer.

<table>
<thead>
<tr>
<th>The Top Leaders in Pharmaceutical Sales 2008</th>
<th>Sales (Millions USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott (US)</td>
<td>19,466</td>
</tr>
<tr>
<td>Amgen (US)</td>
<td>15,794</td>
</tr>
<tr>
<td>AstraZeneca (UK/ Sweeden)</td>
<td>32,516</td>
</tr>
<tr>
<td>Bayer (Germany)</td>
<td>15,660</td>
</tr>
<tr>
<td>Eli Lilly and Co. (US)</td>
<td>19,140</td>
</tr>
<tr>
<td>GlaxoSmithKline (UK)</td>
<td>36,506</td>
</tr>
<tr>
<td>Hoffman-LaRoche (Switzerland)</td>
<td>30,336</td>
</tr>
<tr>
<td>Johnson and Johnson (US)</td>
<td>29,425</td>
</tr>
<tr>
<td>Merk &amp; Co. (US)</td>
<td>26,191</td>
</tr>
<tr>
<td>Novartis (Switzerland)</td>
<td>36,506</td>
</tr>
<tr>
<td>Pfizer (US)</td>
<td>43,363</td>
</tr>
<tr>
<td>Sanofi-Aventis (France)</td>
<td>35,642</td>
</tr>
<tr>
<td>Takeda (Japan)</td>
<td>13,819</td>
</tr>
<tr>
<td>Teva (Israel)</td>
<td>15,274</td>
</tr>
<tr>
<td>Wyeth (US)</td>
<td>15,682</td>
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Figure: 3.1: The Top Leaders in Pharmaceutical Sales 2008. (Source: IMS Health 2008).
The countries of Brasil and India are attempting to provide proper health care to HIV/AIDS patients via creating generic antiretroviral medications and distributing these medications with little or no cost. Immediately, one question that may arise would be how these two countries are strategically obtaining patents to these medications fairly and legally without conflicting with big medication companies regulations. Dr. Yusuf Hamied the son of the founder of India’s CIPLA (Chemical, Industrial and Pharmaceutical Laboratories) found a way to answer this question. In an interview with Dan Rather, Dr. Yusuf Hamied states, “What is the point of developing new and lifesaving drugs if they are not accessible to the common man worldwide at affordable and reasonable prices?” (Dan Rather Reports, Episode 240 Transcript). The price of combination drugs given to an individual to treat HIV in 2001 was approximately $10,000 to $15,000 USD per person per year. In February 2001 CIPLA reduced the price of antiretroviral medications by 97% to significantly below $1.00 USD per person per day or approximately $100.00 USD per person per year (Dan Rather Reports, Episode 240 Transcript). Although a very complex issue, it is obvious that large pharmaceutical companies are making obscene amounts of profit on antiretroviral medications. In 1972, India’s parliament allowed pharmaceutical companies to copy products as long as the engineering process differed slightly (Dan Rather Reports, Episode 240 Transcript). As a result, big international pharmaceutical companies withdrew from the country, leaving an open market for Indian pharmaceutical companies to manufacture drugs free of patents and distribute worldwide cheaply, thereby expanding their market.

In order to create the success that the company CIPLA has today, a foundation created by Dr. Hamied’s father, Dr. Khwaja Abdul Hamied was needed. He geared his
education goals towards chemistry and technology of Barium compounds research. He later received his Doctorate degree in 1927. Dr. Khwaja Abdul Hamied dedicated his studies to helping the people of India. The strong nationalistic pride for his country and recognition of appreciation of the diverse cultures of India allowed Dr. Khwaja Abdul Hamied to properly care for his country’s people. By having a cultural element added to healthcare research, a more personal approach was made to facilitating the process of creating a feasible solution to the problem of access to proper medications. In 1935, Dr. Khwaja Abdul Hamied then created CIPLA. To keep production going and costs down, he gave the company all his patent and proprietary formulas for several drugs and medicines, without charging any royalty. He then registered his company as a public, limited company and opened in 1937. In 1942, Dr. Khwaja Abdul Hamied’s model for creating the research institute was accepted by the government, which in turn created the Council of Scientific and Industrial Research (CSIR). CIPLA focused on producing basic chemicals required for all pharmaceuticals and selling to other companies. This is another way to generate funds without raising product costs because the research and development is largely completed. Following the model of Dr. Khwaja Abdul Hamied, but customizing the model to the U.S., one would suggest that by creating B.S. degree programs at universities, partial funding for HIV/AIDS research could be generated via government scholarships in exchange for academic excellence in high school. After completing degree programs critical to HIV/AIDS research and development, the government should fund small pharmaceutical company projects with goals of addressing the health on an individual holistically. The key to this model is starting out small. With small business, costs remain relatively small allowing product cost to remain low,
resulting in more access to medication for more people. By removing patents the market has potential to expand to international markets where medications are needed more and increase revenue that can go back into research and development. If India and Brasil can facilitate similar processes to provide proper access to antiretrovirals, why can’t the U.S. do the same? The Brasilian AIDS program believes that the population does not need to pay anything for medications. This is backed by their legislation that states that the government must treat the population rich or poor. Farmanguinos, a Brasilian public pharmaceutical laboratory, received a request from the Brasilian ministry to facilitate production of generic drugs in order to uphold its legislative obligations to the citizens of the country. If these obligations are not upheld, the legislation faces prosecution A company with a patented drug in Brasil can either submit a voluntary license for other companies to produce the drug under specific terms and conditions or submit a compulsory (court ordered) license for the production of their drug. In an interview, Dr. Herman Reuter from Doctors without Borders Khayelitsha states that, “We believe that we have to put the health of our patients above the rights of companies to make unjust profits.” (Beat It! 2002 Ep.8 - Special Report - Generic ARVs – Brasil) Eloan dos Santos head of Farmanguinos stated that the workers of Farmanguinos are paid by the production of Farmanguinos. Out of all of the research conducted, all sources indicate that the price for antiretroviral drugs are at best unreasonably higher than the cost of research, development, so the argument of how will the cost of research and development is afforded is outdated and irrelevant. The life of an individual should not be held to patent rights. Monopolies on medications in high demand are seen as a lucrative business opportunity and are not contributing to better health care.
Epstein reveals in her book, The Invisible Cure: Africa, the West and the Fight Against AIDS, that western pharmaceutical companies do in fact sell about twenty antiretroviral medications that extend healthy years to HIV-positive patients, but in 2000, the patents of these medications secured the rise in cost to an annual amount of about $USD 10,000 per person (Epstein, 2007). Because these drugs are patented, the availability of these drugs depends on the distribution practices of the companies. A cornered market on antiretroviral medication is seen as a great opportunity to capitalize upon. Here, health is commoditized and withheld from the masses strictly for profitable reasons.

Epstein also mentions the effects of no access to antiretroviral treatments for pregnant, HIV-positive mothers. Epstein states:

“…researchers had found that a cheap, short course of some of these drugs, such as AZT or nevirapine, taken for a few weeks around the time of childbirth, could reduce by half the chances that an HIV-positive mother would transmit the virus to her baby.” (Epstein, 2007)

In these cases, the use of the cheaper antiretroviral medications would substantially reduce the number of HIV transmission, but the cost even for these cheap drugs was too expensive in 1998 for South Africa. The Minister of Health in South Africa at the time, Nkosazana Zuma, decided that the purchase of these cheap antiretroviral medications was basically a waste of funds and the money could be better used elsewhere. Epstein argues that it would be even more expensive to actually treat HIV-positive children than it would be to prevent the transmission before birth through antiretroviral medications given to the pregnant mother (Epstein, 2007). Clearly, different
opinions and politics about medications and government policies steered the decision to withhold treatment to HIV-positive people.

