



Afro-Brazilian Religions and Ethnic Identity Politics in the
Brazilian Public Health Arena

A. Pagano

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Abstract

In this article, I examine the ways in which health activists from Afro-Brazilian religions deploy ethnic identity politics within the Brazilian public health arena to gain recognition and respect for their beliefs and practices, as well as public health goods for their communities. I then discuss the creation and enactment of “culturally competent” healthcare initiatives for members of Afro-Brazilian religions. Finally, I provide a critical analysis of the tension between universal and particular identity frames that emerges within the political discourses of health activists from Afro-Brazilian religions. Throughout, I place this case study in dialogue with global health policy as well as scholarship on minority health politics and cultural competence initiatives in other parts of the world.

Keywords: Brazil; identity; ethnicity; religion; minority health; cultural competence

Afro-Brazilian Religions and Ethnic Identity Politics in the Brazilian Public Health Arena

A. Pagano¹

1. Introduction

The debate about health care within Afro-Brazilian religions raises ethnic and racial issues because it involves spiritual factors that are molded by African ancestry....Our health care model, practices, and instruments are all associated with a worldview that is neither Afro-Brazilian nor Japanese—it's *African*. (Pai Mário, May 2009)²

Pai Mário is a priest of the Afro-Brazilian religion Candomblé in São Paulo, Brazil.^{3,4} When he is not presiding over his *terreiro* (temple) or working as a policy analyst at the city's STD/AIDS Program, Pai Mário lobbies the state to secure better health care for black Brazilians and for members of Afro-Brazilian religions. Through his simultaneous roles as health activist, public health administrator, and religious authority, Pai Mário helps to enact a new paradigm of public health policy in Brazil— one that is infused with a politics of racial and ethnic difference.

In the last several years, Brazil has become a prominent site for health activism and medical intervention directed toward individuals of African descent. It is now one of the few nations in the world with race-specific health policies and programs (others include the United States and Britain). Similar to what Steven Epstein (2007) describes in the case of U.S. biomedical research, Brazil has adopted an “inclusion-and-difference” biopolitical paradigm wherein citizens are able to claim equitable access to certain public goods by identifying as members of a racial or ethnic minority group—in Brazil, these groups are black (*negro/a*) and indigenous (*indígena*).⁵ The public goods in question include health services, such as screening for certain diseases considered more prevalent in minority individuals, and educational measures such as affirmative action quotas within higher education. Here, I

¹ School of Public Health, University of California, Berkeley / Prevention Research Center, Berkeley, California.

² All names have been changed for purposes of confidentiality.

³ Afro-Brazilian religions are a variety of African-based, spirit-possession religions with diverse pantheons, ritual registers, and ritual practices. They arose through an amalgamation of several different African religious systems during the transatlantic slave trade to Brazil, and subsequently became syncretized to varying degrees with Catholicism and Kardecist Spiritism.

⁴ “Pai” means “father.” It is short for “pai-de-santo,” or “father of the saint.” The title refers to a male member of an Afro-Brazilian religion who has initiated other members (“filhos-de-santo,” or “children of the saint”). The female equivalent of “pai-de-santo” is “mãe-de-santo” or “mother of the saint.”

⁵ See Fry (2004) and Maio & Monteiro (2005) for critical analyses of how “black health” (*saúde da população negra*) became a separate area of health policy in Brazil. On the development of indigenous health policy, see Langdon (2004). Also, see Varga (2007) for a useful summary and critical discussion of racialization debates surrounding minority health policy in Brazil.

focus on health policies created for Brazilians of African descent, rather than indigenous Brazilians, due to the greater visibility and controversy of identity politics surrounding health programs for the black population.⁶

There is little question that significant health disparities exist in Brazil between “whites” (*brancos*) and “blacks” (*negros*).⁷ Recent studies show that black Brazilians (operationalized within health policy as individuals identifying as “black” or “brown” on the Brazilian Census) die in greater numbers than whites from HIV/AIDS, homicide, alcoholism and mental illness, stroke, diabetes, and tuberculosis (Araújo 2009; Batista, Escuder, and Pereira 2004; Santos 2007). Epidemiological data also demonstrate that blacks experience higher rates of maternal and infant mortality in comparison to whites (Martins 2006). As of 2000, black Brazilians’ life expectancy was 5.3 years less than that of whites (Cunha 2008). This scenario presents a serious public health problem for Brazil, especially given that just over half of the Brazilian population now identifies as either *preto* (black) or *pardo* (brown) on the country’s Census (IBGE 2009).

The identification of black individuals in Brazil, however, is challenging due to the country’s famously complex system of racial classification. Because Brazilians’ popular race taxonomy describes appearance rather than ancestry, there is a plethora of terms to indicate variations in skin shade, hair type, etc. When the Brazilian Census bureau included an open color question on a 1976 household survey, for instance, respondents responded with 136 different color terms (Nobles 2000). This is an example of the “popular” system of racial classification (Telles 2004). As for the “official” classificatory system, the Brazilian Census currently provides only four color categories: white, brown, black, and yellow (*branca, parda, preta, amarela*) and one “ethnic” term, *indígena* (indigenous). The Census model is used for bureaucratic recordkeeping and official documents such as birth certificates. In recent years, yet another system of race classification has emerged in Brazil: this is the bipolar or “black-white” race model propagated by black movement organizations.⁸ The bipolar model includes the terms *branco* (white) and *negro* (black), where “negro” encompasses those with any degree of (visible) African ancestry—including *pardos*. This model is used in affirmative action policies in health and education, and has become a common model for scientific studies in Brazil that stratify population samples by race.

In this article, I focus on a cultural subgroup included in health policies and programs for the black population in Brazil: members of Afro-Brazilian religions. In the last few decades, health activists from Afro-Brazilian religions have increasingly entered the realm of “black health” activism, or lobbying and participatory policymaking with the goal of reducing health disparities between black and non-black Brazilians. Specifically, this article examines the ways in which health activists from Afro-Brazilian religions deploy ethnic identity politics within the Brazilian public health arena to gain recognition and respect for their beliefs and practices, as well as enhanced health services for their members. This analysis of identity politics provides an entrée for discussing one of the solutions implemented jointly by activists and the state: the creation and enactment of “culturally competent”

⁶ As Warren (2001) observes, the process of delineating a separate black identity in Brazil for political purposes has been much more explicit and deliberate in comparison to indigenous Brazilians, who have been treated as a separate ethnic group since the inception of the Brazilian nation.

⁷ “Black” and “white” are quite complex labels in Brazil, and do not reflect the multitude of intermediate and alternative terms that exist to describe one’s race/color there. I use these terms throughout this article for lack of a more precise English lexicon for translating Brazilian racial identity classifications. Here, the term “black” is my translation of the category *negro/a* that appears in affirmative action policy and in many scientific papers in Brazil.

⁸ My use of the term “black movement” comes from the Portuguese term “movimento negro.” I use the term in accordance with academic literature and Brazilians’ common use of the term to denote a set of political and cultural organizations generally dedicated to the empowerment of black Brazilians and the valorization of black identity in Brazil.

healthcare initiatives for members of Afro-Brazilian religions. The article concludes by critically analyzing the fundamental tension between universalist/particularist identity frames that troubles the activists' political discourses.

II. Public Health and Community Participation in Brazil

In order to fully appreciate the significance of ethnically tailored health care in Brazil, it is necessary to understand the egalitarian citizenship ideologies underpinning the Brazilian public health system. Brazil's universal health care system, SUS (Sistema Único de Saúde, or Unified Health System), was created in 1988 as part of the country's new democratic Constitution. The grassroots Health Reform Movement (*Reforma Sanitária*) that spurred the creation of SUS arose within the context of re-democratization following a lengthy period of military rule. As one of many new urban social movements that emerged in Brazil during the late 1970s and 1980s, the Movement demanded improvements for the ailing national health care system that, prior to 1988, served only citizens who were formally employed. Its rallying cry was "Health for all!" (*Saúde para todos!*), reflecting the slogan popularized by the World Health Organization in the 1970s to declare health as a human right (Cohn 1995).

SUS introduced several important innovations in the way health was conceptualized by the democratizing state. For the first time, health care became a universal citizen's right and the state assumed responsibility for guaranteeing "universal and equal access" to health care (Brazil 1988). According to the language of the Constitution, SUS is guided by the basic principles of equality, universality, and *integridade*, which translates roughly to the goal of providing an "integrated" or comprehensive array of health services. Another major change was the institutionalization of community participation in the planning, monitoring and evaluation of health care. These elements were informed, respectively, by the Declaration of Alma Ata (1978) and the Ottawa Charter for Health Promotion (1986) of the World Health Organization. The requirement of community participation has produced numerous partnerships between public health departments and civil society organizations in Brazil.

