Cultural determinants of health: an approach to promoting equity

Determinantes culturais da saúde: uma abordagem para a promoção de equidade

Juan Carlos Aneiros Fernandez
PhD in Sciences. Professor, Department of Collective Health, Faculty of Medical Sciences, Universidade Estadual de Campinas and collaborator with the Center of Studies, Research and Documentation in Healthy Cities and Municipalities – CEPEDOC.
Address: Rua Tessália Vieira de Camargo, 126, Cidade Universitária "Zeferino Vaz", CEP 13083-887, Campinas, SP, Brasil.
E-mail: juancaf@fcm.unicamp.br

Abstract

This article discusses the use of a socio-anthropological approach to the health-disease process as a way of dealing with health inequities. Considering that cultural elements have been poorly treated in the approaches on the Social Determinants of Health, this article explores the idea that ethnic and cultural factors may be related to producing inequalities in health by exposing segments of the population to a more vulnerable condition. The aim, therefore, is to contribute to the challenge of aggregating emerging or repressed ethnic and cultural health related needs to the consolidated current model of care and attention. To do this, we consider, on the one hand, uses of the issue of diversity in the contemporary context and, on the other, the issue of "incompleteness" also related to the institutions created. It suggests, finally, the opportunity presented by the focus of interest of this discussion of cultural aspects relating to worldviews and, in particular, the experience of communities of "terreiros".
Keywords: Socio-Anthropology Health; Social Determinants of Health; Equity; Health-Disease Process.

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Resumo

Este artigo pretende discutir o emprego de uma abordagem de natureza *socioantropológica* do processo saúde-doença como forma de se produzir o enfrentamento de iniquidades em saúde. Considerando-se que os elementos culturais têm sido pouco tratados nas abordagens sobre os Determinantes Sociais da Saúde, neste artigo explora-se a ideia de que fatores étnico-culturais podem estar relacionados à produção das desigualdades em saúde ao exporem segmentos da população a uma condição de maior vulnerabilidade. Pretende, por essa razão, contribuir para o desafio de se agregarem necessidades emergentes ou recalcadas de ordem étnico-cultural relacionadas à saúde ao já consolidado modelo vigente de atenção e cuidado, considerando para isso, por um lado, os usos da questão da diversidade no contexto contemporâneo e, por outro lado, a questão do "inacabamento" também em relação às instituições criadas. Sugere, por fim, a oportunidade que representa tomar por foco de interesse para essa discussão os aspectos culturais relacionados às cosmovisões e, em particular a experiência das comunidades de terreiros.

Palavras-chave: Socioantropologia da saúde; Determinantes sociais da saúde; Equidade; Processo saúde-doença.

Introduction

A socio-anthropological discussion of the health-disease process in the contemporary situation is justified both by its filling what could be viewed as a "gap" in academic output as far as the element of "culture" is concerned in many nationally and internationally studied "Social Determinants of Health", and because of the growing interest on the part of health authorities in Brazil in innovations to deal with inequalities in health[1].

The different moments predominating in concepts of the health-disease process throughout Western history are widely known and include theories of equilibrium-disequilibrium-re-equilibrium, of Hippocratic medicine; of miasmas, such as those developed from the mid-19th century onwards; of micro-organisms as essential etiological agents which marked the development of 20th century medical science (Buss and Pellegrini Filho, 2007), as well as the conceptions of positivity and negativity which characterize the terms and their relationships (Canguilhem, 1995; Czeresnia, 2003; Lefèvre, 2004).

This article aims to focus the discussion on the complexity of determining the heath-disease process and, therefore, it aligns itself with current formulations of social determinants of health although intending to highlight the cultural aspect, which seems to have been little explored compared with the economic aspects present in this determination.

This means starting from a point of the predominant ontological approach to disease to an approach from a relational perspective, and with special interest in relationships with cultures. As Laplantine (1991, p. 49) notes,

> in the extremely diversified field of ethnographically known etiological imputations, two overall trends can be distinguished: medicine centered on disease, the representation systems of which are commanded by an ontological model usually of a physical nature; medicines centered on the sick man, the representation systems of which are commanded by a relational model which can be

1 As an example of this, consider the project "Popular health care practices in communities of *terreiros*" financed by the Ministry of Health/ pelo Ministério da Saúde/ Department of Strategic Management in partnership with the Pan-American Health Organization and the Center for Studies, Research and Documentation in Healthy Cities and Municipalities, developed between 2013and 2015, and coordinated by the author.

> thought of in physical, psychological, cosmological or social terms.

Such a position makes "expropriation of the existential meaning of disease" difficult (Laplantine, 1991, p. 104) for whom "the issue of meaning and of why [concerning the health-disease process] [...] continues to appear as a pointless duplication of the causal problem, form the biomedical point of view" (Laplantine, 1991, p. 217). As Menéndez (1998) notes, hegemonic medical knowledge in the field of health "views the representations and practices of the population merely as factors which negatively affect health; they perceive them as knowledge to be modified" (p. 75).

