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Syncing Umbanda and Science (SUS): Using Umbanda's Holistic Healing Methods to Increase Access to Healthcare

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Abstract

In 1988, after the 1985 termination of the military dictatorship in Brazil, the constitution was rewritten to guarantee individual rights to all citizens of Brazil. Among the various other rights that the new constitution protected, anyone in Brazil was granted the right to government-funded healthcare under the regulation of the Unified Healthcare System, SUS. Because of structural inequalities in Brazil as well as the rise of privatized healthcare, equal access to healthcare is not a reality in modern-day Brazil. Many citizens who live in the periphery are limited to understaffed and underfunded primary health centers.

This monograph explores the healing methods that are intrinsic to the Brazilian Umbanda religion and the connections that are being made between Umbanda and SUS in the attempt to improve universal access to healthcare. Through interviews, observations, and gira participation, this paper not only looks at past, present, and future of healthcare programs that involve the bidirectional flow of healthcare knowledge between health centers and terreiros, Umbanda religious centers, but also concludes that integrating holistic, traditional healing into the conventional biomedical system has the potential to improve the quality of healthcare for all citizens. This paper argues, however, that this potential is limited by the heavy stigmatization and marginalization of the populations that develop these treatments and lack of continuity of program development as a result of government structure. The topic is then contextualized within the larger framework of healthcare in Brazil through a discussion of João Biehl's research on the Brazilian AIDS initiative.

Glossary of key terms

Banho – Herbal bath used in Umbanda healing methods

Brazilian National Commission on Social Determinants of Health (NCSDH) – WHO commission dedicated to improving healthcare among social groups facing social barriers to good healthcare (Afro-Brazilian religions, handicapped, men)

Caboclo – Indigenous spirits in Umbanda

Candomblé – African matrix religion with some similarities to Umbanda

Centros de Atenção Psicossocial (CAPS) – Centers for Psychosocial Treatment; government program

Chá – Tea, used in Umbanda healing methods

Coordenação Municipal de DST, Aids e Hepatites Virais – Municipal office of STDs, AIDS, and Viral Hepatitis

Coordenadoria de Diversidade Sexual – Coordinating Body of Sexual Diversity

Coordenadoria de Políticas de Promoção da Igualdade Racial (COPPIR) – Coordinating Body of Policies Promoting Racial Equality

Coordenadoria de Políticas Sobre Drogas – Coordinating Body for the Policies Concerning Drugs

Filho-de-Santo – Umbanda follower

Fundação Oswaldo Cruz (Fiocruz) – Public health think tank with a mission to spread knowledge related to healthcare

Gestão – Administration (changes every four years on municipal level)

Gira – Name of an Umbanda religious ritual session

Homen de Anel – Umbanda term for a medically trained doctor (literally "man of the ring")

Iemanjá – Orixá linked to the sea and the moon that has an annual celebration at Praia do Futuro in Fortaleza, Brazil every August

Incorporada – Word used to describe the state the mãe/pai-de-santo is in when they are in trance

Lambedor – Herbal, medicinal syrup

Mãe/Pai-de-Santo – Umbanda religious leaders

Medium – A medium; in Umbanda it is the mãe/pai-de-santo who receives the spirits during the gira; in spiritism the person who receives the spirits heals with spiritual energy

Movimento Político Umbandista (MPU) – The Umbandist Political Movement

Obaluayê – Orixá who brings health and heals

Ogun – Orixá who protects the terreiro at the beginning of the gira

Orixá – Divine intermediate deities of Umbanda

Phytotherapy – The use of plants for complementary medical treatment

Preto Velho – Spirits of old slaves who are often called upon for cures. They prescribe herbal remedies and do not want assistance from homens-de-anel.

Rede Nacional de Religiões Afro-Brasileiras e Saúde (RENAFRO) – National Network of African-Brazilian Religions and Health; anyone can support but only people of Afro-Brazilian religions are part of this network

Reza – Prayer, common form of healing done by mães/pais-de-santo who are or are not in trance

Secretaria de Direitos Humanos (SDH) – Office of Human Rights

Secretaria de Políticas para as Mulheres – Office of Policies for Women

Sistema Único de Saúde (SUS) – Unified Health System; Brazil's constitutionally established public health system

Social Capital – The solidarity and trust relations that take place between individuals and groups

Terreiro – Umbanda religious building (literally "yard")

Umbanda – A Brazilian religion of rebellion that combines the beliefs of African religions, Catholicism, Spiritism, and Brazilian Indigenous traditions

União Espírita Cearense de Umbanda (UECUM) – Spiritualist Union of Umbanda in Ceará

Glossary of Key Figures

Anderson Zen – Atypical Umbandist who is a friend of my host mom and took me to small giras with Mãe Socorro

Anna Beatriz F. **Paula** – Granddaughter of Dona Nene; interviewed in Fortaleza, Brazil on May 13, 2014

Bet Cost – My host mom who took me to small giras and introduced me to Anderson Zen and Mãe Socorro

Carminlurdes Gadelhe – Mãe-de-santo who lives in Maranguape; interviewed in Fortaleza, Brazil on May 12, 2014

Clayton More – Director of the Povo-de-Santo project in the Coordenação Municipal de DST, Aids e Hepatites Virais; pai-de-santo; interviewed in Fortaleza, Brazil on May 19, 2014

Cristian Perr – Coordinator of COPPIR; interviewed in Fortaleza, Brazil on May 21, 2014

Dona Nene – Mãe-de-santo from Fortaleza who lives in Brasilia; works mainly with cures; interviewed in Fortaleza, Brazil on May 13, 2014

Dr. Rick Fig – UECE veterinarian/researcher focused on reproduction; Spiritist medium; interviewed in Fortaleza, Brazil on June 2, 2014

Julie Hole – Works with RENAFRO and is of the Candomblé religion; interviewed in Fortaleza, Brazil on June 3, 2014

Klema None – Coordinator for Mulheres de Axé at RENAFRO; interviewed in Fortaleza, Brazil on May 26, 2014

Leda Albino – Ouvidora (hears complaints) at Mereiles Health Center; interviewed in Fortaleza, Brazil on May 30, 2014

Lucia da Silva – Executive Coordinator of Coordenadoria de Diversidade Sexual; interviewed in Fortaleza, Brazil on May 21, 2014

Mãe Socorro – Mãe-de-Santo of Anderson Zen whose giras I attended

Marco Grow – Institutional Coordinator of Coordenadoria de Diversidade Sexual; interviewed in Fortaleza, Brazil on May 21, 2014

Monica Merezes - Social Assistant at Mereiles Health Center; interviewed in Fortaleza, Brazil on May 30, 2014

Rita dos Anjos – Mãe-de-Santo who takes part in public health programs working to increase access to public healthcare; interviewed in Fortaleza, Brazil on May 23, 2014

Introduction

After the Brazilian military dictatorship ended in 1985, the constitution was rewritten in 1988 to guarantee individual, human rights to all people in Brazil. Written into Chapter II Section II of the constitution, which outlines provisions for human and environmental health responsibilities of the government, article 198 clearly states:

> Health is a right of all and duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery.

This same section of the constitution also establishes the Unified Health System, SUS, which is designed to implement all aspects of healthcare that are founded upon the principles of universality, equity, and integrality (Ministério da Saúde 2014). SUS' role is thus to promote health and provide equitable, free care to all people in Brazil.

In an interview, my informant Klema None, a coordinator for the NGO National Network of African-Brazilian Religions and Health (RENAFRO), broke down SUS' structure in a digestible way that facilitated understanding the inequity that exists in the current system as well as the possibility for SUS to work with Umbanda terreiros. None explained that there are three levels of medical assistance that serve different purposes and take place in different types of institutions. The first level is primary or basic care. This includes family and preventative care, as well as community health worker programs. Primary health clinics target common and chronic diseases and often have the ability to diagnose and refer patients who need specialized care. Secondary care requires a referral to a specific type of doctor. None gives the example of the Center for Psychosocial Treatment (CAPS) clinic where she works. It is specialized care for mental health, so it is a level two health center. Tertiary care takes place in hospitals and is for emergency or surgical care. Heart surgery is an example of a treatment that falls under the category of tertiary care (personal communication, May 26, 2014).

Since its development, SUS has created programs such as "Agents of Health", "Family Health Program", and "Ouvidoria Itinerante" (OI), in the attempt to increase the access to healthcare for poorer sectors of Brazil's population (World Health Organization 2008), but this

aid has been unevenly distributed. The national statistics, with regards to indicators of improved healthcare, have thus greatly improved since the employment of SUS, but national averages mask the regional inequalities that exist between the north and the south of Brazil (Nations 1997).

The right to healthcare is one of many human rights guaranteed in Brazil's constitution. Chapter III Section II of the 1988 constitution outlines a government-enforced guarantee of cultural rights, specifically for Afro-Brazilian and indigenous populations, both of whom have been marginalized throughout Brazilian history. Paragraph 1 of Article 215 states:

> The state shall protect the expressions of popular, Indian and Afro-Brazilian cultures, as well as those of other groups participating in the national civilization process.

Since 1988, cultural rights have been extended to various other demographics of the population. Coordinating bodies under the Office of Human Rights (SDH) have been created to establish the fight for equality through local education and integration programs.

Umbanda, the Brazilian religion that is the product of religious syncretism of indigenous, African, and European religious beliefs, is one of the religions that the SDH works to protect and empower. While the rights of this religious group are written into the constitution, it continues to suffer from various forms of unmasked religious intolerance. On May 21, 2014, Federal Judge Eugênio Rosa de Araújo publicly decreed that Umbanda and Candomblé would no longer be recognized as religions (Prado 2014). While this announcement sparked protest from many social groups, this instance of unlawful political condemnation of African matrix religions is only one example of the religious intolerance that Umbandists face. This denouncement of Umbanda demonstrates how African Matrix religions are still hindered by the government even if they are constitutionally granted the right to be practiced and celebrated.

Thus, while the constitution articulates the individual rights to health and cultural diversity, the reality in Brazil is that marginalized populations, such as those who practice Afro-Brazilian and indigenous religions, are still highly stigmatized and live in the periphery of the city where they do not receive equitable healthcare. Many of the peripheral cities only have primary health clinics that are both understaffed and underfunded, and are thus unable to provide quality healthcare. The lack of secondary and tertiary health institutions in these areas is also

problematic because it restricts access to specialized and emergency care, which the constitution technically guarantees to all Brazilians.

Many states, including the northeastern state of Ceará, are currently running and developing programs to increase equitable access to healthcare. In Ceará, these programs are generally referred to as "povo-de-santo" programs. Coordinating bodies in the Office for Human Rights (SDH) sector are working to partner primary health posts with Umbanda terreiros in order to establish a bidirectional flow of medical information between providers of both traditional and biomedical healthcare. The programs seek to promote public health practices inside the terreiros by sending doctors and community health workers into the religious centers to increase access to preventative health information, but they also want to introduce mães/pais-de-santo into the health clinics where these alternative healers can apply their traditional knowledge to provide holistic, accompanying treatment. The end goal is to increase the effectiveness of the health centers in the periphery through holistic treatments and education regarding the use of natural remedies that are intrinsic to the Umbanda religion.

In this paper I will first explain what I learned about past, present, and future povo-de-santo programs in Ceará with regards to who runs them, what purposes they serve, who benefits, and ways in which the knowledge from the terreiros is spreading. I will then seek to analyze the type of information I gathered in order to discuss different factors that are hindering the success of these programs from reaching their full potential with regards to improving healthcare as well as educating the general population in Ceará.

The literature review begins with an exploration of Brazil's religious history and describes how religion is an essential element of the flawed healthcare system. It then provides background information regarding the historical connection between religion and healthcare as both a force for disparity but also potential equity. Next, it explores ways in which legislation provides an international and national framework for a shift in healthcare practices to a more holistic type of healthcare. From there, its shifts to applications resulting from the legislations and explains some initiatives that are already underway in the wealthier south of Brazil. Finally, it provides a critique of existing programs and describes ways in which southern programs can be improved and adapted to fit the public health needs of the impoverished northeast.

My empirical data deepens the analysis provided in the literature review. First, I explain what the Umbanda religion means to different people living in the northeast. I then explore the

past, present, and future of the terreiro project that has continuously shifted between reformation to integration of Umbanda practices in a medical context. Through this combination of secondary and primary data, I argue that in order to increase pursuit and accessibility of basic healthcare among the poor, government programs need to create a dynamic medical system that uses Umbanda as complementary treatment as a means to foster a bidirectional flow of health information between the biomedical and traditional medical practices in Brazil, which together have the potential to improve physical, social, and environmental health in the poorest regions of Brazil.

I close the paper by contextualizing my analysis in the framework of João Biehl's study of the HIV/AIDS public health initiative of the late 20th century, an initiative which was deemed one of the world's most successful HIV/AIDS initiatives. I compare my findings to Biehl's study of houses of support where he did a large amount of his fieldwork and find overlaps in benefits that stem from the community health worker model of treatment for the poor. I use the context of Biehl's work to explain ways in which the terreiro projects have the potential to go further than the houses of support in Salvador that treat impoverished AIDS victims. I end this with ideas for future research on these topics, which opens up the discussion to other religions in Brazil.

Ultimately, I hope to demonstrate the value of the bidirectional flow of information between terreiros and the conventional medical system in Ceará. I show that Brazil has progressive ideas in regards to equity and healthcare, but the goal is difficult to achieve and a distant reality that can only be accomplished through a cultural and political shift in public health that pushes for a system that deconstructs social barriers. This paper, thus, is an initial exploration of one method that Brazil has begun to implement in order to improve the practice of its forward-thinking medical policy.