At this time, South Africa was also dealing with opposing opinions about antiretroviral medications and the true effects of taking the medications. Mbeki and his staff were heavily influenced by information that emphasized the drawbacks to antiretroviral treatments rather than focusing on the good aspects of these treatments. While it is true that antiretroviral medications have a history of actually making people feel sick, I would not go as far to say that they are toxic to the person. Generally speaking, if something is toxic, it means that it is poisonous and will eventually kill an individual. This is simply not the case for these medications. Although strong, they did improve the health of individuals living with HIV/AIDS and the government should be able to have enough good judgment for its citizens to see that they actually help the individual.

Epstein also mentions in her book more about the backlash of antiretroviral medications in South Africa. It seems as though propaganda about the sick feelings associated with the treatments were known publicly and the general consensus about the treatments was that it was a conspiracy to exploit blacks in South Africa (Epstein, 2007). This general feeling got stronger after Parks Mankahlana, Mbeki’s spokesperson died of AIDS in 2000. The following passage describes the sentiments felt by black South Africans towards these treatments, but most importantly, the corporate executives that were responsible for the exploitative practices.
Epstein quotes Mankahlana before his death in his published article in the newspaper, *Business Day*:

“Like the marauders of the military industrial complex who propagated fear to increase their profits, the profit-takers who are benefitting from the scourge of HIV/AIDS will disappear to the affluent beaches of the world to enjoy wealth accumulated from a humankind ravaged by a dreaded disease...Sure, the shareholders of GlaxoWellcome [the company that makes AZT] will rejoice to hear that the SA government has decided to supply AZT to pregnant women who are HIV-positive. The source of their joy will not be concern for those people’s health, but about profits and shareholder value.”(Epstein, 2007)

This quote reveals the unethical side of the pharmaceutical industries because regardless of whether or not the profits come from the South African government or private individuals who are HIV-positive, a profit is still made through exploitation. These companies know exactly how much money it costs to create and produce the antiretroviral treatments, but because the need is so great, anyone who wants to be healthy will have to pay the price. For the black South African population with HIV/AIDS it is a losing situation all around. If an individual has no money and the government provides the drugs for him, there is no guarantee that the medication will be available for extended periods of time because access to drugs depends on government willingness. On the other hand, if an HIV-positive individual can afford his own treatment, he still gets the sickening effects of the medication along with the knowledge that the government has the means to provide the medications needed to prolong his life. These are just a few complicated issues that come up when the topic of antiretroviral medications gets caught in the crosshairs of global political economy.
The following figures give deeper perspective into how severe the lack of access to affordable antiretroviral medications actually is. In some areas, the only medication available is the kind in which an individual signs up to be a test subject for the trial run of a drug. Sadly, this form of treatment is also given to children with poor parents who cannot afford the real medication. Drug companies should be held accountable for this type of inhumane activity. If it is illegal within the United States, then why should the accountability be any different in another country? Figure: 3.2 reveals the estimated number of people covered among those in need of antiretroviral treatment, as November 2003. Figure: 3.3 explains the relationship between the doubling in AIDS cases in Sun-Saharan Africa and the rise in sales of antiretroviral treatments for GlaxoWellcome.

After reviewing the pharmaceutical practices of Pfizer, GlaxoWellcome and formally GlaxoSmithKline, and Wyeth, it is no surprise that other countries have chosen to generate their own antiretroviral treatments in order to meet the needs of the people of their own country while boosting their own economies. The two cases that will be explored are Brasil and India. Both countries are reasonably competitive with Pfizer in producing generic drugs for HIV/AIDS patients.

Brasil has subscribed to the idea that intense government involvement, generic production of antiretroviral drugs in country, combined with a health care system that allows for available access to treatment for the country’s citizens is the best method for combating the pandemic. Teixeira, Vitoria and Barcarolo discusses in depth Brasil’s success. Their article, Antiretroviral Treatment in Resource-Poor Settings: The Brasilian Experience explains this notion:

“…early governmental response, a strong and effective participation of the civil society, a multisectoral mobilization, a balanced prevention and treatment approach and the advocacy of human rights in all strategies, particularly with the policy of wide access to antiretroviral drugs. This policy made highly active anti-
retroviral therapy (HAART) universally available since 1996, with logistic and criteria distribution based on regularly updated national guidelines. Approximately 140,000 patients now receive antiretroviral (ARV) treatment through the public health system.” (AIDS: June 2004 - Volume 18 - Issue – pp. S5-S7)

Clearly, Brasil has created a health structure that is not subject to big pharmaceutical industry control. Along with this model, India, Mumbai in particular has also attempted to seize the monopoly of antiretroviral treatments on the global market. The Indian government has worked with its citizens as well to ensure that affordable and effective antiretroviral treatment is accessible to everyone. The best example of this idea in action is the creation of CIPLA, India’s generic antiretroviral medication pharmaceutical company. Again, the creation of this company reflects the true interest the government has in its own people, their health and their well-being.

In conclusion, with all of the many different socio-cultural aspects of HIV/AIDS forming the way by which we face this pandemic, we as human beings should always be striving to better this problem the best way possible without succumbing to the practices of greed used in unregulated capitalistic practices because it always costs, rather it be direct or indirect, and it is usually at the expense of human life. By focusing on the mental physical and emotional health of individuals diagnosed with HIV/AIDS, physicians can have a better chance of giving proper and adequate care to patients. The mixed approach method to health can ensure that individuals living with HIV/AIDS have a voice that is being listened to. In other words, when using a mixed approach, one is acknowledging that patients have more than just a physical, static, biochemical ailment. It does not make sense to acknowledge a physical health issue as severe as HIV/AIDS and
not discuss with the individual and his or her family on helpful ways to cope with having the disease or financing treatment. As people who care for the health of others, it is our duty to get to the bottom of why treatment is so costly even when it does not have to be. It is extremely difficult to be diagnosed with HIV/AIDS, but one can only imagine how frustrating it may be to finance the treatment in a capitalistically driven health industry.
Chapter 4 Environmental Insults and Low Birth Weight

Infant mortality rates serve as an important indicator for how progressive a society actually is. (LaVeist, 2002) This is significant information because when a nation as powerful as the United States has the same infant mortality rate as that of some underdeveloped countries, it is clearly indicates that there is something severely wrong going on the United States concerning women with low birth weight babies. To add to the problem, it is not an issue of all women in the United States, it is an issue plaguing African-American women in particular. This is what makes this issue so puzzling. It raises so many important questions concerning race, food availability, genetics, diet, stress and other important environmental factors. As stated in earlier chapters, a mixed approach to health, including addressing an individually mentally, emotionally and physically can better help physicians understand not only the health issue of an individual, but also some background of other issues that if treated, could improve the health of that patient. This is the reason why this health issue must be addressed holistically. For example, because pre-natal care is the best way to prevent pre-mature births, the financial resources needed to receive the care are just as important as the care itself. The cost of running a clinic may outweigh the services it provides for a particular community and the result is fewer people having proper access to proper pre-natal care. This is called “stratified reproduction.” This is when social economic status separates one individual’s ability to carry out a pregnancy with no or few economic hardships from
another. It is important to note that this issue is even more severe among women who are trying to get pregnant also. The cost of treatment such as in vitro fertilization can be quite high and out of reach for the average person. In this chapter, issues of low birth weight in African born women, Brasiilian women and finally African-American women will be addressed. Then a comparison between the three will be made followed by a discussion on all of the factors that may attribute to low birth weight among African American women. It is very important to understand this issue because the cause of it seems preventable. The study of low birth weight statistics worldwide reveal social interactions, race relations and susceptibility that cannot be observed when studying one country alone.