Public health-civil society partnerships involve collaboration between representatives from NGOs (non-governmental organizations) who represent population subgroups (e.g., people with disabilities or LGBT individuals), on the one hand, and SUS administrators who are designated as community liaisons, on the other. Often, NGO representatives will participate in health policy planning meetings at health department headquarters. Another area of collaboration is funding for community health projects. Each year, NGOs compete for Health Ministry funding to carry out health education and/or health screenings geared toward the populations they represent. In some cases, NGOs have conducted workshops to educate SUS employees on the special needs of their interest group.

Although the requirement of community participation is in line with Brazil's social democracy, the state's outsourcing of certain health education and screening activities to civil society reflects a "rolling back" of the state that is often associated with neoliberal techniques of government (Ferguson 2002). Rose (1996) terms this process a "de-statization of the government" wherein NGOs assume regulatory, planning, and educative functions (56). In his theoretical sketch of "advanced liberal democracies," civil society groups "partner" with the government in order to "ensure democratic control" (57). The language of partnership (*parcerias*) and the nature of civil society-public health relations in Brazil certainly seem to fit these criteria, although most Brazilian health activists would balk at the association of SUS with neoliberal ideology. The Health Ministry's rationale for devolving services to the community is that NGOs are more in tune with the needs of the populations they represent; this rationale is frequently applied in reference to "vulnerable," hard-to-reach, or stigmatized populations such as intravenous drug users, transvestites, and—more recently—members of Afro-Brazilian religions.

Afro-Brazilian Religions and the State

The proliferation of partnerships between public health departments and terreiros is remarkable given that the Brazilian state once repressed Afro-Brazilian ritual practices through a series of public health codes (Maggie

1992; Johnson 2001). Indeed, through much of Brazil's history, practitioners of spiritual healing and herbal medicine within terreiros were persecuted by the state. From roughly the mid-twentieth century on, however, legal persecution gave way to tolerance, and even appreciation in some cases. In the state of Bahia, for instance, Afro-Brazilian religions are celebrated in official discourse as a unique cultural patrimony (Silverstein 1995).

Several global trends have influenced the Brazilian state's increasingly tolerant attitude toward Afro-Brazilian religion and culture in recent years. These include the UN's World Conference on Racism in 2001 and the World Health Organization's campaign to promote popular medicine and healing knowledge, which intensified around the same time.⁹ Despite these changes in official discourse, however, there is still widespread prejudice surrounding members of Afro-Brazilian religions. Non-members often associate the religions with "black magic" and regard animal sacrifice, which is an important ritual element of Candomblé, as a barbaric practice.¹⁰

Health activists from Afro-Brazilian religions claim that the prejudice they face carries over into public hospitals and clinics. During my field research, activists recounted incidents of healthcare personnel making discriminatory remarks about their religious practices, or giving them advice that contradicted their religious principles (e.g., prohibiting the consumption of certain ritual foods or instructing them to discontinue the use of herbal concoctions made in the terreiro). A number of activists also reported being barred from visiting their initiates (*filhos de santo*) in the hospital when they were clothed in ritual garments.

In particular, the practice of ritual cutting (scarification) within some Afro-Brazilian religions has been a significant focus of stigma against members. This was especially the case during the late 1980s, when the Health Ministry identified members of Afro-Brazilian religions as a risk group for HIV/AIDS due to communal razor-sharing during initiation rites in some terreiros, as well as to the large proportion of homosexual terreiro members. To make matters worse, Brazilian media outlets broadcast reports that reinforced the putative association of both Afro-Brazilian religions and homosexuality with HIV/AIDS contagion (Mesquita 2002, 125-130; Silva and Guimarães 2000).

In response, terreiro members and civil society organizations in Rio de Janeiro collaborated to create HIV prevention campaigns using religious symbols and stories from Candomblé. In 1989, the Institute for Religious Studies (ISER—Instituto de Estudos da Religião) and local terreiro leaders undertook Project Odô-Yá (Galvão 1991; Silva and Guimarães 2000).¹¹ Odô-Yá received funding from several international organizations, including the World Health Organization (Galvão 1991).

Among the project's contributions was a health education manual titled *Odô-Yá!*, printed in 1991. The manual featured three Candomblé parables in comic strip form that cautioned priests and priestesses (*sacerdotes*) against using the "navalha da casa" (a ritually blessed razor belonging to a specific terreiro) on multiple initiates, and recommended modifications such as using disposable razors or disinfecting them with bleach before re-use (Galvão 1991, 18). The project also published a periodic newsletter called *Informativo Odô-Yá*, which described project-sponsored events and offered information concerning HIV/AIDS prevention. The final issue was printed in 1994.

The Odô-Yá project was succeeded by "Arayê," a collaborative initiative between terreiro members and the Interdisciplinary Brazilian AIDS Association (Associação Brasileira Interdisciplinar de AIDS, or ABIA) in Rio de

⁹ World Health Organization, 2002, <http://www.who.int/mediacentre/news/releases/release38/en>. Last accessed September 10, 2012.

¹⁰ See Oro (2005) on contemporary legal battles regarding animal sacrifice in Afro-Brazilian religions.

¹¹ "Odô-Yá" is the greeting called out by terreiro members and attendants when Iemanjá, the *orixá* (divinity) of the sea, descends into someone's body.

Janeiro. Arayê lasted from 1996-2001 and was funded by the MacArthur Foundation. The project was similar in scope to Odô-Yá and featured the same director, who is a terreiro member, black movement activist, and public health dentist in Rio de Janeiro. This time, however, the project's focus shifted more to racial identity politics due to the director's inclusion of black movement organizations in project activities. As Mesquita (2002) observes, Arayê went further than Odô-Yá in "superimposing *négritude* onto Candomblé" (119). For instance, Arayê's print materials used terms such as "comunidade afro-brasileira" (Afro-Brazilian community) and "povo negro" (black people) interchangeably, as if each one referenced the same population. Materials also referred to Afro-Brazilian religions as if they were a natural part of "cultura negra" (black culture) (*ibid.* 178-9). This fusion of ethnic, racial and religious identities would endure and grow stronger, as evidenced by the later inclusion of provisions regarding Afro-Brazilian religions within the National Health Policy for the Black Population.

After Arayê's funding period came to an end, the same core group of terreiro health activists continued their work through an initiative called "Ató-Ire" (2001-2003).¹² "Ató-Ire" refers to the sacred vase used by the orixá of healing, Ossain, to store medicinal herbs (Silva, Dacach, and Guimarães 2003). Ató-Ire was funded by the Ford Foundation and was based in the Center of Black Culture (Centro de Cultura Negra), a black movement organization in São Luís do Maranhão, although project activities were also carried out in Rio de Janeiro, Recife, Salvador, and São Paulo.

Ató-Ire commenced with a large survey of terreiros in Rio de Janeiro and São Luís to gather data on terreiro members' health knowledge and practices. Core project members then used this information to plan a series of workshops on traditional health practices, sexuality, sexual health, and mental health. Their goal was to create a health promotion center (*núcleo de promoção da saúde*) in each partner terreiro for the purpose of disseminating health information among its members (Ató-Ire 2003a).

Throughout the project's duration, terreiro health activists in each state forged relationships with public health administrators; later, these relationships would bear fruit in the form of government funding for conferences, health fairs, and public health education materials geared toward members of Afro-Brazilian religions. In 2003, when Ató-Ire's funding ended, terreiro health activists created the National Network for Afro-Brazilian Religions and Health (Rede Nacional de Religiões Afro-Brasileiras e Saúde) in order to maintain their activities and expand them to a national level.

During my field work from 2005-2009 in northeast and southeast Brazil, I accompanied the Network's activities in the cities of São Luís, São Paulo, Salvador, and Recife. The Network comprises terreiro members, black movement activists, and public health workers in over 25 Brazilian cities who are interested in the official valorization of Afro-Brazilian ethno-religious identity and health knowledge. As of 2008, the Network included 300 Afro-Brazilian institutions (i.e., terreiros and black movement organizations) around the country (Silva et al. 2009).

