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Health in black and white : debates on racial and ethnic health disparities in Brazil

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Health in Black and White:
Debates on Racial and Ethnic Health Disparities in Brazil

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy

in

Anthropology

by

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2011

The Dissertation of Anna Pagano is approved, and it is acceptable in quality and form for publication on microfilm and electronically:

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ABSTRACT OF THE DISSERTATION

Health in Black and White:
Debates on Racial and Ethnic Health Disparities in Brazil

by

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Doctor of Philosophy in Anthropology

University of California, San Diego

Professor James Holston, Chair
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In 2006, the Brazilian Health Council approved a National Health Policy for the Black Population. The Policy is striking because it promotes the image of a biologically and culturally discrete black population in a nation where racial classification has historically been relatively fluid and ambiguous. It transforms established patterns of racialization by collapsing "brown" (*pardo*) and "black" (*preto*) Brazilian Census categories into a single "black population" (*população negra*) to be considered a special-needs group by the public health apparatus. This construction resembles the United States' dominant mode of racialization based on hypodescent and represents a significant

departure from hegemonic portrayals of Brazil as a racially mixed nation. Furthermore, the Policy challenges national ideologies of racial and cultural unity by affirming the existence of an essential black body with specific health concerns, as well as an essential Afro-Brazilian culture that materializes in recommendations for culturally competent health care. As such, the Policy constitutes an important site for new negotiations of racial and cultural identity in Brazil.

In this dissertation, I explore the political and social implications of treating racial and ethnic groups differently within Brazilian health care. I examine how the re-definition and medicalization of racial and cultural identities unfolds in public clinics, temples of Afro-Brazilian religion, and social movements based in São Luís and São Paulo, Brazil. Through an analysis of ethnographic data that I collected over twenty-four months, I assess the impact of recent developments in race-conscious health policy on Brazilians' lived experiences of race, ethnicity, and health disparities.

I argue that the new Policy, and its associated health programs, signals the emergence of a new biopolitical paradigm in which the Brazilian state formalizes citizens' racial and ethnic differences in order to address inequalities among them. I also show that many aspects of these programs, which incorporate global discourses and concepts related to health equity, fail to resonate with Brazilian citizens' notions about race and health. Consequently, patients and healthcare providers often resist the new measures. The result is a disjuncture between policy and practice that ultimately hinders Brazil's efforts to reduce health inequalities among its citizens.

PART I: RACE, MEDICINE, AND BIOPOLITICS IN BRAZIL

Chapter 1: Introduction

Recently, in response to over two decades of mobilization by black movement activists and health professionals, the Brazilian government implemented a National Health Policy for the Black Population. This health initiative is striking because it promotes the image of a biologically and culturally discrete black population in a nation where racial classification has historically been relatively fluid and ambiguous.[1] In so doing, it transforms established patterns of racialization by collapsing "brown" (*pardo*) and "black" (*preto*) Brazilian Census categories into a single "black population" (*população negra*) to be treated as a special-needs group by the public health apparatus. This construction resembles the United States' dominant mode of racialization based on hypodescent and represents a significant departure from hegemonic portrayals of Brazil as a racially mixed nation.[2]

The new Policy, and its associated race-conscious health programs, signals the emergence of a new biopolitical paradigm in Brazil. Under this new paradigm, the state formalizes citizens' racial and ethnic differences in order to address inequalities among them. Other examples include race-based affirmative action programs in higher education and employment, which Brazil implemented in 2001. Although these biopolitical maneuvers have raised awareness about the extent of inequalities by skin color, they have also contributed to increased racial essentialism in the public sphere. More than ever before, Brazilians are making citizenship claims based on supposed biological and

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[1] E.g., Harris (1974).

[2] See Davis (1999), Silva (1998), Schwarcz (1993), and Skidmore (1993a) on political and intellectual discourses of race mixing and nationhood, particularly during the Vargas regime (1930-1945).

cultural differences among them. This is especially the case in the arenas of health policy, health activism, and medical research. In "fixing" the black population numerically and politically, the state reinforces the image of an essential black body with unique health concerns, as well as an essential Afro-Brazilian culture that emerges in "culturally competent" health care programs directed toward black citizens.

There is little question that significant health disparities exist in Brazil between racialized groups. This fact is demonstrated by a spate of epidemiological studies produced by Brazilian researchers in recent years. These studies have only begun to appear in the last few years because prior to the late 1990s, the Brazilian public health system did not record patients' race data. Since the Ministry of Health mandated the collection of these data, researchers have been able to demonstrate that black Brazilians die in greater numbers than whites (*brancos*) from HIV/AIDS, homicide, alcoholism and mental illness, stroke, diabetes, and tuberculosis (e.g., Araújo et al. 2009, Batista 2005, Batista et al. 2004, Santos et al. 2007). They have also shown that blacks experience higher rates of maternal and infant mortality in comparison to whites (e.g., Martins 2006). In fact, black women's (*pretas*) maternal mortality rates were seven times those of whites in 2001 (Chor & Lima 2005). As of 2000, black Brazilians' (*pretos* and *pardos*) life expectancy was 5.3 years less than that of whites (Cunha 2008). This scenario represents a serious public health problem for Brazil, particularly given that just over half of the Brazilian population now identifies as either *preto* or *pardo* (IBGE 2009).

As in the United States, Brazilian epidemiologists have not yet reached a consensus about the etiology of these disparities. Are they caused principally by widespread socioeconomic inequality? Racial discrimination in health care? Genetic or lifestyle characteristics? At first glance, socioeconomic status would seem to be the most likely cause based on the unrelenting correlation between skin color and life chances in Brazil (Lovell & Wood 1998). Blacks (*pardos* and *pretos*) represent nearly three-fourths of the poorest ten percent of Brazilians. Meanwhile, whites account for nearly 83 percent of the richest one percent (IBGE 2009). Furthermore, the illiteracy rate for *pretos* and *pardos* in 2008 reached a total of twenty-seven percent (13.3 and 13.7 percent, respectively), whereas for whites it was only 6.2 percent (ibid).

Many Brazilian epidemiological studies attribute health disparities to poverty, arguing that residing in poorly served areas interferes with treatment access and adherence (e.g., Batista 2005). Others, however, show that racial health disparities persist even after controlling for factors such as income and education (e.g., Barata et al. 2007). Meanwhile, explicitly racialist studies are becoming increasingly commonplace in Brazil; more and more researchers assume that medically significant differences exist *a priori* between "blacks" and "whites," and thus set out to test hypotheses based on that assumption (e.g., Jaime et al. 2006, Ribeiro et al. 2009, Vale et al. 2003).

Complicating the picture further is a pervasive problem of statistical ambiguity. Many recent epidemiological studies do not separate "preto" and "pardo" into separate categories, but instead lump them together to form the epidemiological category of "negro." This practice is endorsed by social demographers of Brazil such as Lovell & Wood (1998) and Silva (1988), who argue that individuals switch more frequently between these self-declared categories than between either "preto" or "pardo" and "branco" (white). These demographers also claim that similarities between pretos' and pardos' life chances (i.e., educational attainment, income, life expectancy) justify consolidating the two categories within statistical analyses (Wood & Carvalho 1988, Silva 1985).

When it comes to health data, however, the consolidation approach obscures internal variations between pretos' and pardos' epidemiological profiles. For instance, recent epidemiological studies show that pardos' morbidity and mortality patterns are either similar to those of whites (Chor & Lima 2005, Cardoso et al. 2005) or are intermediate between those of blacks and whites (Lotufo et al. 2007, Fonseca et al. 2007, Lessa et al. 2006). In spite of these findings, the Brazilian government has opted to institute a black health initiative that combines blacks and browns into a single epidemiological category, and treats them as a homogenous population within Brazilian public health care. In this dissertation, I will examine the sociopolitical origins and consequences of that decision.

In addition to examining the implications of this new biopolitical paradigm for Brazilian ideologies of race and citizenship, my analysis engages a broader debate concerning racial profiling in medicine. While some scholars argue that race should be purged from medical research altogether (e.g., Fullilove 1998), others maintain that race impacts health in real and measurable ways and should therefore be preserved as a scientific variable (e.g., Risch et al. 2002). My own position approximates Troy Duster's (2003b) argument that, since social stratification among racialized groups produces health disparities over time, race-conscious research and policy can be important tools for addressing the health effects of racism. However, if these tools describe and operationalize race in an uncritical manner, they may also contribute to the reification of racial differences (Duster 2005).[3] Indeed, race-specific health policies can easily become critical sites for the production of re-biologized discourses of race because they often (re)inscribe differing biological phenomena between racialized groups. Even when policy rationales attribute health disparities to both biological *and* social factors, the process of defining a racialized body according to health criteria has a race-naturalizing effect.

This topic is timely because in the last few decades, race has regained vigor as a primary site of action and investigation within the domains of epidemiology, public health, pharmacology, and genomics in societies across the globe. The contemporary medicalization of race represents a revival of similar practices in various locales during the eighteenth, nineteenth, and early twentieth centuries (e.g., Epstein 2004, Laguardia 2005). Despite its promised health benefits, however, the re-introduction of race as a central variable in medical research and practice remains controversial. Many scholars have issued warnings about the possible consequences of affirming race as a biological reality, such as increased racism, eugenics, and genocide in extreme cases (e.g., Stepan 1991). With this in mind, I argue that even ostensibly antiracist initiatives and discourses, like the ones I analyze here, must be alert to race-naturalizing elements.

In addition to raising concerns about the medicalization of race, the case of race-conscious health care in Brazil invokes the problem of reconciling citizenship equality with special recognition and/or rights for certain kinds of citizens. As Holston (2008) has argued, the doling out of special treatment to subgroups of citizens is a fundamental feature of Brazilian citizenship. In Brazil, women are permitted to retire five years earlier

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[3] I assume that biological human “races” do not exist. Rather, I use the term “race” to signify a shifting social construct that can nevertheless impact health due to social stratification and exclusion. So as not to compromise readability, I have avoided placing the word “race” in quotes throughout the body of the text.

than men; college-educated prisoners have the right to a private cell; and senior citizens are allowed to go to the front of the line in all public spaces, including public clinics and hospitals. These examples of "differentiated citizenship," as Holston calls them, have never generated substantial controversy among Brazilians—perhaps because, as Holston points out, group-differentiated rights have historically benefitted elites.

Race-based affirmative action, by contrast, maintains the regime of differentiated citizenship but favors those with less power. Affirmative action has therefore met with significant resistance since its inception in 2001, when the Brazilian government began to implement quotas for black (*preto*) and brown (*pardo*) citizens in some sectors of federal employment and several public universities. In some cases, quotas are also set aside for indigenous citizens and/or for former students of Brazil's beleaguered public school system. Citizens have responded to the quotas with public outrage and lawsuits; many Brazilians believe affirmative action amounts to state-sponsored racism (e.g., Veja 2006). Prior to the advent of affirmative action, Brazil had never formalized citizens' racial differences—at least, not since slavery ended in 1888. Even in times of slavery, the crown made legal distinctions based on individuals' status as slave, freed (*liberto*), or free, as opposed to their race per se (Holston 2008). The new race-based affirmative action policies in education and health, therefore, represent a striking reversal of the Brazilian state's historical reticence on race within the realm of policy.