In order to discuss low birth weight and all of its implications, we need to define a few terms. First, the term, “very low birth weight,” is used to describe babies, who are born weighing less than 1500 grams (3 pounds, 4 ounces). (www.lpch.org/DiseaseHealthInfo/HealthLibrary) The next term, “low birth weight,” is used to describe babies, who are born weighing between 2500 and 1500 grams (5 pounds, 8 ounces). (LaVeist, 2002) A “healthy birth weight” is a term used to describe babies who are born weighing 2500+ grams. (www.aspe.hhs.gov) Finally, “infant mortality” is the number of babies out of every 1,000 born alive, who die before their first birthday. (www.dictionary.com) It is important to understand these terms clearly because when statistics are given, they can be misleading if the proper term is misused or misunderstood.
Low birth weight is an issue that crosses all cultural lines, but the distribution is not equal worldwide. Statistics of low birth weight babies in Africa are difficult to locate reason being that many births as well as deaths happen unreported. Some areas such as South Africa’s provinces have well documented reports of birth weight statistics.

(See Figure: 4.1) It is very interesting to find that the overall average of low birth weight rates for babies born in South Africa is 8.3%. (a country in which whites are a small minority). The real significance in these findings is that United States born black women have a low birth weight rate of 13.2%, which is much higher than the number for South Africa even though black and mixed-colored women, who are part of an ethnic majority, live in a society which is far less developed than the United States. To add to these staggering numbers, African born women who move to the United States and have their babies in the U.S. still have a lower low birth weight rate than their African-born counterparts (LaVeist, 2002). These numbers lead to implications that will be later discussed.

Figure: 4.1 The Proportion of Children with Low Birth Weight in South Africa by Province in 1998

38
Statistics presented in the Figure above lead to the conclusion that the birth weight patterns of infants of African born black women and U.S born white women are more closely related to one another than to the birth weights of infants of U.S born black women. There is something significant about being a pregnant African-American female living in the United States. For instance, the numbers show that U.S. born African-American women in Illinois, a state which has a demographic composition similar to that of the U.S, are almost identical to the numbers for the US born black women as a whole. These numbers show that it does not matter where a person lives, unless the society in which they live is conducive to healthy birth weights, disparities such as these will always exist. (See Figure: 4.2)
Figure: 4.3 Low Birth Weight Rates by Country Development (Source: LaVeist, 2002).

Figure: 4.3 reveals that even though the U.S. state of Illinois is within a “More Developed Country,” the rate at which low birth weights occur for Black women in that state is still closer to that of “Developed countries” and “Least Developed Countries.” The World Health Organization also gives statistics on the low birth weight rate for the Latin American and Caribbean Region. The region as a whole has a low birth weight rate percentage of about 10.0%. Areas of Central and South America have a 10.1% and 9.6% rate respectively. (See Figure: 4.4) It is important to note that even though the low birth weight statistics for the Caribbean somewhat mirror those of African-American U.S. born women (13.2%), it is still close to the low birth weight statistic of less developed countries. (16.5%) Why does U.S. born black women experience such a high level of low birth weight rates? Why is it that these same numbers are reflected in lesser developed countries? Ideally, one would think that the more developed a country is, the lower the rate of low births would occur. In the U.S. and Brasil, this is not the case. For some
reason, the mixing of races in multi-ethnic societies creates a negative atmosphere for minority pregnancies. It could be due to a high disparity gap between social classes where the minorities are always on the bottom, or it could be due to a combination of issues. The important thing to recognize is that one solution will not cover all aspects of this problem.

Figure: 4.4 Low Birth Weight Percent Across the Americas and the Caribbean (Source: www.who.org)

All of these statistics and comparisons reveal that there is no genetic explanation for such a high disproportionate outcome when dealing with low birth weights for U.S. born African-American women. For the final set of statistics, I will explore Brasil’s numbers for low birth weight infants. Brasil is unique in that it best mirrors the United States in statistics and in racial terms. In Brasil there are many types of distinctions for Brasilians. For the purposes of this study, I will only focus on three distinctions. White, Mulatto and Black are three of many race distinctions in Brasil, but since Black
Brasilians and White Brasilians as well as Black Americans and White Americans, best parallel in finding similar cases, these three will be used. Figures: 4.5, 4.6 and 4.7 provide information on pre-term birth rate, low birth weight rate and infant mortality rate for illiterate mothers in Brasil. Each case is a reflection of many factors resulting in this outcome, education in particular, the last case.

Figure: 4.5 Pre-term Birth Rates Among Mulatto, Black and White Ethnic Brasilian Populations in Brasil
(Source: www.who.org)
These figures indicate that there is a relationship between high rates of low birth weight babies from mothers than are non-white and illiterate. It seems as though the more
education an individual receives, the risk of having a low birth weight baby decreases. The opportunity to a proper education in Brasil is not spread equally among different the ethnic groups and as a result, a marginalization of populations occur, making them more susceptible to lower birth weight births.

![Figure: 4.8 Percentage of Mothers Receiving Prenatal Care, 1998](image)

<table>
<thead>
<tr>
<th>National Average and Ethnicity</th>
<th>First Trimester</th>
<th>Early and Adequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>83%</td>
<td>74%</td>
</tr>
<tr>
<td>Native American</td>
<td>69%</td>
<td>57%</td>
</tr>
<tr>
<td>Asian/ Pacific Islander</td>
<td>83%</td>
<td>74%</td>
</tr>
<tr>
<td>Asian</td>
<td>86%</td>
<td>76%</td>
</tr>
<tr>
<td>Native Hawaii/ Pacific Islander</td>
<td>75%</td>
<td>67%</td>
</tr>
<tr>
<td>African/Black American</td>
<td>73%</td>
<td>67%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>88%</td>
<td>76%</td>
</tr>
<tr>
<td>Hispanic/ Latino</td>
<td>74%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Figure: 4.8 Percentage of Mothers Receiving Pre-natal Care, 1998(Source: www.who.org).

Figure: 4.8 reveals the actual amounts of pre-natal care African-American women receive compared to their Caucasian counterparts. This number is crucial because as stated earlier, often and early pre-natal care greatly contributes to a healthy pregnancy.
After reading all of these numbers and statistics, it may be difficult to understand everything in full scope. The reason why these numbers are so important is because they are indicative of the society in which we all live in. Most low birth weight deliveries in developing countries are due intrauterine growth restrictions (IUGR). (Bale et al, 2003). This may be the result of many factors from poor nutrition to low social economic status. Since no single approach to solve low birth weight exists, it is necessary to explore all of the major causes that may be responsible (Committee to Study the Prevention of Low Birth Weight 1985: 5-6).

The first factor of importance in low birth weight disparities is race. Although the term “race” is defined as a social construct, the results of its creation makes it necessary to be analyzed. In the case of Brasil, Brasilians classify themselves into one hundred and twenty-four distinctions, however, the three primary classifications are Black (darker skinned), Mulatto (brown skinned) and White (light skinned). These terms stem from ethnic origin of the individual. Typically, black Brasilians are of African descent, mulatto Brasilians are of mixed Portuguese and African descent and white Brasilians are of Portuguese descent. As seen in the figures, the group that suffers the most in all three aspects of low birth weight is blacks. Immediately the question of why are women in Africa having lower rates of low birth weight babies that their counterparts who live in Brasil? With 11% of blacks in Brasil having low birth weight babies and 13.2% of U.S. born black women having low birth weight babies in the U.S., a direct correlation between the treatment of women living in a multi-racial or multi ethnic society and their pregnancy outcomes can be made. In the poorest community, the risk of low birth weight was almost similar for white and black mothers born in the Caribbean and Africa. On the
other hand, U.S born black mothers living in the lowest income communities had the highest rates of low birth weight babies. A good example of how severe these disparities are in the U.S. is Memphis, TN. With the highest African-American infant mortality rate in the U.S. at 20.3% and the highest African-American population zip codes (38126) it is easy to see how race portrays a role in low birth weight statistics. In the Memphis zip code 38126, other serious statistics contribute to low birth weight frequency. These factors (low graduation rates, low bachelors degree or above rates, low “in labor” force, low median household income, low per capita income, high poverty rates, and high rates of households living below the poverty level) are all Social Determinants of Health (See Table: 4.1).