Each of the Network's state- and city-level chapters has a coordinator and a core group of members that organizes political meetings and health education events in local communities where terreiros are located. Community health education events, such as health fairs, workshops, and lectures, generally take place on terreiro grounds. Health fairs usually include SUS employees who provide vaccination services, blood pressure checks, and sometimes HIV/AIDS tests to the public. Political meetings often occur within local public clinics (*postos de saúde*)

¹² For the sake of convenience, I use the term "terreiro health activist" as shorthand for "health activists who advocate for culturally appropriate health care that respects the healing model and cultural practices of members of Afro-Brazilian religions." Below, I also use the term "Network members" to describe a specific subset of "terreiro health activists," i.e., terreiro health activists who belong to the National Network for Afro-Brazilian Religions and Health. It is important to note that the activists I describe use none of these terms, preferring to identify themselves by their ritual posts within their terreiros.

or public health administrative offices. In several cities, Network members also work with public health departments to create health education materials that incorporate concepts and symbols from Afro-Brazilian religions.

Unlike its predecessors, the Network is not a project; rather, it functions as an umbrella social movement that receives ongoing financial support from the government, rather than temporary funding from philanthropic organizations. Its configuration reflects the “web” model of new social movement theory, which accounts for the fact that social movement actors may originate from a variety of political and cultural institutions and organizations, as opposed to a single, centrally-constituted organization (Alvarez, Dagnino, and Escobar 1998). By virtue of its “partnership” between community organizations and public health departments, the Network also defies the separation of civil society and state central to classical political theory (Hegel 1955).

III. The Black Health Movement in Brazil

Although not all Network members self-identify as “black,” the Network aligns itself with the larger black health movement in Brazil. Since 2004, Brazil’s Health Ministry has worked with civil society organizations—particularly black movement organizations—to create the National Health Policy for the Black Population (Política Nacional da Saúde Integral da População Negra). The Policy’s roots go back to the 1980s; black health activists first lobbied the state to address racial health disparities on a national level at the 1986 National Health Conference.¹³ The Conference’s final report recommended that public funding be allotted for the study of illnesses believed to affect certain “racial-ethnic groups” (*grupos étnico-raciais*) disproportionately (Oliveira 2002).

Despite activists’ efforts, however, there were no significant national policy developments concerning black Brazilians’ health until 1995, when President Fernando Henrique Cardoso convened an Interministerial Task Force (GTI) for the Valorization of the Black Population. The formation of the GTI occurred within a larger political context of deepening human rights discourse in Brazil, signaled most clearly by the 1996 launch of Cardoso’s National Human Rights Program (Fry 2005). Although the GTI’s Health Subgroup concluded that specific health programs for blacks were unnecessary, its participants endorsed the creation of a special program for sickle-cell anemia. The 1996 launch of the Sickle-Cell Anemia Program (PAF) marked the first time the Health Ministry had instituted a program targeting an illness associated with the black population (Oliveira 2004). Another landmark was the GTI’s recommendation that public clinic and hospitals record patients’ race/color data. This measure was introduced nationally in 1996, although its implementation remains uneven in some parts of the country. With the data that were produced, however, it became possible for Brazilian researchers to demonstrate the existence of health disparities by race for the first time.

Yet another important precursor for race-specific health measures in Brazil was an international conference on “Diversity, Multiculturalism, and Affirmative Action” sponsored by the Ministries of Justice and Foreign Affairs in 1996. The event represented the first time such concepts had been utilized in an official capacity in Brazil (Reichmann 1999). Wide-scale dissemination of these concepts helped to legitimize and naturalize the image of distinct, discrete cultures coexisting in a “diverse,” “multicultural” polity such as Brazil. Although this image contradicted the traditional Brazilian ethos of racial and cultural unity achieved through miscegenation (Silva 1998), it was necessary to delimit racialized populations in order to identify the beneficiaries of race-based affirmative action policies. This aspect of affirmative action has been problematic for its implementation in Brazil due to the deeply-ingrained cultural theme of racial fluidity among the general population (Telles 2004).

¹³ National Health Conferences bring together representatives of civil society groups, SUS providers, and SUS administrators every three years for participatory planning at the local, state, and national levels.

Perhaps the most critical event leading up to the creation of black health programs in Brazil was the Third World Conference against Racism, Racial Discrimination, Xenophobia, and Related Forms of Intolerance in Durban, South Africa in 2001. The Conference's Plan of Action called for national governments to invest in public health strategies directed toward "communities of African origin" as a form of affirmative action (Conferência Mundial de Combate ao Racismo 2001, 42-3). Shortly after the Durban Conference, Brazil began to craft partnerships with the Pan-American Health Organization (PAHO), the United Nations Development Program (UNDP), and the British Department for International Development (DFID) to help guide the creation of a national policy directed toward the health needs of black Brazilians. These international organizations provided both financial and ideological support to cohorts of black movement activists and health policymakers through workshops, conferences, and seminars.¹⁴

In 2004, the Brazilian Health Ministry, along with the country's Special Secretariat for the Promotion of Racial Equality (SEPPIR) and PAHO, signed a declaration expressing their intent to develop "saúde da população negra", or the black population's health, as a special area within the Brazilian public health system (SUS). At that time, the Health Ministry appointed a task force of black movement activists, researchers, and health professionals to formulate the National Health Policy for the Black Population.¹⁵ For simplicity, I will refer to it here as "the Policy."

The Policy was approved by the National Health Council in 2006, and it became official on May 13, 2009, although by that point state and municipal versions of the Policy were already in effect in many areas.¹⁶ The Policy opens with discussions of the principles of social control (*controle social*), or citizen participation, and equity. Specifically, it asserts that, "the principle of equality...should entail the principle of equity, which is based in the promotion of equality through the recognition of inequalities and strategic action to overcome them."¹⁷ The Policy thus establishes equity, or compensatory justice, as a necessary pre-condition for the fulfillment of equality. After establishing these principles, the Policy lists the following main directives:

1. Inclusion of the themes "racism" and "the black population's health" in medical education for public health professionals;
2. More substantive opportunities for the black movement to participate in policymaking and policy monitoring (*controle social*);
3. State subsidization of scientific research concerning target health issues;¹⁸

¹⁴ See Maio et al. (2010) for a detailed account of international cooperation and, especially, PAHO's influence on Brazilian policymakers' appropriation and use of themes such as "equity" and "institutional racism" within the realm of Brazilian health care policy.

¹⁵ The official name for the Policy is "Política Nacional de Saúde Integral da População Negra" which can be translated roughly as "Comprehensive National Health Policy for the Black Population."

¹⁶ On May 14th, 2009, the Policy was published in the *Diário Oficial da União*, the Brazilian official press that serves to publicize new laws and normative orders, among other official appointments and communications. The Policy was published not as a law, but as a *portaria*. A *portaria* carries the force of a law in some cases, but is issued by a Minister of State (in this case, the Health Minister) rather than decreed by the President or legislated by Congress.

¹⁷ *Diário Oficial da União*, 90, 14 May 2009, p. 31.

¹⁸ Target health issues include infant and maternal mortality, violent deaths, sickle-cell anemia, sexually-transmitted diseases and HIV/AIDS, tuberculosis, Hansen's disease (leprosy), cervical cancer, breast cancer, and mental health issues (in that order).

4. Official recognition of traditional health knowledge and practices, *including those of Afro-Brazilian religions*;
5. Increasing the black population's access to health services;
6. Improving epidemiological data through the systematic collection of patients' race/color data;
7. Creation of health education materials geared toward the black population that respect diverse knowledges and values, *especially those of Afro-Brazilian religions*;
8. Establishment of international cooperation with the goal of improving the black population's health;
9. Establishment of partnerships between the government and non-governmental organizations in order to strengthen the implementation of black health initiatives within SUS;
10. Earmarking funds within state and municipal health care budgets to implement the Policy.¹⁹

The Policy's language is striking because it promotes the image of a biologically and culturally discrete black population in a nation where racial classification has historically been fluid and ambiguous.²⁰ Within the Policy and related documents, Afro-Brazilian religion continually emerges as the main diacritical marker for black cultural specificity, although most black Brazilians do not belong to Afro-Brazilian religions.²¹ This tendency is consistent with the black movement's ideological construction of Afro-Brazilian religion as an ethnic emblem and authentic repository for African cultural elements such as music, food, aesthetics, social organization, and values (Hanchard 1994; Burdick 1998; Pagano 2002; Selka 2007). This discourse is predicated upon their assertion that Afro-Brazilian religions have managed to preserve a number of African cultural elements that otherwise would not have survived slavery (Braga 1995; Harding 2000; Hanchard 1994). A corollary is that terreiros whose rituals display the fewest elements of Catholicism have maintained the most "pure," unbroken ties to Africa (Dantas 1988).

