**RESUMEN**

Objetivo: comprender las similitudes y diferencias entre los sistemas de salud popular y oficial, desde el punto de vista de las bendiceras. Método: estudio exploratorio y descriptivo, realizado con cuatro bendiceras en Maceió, Alagoas, Brasil. Los datos se produjeron por medio de entrevista narrativa y el análisis se basó en la técnica de Análisis del Contenido, en su modalidad temática, sumada a discusiones de las áreas de enfermería y antropología médica. El estudio fue aprobado por el Comité de Ética en Investigación de la Universidad Federal de Alagoas (UFAL), bajo el Protocolo 292641. Resultados: se constató que las bendiceras comprenden similitudes y diferencias con profesionales de la salud oficial que no tienen relaciones cercanas. Se observó que las bendiceras comprenden la especificidad y la importancia de los conocimientos profesionales, aunque afirmen que la inversa no ocurre. Conclusión: la desvalorización de las prácticas populares por profesionales de la salud aumenta la separación en la relación entre los sistemas oficial y popular de salud, así como la invisibilidad y la falta de confianza del conocimiento popular. Descriptores: Medicina Tradicional; Antropología Médica; Cuidados de Salud; Enfermería.

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INTRODUCTION

All societies develop knowledge, practices, and private institutions as a response to situations of disease or health needs, the so-called health care systems. These systems may be understood as a conceptual and analytical model, not a reality itself for the social groups with which people live or study. However, it helps to systematize and understand a complex set of elements and factors experienced in daily life, in a fragmented and subjective manner, either in our society and culture themselves or in face of others that are not familiar.

Two dimensions stand out when addressing these systems. The first refers to their cultural feature, where a symbolics shows up by providing each and every culture with unique concepts on what means being sick or healthy, as well as the several classifications that involve illness states and their therapies; the other refers to a social feature, where health care is defined by means of the presence of health-related institutions, as well as the presence of professionals, standards, and power relations involved in them; it also includes experts usually not acknowledged by biomedicine, such as the faith-based healers participating in our study.

Mostly showing up as a female practice, faith-based healing stands as an ancient practice in our society, which emerged in the midst of popular Catholicism, usually practiced by women and transmitted from generation to generation or received as a “divine gift”.

After the development of the official medical system in the country, faith-based healers, who used to provide the population with one of the few therapeutic alternatives, started being regarded by the official system as points of “resistance” to the entry and spread of medical services in the communities. Afterwards accused to illegally practice medicine, these women kept on doing their practices supported by the communities, even coping with adversities. Faced with so many conflicts, then, they started occupying a peripheral social space in their communities, whose core became aimed at the official and institutionalized medical practices.

Faith-based healers pursue an activity that was once very common, it is increasing rare nowadays, at least in big cities. "Urbanization, universal health, entering and remaining in the labor market, the growth of evangelical religions (which usually condemn this practice), and lack of interest on the part of new generations to grasp it are among the factors that seem to interfere with the continuity of faith-based healing practices in our society. Despite the current invisibilization process around the faith-based healing, many regions in the country have never ceased to use it.

Taking as its context the development of faith-based healing practice in Maceió, Alagoas, Brazil, this study aims to understand the similarities and differences between the popular and official health systems, from the viewpoint of faith-based healers.

METHOD

This is an exploratory and descriptive study, with a qualitative approach. The descriptive research describes the phenomenon under investigation, allowing us to know the problems experienced. The qualitative research considers, as a study source, the viewpoint of individuals who experience a certain phenomenon, its universe of meanings, aspirations, beliefs, values, and attitudes.

The research subjects were four faith-based healers from a northeastern Brazilian capital who were pursuing faith-based healing within the data collection period. Taking as its scenario the very house of faith-based healers, data collection was carried out from June to November 2013, by using as technique the narrative interview. A narrative interview is aimed at encouraging respondents to tell the story related to something important in their lives and in the social context. This technique consists of four phases, preceded by its preparation, which implies field prospecting and the preparation of exmanent issues. These, in turn, concern inquiries the researcher is interested in, reflecting her/his language and thought. The first phase is initiation, followed by the central narration. The third phase involves the formulation of questions and the fourth phase is that of conclusive speech.

Data analysis was performed by means of Content Analysis, in its thematic modality, and the discussion was supported by authors from the areas of nursing and medical anthropology.

The study was approved by the Research Ethics Committee of the Federal University of Alagoas (UFAL), under the Opinion 292641, as required by Resolution 466/12, from the National Health Council. To ensure anonymity, the study participants were
identified by names of plants commonly used in healing rituals.

RESULTS AND DISCUSSION

In the Brazilian scenario, faith-based healing settles and develops before the insertion of official medicine. Its practices dialogue with the subjects who seek for it and are directly applied to the reality of their social groups, and faith-based healers themselves are members and constructors of community life, as they live and pursue their craft within the community itself. Since they believe in the existence of diseases having a spiritual and physical origin, faith-based healers seem to understand the need for scientific knowledge in the health field regarding the specific cases of physical illness.