<table>
<thead>
<tr>
<th>Memphis, TN 38126 Zip Code Case Study Social Determinants of Health</th>
<th>Memphis, TN 38126</th>
<th>U.S. National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons Classified as Disabled</td>
<td>33.80%</td>
<td>19.30%</td>
</tr>
<tr>
<td>High School Graduation Rate</td>
<td>45.10%</td>
<td>80.40%</td>
</tr>
<tr>
<td>Bachelor’s Degree or Beyond</td>
<td>4.50%</td>
<td>24.40%</td>
</tr>
<tr>
<td>In Labor Force (16 yrs. and older)</td>
<td>44.50%</td>
<td>63.90%</td>
</tr>
<tr>
<td>Median Household Income</td>
<td>$10,734</td>
<td>$41,994</td>
</tr>
<tr>
<td>Per Capita Income</td>
<td>$6,291</td>
<td>$21,587</td>
</tr>
<tr>
<td>Individuals Below Poverty Level</td>
<td>60%</td>
<td>12.40%</td>
</tr>
<tr>
<td>Families Below Poverty Level</td>
<td>59.30%</td>
<td>9.20%</td>
</tr>
</tbody>
</table>


Because of all of these contributing factors, low birth weight statistics will remain high until race is recognized as a factor. In order to end race issues, the disparities must disappear first. Then the stratification will shift to social economic status, which is the next factor in low birth weight statistics.
Social Economic Status is defined as, “a proposed model with perceptions of racism, ethnicity, and bio-psychosocial functioning” (LaVeist, 2002). It is clear that a low social economic status can cause low birth weight outcomes. As mentioned earlier, health clinics may not have the funds to sustain proper function in poor areas. When this occurs, the facility usually moves to another area, or shuts down all together. In either scenario, the people who need the help are not being assisted. The best way to prevent low birth weight outcomes is to have proper pre-natal care consistently throughout the pregnancy, as well as follow up examinations to ensure complete health. Having poor social economic status is a breeding ground for other factors to set in that cause low birth weight. With no source of substantial income, an individual worries about where their next meal may come from. An individual who is pregnant has that worry twofold. This brings on stress, which is the next factor of low birth weight pregnancies discussed.

Stress is defined as, “The sum of the biological reactions to any adverse stimulus, physical, mental or emotional, internal or external, that tends to disturb the organisms homeostasis, should these compensating reactions be inadequate or inappropriate, they may lead to disorders” (http://cancerweb.ncl.ac.uk). The key point of this definition states that stress, “may lead to disorders.” African- Americans living in the U.S. have a history of and still are being subjected to environmental insult, racism and social mistreatment. The fact that more African-Americans in the U.S. do not have healthcare than Caucasians is a clear example of this. After reading LaVeist, it is painfully clear that African-Americans receive the worst scenarios in almost all health situations.
Education is the final factor of low birth weight statistics reviewed in this chapter. This factor is very important because with recognition of the lack of education, for certain populations, one can at least start to define the problems that may occur with living in a multi-ethnic society. The identification of these problems can better help us understand perhaps why these pregnancy and low birth weight rates occur. As individuals that makeup a society, everyone must recognize that race plays a major role in pregnancy outcomes, and as uncomfortable as it is to face it, we are better off doing so, that way we can begin progress in solving the problem.

Elisa J. Gordon’s article, *Bioethics: Contemporary Anthropological Approaches* explores how the inclusion of anthropological studies can be used to humanize bioethics. This article makes the important contribution to the medical community in that it focuses on how a better understanding of bioethics can be achieved via looking at cultural perspectives. The article also mentions two specific cases in which looking out for the best interest of the patient is closely linked to cultural perspectives (Davis, 2004). End of life and beginning of life issues are the two cases which Gordon notes have the most moral value culturally (Davis, 2004). The idea that physicians have some discretion as to how much information is provided to the patients and the patients’ families is part of the underlying theme in anthropological approached. Here the physician as an individual with discretionary powers has to decide on whether to be a physician only or a physician and anthropologist. Bio-medicine fails in dealing with cultural issues of death and dying because technological advancements do not adhere to natural processes of entropy and cultural relevancy. These important issues in Gordon’s article really force one to think
about the effects of biomedicine and the recent growth of bioethics and ethnoethics and how they should complement, not conflict with one another.

The most important issue of this article is the idea that decisional authority is not always up to the individual suffering (Gordon, 2004). This is such a thought provoking issue. Who has the right to determine when a life is to end or begin if the individual is incapable of making that decision? This topic highlights the question of if there was a difference between being capable of making a life or death decision or making a life or death decision that complies with the wishes of physicians and family members. Individuals are capable of making these types of decisions, but because they do not comply with general consensus, the individuals who make these decisions are regarded as incapable of doing so. Although not easy to decide, the correct conclusion to this topic is that the answer to this type of situation is as individual as the person it is happening to and the “right” decision is somewhat relative.

Another significant point made in this article is about the historical development of bioethics as a cultural domain of inquiry (Davis, 2004). This point holds so much importance because issues of quality of life and physicians’ authority to know patients’ best interests have to be addressed when discussing bioethics. Examples of the Tuskegee Syphilis Study and World War II prisoner experimentations demonstrate that both physician discretionary authority and patient informed consent authority are necessary in deciding whether, when or how a human life ends. Many other implications arise out of this point made in the article. For example, after gaining knowledge about the mistreatment of blacks in the medical community, one cannot help but have a low level
of trust for physicians, especially white, male physicians. This example in particular could lead to explanations of negative race relations between white physicians and black patients. This article is important because it questions why a society would have to even go through those experiences to realize that the protection of the participant’s rights needed to be stronger. Gordon touches on an issue that is usually never addressed outside the field of social sciences yet needs to be discussed particularly in the fields of medicine and allied health sciences. The article finishes with the future of bioethics and the impact that globalization has on public health. This article demonstrated well how the study of anthropology can better enhance the function of bioethics.

There is evidence to suggest that the youth in the United States, in particular black males in structurally violent inner cities, are being lost in the public school system and are more often than not choosing to take part in behavior that is not only harmful to them, but also fatal (Burrell: 2010). There is growing literature which argues that the topic of structural violence should be addressed in public health policies (LaVeist, 2002). Because an environment set in structural violence is almost impossible to escape, the possibility of positive life outcomes, including health outcomes, is diminished. Additionally, such environment increases the likelihood of psychological and mental stress (LaVeist, 2002). It is important that people have access to resources which enable them to get out of unhealthy mental, physical, and emotional environments because if they do not, the outcomes these environments produce will be passed on to their children. Mentally, structural violence damages the chance of improvement in an individual’s life. Without hope for improvement, an individual has no real reason to strive for a better life. In many cases in the inner cities, young black males see that there is nothing better for
them in life so they succumb to the negative influences in the environment in which they live. In the realm of public health, if an unhealthy mental, physical and emotional environment is never addressed and fixed, the cycle of individuals feeling hopeless about their potential will never change and there will always be a pool of untapped potential in the ghettos and favelas around the world.

What happens to an individual in the healthcare industry when end of life issues arise is another area of scientific research concern (Baer and Singer, 2007). Human compassion and intellectual wit determine the type of treatment an individual receives before dying. However, human compassion and intellectual wit are not to substituted for one another during the care of a dying patient. This cannot work because these two roles are not the same and should be used in a complimentary structure in order to benefit the patient’s health. This substitution only makes the condition worse for the patient. The scenario of being faced with knowing that death is fast approaching and a new type of intense therapy is available is not uncommon to many dying patients. However, sometimes therapy is accompanied by risks and severe side effects. Despite the risks, the patient is often strongly encouraged to go through with the new therapy. Here is where intellectual wit outweighs human compassion by the physicians, especially if the primary motive behind the patient receiving the treatment is to further research. When dealing with human beings, human compassion and intellectual wit should be used jointly.