Literature review

Introduction

While the 1988 constitution guarantees all Brazilians equal access to public healthcare, there are various government spending and social factors that impede the reality of equitable healthcare in Brazil. Various analyses of different healthcare indicators have been used to demonstrate the healthcare inequity that exists between the northern and southern regions of Brazil. These same indicators have pinpointed the groups within the northeast that are the worst off, and those groups generally lack access to the most basic human needs, which in turn limits their ability to receive even the most basic form of healthcare.

Maria Cristina N. Gramani's (2014) uses a variety of indicators to demonstrate the inequalities in quality of care and spending in the different regions of Brazil. Gramani's analyses of social factors, such as education, employment, sewage treatment, and income, as well as quality of care in regional, federally funded health institutions, all conclude that the northeast region of Brazil performs the worst in every healthcare related category. In terms of quality of care, the study reveals that the north and northeast regions of Brazil also have a significantly greater need for healthcare improvement in order to function efficiently. The study thus concludes that the northeast region, which includes the state of Ceará, faces extreme structural inequalities that result in inferior quality of healthcare.

The Brazilian National Commission on Social Determinants of Health (NCSDH), a WHO commission supported by Fiocruz and the Ministry of Health, sites child mortality rates as a clear indicator of regional healthcare disparity. In the document "Health Inequities in Brazil: Our most serious disease" (2006), the commission sites the 2004 national and regional statistics in order to show the stark gap. While the national average of childhood mortalities in Brazil was 23.1 per thousand live births, the rate in the south was five times lower than that in the northeast (10 deaths per live birth as compared to 50). Fortaleza, the capital of Ceará and the city in which I conducted my research, is the largest urban area in the northeast, health-deprived region of Brazil.

The drastic regional inequalities specific to the state of Ceará can be exemplified through Nations' study, "Umbanda healers as effective AIDS educators: case-control study in Brazilian urban slums (favelas)" (1997). Nations explains that in 1980, HIV/AIDS rates began to increase in the northeast region of Brazil as they simultaneously decreased in southern regions. Nations attributes this to the virus "attacking the poor, malnourished, least educated and most

discriminated" (p. 60) groups. Nations' HIV/AIDS case study thus reiterates the trend of inequitably distributed healthcare reforms among the various regions of Brazil.

State and municipal governments have begun to tackle the poor distribution of federal funds through the enactment of regionally based programs that seek to improve the quality of healthcare of the structurally limited segments of the population. One method that states have used is the enactment of federal programs such as the "Family Health Program", "Agentes de Saúde", and "Ouvidoria Itinerante" (OI), which all find different ways to reach the poorest areas of the state. More recently, however, there have been municipal level programs in Ceará that seek to improve healthcare by increasing the role of local knowledge in the provision of basic healthcare to the neediest populations. While the empirical portion of this paper will detail the development of religious-focused government initiatives to tackle this disparity in Ceará, I will first explore literature that provides a historical background on the religious and political basis of health inequity in Brazil as well as the potential use of religious space to increase equity in healthcare.

The Political Aspects of Religion through History

There are many structural obstacles that stand between the impoverished populations of Brazil and access to better healthcare, but this portion of paper will focus on ways in which religion has played a role in inequitable distribution of health in Brazil. In order to understand the value of integration of religious systems into basic healthcare practices in Brazil, it is critical to know about how religious dynamics have developed in Brazil since the Portuguese colonized the country and brought in slave labor from Africa. The interaction among populations from these three religiously and culturally different parts of the world have set up an interesting blend of religious beliefs, including those regarding the role of religion in health and medicine. The resulting religious layout has mainly served to push people apart, but some aspects, especially those regarding healing, have also brought people together, and it is those characteristics of religion on which SUS is trying to capitalize in order to increase healthcare equity. The dominant religions in Brazil are Catholicism, Pentecostalism, and religions rooted in African traditions, commonly referred to as African-matrix or Afro-Brazilian religions. These three practices have developed simultaneously and contributed to social, political, and economic conditions of Brazil that together play a role in the existing healthcare landscape of the nation.

While the religious demographics have shifted significantly over the past 40 years, 60 percent of the Brazilian population still identifies with the Catholic Church (Pew 2013). In his volume *The Brazilians,* Joseph A. Page explains the historical context of Catholicism in Brazil. When the Portuguese first arrived in Brazil in 1556, they landed there ready to spread their Catholic beliefs and convert the native population into Catholics. While Catholicism was considered "soft" (p. 323) in Brazil as compared to other colonized New World nations, there was no separation of Church and State so Catholicism became the national religion. The unity of Church and State lasted until the birth of the Republic in 1891, but even after the official separation, religion and politics remained intertwined.

The separation was highly contested, especially in the northeast, where rebellious leaders took power and appealed to the "have-nots" (p. 332) of the region. In the northeast, the level of religiosity is still notably higher than in other regions of Brazil for a variety of reasons, but it can largely be attributed to the Catholic rebels of the late nineteenth and early twentieth centuries (1995).

Catholicism did not only remain intertwined in the politics of the northeast, but also throughout the rest of the country. The latter portion of the twentieth century was a radical time for Catholics in Brazil who still made up over 90 percent of the population (Pew 2013). During the 1960s and 1970s the Catholic Church reached marginal communities and used Liberation Theology to lead the poor out of "hunger, misery, ignorance, and oppression" (Page 1974: p. 341). Liberation Theology used the teachings of the Bible to motivate the oppressed to fight for justice by preaching that under God, all people are equals. Liberation Theology challenged the hierarchal structure of the Vatican, so in the late 1980s, after the dictatorship had lost power, the Vatican replaced the archbishops in Brazil with more conservative voices, which as a result pushed the poor to seek support from other religions.

Since the fall of the military regime, there has been a significant shift in the religious demographics in Brazil. The rise of Pentecostalism since the 1970s in Brazil is strongly correlated to a variety social ills from which the Pentecostal church promises to provide a place of refuge and healing (1995).

Brazil's current form of Evangelism was born in the early twentieth century in Los Angeles. California. About ten years after is founding, missionaries from North America began to spread the religion throughout Latin America. By the middle of the twentieth century it was the only

form of Pentecostalism remaining in Brazil. At that point, the Catholic Church began to view Evangelicals as a threat to their dominance, and took violent action against the Protestants. In the end, opposition to Catholic repression only served to strengthen the growing Pentecostal religion through the shared experience of defense and rebellion (Chesnut 1997).

The Pentecostal surge took hold in the 1950s when the media began to promote Evangelism. Religious leaders took advantage of this situation to reach virtually every demographic in Brazil with their "timeless message of healing" (p. 36). Since the 1970s, the combination of the increase the Pentecostal outreach to marginalized communities, the Catholic return to conservatism and focus on the middle and upper class, and the worsening socioeconomic conditions have all been drivers in the growth of Protestantism from five to 22 percent of the population and the Catholic fall from 92 to 65 percent of the population (Pew 2013).

The simple explanation of the changing religious landscape in Brazil is the fact that Pentecostalism preaches a lifestyle free of sin and promising a life full of "physical and social wellbeing (Chesnut 1997: p. 52), which provides people with a space where they can dissociate themselves from the impoverishing aspects of culture. There is a vast array of unfortunate living conditions that are associated with the extreme poverty of Brazilians living in slums throughout the country. The social programs in place that aim to improve these conditions lack adequate government funding. Pentecostalism capitalizes on the situation and gains followers by offering an escape from social ills for anyone who accepts Jesus as the "Physician of Physicians" (p. 54). In a country like Brazil, where the majority of the population lacks access to healthcare (Chesnut 1997), people are bound to seek alternate sources of medical treatment.

The teachings of Pentecostalism also provide an escape from social realities, like alcoholism and domestic violence, that manifest themselves in the poor regions of the country. Many Brazilians turn to alcohol as a means to self medicate. The use of alcohol has negative impacts on both physical and financial health of individuals and families. When people (primarily men) spend family income on alcohol, there are fewer resources available for the rest of the family. The Pentecostal church offers rehabilitation services that the government does not provide. As a result, men will convert to access these resources.

Alcohol abuse and a culture of male dominance both contribute to high rates of domestic violence. Women and children who are abused in their homes often seek the church community as a place where to escape the violent conditions in their homes. The community that the church

provides gives victims a physical and emotional refuge. While alcohol treatments often convert men, the escape from violent homes often leads women and children to convert.

Pentecostalism offers full salvation while the other main religions of Brazil (namely Catholicism and Umbanda or other Afro-Brazilian cult traditions) do not. Chesnut (1997) argues that this is because Pentecostalism forces conversion and rejection of certain aspects of Brazilian "festa" or party (p. 111) culture that are engrained in Catholic and Afro-Brazilian traditions. Those who find Jesus through Evangelism reject the use of alcohol and in turn the street life of Brazil, which often results in the improvement of social and economic conditions for the family. While this form of salvation offers lifestyle improvement for vulnerable populations, it also fosters a culture of stigmatization of Afro-Brazilian traditions through the effort to seek converts from a religion that offers similar health and lifestyle benefits to its followers, while preaching that any non-Pentecostal beliefs are demonic and evil. There are striking similarities between the traditions of Pentecostalism and Afro-Brazilian traditions, which make followers of Afro-Brazilian religions easy targets for conversion. Evangelicals have the cultural stigmas against African traditions on their side. They have the ability to use the media to gain support, promote healing, and demonize other traditions in order to popularize their teachings and promote conversion (Page 1974).

The healing power of religion is similar in all dominant forms of Brazilian religions, which why even if Pew Research Center only lists about five percent of the Brazilian population as followers of Afro-Brazilian traditions, as many as a third Catholics have attended African matrix ceremonies (Page 1974). There is a wide range of reasons for the lack of self-claimed religious identity of cult religions, two of which are the importance of Catholicism in cult religions that lead to interchangeability between the two, as well as the historically rooted stigmas that are associated with African-matrix religions and their origins in slave rebellion to white power.

The African slave trade truly began to take hold late in the sixteenth century after the Portuguese colonists realized that the indigenous peoples did not provide an adequate labor force (Bastide 1960). Three different African regions were the primary targets of the slave trade. These regions were grouped as the Sudanese, the Bantu, and the Islamic tribes[1] (Page 1974). When

[1]The Sudanese were from what is now Liberia, Nigeria, Dahomey (southern Benin), and the Gold Coast (Guinea), the Bantu were from what is now Mozambique, Zaire, and Angola, and the Islamic were from what is now the western region along the Niger River (Niger Valley)

mixed together on the plantations, these different tribes defied expectations. Instead of clashing, as the three tribes interacted, they created new traditions adapted to their new landscape and living conditions (1974). Page (1974) claims that the overarching reason behind this is that Africans could only bring with them their traditions, so they intentionally found ways to preserve that part of their lives.

Different sources provide slightly different histories and reasons for the merging of the variety of African cultures and their mixing with the preexisting indigenous and Catholic religions in Brazil, but there are some commonly posed hypotheses and explanations. I will share some of these overarching theories in order to create a better understanding how slavery and freedom of Africans in Brazil allowed these religious practices to evolve and thrive.

Sugar plantations in the northeast region of Brazil are a commonly cited example of conditions that led to Afro-Brazilian religions. Scholars often attribute the birth of these religions in the northeast to the shortage of Catholic priests and the encouragement of the continuation of African traditions by the plantation owners.

Catholicism was forced upon all Africans upon their arrival in Brazil, but the slaves were able to use the inherent inequality that exists in Brazilian Catholicism to preserve the essence of their own traditions. Africans were baptized at the earliest convenience and each plantation had its own chapel. Page (1974) explains that blacks viewed the white God as a powerful one, who was the source white man's rule in Brazil. Africans thus, were willing to accept aspects of Catholicism, but morphed it to fit into their own belief system. The inherent inequality of the two coexisting forms of Catholicism is the root of the religious inequality that exists between Umbanda and Catholicism today.

Page (1974) explains that while the slaves were forced to attend mass and pray to the white God, the slave owners also allowed them to continue their beliefs through dances and by frequently bringing in new African slaves. Slaves took advantage of their masters' ignorance and preserved their traditions through these dances that worshipped their own deities that they associated with Catholic saints.

Bastide (1960) describes the schism that syncretism created in Catholicism. He names the resulting phenomenon as the "Black Church" and the "White Church" (p. 115). While slaves were forced into the Catholic belief system, their social inferiority gave them freedom within the system. This how the modern practice of Afro-Brazilian traditions is still used as a way to

discriminate against black populations in Brazil, but it can also be used by black populations as a means of fostering community, self-realization, and empowerment.

As demonstrated by Black Catholicism, Africans used aspects of socially acceptable ritual practices as a means to preserve their own culture. The social stratification that Catholicism created between whites and blacks also served to reinforce the importance of maintaining African traditions by creating racial awareness in a divided country. Slaves were able to transform "a religion of social control into a religion of racial protest" (Bastide p. 114). This was taken even further through the merging of African traditions with other rituals practiced in Brazil to create the African-matrix religions, the most nationally recognized being Umbanda, Macumba, and Candomblé.

Other than the reasons already explained, Bastide (1960) cites two specific reasons explaining why denigrated African traditions were able to survive and thrive throughout the slavery period. Firstly, Africans were able to preserve their burial rites, but more relevantly, whites benefitted from African religious healing rituals and witchcraft. During Brazil's colonial period, there was a major shortage in Portuguese healthcare and the Portuguese were experiencing new illnesses from the unfamiliar climate. The plantation owners observed the healing methods of their slaves, and while they feared the black magic associated with cult traditions, they were intrigued by the healing abilities that the African cures possessed. Landowners would often seek treatment from their slaves when conventional care was not available or working.