Alternative to this understanding, in the cultural determination approach to the health-disease process, it is worth considering, for example, the world visions of different groups as "total social phenomena", which permit the "apprehension of the world as a social reality gifted with meaning" (Berger and Luchman, 1991, p. 174); as a symbolic universe which "puts everything in its place" (Berger and Luchman, 1991, p. 135).This alternative understanding is what can establish a watershed between considering the culture of others as the possibility of an encounter producing power or, differently, seeing the culture of the other as an obstacle to be overcome.

In this approach, the health-disease process would no longer thought of in a network of causality which would be intrinsic - the positivist mode of scientism of knowing to predict and, thus, to be able to control -, but rather come to be seen as "an historically constructed psychosocial phenomenon [...]" (Berger and Luchman, 1991, p. 134). This argument, taking the socio-anthropological perspective, looks at the response that cultures offer to the health-disease process, that is, which day-to-day knowledge – which does not, therefore, require greater verification – is used by the subjects in their experience of these processes.

This argument intends to preserve, in this discussion, what Minayo (1998, p. 43) terms

> [...] two salutary tensions. In other words, what is established between theoretical and basic research without immediate commitment to reality and strategic and operational research aimed at formulating, monitoring and evaluating policies and solving problems. The second tension would be between disciplinarity which leads to deeper investigation of the place, role and contribution of anthropology in its incursion into the health care sector and interdisciplinarity, meaning the interface with other disciplines [...].

On the one hand, thinking in the theoretical-operational binomial explained by this author, not only information relevant to developing an Anthropology of Health may be produced, but also information necessary to the appropriate functioning of the Brazilian Public Health Care System, as ethnic-cultural characteristics or factors may be related to producing inequalities in health, exposing segments of the population to a more vulnerable condition.

To explore this possibility, we used the example of ethnicity which corresponds to the "conscious and symbolic use of elements of race, history, common origin, customs, values and beliefs which lead members of this group to create an exclusive and cohesive community demanding recognition from other groups" (Valdívia, 2011, p. 130). Affirmation of these identities and differences – and regardless of their being a positive product or irrefutable human plurality – has constituted tense scenarios with detrimental outcomes throughout history. Active processes of exclusion and/or of reciprocal distancing resulted and still persist as an expression of different dimensions of the prevailing ethnocentric practices of the dominant orders, cultures and contexts from a social, economic and political point of view. This, therefore, means that movements recognizing these differences can be brought closer to the production of health and health equity.

Important advances in creating institutions represent attempts to regulate tensions provoked by these differences. The statutes of equality in different countries and international declarations of rights are successful examples of this. Actions of positive discrimination aimed at historically prejudiced groups can be understood in the same way, as can universality of access to goods, services and tights, of which the Brazilian Public Health Care System is an example. However, if these advances protect some groups from discriminatory or "violent" actions, they are, by themselves, incapable of promoting recognition of differences as legitimate and important.

On the other hand, maintaining the previous tension but, also, achieving that explained by the author between disciplinarity and interdisciplinarity, this discussion enables socio-anthropological studies to be brought closer to studies of institutions.

Currently, one of the entrances for facing the shocks constituted by the meetings of different cultures lies in considering the limits of the institutionalization of policies which, as such, equate to disputes of interest and contrast values without erasing the differences (Baptista and Mattos, 2011). In this sense, the institutional models arrived at by modern societies and states in their development processes, including the models of public health care, of particular interest here, should remain open to instituting actions on the part of the individuals and groups at whom they are aimed. The challenge this represents consists in aggregating emerging or repressed health-related ethnic-cultural needs to the already consolidated current model of health care. It also means recognizing the "incompleteness" in relation to created institutions.

In addition, constitutive elements also come into play, from Anthropology such as the idea of relativization or hermeneutic approach, in the significant clinical task, essential in producing lines of care, whatever they be, of "rethinking the care model practiced, prioritizing curative acts and autonomy of the subjects" (Malta and Merhy, 2010, p. 594), which is only possible in contexts which welcome diversity and singularity.

Diversity and Recognition

As noted by Geertz (2001, p. 77), "social and cultural frontiers coincide less and less", as, currently, cultural diversity is increasingly within societies themselves, causing confrontation and exchanges to be much more present in processes of cultural renovation than they were in the past. This situation in which others are not now so distant as in the past and their ways of being and living develop interwoven with ours seems to create a series of new challenges.

Regardless of accumulated criticism of ethno-centrism and its harmful effects, living daily life within the diversity requires constant affirmation and reaffirmation of values and moral judgments by subjects and social groups concerning ourselves and others. This may lead to re-examining ethno-centrism, finally recognizing it as having virtues, based on the subjacent idea that celebrating difference and being sympathetic towards them reduces, or even eliminates, our capacity to make judgments based on our own culture, which we cannot renounce, so, in other words, a certain amount of ethno-centrism is justifiable to contain the risk of moral entropy[2] (Geertz, 2001).

