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Health care in a community of followers of traditional African-Brazilian religions

ABSTRACT

OBJECTIVE: To understand the concept of health and the source of psychological distress among followers of a traditional African-Brazilian religion.

METHODOLOGICAL PROCEDURES: Qualitative study performed in a community of followers of a traditional African-Brazilian religion, in the city of Porto Alegre, Southern Brazil, between 2007 and 2008. The priest/*Babalorixá* and six followers of this community participated in the study. Open interviews, which were recorded and subsequently transcribed, were conducted to collect data and construct the corpus of analysis. Report categorization, based on the complex systemic approach, enabled the construction of two main themes: 1) religious community and concept of health, and 2) origin of psychological distress and cultural identity.

ANALYSIS OF RESULTS: In this religious community, traditional health therapies, such as the use of herbs, baths, diets and/or initiation rites, were associated with conventional therapies proposed by the *Sistema Único de Saúde* (SUS – Unified Health System). Bonds with and belonging to a territory, the relationships among individuals, and the relationship among their spiritual, psychological and physical dimensions are considered in their concepts of psychological distress and health.

CONCLUSIONS: The way to understand and act in the world, as experienced in this community, with its myths, rites, beliefs and values, constitutes a set of legitimate types of knowledge in its context, which oftentimes opposes and goes beyond professionals' technical-scientific knowledge and truths. This community is a space marked by welcoming, counseling and treatment of followers, where the physical, psychological and spiritual dimensions are integrated in these practices. As regards the black population health, psychological distress results from their having been uprooted from African black cultures.

DESCRIPTORS: Religion and Psychology. Primary Health Care. Health Knowledge, Attitudes, Practice. Qualitative Research. Community of Followers of African-Brazilian Traditional Religion.

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INTRODUCTION

Communities of followers of traditional African-Brazilian religions – common territories of preservation and cult of African-derived and African-Brazilian religions – are places for welcoming and counseling of historically excluded groups,[17] among which is the black population. According to Silva,[17] ritual practices and interpersonal relationships brought about in the community

enable welcoming, emotional exchanges, construction of knowledge, health promotion and prevention, and renewal of traditions, such as the therapeutic use of plants.

The *Ministério da Saúde* (Brazilian Ministry of Health) considers service improvement and the increase in resolubility and number of approaches, such as traditional therapies, to be priorities in the *Sistema Único de Saúde* (SUS – Unified Health System) user care, once therapy and prevention choices are made available, increasing access to health. Thus, Ministerial Decree N. 971/MS, approved in 2006, made a decision on the *Política Nacional de Práticas Integrativas e Complementares no SUS* (SUS National Policy on Complementary and Integrative Practices),[a] meeting the World Health Organization (WHO) recommendations[15] about valuing traditional and complementary/alternative medicine. Among these are drug therapies (use of phytotherapy, animal and/or mineral parts) and non-drug therapies (manual and/or spiritual therapies).

In the perspective of this policy, a health care proposal for the black population in Brazil needs to consider the recovery, de-stigmatization and valuing of African-based knowledge and therapeutic practices,[14] as well as the dialogue between traditional knowledge present in the community and technical-scientific knowledge proposed by the SUS. Lopes[8] points to the need to reestablish the bonds among subjects[b] and their black African ancestry, recovering their cultural identity through knowledge about their past and current reality, which necessarily leads to health.

The proposal to design a health policy for the black population is recent in Brazil, with the following historical marks: 3rd World Conference against Racism, Racial Discrimination, Xenophobia, and related Intolerance Practices, held in Durban, South Africa, in 2001, and the 1st National Seminar on Black Population Health, held in Brasília, Brazil, in 2004.[9] In 2006, the National Policy on Black Population Comprehensive Health[c] was approved, including in its directives the encouragement of recognition of health practices and knowledge preserved in religious communities.

In professional practice, it is well-known that people, before seeking SUS services, search for welcoming, counseling and care in these traditional communities. However, it is unknown in the academic world how these practices are based and performed, which, oftentimes, leads to a psychopathological and stigmatizing interpretation of African-Brazilian religious phenomena, preventing dialogue between professionals and community leaders. This lack of awareness results from scarce academic production about such practices. Research performed with the main databases indexed in the international scientific literature found only one study on this issue performed in Brazil.[17]

In view of this, the present study aimed to understand the concept of health and the source of psychological distress in followers of a community of a traditional African-Brazilian religion.