This particular reason behind cult-tradition survival is particularly relevant to the discussion that follows because it is not unique to the colonial period. In modern day Brazil, many of the people who condemn Afro-Brazilian religions secretly pursue them in times of need. All social classes of Brazilians thus see the value of Afro-Brazilian healing traditions, and this is part of what can give rise to their de-stigmatization and their integration into Brazil's public health system.

Overall, it is clear that religiously rooted inequality in Brazil has contributed to the inequitable distribution of public health services, but the historical validation of African and indigenous healing methods in times of biomedical shortages demonstrates that the fundamental idea behind a SUS's initiative is not a novel one. The fundamental human pursuit of health

improvement has the ability to unite people who can mutually benefit from exchanging resources and traditions in order to work towards the common goal of the best possible healthcare.

Legislative Basis for the Introduction of Holistic Care

While using traditional healing methods alongside biomedical treatment is not a novel concept, it is often done in secret because of the discrimination that alternative doctors face. International recognition and legitimization of complementary treatments at the beginning of the twenty first century marked a turning point in global public health initiatives. The change in political perspective of these practices endorses the use of previously stigmatized treatments. The Brazilian government followed the World Health Organization's (WHO) legislation to capitalize on complementary treatments available in Brazil and to make them a public good rather than a dirty secret.

In 2002, the WHO drew international attention to the potential role of traditional healing methods in public health systems through its "Traditional Medicine Strategy." This document developed definitions and action plans that help nations develop their own policies for the safe, appropriate, and affordable integration of traditional healing methods into their public health systems. The WHO thus, initiated the use of alternative treatments, which led to Brazil's national pursuit of local and cultural knowledge in curing disease.

Because of its biodiversity and religious diversity, Brazil is a country where traditional healing methods, especially herbal treatments, have existed for centuries. In 2006 Brazil passed its own form of the "Traditional Medicine Strategy" called, "Policy of National Integrative and Complementary Practices in SUS."[2] This policy included an entire section dedicated to phytotherapy, which outlines the scientific background of why medicinal plants should be used and explains that Brazil has the resources and knowledge that together can make use of the various medicinal plants. Marginalized groups like black and indigenous tribes have generationally accumulated knowledge of these cures.

In the same decade that Brazil nationally recognized the value of alternative treatments, the government also passed policies regarding the need to ameliorate the health status of Afro-Brazilians and Indians. Various policies were passed to recognize the inferior status of Afro-Brazilians and Indians, as well as to suggest ways that their socioeconomic status could be

[2] Política Nacional de Práticas Integrativas e Complementares no SUS.

improved. In 2010 the Ministry of Health published "Booklet HumanizeSUS: Formation and Intervention,"[3] which outlined specific programs and explained their intervention. One of the included related documents, "Phytotherapy in Primary Care: New Possibilities for Dialogue,"[4] (2010) explains the potential for phytotherapy in Brazil and the positive impact its use could have on the marginalized followers of African matrix religions, such as Umbandists. Maria Esther Vilela summarizes the health related and cultural benefits by stating that, "these actions have the potential to transform the relationship between health professionals and the community, fostering solidarity exchanges and overcoming the relationship of domination, advancing in a sense that this process is the democratization of knowledge, that is not exclusively attributed to anyone, and that should, therefore, be validated in its diverse forms and used for the benefit of all."[5] (218). The policy thus argues that the use of phytotherapy can empower marginalized communities through a knowledge exchange between conventional and traditional healers.

Together, these international and national policies that were developed in the beginning of the twenty first century create a political basis for the introduction of SUS' povo-de-santo programs in Brazil. By validating marginalized populations as a knowledge base, SUS has sought to exchange information with these populations. Unfortunately, there is a difference between policy and practice and some states have been slower to develop their own initiatives to increase alternative treatments and improve conditions of African and indigenous descendants in Brazil. There are, however, some good cases in southern Brazil where policy has been put into practice and these initiatives have begun to demonstrate the positive potential of using national legislation to make positive cultural changes that improve living conditions standing in the way of good health.

Ideas for Implementing Policy

Much of the discourse surrounding the quality of healthcare is Brazil focuses on the amount of money that is spent and that people have to spend on healthcare, but in reality the

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[3] Carderno HumizaSUS: Formação e Intervenção

[4] Fitoterapia na Atenção Básica: Novas Possibilades de Diálogo

[5] Estas ações têm o poder de transformer a relação entre profissionais de saúde e comunidade, fomentando trocas solidárias e superando as relações de dominação, avançando no sentido de que este processos leve à democratização do saber, que não é atribuição exclusive de ninguém e que deve ser, portanto, valorizado em suas diversas formas e usado em beneficio de todos.

discussion should be centered on equalizing distribution. Rather than focusing on increasing wealth of the nation, an initiative emphasizing better distribution of wealth has the most potential to improve the nation's health.

As previously noted, the southern region of Brazil receives much more aid and funding to improve universal access to healthcare. While southern systems are still far from perfect, the programs in the northeast are even farther behind in their improvements. The aforementioned WHO's Brazilian National Commission on Social Determinants of Health (NCSDH), is dedicated to breaking down social obstacles that limit the poor's access to healthcare. One of the main goals of the commission is to increase income distribution, a method that has been recognized as the means for improving the quality of healthcare in other nations.

While funding of healthcare programs is a critical issue, a 2006 paper produced for the launch of the NCSDH presents evidence that wealth distribution is more important than GDP in determining equitable healthcare in a country. The paper sites differences among states in the United States to prove this point. Studies show that the states with even wealth distribution have better health conditions than those where wealth is concentrated in the upper class. This theory is used to explain Japan's high life expectancy as a product of being the world's most egalitarian society.

The WHO explains this concept as "social capital," defined as "the solidarity and trust relations that take place between individuals and groups" (p. 4). When a society has high levels of social stratification, social groups isolate themselves, which limits the dynamic nature of health promotion and prevention practices. According to the World Bank 2012 statistic, Brazil has a Gini Index of 52.3 percent, making it one of the least equal countries in the world (2015). The wealth disparity in Brazil thus results in a lack of social capital, which is a major obstacle that stands in the way of proper healthcare. The gravity of the poverty in Brazil magnifies the healthcare issue because on top of lack of social capital, the lower class does not have access to the most basic human needs.

The SUS programs that bring together traditional and conventional healing methods thus have the potential to create a culture of social capital within a medical and religious context. The programs can facilitate communication among different social, cultural, and religious groups to create an environment where healthcare topics are discussed among people with different belief systems. As a result, people are no longer limited to a single-minded, socially dictated, form of

medical care. This communication opens doors not only for the poor, but also for the middle and upper class citizens who are also not satisfied with their quality of healthcare. The exchange thus fosters healthcare improvements while also validating practices and customs of the poor who often shy away from unfamiliar programs that they do not understand due to communication issues.

Umbanda for Holistic Care

While the legislation creates a path for holistic integration into the public healthcare system, actions must be taken to destigmatize Umbanda treatments and make them a respected form of care. In a culture that was founded on principles of inequality among different groups, namely European colonists and indigenous and African servants, achieving social capital is a difficult task. Due to its foundation among the lower social classes, Umbanda is not viewed as a religion for European descendants, so it is unlikely that the wealthier and more powerful faction of the nation will engage in actively seeking out discussions that nurture practices that lead to a nation with social capital. Brown and Bick (1987) argue that Umbanda's inclusive, syncretic principles have the potential to create an environment where all Brazilians can feel welcome. Brown and Bick assert that if SUS capitalizes on this notion, Umbanda is the ideal religion to deconstruct social barriers through an increase in national pride. National acceptance of the religion can then allow it to be valued for its contributions to holistic healthcare. This section of the literature review will outline reasons why and ways in which Umbanda can be used to improve Brazil's medical system and emphasize the value of making the system a bidirectional flow of information between equals rather than a unidirectional, top-down stream of information from the dominant to the marginalized healing traditions.

The first step in changing medical culture in Brazil is deconstructing the existing binary between modern and traditional treatments and instead approaching illness as biological, spiritual, social, and environmental entity. Alves and Seminotti (2009) describe this binary as the difference between "the symbolic and the concrete, the natural and the technological, the mythical and the empirical" (p. 3) and they find that when both elements are used together in treatment, the resulting holistic care captures the whole person by "integrati[ng] the individual and the context in which they live" (p. 4). Márcio Luiz Mello (2013) shares similar views on illness, which he asserts is "more than a biological configuration, it [illness] is also a socially and

culturally constructed reality and the sufferer is, above all, a social being" (p. 4). For this reason, Mello argues, treatments should be approached in culturally appropriate ways that do not just treat the physical characteristics of illness, but also the mental, spiritual, and social aspects that biomedicine often ignores. Mello gears his discussion specifically to the use of Umbanda in Brazil and its potential power as a preventative healing method that incorporates spirituality in order to encourage lifestyle changes for the sick; but he does not ignore the importance of seeking biomedical treatment in cases where the physical parts of disease require conventional medical attention. Lages (2012) also views Umbanda as a means to remove the detrimental binary from medical practice in Brazil. Umbanda offers a holistic approach to illness that treats the person and physical ailments with a combination of traditional and conventional treatments. This dualistic form of healthcare, thus, treats the whole person by providing both western therapies as well as complementary therapies that improve and add to the benefits of the reductionist conventional medical system.

Inclusion of community-based knowledge from Umbandists into the public health system can be achieved through primary healthcare. Mães/pais-de-santo, or Umbandist religious leaders, work in primary health clinics. These mães/pais-de-santo oftentimes have nursing degrees and the scientific knowledge to treat conventionally, but still use their position to educate the sick about natural healing methods. RENAFRO, an NGO committed to integrating African-Matrix religions into the public health system, is one of the driving forces behind the inclusion of mães/pais-de-santo in primary and secondary health centers. Over the past 10 years RENAFRO has been making a national effort to increase the use of Afro-Brazilian knowledge in the public health system and has done so by establishing a formal partnership between SUS and terreiros, Umbanda houses of worship. Da Silva (2007) explains the role RENAFRO has played in nationally integrating terreiro-based knowledge into the healthcare system. He lists the introduction of mães/pais-de-santo in public health clinics as one of RENAFRO's accomplishments with regards to increasing the use of traditional knowledge to improve healthcare. Respected Umbandist religious leaders are thus already taking initial steps in increasing their role in the medical system by entering the system at the most basic level and aiming to ensure prevention of disease and good health for all.

Both Lages (2012) and Mello (2013) emphasize the role Umbanda can play in changing the practice of medicine, but they also look at ways in which the incorporation of Umbanda into

the medical system can improve social health. Biehl (2007) uses narratives to articulate the poor's self-exclusion from the biomedical world due to lack of understanding of the treatments and lack of acceptance in hospital settings. Biehl stresses the importance in changing medical language to translate "'technical information into a language they [the poor] can understand'" (p. 273). Umbanda and its alternate view of health and healing are thus the missing connection between the poor and the biomedical world. The use of familiar language and tools in conventional settings can make the poor feel that they are contributing to the system while the use of more familiar language can also aid in understanding what was once foreign and intimidating. This mixture of practices can thus end the positive feedback loop of personally and socially imposed exclusion that the poor face in the biomedical health system that dominates Brazilian medical culture.

Many regions in Brazil have started using Umbanda as a mediator between doctors and patients for specific forms of treatment that involve chronic or long-term conditions that have no cure. Magnani (2002) explores ways in which Umbanda is being used to treat mental health patients. The causes of mental illness vary drastically among different cultures. Medicating mental illness is controversial, and so the holistic and spiritual approach for treating mental disorders can be a more culturally effective way to approach treatment and compliance. While certain disorders have powerful biomedical treatments that should be used, there are others that can be socially constructed or exacerbated, and in those cases "religion [can provide] a place of refuge, health, and healing for those in need" (Mello 2013:p. 2). Because of the lack of availability of care and the power of holistic treatment for mental disease, mental health is an area in which SUS can focus its effort to integrate traditional and western systems of medicine.

Communicable disease is the other major current use of Umbanda in medicine. Communicable disease is often seen as a result of structural violence among the poor. The Umbandist population is a high risk HIV/AIDS population because of the prevalence of homosexuality in Umbanda communities as well as the physical rituals that accompany traditional Umbanda practices. Pagano (2013) details some of the communicable disease prevention programs taking place in the south of Brazil. The main focus of these programs is to educate the people about risks associated with their cutting and homosexual behaviors, to provide materials to allow them to live their lifestyles in a safer manner, and to regulate their practices to ensure that they are being done safely. If the terreiros adhere to all of SUS'

guidelines, they become accredited primary health facilities in the region and receive funding and resources from SUS. Mental health and communicable diseases are thus effective current applications that serve as examples of complementing and reforming Umbanda practices in order to create a basic health network among the poor, which results in providing the nation with more options for healthcare.

The underlying goal of the recognition of holistic healing in healthcare is the sharing of information between conventional and traditional healers, but the government's role in current initiatives is inhibiting this from happening. Pagano's article follows up the description of the programs with an analysis of their successes and failures. While Pagano praises the progressive use of Umbanda centers to reach at-risk populations, but she problematizes the unidirectional flow of information in existing SUS-Umbanda partnerships. Pagano explains that SUS controls the programs and must approve the Umbanda centers before they can be recognized healthcare institutions. As a result, SUS controls everything that is done and said in these healthcare facilities. Ferretti (2003) validates Pagano's analysis by explaining the current relationship between conventional and traditional healers. He explains that mães/pais-de-santo often recognize that they should work alongside biomedical doctors in order to treat holistically, but it is rare for a doctor to send a patient to a terreiro to receive the complementary dimension of care. Ferretti uses this point to emphasize that the biomedical community still views itself as the dominant form of treatment. While this mentality of superiority exists, patients are unlikely to feel comfortable seeking alternative treatments and will continue stigmatizing the knowledge that marginalized populations contribute to the healthcare system. Thus, while the information has begun to flow between conventional and traditional medical practices in existing SUS programs that are working in terreiros, there still exists a bias regarding western medicine as superior, which limits the success of the programs.