For Geertz (2001), this idea is the expression of "recent social thinking" which does not deal with relativism and seems to ignore the contribution of anthropology, reinforcing still more the contemporary situation due to the outbreak of diversity, through "ethnographic work [...] [which presents] a world replete with immovable rarities, which we cannot avoid" (Geertz, 2001, p. 82).

Increased contact with differences, provoked by this present situation, does not eliminate them, but has the effect of proliferating them, permanently resetting the challenge of dealing with moral imbalances. The impact that this could have on health care knowledge and practices, historically marked by a moral and normative perspective, can easily be imagined.

To obscure or ignore there imbalances through contemporary ethnocentric postures, such as sealing the "us" sphere, an affirmation that we are lucky not to be "them", or adopting the "relax and enjoy" maxim means, for Geertz (2001, p. 76), losing the possibility of "changing our minds" [...], [as the history of peoples and people is] "the history of changing the mind".

Thus, Geertz's conclusion about what could lead to a non-destructive encounter between cultures:

> The uses of cultural diversity, of studying it, describing it, analyzing it and understanding it, is less separating ourselves from others and separating

2 Clifford Geertz is referring here to the argument on necessary incommunicability between cultures, developed by Lévi-Strauss, see LÉVI--STRAUSS, C. O olhar distanciado. Lisboa: Edições 70, 1986.

others from us, aiming to defend group integrality and loyalty, and more defining the field which reason needs to cross, so that modest recompenses are achieved and become real" (Geertz, 2001, p. 81).

The argument developed by this author ends in the idea that the issue of recognizing differences is still, today, a key piece, so to speak, in accessing a better world, with more solidarity between cultures.

Bauman's (2003) approach can be seen as a counterpoint to this reading of the modern situation and what seems to be left over from it. Although the sociologist is also strongly committed to the idea that the contemporary situation is a chance – albeit only a chance, given the condition of having to live amid insurmountable contingency -, to lead us to tolerance and thence to solidarity (Bauman, 1999), this context of struggling for recognition, according to him, corresponds to the abandonment of the "social justice model as the ultimate horizon of the sequence of trial and error – in favor of a rule/standard/measure of 'human rights' which passes though endless experimentation with forms of satisfactory, or at least acceptable, coexistence" (Bauman, 2003, p. 69).

According to this author, "the logic of the 'battles for recognition' prepare the combatants to absolutize difference. There is a trace of fundamentalism [...] [which] tends to become 'sectarianism' [...] in the demands for recognition" (Bauman, 2003, p. 72).

Criticizing approaches to the issue of recognition as "self-realization" or as a "culturist trend", Bauman (2003) intends to propose the issue of "recognition within the framework of social justice" (Bauman, 2003, p. 72). As the author points out: "demands for redistribution made in the name of equality are vehicles of integration, whereas demands for recognition in terms of mere cultural distinction encourage division, separation and end by interrupting the dialogue" (Bauman, 2003, p. 72).

Relativization, or "relativistic precipice" as he calls it, has had considerable impact on Bauman's thinking. To the author, equality in seeking social esteem seems to be an objective which is above suspicion or doubt, an inescapable aim of individual and social existence. Such an impact ends up producing an inverted reading of what relativization is capable of promoting. Distinguishing culturally, in his reading no longer shows a divided society, separate and without dialogue, quite the opposite, it would produce a society with these characteristics.

We cannot simply conclude that it was the culturist approach or relativization which produced the differences. It does seem plausible to consider that they gave rise to them. If recognizing differenced leads to relativization, it is contemporary living conditions which lead to seeking recognition. As Crespi (1997) notes,

> the impossibility of basing identity on absolute foundations, as it was in the past (God, nature, reason, historical ends, etc.), in a situation in which the only universal reference which seems to be maintained is the principle pf equality, appears to lead those in society to seek new identifications in specific cultural forms, claiming unconditional recognition for them (p. 245).

What Geertz (2001, p. 51) says: "anti-relativism, on the whole, engenders the anxiety on which it feeds", also appears to apply to Bauman's (2003) argument on the topic, as the struggle for social justice and the struggle for self-realization as a culturist trend are perhaps not so different as they appear at first glance.

What underlies this analysis seems, in fact, to be anti-relativism, rather than denial of a policy of recognition, the mixture of which with a distributive justice "is, it could be said, a natural consequence of the modern promise of 'social justice' in the conditions of 'liquid modernity' [...], which is [...] a condition which, above all, calls for the art of peaceful and charitable coexistence [...]" (Bauman, 2003, p. 73).

The place of a policy of recognition, for this author, is a result of readings of the contemporary situation, in which there is now no hope or belief in a planned, pre-established order, which would indelibly characterize modernity. It is not, therefore, about removing obstacles "in one swoop" to produce a fair society, but rather doing it based on "coordination, demonstration and effort of successive demands for recognition" (Bauman, 2003, p. 73).

Bauman admits "that freedom to articulate and pursue demands for recognition is the principal condition for autonomy, the practical capacity of self-constitution [...] of the society in which we live [...]" (Bauman, 2003, p. 74). It should be pointed out

that, in this understanding, it is about refuting both a "universalist foundation", as well as an "essentialist nature of differences" in favor of dialogue and negotiation.

