

Health, religion and culture: a dialogue based on Afro-Brazilian customs¹

Saúde, religião e cultura: um diálogo a partir das práticas afro-brasileiras

Márcio Luiz Mello

PhD in Public Health Sciences. Researcher in the Laboratory of Innovation in Treatment, Teaching and Bioproducts, Fundação Oswaldo Cruz.

Address: Av. Brasil, 4365, Manguinhos, LITEB/IOC/FIOCRUZ, CEP 21040-360, Rio de Janeiro, RJ, Brasil.

E-mail: mello@fiocruz.br

Simone Santos Oliveira

PhD in Public Health Sciences. Researcher in the Center of Workers' Health and Human Ecology Studies of the Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz

Address: Av. Brasil, 4365, Manguinhos, CESTE/ENSP/FIOCRUZ, CEP 21040-360, Rio de Janeiro, RJ, Brasil.

E-mail: simone@ensp.fiocruz.br

¹ Financial Support: CAPES Sandwich Doctorate scholarship.

Resumo

Parte-se da constatação de que o modelo biomédico de atenção à saúde é incapaz de lidar isoladamente com a complexidade dos problemas de saúde. Sendo assim, produz-se maior interesse pelas ciências sociais aplicadas ao campo da saúde para se pensar a atenção integral ao paciente e a integração dos conhecimentos biológicos, sociais e culturais na compreensão das doenças. Este trabalho busca compreender as relações da religiosidade com a saúde e os processos de cura, procurando entender as formas como os indivíduos vivenciam a doença, o sofrimento, a dor e as práticas de cura. Trata-se de pesquisa exploratória de caráter etnográfico, com observação participante em um templo religioso afro-brasileiro, localizado no Rio de Janeiro. Um efeito fundamental da religião é alterar o significado de uma doença para aquele que sofre, não implicando necessariamente remoção dos sintomas, mas mudança positiva dos significados atribuídos à doença. A religiosidade dá sentido à vida, diante do sofrimento, ao criar uma rede social de apoio. Constatamos que a prática religiosa tem complementado as práticas médicas oficiais. As informações coletadas nos permitem afirmar que as práticas religiosas se constituem em lugares de acolhimento, de cura e de saúde para aqueles que as buscam. Apontamos para a necessidade de aprofundamento de estudos dessa temática que venham a se somar enquanto possibilidades de ajuda e alternativa de “cura” às pesquisas da prática biomédica.

Palavras-chave: Saúde e doença; Religião; Antropologia da saúde; Umbanda; Etnografia; Promoção da saúde.

Abstract

Resulting from a qualitative study of ethnographic characteristics, with participatory observation in an Afro-Brazilian religious temple located in a neighborhood of Rio de Janeiro, this investigation attempts to understand the relationship between religion, health, and the healing process, trying to comprehend the ways in which individuals experience illness, suffering, pain, and healing practices. Since the biomedical health model is unable to cope with the complexity of existing health problems, there is a greater interest in the way that social sciences can be applied to the medical field, allowing greater attention to be paid to patients, as well as to the integration of biological, social, and cultural understanding of disease. This approach reinforces the dynamic relationship between religion and health. A fundamental effect of religion is to alter the meaning of disease for the sufferer, not necessarily implying the removal of symptoms, but a positive change regarding the potential outcomes of the disease. Religion gives meaning to life when one is suffering, creating a network of social support. We have found that religious worship supplements official medical practice. The information collected allows us to confirm that religion provides a place of refuge, health, and healing for those in need. We note the necessity for further research that can be added to existing biomedical studies, so that people have a greater chance of being helped during the healing process.

Keywords: Health and disease; Religion; Anthropology of health; Umbanda; Ethnography; Health promotion.