Affirmative action in health care, however, is distinct from affirmative action in education because Brazil's new initiative does not mandate health care quotas for black citizens, give them special priority in the clinics, or afford them the right to special treatment. Rather, it makes the moral claim that citizens who self-identify as black (*negro*/*a*) should be *recognized* as physically and culturally different from the rest of the population, at least in regard to health care. Brazil's National Health Policy for the Black Population, then, embeds both a politics of recognition and a politics of difference, but not a substantial politics of redistribution. The limited redistribution that occurs lies in the state's reallocation of public funds to promote scientific research on the health specificities of the black population, in addition to financing public forums and educational materials on black health issues. These measures carry significant symbolic weight but, I argue, are negligible in terms of ameliorating health disparities or changing public health practice on a grand scale.

For several reasons, it is difficult to situate this case vis-à-vis the vast body of literature on reconciling group rights and individual rights within liberal democracies (e.g., Taylor 1994, Kymlicka 1995, Benhabib 2002, Young 1990). First, Brazil is not a liberal democracy in the classic sense. It is closer to a social democracy due to the state's strong emphasis on social rights. Second, as stated above, race-conscious health policy in Brazil does not extend special rights to black citizens, at least not in the sense of obligating health care providers to treat self-identified black patients differently. The literature cited above, by contrast, addresses legislated group rights within such spheres as political representation and legal pluralism, as opposed to recognition in and of itself.

Nevertheless, a few concepts from the literature on multicultural citizenship are useful for understanding the cultural politics of race-conscious health care in Brazil. One is what Taylor refers to as "cultural survival" and Kymlicka calls "polyethnic rights." Polyethnic rights include legal protection and/or government funding for certain cultural practices of minority groups, with the goal of helping these groups to integrate more effectively into the wider society (Kymlicka 1995: 30-31). “Cultural survival” implies state protection for the maintenance of minority groups’ cultural traditions (Taylor 1994: 61). There is an element of state protection for cultural survival when, under the new black health initiative, the Brazilian state funds conferences on Afro-Brazilian religious healing, as well as cultural competence training for public health employees on Afro-Brazilian religious practices. Furthermore, by funding cultural competence training, the state indirectly attempts to protect the right of Afro-Brazilian religious practitioners to non-discrimination within public health care on the basis of creed. In affiliation with the new black health initiative, members of Afro-Brazilian religions have launched a movement against religious intolerance within public health care facilities. I discuss this movement in detail in Part III.

Taylor’s (1994) theorization of multiculturalism and the politics of recognition also helps to elucidate the case I analyze here. Taylor frames his discussion in terms of the tension between the politics of universalism, or equal recognition, and the politics of difference. The politics of equal recognition arises from a “difference-blind” liberal tradition that upholds human dignity as a universal value. Universalism implies identical rights for all citizens, while the politics of difference entails differentiated citizenship claims by specific individuals or groups. Despite the apparent opposition between the two orientations, Taylor argues that the politics of difference is actually informed by a presupposition of universal and equal human potential, which he interprets as the equal right of all members of society to assert their own identity and to have it recognized by others. The paradoxical result is that “the universal demand powers an acknowledgement of specificity" (39). As I show in Parts II and III, advocates of the new health initiative for black Brazilians make the same argument.

This tension between universalism and the politics of difference emerges in the case at hand because the Brazilian health care system is based on a strong universalist philosophy that proclaims the value of equal treatment for all citizens. Although the National Health Policy for the Black Population does not currently mandate differentiated treatment according to race, the emergence in Brazil of a special area of medicine devoted to black patients' particular needs has sparked protest from Brazilian intellectuals, scientists, and health care professionals who interpret the Policy as racist (e.g., Fry et al. 2007). Furthermore, the idea that practitioners of Afro-Brazilian religions should be allowed to wear their religious ornaments during certain kinds of medical examinations, while other patients must remove all ornamentation, constitutes a claim for differentiated treatment. Thus far, though, I have heard only anecdotal evidence that some public health providers have refused to accommodate these patients' religious-based needs. In contrast to affirmative action quotas in higher education, opposition to the black health initiative has not yet escalated to the level of litigation.

Although Brazil's new black health initiative does not currently entail legally enforceable special rights for black patients, I argue that it has important implications for biopolitical citizenship. Biopolitical citizenship can be defined as the relationship of citizens to the nation-state in matters of not only biological life and health, but also "political representation and inclusion in the polity and society" as enacted through these realms (Epstein 2007:13). As Epstein notes in his study of U.S. minority activism for inclusion in clinical research, "biomedical inclusion was not just a matter of counting up bodies; it also was a broader indicator of 'who counted.'" (2007: 90). Epstein's formulation of biopolitical citizenship, aptly characterized in this quote, is useful for understanding some of the aims and effects of Brazil's new black health initiative.

This case differs in important ways, however, from both affirmative action in higher education and the case of U.S. minority health activists described by Epstein. Affirmative action claims within Brazilian higher education and public employment rest entirely on the premise that racism leads to unequal educational and socioeconomic outcomes for black and brown Brazilians as compared to whites. These claims make no reference to biological differences by race. Meanwhile, in Epstein's analysis, minority health activists demanded to be included in biomedical research on the grounds of supposed biological differences that were already widely accepted within U.S. society; therefore, the process of "categorical alignment," or "the merging of social categories from the worlds of medicine, social movements, and state administration," encountered little resistance (13). Brazilian black health activists, by contrast, have had to import the discourse of medically significant racial differences wholesale from abroad, complete with racial categories informed by hypodescent, and have therefore faced an uphill battle in convincing many Brazilian healthcare providers, health officials, and researchers to take their concerns seriously. At the same time, as I will show, international pressure and socially liberal political regimes conspired to facilitate the creation of the black health agenda in Brazil.

The case I analyze is similar in some aspects to the one described by Petryna (2002), in which Ukrainian citizens demanded reparatory treatment from the government based on health damages incurred from Chernobyl. Petryna interprets their claims as the exercise of “biological citizenship,” which she argues is instantiated when the “biology of a population has become the grounds for social membership and the basis for staking citizenship claims” (2002: 5). Although biology is certainly a significant part of the citizenship claims made by Brazilian black health activists, it is not simple biology or the right to protection of “bare life” (Agamben 1995) that underlies their claims. Rather, they demand to be included in a specific way. Their claims are based on the choice to identify, and to be identified, as an innately different kind of citizen, as opposed to a citizen who acquires special needs following a disaster (as described by Petryna). On the Brazilian Census, and on the patient race forms now utilized within public clinics and hospitals, citizens (at least in theory) declare their own racial identity. Black health activists’ campaign to re-constitute “black” and “brown” as “negro” expresses their intent not only to massify the black population for stronger political representation, but also to be counted in a particular way.

Another important aspect of Petryna’s analysis that pertains to Brazil’s black health initiative is the concept of compensatory justice. Alongside their claims for specialized health care, Brazilian black health activists demand reparation for health damages incurred due to racism. In these compensatory claims, they attribute health disparities to not only racial discrimination within public clinics and hospitals, but also to generalized social inequalities between blacks and whites. Activists identify entrenched racism as the ultimate cause of inequalities in health, housing, education, and the like. In making these claims, activists construct the Brazilian black population as “vulnerable” (*vulnerável*) and hold the Brazilian state responsible for rectifying black citizens’ bodily suffering, if not the underlying social inequalities that produced them. In the compensatory aspect of their claims, activists invoke the principle of citizenship equality by demanding equal access to public health services.

Taking Brazil's new race-conscious health programs as a point of departure, this dissertation examines how citizens in two contrasting Brazilian cities, São Luís and São Paulo, negotiate the contentious issue of formalizing racial and ethnic differences for health purposes. Through an analysis of ethnographic data that I collected over twenty-four months in public clinics, low-income neighborhoods, and temples of Afro-Brazilian religion, I assess the impact of recent developments in race-conscious health policy on Brazilians' lived experiences of race, ethnicity, and health disparities. I show that race-conscious programs designed by the state, and informed by global norms of racial identity and health, contradict well-established notions of race and health in Brazil. Whereas a relatively small group of Brazilians in social movements and government support the creation of health programs for blacks, non-activist citizens tend to deny the existence of health disparities by race. They also construct racial identity in ways that challenge the race categories deployed within the context of new race-conscious health measures. Furthermore, healthcare providers routinely circumvent the new initiative in various ways, for instance by neglecting to record their patients' self-declared racial identity. Together, these factors create a disjuncture between policy and practice that, I argue, ultimately hinders the Brazilian government's efforts to reduce racial and ethnic health disparities amongst its citizens.

In the next section, I provide an overview of key concepts that I employ throughout the dissertation.

Note on Language

It is difficult to choose appropriate terminology when discussing race in any context; this difficulty is compounded when writing in English about Brazil's famously complex system of racial classification. My intention is not to import or superimpose North American norms of racial classification, but rather to present my analysis in as clear a manner as possible. It is challenging to create etic terms for the purpose of analytical distance, given that my Brazilian informants use multiple words (e.g., *preto*, *pretinho*, *negro*, *negão*, *negrinho*, *escuro*, *escurinho*, *afro-descendente*) that in English can only be meaningfully translated as "black." Each of these terms connotes a specific feeling or political message that does not reliably come through in my attempts to translate them directly into English. Throughout this dissertation, therefore, I use English-language terms such as "black," "white," "African Brazilian" and "European Brazilian," in addition to emic terminology whenever possible. I am aware that I may be recreating the very "black/white" discursive divide I critique in the Brazilian case by using those terms, but I do so for lack of a more precise analytical lexicon for discussing race in Brazil.

Race and Ethnicity

At various times throughout human history, "race" has been used in many ways: to describe separate species united under a common human genus (polygenism); distinct genetic subtypes within the human species (monogenism); or, most recently, a group of individuals who subscribe to a particular identity based on putative shared biological and/or cultural traits. The concept of ethnicity usually refers to the sense of cultural difference and shared traditions that members of a group experience vis-à-vis the larger society in which they are embedded. However, ethnic identity also includes, more often than not, members' belief in a common biological origin or descent—aspects that also pertain to the concept of race. These concepts are therefore not easily separated. As Wade (1997) observes, the concepts of race and ethnicity are often used interchangeably:

> Racial identifications use aspects of phenotype as a cue for categorization, but these are seen as transmitted intergenerationally—through the "blood"—so that ancestral origin is important; likewise ethnicity is about origin in a cultural geography in which the culture of a place is absorbed by a person (almost "into the blood") from previous generations. (21)

There is, then, a notion of biological inheritance (blood) implicit in both race and ethnicity. Wade makes two other pertinent observations: first, that ethnic distinctions are often made within a single race category such as black or white, and vice-versa; and second, that biological clues used to categorize people in terms of race are interpreted in strikingly different ways depending on the cultural/geographical context (20-21). The same phenotype that signifies "black" in the U.S., for example, may signify *moreno, mulato,* or *pardo* (mixed/brown) in Brazil. These two factors call attention to the mutable, unstable nature of both racial and ethnic identity.