In order for human compassion and intellectual wit to work together in improving the quality of a patient’s life before they pass away, physicians should not be the only people involved with the heaviest hand in decision making for the patient. If hospitals
incorporated medical anthropologists, traditional or spiritual healers and worked as a team, a patient may improve their health at most, but more importantly improve the quality of life they have left. Too much power concentrated in one entity may distort decision making. This is an important reason for advocating multiple advisor treatment. Health is holistic and so should be the treatment of a patient. With multiple advisor treatment, the patient’s mind, body and emotions are tended to, which may improve the quality of life of an individual no matter how much time he or she may have left to live. The use of multiple health advisors also automatically creates a system of checks and balances between advisors so that no one is overwhelmed with patient issues. The coming together of multiple health advisors allows for the complimentary structure of human compassion and intellectual wit to be effectively used in patient health and end of life issues (Erickson, 2008).

In conclusion, low birth weight remains a greater public health problem in the United States than in most other industrialized nations. It is more common among blacks and it is a major determinant of infant mortality. The role of inheritance and environment in determining birth weight remains unresolved, although recent evidence suggest that genetic influences may not be the overriding determinant. Because genetics is no longer a factor in these outcomes, environment and race relations along with environmental insult, socioeconomic status, education and stress have to be further explored. Low birth weight is a problem that should not exist. In a world where there are regions where this problem is virtually unheard of, there are also regions where it is as serious as an epidemic. The solution to the problem involves a complete structural framework change. This includes change in education, health care, as well as attitudes in a given society. Until this change
or a need to see this change occur, this will be an ongoing issue at the expense of innocent children.
Chapter 5: End of Life Issues

When an individual is faced with the possibility of having to deal with the phrase, “end of life,” concerning their medical condition, many different types of emotions, thoughts, and even worries may run through that individual’s mind. When having to prepare for the end of one’s life, the question of one’s significance in life is always contemplated. The experience of death affects not just the individual dying, but also the people who have come into contact with them. This results in death being a multidimensional occurrence. For example, Dr. John S. Stephenson, Associate Professor in the Department of Sociology at San Diego State University, did a study on death counseling competency from 119 members of the American Association of Marriage and Family Therapists. His statistics revealed that when asked about the amount of emphasis placed in training, 10% of the therapists replied that there is major emphasis on death competence training, 42% stated that there is minor emphasis on death competence training, and finally 48% of therapists stated that there is no emphasis on death competence training in their specific areas of study. (Stephenson, 1981) When asked if satisfied with the amount of death education, 34% of therapists responded, “yes” and 66% responded, “no.” (Stephenson 1981: 460) When asked if they have ever counseled a dying person, 87% of therapists responded, “yes,” while 13% responded, “no.” (Stephenson, 1981) Finally, when asked if they have ever counseled a family which has recently lost a member, an overwhelmingly 97% of therapists responded, “yes,” while
3% responded, “no.” (Stephenson, 1981) These statistics prove that death and end of life issues have a psychological depth that therapists recognize, but need to be more experienced in, in order to better counsel their patients, including family members. In my research, I will discuss two different theoretical orientations concerning end of life issues, along with their weaknesses and strengths. I will explore three different aspects of death. The first is personal reflection by the patient, the second is death in relation to the physician and patient and the third is death in relation to the response of the individual’s family. I will define each aspect, and then discuss how each one affects the individual dying, the people in which they come into contact with upon finding out their circumstance, for example therapists and clinicians, and finally, their loved ones. It is equally important to conclude with contributions made by anthropologists in this field of study. The interaction between the multidimensional aspects of death and how they may complement one another will better help an individual in grasping an understanding of death that transcends sorrow, mourning, fear and grief.

Death is defined as, “the irreversible cessation of all vital functions especially as indicated by permanent stoppage of the heart, respiration, and brain activity: the end of life” (www.medlineplus.gov). For the purposes of this research, I will use this definition. Because death is defined as irreversible, the thought process that leads up to it is very significant. From the time a physician tells a patient that they are approaching the end of their life to actual death, everything in between holds great meaning to that individual’s life.
The first theoretical orientation discussed about end of life issues is from the viewpoint of therapists as well as clinicians. As mentioned earlier, therapists feel a great need to have more training in counseling patients and their families when death is approaching a loved one. Stephenson even states that, “the clergy are much more likely to consider themselves as having received satisfactory training in death and dying when compared to those holding secular degrees” (Stephenson, 1981). With that being said, it is reasonable to explore the reasons why therapists feel that additional training is needed in their field. Death and the experience of dying brings about deep, thought provoking and even philosophical viewpoints for the person going through it. This is why therapists need to feel comfortable and be qualified to handle counseling individuals. Stephenson also brings up the interesting point of society’s need for grief therapy. He mentions that as society is more outspoken about death, the realization of the need increases (Stephenson, 1981). Therapists hold a great responsibility when end of life issues are involved with societal matters.

The strength of this theoretical orientation is that clearly, a psychologist or therapist has extensive knowledge about the human psyche and can better rationalize reasons for certain thought processes and reactions when death is discussed. Death as a role in society can be confidently defined by therapists. The weakness of this orientation is that when applied to an individual’s life the rationale will shift depending on the individual. At that point, the implications of death are relative to the individual. For example, many times people associate death to religion and supernatural ideology, so the therapist is rendered less useful than a clergy member. It can be difficult to draw the line between the need for psychiatric counseling and the need for spiritual or religious
counseling, but the best system, I would argue, would involve both components that work together and fill in the gaps where the other is lacking.

The second theoretical orientation discussed about end of life issues is from the viewpoint of the patient. As stated earlier, the implications of death are relative, depending on the individual. The meaning of an individual’s life can be best described by that individual themselves. A person whose life is approaching its end may have to think about what will happen in the future, for example if they have young children. Perhaps if an individual knows that their time is short, maybe they do not want to go through a painful death of medication, away in a hospital apart from loved ones. Siv Kristin Ostlund from the Department of Anthropology of Western Washington University even states that what if an individual, “wants to die in her home, with her family around her, free from pain in her own time?” (Ostlund, 2000). The patient who is dying may know of their medical fate, but the acceptance of it may also be an issue they have to face. After speaking with loved ones before they died, I have observed that the acceptance of one’s own death is not easy, by any means, but makes the notion of death as a part of life more understandable. When a person is approaching death, the temptation of giving up on one’s own life also presents itself. From personal experience, to hear that a loved one has lost their will to live and ultimately died is a reflection of their own personal view of death. Just because a person has accepted death does not mean that they have to give up on the life they are living at the moment.

Since the theoretical orientation that describes end of life issues is from the viewpoint of the person dying, it is extremely difficult to sum up the strengths and
weaknesses of this framework. Death from this perspective is very delicate and we will 
not fully know this perspective until we are placed in the situation ourselves. Weaknesses 
of this framework are hard, if not impossible to find, strictly because of the subject 
matter. Strengths, on the other hand may be clearer to find. The most insightful notion 
about addressing death from this angle is the idea that after personal reflection, important 
insight may be passed on to future generation. Many times, our most profound ideologies 
come from people who are on their deathbed.

The first aspect of death being explored is personal reflection. Reflection can be 
defined as, “a fixing of the thoughts on something; careful consideration.” (2008. in 
Merriam-Webster Online Dictionary). A personal reflection would be those same 
carefully considered thoughts, on one’s self. Personal reflection can be a window of 
insight into what an individual who is dying may be thinking before they actually pass 
away. Issues of not only the quality of that person’s life are considered, but also the 
quality of their death (Ostlund, 2000).