The current programs thus undermine the knowledge contribution of half of the partnership that SUS wants to create. While this unequal relationship exists, Umbanda cannot be fully incorporated into the public health system because it is still not regarded as an equally valuable form of treatment. Both SUS' control and the unwillingness of doctors to cooperate thus inhibit the progress towards a nation with social capital as a fundamental aspect of its medical culture.

Umbanda as Holistic Care in Ceará

While there is not yet literature outlining government terreiro programs in Ceará, Nations (1997) saw the potential value of using Umbanda terreiros as healing centers in marginalized regions of the country and studied the impacts these types health centers could have in Fortaleza.

The two main reasons Nations gives for using terreiros as a space to promote HIV/AIDS awareness education programs are that Umbandists are a high-risk population because of their social status and blood-related rituals, but also because they are an open-minded and accepting group that will offer anyone care. Nations' study is able to quantitatively demonstrate that by providing mães/pais-de-santo with biomedical information adapted to their cultural context, religious leaders can empower a marginalized population and allow them to be more mindful during their religious ceremonies and personal lives.

Looking at some of the materials that Nations used in her fieldwork, it is evident that the books and pamphlets are catered to their audience. One book I looked at, *Levante a Vida,* is a graphically appealing workbook that explains scientific information about HIV/AIDS but incorporates it into the songs and prayers that make up a large part of the Umbanda religion. The workbook provides detailed information about HIV/AIDS treatments and prevention practices relevant both to general lifestyle choices and for Umbanda specific practices. The book demonstrates alternative practices for cutting and blood sharing rituals, and explains how to support HIV positive filhos-de-santo through Umbanda's holistic treatments such as prayers, phytotherapy, and massage therapy. SUS, which Nations told me in an email was not officially affiliated with her study (personal communication, May 16, 2014) could use materials similar to those developed through Nations' study to effectively partner with terreiros by culturally modifying scientific information in order to educationally empower the leaders inside marginalized communities.

Nations' work was not funded by SUS, but RENAFRO's 2007 entry into Ceará has increased local demand for SUS sponsored terreiro projects in the region. RENAFRO has pushed for programs from various offices that make up Ceará's municipal government and partnered with other government health organizations such as Fiocruz to further advance health promotion

within marginalized communities as well as destigmatization of African matrix religions in Cearà. Fortaleza, the city in which I did my fieldwork, has thus already had some experience and success with Umbanda terreiro programs and is now furthering these types of programs by engaging the local government in order to extend the span of the programs to the entire city and eventually state.

Conclusion

This literature review has explained the fundamental background of the Brazilian culture of religious and social inequality that spreads to the area of healthcare; laid out political, social, cultural, medical reasons Umbanda should be incorporated into SUS to improve the Brazilian healthcare experience for all; and explained current attempts and initial shortcomings of projects that have sought to initiate communication between Umbanda and the biomedical system to change the healthcare system at the most fundamental level. The remainder of this paper will take these perspectives into account to analyze the validity and the effectiveness of a program that is currently being developed by the municipal government in Ceará that hopes to improve physical health while deconstructing social barriers standing in the way of a holistic system that includes a variety of perspectives on health and illness.

Methodology

I collected all of my primary data during my School for International Training (SIT) study abroad program in Fortaleza, Brazil. The "Social Justice and Sustainable Development" Spring 2014 program lasted from March through June, but all of the primary data was collected over a month-long period from early May through early June of 2014. During my research period, the municipal administration was in its second year of its four-year term.

In order to gain a deeper understanding of the public healthcare system, the Umbanda religion, and the connections between the two, I had to employ a variety of formal and informal research methods. I interacted with a diverse group of people including, but not limited to, mães/pais-de-santo, government officials, various spirits (through the mediums), professors, directors of different social movements, and Umbandists within the general population of Fortaleza. In order to fully understand my surroundings and the different perspectives regarding Umbanda and the SUS program, I collected primary data through formal and informal interviews, participant observation, and outsider observation.

The early stages of my project consisted primarily of outsider observation and informal interviews. The first week of my fieldwork was spent attending Preto Velho parties and speaking with different people who could connect me to terreiros or Umbandists who work with SUS. In order to establish rapport in a short amount of time, I observed different Umbanda parties and had casual conversations with people at those parties. I also sent emails and made various phone calls to government offices that I thought could be working with the program. Lastly, I reached out to a UNILAB professor, Violeta Maria De Siqueira Holanda, who wrote her thesis on HIV/AIDS in terreiros in Fortaleza, to ask her for connections to terreiros where she studied. Through these conversations and observations I was able to reach people who I could formally interview and who could take me to places where I could participate and observe in different Umbanda rituals.

After I connected with the different divisions of the Office of Human Rights (SDH) that are working on this program, I discovered that the program that is being developed with the povo-de-santo and SUS is much bigger than HIV/AIDS awareness and prevention. I decided that while I still wanted to include HIV/AIDS in my monograph, I would be able to get more information if I expanded my question to other aspects of the public health system that can also benefit with the help of mães/pais-de-santo. All of these interviews were semi-structured, but often the questions

I prepared were answered during a conversation and most of the things I asked were follow-up questions to what had been said. I realized early on that what I wanted to know about the program was what they wanted to share.

I continuously followed up with government officials and mães/pais-de-santo who told me they might be able to take me to observe discussions in terreiros that are located in the periphery and are participating in the program, but when I realized this might not work out I interviewed people who work at those sites and could share their experiences with me. During the whole research period I called these connections daily, but due to their closed communities, safety concerns, and lack of access to transportation, I unfortunately was never able to visit one of these sites.

While I observed many Umbanda parties at the beginning of the research period, I realized that I did not understand what was happening. My host mom, Bet Cost, took me to the terreiro of Mãe Socorro to participate in more intimate rituals. At these smaller giras I had a chance to ask questions during and after the event. This was incredibly useful in increasing my understanding of the religion that is orally rather than scripturally passed down.

All of my fieldwork took place in Portuguese, so all of my included quotations are included in Portuguese in the footnotes. It is important to note that while I did my best to translate directly and objectively, the translations are not perfect and are subject to my personal biases.

Ethical Responsibility

The first ethical responsibility I undertook was time for self-reflection. Before taking on my research project, I asked myself various questions about my personal background regarding what I considered to be medical knowledge. I came to terms with the fact that I was raised in a country dominated by biomedical treatment of specifically diagnosed diseases. I also recognized the difference between the privatized healthcare system in the United States and the attempt to make healthcare a constitutional right in Brazil. After making myself explicitly aware of the presence of these western concepts as part of my history, I began to make a conscious effort to keep an open mind and allow myself to culturally redefine the concepts of disease, illness, doctors, and medicine as I collected my research.

In order to responsibly tackle ethical questions during interviews, I had to acknowledge the context in which I was interviewing. Whenever conducting a formal interview, I presented the informant with a form, in Portuguese, for them to read and sign in order to obtain informed consent. When recording interviews, I took a few notes on key terms that I wanted to remember, but for the most part I physically engaged in the conversation and actively listened to what the informant wanted to tell me. In the final draft of my project, all names of informants are changed in order to protect my informants, even if they all signed consent waivers.

In some contexts, recording conversation seemed inappropriate due to the casual nature of the conversation. In those settings I did my best to listen, to remember, and to immediately write down thoughts after the conversation. While some details were undoubtedly lost as a result of this method, I was able to build relationships founded upon trust and respect rather than researcher and subject, which in the end proved to be more valuable than the minute details that I lost.

Because a large part of my research took place in religious institutions, I was sure to always dress and behave appropriately. When attending Umbanda giras, I always wore light colors and covered my legs. When inside the terreiros, I did my best to avoid behaving inappropriately with regards to superstitions. I always entered and left terreiros facing forwards and never crossed my arms or legs. During participatory observation of giras, I was aware of my surroundings and blended as much as possible by following the lead of other attendees.

During the entire research period, I repeatedly asked myself, "Whom am I benefitting with this project?" If the answer to this question was ever "*only* myself," I made sure to immediately

refocus and adjust my research question. This form of mindfulness allowed me to deepen my research question and shift the focus to one that probed at the removal of structural violence in marginalized communities in order to achieve SUS's goals of national healthcare equity. It was however, important for me to remember to show gratitude whenever possible because I did and will continue to benefit from this research process in both academic and personal ways. Many of the situations I observed and conversations I had assisted in reshaping my mentality towards healing that will positively alter my development as a medical professional.

What is Umbanda?

Before starting my fieldwork I wanted to become an expert on Umbanda. I found myself looking through every book that included Umbanda in the index and Google-ing "what is Umbanda?" only to realize that since it is strictly a Brazilian religion that asking the question in Portuguese might be more effective. Contrary to my original logic, the more I read about Umbanda, its rituals, beliefs, cures, traditions, myths, stigmas, origins, etc., the more confused I became. In the end, I gave myself a foundation of knowledge by reading blog posts and Wikipedia pages and watching YouTube videos, but began to understand that Umbanda cannot be defined. Like any religion, it is based on unique, personal experiences that can only be taught through personal communication with those who live by its teachings and doctrines, which is only further complicated by the regional and localized development of the religion that varied among different African populations during the period of slavery in Brazil.

As discussed in the literature review, African slaves were captured all over Africa, but in order to preserve their culture they were forced to blend their traditions with those of other slaves belonging to different tribes. Different plantations, mines, and other slave centers had different African demographics and different religious needs, so naturally Brazilian manifestations of African traditions varied.

Bastide (1978) addresses this phenomenon in his discussion of selective worship of orixás based on localized needs. The blending of religions as well as limited resources forced slaves to be selective in their worship, and in Bastide's example of slaves on sugar plantations in the northeast, orixás that improved agriculture were forgotten, while those that provided more abstract qualities that could strengthen slaves and help them endure the hardships of slavery were retained. The orixás that remained, namely Ogun (god of war), Xango (god of justice), and Exu (god of vengeance), were adapted to help slaves combat regional hardships. Thus the introductions of orixás into Brazilian culture through slave traditions created ambiguity regarding the specific roles of orixás in different regions of the country.

Bastide (1978) also notes that historical documentation by the literate elite largely neglects the personal histories of slaves in Brazil. When describing reasons behind the survival of African traditions in Brazil, Bastide cites only three forms of documentation of slave traditions, which limits the understanding of religious development, and thus modern practice.

All literature that I have come across agrees that in practice it is nearly impossible to identify the specific affiliation of Afro-Brazilian religious spaces, but in theory there are clear differences. Page (1995) describes Umbanda as an Afro-Brazilian religion the "glories in its Brazilianness" (p. 364). While a major element of Umbanda is the African deities, its origins are in the "low" spirits discovered through Kardecist mediums in the early twentieth century. Reading about the different types of spirits provides an interesting perspective on Umbanda, but I learned more from localized personal narratives that I heard in my interviews.

My historical perspective on the development of Umbanda came from the history lesson that None gave me during her interview. After emphasizing the Brazilian origin of the religion, None started with the foundation of Umbanda in 1907 in Rio de Janeiro. Brazil already had Spiritists who followed Allan Kardec's teachings, but in 1907 one of the mediums named Zélio de Moraes received a caboclo, indigenous spirit, Caboclo das Sete Estrelhas, who instructed Zélio to start the Spiritualist religion of Umbanda. This religion, the caboclo explained, would give the "unqualified or inferior spirits"[6] (personal communication, May 26, 2014), not welcome in Kardec's Spiritism, their own space. The spirits that had indigenous and African roots would thus have a place to be heard in a way that they did not before. This origin from spiritism, None explained, is the contribution of the first of five matrices that make up None's Umbanda.

None then went on to explain the other four matrices along with their contributions to Umbanda. The African matrix is what contributes old slave spirits known as pretos velhos, orixás, and drums. The indigenous matrix, where the original caboclo came from, introduces aspects such as pipes, herbs, feathers, and smoke. The fourth matrix, the Catholic matrix, comes from the European immigrants, primarily the Portuguese colonists. Catholicism shares many of its prayers, used to open and close religious rituals called giras. It also is the source of saints, each of whom corresponds to an orixá from the African matrix. Lastly, there is the fifth matrix, the gypsy matrix from the orient. This matrix is the origin of the use of incense, minerals, and gypsy spirits. Page (1995) addresses this matrix and explains that it is more specific to the "northeast in some of the lower-class cult centers" (p. 367). It is not a commonly discussed aspect of the religion, but as None practices in the northeast, she includes it in her description, as it likely is part of her personal experience with Umbanda. All of these spirits, from these different matrices that make

[6] Espiritos desqualificados ou inferiores

up the Brazilian mestizo[7], are the spirits that come from Aruanda, Umbanda's spiritual realm, when they are summoned to a terreiro. They come to give care, love, and opportunity to those who worship them. None then concluded that Umbanda "is a very complex religion for us to understand"[8] (personal communication, May 26, 2014). And my thoughts to that statement were "amen," but that history lesson did contribute to my understanding of the focal vocabulary critical to understanding the underlying principles of Umbanda.

While None provided the history lesson, many of my other sources shared personal opinions regarding the religion and its use, its stigmas, and its cures. Many times there were overlapping themes, so I will select specific individuals to illustrate some of what I learned.

My first day in the field, I had an unexpected informal interview with Carminlurdes Gadelhe. As a mãe-de-santo, Gadelhe had a lot to say about Umbanda, but what captivated me was her passion and love for the religion. Nearly every other sentence was a statement about how much she loves her religion because it brings goodness into her life and the lives of others. She shared with me ways in which Umbanda saved her life by curing her and filling up the emptiness that had been caused by tragic, uncontrollable circumstances (personal communication, May 12, 2014).