Nevertheless, race continues to animate and inform identity politics around the globe. Although social scientists have eschewed the race concept as a unit of sociological and biological analysis for human populations, we find ourselves obligated to retain them since they organize the lifeworlds of our informants (not to mention our own). In this dissertation, I assume that biological human races do not exist. Rather, I use the term "race" to signify a shifting social construct that can nevertheless impact health due to social stratification and exclusion. Although I recognize that race is a culturally- and historically-contingent social construct, and not a biological reality, I must deal with race and racism here because my informants use this terminology. Additionally, I must unpack their understandings of race as a biological entity as well as a sociocultural one. That being the case, it is important to review the epistemic precursors for the conceptualization of race as biology.

Biologization and the Re-Biologization of Race

According to Graves (2001), the genealogy of race as a biological concept can be separated into two general phases: pre- and post-Darwin. Prior to the early fifteenth century, Europeans' awareness of human diversity was limited, although social and cultural stratification was well established. Graves notes that in many areas of Europe, Jews were considered inferior and were believed to carry contagious, blood-borne diseases. There is no evidence, however, that they were considered a biologically distinct type of human. The European conquest missions radically changed the way Europeans conceptualized diversity. Western colonialism brought highly diverse world populations into close contact, which led to a shift from "gradient" to "categorical" understandings of human variation (Brace 2005). This was particularly the case in the Americas, where the juxtaposition of Europeans, indigenous peoples, and later enslaved Africans created a social context that naturalized the idea of absolute racial difference. The subjugation of indigenous peoples and Africans in colonial contexts also introduced a racial hierarchy that was reflected in emerging biological theories of race in Europe. This historical shift is often termed the "biologization" of race.

French physician François Bernier presented the first formal classification of human races in 1684, although he saw the aggregate of humans as one species "form" and races as sub-varieties (after Plato's theory of forms) (Graves 2001). Enlightenment scientists often drew on Aristotle's scala naturae to posit a "Great Chain of Being" of human races. For example, Linnaeus' *Systema Naturae* (1735) stratified Homo sapiens into four varieties (European, African, Asian, and American), with Europeans occupying the top rung of the ladder and Africans, the lowest.

In general, eighteenth-century naturalists put forth monogenic theories of race, whereas during the nineteenth-century, polygenism became the dominant model for race theories. "Monogenism" refers to the theory that human races have a common biological origin and thus belong to a single species, while "polygenism" denotes the idea that human races are actually separate species. Monogenists' belief in the unity of the human species, however, did not prevent them from advancing racist theories. Perhaps the most striking example of this was presented by Joseph Arthur Comte de Gobineau, a monogenist who published his "Essay on the Inequality of Human Races" in 1853-1855. Gobineau divided the human species into three major races: Negroid, Caucasoid, and Mongoloid. He then measured the relative worth between each race according to its ability to found a "great civilization." Predictably, Gobineau concluded that "Aryans" (Caucasoids) were the superior race, while Negroids were the lowest. He also posited racial intermixing as the primary cause of the downfall of great civilizations. His ideas had a profound impact on the racial policies of many states, including Brazil (where Gobineau served as a diplomat) and Nazi Germany.

In addition to numerous other contributions to the field of biology, Darwin's *On the Origins of Species* (1859) affected the perception of human variation in lasting ways. His theories of evolution and species-level progress were taken up by racist thinkers who used them to affirm the biological superiority of Europeans. In his later work *Descent of*

Man (1871), Darwin attempted to debunk polygenist theories of race by invoking the principle of interfertility as well as the general likeness of human physical form (Graves 2001). Since humans of different “races” could interbreed, he reasoned, they must be members of the same species. He also pointed out that individuals from different racial groups displayed many more physical commonalities than differences from one another. Furthermore, he argued that humans’ physical variations were actually gradations that blended into each other so subtly that it complicated scientific efforts to group humans into sub-varieties (ibid). Although Darwin did not dispute the thesis of inequality among races, he did offer an alternative explanation for them by attributing supposedly unequal abilities and traits to environmental factors rather than to innate incommensurability.

Darwin’s theories influenced various fields of social as well as scientific inquiry. Social Darwinist theories soon emerged that adapted Darwin’s theory of natural selection to create models of social progress and evolution. Herbert Spencer, arguably the most important Social Darwinist, coined the phrase “survival of the fittest.” This phrase expresses the idea that competition between individuals and groups in society is what drives social evolution. Spencer devised a Lamarckian theory of the heritability of acquired social traits, such as culture, intelligence, and even social status, from previous generations. The tenets of these Social Darwinist theories influenced racial science to a great extent, since human races considered inferior were further denigrated by the idea that not only biological deficits, but also social and cultural deficits, could be passed down from generation to generation. These theories also served to legitimate the status quo of social hierarchy by blaming subjugated groups for their disadvantaged position.

Another area profoundly marked by the concept of evolution was the burgeoning field of physical anthropology. Early anthropological studies of human variation sought to determine racial differences in traits such as intelligence. Paul Broca founded the field of physical anthropology in France, while physician Samuel George Morton founded the American School of Anthropology. Both were polygenists who examined various aspects of the human anatomy, particularly brain size, to support theses of racial inequalities in intelligence and other developmental measures.

In his discussion of these historical lowlights of anthropology, Brace (2005) asserts that the biological race concept was the basis for the creation of anthropology as a formal academic discipline. Anthropology, in addition to other fields of study such as craniometry and phrenology, was frequently employed during the nineteenth century in service of scientific racism. “Scientific racism” refers to the use of (pseudo) scientific methods to demonstrate supposedly scientific bases for inequalities between people of different “races.”

In the United States, scientific racism reached its peak during the years surrounding the Civil War. Uncertainty regarding the future of slavery, and later anxiety over the increasing integration of freed slaves into U.S. society provided powerful stimuli for research that sought to demonstrate blacks’ inferiority as well as the supposed degeneracy that could result from miscegenation. As in other nations undergoing the transition from slavery to emancipation during the nineteenth century, social forces determined the directions of scientific research in the antebellum United States and encouraged the production of racist theories bolstered by apparently neutral scientific methods.

Another influential figure of the nineteenth century was Sir Francis Galton, who in 1883 coined the term "eugenics" to describe the science of improving human stock through careful mating decisions.[4] Galton argued that the English state should encourage its most intelligent subjects to reproduce at a greater-than-average rate in order to compensate for overpopulation among the working classes, whom he assumed were less intelligent. Galton termed this problem of overpopulation among less fit individuals "dysgenesis" because their reproduction supposedly brought down the intellectual quality of the population. His ideas were taken up by eugenics movements in the United States, Latin America, and Europe during the early twentieth century.

Galton's formulation of eugenics is often described as "positive eugenics" because he recommended increased reproduction among individuals assumed to be fit, as opposed to limiting reproduction among less fit individuals or even eliminating them. The interpretation of Galton's ideas varied considerably according to national context. In Brazil, for example, Galton's ideas were combined with Lamarckian theories that stressed the heritability of acquired traits. This engendered a "softer" form of positive eugenics in which public sanitation and hygiene were stressed over and above restrictive mating practices (Stepan 1991). In both Brazil and the United States, however, restrictive immigration policies appeared with a view toward keeping people from Asian and African countries out of the national body, while encouraging others to enter freely. The earliest restrictive policy in the U.S. was the Chinese Exclusion Act of 1882. Beginning in 1913, the U.S. Public Health Service allowed eugenicist Henry H. Goddard to administer IQ tests to immigrants at Ellis Island. The result was an exponential increase

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[4] Galton, Francis. 1883. *Inquiries into Human Faculty and its Development*. London: Macmillan.

in the number of immigrant deportations based on diagnoses of "feeble-mindedness" (Brace 2005). Soon thereafter, Congress passed the Immigration Act of 1924, which instituted nationality quotas and expanded existing restrictions to such an extent that most groups aside from northern and western Europeans were barred from entering the country.

Although eugenics discourses of the early twentieth century did not always invoke race explicitly, they were key to the biologization of race because they reinforced the idea that characteristics such as intelligence and resistance to disease, as well as moral character and degeneration, were heritable traits. These elements have surfaced repeatedly in discourses that biologize race. The eugenics movement gained popularity in the United States during a time of intense racial strife and anxiety about the character of the nation. This fact was reflected in the compulsory sterilization laws and immigration restrictions, as well as frequent lynchings of blacks in the U.S. South.

Eugenics reached its peak around the end of the 1920s. By the 1930s, a significant number of scientists in the United States and Britain had begun to doubt its tenets. Just as anthropologists had played a key role in the development of scientific racism, they were instrumental in its dismantling. The investigations of Franz Boas were crucial to challenging theories of racial variation in cranial size and intelligence. By measuring the cranial forms of immigrants to the United States and their children raised in the U.S., Boas demonstrated the low heritability of head shape and cranial capacity. The children's crania often changed remarkably in regard to size and shape as compared to their parents, and Boas concluded that this was a result of environmental factors such as nutrition. His student Ruth Benedict later published *Race, Science, and Politics* (1940), which attempted to discredit racist concepts in science and linked race science to fascism.

During the 1930s, population genetics began to challenge earlier theories regarding biological variation and eugenics. Early genetic studies of sickle cell anemia, for example, demonstrated that genetic mutations and variability could be beneficial in certain environments, rather than absolute liabilities. Around the same time, the new technology of electrophoresis began to demonstrate great hemoglobin variability in world populations that did not correspond to existing racial categories. In 1946, A.S. Wiener used serological data to show that Australoids and “Negroids” (Africans) had different blood allele frequencies, thus contradicting earlier anthropometric models that had placed them within the same group based on similar phenotype. Also in 1946, geneticists Theodosius Dobzhansky and Leslie Dunn produced a study titled *Heredity, Race, and Society* that challenged the concepts of correlation between physical features and mental ones; racial purity; and the inheritance of grouped traits, as opposed to the inheritance of separate traits. This last finding was particularly important, since it indicated that traits such as skin color, for instance, are inherited independently of biologically adaptive genetic traits such as the sickle cell trait. This finding lent scientific validity to the idea that there could be no significant differences in adaptive fitness or ability between so-called “races” (Templeton 2003).