Certainly, terreiros benefit from being associated with African purity. In several states, the oldest, most "traditional" terreiros have been rewarded with public honors, land rights, and funding for state-sponsored educational, cultural, and health programs to be carried out on terreiro grounds (Matory 2005; Santos 2005).²² Many of these elite terreiros have members who occupy leadership positions within the Network. All of the Network members I encountered throughout my fieldwork wholeheartedly endorsed the view of Afro-Brazilian religions as a rich cultural patrimony of Africa in Brazil, regardless of their personal racial identities. In the next section, I

¹⁹ *Diário Oficial da União*, 90, 14 May 2009, p. 31-32 (emphasis mine).

²⁰ Similar to other affirmative action policies in Brazil, the Policy has met with considerable controversy. Its premises have been vociferously criticized by a group of scientists and researchers who argue that the Policy racializes medicine and promotes unnecessary racial divisions (Fry 2004; Laguardia 2005; Maio and Monteiro 2005; Pena 2005; Maggie 2007). Government officials also challenge black health programs in both direct and indirect ways. In 2010, the Brazilian Senate approved the Racial Equality Statute (Estatuto da Igualdade Racial) but eliminated provisions for black health programs based on a lack of conclusive genetic evidence for diseases considered more prevalent in Brazilian blacks. At the level of patient care, both patients and providers have expressed resistance to the Policy's mandate that public clinics and hospitals collect patients' race data (Pagano 2011).

²¹ For examples, see Lopes (2004); (Oliveira 2002).

²² I have placed "traditional" in quotes here not because I doubt the veracity of these terreiros' claims to tradition, but rather in recognition of abundant recent scholarship on the polyvalent uses of concepts such as "tradition" and "cultural authenticity" around the world, including within the African Diaspora; e.g., Gilroy (1993); Hobsbawm and Ranger (1983); Scott (1991).

describe some of the discursive practices they employ to reinforce the cultural specificity of Afro-Brazilian religions and their faithful.

IV. Establishing a Unique Afro-Brazilian Cultural Identity

Pai Mário's comments in the quote at the beginning of this article exemplify how he and other terreiro health activists construct a health-related identity through claims to their own racial and ethnic difference—and in particular, to their African-based health beliefs and practices. In so doing, these activists challenge the universal health care system's claims to color-blindness and equal access for all citizens. They question the value of equal treatment upon which the health care system is based, maintaining that equal *access* to quality health care (tailored to patients' particular needs) is an inalienable citizen's right.

Terreiro health activists draw on images and language rich in symbolism from Afro-Brazilian religions in order to construct a collective public identity, which then becomes a point of departure for making demands on the state. During state-sponsored events and meetings of the National Network for Afro-Brazilian Religions and Health, religious symbols are put to work in various ways to affirm the group's specific, health-related identity. As I entered the room at the Network's national meeting in 2006, which took place at a hotel on the beach in the northeastern city of João Pessoa, I was greeted by a number of large, full-color illustrations of orixás with their names printed at the top. Other posters featured photos of Network members in ritual dress. At the front of the room was a large statue of Obaluaiyê, the orixá of epidemic illnesses such as smallpox and, today, AIDS. In accordance with the orixá's ritual dress, the statue was adorned with cowry shells and covered from head to toe by a long, thick sheet of raffia. Clay pots and vases decorated the front of the room; some overflowed with popcorn, while others were decorated with fragrant green leaves that had been scattered all over the display. Popcorn is Obaluaiyê's ritual food, said to represent the smallpox lesions from which he is believed to have suffered. The green leaves and tall-necked vases completing the Network's makeshift altar represented the herbal medicines prepared by Ossain.

This national meeting, like most other Network meetings I have attended over the years, commenced with the singing of hymns to the orixás. On that oppressively hot day, the opening ceremony took place on the shore since it was to be followed by a ritual offering of flowers and perfume to Iemanjá, the orixá of the sea. Men and women of various ages and ethnicities stood in a circle, dressed in white, African-inspired ritual garments: short-sleeved blouses and full lacy skirts for women, loose cotton pants and short-sleeved tunics for men; both women and men wore head wraps. They took turns leading the sung prayers while the others in the circle either clapped softly with cupped hands or brushed one hand against another in a regular rhythm.

After a few minutes of quiet singing, some Network members began to play *atabaque* drums. Immediately, the circle began to move, and the participants started to perform the prescribed ritual gestures and rhythmic dance steps for each of the orixás in sequence. After about half an hour of dancing around the circle, several people "received" Iemanjá into their bodies. At this point, members of Afro-Brazilian religions greeted the orixá's arrival joyously and took turns embracing her/them and kissing her/their hands while she/they bestowed her blessings upon them. SUS employees and black movement activists, most of who did not belong to Afro-Brazilian religions, looked on in interest. Finally, the group sent off Iemanjá's gifts in a small white boat that had been anchored nearby for this purpose.

Although Network meetings are often held in non-terreiro spaces, including hotels, universities, and black movement headquarters, terreiro health activists prepare these spaces by adorning them with religious symbols that mark them as "Afro-religious," as described above. They also perform ritual behaviors, like the spiritual circle, and use ritual clothing and adornments that mark their bodies as living symbols of Afro-Brazilian religious tradition. In their public meeting narratives, Network members also use language strategically to construct a collective, health-related identity that is distinct from that of the wider society.

During a Network task force meeting on the HIV/AIDS epidemic in the northern Brazilian city of Belém, for instance, a local Candomblé priest spoke about the special kind of health care practiced in terreiros. Before beginning his lecture, he pronounced several phrases in Yoruba, which prompted the audience to respond reverently with the word “axé” (the life-force) while clapping slowly several times with cupped hands. During his lecture, the pai-de-santo referred to terreiros as “urban *quilombos*” (maroon communities) and praised the “preventive and curative popular medicine” practiced in terreiros. He then positioned the terreiro’s medicine in contrast to “official, allopathic medicine” and extolled *rezadeiras*, *curadores*, and *raizeiros* as “health agents for black people.”²³ Finally, he described Candomblé as “tolerant” and “humanist,” observing that terreiro priests and priestesses care for people without regard to color, gender, or sexual orientation. He contrasted these characteristics with SUS’s alleged discrimination against black patients and members of Afro-Brazilian religions. He ended his speech with a Yoruba myth about twin brothers (*ibeji*) who outsmart Death with a magic drum.

In this example, the pai-de-santo used several linguistic devices which served to establish an image of the terreiro as an alternative ethnic and religious space wherein holistic health care is delivered to the community. For example, he emphasized the uniqueness of Afro-Brazilian religious culture by prefacing his lecture with phrases in Yoruba, a language that only members of Afro-Brazilian religions could understand, and by telling an African folk story. Both of these elements stood in stark contrast to the language used by black movement activists and SUS employees who made presentations at the meeting. Black movement activists employed the language of social justice and citizenship by choosing words and phrases such as *participar* (participate), *buscar os nossos direitos* (demand recognition of our rights), *controle social* (citizen monitoring of public policy), and *equidade* (equity). SUS employees presented epidemiological data on Power Point screens and used public health language to lecture the audience about modes and prevalence of HIV/AIDS transmission. They used technical words such as *insumos* (in this case, policy-speak for condoms), *retrovirais* (antiretroviral therapy), *transmissão vertical* (vertical transmission), and *HSH* (men who have sex with men).

Another “traditional” linguistic strategy utilized by the pai-de-santo was his comparison of the terreiro to the quilombo, or Brazilian maroon community. Historic quilombo sites (*comunidades remanescentes de quilombos*) are often invoked by policymakers and black movement activists as areas where an “authentic” Afro-Brazilian culture has been preserved.²⁴ They claim that quilombos have managed to retain Afro-Brazilian culture due to their rural, isolated locations and to their status as alternative societies. In fact, terreiros and quilombos are the two “traditional communities” most often cited by black movement activists and policymakers as repositories of Afro-Brazilian culture. The pai-de-santo thus invoked a politically salient politics of authenticity (Gilroy 1993) by drawing strategically on this association between quilombos, terreiros, and the preservation of African culture in Brazil.

He then described specific healing services, including herbal baths and medicines provided by ritual specialists in the terreiro, which helped to establish an image of terreiro medicine as a parallel system of health care. Finally, he selected a story that portrayed traditional figures from the Yoruba culture (the elected cultural and

²³ A “rezadeira” or “benzedeira” is a traditional female healer who treats illness through prayer. Although rezadeiras are often associated with popular Catholicism, this does not preclude participation in Afro-Brazilian religions. In fact, many terreiro leaders whom I have interviewed over the years have reported either being rezadeiras/benzedeiras themselves, or else having a family member (either ritual or biological) in the terreiro who prayed over sick people. A “curador” is a traditional male healer. A “raizeiro” is a traditional healer who works specifically with roots and herbs. The term “health agent” (*agente de saúde*) refers to the community health workers who visit family homes as part of SUS.