The next interaction I had with a mãe-de-santo was with Dona Nene who I met at the preto velho party at UECUM and she invited me to another preto velho party that evening where she would be curing. Dona Nene inviting me into her house and into her religious space ten minutes after meeting me, which showed me first hand the welcoming nature of Umbanda. As her granddaughter, Anna Beatriz F. Paula, explained to me when we were sitting in Dona Nene's house waiting for the gira, Umbanda does not and cannot discriminate. It must offer its cures to all, even people whom the mãe-de-santo does not personally like (personal communication, May13, 2014).

Before we left for the party, Dona Nene shared with me the story of why she became a mãe-de-santo, and similarly to other narratives I heard during my time in the field, she did not choose the religion but rather, it chose her. Dona Nene went to a Catholic school where she suffered from anxiety and other behavioral complications, so the nuns sent her away because they thought she was crazy. After many failed medical treatments, she was eventually taken to a terreiro

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[7] The racial mixture that is celebrated in Brazilian culture

[8] Umbanda é uma religião muita complexa para a gente entender

where she developed her medium abilities and learned to communicate with the spirits who had been communicating with her, making others view her as mentally ill. After this, she had no choice but to keep developing her abilities and using her power to communicate with spirits to cure others (personal communication, May 13, 2014).

After hearing Dona Nene's story, I asked Paula if she considers herself Umbandist. She laughed and said no because she only believes in her grandmother's cures. She goes with her grandmother to other terreiros, but the only place she trusts is her grandmother's healing center in Brasilia because she has seen the power of the cures there (personal communication, May 13, 2014). Anderson Zen, who does consider himself an Umbandist, shared similar sentiments about his faith. Zen told me that he only trusts Mãe Socorro and does not frequent large giras. He only goes to her house or has giras in his own home because he does not trust the energy in unfamiliar terreiros. He has full faith in the religion, but he thinks that the majority of people use it to wish bad things upon other people (personal communication, May 22, 2014). These two interviews opened my eyes to the variation that exists among practices in different terreiros as well as one of the most commonly heard stereotypes that Umbandists face, which is the use of their religion for evil purposes. Nei Lopes (2014) explains the evilness in Umbanda from which these stigmas arise. The dark spirits in Umbanda, or the Exus, work for both good and evil. While other religions pride themselves in working only for good, Umbanda recognizes that for every good there is also evil, and thus if evil exists in life it must also exist in the spirits of the deceased. Opponents of the tradition pinpoint the evil aspect of Umbanda to denigrate its practice and instill fear in non-followers.

I was struck by the strength of the religious roots of the stigmatization during my conversation with Lucia da Silva. I asked da Silva if she was an Umbandist, and she replied that she strongly identified with Umbanda and felt at home in terreiros, but did not actually follow the religion because she was raised Catholic and her family would not accept it (personal communication, May 21, 2014). Da Silva beautifully articulated her identity struggle when she explained, "This is something really bad, when you identify, when you like it. Because I am a black woman, so when I go into the terreiro I feel really good.[9] (personal communication, May

[9] Isso é uma coisa muito ruim quando você senti identidade, quando você gosta. Porque eu só uma mulher negra. Então quando eu entro no terreiro eu me sinto bem.

21, 2014). The stigmatization is thus so strong that da Silva chooses to have a constant inner conflict over her religious, racial, and cultural identity rather than challenge her family's beliefs and follow the religion that makes Lucia feel like her best self.

What finally helped me see how the rituals work was having the opportunity to participate in small giras with Mãe Socorro. Through this type of involvement I was able to physically understand that each person experiences Umbanda differently and uses it for his or her own reasons. The participation in giras showed me how Umbanda molds itself to each individual to help an individual challenge personal struggles with which they are suffering at the time of that gira. By allowing each member of the congregation an opportunity to go up and consult the spirits, each person is provided with "down-to-earth" advice from the spirits that relate to anything going on in life. This personalized consultation provides a means to improve personal physical or mental health through a communal religious ceremony (Page 1995).

These interactions highlight some of the main themes that I found in my study of Umbanda, and only begin to touch upon the mixture of feelings that people have about the religion, but the last theme I want to share is the one that directly connects Umbanda to SUS. Rita dos Anjos told me about the cures in Umbanda and emphasized the importance of the roles of the orixá Obaluayê and the spirits of the pretos velhos in those cures. The pretos velhos are the old slaves who have general knowledge about the healing powers of plants. When someone needs a cure, the pretos velhos are called upon. Similarly, Obaluayê is the orixá responsible for health, healing, and death. He is the orixá associated with nature and the natural remedies of the earth and it is Obaluayê who the mães/pais-de-santo summon to heal the sick. The charitable aspect of Umbanda was also emphasized by the shocked look on Dos Anjos' face when I asked her if she charged people for cures. She responded that it was against the religion to charge for the work and that the only things that the filho-de-santo pays for is any type of material used to make the bath, tea, or other cure (personal communication, May 23, 2014). According to Page (1995), however, Umbandists often charge outsiders for consultations . While this may be controversial, nonmembers do not give to the Umbandist community of the congregation through regular attendance, so many believe it is only appropriate in order to avoid exploitation of the religious houses or unidirectional benefit. Dos Anjos thus outlined the spiritual and charitable basis that is the foundation for any partnership that can exist between SUS and Umbanda to increase access to healthcare, but also stressed the importance of using the relationship as a means for religious

leaders to economically benefit from their healing role in the community and in the healthcare system.

While my regional sample of conversations had a set of underlying themes, it is clear from my conversations that Umbanda is something different to each individual. It is important to acknowledge these differences, but also find a way to shift people's visions of the religion towards being an integral part of the healthcare system. For some, this belief already exists and Umbanda's connection to SUS feels natural, but to others this change forces them to view something they were raised to see as evil as a government-endorsed medical program. The latter portion of the population is what creates a challenge for the municipal government. While there is inherent value in the traditional Umbanda healing methods, government programs with terreiros have mainly sought to reform Umbanda traditions to make them healthier and safer for followers or find ways to use certain parts of Umbanda traditions as complementary treatments.

Creating the Framework for Partnership in Fortaleza

The successes that have resulted from training religious leaders in Fortaleza have set a solid foundation for the program that the municipal government is currently planning. The first big push for SUS-terreiro partnership program came from RENAFRO. RENAFRO was founded in 2003 and since then, has made a national effort to fight for the human right of health, to unveil the health knowledge of terreiros, to monitor and take part in public health policies in order to gain social control, to combat intolerance and discrimination, to create an environment where the culture and health knowledge of religious leaders in terreiros are respected and recognized, and to integrate the health knowledge and practices that come from terreiros into the conventional medical system (Rede). According None, RENAFRO started the push in Fortaleza for the mães/pais-de-santo to give and receive quality primary healthcare by working with the public health system rather than trying to continue working separately (personal communication, May 26, 2014).

RENAFRO's push for a government-terreiro program indicated that there was demand for this type of system and in my research, I wanted to pinpoint the force the initiated the push towards this type of government program in Fortaleza. Clayton More explained that the national programs, initiated by RENAFRO, introduced the idea of government programs to the city of Fortaleza. RENAFRO entered Fortaleza eight years ago, but the efforts from the municipal level were initiated five years ago during the August festival at Iemanjá at Praia do Futuro, an annual Umbanda religious procession. The Municipal Office of STDs, AIDS, and Viral Hepatitis set up tables at the festival where they handed out prevention materials such as condoms and information pamphlets. Mães/pais-de-santo who collected this information became interested in the use of their religious spaces for broader health promotion. Alves and Seminotti's study (2009) explains the value in the use of cures from cult religions as healing methods. It highlights the value of combining traditional and conventional therapies to treat the physical and the spiritual elements of illness. The effectiveness of these programs in other regions of Brazil, as well as the availability of government resources presented to the religious community, triggered discourse between the terreiros and the municipal government to develop health prevention programs for the povo-de-santo in Ceará (personal communication, May 19, 2014).

The demand for a health prevention program in terreiros also came from the citizens of Fortaleza who expressed interest during a city counsel meeting. The attendees expressed concern

with regards to the poor's lack of access to health information and resources, and suggested that these concerns be addressed at the municipal level. The counsel recognized the marginalization that the stigmatized populations faced, and thought that health promotion and prevention programs in those communities could be beneficial (personal communication, May 19, 2014).

I want to make a side comment here about a contrast between my observations and Biehl's 2007 ethnography regarding public awareness of the unjust health conditions of the poor in Fortaleza. Biehl claims that the underlying causes of disease are invisible from the public eye. More claims that the city counsel meeting pushed for education of the poor to help them improve their conditions, which implies public understanding of the fact that the poor are face bad healthcare not as a result of distasteful life choices, but rather from a socially imposed lack of resources and education about prevention and treatment. This shows that unlike Biehl's findings, there may be interest and awareness of the injustices that the poor face.

While More explained the citizens' desire to help the people in marginalized communities, Cristian Perr clarified that the demand is not one-sided. Perr told me that the mães/pais-de-santo who live in marginalized communities seek a means to help their communities with problems such as basic illnesses, drug abuse, mental disease, etc. (personal communication, May 21, 2014). Perr thus sheds light upon the fact that terreiros want help from the government, but also want to help others with the government resources that they receive. Both dimensions of the government programs could work to improve healthcare, but also to reduce the stigmatization hindering the advancement of these marginalized populations.

RENAFRO interacted with SUS at the municipal level, but also created a relationship with government think-tank Fiocruz, which works to produce, spread, and share health related technology and information with SUS in order to contribute to the promotion of healthcare equity that will improve the quality of life of the Brazilian population. Fiocruz aims to achieve its goals through systematic change that reduces existing inequalities (Fundação 2012). Julie Hole, a member of RENAFRO, explained to the role that RENAFRO's partnership with Fiocruz played in advancing the launch of the initial partnership between terreiros and SUS. In 2006, before any programs had been planned or run, Fiocruz formally educated mães/pais-de-santo within the RENAFRO network and gave them information regarding the approved uses of phytotherapy as well as other information for them to share with their filhos-de-santo. This partnership certified mães/pais-de-santo to work in primary health posts with massage therapy

and phytotherapy, and also enabled them to work with Farmácia Viva to sell their natural baths and remedies (personal communication, June 3, 2014). The partnership between RENAFRO and Fiocruz, thus, was the first step towards advancing the development of any type of partnership program because it began to use formal education to empower mães/pais-de-santo, who after the Fiocruz course had a more visible and legitimate role in society.

One of my key informants, Dos Anjos, is a mãe-de-santo who underwent Fiocruz training in Fortaleza. During an interview she shared ways in which the course gave her power to use her Umbanda-based healing knowledge to help her community and to develop a way to economically support herself. Dos Anjos spoke first about the curriculum of the course, which included official massage therapy training, information about herbal treatments, and information about disease prevention and health promotion for her to share with her community. She explained that as a leader in her terreiro, she could use her position of power to spread this information among her filhos-de-santo. After the course, the mães/pais-de-santo were also able to increase the safety of the rituals in their terreiros. They understood the importance of using clean razors for shaving rituals, so they began using disposables; they decided to require parental permission to perform rituals on minors; and Umbandists terminated the practice of animal sacrifice and were able to justify this action within their religion (personal communication, May 23, 2014). The religious leaders who underwent the Fiocruz course thus used what they learned to educate other leaders and their filhos-de-santo on how to continue practicing religious rituals that are a major part of their religious beliefs in safer ways in order to prevent the spread of disease (personal communication, May 23, 2014).

Dos Anjos continued by explaining her new role as a health attendant in community health centers and as a pharmacist for the poor. With the Fiocruz education, Dos Anjos was able to use her religious knowledge-base, including, but not limited to massage therapy, teas, bathes, and counseling abilities, to work in the health centers such as Center for Psychological Treatment (CAPS) in Bom Jardim where she can provide the holistic element of treatment that conventional medicine lacks (personal communication, May 23, 2014). None told me more about the role of mães-de-santo in primary health clinics. She told me that religious leaders provide holistic treatment and engage in conversation. They often treat people simply by providing a person to listen to their problems and to pray for them. Inside the health clinics, the mães/pais-

de-santo treat patients differently than how they would treat them in a terreiro and focus mainly on therapy and discussion rather than spirit possession (personal communication, May 26, 2014).

While Dos Anjos was able to use her Fiocruz education to help her community, she also gained economic independence by creating her own Farmácia Viva with an accompanying NGO, Angels of Prevention[10] (ONGAPE). Dos Anjos not only makes and sells natural medicines at a reduced price to make them affordable in needy communities, but she also runs courses in these communities that teach people how to plant and use garden plants to treat a wide-range of diseases (personal communication, May 23, 2014). Dos Anjos' experience thus demonstrates the potential empowerment that municipal programs can provide to a knowledgeable povo-de-santo so that they can help their needy communities. Dos Anjos' experiences reflect how reformed Umbanda practices can lead to health improvements of Umbanda followers, but also highlight ways in which Umbanda leaders can be empowered by contributing their own healing knowledge as complementary treatment in health centers and among needy community members.

What all of these examples serve to show is that there is high demand for increased visibility of complementary practices as well as encouragement of lifestyle reform through education in marginalized areas, both of which are critical in developing the program that is underway in Fortaleza's municipal government. The question then becomes how to involve the government healthcare system, SUS, in these initiatives without hindering the empowerment of Umbanda religious leaders who are educating their communities both in health centers and in their own terreiros.