The personal reflections of a patient can also affect therapist, physicians and other 
clinicians. One oncology nurse interviewed in Ostlund’s article stated, “everybody dies 
someday, oncology patients just have a better idea when.” (Ostlund, 2000) This 
statement reveals that patients who are diagnosed with a terminal illness have to face this 
issue on a daily basis. Personal reflection would give an even more in depth look into life 
of that person and what they are actually experiencing. There is no amount of data that 
can be collected to substitute for the personal reflection of a dying individual. It can also
prove itself useful to clinicians in the future to better understand death in talking with others.

Personal reflection when applied to a patient’s loved ones may be the most complicated interaction of all. Because sentiments are so strongly tied between the patient and their loved ones, personal reflection holds the deepest meaning. This is when strong ties such as memories, feelings and inspiration are expressed to the dying individual’s loved ones. This is particularly important when children are involved. If a child has to deal with the death of a loved one, personal reflection of that loved one may not be clear for many reasons. One of those reasons may be stress. Joseph A. Weber and David G. Fournier, Assistant and Associate Professors of Family Relations and Child Development at Oklahoma State University respectively, reveal this reason in their journal article, “Family Support and a Child’s Adjustment to Death.” (1985) Along with stress, avoidance, and depression, emotional insulation may also be experienced with the loss of a loved one (Weber and Fournier, 1985). It is important, in the child’s case that a support system is intact. “Open communication between parents and children can positively influence a child’s understanding of death and can provide emotional support for all family members” (Weber and Fournier, 1985). A dying person’s personal reflection on their life is an important aspect of the dying process in that it provides insightful and thoughtful realizations and lessons learned by the individual. It is important because these lessons can be passed on to others long after the person has passed away. These personal perspectives contribute positively to the overall process of dealing with death.
The second aspect of death being explored is death in relation to the physician. This term simply describes the physician’s role in working with a patient who has been diagnosed with a terminal illness and is facing end of life issues. This relationship is also a delicate one. “Doctors are not only treating the patients, they are treating the patient’s families as well” (Ostlund, 2000). Because the families of patients do not want to see their loved one suffer, the extent of treatment is also a factor. Ostlund’s article mentions the issue of aggressively pursuing medical treatment. Some nurses observed that the choice of treatment varies, depending on the age of the patient. “Younger patients may want to seek treatment that is more aggressive because they still have much that they want to accomplish.” (Ostlund, 2000). It is also noted that older patients may have an already fulfilled life and may not want to experience harsh medical treatment (Ostlund, 2000). This distinction brings up another point of the physician patient interaction relationship. Since some people may not want to experience medical treatment that may or may not cure the illness, the option for a hospice may be a better choice for the patient verses a hospital. In this case, the patient is treated for the symptoms of the illness, but treatment is not focused on curing the illness (Ostlund, 2000). Susan Macran and Paul Kind from the Centre of Health Economics at the University of York addressed this issue in more detail. “Death is an event that awaits us all- accidental, planned, but inevitable… health care may temporarily prevent or induce that event” (Macran and Kind, 2001). The physician patient relationship created in end of life issue situations determines the tone of all other interactions when death is involved.

When the relationship between the primary physician, other physicians, clinicians and therapists involve death, a more objective approach is assumed. The goal of keeping the
patient healthy is the primary concern. Because health is defined in this paper as holistic, it is necessary to discuss the interaction of not only medical doctors, but also nurses and therapists. Each type health care professional contributes to the overall well-being of the individual. For an example, a patient may be suffering from cancer, but the psychological effects of cancer need to be addressed as well as the physical ones. This is why it is important for health care professionals to have constant and clear communication with one another. Hospitals are now giving special attention to end-of-life or EOL services. “The EOL period is one in which medical and nursing care; psychological, social and spiritual support for the patient and family...can alter the quality of life... but not cure the fundamental underlying disease.” (White et al, 2002).

With this type of medical professional interaction, it is very easy to see that health is an overall issue of wellness. End of life care tends to the person as a whole and is best implemented with multiple health care professionals interacting with each other.

Death, in relation to the physician and family interaction, is another important relationship concerning end of life issues. The family may serve as a support system for the patient, as well as for each other and it is important that they have a good relationship with physicians. Even within the hospice setting, patient’s families have to trust caregivers with the life of their loved ones. Ann Julienne Ross discusses this topic in her article, “Love’s Labor Paid for: The Gift and the Commodity at the Threshold of Death.” She writes, “The focus of the movement (hospice) was palliative and holistic, and the aim was to provide a space in which “acceptance” of death might be reached, and the healing and work necessary for a “good” or “gentler” dying achieved” (Russ, 2005).
statement reveals that regardless of the setting, hospital or hospice, the trust a patient’s family has with the health care professional is involved with the treatment the patient receives. In other words, an exchange is made between the patient’s loved ones and the health care professionals. The loved ones trust the professionals with the life of their family member and the health care professionals are supposed to take care of that person in the best way they can. A great deal of trust is required in this scenario because loved ones cannot always be around the patient at all times. This is another reason why a healthy relationship between the patients’ loved ones and the professionals is necessary. Without a stable and healthy interaction between family and physician, good communication can be lost. It is important that during this particular time that the family feels that the clinicians are very supportive.

The final aspect of death being explored is in relation to the family of the patient. As discussed earlier, the patient’s loved ones play a major role in the treatment of the individual who is going through end of life issues. Now, from the family’s perspective, I will discuss how their presence affects the relationship with the patient, the health care professionals and finally how their relationship with each other affects each other.

Death, from the perspective of a loved one, is the most emotional perspective. This is true because familial ties, feelings of love, respect and care are all associated with loss when that person dies. Even though the person may be gone physically, it is important to know that the memory of that person remains alive. This notion is believed universally. For example, the Matsigenka people of Peru believe that a person is still with the family even after they die. Glen H. Shepard Jr. from the University of California,
Berkley and Instituto Nacional de Pesquisas da Amazonia (Brasil) states that, “Life without family is inconceivable to the Matsigenka and apparently, so is death” (Shepard, 2002). This is just one example of how important the family perspective is when discussing end of life issues. It is also important to note that the term “family” is used interchangeably with “loved one” and also can be extended to represent close friends or other people with very close ties. The stress a family may go through during the passing of a loved one is always difficult. The family also wants to make sure that their loved one is in as much comfort as possible during the difficult time. J. G. Catalan-Fernandez et al wrote the article entitled, “Dying of Cancer: The Place of Death in Family Circumstances,” that specifically discusses the family’s role when dealing with a loved one with cancer, “In most cases, the quality of life is much better at home.” (Catalan-Fernandez, et al., 1991). In this case, it is assumed that if the patient is in the company of their family members in a home atmosphere, then their quality of life is better verses being in a hospital.

Family to physician interaction from the perspective of the family members is important as stated earlier, but that interaction from the perspective of the family has yet to be discussed. Families generally come to medical professionals to seek help for sick family members, but when it is determined that the family member is close to death, the perspective of the situation for the family changes. In other words, the family is now concerned with deeper issues, making the medical professional more than just a physician, but a family counselor and an advisor before, during and after death. From the family’s point of view, the medical professionals accompany them from diagnosis and through the death process.
The last interaction concerning death discussed is the family member to family member interaction. This may include mortuary practices that may represent complex interplay of emotions, material culture and social memories (Chesson, 1997). Different families from different cultures react differently to death and have diverse end of life rituals. For example, Stanley Brandes’s article, “Is There a Mexican View of Death?,” discusses the Mexicans relationship with death. He reveals a “unique” and different view of death held by Mexicans. Brandes states, “…they (Mexicans) convey the impression that Mexicans develop a close relationship not necessarily to deceased relatives but, rather, to an abstract entity known as Death” (Brandes, 2003). This means that death is laughed at and even sometimes mocked in order to show true bravery in the face of it. Exhibiting this type of attitude in front of other family members demonstrates that nothing, not even death forces anyone to be fearful. (Brandes, 2003). Unlike Mexican culture, death in American culture does bring about a sense of fear and even sorrow. Families who cope with fear and death together have a better chance of being more resolved than families who do not. The topic of couples coping with stillbirth and newborn death is discussed in Callan and Murray’s article, “The Role of Therapists in Helping Couples Cope with Stillbirth and Newborn Death.” Parents were advised in the past to not spend time with their newborn that died in childbirth or name the child or have funerals for them because it would make the grieving process harder, but it is actually healthier for parents to acknowledge together the death, cope together and grieve together and have a clear memories of the passing of their child (Callan and Murray, 1989). This case seems the most applicable to the need of a strong family member to family member support system. Society as a whole sees the loss of a baby as an extremely painful one.
Strong family member to family member interaction deals with coping strategies better than any other interaction, given that the family is in loving support of one another, because it is grounded in the trust and love each member has for one another.