World War II was another watershed in the “de-biologizing” of race. The extreme scientific racism deployed by the Nazi regime in the Holocaust shocked world communities to the extent that theories of scientific racism fell out of favor more quickly than might have otherwise happened. In 1950, UNESCO declared in its “Statement on

Race" that theories of racial inequality were irrational and that, in light of the Holocaust, it was important to realize that "racial groups" were more alike than different. The following year, however, UNESCO issued a "Statement on the Nature of Race and Race Differences" that characterized the race concept as useful to scientific inquiry in some contexts. Nonetheless, biologized discourses of race were sidelined for several decades following World War II. Although racialist practices persisted in U.S. identity politics and scientific research during this period, racialist discourses in policy decreased markedly. Rabinow and Rose (2003) observe that "the link between biological understandings of distinctions amongst population groups and their sociopolitical implications seemed broken or at least denaturalized" (18).

According to Duster (2003a), race re-entered public discourse noticeably in the mid- to late 1970s. At that time, scientific journals in addition to more general media began to demonstrate a rekindled interest in identifying genetic explanations for phenomena that had been explained using terms of social or environmental models. Due to advances in molecular genetics, scientists began to hypothesize differences in disease course and drug response between African-Americans and whites, which in turn were attributed to genetic differences (e.g., Kahn 2004). Duster (2003a) questions the theory of genetic causality in relation to heart disease and cancer, noting that whites had exhibited higher rates than blacks of both during the 1930s. Regardless, the last few decades have seen a dramatic increase in the search for genetic markers for disease and in the development of drugs tailored to presumed genetic specificities among racial or ethnic groups. These trends have prompted scholars to proclaim the advent of a new era in which race is increasingly medicalized.

Medicalization

Although there are many definitions of the term, “medicalization” generally denotes a process by which problems or conditions that were once understood as primarily social are recast as objects of medical interest and authority (Zola 1972). Examples include substance abuse, depression, and even homelessness (Mathieu 1993). Medical anthropologists have argued that medicalization often preempts political responses to social problems by reinterpreting them as isolated pathologies that afflict individuals, rather than as systemic issues that impact social groups (e.g., Kleinman, Das, & Lock 1997, Lock & Scheper-Hughes 1996, Rhodes 1996). Like other forms of social suffering, racism and the disadvantages associated with being a racial or ethnic minority can be medicalized if they are framed as risk factors for illness. Additionally, many scholars have argued that race itself is increasingly medicalized to the extent that “race groupings have been legitimized by their use in medical literature and practice as acceptable descriptive labels that are integral to the proper diagnosis and treatment of disease in humans” (Witzig 1996: 675).

Prior to the appearance of the term “medicalization” in the social science literature, several scholars had already explored the encroachment of medicine into an increasingly wide array of social arenas. An important contribution of medicalization theories in general is the recognition of medicine as socially constructed, rather than neutral and value-free. Talcott Parsons was one of the first to theorize medicine as an institution of social control. He did so through the concept of the “sick role,” explained as a mechanism that temporarily legitimated the social deviance created by illness episodes (Parsons 1951). According to Parsons’ theory, the medical doctor held great authority due to his power to confer sick roles through diagnosis and to help patients achieve social reintegration through recovery. Michel Foucault was another key theorist in regard to medicalization, as evidenced by his treatises on the transformation of the folk category “unreason” into the psychiatric diagnosis of “madness” (1965) and on the emergence and consolidation of the medical “gaze” (1973).

Freidson (1970) and Zola (1972) later drew on Parsons’ work to develop the concept of “medicalization.” Freidson described medicalization in the following critical manner: “The medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively” (1970: 251). This viewpoint is characteristic of the early medicalization theorists, who tended to minimize any positive effects stemming from the marked expansion of biomedicine as a primary arbiter of social concerns. Instead, they implied that medicalization was actually *over*-medicalization, and that it was not only unnecessary, but ultimately detrimental. Some political economy theorists, such as Navarro (1986), viewed medicalization as motivated primarily by the capitalist expansion of the medical industry, rather than by the goal of optimizing human health.

Irving K. Zola, who is often considered the most influential medicalization theorist, also viewed the “medicalizing of society” as a consequence of the medical profession’s increasing authority over various aspects of social life:

> …medicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts (1983 [1972]: 247).

Subsequent theorists, such as Conrad (1992) and Lock (2001) have challenged earlier portrayals of medicalization as a totalizing process. Conrad offers a much broader definition of medicalization than Zola’s:

> Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession (211).

He offers an analytic framework of medicalization comprising three levels: the conceptual, the institutional, and the interactional. At the conceptual level, medical vocabulary comes to define a problem or condition, regardless of involvement by the medical institution. At the institutional level, organizations adopt a medical framework for treating a problem, with or without medical authorities—although, he argues, this level often does involve some kind of input from medical authorities. The interactional level is the one that involves the medical profession to the fullest extent, because it occurs through doctor-patient interactions where doctors prescribe medical treatments for “social” problems. Conrad’s multi-level schema of medicalization preserves the agency of laypersons by suggesting that at all levels, individuals or subgroups may choose to reject medicalization or actively seek it.

Medicalization of Race

The “medicalization of race” denotes a process through which the race concept is taken up by the domains of biomedical research and practice as a key variable in explaining patterns of variation in human disease. Often, race is treated within these domains not as a social concept or indicator of cultural behaviors, but rather as a proxy for genetic variation (Root 2003). Although the medicalization of race is commonly portrayed in the literature as a recent phenomenon due to the advent of geneticizing discourses, race has been medicalized for quite some time now.

Epstein (2004) observes that in the nineteenth century, U.S. physicians applied the "principle of specificity," tailoring treatment to the idiosyncrasies of the patient (190). The application of this principle subsided around the late nineteenth century as U.S. physicians began to adopt the tenets of European scientific medicine that treated the illness using a "one size fits all" approach (ibid). The practice of focusing on racial and gender differences in medicine, however, re-emerged in the U.S. around the 1980s. A similar pattern occurred in Brazil, although the timeline was slightly different. Around the end of the nineteenth century, some notable Brazilian physicians and psychiatrists advanced theories of medically significant racial differences between blacks, *mulatos*, and whites.[5] It is not clear, however, whether these theories influenced medical practice to any significant degree. During the twentieth century, these theories subsided and have only re-emerged in the last ten to fifteen years.

The literature is replete with examples of historical emphases on racial difference in medicine. Comaroff (1993), for instance, describes how eighteenth-century British missionaries to Africa associated black bodies with myriad kinds of diseases. On a similar note, Tapper (1999) analyzes colonial physicians' role in establishing a link between African bodies and sickle cell anemia. Later, medical researchers in the U.S. drew on these physicians' theories to conclude that sickle cell anemia was a "black"

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[5] For instance, Bahian psychiatrist Raimundo Nina Rodrigues conducted forensic studies of alleged criminals. He concluded that *mulatos* were particularly susceptible to mental instability and criminal insanity, while blacks were so mentally inferior to whites that accused criminals of different "races" should be judged using different legal criteria according to their mental capacities (Skidmore 1993).

disease based on assumed genetic continuity between Africans and U.S. blacks. Additionally, several scholars show that the rationale for the Tuskegee syphilis project stemmed from medical experimentation on U.S. slaves that allegedly "proved" the existence of medically significant physical differences between blacks and whites (e.g., Hickey 2006, Washington 2006). These scholars' analyses demonstrate the considerable historical depth of race-medicalizing practices; perhaps a more apt term is the "re-medicalization of race."

Regardless of the terminology used, the contemporary medicalization of race is enacted in various sites, including biomedical research, health policy, health activism, and pharmaceutical markets. Race in medicine and health-based identity politics is so tenacious precisely because pragmatism trumps moral concerns about the possible consequences of medicalizing race. As King (2000) notes in her discussion of the Tuskegee Syphilis project, the issue of whether to recognize racial differences in medicine or to assume that all subjects are biologically the same presents a major dilemma: "Because medicine is pragmatic, it will recognize racial differences if doing so will promote health goals. As a consequence, potential harms that might result from attention to racial differences tend to be overlooked, minimized, or viewed as problems beyond the purview of medicine" (425). Even when it is not clear that medicalizing race will promote health goals, however, market logic and citizenship claims conspire to ensure the longevity of race in medicine. Although race is now medicalized in different ways and for ostensibly different ends than in the past, it remains a uniquely powerful metaphor for conceptualizing human difference, at ever-deeper levels and in subtler ways.

Biopower and Biopolitics

The concepts of biopower and biopolitics help to clarify the link between the medicalization of race and techniques of governance. “Biopolitics” refers to the constitution of life and welfare as central targets of modern state techniques for regulating the productive potential of their populations (Foucault 1978, Rose 2006). Foucault (1978) asserts that, whereas in the past sovereign power asserted itself by deciding its subjects’ life or death, modern forms of state power (especially from the end of the eighteenth century on) are expressed through a “positive influence on life, that endeavors to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations” (137). This power over life exists in two “poles”: the “anatamo-politics of the human body” and the “bio-politics of the population” (139). The first is dedicated to increasing the (individual) body’s productive potential, while the second is focused on regulating the population at large. The main purview of biopolitics is “public hygiene, with institutions to coordinate medical care, centralize power, and normalize knowledge” (2003: 244). Accordingly, biopolitics is often channeled through “campaigns to teach hygiene and to medicalize the population” (ibid). Within Foucault’s analytical scheme, medicine thus emerges as “a power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and it will therefore have both disciplinary effects and regulatory effects” (2003: 252).

At first glance, medicine seems to function primarily as a tool of state dominance within this theory. As Rabinow & Rose (2003) have noted, however, Foucault later refined this portrayal of state power through his theory of governmentality that accounts for “the variety of ways of problematizing and acting on the individual and collective conduct in the name of certain objectives which do not have the State as their origin or point of reference" (5). This second phase of theorizing state power and, by extension, biopower, is crucial to understanding various ways in which individuals and groups participate willingly in medicalization and even self-medicalize, as discussed by Lock (2001) and Conrad (1992). In this dissertation, I draw on theories of biopolitics and governmentality to explain how the medicalization of race and racism occurs through both state-centered and non-state-centered mechanisms.

Applying a Biopolitical Framework to the Medicalization of Race

In the final analysis, do developments such as pharmacogenomics empower the patient to manage his or her own treatment, or do they imprison the patient within a racialized system of medical logic? Many theorists of contemporary biopolitics have interrogated the mixed impulses that pervade the contemporary medicalization of race. While many of them note the potential for renewed scientific racism, they often suggest that biopolitical processes in the age of genomics are not as totalizing or top-down as in the past.