²⁴ See French (2006) for an insightful analysis of politically strategic identity discourses related to quilombos.

religious affiliation of most activists at the meeting) “beating the system,” so to speak. These linguistic devices served as diacritical markers which reaffirmed the status of Network members (and, by extension, all terreiro members) as members of a particular culture with its own health-related values and practices that differ from, and are in some ways opposed to, those of general Brazilian society.

In these public performances of identity, terreiro health activists carefully select and deploy culturally charged symbols in their words and on their bodies. Social movement theorists have called these symbols “identity frames” or “collective action frames” (Snow et al. 1997) after Goffman’s (1974) theory of frames as cognitive tools that social actors apply to their experiences to organize them and render them coherent. Collective action frames emphasize certain symbols, objects, and events while obscuring others. The Network’s collective action frames are apparent not only through individual members’ discursive practices, but also through more systemic platforms such as “culturally competent” initiatives and materials.

V. Cultural Competence and the Terreiro

Although they rarely use the term “cultural competence,” terreiro health activists and SUS professionals employ the concept when they advocate for health care strategies that reflect the worldview and health/illness beliefs of Afro-Brazilian religions. Cultural competence in health care refers to the practice of “tailoring health care services to the needs of particular populations whose difference is understood in cultural, ethnic, and sometimes biological terms” (Shaw 2005, 292). Cultural competence measures aim to counteract the tendency of the “medical gaze” (Foucault 1973) to focus on biological disease processes, while ignoring the patient’s identity and personhood. Like other “exact” sciences, biomedicine is often viewed as a truly objective body of empirical knowledge, free from the trappings of culture. Cultural competence supporters argue, however, that a “one size fits all” approach to clinical care contributes to racial and ethnic health care disparities (Smedley, Stith, and Nelson 2003). In Brazil, black health activists and terreiro activists voice this same logic.

By providing patients with a more familiar cultural context, “culturally competent” or “culturally appropriate” health care efforts strive to honor patients’ social and cultural characteristics and beliefs. The ultimate goal, from the perspective of health care providers, is to increase marginalized groups’ utilization of health care services and adherence to prescribed treatment. Members of marginalized groups, in contrast, often seek official recognition of the value and legitimacy of their cultural beliefs and practices.

Cultural competence initiatives in other national contexts have been the subject of critical examination by many scholars. In her analysis of a “culturally competent” mental health program for U.S. Hispanics, Santiago-Irizarry (1996) links the cultural competence movement in the U.S. to an ideology of multiculturalism and a preoccupation with respecting diversity: “because of the premium placed on a discourse of cultural pluralism in U.S. society, domains of practice are opened up for the token insertion of ethnicity to reposition ethnic subjects within social, political, and economic structures of entitlement” (18). In the case she analyzes, culturally “emic” actors (Hispanic mental health providers) pressured the government to recognize the cultural specificity of an ethnicized population (Hispanics) and allocate resources toward culturally competent measures, including training for health professionals on how to treat the “ethnic” patient.

Shaw (2005) describes a similar case in which African-American community members lobbied the government for culturally competent services (operationalized as linguistic competence and doctor-patient resemblance) at their community health center. The community members in question viewed themselves as culturally distinct from the dominant culture, just like the Hispanic mental health providers in Santiago-Irizarry’s case study. Although Shaw’s case study occurred in the U.S., her analysis could be applied equally to the case of the Network:

Working from the assumption that public health institutions are a material expression of the state's responsibility to maintain the health of the people, ethnic minority groups mobilize liberal beliefs about equality of access in their appeals for (paradoxically, to some) different treatment by the state....using cultural difference as the lever and health-care-for-all as the fulcrum, minority groups are able to reposition themselves vis-à-vis the health clinic and the state more generally, thereby gaining resources for previously disenfranchised or marginalized communities. (292)

Both Shaw and Santiago-Irizarry identify a fundamental tension between the ideal of formal equality and the right to different treatment (but equal access to public services) invoked by minority groups. Similar to the Network, the activists in Shaw's and Santiago-Irizarry's case studies demanded equity of *access* to public services but wanted their unique cultural heritage to be accounted for in the delivery of these services. It is important to note that in the Brazilian context, demands for both equality *and* the recognition of difference do not appear to be problematic or mutually exclusive for either activists or policymakers (I elaborate on this in the next section).

Another source of scholarly critique on cultural competence concerns the unintended but common effect of cultural essentialism (Santiago-Irizarry 1996, 2001; Shaw 2005; Lambert and Sevak 1996). Essentialism implies the homogenizing attribution, to all members of a group, of certain characteristics presumed to express the group's particular character or "essence." Often, cultural competence initiatives consist merely of selecting ethnic symbols believed to represent a certain group, and then incorporating those symbols into health services or materials. Santiago-Irizarry (1996) argues that in her case study, clinical staff viewed their practices and services as "decultured spaces for clinical, objective undertakings" wherein bits of culture could be inserted (12). Another problematic detail, according to Santiago-Irizarry, was the treatment of culture as "content that could be decontextualized, isolated, and transferred beyond the sited relations that produce it" (14).

Cultural elements can indeed take on an essentialized cast when utilized for political gain. However, "strategic essentialism," as Conklin (1997) aptly terms it, can also be a powerful tool for re-signifying historically denigrated cultural symbols in a positive manner. With the acceleration of globalization and the explosion of mass media, cultural symbols have assumed a magnified role in articulating the political claims of social movement actors worldwide (Yúdice 2003).

These theoretical assertions are clearly manifested in the Network's uses of cultural symbols. As I described earlier, the Network's conferences include diverse publics of non-terreiro members originating from black movement organizations, state health departments, and academic institutions.²⁵ These conferences often take place in non-religious spaces such as hotels or university classrooms. Regardless, cultural symbols such as the statue of Obaluaiyê, the long-necked gourd surrounded by scattered herbs, and the ritual dress of terreiro members are understood even by non-terreiro members as representations of African tradition and medicine. The same applies to health education materials, Network publications, and the Network's blog, all of which incorporate images such as orixás and sacred herbs. In these cases, these symbols (signs) are "objectified and made available to users distant in time or space from the sign's site and social locus of production," or the terreiro (Johnson 2002, 154). Nevertheless, they serve a political purpose in articulating the Network's association between Afro-Brazilian religions and health promotion. In my own research interviews, both Network members and black health activists remarked that a negative essentialism of Afro-Brazilian cultural symbols already exists; their goal is to take the symbols that are already "out there" and imbue them with positive health messages.

²⁵ Of course, some of these individuals also belong to terreiros; I use categories such as "terreiro member," "black movement activist," and "SUS employee" for conceptual clarity, but these categories are not mutually exclusive.

Culturally appropriate health care is often characterized as a process of translation wherein biomedical information is rendered into a cultural codex that patients can better understand. Mattingly (2008, 2006) describes the clinical encounter as a “cultural borderland” in which both providers and patients often assume they possess drastically different cultural perspectives that must be bridged by a cultural lingua franca. She argues that this focus on miscommunication carries over into cultural competence efforts and ends up reinforcing and reproducing cultural difference.

In a similar vein, Mesquita (2002) critiques the theme of cultural translation that informed the creation of “culturally appropriate” health education materials within the Odô-Yá and Arayê projects (described above). Because the projects originated from the premise that official HIV/AIDS prevention messages were not presented in the correct cultural codex to reach blacks, he argues, the projects unintentionally reinforced the public perception of absolute cultural difference between blacks and non-blacks (178-9). This discourse of cultural incommensurability, according to Mesquita, promoted cultural segregation rather than expanding terreiro members’ freedom and rights, which was the intention of the project leaders.

While an increased discourse of cultural segregation may well have been an unintended effect of the projects, I would argue that the health education materials they yielded had a very different meaning for their creators. According to the Network members I interviewed (many of whom were part of Odô-Yá and Arayê), these cultural competence initiatives actually represented less of a translation effort and more of a desire for symbolic legitimization and official recognition of Afro-Brazilian religions’ contributions to health care in their communities. In my view, the racialization of the Network’s collective identity (which occurs by virtue of its association with the black health movement) goes further in reinforcing a discourse of cultural difference due to the black health movement’s focus on defining blacks as a culturally distinct population in Brazil. Even within the Network, many activists’ conflation of the two groups produces a semantic ambiguity between the “black population” (*população negra*) and the “terreiro population” (*população de terreiro*). This semantic ambiguity, in turn, makes it possible to define the black population as a unique cultural group within multicultural health policy. Likewise, the inclusion of provisions for the terreiro population within the National Health Policy for the Black Population makes it seem as though the terreiro population is a subset of the black population, when in reality many terreiro members do not identify as black, and the majority of black Brazilians do not profess Afro-Brazilian religions (Prandi 2005).