After defining all three of the aspects of death and applying them to the three major groups of people involved, it is not hard to see how anthropologist have positively contributed to the field of end of life issues. Anthropologists studying this field have to do careful analysis of people’s emotions, feelings and reasons for why they act and say the things they say regarding the death of a close friend or family. They also have to gently discuss death with the actual people who are dying. This is very difficult to do and when handled incorrectly, can be disastrous. When handled correctly, a great deal of information can be discovered and applied to future situations. None of us will ever get to experience death first hand and then be able to write or talk about it, so the closest insights we are able to learn from are those that anthropologist and medical professionals have written or spoken about. This is a major contribution to the understanding of end of life issues. Once we have grasped a better understanding of end of life issues, we can help people who are having those same issues. We can also use that knowledge and apply it to ourselves when necessary. Understanding the issues that a person deals with upon the end of their life can be very powerful. Also, anthropologists who study other cultures besides their own may also discover that death is not handled the same way worldwide. Despite the fact that death is experienced cross-culturally, rituals, coping strategies, and acceptance are experienced in different forms. An anthropologist who studies end of life issues will be able to address all of those forms and possibly explain better why some strategies and rituals work better for others. Anthropologists who address immediate
and/or accidental death may enlighten the public on ways to cope with this form of death also. Accidental deaths such as car accidents, catastrophic events or even plane crashes still take a toll on a loved one’s emotions. It may be even more distraught because it happened so abruptly. One may get the feeling that they never had the chance to tell their loved one how they really felt about them. The study of dealing with these emotions will again lend itself well to people who will experience the same type of event in the future.

Another contribution anthropologist make in this field is the notion is that death is, in fact, a part of life and should not be feared. The notion of death seems so final and cold gives it the stigma of even talking about it should be avoided. Because of the work of anthropologist working side by side with therapists, new developments are made when dealing with the fear of dying. The study of end of life issues is also holistic because it addresses the patient spiritually, emotionally, and physically. Often times we discuss what happens to us when we die. Thoughts of the supernatural and afterlife soon follow. When pursuing the study of death, spirituality usually connects with those thoughts. This is why people tend to seek religious help or counseling from the church or clergy because they are the ones generally more comfortable with issues such as life and death. The emotional aspect of death can also be explored by anthropologists. Understanding or just recognizing and identifying people’s emotions in certain situations can be helpful in coping with death. The physical side of end of life issues involves the actual breakdown of the human body system until it is no longer able to function. This usually occurs when the person is minutes away from passing away. This is the point literally where someone’s life is hanging in balance. This point is the most interesting on so many levels. The more anthropologists uncover about this point in death, the more society will
understand about what an individual goes through. This could be instrumental in understanding what happens when one person attempts to take the life of someone else. Understanding what is going through the mind of someone begging for their life and what is going on in the mind of someone who is about to take it will reveal how we as humans place a value on life. This is how anthropologist can contribute to the understanding of end of life issues, but also the understanding of issues outside the field of anthropology.

The study of end of life issues is necessary in that as humans we deal with death regardless of race, religion or any other distinction that makes us unique. The study of these issues can make death a more open topic of discussion. With the discussion of death being more open we are able to understand it better. End-of-Life Services can benefit from this better understanding of death. These services are for patients who no longer desire to pursue aggressive medical treatment and as a tradeoff, receive End-of-Life treatment. This type of care attends to the mental, social, physical, spiritual, emotional needs of a person with a life limiting illness (White et al, 2002) White notes in his article, “Hospital Provisions of End-of-Life Services: Who? What? and Where?” that despite a pressing need for these services, to actually allow them to be used by a dying loved one would require the patient and their family to accept the inevitable result of death. (White et al, 2002). Patient’s families are usually uncomfortable with death. This brings our society to the realization that our culture does not accept death initially, we choose denial first (White et al, 2002). White also points out that although most people would like to die in their home, because that is where the best care takes place, the reality is that most people die in hospitals and End-of-Life care is in fact, needed (White et al, 2002). This type of care deals with not only healing mentally, but healing through coping with
chronic conditions as well as maintaining personal dignity in the time of dying. When facing a terminal illness, families are so concerned with doing all that is possible to keep the person alive, that the patient is sometimes overlooked. This is maintaining personal dignity is extremely important. No one wants their last days on earth connected to medical instruments, immobile and with no voice to control the situation. End-of-Life Services allows the patient control over their life, even the death that follows it. While End-of-Life Services are a great way to help dying patients cope with their illnesses, there are some critiques of this service. The main critique is a moral one. The question of who actually knows what is best for an ill patient is always raised. Is the patient well enough to make the decision of refusing traditional life sustaining treatment or should the decision be made for them? Do doctors have the authority to influence patients in any way? Asking questions like these are helpful in bettering End-of-Life Services and programs because they force creators of these programs to tackle tough moral issues that are so integral to end of life issues. The emergence of more End-of-Life Services can better prepare families as well as patients for the inevitable acceptance of death in a peaceful manner.

In conclusion, the interaction between the multidimensional aspects of death and how they may complement one another will better help an individual in grasping an understanding of death that transcends sorrow, mourning, fear and grief. By looking at personal reflection applied to the patient them self, to other medical care professionals such as clinicians, therapists and doctors and to family members, we can get a better idea of how death affects the individual dying. By looking at death from the perspective of the physician and how it affects the patient, other physicians, and the family of the patient,
we can get a better idea of how death affects medical professionals. Finally, by looking at death from the perspective of the family members of the patient and how it affects the patient, physicians and other members of the family we can better understand the need for a strong familial support system during the time of tragedy. By analyzing end of life issues from the general viewpoint of clinicians and patients, it is revealed that the process of dying is holistic and requires holistic therapy. Therapy for the mind, body, and spirit will be the only way end of life issues can be handled properly. The neglect of either aspect of a human being may result in a troubled end of life experience. Hospitals and hospices do contribute to easing the pain of losing a loved one via the use of End-of-Life Services, providing religious counseling within the hospitals and advising patients families to the best of their capabilities. It is important to know that regardless of all of the preparation one may do to be at ease with their own death, it is still an inevitable fate that we all must encounter. Addressing death and end of life issues earlier on before death helps us be more resolved when we do actually encounter it. The irony in all of this preparation is that once we do pass away, it is no longer needed. It is almost as if resolving end of life issues affects everyone on a long term basis except the person who is dying, but nonetheless it is important to discuss so that we can use this information in the event of one of our loved ones pass away.
Chapter 6: Conclusion

Cultural and traditional beliefs serve emotional needs as well as cognitive ones. (Kottak, 2010). These traditional beliefs help individuals face life, death and crisis that come along with the lived human experience. We have looked at how language in culture can influence emotional ties with individuals to enforce healthy mental stability. Then I have shown how the impact of having one healing modality of western medicine in an unregulated capitalistic environment can actually further damage the health of an entire society who is otherwise helpless economically. I have also addressed the importance of including environmental insult and structural violence as factors that heavily influence health outcomes, reiterating the holistic nature of health and the notion that it is pertinent to have medical anthropologists as well as physicians to address the complete health of an individual. The reduction of psychological stress is manifested via the belief that traditional healing rituals contribute to the explanation of the unknown, such as sickness or illness. This is why the structure of a healing system that combines Western Bio-Medicine and Traditional Healing is complementary. Finally, I have explained the holistic nature of end of life issues as how it pertains to not only the individual who is in the process of passing away, but also how it affects the loved ones around that individual and the physicians involved.