[10]Anjos de Prevenção

The Development of Municipal Programs

The original program that past city hall management created focused mainly on reforming Umbanda practices in order to prevent the spread of disease in communities that attend rituals in terreiros. This program was run by two governing bodies: The Coordinating Body for Sexual Diversity and the Municipal Office of STDs, AIDS, and Viral Hepatitis. In the one terreiro that da Silva visited, she observed that the goals of the program were catered to the high-risk behavior often associated with the LGBT community. The government worked with the povo-de-santo on preventative measures with regards to STIs and communicable diseases that spread through promiscuous sexual behavior as well as blood related religious practices (personal communication, May 21, 2014). None explained more about the reforms included in the "Health and Citizenship in Terreiros"[11] program. It sent SUS-trained health professionals into what More described as the 16 most influential terreiros spread through all six regions of Fortaleza to provide prevention and health promotion measures for STIs, tuberculosis, hypertension, diabetes, depression, anxiety, syphilis, and other communicable and chronic diseases. This was done by taking preventative materials, like condoms, into terreiros as well as increasing compliance by providing accompanying treatment for chronic diseases or illnesses with lifelong treatment regimens (personal communication, May 26, 2014). This initial initiative thus met the demand of the city counsel that called for dissemination of sexual health and sanitation education in terreiros and marginal regions of the city where rate of communicable disease are highest. The program, however, did not directly address the use of Umbanda in the larger healthcare context as a source of complementary treatment.

The current program of reform has indirectly made positive impacts that created a foundation for the creation of the bidirectional program that is underway. More mainly attributes these successes to the power of the discussion circles that are a space for religious leaders, religious followers, and conventional doctors to interact and discuss health issues. The discussions do much more than provide information to community members about preventing risky behaviors that can cause communicable diseases. More believes that the discussions are the first step along the path to viewing the terreiro's relationship with SUS as a true partnership. In the discussion circles, many of the messages that the mães/pais-de-santo share with their followers are delivered in a way that resembles Nations' (1997) work. The leaders find ways to incorporate Umbanda

[11] Saúde e Cidadania no Terreiro

healing methods into the discussion through the use of familiar religious symbols, which they use as their toolset to aid in spreading health messages. Secondly, the discussion circles educate health workers who may at first be hesitant to work inside the programs. These health workers are have a chance to interact with a highly stigmatized and marginalized community when they work inside the terreiros, which More explained provides a form of education that has the potential to reduce the stigmatization that the povo-de-santo faces. This relates to a key issue Biehl (2007) highlights, which is the negative self-perception that the poor adopt when doctors and other healthcare workers are visibly displeased that they have to work with lower class patients. The change of setting for these interactions can help to destigmatize these populations by creating a safe and comfortable space for direct communication. Lastly, the government uses the discussion as an informal way of monitoring the success of the program. More told me that there is no quantitative data system at the moment, but the discussions have shifted toward the acceptance of condom use. Health workers have noted a lower incidence of communicable diseases (including HIV/AIDS) and lower rates of unintentional pregnancies (personal communication, May 19, 2014). While group discussions are one of the tools used for reformation, they begin to open up discussion between different sections of the health sector by finding common ground through common language.

The program also begins to provide terminally ill patients with a stronger desire to live by providing necessary resources to increase the capacity of terreiros to promote health and assist HIV positive patients in adapting to a new lifestyle. The initial government program taught mães/pais-de-santo to take care of their HIV positive filhos-de-santo so that those filhos can be reintegrated into the community while taking proper care of themselves. The municipal government connects the terreiros to resources that they can use to help their filhos-de-santo, such as health clinics where they can access ARV treatment, but they also stress the importance of the accompanying treatment that the mães/pais-de-santo should provide to HIV positive members of the community. The government makes sure that the mães/pais-de-santo understand the importance of altering the blood related rituals that Umbandists undergo so that there is no risk of contaminated blood exposure, while they also stress the value of the psychological support that Umbanda can provide to an HIV positive filho-de-santo. Education is thus provided to mães/pais-de-santo to help them use Umbanda to regenerate their filho's will to live by encouraging healthy habits and helping them realize that the disease is not a death sentence

(personal communication, May 19, 2014). The initial government initiative thus seeks out community members who have the ability play the role of community health workers, which Biehl (2007) highlights as the biggest missing piece of AIDS treatment programs at the time of his research.

While the Povo-de-Santo program initially focused on reforms of Umbanda practices, the more recent developments are trying to shift the focus from reform to the use of complementary practices in order to take the program a step further and mimic what is being done in the community that Alves and Seminotti (2009) studied in Porto Alegre. Marco Grow gave me a better understanding of the roles of the coordinating bodies involved in developing the new program. The project was reassigned to five city hall offices: The Municipal Office of STDs, AIDS, and Viral Hepatitis, the Coordinating Body of Sexual Diversity, The Coordinating Body of Policies Promoting Racial Equality (COPPIR), The Coordinating Body for Policies Concerning Drugs, and The Office of Policies for Women. These newly created municipal offices play different, department-specific roles in order to change the style of the program. Along with reducing religious intolerance and promoting healthy lifestyles in terreiros, the program will promote LGBT rights inside and outside of terreiros; combat addiction problems within and outside of terreiros; and provide autonomy for women by facilitating the use of their herbal knowledge to encourage entrepreneurship (personal communication, May 21, 2014). One major new component that was stressed by Perr, the coordinating director of COPPIR, was the reduction of race-related stigmas as a means to improve the quality of healthcare in peripheral communities. Perr explained that this goal is only achievable through a public educational aspect in whatever program the city hall develops. The education needs to take place at many levels. The police need to be educated about the rituals and customs of African matrix religions so that they do not break up peaceful healing rituals; the population needs to be educated to reduce religious intolerance and recognize the rich knowledge these communities posses; and scientists need to be more open-minded and willing to research the remedies that Umbandists offer to increase the use of phytotherapy among the general public. These types of education, Perr stressed, are the tools that can break down social barriers and thus increase healthcare equity in Fortaleza (personal communication, May 21, 2014). Biehl (2007) validates Perr's emphasis of deconstructing racism to improve health through his finding that "blacks receive substandard

care and go unadressed in prevention campaigns" (p. 390), and COPPIR was created to change that reality in Fortaleza.

The new programs in the terreiros will thus change the focus from reforming Umbanda's religious rituals into a system that works to deconstruct structural barriers that stand in the way of marginalized communities achieving the goal of using Umbanda as a form of complementary medicine.

Visions for the Future of the Partnerships

The shift in focus from reform of Umbanda traditions to a use of Umbanda as a complementary medical treatment has the potential to "improve public health, improve the environment, and improve the quality of life of the people"[12] (personal communication, May 21, 2014). Government officials, NGO representatives, and citizens alike share an optimistic view for the potential outcomes of this new form of terreiro program that is in its planning phase in Fortaleza.

The most noted problems in Brazilian healthcare are the shortage of doctors and other resources, both of which contribute to the long wait times. According to Leda Albino, who takes complaints at a public health center in Aldeota, a neighborhood in Fortaleza, long wait times are the most common complaint from patients (personal communication May 30, 2014). The *New York Times* article, "Brazil's Plan Isn't What Doctors Would Order," (Kugel 2013) explains that because 70 percent of Brazilians use the public healthcare system, wait times, even in serious or emergency situations can be months to years long. These wait times are especially bad in marginalized areas that do not have access to emergency medicine or hospitals and lack transportation to emergency health centers.

By providing different options for common health problems, complementary care from Umbanda healers can reduce wait times by reducing dependence on pharmaceuticals and providing daily, accompanying treatment for chronic illness. Perr highlighted the importance of medical accompaniment that the terreiros can provide for people who are undergoing difficult and long-term conventional treatments. Because there is a shortage of doctors, there is no way for doctors to provide these patients with daily care. Perr stressed the value of the role of the terreiros to talk to and work with these patients to provide them with a form of holistic care that is not included in conventional treatments (personal communication, May 21, 2014).

Sharing phytotherapeutic knowledge also has the potential to decrease demand for scarce resources. Grow hopes that educated religious leaders will share their herbal knowledge with their communities, which will inform people about alternative treatments that they can prepare in their own homes. Grow argues that phytotherapeutic education will improve the quality of care in the health centers by reducing the waiting time and drug shortages. An indirect impact of

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[12] Melhorar a saúde pública, melhorar o meio ambiente, e melhorar a qualidade de vida dessas pessoas

increasing phytotherapeutic practices is improved environmental conditions. People who rely on their physical environment will take better care of their resources and thus create a cleaner, greener, safer place to live (personal communication, May 21, 2104). While phytotherapeutic remedies cannot replace all biomedical treatments, their use for daily aches and pains can make limited resources available for cases in which they are necessary.

While increasing herbal remedies among the poor can improve access to care in impoverished areas, it can also have the same effect among wealthier populations who also suffer from long wait times and expensive, private medical treatments. Hole, a member of RENAFRO, describes public education initiatives she has noticed around the city. She told me about posters in health clinics with information about holistic treatments as well as an increasing use of community health workers who travel from house to house in the periphery and in the city with kits of herbal treatments to provide education. While Hole recognizes the value of these initial educational pushes, her vision is a program that fully integrates complementary treatments and makes their use commonplace. She justified the reality of her goal by explaining that it is already happening in Horizonte. RENAFRO friends of hers who live in Horizonte told her that pharmaceuticals have pretty much been replaced by the medications found in Farmácia Viva. Doctors prescribe the herbal treatments and the Farmácia Viva mediates the distribution of these products to all social groups in the city. Because the program is government sponsored, all of these medications are given out for free, just like other pharmaceuticals. Hole thus wants the program to be official so that it can benefit all people by opening up the opportunity for anyone to access.

Umbanda can thus serve a similar purpose to that of African religions during the colonial period (Bastide 1978). The shortage of healthcare provides a niche for African-matrix healing traditions to flourish, and the development of the partnership between government and communities increases the possibility of improved social status for the followers of Afro-Brazilian religions. These therapies can thus work together and create a modern form of treatment that follows the WHO's proposal as well as the National Policy on Integrative and Complementary Practices (Alves 2009).

Making Umbanda treatment complementary to biomedical treatment not only creates opportunities for better physical care, but also empowers marginalized populations economically and socially. Grow exemplifies this fact with the economic empowerment of women who

dedicate their lives Umbanda healing practices, but receive no compensation for their work. Grow spoke passionately about creating a sustainable, economic prospect for the Mulheres de Axé.[13] Many of these women dedicate their lives to their religion and curing people for free, so they do not have time to seek any form of education that could help them develop economic autonomy. Grow believes that the integration of Umbanda healing into the city of Fortaleza as a common practice can create this economic space for the Mulheres de Axé who can prepare herbal treatments to sell in the city (personal communication, May 21, 2014). These women can thus improve their quality of life by contributing their medical knowledge to an improved healthcare system.

While the Mulheres de Axé example demonstrates a direct economic opportunity that results from the program, deconstruction of social barriers indirectly improves the economic conditions of marginalized populations. Grow spoke about his vision for the LGBT community. Grow hopes to increase education regarding the new LGBT terminology and to decrease stigmatization. Grow does not expect that all people will suddenly accept the LGBT community, but he hopes that the population can be more informed and as a result reduce the level of homophobia in Fortaleza, Brazil's second most homophobic city (personal communication, May 21, 2104). Because the terreiros have contact with a large part of the LGBT community, they are a good place to start educating the non-LGBT members of the city who interact with the LGBT filhos-de-santo. This form of outsider education can help undermine the negative ideas that people may hold about the LGBT community.

As the directing coordinator of COPPIR, Perr spoke to me about deconstructing racial inequalities. Perr explained that many of the poor areas in Fortaleza, where the terreiros are located, are also where the Afro-Brazilian population live. These areas are currently viewed as dangerous and closed-off to the rest of the city. Perr hopes that by combatting religious intolerance along with other problems those areas face, such as violence towards black youth, the peripheral areas can be "demystified" and no longer viewed as "X territories"[14] or places people should not go (personal communication, May 21, 2014). My inability to visit these areas without an escort demonstrates how inaccessible they truly are to outsiders. Perr hopes that by removing the negative labels such as Macumba practicing, violent, and dangerous, that are currently

[13] Female religious leaders in African-matrix religions
[14] Territórios xis

associated with these neighborhoods, the program can end the tradition and culture of the peripheral communities in Fortaleza (personal communication, May 21, 2014). While this is clearly a long-term goal, the program has the potential to open up the city's resources to all citizens, which would undoubtedly lead to a more equitable healthcare system in Fortaleza by increasing social capital.

While these widely shared goals are exciting and show much potential, they require a fundamental change in the role of Fortaleza's public health system that is only possible through political action and education.

Grow openly addresses the long-term nature of these goals and expresses the need to make laws rather than a program that varies by city counsel administration. When the program is under municipal-level control, it pauses and changes every four years because the administration is reelected. Grow hopes that if his term does not succeed in establishing the permanence of the program, that his administration will leave sustainability of the program as a clear goal for the next city counsel government (personal communication, May 21, 2014).

In order to increase sustainability, public demand for complementary treatments has to be a unanimous desire among the citizens of Fortaleza. A major way to create the desire for the program is through education. During my time in Brazil, both university and online courses regarding complementary treatments were brought to my attention. Hole shared information about a course that is being offered at Universidade Estadual de Ceará (UECE) called "Course of Knowledge about Traditional Cures."[15] After speaking to the organizer of the course, Dr. Marcélia Marques, I learned that a weekly guest speaker shares his or her knowledge about their own branch of traditional medicine. The purpose of the course is to inform the public health students about the traditional healing methods that exist in Ceará (personal communication, June 4, 2014). Fostering this type of discussion in a university, public health setting opens the eyes of the future generation of health workers to the power of Umbanda healing, which can assist in the advancement of SUS' project with the terreiros.