Rose (2007) is quite optimistic regarding the liberating possibilities presented by genomic medicine. According to Rose, the goal of biopolitics in the age of genomics is to maximize health, rather than to normalize populations. He draws a clear conceptual line between the biopolitics originally theorized by Foucault and that of the twenty-first century: "[Today's] is a biopolitics organized around the principle of fostering individual life, not of eliminating those that threaten the quality of populations; it is a biopolitics that does not operate under the sign of the sovereign state; it is a biopolitics that does not seek to legitimate inequality but to intervene upon its consequences" (167). Rose also claims that the current “molecular gaze of contemporary genomics” actually counteracts the outmoded, racist idea that physical differences index differences in mental and moral characteristics (161). He argues further that, rather than contributing to increased racialism, genomic medicine produces biosocial communities with “shared disease heritages” that demand genome-specific remedies (ibid).

Other theorists are more pessimistic regarding contemporary biopower and race. Shim (2000) argues that by presenting race, class, and gender as individual characteristics that increase the risk of developing certain diseases, biomedical researchers conceal the structural and environmental causes of health disparities. At the same time that they strive to produce personalized medical solutions based on genomic technology, researchers also invoke old racial groupings. In a later study, however, Shim (2005) presents a more nuanced interpretation of how epidemiological knowledge is produced, as well as the existence of resistance from subjects. Both she and Montoya (2007) argue that epidemiologists, more often than not, recognize the weaknesses and limitations of race variables in determining disease patterns. Their analyses provide a counterpoint to totalizing accounts of the medicalization of race, because they show that researchers can and do resist bioreductionism in matters of race and health.

Rabinow & Rose (2003) present a more ominous view of the consequences of medicalizing race through the use of genomic technologies. They argue that, while developments such as SNP (single nucleotide polymorphism) mapping and the Human Genome Project strive to individualize health interventions, they do so by re-inscribing old racial distinctions: “it is striking and disturbing that the core racial typology of the nineteenth century...still provides a dominant mold through which this new genetic knowledge of human difference is taking shape" (20). The authors predict that SNP mapping will "undoubtedly" reiterate historical perceptions of difference between population groups read as "races" (ibid). It is interesting that Rose, in this collaborative text, presents genomics in such a negative light in comparison to his discussion of the liberating and empowering possibilities of genomic medicine in *The Politics of Life Itself* (2007).

Regardless of the race-naturalizing implications of genomic medicine, Epstein (2007) shows that the re-inscription of race categories in biomedical research is not necessarily an unwelcome development for potential subjects. In his study of race categories within U.S. biomedical research and health policy, Epstein identifies a biopolitical paradigm that he terms the "inclusion-and-difference paradigm" (passim). "Inclusion-and-difference" refers to the political objective of including minority groups in biomedical research based on presumed medically significant differences. The inclusion-and-difference paradigm holds that these differences must be measured in order to provide equitable medical care to all groups. Rather than a top-down, state-centered form of biopolitics, Epstein identifies a process of negotiation between state, science, and society. In his case study of minority health activism during the 1980s and 1990s, "inclusion-and-difference" claims were deployed using the mechanism of "categorical alignment," whereby social activists successfully argued that social race categories should also be the operative categories in scientific research and health policy. By presenting their demands in ways that resonated with the language of biomedical research and policy, activists were able to achieve their goal of being included in research that inscribed their differences. This example of negotiated biopolitics presents a striking departure from earlier theories of state-centered, top-down biopolitics. Although the scenario Epstein analyzes bears many similarities to the biopolitical dynamics surrounding the introduction of race-conscious medicine and health policy in Brazil, it also serves as a useful foil to highlight some key differences between the Brazilian and U.S. contexts. As such, I will draw on his work throughout this dissertation.

Other analyses of contemporary biopolitics suggest that the market, rather than the state, has become the ultimate arbiter of biopolitics—particularly in advanced liberal democracies of the West (e.g., Clarke et al. 2003, Rabinow & Rose 2003, Kahn 2004). Although race-based pharmacogenomics and market intervention are beginning to appear in the Brazilian context as well, they lie beyond the scope of this dissertation. When I conducted fieldwork in Brazil between 2005 and 2009, the creation of "black health" (*saúde da população negra*) as a field of medical and political intervention was rooted almost entirely in the realm of public health policy and practice. As I will show in later chapters, black health activists leveraged their universal citizenship right to public health care to make claims on the state for race-conscious health policies and practices.

Overall, the analyses discussed in this section indicate that, although the contemporary medicalization of race has the potential to breathe new life into old racial typologies, the biopolitical rationale at work is somewhat different from the one described by Foucault in *History of Sexuality*. Rather than a state-centered, top-down form of "power-knowledge," contemporary biopolitics involves the "active participation of citizens in the drive for health" (Rose 2001: 6) and is more predicated than ever before on market forces. What this means for the medicalization of race is a greater degree of citizen involvement in negotiating categories and crafting policies that ultimately shape popular consciousness regarding the link between race and health outcomes—for better or for worse.

Race and National Identity in Brazil

As Telles (2004) observes, Brazilians utilize at least three kinds of racial identity models: the traditional/popular model, the Census model, and the model popularized by the black movement. The traditional/popular model features a wide spectrum of terms to describe skin color and physical features. In addition to terms such as "branco" (white) and "preto," (black) it includes many intermediate color terms such as *moreno, mestiço, sarará*, etc. In fact, when IBGE, the Brazilian Census bureau, included an open-response color question on the 1976 national household survey (PNAD), citizens replied with 136 different color terms. The Brazilian Census normally provides only four color/race terms (*branca*, *parda*, *preta*, *amarela*) and one "ethnic" term, *indígena* (indigenous).[6] "Parda" refers to either brown or a grayish color, while "amarela" is yellow or Asian. The Census model is used for official documents such as birth certificates. The bipolar model propagated by the black movement emphasizes the terms branco (white) and negro (black), where "negro" encompasses all people with (usually, visible) African ancestry.

Brazilians' preference for phenotypic description, rather than pseudo-biological classification using fixed categories, reflects their widespread belief that many Brazilians embody a racial mixture. This belief is evident in figures from the 2000 Brazilian Census: nearly 40% of Brazilians classified themselves as brown (pardo), meaning racially mixed. In everyday life, someone who is officially classified as pardo may be referred to as

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[6] There is significant ambiguity embedded in the question posed by Census takers: *Qual é sua raça ou cor*? [What is your race or color?]

moreno, *mulato*, *mestiço* or a whole host of other terms that denote mixed ancestry. Silva (1998) attributes this multiplicity of color terms to Brazilians' collective assumption that separate races do not exist in Brazil.

In addition to asserting a mixed-race national identity and denying the existence of racism in Brazil, Brazilians have traditionally constructed racial identity as a malleable condition rather than an essential one. The ethos of whitening (*branqueamento*) constitutes a major ideological tool through which this is accomplished. "Whitening" refers both to a pseudoscientific theory and to a social practice. During the late 19th and early 20th centuries, prominent scientists and intellectuals affirmed that the Brazilian population was growing progressively whiter due to miscegenation and the mass influx of European immigrants following the abolition of slavery (Skidmore 1993a). Although this belief was subsequently debunked, the ethos of whitening continues to influence racialization practices in Brazil. As a social practice, "whitening" refers to Brazilians' tendency to identify with the lightest racial category permitted by their skin color. Socioeconomic class also plays an important role in social whitening. There is a popular saying in Brazil that "money whitens" (*o dinheiro embranquece*), meaning that higher socioeconomic status may allow an individual to be identified with a more desirable race category than someone of similar appearance but less material wealth. Brazilian "whitening" is often contrasted with the U.S. practice of "hypodescent," or the tendency to assign mixed-race individuals in the United States to the more socially subordinated racial identity they embody, e.g., "black" instead of "white."

Although Brazilians' aesthetic hierarchy privileges European features and light skin over African features and dark skin, Brazilians tend to identify strongly with a discourse of mixed-race national identity. This discourse is often accompanied by the argument that, due to a high degree of racial mixing, racial discrimination cannot logically exist in Brazil. The negation of racism based on a discourse of pervasive miscegenation is a key component of the Brazilian ideology of racial democracy (Skidmore 1993a). The ideology is likewise bolstered by the value placed upon cordiality in interpersonal relations in Brazil; many Brazilians claim that there is no racism in their society because people of all colors interact within the same social spaces. Florestan Fernandes, a prominent sociologist of race in Brazil, famously characterized Brazilian cordiality as the "prejudice of having no prejudice."

In the last few decades, the ideology of racial democracy has been dealt serious blows by events such as the Brazilian state's admission that racism is a significant problem in Brazil. Former President Fernando Henrique Cardoso spearheaded this shift in official discourse when he acknowledged the existence of racial discrimination in Brazil during his 1995 inaugural speech. Cardoso also proclaimed in his Independence Day speech later that year that "we wish to affirm, and truly with considerable pride, our condition as a multi-racial society and that we have great satisfaction in being able to enjoy the privilege of having distinct races" (Fry 2000: 100). His statement ran counter to the powerful theme of racial amalgamation present in the Brazilian nationalist text.

In 1996, Ministries of Justice and Foreign Affairs hosted an international conference on "Diversity, Multiculturalism, and Affirmative Action." According to Reichmann (1999: 20), this was the first time such concepts had appeared within the context of a national-level, state-sponsored event in Brazil. These concepts are important for affirmative action discourse because they reinforce the notion of distinct, discrete cultures coexisting in a “diverse,” “multicultural” polity. This idea runs counter to the traditional Brazilian ethos of cultural unity achieved through centuries of miscegenation.

In order to understand the contemporary paradigm shift in Brazil’s policy on racial inequalities, it is necessary to understand how racial ideologies and national identity were co-constituted historically in Brazil. A confluence of state policies and discourses produced by the intellectual elite led to the crafting of a particular nationalist text concerning race, aspects of which endure to the present day. Throughout the nineteenth century, the two major issues confronting the Brazilian state were abolition and nationhood (Holston 2008). Intellectual production of the time reflects a continual preoccupation with formulating a sovereign, unique national identity. This objective was complicated, however, by the fact that much of the population was of color—which, according to European racial determinists of the day, sounded a death knell for national progress (Skidmore 1993a). As pressure for abolition increased domestically and from abroad, Brazilian intellectuals countered racial determinists’ condemnation of their racially mixed population with the theory of whitening (*branqueamento*). This theory held that people of color were steadily disappearing from the Brazilian population through miscegenation with whites. The *mulato* was tentatively accepted as the face of the nation, but only with the accompanying understanding that he would grow progressively whiter (Skidmore 1993a).