However, when accompanying the development of this argument, we can perceive that if a policy of recognition is not denied, as indicated above, a judgment on its pertinence appears conditioned by its effectiveness in coordinating another policy or movement, to something that does, in fact, matter, in this case, the struggle against distributive inequalities. Different forms of economic privation, as well as different ways of dealing with them over the centuries, is what occupies Bauman's (2003) central argument and, in conclusion, what happened in the contemporary situation was the substitution of social justice for cultural distinction.

The persistent denial of a culturist approach, by this author, may thus reveal more than a concern with the absolutism of differences. It is the location which the elements of culture can occupy in relation to the material and economic conditions of existence which seems to be under discussion, thus actualizing or repositioning classic and constitutive tensions in the field of sociology. The elements of culture which can eventually come into play end up being treated as mere epiphenomena, such as secondary effects or by-products.

This, we understand, is a tension inherent to the design of socio-anthropological approaches. As indicated by Crespi (1997):

> The distinctive feature characterizing contemporary culture relative to those of previous eras is, without doubt, the fact that, for probably the first time in the history of humanity, the symbolic order is seen as a dimension with its own autonomy relative to reality and, at the same time, as a constituent component of that reality (p. 239).

The feature highlighted by this author, however, is one among many. Notwithstanding Weber's contribution, it has to be constantly questioned to what extent the problem of "meaning" in the area of social sciences "began [in fact] to be seen as something more, or as something different from the usual varnish applied to a stable reality" (Geertz, 2001, p. 153) this continues to be a task for anyone intending to construct knowledge in this area.

At this present time of a sociology of culture, on which Crespi (1997, p. 81) holds forth, it is possible to consider "the cultural-societal relationship in terms of reciprocal interaction between diverse, but equally relevant, components". For this, they corroborate approaches based on "symbolic interaction" which focus on the relevance of "*beliefs* and *convictions* based on which those involved represented the situation aiming to determine what, in fact, their attitudes and way of acting are" (Crespi, 1997, p. 113), in other words, of the symbolic order which is "constitutive of the social actor and is found based on interaction between the subjects" (Crespi, 1997, p. 115).

However, another equally strong presence tends to subordinate this symbolic order "the objective structures resulting from the division of the classes" (Crespi, 1997, p. 133) such as, for example, in the theory of Bourdieu. This appears to be a significant example, as this sociology is frequently resorted to in producing knowledge in the area of social sciences in health care, above all in the notion of *habitus* as developed by this author.

The tension inherent to socio-anthropological approaches can be more clearly perceived if we turn our attention to religious-type narratives, "global conceptions of the world and of human life" which are "among the cultural forms which most develop a generalized influence on socially shared representations, values and rules" (Crespi, 1997, p. 152).

Approaches to this topic by Marx, Weber, Durkheim, Malinowski and Radcliffe-Brown, among others, are the "classic" works on social science and, currently, according to Geertz (2001, p. 159), "the underlying vision to these countless analyses of religious expression [...] [is] that religion is no more than a mask and a mystification, an ideological covering for perfectly secular and more or less selfish ambitions [...]". According to this author, in the social sciences, in general, "'Religion' is the favorite dependent variable" (Geertz, 2001, p. 155).

Religious manifestation in communities of *terreiros* is considered in this way – the expression of worldviews from the African matrix as cultural determinants of the health-disease process, around which inequalities in health may be produced - as the basis for reflection on the cultural determination

of the health-disease process seems to be a profitable way of developing the topic. As a "constant dimension of human experience" (Crespi, 1997, p. 166), religion as the focus of the investigation may tell us more than "private struggles with personal demons" (Geertz, 2001, p. 151) or than "mere unreason" (Geertz, 2001, p. 156). As usual in a socio-anthropological approach, it can give information about the other and, therefore, about ourselves and the way we think about health.

Moreover, an approach of this type also contributes to developing a self-reflexive perception of the production of knowledge in this area when conducted in the mold of sociology of emergencies, as proposed by Santos (2004).

This author denounced the role played by modern Western science – including social science productions – in concealing experiences, meaning making "other discourses or narratives about the world [...], [other] forms of interaction between culture and knowledge [...]" irrelevant, "[in short,] hiding or discrediting the alternatives" (Santos, 2004, p. 778).

According to this author, "without a criticism of the Western rational model which has dominated for the last two hundred years, all of the proposals presented in the new social analysis, for all that they are judged to be alternative, tend to reproduce the same effect of concealing or discrediting" (Santos, 2004, p. 778).

What sustains the role played by science is, according to Santos (2004, p. 782), an obsessive "idea of the totality in the form of order". This primacy is due to a totality, a single totality, based on the idea of progress, the effective imposition of which "manifests itself in the twin track of productive thinking and legislative thinking". In such a situation, everything appears to be composed of homogenous parts which should follow a particular order. Thus, "what does not exist is, actually, actively produced as inexistent, that is, as a no-credible alternative to what exists" (Santos, 2004, p. 786)[3].