Introduction

The biomedical health care model alone is not capable of dealing with the complexity of health problems in the Brazilian population, nor does it take into consideration the local characteristic of each region in a country the size of a continent, like Brazil. Analysis of this model produces greater interest in the field of health through applying social sciences as a way of thinking of the comprehensive care of the patient. Comprehensiveness, a basic principle of the Brazilian public health care system - Sistema Único de Saúde (SUS), seeks to combine biological, psychological, social and cultural knowledge in understanding the health/disease process. From the social science point of view, we can think of the biomedical model based on other, different models.

Thus, we resorted to studies of the socio-cultural dimensions of health/disease as a field of knowledge, above all in Brazil, which possess a great cultural variety of beliefs and religious orientations disseminated throughout its population. There are many studies, with a variety of foci, carried out in social science and health research institutes, in the field which is usually known as anthropology of health and disease (or, for some authors, medical anthropology), which includes research on meaning and significance attributed to disease and its treatment by societies, cultures and religions.

This study aims to contribute to the discussion of the complementarity which exists between official health care systems and religious treatments, the ways in which individuals experience and interpret disease, suffering, pain and curative practices, especially those contained in the afro-religious field. Thus, we seek to reflect on the way in which these religious practices interact, or may interact and what improvements in health care policies and practices can be made, knowing about this relationship.

Coordinating health care services with cultural practices and those of "traditional medicine" has been encouraged in international documents since the World Health Organization (WHO) Declaration of Alma-Ata, formulated for the International Conference on Primary Health Care in Kazakhstan in 1978, and stimulated globally by public policies.

Individual experiences relating to health and illness are not reported only in scientific publications. Patients are making their experiences known and using them as arguments to be taken into consideration when formulating health care policies (Herzlich, 2004, p. 386).

Thus, in 1996, the WHO and the United Nations Organization for Education, Science and Culture (Unesco) officially recognized the relevance of cultural aspects in many factors of international health. These two bodies proposed that health care and culture should be approached in a mutually integrated way from the perspective of benefitting individuals and countries (Helman, 2009).

Anthropologists such as Claude Lévi-Strauss and Marcel Mauss had already made important contributions to the field of health care:

[...] empirical studies by the abovementioned authors and by other anthropologists have shown what we already know from common sense: the fact that diseases, health and death cannot be reduced to organic, natural objective evidence, but that the experiences of individuals and social groups is closely related to the organizational and cultural characteristics of each society (Minayo, 2006, p. 205).

However, it is not so easy to define culture “[...] nobody really knows what it is [...] It is more than just a contested basic concept, [...] it is also defined in a variety of ways, used in all multiple ways and hopelessly imprecise” (Geertz, 2001, p. 22). Thus, this imprecise concept may result in mistakes in understanding cultural practices, either as isolated or as unchanging, leading to its reification. On the one hand, relationships between health care services and these different cultural practices reflect the appropriations and circulation of biomedical discourses and the health care field is their political workspace. On the other, operational difficulties regarding health care professionals working with non-dominant cultural groups are marked by tensions which underlie the logic of universality and normalizing health care procedures (Langdon, 2010). Thus, reflection on the relationships between health care services, different cultures, different religions, common knowledge and public policies need to be deepened.

The relationship between social science, anthropology and health care

With the development of the interpretative strand of anthropology came a new concept of the relationship between individual and culture, making a real integration of the cultural context into the way of approaching health problems possible (Uchôa e Vidal, 1994).

In the field of anthropology of health, as many interpretations of the health/disease phenomenon are valued, they seek to understand the ways in which individuals express and interpret suffering and pain, as well as therapeutic systems.

Anthropology’s growing interest in the health disease phenomenon, is far from the hegemonic biologist and mechanistic model of medicine, approaching analysis from the sociological and cultural slant of the different therapies, their institutional configurations and diverse specialties. It is possible to highlight a plurality of thought and practices about cures in societies in which culture binds together elements of beliefs and customs from various groups. There is a great variety of discursive interpretations of doctors and patients in whom disease can be studied in all its multiple, symbolic aspects, often through the narratives of the ill subjects themselves, as has been verified in several different studies (Costa, 2010; Caprara e Landim, 2008; Nunes, 2006; Carvalho, 2005; Alves and Minayo, 1994).