METHODOLOGICAL PROCEDURES

This study was performed based on qualitative theoretical-methodological assumptions of the case study[19] and on complex system thinking principles.[10-12] Participants were the priest/*Babalorixá* and six followers of an African-Brazilian religious community in the city of Porto Alegre, Southern Brazil.

The community investigated was chosen for convenience. It is a *terreiro de batuque* (common territory of preservation and cult of African-derived and African-Brazilian religions in Southern Brazil) which has 80 years of history, is based on the *Jeje-Nago* tradition, has about 150 followers, and is located in a predominantly black community which is socially vulnerable. The leadership of this community has had, in the last ten years, significant inclusion and also played a major role in the African-based black social movement and religious groups. The priest/*Babalorixá* was selected as the reference participant for data collection and validation of study as he was the highest authority in the community, belonged to the community, and knew the subject studied. According to Yin,[19] one strategy for data validation is to send the report draft for key-informant review, named reference participant. A total of three participants were recommended by the reference participant and the other three were conveniently selected. Selection criteria were the following: to have participated in the community for at least ten years and to be available to take part in the study. To collect data and construct the corpus of analysis, open interviews were conducted, focusing on the research topic, recorded and transcribed, after obtaining consent from participants and guaranteeing secrecy and anonymity. A total of two interviews were conducted with the priest/*Babalorixá* and one with each of the remaining participants, totaling eight interviews, between January 2007 and May 2008. All interviews were conducted in places suggested by the interviewees.

Interview analysis was performed in two stages:

[a] Ministério da Saúde. Portaria nº 971, de 3 de maio de 2006. Aprova a Política Nacional de Práticas Integrativas e Complementares (PNPIC) no Sistema Único de Saúde. *Diario Oficial Uniao.* 4 maio 2006;Seção 1:20-5

[b] Subject's notion by Morin (2003),[11] derived from a bio-logical basis, corresponding to the proper logic of the living being. It refers to an individual that depends on the biological, social and cultural environment for becoming autonomous – auto-eco-organized subject

[c] Ministério da Saúde. Secretaria Especial de Políticas de Promoção da Igualdade Racial. Política nacional de saúde integral da população negra. Brasília; 2007.

1. After transcription of the first interview conducted with the reference participant, his reports were categorized into two main themes: religious community and concept of health/ psychological distress and cultural identity. These themes were built in an interrelated manner and enabled the interpretative process from the complex systemic approach,[1,2] which proposes a dialogue among empirical material, participants, researcher and theoretical knowledge. In this way, researcher would analyze the material according to a point of view that must be clarified to the participant.

After theme categorization, a second interview was conducted with the reference participant to provide validity and reliability to both themes and produce complementary information.

When the two interviews were concluded, a text that combined the empirical material and theoretical knowledge was produced. This was subsequently shown to the reference participant for detailed reading and for new inner validation and reliability of analyses.

2. After transcription of the six interviews conducted with the remaining participants, reports were combined to the main themes previously developed. Results were shown to the reference participant once more for inner validation and reliability of analyses, as in stage 1.

In agreement with Morin's[10-12] complex systemic thinking, constant dialogue between researcher and reference participant was essential for data analysis. Dialogic, hologramatic (relationship between parts and the whole) and organization recursivity assumptions between researcher's knowledge and participants' knowledge were adopted.[10,11] Academic visibility was sought to be given to traditional knowledge, without its being uncharacterized or decontextualized.[1,2]

The study was approved by the *Comitê de Ética em Pesquisa da Pontifícia Universidade Católica do Rio Grande do Sul* (Rio Grande do Sul Pontifical Catholic University Research Ethics Committee) and followed ethical procedures from the *Conselho Federal de Psicologia* (Federal Psychology Council), which regulates human research practice.