The relation between institutional medicine - biomedicine - and popular healing practices goes through the contact of two unique historical developments, with specific and individual dynamics. This specificity shows up since the very contact between a “development of medicine as a science - and its institutionalization as ‘official knowledge’ - and the historical development of traditional conceptions of health and healing, linked to the culture of each people”. 11,7

In turn, in the case of non-spiritual diseases (concerning physicians), faith-based healers do not seem to have any fear to advice subjects to seek for help by health professionals - and the figure of a physician stands out as the focus of referral.

If it is related to a physician I ask to [...] go to the doctor, if it is spiritual I do say: now you take a shaking and then you take some baths and smokers to get better! [...] Then I play, you know, when it is a problem related to physicians I say ask to go to a doctor, but when it is a spiritual problem... (Ms. Vassourinha)

Look, when I see that I cannot do anything, that it is not a disease that requires praying, then I ask the person to go to a doctor, seek for help there... (Ms. Common Rue)

This referral to the medical professional was something that disturbed us throughout this analysis. We wondered, indeed, if this referral might be based on these women’s understanding about the specificity of care provided by health professionals or if it was done having as background the fear of treating diseases with a recognized diagnosis and being accused to illegally practice medicine (these accusations could be made both by society and people who seek them as by physicians).

Still grounded in the referral situations, we highlight in the reports the fact they never receive people due to the advice of a health professional. According to Ms. Bellyache Bush, this occurs because most professionals prefer keeping a clear and wide separation between their science-based practices (considered as the only possible and correct way of action) and those pursued by faith-based healers, whose actions are based on their personal experiences when dealing with popular knowledge. Ms. Sambacaita has the same thought, and she also adds that each healing agent (faith-based healers and health professionals) has specificity in their actions. According to them:

Because sometimes they do not want to join medicine with the healer, do you see?! (Ms. Bellyache Bush)

Look, everyone has things of her own, does things her way. Sometimes, things could go on together, but it is very difficult for them [health professionals] to wish it! Then, we keep on playing our role, in silence, and they play their role... (Ms. Sambacaita)

An exception was commented by Ms. Bellyache Bush, who reported receiving a lady by medical referral. This fact is reported by her with an enthusiasm, seemingly, she regards the referral as a sign of appreciation for her craft and recognition of the significance of her healing practices.

The almost generalized denial of actions taken by faith-based healers by health professionals ends up strengthening the process of invisibilization of popular knowledge and practices. The current model of professional education, which is grounded in a growing attempt to make professional practices purely based on scientific method and on high technology apparatus, ultimately ignores everything (and everyone) that do not adopt/agree with such a model, contributing to the process of deletion of popular knowledge that, it is worth recalling, has been constructed since the beginning of human existence.

In addition to the practices exclusive to faith-based healers or health professionals, we observed in the speeches that, in certain situations, the use of both treatments is advised - professional and popular. In such cases, subjects are advised by faith-based healers to seek health services for treating physical problems and, concurrently or subsequently, undergo spiritual treatment. This is like mentioned by Ms. Vassourinha:

Because there are people who have a spiritual problem and there are people who have a medical problem. Together! So, when the person does things just to annoy those
who are in charge, then anything the person feels, one thing is added with the other and the person suffers even more! Then I say: go to the doctor and, when you get back, come here! So, when the person comes here, then I say, ready, now you will do this and that! But it has to be done, you have to go! (Ms. Vassourinha)

Such concomitant action allows us to realize that, from the viewpoint of faith-based healers, the use of a health system does not prevent the use of the other. We see that their practices do not necessarily exclude each other, a fact that enables the development of a partnership/link between professionals and faith-based healers, whose joint action might have as main objective the recovering the subjects’ health.

Although currently the deadlocks and divergences between the official and traditional health systems are noticed, we observe that faith-based healers tend to seek the creation of a relation to the official system. This fact shows their commitment to help subjects, considering them as comprehensive beings.

The partnership between faith-based healers and health professionals could significantly contribute to promote the health of individuals and communities. This is so because since the establishment of links between these actors, expanded health care procedures could be proposed (especially those related to health education), whose reception by the community might probably be more natural, due to ease of access and similarity of languages and beliefs shared by faith-based healers and their communities.