We know that the experience of illness is both individual and social; it belongs to the private domain and to public spaces “[...] the history of health care is also the history of countries and cities, of work, of war and of travel” (Herzlich, 2004, p. 384).

The meaning of being ill may be understood as feeling disagreeable sensations and symptoms (tiredness, headache, pain, drowsiness, weakness, lack of appetite, fever) which, identified by the doctor or by the patient, also represent the disease as a social and changeable construction, according to social group and cultural identity. Different diseases may manifest themselves differently in people in the same group, and in a similar way in members of different groups.

Patients' "discourses" about health and disease relate personal, private experiences which are, however, "socialized". They clarify some aspects of the relationships between the individual and their group in specific biographic contexts, marked by the disease (Herzlich, 2004, p. 386).

In other words, disease is more than a biological configuration, it is also a socially and culturally constructed reality and the sufferer is, above all, a social being.

Empirical and comparative anthropological studies have contributed to confronting the hegemonic biological model when this is presented to society as "the truth" or "the only truth". When it disregards the knowledge and experience of the patient with regard to the disease, as if this were not also a "truth"; as Minayo (2006) states, "[...] which is to say that there is no biomedical rationality independent of the cultural and historic context in which it is exercised" (p. 206). The author adds:

Within the logic of the structuralist methodology, on which evidence the similarity between scientific and mythic thinking is based, Lévi-Strauss [1963] contributed to the thinking of various therapeutic systems exercised in complex societies, including the hegemonic model. The author calls our attention to the fact that the social and individual contexts of the process of healing has a similar mindset. Everyone depends on the symbolic efficacy created by the interactive relationship of trust between doctor, patient and social expectations surrounding the model. Which is to say, that there is no biomedical rationality independent of the cultural and historic context in which it is exercised. (Minayo, 2006, p. 206).

Anthropology of health organizes the symbols and categories of disease through sources producing meaning - biological, social, cultural or religious. They seek to follow paths which do not always converge, emphasizing the importance of understanding everyday life and the views of those who live in communities with different cultural and social standards, as well as studying how these are related to health and disease. According to Costa (2010), it allows individuals to be understood from a holistic viewpoint, which covers not only their

cultural context but their subjectivities on delving more deeply into a closer understanding of the reality of falling ill.

Thus, anthropology of health takes into consideration different visions of the world of disease and the health care professional, collective attitudes to dealing with health problems, the disease from the point of view of the sufferer in light of society's norms and rules, as translated in moral or religious codes and, finally, the social ideal of what it is to be healthy (Minayo, 2006).

The relationship between health and religion in Brazil

In Brazil, social sciences in health care, including sociology, anthropology, political science and history have managed to develop and establish themselves as an area of research and teaching in a relatively short time - around three decades -, with many of the authors carrying research at the interface of sociology, anthropology and history.

Since the 1960s, various authors have dedicated themselves to mapping and characterizing the field of studies dedicated to anthropology in health in Brazil. According to Alves and Minayo (1994), even when it is opposed to the medical model, anthropology takes it as an object which reflects the multiplicity of therapeutic resources and "new" treatment forms, inside and outside official medicine, making it possible for knowledge and practice to appear which mix, and recreate and impose themselves on Brazilian society.

Thus, it is possible to recognize one of the most general characteristics of culture in Brazilian society is a belief in spirits, either of ancestors or other beings, and belief in their manifestation. ON this point, Velho (2003) states that:

The vast majority of Brazilian society is made up Roman Catholics. However, there are endless and frequent examples of Catholics attending spiritist centers and *umbanda* and *candomblé* rituals. When they do not do this in person, they use friends and relatives as intermediaries. Illness, employment and love are some of the issues which may lead traditional Catholics and Protestants, Jews, Atheists, Agnostics etc., to seek help, advice

and solutions with spirits of light, *pretos velhos*, Ogum, Xangô, and, why not, *exus* and *pombas-giras* (Velho, 2003, p. 25).