Information about the partnership is being shared not only with university students, but also with the general public through a course called "Promotion of Equity in SUS."[16] This online course is offered through *Fundação Demócrito Rocha*, which a health post social worker,

[15] Curso Saberes Tradicionais da Cura
[16] Promoção da Equidade no SUS

Monica Merezes, described as a periodical that exploits the reality of the people (unlike the privately owned media sources) and offers free online course that are often associated with current events (personal communication, May 30, 2014). A free online course is a form of public education that informs people about the program that the municipal office is creating and the ways it can benefit the city. It can assist in the educative process that Perr expressed is vital to the success of any healthcare program that SUS runs with terreiros. This type of course begins to inform the public about holistic treatments and thus start the process of destigmatization. Publicly accessibly courses and university programs are good starting points for public awareness regarding the partnership between SUS and terreiros. The program that the city hall is designing hopes to create more even more dialogue among the population of Fortaleza.

Virtually everyone who I talked to or told about this program had positive feelings about its potential and hoped for its success. The shift from reformation to complementation made people like the mãe-de-santo Carminlurdes Gadelhe optimistic about the role Umbanda can play within the healthcare system to improve a multidimensional notion of health. The emphasis on Umbanda alone, however, often led to discussions with people who follow other belief systems, and the question of why Umbanda is one that I think is important to address in this section of my work.

Why Umbanda?

While the program requires political and social shifts that change the role of public health in Brazil, Umbanda is a good religion to use to complement biomedical care because its structure and principles are perfectly suited for the role it plays in the program. Firstly, mães/pais-de-santo are accustomed to playing the role of 24-hour religious leaders and healers within their communities. If a baby is sick and needs a healing ritual in the middle of the night, it is the mãe/pai-de-santo's job to take that child in and help at that moment (personal communication, May 19, 2014). Because, according to Dos Anjos, Umbandists view their role in society as one to care for anyone, even those rejected by their families and the rest of society. Mães/pais-de-santo strive to help anyone in need along the path to better health (personal communication, May 23, 2014). Placing mães/pais-de-santo inside health posts would not change the culture or lifestyle of the religion and community leaders and would allow them to attend to more people (personal communication, May 26, 2014).

The existing, pre-determined hierarchies that exist within Umbanda also facilitate the process of spreading healthcare information in communities. The hope is that the information will infiltrate the community from the respected religious leaders down to their religious followers. The mães/pais-de-santo will know how to explain the health information they receive in such a way that the community will listen and understand (personal communication, May 21, 2014). Mães/pais-de-santo embrace their esteemed roles as educators and caretakers in their communities, but they also recognize their limited role as medical healers. Dos Anjos, for example, told me that she would not try to treat any form of substance addiction because it is a disease that needs to be taken care of by someone with a psychiatry or neurology degree and her Fiocruz education as well as her previous healing knowledge does not suffice (personal communication, May 23, 2014). Umbandist mães/pais-de-santo thus are ideal healthcare providers for their communities because they can and will treat people to the best of their ability, but also will advise their filhos-de-santo to seek conventional medical attention when it is necessary. This type of behavior was noted by Alves and Seminotti (2009) and articulated by one of their informants who told them that he was "gonna continue taking the medication, follow both things together, science and religion" (p. 4). This primary account illustrates the taught value of benefitting from a variety of treatments at the same time.

Environmental preservation is another preexisting characteristic of Umbanda that makes it ideal for the program. The religiously founded relationship between Umbanda and the physical environment emphasizes both the symbolic and practical value of the environment. Bastide (1978) explains that African traditions are strongly linked to the land and it is against the religion to harm the sacred belongings the orixás. This value of the environment motivates people to preserve and protect their physical environments, but also provides umbandists with herbal knowledge and resources essential for phytotherapeutic treatments. Because environmental awareness is a fundamental principle of Umbanda, Umbandists in the city have formed relationships with people living in areas where the herbs needed for herbal remedies grow (personal communication, May 23, 2014). Umbandists thus have access the wide array of plants necessary to concoct their phytotherapeutic remedies.

Associations between religion and nature also assist religious leaders in their healing practices. Umbandists work with nature to benefit from their rich, orally transmitted knowledge base with regards to natural remedies and they are able to remember what herbs treat what illness by their religious associations. Dos Anjos explained that many chronic illnesses with no known cure can be controlled with a combination of the care of a mãe/pai-de-santo and her/his natural remedies. As previously noted, there is often a shortage of pharmaceuticals and reliance on inconsistent chemical treatment can result in harmful side effects. Herbal knowledge provides an alternative to these treatments that is not only cheap, but also less toxic when not taken regularly. Dos Anjos gave the examples of rosemary leaves to lower glucose levels of diabetics and lemongrass with lime to lower blood pressure (personal communication, May 23, 2014). Grow also gave the examples of fish head soup for cancer and watercress and honey for TB treatment (personal communication, May 21, 2014). All of these diseases require long-term or lifelong medication, so an herbal alternative to chemical treatment is not only healthier and more affordable, but also more familiar to the mãe/pai-de-santo who is providing the accompanying treatment.

Finally, Umbandist terreiros are also a good place to initiate this program because they have the diversity needed to facilitate the human rights aspect that is in place to deconstruct social barriers. Terreiros are made up of a variety of marginalized groups, which is part of the reason Umbanda is known as a religion of rebellion and as a religion of the poor. The programs inside terreiros can thus reach many demographics at the same time and encourage a cooperative effort

in a fight against similar struggles. Da Silva pointed out that terreiros also have some affluent members who identify as Umbandists (personal communication, May 21, 2014). Their inclusion in the discussions can take the program initiatives out of the terreiros and into the city centers so that the medical aspects of the program can eventually be incorporated into all medical centers.

The open-minded and understanding nature of Umbanda and its followers also creates an environment that is willing to adapt, change, and accept outside help. Religious leaders not only welcome but also seek out SUS' contributions. Umbandist leaders are willing to alter their traditions in order to create a safer and healthier place for their followers.

Awareness of their surroundings and strong ties to the community also make religious leaders ideal care takers and perfect resource allocators. The mães/pais-de-santo are aware of their patients' socioeconomic realities. Because the terreiros are located in peripheral areas, the mães/pais-de-santo can ensure that government resources are going to those with the most need (personal communication, May 26, 2014). The program's first task would thus be to address the healthcare and eventually socioeconomic situations of these structurally limited populations. The healing practices in Umbanda are free, so virtually anyone in the community can afford the treatment. The natural remedies are also inexpensive enough to make them financially accessible. Grow gives an example of a baby with a fever who needs seven drops of limejuice. Almost anyone can access a lime, and if not, asking a neighbor for seven drops of limejuice is socially acceptable (personal communication, May 21, 2014). The baby can thus be treated right away without having the wait to for attendance at the health post or for the availability of fever medication.

While the structural characteristics of the religion foster the development of Umbanda as a complementary form of treatment, the traditional, unaltered, healing ceremonies also have their own healing powers. From my own experiences I want to argue that unreformed Umbanda rituals have been and continue to be used to change and improve people's lives. I learned this lesson during my fieldwork both by hearing the experiences of others and through personally experiencing religious ceremonies or giras during my own emotionally difficult moments. The first two cases that I will share are more extreme and tangible, but the second two are also valuable because they demonstrate the use of Umbanda to reenergize people and remind them of their values and the good things in their lives.

When I asked Zen how long he had frequented Umbanda, he told me that he had been of the religion his whole life, which he now understands is because Umbanda is the reason he was born. Zen's mother received fertility treatments for 15 years, but was never able to get pregnant. When she was about to give up on having children, she went to a terreiro where the mãe-de-santo, while in a trance by the preto velho that Zen refers to as "Pai Ze," told Zen's mother to adopt a black child and to bring the child to the next gira. Zen's mother did as she was told and after the adoption, she got pregnant with Zen. After sharing this story with me, Zen saw the look of disbelief on my face. He told me would not believe the story either but his mother did everything she could to keep him away from Umbanda when he was a child so that he would never find out, but when he and his mother finally attended a gira together, the spirit of Pai Ze told the story through a different medium. Zen's mother, who Zen asserts cannot tell a lie, put down her head and denied nothing (personal communication, May 25, 2014).

Mãe-de-santo Rita Dos Anjos told me about her relationship with one of her filhas-de-santo. Dos Anjos has cured many people and most likely undergone some form of personal healing, but the story she shared with me was about one of her filhas-de-santo who is an HIV positive, 22 year-old woman who Dos Anjos "brought back to life" (personal communication, May 23, 2014). Dos Anjos explained that when this anonymous filha-de-santo was diagnosed with HIV, she was dying in the hospital for three months. Dos Anjos found her, took her on her lap, sang her a lullaby, and used the power of the orixá Obaluayê to pray for her and treat her with his plants (personal communication, May 23, 2014) such as agrião-do-brejo (Nations 2001). Today, Dos Anjos concluded, this filha-de-santo is still undergoing both ARV and Umbanda treatments, but her immunity is back to normal and she lives a healthy and fulfilling life. This woman completed her human resources degree in 2013 and now has a full time job. Because of the complementary care she receives from Dos Anjos, she has been able to live an HIV positive, but otherwise normal life (personal communication, May 23, 2014).

Bet Cost, my Catholic host mom, has some background in spiritual forms of healing, but before I got to Fortaleza and began researching Umbanda, she had never paid much attention to its existence. One afternoon Cost went to discuss a social project at a coworker's home and while she was at his house she spotted a terreiro and asked about it. Cost was surprised by this man's Umbanda faith because he did not fit the stereotypical profile, but she learned that he frequents a mãe-de-santo and often has giras in his own yard. This man was Zen, who explained to her his

atypical background in Umbanda and the origins of his faith. Zen invited Cost to a gira with his mãe-de-santo where Cost was told that she was "burdened"[17] and needed to undergo more giras and baths to heal and reenergize herself. Cost did as she was told, and she did so with an open-mind. When she finally told me about her experiences, she had nearly completed the treatment. Before Cost told me about her newfound faith, I was unaware that she had been facing difficulties with employment, and she decided to tell me when employment opportunities started opening up. After the completion of her treatment, her revitalized energy was noticeable. From the first gira on, Cost actively looked for employment opportunities and was offered many positions, including a well-paying position in São Paulo. She came home every night after meetings excited to tell me about the new ideas for projects and the receptiveness of her team towards her ideas (personal communication, May 24-June 6, 2014).

Similar to Cost's story, I too went through a low point during my research period. There was one day that I was uncharacteristically exhausted and all I could do was lay in bed. Cost had invited me to attend a gira with her that day, and if she and Zen had not forced me out of bed I would not have gone. When I got to the gira, I realized that I was going to participate with Zen, Cost, and another friend of theirs. I was confused during the ritual so I just followed their lead, but as the afternoon turned to night I began to feel more comfortable, get a better understanding of what was going on, and participate with more energy. By the end, I was much more energized and the next day I felt as if I had been brought back to life and recharged. I went to my meetings with a positive outlook, and amazingly my research began coming together. People who I had been trying to coordinate with for over a week were finally calling me back and providing me with information and opportunities that led to even more information and opportunities. While I do not consider myself an Umbandist, I do recognize that the positive energy that was part of the gira had an uplifting effect on my mood. When the spirits incorporating Mãe Socorro prayed for me and told me that everything in my life was going to work out for the best, I took it to heart and believed it to be true. The gira gave me the ability to think positively and to regain a strong sense of self that helped me not only pursue my research but also enjoy it with a deeper understanding of its importance, value, potential, and meaning.

While these narratives are all related to different health issues, they all have the same outcome: the ability to pursue desires and dreams with increased confidence. Umbanda, if

[17] Carragada

nothing else, can provide the needy with a sense of purpose, a reason to live, a family, or anything else that person may need. In this way, Umbanda is the perfect religion to partner with SUS not only because of its community-based hierarchal structure founded in diversity, openness, and understanding, but also because the people who need access to healthcare could benefit greatly from Umbanda's ability to stimulate self-actualization.

Factors Holding Back Progress

The three main factors that I saw are holding back progress regarding the partnership between SUS and terreiros are religious intolerance, lack of sustainability of program development, and corruption by the rich that is integrated into Brazilian culture.

The prevalence of religious intolerance, fostered mainly by Evangelicals, but also by other Christian religions that are dominant in Ceará, spreads negative messages about Umbanda. Evangelicals use the media to popularize the message that Umbandists perform the work of the devil. Media outlets show images of the devil in association with Umbanda. Perr worries that this type of intolerance will negatively impact the government-terreiro relationship because Umbandists are so heavily stigmatized (personal communication, May 21, 2014). Grow expresses a different concern regarding the government-terreiro relationship. He explains the Evangelicals often enter Umbandist homes disguised as government officials where they destroy the religious artifacts and beat up the mães/pais-de-santo (personal communication, May 21, 2014). This type of behavior has the potential to make the povo-de-santo act in a guarded fashion in of fear outsiders.

Religious intolerance not only affects political and social relationships, but also influences the way that doctors view holistic healing methods. Dr. Rick Fig shared many of his spiritual beliefs with me and afterwards told me that I was the first American with whom he had ever discussed his faith. While he is a Spiritist, not an Umbandist, he expressed the taboo of discussing alternative healing in medical settings because the Brazilian medical system is grounded in physical science (personal communication, June 2, 2014). This type of mindset limits the potential of the program that needs the support of doctors in order to function properly. The same way mães/pais-de-santo encourage filhos-de-santo to seek medical treatment when herbal remedies are not enough, doctors must be willing to advise their patients to seek alternative remedies when patients cannot fully heal from conventional methods.