ANALYSIS AND DISCUSSION OF RESULTS

Religious community and concept of health

In the community, therapeutic practices with health promotion and prevention actions are developed, based on a universe that integrates the physical and spiritual worlds. Thus, such worlds are believed to coexist, to be interdependent and to complement each other, constituting a cosmic unit in which all elements or beings are connected. The physical world is visible and palpable, while the spiritual is invisible and immaterial. This is one way to understand the world and, as a result, the health-disease process, based on the mythical-religious cosmovision and, at the same time, on the complex systemic field, as it conceives the dialogics between the physical and spiritual worlds:

"(…) The nervous system is interconnected to the spiritual part (…)." (reference participant)

Ancient civilizations have two types of knowledge and action: a "symbolic/mythological/magic" one and an "empirical/technical/rational" one.[12] Though distinct, they complement each other and are intertwined in the complexity of their context, without one reducing or diminishing the other.[12] It is in this perspective that these traditional communities know and act towards the health-disease process. Reports of herbal baths associated with prayers are an example.

The community works with a concept of health which is thought about and developed in the relationship between the symbolic and the concrete, the natural and the technological, the mythical and the empirical, complementing each other and constituting the meaning of comprehensiveness experienced by this community. While the SUS understands comprehensiveness as an "integrated and continuous set of preventive and treatment-centered actions and services, both individual and collective, required for each case in all levels of complexity of the system.[a] In this community, comprehensiveness presupposes the relationship between the spiritual and physical dimensions that constitute individuals. This concept of health comes from a view of the complete individual:

"Conventional medicine conceives man as a machine (…). It doesn't do what African religion does, which is to see a person as a whole, as a complex." (reference participant)

Mattos[b] mentions that comprehensiveness is a guiding principle for professional practices, service organization and health policy-making, thus implying refusal of reductionism and objectification of individuals, and perhaps an affirmation of dialogue being opened between them. However, it is understood that "the act of opening a dialogue" needs to be seen as an organizer of all and any health action, service and policy, so that, in this way, dialogue between the community and the SUS does not remain under the sole responsibility of the individual, attributing importance and need to both traditional and conventional therapies:

[a] Ministério da Saúde. Lei n.° 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e da outras providências. *Diario Oficial Uniao.* 20 set 1990; Seção 1:018055.
[b] Mattos RA, Mattos RP, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: ABRASCO; 2001.

"I'm gonna continue taking the medication, follow both things together, science and religion (…)." (participant A)

According to the WHO,[15] different approaches to traditional and complementary/alternative medicine encourage natural health promotion and prevention resources, with an emphasis on welcoming listening, the establishment of bond and integration between the individual and the context in which they live. The religious community has a way to produce health that puts into practice a proposal from the *Humaniza SUS* (SUS Humanization Program):[a] individuals have their place of belonging and established bonds, associated with being with another in a subjective-objective relationship, building a support network that produces health in its broad sense. This network results from actions of individuals in relationship, it is a health producer.[2] In this community, followers know there is space to care and be cared for, to listen and be heard:

"That family sought the community to be (…) guided as to how to deal with that being, how to include that being in society (…)." (participant D)

The religious community, with its rules and values, enables the building of collective and interpersonal relationships when seeking to listen to, care for and welcome the other, which, due to similarities and differences, is associated with the SUS National Policy on Humanization[b] and with one of its directives of "ethical/aesthetic/political" relevance, the welcoming practice.[b] Both presuppose valuing individuals when producing health, establishing bonds, identifying health social needs, and being in relationship with the other with a subject-subject attitude:

"The humanization of the SUS (…) is a term that has close ties to African roots, because (…) we conceive ourselves as part of a whole, we're collective beings. (…) People are warmly welcomed. We say 'stay in the community, don't leave, sleep over, have a cup of coffee, let's chat (…)', apart from all spiritual care (…). We got to know how to listen, because people need to talk, to communicate, to explain their problems." (reference participant)

The support network built in the religious community, the collective and interpersonal relationships, and the bonds established acquire sense and meaning for each of the followers. They constitute a group, which creates a self-organized path/method, aiming to make the community a place of solidarity, welcoming and health production:[16]

"I grew fond of going there [in the community] and to discover that I was finding answers for many nagging questions. When I had a question, there was someone who could listen to me. If I had a problem (…) I'd start talking about this problem with someone who always had something to say (…)." (participant D)