In Brazil, the majority of people believe in the action of the divine in preventing and curing illness. Around 89% of the Brazilian population agree that religion is important, 50% attend some kind of religious service. In 2009, a mere 6.72% of the population stated that they had no religion².

It is no coincidence that health problems are among the main reasons individuals seek religious help in Brazil. Although Brazilians talk about disease, both in etiological terms and in terms of available resources, they frequently question the distinction between material or physical disease and spiritual disease (Ferreti, 2003; Fry and Howe, 1975).

The logic of religious discourse, classifying diseases as material and spiritual, brings with it the supremacy of the spiritual (Montero, 1985). Even so, this differentiation is tenuous and the majority of diseases can be classified in both categories, according to the diagnosis and the treatment received (doctor, religious leader) or the decision to seek help with a “body specialist” (doctor, pharmacist etc.), a “soul specialist” (*mãe de santo*, Protestant or Catholic leader) or from all of these specialists at once. Religious specialists are frequently called on to deal with the same symptoms as doctors, as different studies have shown (Puttini, 2008; Redko, 1997; Rabelo, 1993; Laplantine and Rabeyron, 1989; Loyola, 1984).

Studies show, for example, that individuals suffering from mental illness seek religious institutions as part of their self-help mechanisms (Redko, 1997). In a study on the relationship between belonging to a religion as a protection factor in mental illness, Dalgalarondo (1997) observed that religious groups can function as an intense social support network, directly influencing the community’s tolerance of an individual suffering mentally, which may impact on the feeling of belonging and wellbeing on the part of the sufferer.

Studies of religion among the urban masses have indicated the central role of religious cults in thera-

peutic spaces. Rabelo (1993) argued that, in popular neighborhoods of Salvador, the number of cults which offer healing services “[...] is eye-catching [...]” (p. 316), raising the issue of understanding in what ways individuals make use of such services to deal with experiencing suffering. In these studies, the central argument is that religious therapies cure by organizing the chaotic experience of suffering and of those directly involved in the healing or responsible for it, demonstrating symbolic efficacy just as conceptualized by Lévi-Strauss.

In interpretative anthropology, Geertz (1989) stated that “[...] sacred symbols work by synthesizing the ethos of a community [...] and their vision of the world [...] religion adjusts human actions to an imagined cosmic order and projects images of cosmic order onto human experience.” (p. 67). And defines religion as follows:

A system of symbols which act to establish powerful, penetrating and lasting dispositions and motivations in man by formulating concepts of an overall order of existence and investing these concepts with such an aura of factuality that the dispositions and motivations appear uniquely realistic (Geertz, 1989, p. 67).

For the author, religion, through its symbolism, in which a truth is recognized, acts on the individual’s spirit and state of health:

For an anthropologist, the importance of religion lies in its capacity to serve both the individual and the group, on the one hand as a source of general concepts, albeit different, of the world, in itself and in relation to them - its model of attitude - and, on the other, of the entrenched “mental” dispositions, no less different - its model for attitude. From these cultural functions, social and psychological functions flow in turn (Geertz, 1989, p. 90).

He also comments from the point of view of religion, that suffering is not eliminated. This, the individual should understand it, tolerate it and bear it. In other words, instead of being consoled, the individual should learn to deal with suffering. Thus, religion allows us to understand the resour-

² These data were the result of research carried out by the Centro de Políticas Sociais/FGV, using the Household Budget Survey - Pesquisa de Orçamentos Familiares (POF) 2009 by the IBGE, as, at time of writing, statistics from the 2010 Census (the database traditionally used in studies on religion in Brazil) had not been published.

ces humans possess for expressing emotions, understanding the world, positively influencing their situation in life and adjusting to human experience and actions. Religious discourse enables us to think about problems within an organized logic, providing criteria for classifying and representing an integration of disorganized events, making them more bearable “[...] for the spirit the pain the body refuses to tolerate [...]” (Lévi-Strauss, 2003, p. 228); and this is often interpreted as a “cure”.