Another factor limiting the success is lack of sustainability in development and implementation of the program. The original program was paused with the change in management (personal communication, May 21, 2014) and because each new administration may have a different political affiliation, it is likely that the program will pause and change every four years with each election. Changing the project in Ceará with each change in management while other states keep advancing with their legally established programs can make Ceará trail

even further behind the rest of the country with regards to healthcare (personal communication, May 26, 2014). As the national status of healthcare continues to improve, Ceará will continue to be ignored because SUS programs are working at the national level and failing at the state level.

Both Grow and Perr expect this administration's program to be ready for launch in 2015 (personal communication, May 21, 2014), at which point they will be two years away from reelection. Again, this can be problematic because the new administration will be left with responsibilities from the current city counsel and may choose not to undertake predetermined tasks that are vital to the sustainability of the program and maintaining the partnership between SUS and terreiros.

The lack of permanence not only limits the program inside the marginalized communities but also for those in the city centers who want access to holistic treatment and do not know where to find it or how to look for it. Hole expresses that she knows alternative treatments exist and that they appeal to her, but if she wants a Reike treatment she does not know where to get it (personal communication, June 3, 2014). SUS needs an official program that can provide this type of information so that people can know how to access complementary treatments.

The culture of government corruption by the wealthy is another major restriction on SUS' success. Merezes expressed that in her eyes, SUS as written into the law is almost perfect, better than anything found in the first world, but it in reality, the law is not respected. The wealthy use the public health system to access high level, expensive treatments. As a result, the poor and the working class are not able to use the healthcare program that was created primarily for their benefit (personal communication, May 30, 2014). If the government would prioritize localized prevention programs over high-end, expensive and unnecessary treatments, then the program could have more resources available to reach a broader, needier population.

Thus, success of the program in Fortaleza is being hindered by a combination of political, social, cultural, and economic factors. It is essential to take a multidimensional approach to target these problem areas so that that program can accomplish its goal of increasing the quality of healthcare for the poor. While these hindrances remain unaddressed, the government and the terreiros will be limited in the progress they will be able to make with regards to reaching their idealistic, long-term goals.

Conclusion

The empirical section this paper uses primary data to personify different perspectives of Umbanda and its healing methods, to describe the program that is currently underway to use these healing methods in the public health system, to demonstrate Umbanda's potential positive impact on the population of Ceará, and to analyze the factors holding back the development of a strong relationship between SUS and Umbanda terreiros in Fortaleza.

While my fieldwork exposes some of the weaknesses in the program planning that derive from unsustainability and stigmatization of Umbandists that currently practice in Fortaleza, it also sheds light upon the magnitude of the effort that is taking place to increase the poor's access to their constitutional rights to equitable healthcare and religious freedom. The issue of unequal healthcare resulting from structural violence is difficult to tackle because it is often socially engrained in a population's history, but the comprehensive and integrated approach that the government in Ceará plans to take uses progressive definitions of education and knowledge to deconstruct social barriers and provide opportunities for the poor.

Overall, because of the legislative legitimacy of the use of alternative treatments, the public health system is going to continue to increase the use of these alternative and accompanying remedies. The government has the responsibility to research ways to incorporate holistic medical treatments into the medical system so that complementary care can benefit the people who need it most. The government ought to take advantage of the diverse knowledge sources of alternative healers as a means to the greatest possible healthcare impact that broaden good health to include social, economic, cultural, political, and environmental factors.

Social Relevance

The Ministry of Health in Brazil is a well-funded department of the Brazilian government and aims to provide all Brazilian citizens with equal healthcare, but there are problems with the system that are limiting who receives care and the quality of care that people receive. Statistically, the conditions of the Brazilian healthcare seem to be improving throughout the country, but upon a closer look, it becomes clear that this is not the case. Biehl (2007) demonstrates the discrepancy between numbers and reality through what he describes as the most successful public health intervention in Brazil: controlling the AIDS epidemic. Biehl details the introduction and progression of the disease in Brazil, beginning in the 1980s, and its

progression from the south to the north. AIDS activism in Brazil yielded a strong public health response from both governmental and nongovernmental groups, and changed the perspective on the national right to healthcare to include pharmaceuticals, which are ARVs in the case of AIDS.

While HIV rates appear to have decreased significantly as a result of the implemented programs, Biehl's case study in the northeast region of Brazil, specifically Salvador, uncovered that the epidemiological data excluded the poorest members of the population. Because of structural violence in Brazil that limits upward mobility and safe living environments for the poor, homeless and desperately needy people are at the highest risk of contracting HIV/AIDS, or any other communicable diseases. Through his fieldwork, Biehl found that these populations were overlooked in the AIDS treatment programs and stereotyped as "marginais" (p. 296) or people who lived in the margins and were responsible for their own unhealthy practices. From his research, Biehl concluded that "bureaucratic procedures, sheer medical neglect, moral contempt, unresolved disputes over diagnostic criteria, and unreflexive epidemiological knowledge mediate the process by which poor and marginalized AIDS patients are made invisible" (p.204). Throughout his discussion, Biehl cites various political, social, and medical factors that play into this neglect, but for the AIDS epidemic it was largely due to the scientific focus of treatment that helped those with the ability to adhere to the treatment and seek it out, while it excluded others who lacked basic resources such as food, shelter, and water and left the latter to die in the streets.

Biehl thus demonstrates a case in which the biomedical focus of the public healthcare system in Brazil fails those who it aims to serve. The system not only uses money corruptly to pay for expensive treatments sought by the wealthy, but also simultaneously prevents marginalized populations from receiving basic healthcare by failing to recognize cultural and socioeconomic factors that contribute to illness and disease. A large portion of Biehl's ethnography focuses on "casas de apoio" or houses of help, which are nongovernmental organizations that treat the poor by teaching them methods of self care and helping them understand the importance of adhering to their medical. Biehl spends much of his time in the field in one of these organizations in Salvador, where he learns a great deal about the investment required to improve the health conditions of the poor living with AIDS. He finds that the mental aspect of treatment is a more challenging obstacle in the way of helping patients live with AIDS because it requires giving homeless people a reason and desire to live. Through this experience,

Biehl learns that the houses of help do not have the means to help everyone as they are not well funded or sufficiently supported, but that the form of treatment the houses of help can provide is well-rounded and caters to the wide range of needs of the poor. The problems arise, then when people are forced to leave the NGO facilities and are expected to continue living healthy lifestyles, free from drugs and promiscuous activities, but do not have the basic resources to do so. Biehl finds that in their time of care, some of the previously homeless are able to fight and find reasons to live, such as religious beliefs, children, or spouses, but others decide that they are totally alone and abandoned by their friends and families. What the public health system thus fails to address is the people who need its help the most. Previously mentioned health indicators like regional disparities in infant mortality rates in Brazil demonstrate this point, but Biehl's study exposed the AIDS case, which the country deems as a successful public health intervention, that in reality failed in ways that continue to contribute to the lack of equity in healthcare in Brazil.

While there is disparity among states with successful terreiro programs, the more successful initiatives currently in the south, the case study of the development of a program at the municipal level in Fortaleza may reveal an initial attempt to fill the gaps between the public healthcare system and the neediest populations in Brazil. Biehl's work highlights the issues of stigmatization, profiling, and lack of doctor attentiveness in an initiative described as a public health success in Brazil, and the program addressed in this project aims to target exactly those problem areas. Firstly, the program itself is a SUS initiative, so funding is coming from the government's budget. One of Biehl's major criticisms of Brazil's public health system is the improper allocation of public resources, especially at the state and local level. The terreiro project in Fortaleza uses public funding to promote prevention and basic healthcare for the neediest populations, which is how public health funds should be allocated.

Another major problem Biehl discusses is the stigmatization not only of marginalized, impoverished populations, but also the stigmas that certain diseases (AIDS) and lifestyles (homosexuality) carry in Brazilian culture. The program includes collaboration among representatives from the Municipal office of STDs, AIDS, and Viral Hepatitis but also other recently created branches of the municipal government that aim to dismantle prejudices like those against race, sexuality, gender, and drug use. The program thus aims to tackle cultural

barriers that Biehl demonstrates stand in the way of assisting the poor in accessing and properly using healthcare resources.

Lastly, the program aims to foster communication between the biomedical system and holistic forms of treatment to create a bidirectional flow of healthcare discourse in order to improve communication between doctors and patients. Biehl addresses miscommunication between doctors and AIDS patients as a two-fold issue standing in the way of healthcare access for the poor. On the one hand, there is a misunderstanding on the side of doctors on the importance of treating the poor in halting epidemics. Biehl details an experience with a hospital doctor, Dr. Ribeiro, who explains that "other social groups might be more decisive to the spread of HIV. Anyway, to diagnose is not the most important thing. It is important to treat and to educate the person that from now on he should no longer be a vector" (p. 235). I agree with Biehl that this perspective is problematic because it overlooks the majority of the infected population and neglects to treat those cases, thus proliferating the spread of AIDS and other diseases among the poor and leaving them in their socially and biologically restricted conditions. Ideally, the terreiro program can increase communication between doctors and members of these marginalized communities so that doctors will know how to treat these populations in ways that they can be treated and educated and also stop the spread of the disease.

On the other hand, Biehl explains that many poor people do not want to take medications, such as ARV treatments because the poor have a general distrust of doctors. Biehl exemplifies this through a first person perspective, Valquirene, who "'hates' medical professionals, whom she also blames for her mental disorders. She sees her depression originating not in disease but in the combination of family exclusion, psychiatric diagnosis, and overmedication. […] she was devalued both as a person and as a patient" (p. 215). Even when hospital doctors do care for those in high need, those patients do not trust the treatment or the physicians whom they often feel treat them in a dehumanizing manner. The terreiro project seeks to dismantle miscommunication between doctors and patients by educating each party about the other's perspective.

Biehl (2004) did note places in which the AIDS project succeeded, and this was mostly in what he described "biomedical inclusion" (p. 122). Projects like the house of support that Biehl visited in Salvador give the poor the means to be accountable for taking their medications and caring for themselves. Through the proper use of pharmaceuticals, patients feel accountable for

their treatment and are given a reason to fight for their lives. Problems arise, however, once they leave the houses of support and no longer have adequate resources to maintain healthy lifestyles. This is where the terreiro project, again, has the potential to be more successful than the AIDS policies in Brazil. Rather than just providing people with a biomedically enhanced view of self, terreiro projects also generate a new form of social inclusion. By using the traditions of marginalized populations inside the widely accepted healthcare system, marginalized people will find a new entry into medical language and feel they have the means to help themselves and others.

A new perspective on the value of holistic healthcare, thus, has the potential to improve the medical conditions of the poor by doing more than providing them with medications, but also, by targeting the structural factors that Biehl points out are problematic in tackling the AIDS epidemic. Since the time of Biehl's work in Salvador, SUS has begun to target these issues by seeking partnership with holistic Umbanda treatments that recognize treatment of the whole person within their social context and have the ability to serve all members of society regardless of race, gender, social class, etc. While Biehl demonstrates ways in which access to pharmaceuticals can enhance one's view-of-self, new programs inspired by both international and national initiatives encourage an introspective increase of self-esteem through the use of complementary healthcare practices that positively impact mental health.

Due to the recent development of terreiro programs, they are constantly being tweaked and introduced into new cities. Their introduction requires funding not only to support medical treatment, but also to destigmatize Umbanda healing methods that have historically been seen as primitive. Fortaleza has a large number of terreiros and is working on introducing Umbanda treatments into the public health system as can be demonstrated by the development of a government program, the offering of university and online courses, and the increasing number of mães/pais-de-santo treating patients in public health clinics.

This paper is written with the intention of raising awareness of the effort that is being made to provide the population of Ceará with holistic medical treatments and improve access to healthcare. Many people have limited knowledge with regards to the natural remedies Umbandists can offer them and many Umbandists in peripheral communities do not have the means to share that knowledge for self and public benefit. This paper and the discussions during my fieldwork that made the paper possible, will hopefully help spread the message of inequity in

healthcare and efforts being made to improve it by shedding light on the positive role Umbanda's traditions, spirits, and healing methods can play in the healthcare system.

Future Research

This research could be extended in many ways that could either explore the current status in terreiro communities and development of the SUS program or analyze the effects of the program after its launched. In order to deepen the topic of program development, it could be interesting to visit sites where the past programs are taking place as well as health clinics and terreiros in the peripheral communities where the government hopes to implement the new program. This could add a personal element to the social suffering in those areas.

It could also be interesting to hear opinions from medical doctors and their perceptions of alternative healing practices, especially those practices that originate from stigmatized religious practices. If doctors in the health clinics are on-board with the holistic methods that the government hopes to employ, they can use their position of power in a conventional medical setting to promote the use of complementary treatments.

While I chose to focus specifically on Umbanda, there are many other alternative healing methods in Brazil, including but not limited to Reike, Spiritism, and Candomblé. Their use for complementary treatments and their perspectives on partnering with SUS could also be interesting to explore in comparison to Umbanda.

Tracing the progress of the municipal program as it develops and participating in discussions in the terreiros could also be a good extension of the project. Following the project development and implementation would allow me to analyze the progress and success of the program with a clear point of comparison.

It could also be beneficial to look into SUS' alternative medical programs in other states that have been successful and sustainable. This could provide the Ceará with ideas of how to create their own programs. While each state differs demographically and environmentally, it could help to study a functioning program and analyze its strengths and weaknesses to facilitate developing a strong program that avoids the errors made by other states.

Lastly, it would be interesting to follow the implementation of the program with a study similar to Biehl's that analyzes any shift in epidemiological data and determines whether or not target populations are being helped. In the case of the AIDS project that Biehl studied, national

demographic data showed that the AIDS initiative was the biggest success in Brazilian public health, but a Biehl's closer look at specific demographics revealed the exclusion of marginalized populations both in treatment and in statistical analysis, and Biehl discussed the AIDS epidemic as a lingering issue in the marginalized northeast region of Brazil.

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