Through this discussion, it is clear that complete health mentally, physical, emotionally must be made up of more than just one healing modality. Complete health is
defined in holistic terms to mean the stability and wellness of the mental, physical and cultural aspects of a person (Weissman, 2005; Baer and Singer, 2007). By combining the practices of indigenous Ethnomedicine (traditional healing) with the technological advances of western Biomedicine, physicians, traditional healers and medical anthropologists who use such a holistic approach all have a better chance of understanding, sustaining or recovering a patient’s complete health.

In chapter two, a discussion on how the use of language contributes to the importance of positive health outcomes. Chapter two focuses on this idea through using the Afro-Brasilian martial art of capoeira as an example. In particular, the capoeira songs sung give life and energy to the participants in the roda, creating good Axé or energy. That energy is transferred to the participants and created a sense of camaraderie and brotherhood and sisterhood among the jogadors. The solid sense of camaraderie used in capoeira can extend to the health of the individuals participating in it via Axé. Feelings of positivity and good Axé are also linked to traditions in the practice of the diaspora religion of Candomblé. When analyzing the history of Candomblé and capoeira, significant similarities help link the two to healing. It is logical to consider these two traditional practices in holistic treatment in Brasilian culture.

Chapter three analyzes the reality of what happens when health is commodized for patients with HIV/AIDS. Approaching health in a way where mental and emotional issues are taken into account can improve the health of an individual. By looking at how big pharmaceutical industries attempt to monopolize the market on antiretrovirals, the public can make informed decisions about what they purchase and from whom they
purchase. If a company is exploiting the disadvantaged, the public, if banned together, can work to economically damage that company. Countries like Brasil and India are working with their respective governments to provide fair and proper treatment to its citizens. Questions of the true meaning of citizenship arise when basic fundamentals of life are not provided for citizens. Brasil’s government prosecutes legislators that prohibit healthcare to be administered to citizens regardless of socioeconomic status. In India, cultural pride and nationalism helped Dr. Yusuf Hamied and his father recognize their personal responsibility to serve their country in the health sector. The model that Dr. Yusuf Hamied’s father created demonstrated that it is possible to sufficiently fund research and development for new medical advancements and treatments for HIV/AIDS patients while still keeping drugs affordable.

The following chapter examines how the social determinants of health, structural violence and environmental insult contribute to negative health outcomes, particularly among black women in the diaspora. This chapter reveals the significance of knowing how the socioeconomic status of black women in the United States affects frequencies of the delivery of low birth weight babies. By analyzing low birth weight rates among black women in the diaspora, it can be concluded that the high frequency of low birth weight rates among some black women in the diaspora is not because of genetic reasons, but rather because of tensions that arise living in a mixed racial society. When these tensions are not recognized by a country’s population as a whole, but merely suffered by marginalized populations, Stoller these tensions become greater and can ultimately affect an individual’s health.
The following chapter about end of life issues discusses the process of death and the interactions between physicians, the patient and the loved ones of the patient. The interaction between the multidimensional aspects of death and how they may complement one another will better help an individual in grasping a complete understanding of death that transcends sorrow, mourning, fear and grief. With that transcendence, acceptance can follow and with a mindset of acceptance, the natural cycle of life can be completed with mental stability. If the mindset of acceptance is transferred to the family of loved ones, the healing process of losing a loved one can begin.

Traditional medical techniques and western Biomedicine are more efficient when combined because the care in which a person receives then becomes all encompassing, thereby addressing the person mentally, culturally and physically. The mixed method approach to health combines the inclusive focus on healing that takes care of an individual mentally, physically and emotionally and healing focusing on communities with cultural knowledge. Once these two entities and addressed properly achievement of complete health can occur.
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Online Terms:

http://dictionary.reference.com/browse/infant mortality


Video Recordings:


Appendices
Appendix A: Capoeira Song Lyrics and Translations

Capoeira Song A1: “Paranáué” (named after the region of Brasil Paranáué)

Paranáué, Paranáué, Paraná
Vou me embora enquanto e cedo
que a noite tenho medo!
Paraná Paranáué, Paranáué, Paraná
Mulher pra ser bonita, Paraná
Não precisa se pintar, Paraná.
Paranáué, Paranáué, Paraná
A pintura e do artista, Paraná,
A beleza e Deus que da, Paraná.

English Translation:

Paranáué, Paranáué, Paraná
I'm leaving while it's early
because at night I'm afraid!
Paraná Paranáué, Paranáué, Paraná
for a woman to be beautiful, Paraná
she doesn't need to paint herself, Paraná.
Paranáué, Paranáué, Paraná
A painting is by an artist, Paraná,
Beauty is given by God, Paraná.
Appendix A (Continued)

Capoeira Song A2: “Eu Ja Vivo Enjoado” (I Am Already Bored)

Eu ja vivo enjoado
De viver aqui na terra
O mamai eu vou pra lua
Falei com minha mulher
Ela entao me respondeu
Nos vamos se Deus quiser
Vamos fazer um ranchinho
Tudo cheio de sapé
Amanhá as sete horas
Nós vamos tomar café
Eu que nunca acreditei
Nao posso me conformar
Que a Lua venha à Terra
Que a Terra venha à Lua
Tudo isso é coversa
Pra comer sem trabalhar
O senhor amigo meu
Veja o meu cantar
Quem é dono nao ciume
Quem não é quer ciumar
Camarada!

English Translation:

I'm already bored
With living here on earth
O my love I'm going to the moon
Is what I said to my wife
So she answered me
Let's go by God
We'll make a little farm
Full of mud
Tomorrow at seven o'clock
We'll have breakfast
Appendix A (Continued)

I never believed it
I cannot agree
That the moon comes to earth
That the earth comes to the moon
All that is just talk
To eat without having to work
Dear sir my friend
Listen to my song
Whoever is the boss won't envy
But who isn't, will be jealous
Camarada!
Appendix B Capoeira Photos Do Maranhão

Capoeira Photos

Escola de Capoeira Mandingueiros do Amanhã Capoeira Charity Event (Sao Luis, Maranhão Brasil) Photo: Candace Oubre

Escola de Capoeira Mandingueiros do Amanhã Capoeira Charity Event (Sao Luis, Maranhão Brasil) Photo: Candace Oubre

Capoeira Roda and Bateria Photo: Candace Oubre
Instruments of Capoeira (Back row from left) Djembe (representing the Atabaque), Berimbau, Caxixi, Baqueta, Pedra (stone) or Dobrão (coin-not shown), Pandeiro (Front row from left) Agogô with playing stick, Reco-reco with playing stick Photo: Candace Oubre
About the Author

Candace Gail Oubre was born in Baton Rouge, Louisiana and earned a B.A. Degree from Louisiana State University focusing in History in 2005. She has travelled to Nueva Rosita, Mexico to do flood relief work during the spring of 2004. She has also spent one month in São Luis do Maranhão, Brasil, studying the roots of racial inequalities as well as the Afro-Brasilian martial art of capoeira. Candace is a recipient of Louisiana’s Taylor Opportunity Program for Students Scholarship Award. She was an undergraduate student lab assistant to Dr. Richard Cooper at Louisiana State University. She was also employed at Shintech L.L.C. as QAQC Lab Technician in the Vinyl Chloride Unit.