From this perspective, Laplantine and Rabeyron (1989) argue that there is no such thing as practice which is exclusively medical or magic-religious; and are in fact different and non-contradictory resources classified in two different levels of interpretation but inter-related: on the one hand, etiological-therapeutic processes and, on the other, questions of feeling and of significance. Thus, despite the hegemony of the biomedical model, there is social space for the coexistence of different forms of therapy and cure, which the authors name parallel medicine³.

This occurs principally in complex, modern-contemporary society, in which individuals have different lifestyles and views of the world (Velho, 1994), are subject to a large and diverse number of stimuli and are at the intersection of different worlds (Simmel, 2005). But which can share common definitions of reality and operate in the same, socially constructed area of significance (Schutz, 1979), as well as having common beliefs and values and interacting using the same networks of meaning in different contexts and experiences (Geertz, 1989), being able to vary the degree of adherence and commitment. These individuals who can live in and travel between “worlds which touch but do not mix” (Park, 1967, p. 32), generally delineated by cultural boundaries. They may play multiple social roles, dynamically associated with experiences and different levels of reality, in multiple contexts and different situations (Velho, 2003).

On discussing this criticism of complex, modern-contemporary society, Velho (2003) uses the concept of project, related to the concept of the field of possibilities. For the author, “[...] in this dialogue, individuals create themselves, they are created,

made and remade through their existential trajectories” (Velho, 2003, p. 8). Concepts such as lifestyle, world view, project and field of possibilities can be used in analyses of the therapeutic choices made by individuals seeking health.

There is a horizon of religious expectation which contrasts with scientific and technical rationalism (Laplantine and Aubrée, 2009). The sufferer - above all the Brazilian -, in general, combines various forms of treatment and alternates continually between them, often simultaneously and, socio-culturally speaking, in a non-linear fashion (Rabelo, 1993). Thus, the individual sufferer can try various possibilities of solving their problem, making their own therapeutic itinerary. “Cure” becomes a continuous search rather than a process of adherence.

The World Health Organization sought to recognize these different forms of practice in incorporating the concept of traditional medicine as an important strategy in improving a population’s health, and defined it as

[...] different health care practices, foci and knowledge which incorporate medicine based on plants, animals and/or minerals, spiritual therapies, technical manuals and exercises applied individually or combined to maintain wellbeing and prevent illness” (OMS, 2002, p. 17).

In Brazil, initiatives such as this drive the establishment of new policies by the Ministério da Saúde, such as the National Policy on Integrative and Complementary Practices, in the SUS (public health care system).

This context accentuates the discussion and requires an in-depth look at the concept of integrality - one of the founding principles of the SUS - with emphasis on social, symbolic and cultural aspects as: “Results obtained by integrative practices show them to be effective, although these practices do not go beyond those of official medicine” (Separavich e Canesqui, 2010, p. 253).

When applied to the health-disease process and the quest for health in religious institutions, interpretative theory does not claim to answer all of our questions, but it allows us to speak, look, understand and interpret the responses given, in the

3 LAPLANTINE, F.; RABEYRON, P. L., *Medicinas paralelas*. São Paulo: Brasiliense, 1989.

form of an interactive dialogue between subjects. Thus, culture provides the elements which make life events, such as health events, comprehensible. Therefore, the study of cultural interpretation is an effort to accept diversity between the different ways in which humans construct their lives in the process of living them (Geertz, 1989, 1999).

With regards to health, we can affirm that therapeutic practices vary according to the individual's culture and it is based on that culture that they explain their suffering and illness, make treatment choices and evaluate their results, redefining their situation in life.