The good fruits obtained through partnerships between traditional agents and health professionals were demonstrated by another study13, which reports the positive effects of including faith-based healers from Paraíba in the process of dissemination the activities aimed at community segments. Faith-based healers

[...] have taken the mediating role in the educational process to help community workers and health care technicians to disseminate the importance of traditional medicine in the process of “curing” diseases among the inhabitants of communities in Paraíba. Popular/local knowledge has been put at the service of advice, counseling, and dissemination of the functions of traditional medicine. Through playful manifestations of popular culture (rhymes and lullabies, puppet and street theater), people’s religiosity conveyed by faith-based healers, those responsible for Education and Health Center have found in the cultural identities of people themselves new possibilities for interaction with community segments in the region.13,2

A study on the incorporation of faith-based healers to the Family Health Program12 also points to the possible contributions of these women to provide a comprehensive care to individuals by considering their cultural specificities. It highlights, however, that there is a need to be careful and ask the way how the connection between faith-based healers and health professionals and services have taken place.12 It wonders whether this insertion might not serve as a boost to the hegemonic biomedical culture, since faith-based healers are induced to suggest that after praying the subjects seek the professional (a physician), with no other way round (the professional refers the subject to a faith-based healer).

Then, three different ways to include faith-based healers have been observed. In the first case (minority), faith-based healers feel appreciated by institutional and governmental apparatus, because they “assume to be no longer seen as folklore elements to be seen by the government as citizens holding some knowledge and capacity to dialogue with the community that the conventional health system does not reach”.12,80 In the second case (majority), faith-based healers only fulfill what they were “taught” by health workers when they were enrolled in the program, where we notice an “attitude of subservience or obedience” towards someone they regard as an authority.12 Ultimately, we realize an attempt to avoid hurting people they know and those to whom they regard themselves as debtors - health workers in their neighborhood or the health center coordinator - influencing the way how these women act in relations involving moral debts.12

These three ways of insertion identified in the study mentioned above illustrate the many relations permeating the coexistence of faith-based healers and the public health system and, more specifically, the professionals who make up such services. Although we believe that it has become increasingly needed to promote linking strategies between the official and popular health systems, we also share the concerns and criticisms pointed out above. We understand that in order to establish an egalitarian and harmonious relation between such systems there is a need that everyone involved are aware of the social and cultural meanings that each agent takes when providing individuals with care, appreciating and respecting their knowledge and practices.
as historical constructions (even if coming from different epistemological grounds).

Although we observe a growing movement in favor of the recognition of popular practices of health care at the national level, health services have adopted purely technicist and biomedical attitudes towards health care. This paternalistic model is provided with means by the mechanistic paradigm - it regards subjects as machines made up of separate pieces, addressing the disease as malfunction of physiological mechanisms and assigning health professionals the responsibility for eliminating the malfunction. Subjects, within this technicist biomedical paradigm, lose their human and personal identity, and the suffering of a subject as a whole is disregarded.

The process of communication and interaction between professionals and individuals (who start being addressed as "patients", subject to biomedical interventions), still faces a context with many difficulties. Consultations, which should be a private time with more interaction between people, are provided in an extremely short time, lacking time and patience to listen to the subjects, who often fail to keep a dialogue due to the difficulties faced to understand the very context of words. The absence of a horizontal communication ultimately preclude the communication process between professionals and individuals who commonly need to be heard and understood, then they are advised and receive the prescription needed for treating each case.

Thus, we see that communication is a problem with an intercultural degree, in the sense that a health professional participates in a world of different knowledge when compared to the culture of a lay person. In both cases - the professional and the lay person - their prospects are based on particular cultural processes. Problems involving professional practice are not related to knowledge, but to a relation of superiority from the professional towards subjects, which are based on institutional power and social hierarchy. A professional should not abandon her/his knowledge, but she/he needs to listen to the other, because without this listening process there is no communication, leading the subject to adopt the practices she/he regards as right and proper, completely disregarding the professional advice.

It is by understanding the culture and needs presented by the subjects (identified through a qualified listening) that professionals should propose interventions congruent with the reality of these subjects. According to theorists on nursing, the practice of nursing professionals will be "culturally congruent" and beneficial when the subjects and their patterns, expressions, and values are known and used in an appropriate and meaningful way by the nurse. As stated earlier, this congruence of nursing care with the sociocultural reality of subjects concerns the practices designed to fit cultural values, beliefs, and lifestyles of an individual, group, or institution, aiming to provide significant, beneficial, and satisfactory health care, i.e. well-being.

In addition to the growing process of social erasure to which the popular health practices have been submitted, professionals' ignorance and lack of connection to the popular healing agents, including faith-based healers, tend to put into question the effectiveness of such practices, devalue them, and even ignore their existence.

This devaluation, which, in a way, is based on a scientific ethnocentrism of professionals, is acquired through their process of academic education and scientific development. Biomedical sciences, complying with the scientific method, work with "universal" issues (generalizations), by addressing diseases as universal units whose manifestations are independent from the context where they take place. Research in this field, which is mostly ruled by positivist and restrictive methods, reveals life in an objective way and gets close to what may be regarded as "truth", free from cultural values, subjectivities, and specificities.