When this author refers to production of non-existence, he considers other forms of knowing or producing knowledge, different forms of manifesting, organizing and, finally, other forms of living; he refers to the "concealment of so much experience and creativity which happens in the world" (Santos, 2004, p. 53), as well as to "other discourses and narratives about the world" (Santos, 2004, p. 778), among which can be included worldviews of communities of *terreiros*, for example,

This author's approach is, then, opportune for the reflection proposed here for bringing together a certain way of producing knowledge and producing versions of ethno-centric postures. As Santos (2004, p. 792) says, "in all logics of production of absence, the disqualification of practice goes hand in hand with disqualifying the agents".

This author resents the intellectually lazy debate based on metonymic reasoning "obsessed with the idea of totality in the form of order. [According to this reasoning,] there is neither understanding nor action that is not covered as a whole and the whole has absolute primacy over each of the parts of which it is made up" (Santos, 2004, p. 782). This primacy would operate with the production of dichotomies, always containing a hierarchy, and as an example of great interest to this discussion, he refers to "scientific knowledge/traditional knowledge" dichotomy.

Thus, the study of health care practices in *terreiro* communities, conducted by this author from an open perspective, may offer certain visibility to non-hegemonic knowledge, treating it non-dichotomously in relation to knowledge of the hegemonic medical model, but, quite the opposite, aiming to produce non-destructive encounters, or those with solidarity, between cultures, health care models and, why not, improvements in the Health Care System.

Health and Institutions

There is a predominant vision regarding the health-disease process which is established based on a relationship of denial between the terms. It is about the conception in which health corresponds to a lack of disease. Thus, in order to be healthy it is necessary

3 These are the logics of producing non-existence, pointed out by Santos (2004): "[...]monoculture of knowledge and rigor of knowledge [...]monoculture of linear time [...]logic of social classification [...]logic of the dominant scale [...]productivist logic" (Santos, 2004, p. 787-789). And these logics correspond, respectively, to ignorance or lakc of culture, predictability and prgress, naturalization of difference, universal/global weight and economic growth.

to be disease-free, and for health to be re-established, diseases need to dealt with or eliminated. In this predominant view, the ontological dimension of disease prevails (Laplantine, 1991), which is to day, an understanding centered on disease itself, on its intrinsic characteristics.

There is a tipping point at which this concept of the health-disease process gains ground and becomes predominant, which can be identified in the anatomical revolution triggered by Vesalius.

It is the same cultural environment of change resulting from the Renaissance and those who produced the Scientific Revolution of the 17th century, of which Vesalius is an exponent, which Descartes, almost a century later, would experience and in which he would draw up his Discourse on the Method. What was left over from this combination of anatomy and Cartesian rationalism is an objectivized and fragmented body, composed of separate organs and tissues which can be studied in isolation and the "reductionist and objectivist tendencies in modern medicine originate here" (Ortega, 2008, p. 107). And not only medicine, but all modern thinking would be influenced by these two methodological orientations – the empiricism of observation and mathematicalizing rationalism – and its search to produce scientific certainties, clear and distinct knowledge of things.

However, this prevalence does not correspond to annulling differences or disputes of definitions and/or concepts. This is because models, concepts and definitions which are under permanent discussion are social constructions. Having been created by man, by the meaning they attribute to things, they can be permanently recreated and new meanings assigned.

Thus, in the same way as the balance/imbalance understanding of the health-disease process, as in the theory of humors, not the notion of denying terms but a dynamic equilibrium between them, producing situations of health and disease, prevailed before the Vessalian watershed, after this moment, alternative conceptions also occupied the terrain of conceptual disputes. The relational dimension, and not the ontological, which informed knowledge about the process in the theory of humors, returned in the 19th century in the form of the theory of miasmas, in which diseases were related to natural or constructed environmental conditions, especially environmental and industrial environments.

At the beginning of the 20th century, and as a result of new scientific discoveries, allied to exchange value, the prevalent concept gained new strength, informed by what came to be known as bacteriology, marked by the identification of micro-organisms as the principal etiological agents in the diseases which affected the population at that time.

Many decades were to pass before it became evident that not only were diseases refusing to go away and new diseases being identified, but, principally, that they distributed themselves differently according to living conditions in different sectors of society (Laurell, 1982). The perspective of diseases identified with unequal living conditions expresses a wider social criticism which grew in volume from the 1960s onwards, in relation to scientism, to capitalism, to the powers that be and to institutions in general.

Thus we arrive at the point which is of most interest to us when discussing relative conceptions of the health-disease process; the intention to assign it to a field, so to speak, of institutional creation, in the widest sense.

We think of institutions as things created in order to establish desirable degrees of order and stability in life. As noted by Berger and Luckman (1991), they result from typifications we make from the point of view of labor saving, regulating actions, making them predictable and, thus, freeing up our energy to solve new problems. The issue, however, is that despite this meaning constructed in and by history, as Castoriadis and Cohn-Bendit (1981) says, these institutions, once created, constrain us. As Luz (1981, p. 10) notes, "institutions are the foci of conflagrations", the flames of which are fed by the impulses to define and to resist these definitions. Thinking about institutions means having to think about the relationships between the instituted and the instituting (Lourau, 1975; Maffesoli, 1997; Castoriadis, 2000), what is given and what it gives.