We understand that, in interpretation, the principle should be the universe of meanings of individual experience. Thus, for Geertz, analysis of everyday actions enables us to give meaning to the world and these actions which give significance constitute what he calls common sense. The author defines this as an achievable way to discourse with a cultural system, which implies a "[...] single order, able to be empirically discovered and conceptually formulated [...]" (Geertz, 1999, p. 140) through knowledge of the forms it assumes in different locations. However, when studying culture, "common sense" should be taken into consideration, as thinking based on it constitutes a confirmation of the interpretations of experiences and part of real life, not abstract theories, thus constituting a colloquial knowledge which values reality. Such experiences in the area of health and religion provide possibilities for interpreting disease and therapeutic practices (Geertz, 1999)..

Methodology

Ethnography is the search for structures of meanings, contextualized through thick description, according to Geertz (1989). So, he carried out ethnographic exploratory research in an Afro-Brazilian religious house of worship. The group investigated was an *umbanda* group, located in Rio de Janeiro, RJ, to be specific, the Centro Espírita São Lázaro - Filhos de Obaluaê center, in Santa Cruz, a neighborhood in the east of the city. The field work took place using participative observation throughout 2009 and 2010, with widely spaced visits and observa-

tions organized in the form of a field diary. Data was also produced using open interviews, informal conversations and personal material belonging to the attendees and managers of the center, as well as by audiovisual recording.

In the state of Rio de Janeiro, only 15.95% of the population stated they had no religion. In addition to this, it has the highest percentage of attendees of Afro-Brazilian religions, with 1.61%, and of spiritists, 3.37. The city of Rio de Janeiro has the second most Afro-Brazilians in the country, accounting for 2.04% of the population⁴.

We appreciate that it is impossible for those unfamiliar with the cosmology and social organization of this cultural universe to understand issues of health and *umbanda*. Thinking about issues of disease and healing within this religion implies taking into consideration its cosmology, its rituals and the practices of its agents. Therefore, some, albeit synthetic, references are needed on the basics of the of the *umbanda* religion. It is not the aim of this study to provide a detailed analysis of *umbanda*, and we consequently limit ourselves to a few references which will enable the inclusion of this Afro-Brazilian religion in the research to be understood.

The term "*umbanda*" is Bantu in origin and is the name of a Brazilian religion which reflects the history and society of the country and is a set of practices capable of accompanying the rapid transformations of an increasingly global, pluralist, multi-cultural and inter-racial society (Bairrão, 2002; Ligiéro and Dandara, 1998; Freyre, 2005; Birman, 1985).

This religion synthesizes native indigenous spirits, African *orixás* and Catholic saints, as well as reworking the idea of reincarnation into light of the Kardek spiritism (Laplantine, 2001).

In the field work, we consulted Zé Pelintra, the most important cult figure in the group studied. The investigation was driven by the initial perception of Zé Pelintra, a myth from the *umbanda* pantheon, the "malandro divino - divine rascal" (Ligiéro, 2004). After being absolved by the pluralist *umbanda*, the roguish Zé Pelintra is transformed into a significant hero-type being and becomes "light", energizing the convalescent spirits of the people (Lages, 2007; Ligiéro, 2004).

⁴ Research carried out by the Centro de Política Sociais/FGV.

The criterion for choosing *umbanda* and this character was due to their recognized historical importance in forming the Brazilian identity and socio-cultural reality (Birman, 1985).

The religious context of *umbanda* and health in Rio de Janeiro

The Zé Pelintra we came to know in the field work attracted our attention because of his charisma and the welcoming which captivates people, trying to comfort them in their problems, always ready to help those who turn to him. During one of the consultations, Seu Zé surprised us with the following illustrative statement:

I look after my people (...). I deprive wickedness, help find work, help the innocent get out of jail, help them to be healthy, give advice (...). My people count on me (...). The higher my people raise my name, the more I grow spiritually. My people need to know who I am and what I do.