As I have argued elsewhere, this discursive conflation is another example of strategic essentialism (Pagano 2011). From the perspective of the black health movement, the claim to cultural (and biological) distinctiveness is necessary in order to make the case that this population requires special resources and recognition (Fry 2004; Maio and Monteiro 2005)—this was especially true in the 1990s and early 2000s, when there were few epidemiological data to substantiate the existence of striking health disparities by race in Brazil.

The discourse of cultural competence is a key technique in enacting the Network’s politics of difference. SUS-sponsored cultural competence initiatives for terreiro members consist of specialized health education materials and sensitivity training for public health professionals. Like educational materials for the black population more generally, materials created for terreiro members tend to feature an “African” theme with illustrations of items such as orixás, cowry shells or West African drums. One such pamphlet produced by the São Luís municipal health department is titled “Where there’s a terreiro, there’s health!” (“Tem Terreiro, Tem Saúde!”). It features cowry shells on the front and all along the borders, in addition to a photo of the woven straw “dish” used during the *jogo de búzios* (a divining ritual that utilizes cowry shells). On the front of the pamphlet, there is also a photo of a ritual garment with strings of beads (*guias*) hanging down from it. Inside the pamphlet is printed information on various sexually transmitted diseases, as well as illustrated instructions on how to use a condom. The inside flap reads:

We, members of Afro-Brazilian religions, believe that the body is the dwelling of the gods and, therefore, must always be well taken care of...we are the inheritors of our ancestors’ *axé* (vital force), and therefore we must have healthy and well-informed bodies and minds in order to fully experience our ancestry.

This language establishes an image of terreiro members as a traditional population with culturally specific and holistic ways of understanding the relationship between the body and spirituality. It also counteracts the negative image, within Brazilian popular imagination, of terreiros as anti-hygienic spaces due to the practice of animal sacrifice and healing or initiation rituals that require small skin incisions (Johnson 2005). The pamphlets were distributed at the terreiros of Network members in São Luís, and were also used as didactic materials at cultural sensitivity training sessions for SUS employees in the state of Maranhão. When I attended Network meetings in São Paulo and Belém, I found that the pamphlets had circulated to these cities as well.

Other types of Network publications, such as newsletters, also strive to demarcate practitioners of Afro-Brazilian religion as a medically specific population in its own right. For instance, an article from the Network periodical *Tambores de Axé* (Axé Drums) attributes the religions' continuity to terreiro members' health expertise:

Devotees of the Afro-Brazilian tradition have a unique way of understanding and caring for health....The principle and practice of caring for those who seek out the terreiro...is what makes this religion resistant and active through the present day, representing one of the great manifestations of the culture and belief system of the Afro-descendant population. (Rede Nacional de Religiões Afro-Brasileiras e Saúde 2004, 4)

Here, the authors invoke the aura of absolute difference conferred upon them historically and re-signify it in a positive light. They suggest that terreiros have been able to endure because they provide health care to surrounding communities. In statements such as these, Afro-Brazilian ritual healing becomes a primary metaphor for political and social survival. Such representations of collective identity appear to be in dialogue with both domestic and global public health interlocutors.²⁶

In many of their publications, terreiro health activists incorporate global discourses of traditional medicine and cultural competence in order to further legitimize their status as traditional healers. One example comes from an article in *Ató-Ire Bulletin* (*Boletim Ató-Ire*) titled "Caminhos da Cura" (Paths of Healing) (Ató-Ire 2002). The author states that the "relations between religion and health, which society viewed with disdain until recently, are beginning to be recognized scientifically today" (6). He adds that laboratory research has proven the efficacy of herbal medicines used in the terreiros for both "organic" and emotional illnesses. Another article asserts that the medicine practiced in terreiros is holistic and in line with the World Health Organization's stipulation that health is "a state of complete well-being in physical, mental, and social terms, and not just the absence of illness" because terreiros offer "cuidados" (preventive care) as opposed to just "tratamentos" (treatments for existing illnesses) (Ató-Ire 2003a, 6).

These excerpts reveal a strategic engagement with global health policy trends. In 2002, the World Health Organization (WHO) recommended that national health systems become "integrative" or "inclusive" by combining allopathic practices with traditional medicine (TM) or complementary and alternative medicine (CAM) (WHO 2002).²⁷ According to the WHO's *Traditional Medicine Strategy* (*ibid*), the benefits of offering state-subsidized

²⁶ The structure and intended audience of this "dialogue" correspond to the first of three levels theorized by Csordas (1999) in his analysis of Navajo identity politics surrounding ritual healing, i.e., representation of minority group identity in relation to the dominant society.

²⁷ TM is defined as "diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness." CAM is defined as "a broad set of health care practices that are not part of a country's own tradition, or not integrated into its dominant health care system" (WHO 2002,7).

TM/CAM include greater accessibility and affordability to clients as well as the high degree of cultural legitimacy often assigned to traditional medicine by local populations in developing countries.

In addition to health education materials that incorporate symbols of Afro-Brazilian religions, cultural competence efforts for terreiro members also take the form of continuing education for health professionals. During my fieldwork in São Luís and São Paulo from 2007-09, cultural competence training for healthcare providers took place in two major ways: formally, through cultural sensitivity workshops, and informally, during routine interactions between terreiro health activists and SUS employees. I witnessed one such impromptu lesson in cultural competence during a meeting of Project Xirê (Projeto Xirê) at the offices of São Paulo's municipal STD/AIDS Program in August 2008.

Project Xirê is a cooperative endeavor between municipal STD/AIDS Program officials and a group of terreiro leaders in São Paulo. With SUS funding, the Project provides cultural sensitivity training and produces health education materials directed toward members of Afro-Brazilian religions. . Since 2007, the Project has invited health professionals to local terreiros for weekend workshops in which they and terreiro members take turns educating one another about their respective health beliefs and norms. In 2008-2009, the Project Xirê team included Marília, Janaína, Pai Mário, Simone, and Mãe Cíntia.

Marília is a white, middle-aged administrator and self-described Catholic with copper-colored hair and blue eyes. Janaína is a policy analyst in her twenties with olive skin, wild curly black hair, and horn-rimmed glasses. She grew up in the impoverished periphery of São Paulo and identified as *árabe* (Arab) due to her father's Syrian roots. Simone was the departmental secretary at the time; she is also an Umbanda priestess in her mid-forties with medium brown skin and chemically straightened shoulder-length black hair. Mãe Cíntia is a forty-five year old Candomblé priestess who identifies as black despite her light olive skin tone. Mãe Cíntia's *filhos-de-santo* at that time were mostly white, middle-class *paulistas*. During my fieldwork, she was a permanent fixture at Network and Xirê Project meetings and events, and always wore ritually normative clothing: long, billowy white skirts; white sweaters or long-sleeved blouses; and a white head wrap which covered her long, straight black hair. In accordance with Candomblé mores, Mãe Cíntia also wore a long string of beads (*guia* or *fio de contas*) whose colors and pattern indicated her guiding orixás. As Mãe Cíntia's main orixá was Oxum, the orixá of sexuality and prosperity, her beads were mainly yellow and gold.

On the day of this particular Project Xirê meeting, the team was seated around a table in a meeting room at the municipal STD/AIDS Program offices, rehashing the previous workshop. When someone mentioned a discussion from the workshop about the sacredness of ritual ornaments, Marília asked Mãe Cíntia what the *guia* signified for members of Candomblé. In response, Mãe Cíntia pulled her long string of yellow beads out from underneath her sweater and explained that the *guia* transmits the orixá's positive energy and thus protects the wearer from malevolent forces. "It's especially important for members to wear their *guias* when they go to the hospital, because it strengthens the positive energy of their mind and spirit, which is vital to preserving equilibrium when the body's energy is weakened," she added. Mãe Cíntia went on to explain that in clinics and hospitals, Candomblé members are often told to remove their *guias* as well as their *contra-eguns* (straw ornaments worn on the upper arms for spiritual protection).

Marília nodded, and then asked another question: "Do you think doctors have the right to ask patients to remove their *guias* for a clinical exam? And what about their *panos de cabeça* (head coverings)?" Mãe Cíntia replied that it was all right for doctors and nurses to touch the *guia*, but they should not ask the patient to remove it, or else he or she will become vulnerable in the absence of its protection. As for the *pano de cabeça*, Mãe Cíntia explained that it should be kept on whenever possible since it protects the head, which is believed to be the body's spiritual seat within Afro-Brazilian religions.