Outlining a dialogue between the biomedical and anthropological sciences, we see that the biomedical view believes there is an only knowledge on disease and health. This fact emerges as a barrier to understand the contributions and implications that anthropological relativism brings about the health issues.

Guided by the principle of relativism, anthropology thinks that the knowledge and practices from any medical system are sociocultural constructions. Thus, our science itself, like all knowledge systems, emerged through historical and sociocultural processes, and not by means of the discovery of unique and universal laws governing on the real world. In this sense, anthropology seeks not invalidating other kinds of knowledge, it seeks to make them relevant, recognizing there are other ways to produce knowledge about health and disease, and not only that from biomedicine.
Rocha LS, Rozendo CA.

The various health systems, either official or popular, are sociocultural constructions, they also have their own limitations to solve health problems. Thus, a contribution from anthropology to the biomedical science related to greater flexibility in its boundaries with the other ways of thinking through and providing health might be the understanding that the “scientific medicine” is also a cultural system.\(^1\) “The biomedical health care system must be regarded as a cultural system, just like any other ethnomedical system.”\(^2\)\(^,\)\(^180\)

As a sociocultural system, the biomedical system also emerged from a historical and cultural context, with particular methods, but not the only ones to deal with disease, thus it must grasp there are many ways to apprehend and practice health.\(^1\)

Although subject to internal contradictions and, as a consequence, generating predicaments, we advocate for, here, the premise that values, knowledge, and health-related cultural behaviors form an integrated sociocultural system, complete and logical. Therefore, the issues related to health and disease may not be analyzed in isolation from the other dimensions of social life, mediated and permeated by the culture that provides these experiences with meaning.\(^2\)

When not accepting this view of biomedicine as a cultural system, professionals disregard the fact that in many of the social groups people who need care tend to seek first the closest individuals who care for them (such as family members or friends) or other alternatives available (popular traditional healers - such as faith-based healers) and they only seek professional care, later on, if the folk remedies are not effective, their health status worsens, or they are afraid of dying.\(^12,\)\(^15\)

Thus, there emerges a great contradiction between the sociocultural context of health care production in popular groups - which is based on popular knowledge and practices - and the interventions and expertise of health professionals - almost exclusively based on knowledge derived from the scientific method. Then, we might think there is some inconsistency in the professional view regarding popular health practices, since the social importance of traditional agents of care and healing is ignored - in this study represented by faith-based healers, as active subjects in the care/cure to problems and needs required by the community, including the health-related ones.

Faith-based healers, however, usually have an attitude opposite to that of health professionals. The fact that these women share the local and cultural reality of subjects, their linguistic similarity, in addition to their availability of time and interest in understanding the history of subjects who seek them, are factors which contribute to construct an effective communication process. This process culminates in the establishment of strong ties between subjects and faith-based healers, who often start monitoring (at least within a certain period) the subjects’ life situation.

The close relation of health professionals to faith-based healers should, therefore, be promoted when increasing professionals’ knowledge is a goal, both regarding the community life and health reality and the promotion of exchange of care and healing experiences between official and popular health workers. All these possibilities of “cure” involving health workers, religious leaders, community segments, various health experts, and the representatives of manifestations in popular culture and religiosity lack reflection, analysis, and an attentive look from society as a whole.

**CONCLUSION**

This study allowed understanding that faith-based healers seem to grasp the specificity of knowledge from the health field (which is sometimes assimilated and provided with a new meaning in their practices), although they are not included into the official health system. By admitting the existence of “medical diseases”, they advise subjects to seek professional care in cases they deem needed.

The reverse movement (professionals referring subjects to a faith-based healer) is not usual, a fact that ends up strengthening the process of invisibilization and lack of trust of popular health practices, based on the ethnocentric and exclusionary views involving the health professionals’ education and work.

By understanding that health care practices are mainly cultural manifestations of a people, constructed by means of its knowledge and practices traditionally passed from generation to generation, it is believed that the partnership between faith-based healers and health professionals could contribute in a significant way to health promotion among individuals and communities. This is so because, by establishing ties between these actors, expanded health care actions could be proposed (especially those related to health education), whose reception by the community might probably be more natural due to ease of access and similarity between
languages and beliefs shared by faith-based healers and their communities. Such ties might allow reinventing strategies and communication possibilities in behalf of the collective well-being, taking into account the cultural dynamics of our society and the appreciation of cultural identities.

Nursing, as one of the professions more connected within the health team, by understanding the specificity and uniqueness of knowledge and practices of faith-based healers within a community, may be among the dialogue and attitude change facilitators of health professionals in face of the popular care/healing practices. Thus, nursing recognition of the power of faith-based healers’ work and the effective closeness of nursing professionals, especially in primary care, may be a very productive strategy to provide the community with comprehensive care.

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