Thus, we have the possibility of reflecting on the place institutions occupy and the pressure they exercise in the case of scientism of health care knowledge which informs the predominant view of

the health-disease process in our experience. Our place in the creation of and/or adherence to them, they ways in which we think and act and, also, the conflicts and the tensions they create are the substrata which should be permanently under scrutiny.

The issue of care represents, in this sense, a new aspect in this dispute of conceptions regarding the health-disease process; it expresses this tension between the instituted and the instituting applied to health care knowledge.

If we translate this tension into questions, we would have the following: where will this health care technology come from, and who will pay for it? How far do we "do" health care without the subject of the care? Does the bodily experience count for nothing? Is health silence in the life of the organs, or is it the capacity the subjects have to spend life (Canguilhem, 1995)? Is health only achieved in dealing with the biological context of life? Does the life of the individual not come together with the patient (Feuerwerker[4])?

Among the diverse contributions which the concept of care brings to creating tension in the hegemonic understanding of the health-disease process by requiring institutions to "speak" in another way, we wish to highlight the bodily experience, which is to say, the life which each of us has constructed. This means that the focus of interest cannot be reduced to disease; that they are connected with experience as it comes in any culture; that disease is, also, the perception we have of it and, therefore, we need the subjects in order to understand the health-disease processes, we need to learn the differences and peculiarities produced by their experiences.

It is the perspective of health care, above all, in which the discussion propose here can become most relevant. On the one hand, we can view health care in an ontological dimension, as far as it is related to characteristics of "openness" and "plasticity" - which are anthropological constants (Berger and Luckman, 1991; Morin, 1979) - and, as such, bring cultures to the points at which they meet and represent themselves, therefore, a better opportunity of understanding them. On the other hand, it can contribute to examining health care models in the health care system being a repositioning of the issue of human plurality and the unpredictability of their actions (Arendt, 2007), either by health care practices bending to "procedure to the relation", "to the laboratory to the act" (Merhy, 2006) or to "rational to the symbolic" (Caprara, 2003).

Communities of *terreiros* and producing equity

As a starting point to this short section, we take the considerations of Alves and Rabelo (1998), for whom:

> Experience, in fact, never perfectly fits the models or representations proposed to explain it: there is a dynamicity, indetermination or excess of meaning in all experience which means there is always room for new or renewed formulations of it (Alves and Rabelo, 1998, p. 119).

The space for formulations on experience to which the authors refer can, as we understand it, be occupied both by the subject as well as those who will take it into consideration or interpret it. Based on this understanding, we can, on the one hand, approach the *terreiro* community considering that it acts not only due to a reproduction according to a given cultural repertoire, but also based on this repertoire and transforming it based on their own experience. An approach which would, therefore, be capable of overcoming mere descriptive-empiricism of health care practices and reach a perspective of the phenomenon, understanding these practices as their way of existing in the world, that is, as a "subject in relation to the world" (Abbagnano, 1998, p. 932).

On the other hand, using an interpretation along these lines, we can draw close to, interact with or discuss health care practices in a *terreiro* community in relation to the practices instituted in the health care system, thus overtaking both an essentialized approach to the peculiarities and differences as well as a "neomarxist unmasking" style approach (Gomes et al., 2002), seeking to achieve a Gadamerian hermeneutic approach, informed by the idea of

4 FEUERWERKER, L. C. M. *A cadeia do cuidado em saúde.* Pdf file obtained from the author in April/2012 entitled "REVISADO - Capitulo 15_Cadeia do Cuidado_Laura-2.pdf - Adobe Reader".

"fusion of horizons"[5].

This is no easy task, although it is necessary. A socio-anthropological approach offers the best outcomes for this cultural meeting on health care practices. Studies required by this discussion in this sense can reduce the risk of us investing only in accommodation of the differences encouraged by de-mystifying the practices of these communities.

It is exactly this which we must not reduce – taking the Candomblé as an example – the priesthood of Ossaim, or the use of herms, medicinal and phytotherapeutic practices (Bastide, 1978). The justified concern that the following authors show in relation to increasing dialogue with these cultures, which is also what convenes this discussion, should be accompanied by a decentering capable of judging this encounter as an opportunity for learning on both sides.

Alves and Seminotti (2009, p. 86), note that "traditional *terreiro* communities – those which preserve the cult of African and Afro-Brazilian religions – are welcoming spaces, giving council to groups which, historically, have been excluded [...]". According to these authors, and corroborating our understanding of the reach of the symbolic sphere in organizing ways of life, "interpersonal relationships produced in the *terreiro* enable them to welcome, enable affective exchange, enable knowledge to be constructed, health care to be promoted and prevented and traditions to be continued, such as the therapeutic use of plants" (Alves and Seminotti, 2009, p. 86).