This episode demonstrates the process of constructing a health-related ethnic identity through didactic performances (Shaw 2010). During interactions between SUS administrators and terreiro members in the context of

Project Xirê, terreiro members often assumed the role of cultural experts with the mission of teaching the public health apparatus about the health-related culture of Afro-Brazilian religions. In so doing, this elite group of terreiro members with access to the state spoke for all members of Afro-Brazilian religions, despite significant variations in beliefs and practices among them. The informal interaction described above represented an initial stage in the creation of cultural content to be used within “culturally competent” health programs; later, elements of the group’s formative discussions appeared in STD and AIDS prevention posters and pamphlets which were co-designed by the Project Xirê coordinators and produced by São Paulo’s municipal STD/AIDS department.

Over time, as Shaw (2010) argues, these repeated didactic performances of ethnic identity can contribute to fixed, static representations of particular cultural elements and practices, which are then deployed to other members of the target population through cultural competence programs. From there, problems of resonance can ensue when group members fail to identify with the symbols chosen to represent them in health education materials. This had not yet occurred when I concluded fieldwork in 2009, although I witnessed several heated debates between terreiro health activists over which elements from which Afro-Brazilian religions (e.g., Candomblé Nagô, Candomblé Angola, Umbanda, Tambor-de-mina) should be highlighted within *planned* health education materials and campaigns.

As Shaw (2005) and Santiago-Irizarry (1996) observe, cultural competence programs presuppose the existence of distinct cultures that merit special consideration within public policy. Through the kind of interaction described above, terreiro health activists reinforced their claim that members of Afro-Brazilian religion were indeed a special-needs group, distinct from the general population. The construction within the black health movement of terreiro members—and, by extension, black Brazilians—as a cultural minority reflects the rise of multiculturalism in Brazil. Against the universalist ideological backdrop of SUS, the language of cultural competence emerges as a counter-discourse of identity construction deployed by activists. Underlying activists’ claims to ethnic difference, however, is a parallel demand for equitable inclusion as Brazilian citizens within the Brazilian polity.

VI. Universalism versus Particularism

The World Health Organization’s 1999 and 2000 *World Health Reports* recommended that governments around the world implement a strategy called “new universalism” (WHO 2000, 1999). According to the 1999 *Report*, many state health care systems were trying and failing to deliver full health services to all of their citizens. Since this was unrealistic given resource limitations, WHO’s Director-General suggested that governments provide only the most cost-effective, essential services to all citizens—in other words, that they cease to offer services geared only toward specific sectors of the population. Another recommendation was that health care performance should be measured across the population as a whole, rather than using measures that stratified the population by gender, race/ethnicity, socioeconomic status, et cetera—these data would make no difference if the goal was to treat all citizens equally.

These suggestions prompted sharp criticism from public health researchers around the world who asserted the importance of measuring differences in health status and access to health services among population groups in order to track health care inequities.²⁸ Others argued that the “new universalism” strategy threatened traditional medicine, and that it was incompatible with the definition of health from the Declaration of Alma-Ata: “a state of

²⁸ For example, see Almeida et al. (2001).

complete physical, mental and social well-being and not merely the absence of disease or infirmity” (UNICEF 1978).²⁹

Social movements like the Network advance a political agenda that diametrically opposes the WHO’s “new universalism.” In making claims for culturally appropriate services, they demand that the state expend budgetary and human resources on service enhancements that will benefit only a small sector of the population (e.g., terreiro members). It appears, however, that the Brazilian Health Ministry has largely ignored the WHO’s “new universalism” strategy in favor of one that endorses both a discourse of universalism and a substantial politics of difference.

In his theory of multicultural citizenship, Taylor (1994) highlights a fundamental tension between the politics of universalism, or equal recognition, and the politics of difference, or what I refer to here as “particularism.” The politics of equal recognition arises from a purportedly “difference-blind” liberal tradition that upholds human dignity as a universal value. Universalism implies identical rights for all citizens, while the politics of difference entails differentiated citizenship claims by specific individuals or groups. Despite the apparent opposition between the two orientations, Taylor argues that the politics of difference is actually informed by a presupposition of universal and equal human potential, which he interprets as the equal right of all members of society to assert their own identity and to have it recognized by others. The paradoxical result is that “the universal demand powers an acknowledgement of specificity” (39).

Terreiro health activists’ discourses often reveal a similar tension between universalism and particularism. That is, they alternate between identifying foremost as Brazilian citizens, on the one hand, and identifying primarily as a culturally different, vulnerable group vis-à-vis SUS and Brazilian society more generally, on the other. This tension emerged in the comments of Pai Mário at a São Paulo Network meeting in 2008:

Our goal is to discuss public health; this Network is a specific Network, a Network that speaks of health from the point of view of Afro-Brazilian religions and the black population. So, although we discuss general questions like the waiting line in SUS, the privatization of services, the lack of doctors and medications, [we also discuss] more specific issues such as religious intolerance and racism...we have codes and values and principles that aid greatly in health care within our Umbanda and Candomblé temples. Obaluaiyê, Iemanjá, and Oxum, for example, are divinities connected to various health issues. If we look to our mythology, our teachings, we can find [information about] many issues—mental health problems, skin diseases, things that show up often in our own health.

Through this commentary, Pai Mário drew a distinction between general issues that concern all Brazilians who use SUS, and specific issues that concern black Brazilians and terreiro members in particular (again, conflating the latter two populations). While he acknowledged the group’s interest in “general” issues affecting all citizens, he also placed emphasis on the unique “codes, values, and principles” that structure the ways in which terreiro members relate to health and illness. By mentioning the health-related lessons embedded within Umbanda and Candomblé liturgy—and thus available only to those associated with these religions—he reaffirmed the existence of significant cultural difference between members of Afro-Brazilian religions and the Brazilian population at large.

At the same time, Network members often utilize religious symbols to reinforce general SUS and citizenship values, such as “social control” (*controle social*), discussed above. During the São Paulo statewide meeting in November 2008, the Network’s national coordinator told the following story about the orixá Oxum:

²⁹ For example, see Fidler (1999).

Oxum was having some problems, so she decided to make an offering to the king to improve her quality of life. When she arrived at the palace, however, she was startled to behold the king's excessive wealth. She placed her offering in front of the palace gate and began to criticize the king for having so much while his people had so little. Because of her actions, Oxum became the *orixá* of wealth. The moral of the story is that Oxum won her cause by demanding, not asking for, her rights. We in society must do our part in order to secure our rights.

In the public discourses of Network members, Yoruba religious folklore often appears as a metaphor for various kinds of political attitudes and behaviors. In the national coordinator's recounting of the parable above, Oxum served as an example of a "good" citizen, one that voices her opinion and practices "social control" (*controle social*) of public policies. This assertive, participatory model of citizenship stands in stark contrast to citizenship norms during the military dictatorship of 1964-1985, when such behavior was not only discouraged, but was also considered dangerous. The citizenship discourse expressed by the national coordinator's interpretation of the parable is clearly a post-1988 formulation. Oxum's actions in the parable also emphasize the redistribution of wealth, a value that reflects the demands for equity issued by black health activists and terreiro activists in the last decade.

There have been few studies of the political discourses embedded within the traditional stories of *orixás* from Afro-Brazilian religions. In her study of the Afro-Brazilian religion Xangô in Recife, Segato (1995) characterizes terreiro members' religious parables as an "alternative," non-explicit political discourse (598). She argues that the parables reveal a critique of state institutions that is sharp but oblique, demonstrating their sense of alienation and mistrust of a government that does not contemplate their needs. Noting that terreiro members often resist getting involved in politics—especially racial politics—Segato posits that there are fundamental ideological conflicts between the universalist ethos of Afro-Brazilian religions and the fixed, essential categories of gender and color (race) that form the basis of group-specific policies and political interest groups (594). It is interesting to compare Segato's findings to the way parables are used in the case of the Network—a hybrid movement that combines terreiro members with black movement activists and public health employees. Parables like the one recounted by the Network coordinator retain a critique of the state, but also provide a template for active participation, rather than withdrawal, as a strategy for political change.

At times, Network members' call for the state to recognize terreiro members' particular needs and characteristics appeared to be at odds with their simultaneous endorsement of SUS's universalist values. For example, Mãe Lídia stood up at the Network's national meeting in 2006 and proclaimed, "We don't want differences in healthcare...health is for everybody! [We want] healthcare for all, white people, black people, and colored people!" I occasionally heard this type of "universalist" comment from Network members, although it was not nearly as common as the "particularist" comments discussed above. Often, the same speaker would utter *both* types of comment, depending on the focus of the discussion. If the focus was on discrimination against black people and terreiro members in SUS clinics, the first type of comment predominated. When the discussion turned to the need for SUS health professionals to respect terreiro members' "special needs," such as religiously mandated dietary restrictions, the second type of comment prevailed.