Source of psychological distress and cultural identity

As regards the source of psychological distress, it is understood in the religious community that spirits, known as *Egun*, were not properly transported to the spiritual world at the moment of death, remaining in the physical world and causing an imbalance between individuals and the cosmos. Such imbalance is manifested as disorders and suffering, as exemplified in the following report:

"When you start to be influenced by spirits which aren't in a good situation, they end up passing all they feel to you. Then, you get depressed, begin to cry, get anxious (…). Many things that won't show if you go for a check-up and (…) it's labeled as nervous system and sometimes the person is thought to be crazy (…)." (reference participant)

According to Lopes,[7] it is possible to restore balance by conveniently and correctly manipulating the forces present in the cosmos. In the religious community, the mediator of this "manipulation of forces" is the priest/*Babalorixá*, who, by consulting the oracle, prescribes therapies for disorders and suffering resulting from the imbalance between the individual and the worlds that surround him. The *ebós*, herbal baths, diets and initiation rites are among the traditional therapies prescribed:

"Ebó is all that we offer a deity and the orixás (…) Bori is to give food to the head. When we do this ritual, we're organizing the person's head, we're putting everything in its proper place." (reference participant)

The concept of "giving food to the head" expresses the function and what is essential in this ceremony, i.e. "to nourish the head", to strengthen it, may have a therapeutic and healing quality:[3]

"After I did Bori, I was full of energy again (...), gaining vitality. I decided to go back and face it all (...)." (participant B)

Initiation rites constitute a process of life regeneration, of continuation of a cycle, considering what must die to be reborn.[4,5] The *Bori* ritual is a traditional therapy unconditionally accepted by followers, performed in a systematic way, and frequently associated with conventional therapies:

[a] Ministério da Saúde. Humaniza SUS: Política Nacional de Humanização. Brasília (DF); 2004.
[b] Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Acolhimento nas práticas de produção de saúde. 2.ed. Brasília; 2006. (Série B. Textos Básicos de Saúde).

"They [the doctors] say that it's a disease without cure, and they'll give medicines to reduce its effects. The Baba says it's a question of ancestry (…) I think the first thing to do is Bori, (…) to settle down (…) And I'll continue taking the medication." (participant A)

In the perspective of the community, traditional therapies do not usually compete against SUS treatments, nor do they come into conflict with each other. These practices are understood by their followers as complementary, causing them to be committed to and responsible for health care. These practices corroborate the National Policy on Integrative and Complementary Practices in terms of health action rationalization, promoting innovative alternatives that contribute to sustainable development of communities.[a]

The other way to understand the source of psychological distress is associated with the annihilation of the cultural identity of Africans and their descendants during and after slavery, by denying their cultures and ethical, aesthetic and cosmological values, suffered during the compulsory integration into the Western white model, supposedly universal. According to Nascimento,[13] the strategy to reduce Africans and their descendants to the condition of simply "black" stripped them of their cultural-historical point of reference and their identification with the group to which they belonged, thus reducing their ethnic identity to skin color, synonymous with inferiority, submission, subservience and slavery:

"Beginning with the inclusion of our ancestors into the Western world through violence, and the kidnapping in Africa, many psychological problems have been revealed, such as the process of de-identification (…)." (reference participant)

"(...) I want to consult with an entity to be guided, because I'm feeling sick. (…) She said to me: there's a path in your life that didn't begin with you. It began with your ancestors. It's a legacy, a history, a tribute, the very life you haven't realized how to live. But you'll manage to reclaim it." (participant D)

This annihilation of Africans' cultural identity in Brazil brought about a deadly nostalgia, known as *banzo*, which resulted in deep sorrow and apathy.[6] This psychological distress still has negative effects on the black population health. According to a study performed by Souza,[18] feelings of guilt and inferiority, insecurity and anguish, self-deprecation and conformity, and an euphoric, submissive and resigned attitude are all experienced by black Brazilians, who feel disappointed about themselves as they cannot meet the expectations imposed by an ideological process which brings the image of the white individual as an ideal to be achieved.