In the years surrounding the abolition of slavery, the Brazilian government began to implement several pro-European immigration policies. In 1850, the state passed the Land Law (Lei de Terras), which subsidized land sales to European immigrants in exchange for labor. The law also dissolved the previously existing principle of land ownership through occupation. Henceforth, the law stipulated, all agricultural land holdings deemed unproductive would be returned to the Crown (Holston 2008: 131). The passage of this law reflected the state's desire not only to render Brazilian landholdings more productive, but also to gradually substitute slave labor with immigrant labor. The net effect of the law was to deny property to poor immigrants and citizens (Holston 2008: 133). Furthermore, the law did little in terms of land reform; most of Brazil's arable land remained in the hands of a rich few. Thousands of European immigrants who were unable to acquire or maintain land joined the masses of urban poor in the cities. Over generations, immigrant and Brazilian-born populations intermingled and co-constructed the urban periphery of cities such as São Paulo.

On May 13, 1888, the institution of slavery was abolished by means of the Lei Áurea (Golden Law). Following abolition in 1888, there was significant social disruption and, from the point of view of the elite, minimal integration of the slaves into the economy and civil society. Brazilian intellectuals of the time predicted that the presence of African cultural influences would cripple the nation's progress toward modernization. Sílvio Romero was one of the first scholars to defend the premise of whitening through miscegenation. In *História de literatura brasileira* (1888), he praised the mulatto as embodying the true spirit of Brazil, but continued to privilege the contributions of the Portuguese over those of the Indian and the African in the construction of Brazilian "civilization." At the same time, he claimed that the population was gradually growing whiter.

The Brazilian public health apparatus began to flourish in the second half of the nineteenth century in response to epidemics spurred by immigration and urban congestion in Rio de Janeiro and São Paulo (Stepan 1981). The most serious threats to public health were the yellow fever epidemics of the early 1850s and early 1870s that affected Rio de Janeiro and several other areas. Chalhoub (1993) argues that the medical ideology deployed by the state during the yellow fever campaigns in Rio dovetailed with reigning ideas about race. Since elites desired an influx of European immigrants to expedite their whitening project, they chose to focus their energies on eradicating yellow fever, which affected elite whites more than blacks, rather than on staunching the flood of mortality by smallpox and tuberculosis among the urban poor. Chalhoub argues that both elites' action and *in*action demonstrated that they were "changing the environment in order to help nature" to eliminate blacks from the nation (462). Fear of contagion from blacks led the municipal government to raze their *cortiços* (poor urban dwellings) and banish them to the periphery where they constructed *favelas*.

The late nineteenth-century development of Brazil's public health system was prompted not only by epidemics, but also by popular intellectual paradigms of the time such as Darwinism and Positivism. Stepan (1981) argues that the introduction and circulation of these ideas within Brazil encouraged intellectuals to seek scientific solutions for social problems. Borges (1993) refers to this process as the "medicalization of social thought" and documents the prevalence from 1880-1940 of medical and social theories regarding the prevention of environmental and hereditary degeneration in Brazil. The push for hygiene and sanitation was intimately tied to Brazil's modernization project, which was threatened by racial and climatic determinists' condemnations of the country's capacity for progress. Stepan (1981) interprets the development of public health and medical science in Brazil as an attempt to overcome these negative predictions through an emphasis on “cleaning up” the social and natural environment: “through science Brazil could escape an historic fatalism concerning its ability to change events, and the nation could emerge as part of the modern, civilized world” (58).

The concept of using science to improve the population went hand in hand with theories of scientific racism. Scientific racism was based on theories of Social Darwinism and race evolution, and drew on the work of intellectuals and scientists such as Spencer, Gobineau, and Lombroso (Johnson 2002). Two key components of scientific racism were purification and hierarchy: “pure” races were supposedly stronger and more stable than hybrids, and whites were considered superior to blacks, mulatos, and indigenous Brazilians. Around the turn of the century, scientific racism in Brazil continued to coexist with theories of whitening that were bolstered by immigration policies (Skidmore 1993a). For example, in 1890 the Brazilian government prohibited the entry of African and Asian immigrants without a special exemption from Congress (Johnson 2002). Similarly, between 1890 and 1920 the state of São Paulo offered financial incentives to help attract European immigrants.

Explicit support for theories of scientific racism peaked around the turn of the century, but slowed significantly with the arrival of the *belle époque* around 1914. Skidmore (1993a) observes, however, that even after the scientific community rejected scientific racism, the Brazilian elite continued to espouse racist sentiments. The main difference was a shift in the language used, from terms such as racial “inferiority/superiority” to discussions of “ethnic integration.” It was a softened discourse surrounding the same principle of whitening (207).

Scientific racism was eclipsed by the eugenics movement of the 1920s. The Brazilian eugenics movement was largely “positive” in character, meaning that the focus was on Lamarckian theories of hygiene and sanitation rather than on restricting marriage and reproduction practices, as was the case in other Latin American nations around the same time (Stepan 1991). Once again, it was believed that healthy practices could strengthen the Brazilian “race,” thus contributing to the modernization of the nation. Carneiro (1994) suggests that eugenics played a significant role in dictator Getúlio Vargas’ (1930-1945) populist ideology that emphasized discipline of body and spirit, in addition to racial “strength.” At the same time, Vargas’ national propaganda included a celebration of the country's unique mestizo culture.

Intellectual support for the principle of whitening remained popular through the 1920s and 1930s, the period during which the social sciences were consolidated in Brazil. Lima (2007) argues that there were clear parallels between the sanitizing discourse of public health and the ideology of whitening; both proposed the strategy of gradually eliminating undesirable elements from the body politic and replacing them with stronger, purer ones. However, by this point Brazilian biomedical literature rarely, if ever, mentioned race explicitly. Rather, public health discussions of race usually invoked the “Brazilian race” (*a raça brasileira*), especially in terms of strengthening the population through public health interventions.

Beginning with the 1930s, intellectual discourses on race changed dramatically. Sociologists and anthropologists began to publish significant literature on African cultural contributions to *brasilidade* (Brazilian-ness). Gilberto Freyre's work is generally considered to have had the greatest impact ever on the Brazilian race imagination. His seminal work *Casa Grande e Senzala* (The Masters and the Slaves) (1933) praised indigenous and African cultural contributions to Luso-Brazilian civilization. Freyre glorified the Portuguese colonizers' superior capacity for miscegenation, which supposedly led to the forging of an authentic Brazilian mestizo subject. This ideology, subsequently labeled "Luso-tropicalism," held that the Portuguese colonizers of Brazil were accustomed to "intermixing" with Africans and Asians. Due to this contact, he reasoned, the Portuguese were a more hybrid people and therefore could not be racist. Freyre also refuted the idea of innate racial degeneracy among blacks, claiming that any negative traits they were thought to possess, such as indolence, resulted from their former condition as slaves. Ultimately, however, Freyre did not abandon the idea that blacks and Indians were socially inferior subjects. Skidmore (1993a) argues that Freyre unintentionally reinforced the whitening ideal by portraying Indian and black Brazilians as weak subjects, whereas the Portuguese colonizer appeared as a strong, paternal figure. Nonetheless, *Casa Grande e Senzala* propagated the idea that Brazil could be a modern, progressive nation while celebrating its mestizo heritage.

Freyre's best-known legacy, and the central tenet of *Casa Grande e Senzala*, is the image of Brazilian society as a "racial democracy" wherein the three constitutive races receive equal opportunity and treatment. These ideas dovetailed with Vargas' populism and bolstered Brazil's reputation abroad as a racially tolerant nation. The ideology or myth of racial democracy has since been subjected to significant criticism, principally by social scientists in Brazil and abroad.

Freyre was followed during the 1940s and 1950s by scholars of African cultural "retentions" in Brazil. These scholars, who included Ruth Landes (1947) and Melville

Herskovits (1966), predicted that as “archaic “Afro-Brazilian practices disappeared, Brazil would become increasingly modern (Brown 1999). Agier (1995) notes two main trends in academic production on Afro-Brazilians during this period: first, racial differences were interpreted in terms of social class, and were thus predicted to disappear with economic modernization; and second, a significant dichotomy arose between sociological analyses of black populations in industrial areas, on the one hand, and anthropological analyses of Afro-Brazilian cultural practices, on the other.

In 1950, UNESCO funded a large-scale research project on race relations in Brazil. The purpose of this study was to highlight the ease of relations between people of different colors in Brazil, which would serve as a model for the rest of the world. Researchers on the project included Charles Wagley, Roger Bastide, Thales de Azevedo, Marvin Harris, Florestan Fernandes, and Fernando Henrique Cardoso. The focus was on the socioeconomic status of *pretos* and *pardos*, which was shown to be significantly lower than that of whites. For the first time, the ideology of racial democracy had been challenged through statistical data. The new school of thought that resulted from these studies is often referred to as “racial revisionism” since racial dynamics were approached in a new way by “revisionist” scholars (Winant 1994).

The UNESCO researchers attempted to explain how economic inequality between the races could exist in a racial democracy such as Brazil. The fact that they framed their response in this way implies that they were operating under the assumption that Brazil was, indeed, a racial democracy. Researchers such as Thales de Azevedo and Fernandes predicted that the “race problem” would disappear through the continued social and cultural assimilation of black Brazilians. Fernandes (1964) came closest to refuting the validity of the myth of racial democracy. Other revisionists focused solely on the class problem, which they saw as the true cause for inequality between the races. Winant (1992) adds that the revisionists did not consider the social construction of race, but instead viewed existing racial categories as a given.

Beginning in the 1960s, the Brazilian government's stance toward Afro-Brazilian culture changed significantly. The administration of Jânio Quadros (1961) was short-lived but had a significant impact on official discourse regarding African contributions to the nation. Quadros initiated an era of reaching out to decolonizing African nations and promoting Brazil as a cultural bridge between Africa and the West (Santos 2005). He did this primarily in the interest of possible arms sales to African nations, as well as to mitigate potential competition in the area of agriculture from nations with climates similar to Brazil's. Quadros envisioned a political alliance of post-colonial Third World countries in Asia, Africa, and South America, with Brazil as the South American leader. Within Brazil, he created a series of programs and centers destined for the study of Afro-Brazilian culture. Quadros' successor, João Goulart, continued to praise African contributions to Brazilian culture and endorsed the ideology of racial democracy (ibid).

In 1964, a military junta seized the Brazilian government and transformed it into a military dictatorship for the next two decades. The military government opted to remove the color question from the 1970 Census on the grounds that it was irrelevant. According to Nobles (2000), "...military leaders displayed low tolerance for discussions of any sort about race. They characterized criticism of racial democracy as 'acts of subversion'" (111). Skidmore (1993) also attributes the military government's removal of the color question to its reluctance to highlight racial inequalities in the country. This posture did not last long, however, since the Census bureau's 1976 national household survey (PNAD) utilized two kinds of color questions: an open response one, and one with fixed, pre-formulated options. Moreover, the color question was reinstated on the 1980 Census and has been present ever since.