Although the focus of these authors' analysis is apparently aimed at "rescuing collective history" capable of tackling the "uprooting" of cultures, it is not our focus, the results of these studies are of interest from a different perspective. This is the case of their hint that there is a "lack of academic knowledge of on what these practices are based and how they are performed which, often, leads to a psychopathological and stigmatizing interpretation of Afor-Brazilian religious phenomena, impeding dialogue between health care professionals and terreiro leaders" (Alves and Seminotti, 2009, p. 87).

In the same way, we are interested in the noteworthy fact that health care practices in the terreiro communities do not necessarily compete or conflict with those of the Brazilian Public Health Care System (SUS), when weighing up how close such practices might be to the National Policy on Integrative and Complementary Practices (Brasil, 2006).

Recent output on the topic, which can be found in Brazilian scientific literature, has reaffirmed, overall, the above mentioned issues. Difficulties in bridging the gap between communities and the SUS are something frequently highlighted in this output. Serra et al. (2010, p. 172) highlight the "*a priori* that the *povo-de-santo* are ignorant, superstitious, with outmoded ideas, given their irrational practices, incompatible with the health care ideal". Likewise, Mota and Leite (2011, p. 9) state that the "relationship between biomedicine and other curative traditions is still distant and marked by prejudices and stigmatization of the religion".

Mota and Trad (2011), focusing more on the meanings attributed by *terreiro* communities that on their relationships with the SUS, end up converging with the opinions of the authors cited above with regards the situation of discrimination which there communities suffer. According to these authors,

> the link with religions from the African matrix constitutes a double finality: of political resistance and affirming identity – a place for sharing everyday problems and afflictions, as well as for sharing conquests and cures. For many black families, then as now, the *terreiro de candomblé* is perceived as a welcoming space, to share their personal afflictions and to tackle discriminatory experiences and sickness (Mota and Trad, 2011, p. 336).

Another common element which attracts attention in the various studies of the issue concerns the lack of "conflict or competition" between different care practices and health care highlighted by Alves and Seminotti (2009), although this lack may be due to the communities' understanding of the instituted

5 "It is through the fusion of horizons that we risk and test our prejudices. In this sense, learning from others forms of life and horizons is at the very same time coming to an understanding of ourselves. Only through others do we gain true knowledge of ourselves" (Bernstein, 1983, p. 144).

system and not the understanding of the system with regards to them, which is well exemplified in the excerpts on discrimination above. Such an imbalance, considering the resources held by each party in their relations, may be an important source of producing the inequalities of interest to this discussion.

Approaching cultural determination of the health-disease process, then, with a socio-anthropological framework, considering, for example, this public, may give us information about its limitations, but also about the possibilities for extending institutional health care practices within the SUS, renewing the efforts which have been made to make the principle of equity ever more substantial.

It is to this which this discussion aims to contribute.

References

ABBAGNANO, N. Dicionário de filosofia. 2. ed. São Paulo: Martins Fontes, 1998.

ALVES, M. C.; SEMINOTTI, N. Atenção à saúde em uma comunidade tradicional de terreiro. Revista de Saúde Pública, São Paulo, v. 43, p. 85-91, 2009. Suplemento 1.

ALVES, P. C.; RABELO, M. C. Repensando os estudos sobre representações e práticas em saúde/doença. In: ALVES, P. C.; RABELO, M. C. (Org.). Antropologia da saúde: traçando identidade e explorando fronteiras. Rio de Janeiro: Fiocruz: Relume Dumará, 1998. p. 107-121.

ARENDT, H. A condição humana. Rio de Janeiro: Forense Universitária, 2007.

BAPTISTA, T. W. F.; MATTOS, R. A. Sobre política (ou o que achamos pertinente refletir para analisar políticas). In: MATTOS, R. A.; BAPTISTA, T. W. F. (Org.). Caminhos para análise das políticas de saúde. Rio de Janeiro: ENSP, 2011. Não paginado. Disponível em: <http://www.ims.uerj.br/ccaps/?p=443>. Acesso em: 14 nov. 2011.

BASTIDE, R. O candomblé da Bahia: rito nagô. São Paulo: Nacional; Brasília, DF: INL, 1978.

BAUMAN, Z. Modernidade e ambivalência. Rio de Janeiro: Jorge Zahar, 1999.

BAUMAN, Z. Comunidade: a busca por segurança no mundo atual. Rio de Janeiro: Jorge Zahar, 2003.

BERGER, P.; LUCKMANN, T. A construção social da realidade: tratado de sociologia do conhecimento. Petrópolis: Vozes, 1991.

BERNSTEIN, R. J. Beyond objectivism and relativism: science, hermeneutics and praxis. Philadelphia: University of Pennsylvania, 1983.

BRASIL. Ministério da Saúde. Política Nacional de Práticas Integrativas e Complementares no SUS. Brasília, DF, 2006. Disponível em: <http://189.28.128.100/dab/docs/publicacoes/geral/pnpic.pdf>. Acesso em: 2 jul. 2012.