Aiming to meet this demand, the National Policy on Comprehensive Health of the Black Population brings, in its management strategies, the strengthening of the black population's mental health care, with the purpose of preventing psychological distress resulting from the effects of racial discrimination and social exclusion.[b] Similarly, studies point to the need to recover historical, cultural and identity points of reference which enable the black population to build a positive cultural identity[8,13] and, consequently, produce health:

"This period allowed me time to think, assess, and form opinions (…) about some aspects of this religiosity: the question of identity, of autonomy, of ethical principles (…)." (participant C)

Coming closer to and experiencing the cosmology of the religious community tends to lead the individual towards a process involving the initiation itself, which will continue in the network actions of the community:

"My initiation was a recovery, because I found myself (…). I reached a point in my life where I felt something was missing (…). I couldn't sleep well, I'd burst out crying, (…). For one year, I had the same dream many times (…). I asked myself: is this depression? (…) I went to a doctor (…), they did blood and urine tests and it was all fine. (…) I'd already visited this community. Then, one day, I said (…): I'd like to consult an entity, because I'm feeling sick (…)." (participant D)

By working with the physical-spiritual-cultural triad, the religious community, with its self-organization, has a way to produce health that surpasses the technical-scientific truths of conventional practices. It functions based on broader understanding of the health-disease process, corroborating different traditional therapeutic approaches recommended by the SUS National Policy on Integrative and Complementary Practices, which act in the perspective of health prevention, promotion and recovery, emphasizing comprehensive, continuing and humanized care.[a]

In its own way, the religious community organizes itself to deal with questions related to its members, by rearranging and strengthening resources fundamentally based on collective and interpersonal relationships. These relationships imply work with groups

[a] Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Acolhimento nas práticas de produção de saúde. 2.ed. Brasília; 2006. (Série B. Textos Básicos de Saúde).
[b] Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política nacional de práticas integrativas e complementares no SUS - PNPIC-SUS. Brasília (DF); 2006.
[c] Ministério da Saúde. Secretaria Especial de Políticas de Promoção da Igualdade Racial. Política nacional de saúde integral da população negra. Brasília (DF); 2007.

in health services, as stated in the Ministerial Decree N. 224/MS, which establishes norms for care at SUS services.[a] Thus, a group/method which is found to be effective in health care, constituting a non-material health care technology.[b]

FINAL CONSIDERATIONS

In a community of followers of traditional African-Brazilian religions, bonds with and belonging to a territory, the relationships among individuals and the relationships among the physical, psychological and spiritual dimensions are essential for the etiological concepts of psychological distress and health.

As regards the black population health, it should be emphasized that psychological distress results from individuals being uprooted from their African black culture and that the collective history, rather than the individual history, needs to be recovered primarily, to achieve health in its broadest sense.

The way to understand and act in the world, as experienced in the religious community, with its myths and rituals, its beliefs and values, constitutes legitimate knowledge and truths in its context and which oftentimes opposes and surpasses professionals' technical-scientific knowledge and truths. Thus, the truths that develop SUS practices and services should be reflected on, in the sense of being open to other truths, following a dialogical approach. It is necessary to open dialogue between the SUS and the religious community so that new support and care networks can be constituted, enabling human resource optimization and strengthening of social equipment. This is a way of producing health that emphasizes abundance, rather than lack of resources, thus leading to an increase in resolubility and access to health, in addition to enabling the black population, identified with the religious communities, to have comprehensive health care.

Knowledge originated from this study, apart from recognizing the academic importance of traditional African-based health practices, will constitute a potential source of information for professionals who work with black and non-black populations that associate SUS therapies and those provided by religious communities.

[a] Ministério da Saúde. Portaria n.º 224, de 29 de janeiro de 1992. Diretrizes e normas para o atendimento ambulatorial/hospitalar em saúde mental. *Diáario Oficial Uniao.* 30 jan 1992;Seção 1:1168.

[b] Seminotti N, Guareschi N, Pelliccioli E, Alves M, Oliveira C, Baldi M. Projeto Acolhimento: sensibilização de trabalhadores da rede básica de saúde através de intervenções em grupos. In: Ortiz JN, Bordignoi MO, Gralha R, Fagundes S, Coradini SR, organizadores. Acolhimento em Porto Alegre: um SUS de todos e para todos. Porto Alegre: Prefeitura de Porto Alegre; 2004. p. 64-6.

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