In the 1970s, a group of scholars referred to as the "post-revisionists" or "structuralists" began to theorize racial inequality as a central governing technology of the Brazilian state (Hasenbalg 1979). They argued that the Brazilian state depended upon the racial hierarchy in order to function as a capitalist society. Hanchard (1994) criticizes the structuralists' economic reductionism, or their perception of racial inequality as a function of class, as well as their failure to attribute agency to black Brazilians. Their focus, he claims, was on white domination and economic forces instead of on the political construction and contestation of racial inequality. Winant (1992) also notes that the structuralist theories are no different from the revisionist ones in their class reductionism. He adds that the relative political conservatism noted by structuralists on the part of Brazilian blacks can be attributed to the ban on political activity that was imposed by the military dictatorship at that time: "The structuralist problematic—of a frozen racial inequality, 'smoothly maintained' by an all-powerful elite—stemmed from the conjuncture in which it emerged" (182). This political scenario was soon to change.

In the wake of economic disappointments and denunciations of the military regime's human rights violations, the government embarked upon a process of redemocratization in 1975. The late 1970s and 1980s were known as a period of *abertura* or "opening" following the strict repression of civil society. Gradually, political associations and interest groups began to contest their lot in society and demand change. Black activism formed a significant component of this new political backdrop.

Black Movement Activism

My use of the term “black movement” comes from the Portuguese term “movimento negro.” I use the term in accordance with academic literature and Brazilians’ common use of the term to denote a set of political and cultural organizations generally dedicated to the empowerment of black Brazilians and the valorization of black identity in Brazil. When I refer to the “black movement,” it is with the acknowledgment that there is no single black movement in Brazil, but rather a plethora of organizations with diverse membership and areas of focus.

Since its beginnings in the early twentieth century, black movement activism in Brazil has constituted a reaction to the ideology of racial democracy. Bacelar (1989) notes the following general characteristics of black movement organizations: a strong emphasis on black identity; the adoption of a binary model of race (black and white); denunciation of the myth of racial democracy in Brazil; commitment to procuring better social, economic, and political conditions for the black population; commitment to acknowledging the importance of the *negro* in the construction of Brazilian society; and commitment to preserving and protecting “black culture” (*cultura negra*) against undesirable commercialization and folklorization by hegemonic sectors of society (88-89). Brazilian black movement organizations engage in diverse activities such as promoting candidates from their own ranks for political office, staging public protests, organizing Afro-Brazilian cultural events, and holding lectures and conferences to discuss various subjects concerning the “black community” (*comunidade negra*), as activists often call it. The central ideological aspect of Brazilian black movement activism to be explored in this dissertation is the explicit emphasis on the construction of a particular black identity, which is based on an “African” phenotype and the affirmation of certain cultural and, increasingly, biological characteristics assumed to be essential to a collectivized black identity.

São Paulo has been the central site of black movement activism throughout Brazilian history (Hanchard 1994). In addition to a number of São-Paulo based black press organizations that arose in the early years of the twentieth century, the Frente Negra Brasileira (Black Brazilian Front) emerged there in 1931. The Frente demanded full socioeconomic integration for blacks and denounced the state government’s intense recruitment of European immigrants. Frente activists’ main tactics included public protests and organized “invasions” of clubs and associations in the city that prohibited blacks from entering. The Frente managed to become a political party in 1936; it remained active until 1937, when populist dictator Getúlio Vargas shut it down, in addition to all other political parties.

The next wave of black movement activism was characterized by cultural production, ostensibly because artistic activity was considered less of a political threat to the state than outright political organizing. One of the most famous black cultural movements of the 1940s through the 1960s was the Teatro Experimental do Negro (Experimental Black Theater, or TEN), which was created in Rio de Janeiro by Abdias do Nascimento. In addition to theatrical productions that strived to improve the perception of black aesthetics in Brazil, TEN sponsored Afro-Brazilian cultural and literary events. Additionally, TEN published a literary journal, *Quilombo*, which ran articles about black culture and politics in Brazil. In the mid-fifties, the Associação Cultural do Negro (ACN), another major black cultural organization, flourished in São Paulo. The sixties saw the rise of the Black Power movement in Brazil, which centered much more on aesthetics than on political organizing. By the late 1960s, all black movement organizations had been effectively repressed by the military dictatorship.

Activists and scholars usually identify the 1978 creation of the Unified Black Movement (Movimento Negro Unificado, or MNU) in São Paulo as the start of a new, revitalized black movement in Brazil (e.g., Hanchard 1994). Since that time, countless black movement organizations have sprung up around the country. Some focus generally on improving the life conditions and image of blacks in Brazil, while others are dedicated to more specific causes, such as Afro-Brazilian cultural rights, black women's reproductive health, or the preservation and empowerment of historical maroon communities (*comunidades remanescentes de quilombos*). Contemporary black activists in Brazil have constructed hybrid, globalized black identities (Sansone 2003). In so doing, they have taken ideological cues from liberation movements in the Caribbean, Latin America, and Lusophone Africa as well as from the U.S. black civil rights movement.

Public Health in Brazil

In order to fully appreciate the significance of race-specific health care in Brazil, it is necessary to understand the citizenship ideologies underpinning the Brazilian public health system. The health care system in Brazil consists of vastly unequal public and private tiers (Almeida et al. 2001). Citizens who have the means to purchase private health insurance, or who receive it through their employer, are able to access first-rate private medical care. Those without access to health insurance depend on universal, though often precarious, public health services. Although there are significant regional differences in the quality of care and the availability of medications and medical technology, Brazil's universal health care represents an important advance in the social contract between the Brazilian state and citizens.

The Sistema Único de Saúde (Unified Health System, or SUS) was born from the 1988 Brazilian Constitution, which introduced several important innovations regarding the way health would be conceptualized by the democratizing state. For the first time, health became a universal citizen's right and the state became formally responsible for guaranteeing "universal and equal access" to health care (Brazil 1988). Prior to the creation of SUS, many public health services were available only to citizens with a registered employment card (*carteira de trabalho assinada*) since social security financed a large part of public health care. Since the implementation of SUS, the state has provided a full array of primary and complex, preventive and curative medical services to all citizens.[7] As Petryna (2009) has noted for the Ukraine, Brazilians increasingly exercise their "medical citizenship" by making legal claims on the state to provide high-cost medications and medical procedures (*passim*).

Major innovations of SUS include a focus on primary and preventive health services and the institutionalization of community participation in the planning, monitoring and evaluation of health care. The premium SUS places on community participation has produced countless partnerships between public health departments and

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[7] This is also the case for non-citizens. During the nearly five years I spent in Brazil, I often accessed public health services.

civil society organizations, as well as creating participatory health councils composed of citizens, public health providers, and public health administrators. Since the advent of SUS, citizens have been expected to exercise "social control" (*controle social*) of health services by monitoring them and, in a limited capacity, helping to plan them.

The Health Reform Movement (also known as *Reforma Sanitária*, or Sanitary Reform movement) that led to the creation of SUS arose within the context of re-democratization in Brazil. One of many new urban social movements that emerged during the late 1970s and 1980s, the Movement demanded improvements for the ailing national health care system. In addition to health activists from a variety of NGOs and neighborhood associations, the Movement was comprised of public health professionals, professors, and community activists from neighborhood associations (Cohn 1995). Although there were many smaller popular movements organized around obtaining better local health care facilities, the Health Reform Movement was the largest, most diversified, and most durable of them all. Weyland (1995) argues that the Health Reform Movement was more successful due to the elevated social position of many of its members, who managed to penetrate the State by occupying seats in federal- and state-level institutions that influenced policymaking, such as the Ministry of Health, the Ministry of Social Security, and state-level health departments (*secretarias de saúde*).

The Movement's demands included a curb on privatization and the over-emphasis on curative, rather than preventive, services; strengthening of the public sector to provide equal access to health care for all citizens; an increased focus on preventive measures, especially vaccination and sanitation, in order to bring down health care costs; decentralization of health care management to the state and municipal spheres of government; and a focus on providing basic care to the poor (Weyland 1995). The peak of the Movement's influence occurred shortly after the Eighth National Health Conference (1986), when activists presented a proposal outlining their demands to the National Constituent Assembly. Many of their demands influenced aspects of the new Constitution, although subsequent conservative legal interpretation of these principles allowed for a significant degree of outsourcing and privatization of services (ibid).

Despite the relationship between eugenics and the "sanitation" goal of public health in early 20th-century Brazil, race was not an explicit object of biomedical research or epidemiological analysis in Brazil prior to the 1990s. This does not mean that Brazilian medical research and practice were unconcerned with race. During the nineteenth century, some medical researchers drew clear associations between blackness and physical or mental degeneracy (Peard 1999, Skidmore 1993a). However, there was no Brazilian Tuskegee; because post-1920s Brazilian race ideology did not rest on the premise of absolute racial difference, but rather on racial hybridity, there was no cultural logic to support the conceptualization of blacks as a physically distinct population (Silva 1998).

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Ethnographic Field Sites

My study of race and health disparities in Brazil led me to many places in northeast and southeast Brazil between 2005 and 2009. Multi-sited ethnography was an important element of this study, given both the national-level implementation of black health policy, and the vast socioeconomic and cultural diversity that exists among different regions of the country. In general, multi-sited ethnography helps to illuminate trends in the data that would not otherwise be visible and prevents the overgeneralization of findings from one site to an entire field (Marcus 1998). I begin with a brief overview of each of my field sites.

My long-term fieldwork in 2007-2009 consisted of one year in São Luís do Maranhão, followed by a second year in São Paulo. I chose these two cities because my preliminary fieldwork had revealed that northeast and southeast Brazil were particularly active regions of citizen activism and policymaking around race-based health inequalities. The most active locations were major capital cities in the northeast, such as Salvador, Recife, and São Luís, while the most active sites in the southeast included Rio de Janeiro and São Paulo. In the end, I chose São Luís because it was the founding site of the National Network for Afro-Brazilian Religions and Health, which I discuss in detail in Part III. Additionally, I chose São Luís because fewer researchers were examining the creation of black health initiatives there than in Recife or Salvador. I chose São Paulo because it presented a useful ethnic and socioeconomic contrast to São Luís that enriched my understanding of the ways in which the racialization of health policy and health care were unfolding in drastically different parts of the country. Furthermore, despite the existence of sociological research on black health activism in São Paulo, there was little, if any, research on the nexus between black movement activism and Afro-Brazilian religious activism in the area of health.