During this study, we learned that individuals turn to *umbanda* in order solve various types of problems, health problems or otherwise. A large number of individuals turn to *umbanda* cults because of illness, seeking relief from illnesses of the body and afflictions of the soul. *Umbanda* is similar to health promotion as it constitutes a support network, offering “healing” services, operating in various social classes, even where there is access to official health care systems, including the SUS.

For *umbanda*, what causes an individual to be fall sick is a weakening of their *axé*, an African word, signifying life force). *Axé* is transmitted to the individual by various spirit entities which descend on the mediums (loyal followers who act as intermediaries between the divinities and the patients) during the rituals. During the session, the entity used the medium’s body (incorporation) and thus carries out the consultation. Both the followers and the patient receive *axé* during the consultation (Laplantine, 2001).

The religious response to problems such as mental disorders, emotional difficulties, physical illnesses etc. is certainly not restricted to resolving specific, easily identifiable issues. Often, when individuals

turn to religion, we see that what they want is something difficult to define, be that an explanation, comfort, advice, at any rate, “something more” as an answer and to heal diseases, concerns and distress. It is here that the *umbanda* religion essentially differs from the hegemonic biomedical practice: whereas one promotes fragmentation and specialization, (Luz, 2005), the other tries to provide integrality, caring for the individuals as a whole, holistically.

A fundamental effect of religion is in changing the meaning of disease: in the same was as it can lead to a change in the sufferer’s world view. This does not necessarily mean that symptoms disappear, but rather a positive change in the meaning the individual attributes to their illness, perhaps even resulting in lifestyle changes.

In *umbanda*, the spirits address specific types of human requests. In general, *exus* deal with problems involving money and emotional discord; *caboclos* and *pretos velhos* prescribe herbal remedies and give advice. However, for one of our interviewees, *exu* also heals; *it depends on your faith*. These entities are essential to understanding cosmology, diseases and healing processes in *umbanda*.

In the group studied, the adepts classified diseases into five categories: diseases which we bring from other lives (karmic), physical and mental diseases (interpreted as consequences of non-developed or poorly developed channeling), diseases caused by others and diseases caused “by bad spirits” or by “obsession”. It is interesting to note that the four categories could be seen as one bigger category of “spiritual diseases”, in contrast to what we call physical diseases. However, the “physical diseases” category is constituted by exclusion, based on the impossibility of classification in the other four categories and on cultural exchanges with the hegemonic medicine, caused simultaneously by physical and spiritual aspects.

In the words of one of the interviewees, karmic diseases need to be *atoned for as the individual evolves spiritually and morally; it is a form of correcting errors from past lives*. Diseases caused by channeling, according to the interviewee, manifest themselves in the form of *fainting fits and headaches*. They are interpreted as resistance to the passage of a spiritual entity which *needs to develop*.

I was walking in the street and I took ill, I suddenly fell to the floor. I knew that I needed to develop and work on my channeling, but I didn't bother. I have had this since I was a child, when I attended the center with my mother. It runs in the family. After that, I started to attend again, coming to this center here, I started to deal with it better and stopped fainting and falling in the street.

Indeed, this experience of disorders as symptoms of undeveloped channeling is a common factor in stories of entering *umbanda*.

In relation to diseases and afflictions caused by others, they are *caused by envy or by the spells of those who wish to harm you*, as one adept described. Those caused by bad spirits were defined as follows by the director of the group:

It is when a bad or delayed spirit, who is wandering around here, starts to influence us and stays by our side, sucking up our energy, causing weakness, headaches, fainting, putting evil ideas into our heads. You're fine, and then suddenly you become ill.

The other diseases affecting individuals who turn to the group and which do not fit into any of the four classification above are physical or material diseases. In this case, when the sufferers symptoms suggest recognizably organic illness, the entities advise and guide them to an alternative cure, generally associated with the official health care system or popular medicine, in parallel with "spiritual" treatment as, even in such cases, there is a spiritual dimension, as can be seen in the statement below, on the message received by a medium when consulting with an entity, suggesting complementarity between therapies:

Here, we're doing our bit. You have to come here... work... but you can't neglect to see a doctor, the guy in the white coat. You keep taking the baths, but you have to take the medicines.