When invoking the universalist argument, Network members often cited the Brazilian Constitution. After Pai Jeferson left the Network due to feeling excluded as a white pai-de-santo, he began to participate increasingly in an inter-religious health movement. He felt more comfortable with this group, which included SUS administrators as well as health activists from various religions, because its members did not discuss race. When telling me about his reasons for joining the inter-religious movement, Pai Jeferson said:

The health care that an evangelical Christian needs is the same kind of health care that terreiro members need. Whites need the same healthcare as blacks! [...] Health is health, period. Faith is faith, period. We can't create these differences...in Article V of the Constitution, it says, "Brazil is a lay state."...in other Constitutional articles, it says, "We are all equal." In another Constitutional article, it says, "We all have a right to healthcare."...These are Constitutional articles. In the Constitution, black and white do not exist.

As shown in his commentary, Pai Jeferson ultimately rejected the tailoring of health care to patients' particular racial and religious groups. In so doing, he reaffirmed the principle of equality-in-rights that is upheld by the Brazilian Constitution, and in line with the WHO's "new universalism." Similarly, Mãe Cíntia told me during an interview that the 1988 Constitution made a significant difference in terreiro activists' ability to negotiate with the state:

[Now] we are able to speak to [state officials] as equals (*de igual para igual*), and some of our demands are already being approved by the state. One reason is that we now have this right [to negotiate]. It is guaranteed by the Brazilian Constitution...Sometimes, though, I have to demand my rights (*fazer valer meus direitos*). In order to do that, I have to know Article V of the Constitution.

Like Pai Jeferson, Mãe Cíntia cited Article V of the Brazilian Constitution, which states: "Everyone is equal before the law, without any manner of distinction" (Brazil 1988). In this excerpt, Mãe Cíntia emphasized her status as a Brazilian citizen with full equality of rights before the law. She articulated a changing relationship between citizens and the democratic state, a relationship in which citizens have the right to demand their rights. At the same time, she acknowledged citizens' obligation to know the law and to be aware of their state-granted rights, which she implied are not automatically protected by the state. Rather, in her view, citizens are responsible for holding the state to its promise of protecting citizens' full rights.

Many other Network members also told me, and expressed to each other during meetings, that citizens are responsible for ensuring that the state protects their rights. They saw this "watchdog" role as the primary function of their activism, although they perceived their rights to include not only equal treatment, but also the adjustment of health services to accommodate their special needs (equity). The more emphatic discourses of citizenship equality, such as the ones cited above, usually occurred when a phenotypically white or middle-class activist, like Pai Jeferson and Mãe Cíntia, felt excluded from the group's collective black identity. At that point, the activist would reiterate the principle of citizenship equality, perhaps in an attempt to revive some semblance of a common purpose with his or her fellow activists.

It is important to note that many terreiro health activists saw no contradiction between upholding the universalist, egalitarian model of SUS *and* tailoring public health services to reflect different populations' characteristics and "vulnerabilities." Activists and SUS administrators who argued that substantive equality can only be achieved through group-differentiated health care disregarded the logical snafu that accompanies claims for "equal but different" treatment. They interpreted equality not as uniformity of treatment, but rather as the equal right to be recognized as different (Taylor 1994).

Pai Mário's comments during an interview illustrate this point well. First, he stated that "institutional racism" (*racismo institucional*) prevents black Brazilians from receiving equal access to public health services. When I asked him to clarify, he explained that health services are often delivered in a substandard way to black patients as compared to white patients. For instance, the doctor might spend less time with black patients, and consequently miss important diagnoses. Pai Mário's proposed solution was to institutionalize "equity," which he defined as "treating different people unequally...and giving more attention to those who need it more" (*tratar de forma desigual as diferentes pessoas...e dar maior atenção para quem precisa de maior atenção*). He compared this strategy to affirmative action quotas in the university, describing it as a temporary measure to "level the playing field" (*anivelar o campo*). This is the only way, he said, to eventually achieve the goal of equal health for all Brazilians.

VII. Discussion

Since re-democratization of the Brazilian state in the mid- to late 1980s, grassroots social movements representing diverse segments of the population have flourished on an unprecedented level. The recent example of the “People’s Summit” (“Cúpula dos Povos”) that occurred alongside the “Rio+20” conference (June 20-22, 2012) demonstrates not only the remarkable diversity of citizen movements in Brazil, but also the strength of Brazilian citizens’ belief in the power of civil society to effect sweeping political changes. Another striking case taken from recent headlines is the ceasing of the construction of the Belo Monte dam in Brazil; President Dilma Rousseff ordered the project to halt, despite its potential for lucrative economic returns, after a determined group of indigenous activists repeatedly undermined construction efforts in protest of environmental damages and indigenous displacement caused by the project. The case I have described in this paper is no less extraordinary, given the ability of civil society actors to infiltrate Brasília and co-construct policy; obtain government support for initiatives that are critical of the public health system’s status quo; and place historically stigmatized groups at the center of public health education efforts.

In this paper, I have examined the ways in which health activists from Afro-Brazilian religions engage the debate on incorporating attention to racial and ethnic differences into the logic and practice of universal health care in Brazil. Like Brazilian black health activists more generally, terreiro health activists speak of individual patients’ particular needs, but in practice they apply the concept of “niche standardization” (Epstein 2007, *passim*). Niche standardization is a way of segmenting the population and recommending strategies or solutions that apply neither to the whole population nor to the individual, but rather to a particular subset of the population. Within racialized medicine, all members of a chosen subset (e.g., the black population or the terreiro population) are assumed to have (internally) identical health issues and needs. Niche standardization simplifies the selection of target populations for policy and research, but it also homogenizes the internal diversity of these populations. Therefore, niche standardization ultimately fails in its attempt to deliver health care that is responsive to patients’ individual needs. Instead, it ends up replicating the shortcomings of universalized medicine at a level intermediate to the universal and the individual.

Regardless of this problem, and the politics surrounding the selection of cultural symbols for “culturally competent” health care materials and programs, the proliferation of partnerships between public health departments and terreiros represents a significant breakthrough given that the Brazilian state once repressed Afro-Brazilian ritual practices. Through activities such as their cultural sensitivity workshops for SUS employees, I have argued, activists seek symbolic reparation for the past criminalization of their health practices and for the historical (and ongoing) association of Afro-Brazilian religions with poor hygiene, contagion, and charlatanism (Johnson 2001; Maggie 1992).

The debate rages on in Brazil regarding the best strategy for eradicating black Brazilians’ disadvantages in the labor market, the university, and the public hospital. While social movements like the Network advocate for the creation of health policies for specific population groups, many non-activist Brazilians and the popular media denounce these strategies as racist and claim that universalist policies are the only effective way to address the consequences of racial inequality.³⁰ Meanwhile, Network members continue to wage their politics of difference alongside simultaneous appeals for egalitarian inclusion in public health services and protection against religious intolerance and racism.

³⁰ See, for example, Veja (2006).

The Network provides a fascinating context within which to observe terreiros members' negotiation of universalist and particularist claims because, as Segato (1998, 143) has noted, there is a fundamental ideological disjuncture between the universalist ethos of Afro-Brazilian religions, and the strategic essentialism of a race-based politics of difference. She argues that Afro-Brazilian religions' "cultural codex...resists racialization because it perceives itself as bigger than race and aspires to universality (*ibid.*)" As I've described in this article, there is also an ideological mismatch between the universalism proposed by SUS and the Brazilian Constitution, on the one hand, and terreiro activists' demand for recognition of their differences within health care services.

What happens to the universalist ethos of Afro-Brazilian religions when members leave the terreiro, so to speak, in order to participate in mundane public debate with SUS officials and collaborate with black movement activists? The public sphere they create, located somewhere at the interstices of religion and politics, is infused with spirituality—such as when the activists received Iemanjá at the Network's meeting in João Pessoa—but also takes on debates and schisms from the wider society. Terreiro health activists are able to maintain their connection to the spirit world while activating the political aspects of their identities, although this process does not always occur smoothly, as I have discussed. In this aspect, the Network provides an important counter-example to the image of terreiros as apolitical, or "close to magic, far from politics" (Prandi and Pierucci 1996). In keeping with Segato's characterization of the terreiro as "encompassing the other," Network members engage SUS officials in political debate on their own terms, insisting that respect for their particular worldview and health practices be incorporated into public services and spaces. In the process, they re-imagine the relationship of their traditional healing practices to biomedicine, as well as the relationship of Afro-Brazilian religions to the nation itself.

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