BUSS, P. M.; PELLEGRINI FILHO, A. A saúde e seus determinantes sociais. Physis: Revista de Saúde Coletiva, Rio de Janeiro, v. 17, n. 1, p. 77-93, 2007.

CANGUILHEM, G. O normal e o patológico. 4. ed. Rio de Janeiro: Forense Universitária, 1995.

CAPRARA, A. Uma abordagem hermenêutica da relação saúde-doença. Cadernos de Saúde Pública, Rio de Janeiro, v. 19, n. 4, p. 923-931, 2003.

CASTORIADIS, C. A instituição imaginária da sociedade. Rio de Janeiro: Paz e Terra, 2000.

CASTORIADIS, C.; COHN-BENDIT, D. Da ecologia à autonomia. São Paulo: Brasiliense, 1981.

CRESPI, F. Manual de sociologia da cultura. Lisboa: Estampo, 1997.

CZERESNIA, D. O conceito de saúde e a diferença entre prevenção e promoção. In: CZERESNIA, D. (Org.). Promoção da saúde: conceitos, reflexões, tendência. Rio de Janeiro: Fiocruz, 2003. p. 39-53.

GEERTZ, C. Nova luz sobre a antropologia. Rio de Janeiro: Jorge Zahar, 2001.

GOMES, R. et al. As representações sociais e a experiência da doença. Cadernos de Saúde Pública, Rio de Janeiro, v. 18, n. 5, p. 1207-1214, 2002.

LAPLANTINE, F. Antropologia da doença. São Paulo: Martins Fontes, 1991.

LAURELL, A. C. La salud-enfermedad como proceso social. Revista Latinoamericana de Salud, México, DF, v. 2, n. 1, p. 7-25, 1982.

LEFEVRE, F. Promoção de saúde, ou, a negação da negação. Rio de Janeiro: Vieira & Lent, 2004.

LOURAU, R. El análisis institucional. Buenos Aires: Amorrortu, 1975.

LUZ, M. T. As instituições médicas no Brasil: instituição e estratégia de hegemonia. 2. ed. Rio de Janeiro: Graal, 1981.

MAFFESOLI, M. A transfiguração do político: a tribalização do mundo. Porto Alegre: Sulina, 1997.

MALTA, D. C.; MERHY, E. E. O percurso da linha do cuidado. Interface: Comunicação, Saúde, Educação, Botucatu, v. 14, n. 34, p. 593-605, 2010.

MENÉNDEZ, E. L. Antropologia médica e epidemiologia: processo de convergência ou processo de medicalização. In: ALVES, P. C.; RABELO, M. C. (Org.). Antropologia da saúde: traçando identidade e explorando fronteiras. Rio de Janeiro: Fiocruz: Relume Dumará, 1998. p. 71-93.

MERHY, E. Saúde: a cartografia do trabalho vivo. São Paulo: Hucitec, 2006.

MINAYO, M. C. S. Construção da identidade da antropologia na área de saúde: o caso brasileiro. In: ALVES, P. C.; RABELO, M. C. (Org.). Antropologia da saúde: traçando identidade e explorando fronteiras. Rio de Janeiro: Fiocruz: Relume Dumará, 1998. p. 29-46.

MORIN, E. O enigma do homem. Rio de Janeiro: Zahar, 1979.

MOTA, C.; LEITE, L. Corporeidade e saúde no candomblé: um estudo sobre percepções e práticas de cuidado com o corpo no contexto religioso. In: CONGRESSO LUSO AFRO BRASILEIRO DE CIÊNCIAS SOCIAIS: DIVERSIDADES E (DES)IGUALDADES, 11., 2011, Salvador. Anais eletrônicos... Salvador: UFBA, 2011. Disponível em: <http://www.xiconlab.eventos.dype.com.br/resources/anais/3/1307735790_ARQUIVO_TEXTOCONLABcorpoII.pdf>. Acesso em: 6 mar. 2012.

MOTA, C. S.; TRAD, L. A. B. A gente vive pra cuidar da população: estratégias de cuidado e sentidos para a saúde, doença e cura em terreiros de candomblé. Saúde e Sociedade, São Paulo, v. 20, n. 2, p. 325-337, 2011.

ORTEGA, F. O corpo incerto: corporeidade, tecnologias médicas e cultura contemporânea. Rio de Janeiro: Garamond, 2008.

SANTOS, B. S. S. Conhecimento prudente para uma vida decente: um discurso sobre as ciências revisitado. São Paulo: Cortez, 2004.

SERRA, O. et al. Candomblé e políticas públicas de saúde em Salvador, Bahia. Mediações, Londrina, v. 15, n. 1, p. 163-178, 2010.

VALDIVIA, M. Etnicidad como determinante de la inequidad en salud materno-infantil en el Perú. In: HERNÁNDEZ BELLO, A.; RICO DE SOTELO, C. (Ed.). Protección social en salud en América Latina y el Caribe: investigación y políticas. Bogotá: Pontificia Universidad Javeriana, 2011. p. 121-158.

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