It is identifiable that, in *umbanda*, diseases are always of a spiritual origin. In the group, scientific and popular medicine are generally seen as complementary, despite the tensions which exist between them (Ferreti, 2003).

Health related care provided by *umbanda* may vary depending on the cause of the infirmity or affliction. Thus, they are generally provided in the form of works of healing requesting the patients

to make offerings to the spiritual entities, prayers, baths and cleansing the body and the spirit, in addition to guidance regarding nutrition, aimed at re-equilibrating the sufferer's "energy".

Our field work observations in the *umbanda* concerning disease, although preliminary, allowed us to corroborate Magnani (2002) who, studying mental illness and healing in *umbanda* stated:

Bearing in mind that for the *umbandistas* body and mind constitutes a single unit, belonging to the physical world and opposing the spiritual, cosmic, plane mental illness always appears in discussions on disease in general. Bad spirits, sins not atoned for in a previous life, undeveloped channeling, influences of third parties, spells - this can all lead to disturbances in the body as well as the mind (Magnani, 2002).

It is though this system of "exchange" between the human world and that of the entities, in which *umbanda* is the mediator, that "healing is achieved". This system is encouraged by the "obligations" and offerings that the sufferers need to make to the entities who will cure them. *In this way, the entities respond to their requests for health.* (Interlocutor 1). There are other types of offerings: those given in gratitude for requests granted.

It should be underlined that it is not necessary to be initiated into the religion in order to benefit from its "services". Thus, the centers have regular attendees, believers and initiates, and others who turn to them sporadically. What often happens is that the individual obtains what they wished for and becomes a regular attendee and is initiated into the religion.

Final Considerations

Studying a religion enables us to think about the influence of cultural beliefs and practices in incorporating specific habits into the individual's life, including looking after their health. Reassessing anthropology of health concepts invites us to take another look at our understanding of the health-disease process, breaking the dichotomy between them which has been constructed over time, as health became based on Western medical-scientific based discourse.

We affirm that, in the same way as in other religions, as can be seen in research analyzed, in the group we studied, the *umbanda* religious practices complemented official medical practices. They take place in welcoming places, where the meanings of life, of cure and of health are reframed. They incorporate a health support network for those who find themselves in a situation of illness, helping them re-establish health and providing them with a better response to medical scientific treatment. Religiosity gives meaning to life in the face of suffering, including encouraging the creation of a social support network, influencing the acceptance of the sufferer's community, giving them a sense of belonging and of wellbeing.

The study reinforces the idea that a fundamental effect of religion is modifying the individual's world vision. This does not necessarily mean that symptoms disappear, but that the significance the individual attributes to the disease changes, perhaps even resulting in a change in lifestyle.

To summarize, religious practices complemented official medical practice and, despite sometimes being stigmatized, subsidized the hegemonic biomedical model. Although the group was a religious institution and not a health care institution in the strictest sense, its agents generally operated in the field of (popular or alternative) medicine. In other words, these groups are places which promote health and demonstrate the tenuous and fluid character of the borders between the world of official biomedicine and the relative underworld of popular and religious therapeutic practices.

Although this was an exploratory study, the field research, with participatory observation enabled us to get a closer understanding of the everyday reality of the individuals' who attended the *umbanda* places of worship.

It is important to consolidate and deepen knowledge in this area in order to gain a wider perspective of the possibilities of promoting health, from a cultural perspective. Thus, we emphasize the need for more studies on this topic, seeking to understand new meaning and significance for pain, suffering and healing processes which will add to the "healing" alternatives of research in the area of health care.

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Received: 18/04/2012
Approved: 28/01/2013