São Luís is the capital of Maranhão state. Its population in 2010 was a little over a million.[8] São Luís has a hot, humid, tropical climate and is located partially on an island, with bridges linking different parts of the city. The waters surrounding the city are grey

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[8] Source: www.ibge.gov.br/cidadesat. Last accessed February 27, 2011.

and brackish; each day the bay empties out completely, leaving canoes and small boats immobile atop a muddy bank, and then floods again, replenishing itself. Maranhão is the poorest Brazilian state, and even though the infrastructure in urbanized São Luís is much more robust than in Maranhão's rural interior, the city remains significantly underdeveloped. Despite the historic center's status as a tourist destination, the remainder of the city displays the marks of pervasive poverty. These include regular citywide power and water shortages and a large number of shantytowns (*invasões* or *favelas*), many of which are wooden shacks mounted on spindly wooden stilts over sewage-polluted water (called *palafitas*). In 2009, approximately twenty-four percent of São Luís' population self-identified as white (*branca*), seven percent as black (*preta*), sixty-seven percent as brown (*parda*), and one percent as Asian (*amarela*) or indigenous (*indígena*).[9]

São Paulo is the capital of São Paulo state, the wealthiest state in Brazil. It is Brazil's largest city and the world's seventh largest metropolitan area. When I first arrived in São Paulo in May 2008, the city seemed to me like an unfathomable concrete jungle. I had been living in São Luís for nearly a year, and the southern hemisphere winter could scarcely have looked more different between the two cities; it was swelteringly hot in São Luís and bitingly cold in São Paulo. The thick vegetation and ramshackle houses of São Luís were replaced by skyscrapers and asphalt as far as the eye could see. The common sight of donkey-drawn wagons and people dawdling along in shorts and T-shirts in São Luís gave way to businessmen and women in suits, rushing up and down Avenida Paulista and queuing up for the *metrô.* Of course, my initial impression of São Paulo was shaped by the fact that I arrived in the city center and stayed

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[9] Ibid.

there while I got my bearings. Later, I would venture into the urban periphery and visit *favelas* and *invasões* that reminded me of some of the ones I had visited in São Luís. Nonetheless, during the year I spent in São Paulo, I was continually awed by its incredible diversity and sheer magnitude.

The city of São Paulo registered over eleven million inhabitants in 2010.[10] The population density is roughly 7838 people per square kilometer, as compared to 1211 in São Luís. São Paulo's per capita GDP in 2008 was more than twice that of São Luís (roughly US$19,550 in São Paulo, as compared to US$8,977 in São Luís). Although both cities have high Gini coefficients (45 in São Paulo and 49 in São Luís), indicating significant socioeconomic inequality, in 2010 about twenty-nine percent of *paulistas* were living in poverty, as compared to nearly fifty-five percent of *ludovicenses* (residents of São Luís).[11] Figure 1 shows the distribution of income throughout Brazil in 2000. I have inserted arrows pointing to São Luís and São Paulo. The figure makes apparent the significant disparities in income distribution between northeast and southeast regions of the country, and particularly around São Paulo and São Luís. The darker spots represent higher income, while the lighter spots represent lower income.

São Paulo is Brazil's most ethnically diverse city, with substantial enclaves of Italian, Japanese, and Arab descendants. The city also has a huge immigrant population, with particularly large numbers of immigrants from Portugal, Japan, Spain, Italy, Bolivia, Korea, China, Chile, Argentina, and Germany. In 2010, roughly sixty-five percent of

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[10] Ibid.
[11] Ibid.

paulistas identified as white, six percent as black, twenty-eight percent as brown, and 1.4 percent as Asian or indigenous.[12]

Figure 1. Household Income, 2000. [13]

Below, Figure 2 shows the distribution of pretos and pardos throughout the country. I have added arrows to indicate São Paulo and São Luís on the map, and would call the reader's attention to the significant difference in ethnic composition between the two locations.

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[12] Ibid.

[13] Source: www.ibge.gov.br. Last accessed February 26, 2011.

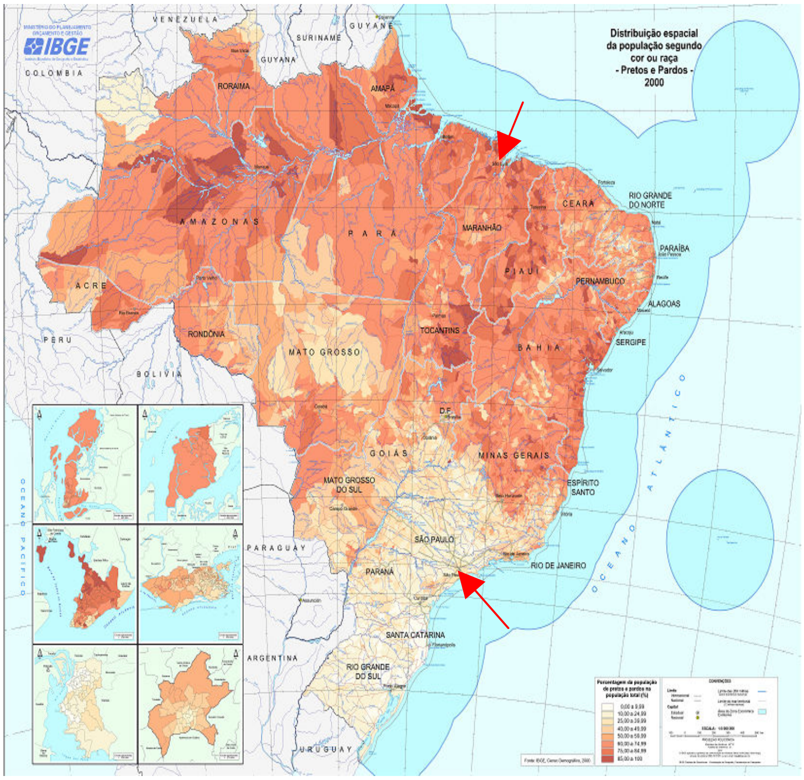

Figure 2. Distribution of Race/Color (Pretos and Pardos), 2000.[14]

It would be difficult to overstate the difference between living in São Luís and living in São Paulo. There are enormous geographical, climatic, socioeconomic, cultural, and ethnic differences between the two cities. Ludovicenses and paulistas speak with different accents and display local variations in inflection, vocabulary and even grammar; ludovicenses prefer to conjugate their verbs using the second-person singular pronoun *tú* while paulistas tend to use the more common *você*. Therefore, in relocating from São Luís to São Paulo at the midpoint of my fieldwork, I had to adjust rapidly to different nuances of living, eating, dressing, speaking, traveling, and even interacting socially to a certain extent. Although I had lived alone in a rented apartment in São Luís, the high cost

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[14] Source: www.ibge.gov.br. Last accessed February 27, 2011.

of living in São Paulo led me to rent rooms in others' apartments. In São Luís, a significant part of my week was spent shopping for and cooking fresh food, hand washing my clothing, and battling one insect infestation after another inside my apartment. I frequently had to collect water in buckets in anticipation of water shutoffs. I wore light sundresses and sandals throughout the year, and I usually travelled to field sites by bus or by collective van *(transporte coletivo*).

In São Paulo, by contrast, I relied heavily on pre-packaged foods and precut vegetables and fruits from the local grocery store, as I tend to do in the United States. I laundered my clothing at home in the washing machine, which was considered a luxury in São Luís but was commonplace in São Paulo. The house and apartment I shared in São Paulo came with access to high-speed, wireless internet, which was a boon after the dial-up connection I had endured during my year in São Luís. I often traveled by subway to field sites in São Paulo, although I often had to take buses when going to the periphery, and then public vans (*peruas*) to my final destination once I arrived in the right neighborhood. In terms of social interaction, my interactions with informants were much more intimate in São Luís than in São Paulo. In São Luís, I often found myself eating meals at people's homes and being invited to stay the night when events ended late. In São Paulo, by contrast, my informants tended to keep me more at arm's length, in that most of our interactions took place in public spaces rather than in their homes. This was due in part to the size of the city, which meant that my informants were scattered around the four corners of the city. Usually, I ended up meeting informants in the city center, unless I was visiting a *terreiro* (temple of Afro-Brazilian religion) or doing household surveys or clinic visits (really, short interviews) in the periphery. While this scenario did not conform to my idea of traditional ethnography, it quickly became apparent that I would need to adjust my expectations, given the hurdles of distance and transport in São Paulo.

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In the next chapter, I explore the racial narratives of Brazilian patients and health care providers. My intent is to establish a “baseline” of Brazilians’ everyday understandings about race and health that will help the reader understand the sharp contrast between the ideological claims of Brazil’s new black health initiative, and the cultural context into which it is being introduced.

Chapter 2: Everyday Narratives on Race, Racism, and Health

Toward the end of my year of fieldwork in São Paulo, I began to teach English to supplement my income. Mário, one of my students, was a financial consultant at one of São Paulo's many multinational firms. His wife, Angela, was a social worker for São Paulo's public health department. Both white *paulistas* in their early twenties, Mário and Angela lived in Liberdade, São Paulo's Japanese district. Liberdade is a middle-class neighborhood located near the city center. One night after our English class, as Mário and Angela gave me a lift to the Liberdade subway station, they asked me about my research. When I described my topic, the following conversation ensued:

> **Mário:** But why should there be a health policy for blacks? That sounds like racism.
>
> **Angela:** No, we had to take a workshop about that at work. Blacks have specific health issues because they are more—genetically they have issues, like they are born with sickle cell anemia because it's a disease of the black race, and they also suffer more from lots of other health problems. Like having diabetes and hypertension that are more complicated [than in whites].
>
> **Mário:** Ah, yes. In that case, it makes sense—if they have specific genetic issues, like for instance the way blacks are better at sports.

This exchange exemplifies several common themes that arose frequently in my conversations with Brazilians about black health issues. Mário, like many Brazilians, considered policies for specific racial groups to be divisive and even racist—unless, that is, they addressed blacks' genetic differences. In other words, he did not see the need to create a special health policy for blacks based on racial discrimination or social inequalities between blacks and whites; the only acceptable reason to treat blacks differently, in Mário's opinion, was their greater genetic predisposition to certain diseases. Mário also expressed his belief that blacks are genetically unique in some way that confers superior athletic prowess.

Meanwhile, Angela had learned at work that black patients had worse health problems than whites, although she could not articulate exactly why that was the case. Like Mário, she seemed to find the genetic explanation most plausible. After all, she had learned that sickle cell anemia was a "black disease," and she knew that it was genetic. From there, she applied the genetic explanation to other health problems from which (she had learned) blacks suffered disproportionately, like diabetes and hypertension.

When I discussed the National Health Policy for the Black Population with other Brazilian friends and acquaintances, they often brought up the race-based affirmative action quotas that had been instituted in several Brazilian universities in 2001. Many denounced affirmative action in both education and health as examples of "puta racismo" ("damned racism"). Not surprisingly, this reaction was more common in white or lighter-skinned Brazilians than in black or darker-skinned Brazilians.

Several months earlier, I had attended a course for community volunteers at a large public hospital in São Mateus, a low-income area of São Paulo. The course, titled "Saúde da População Negra e Controle Social" (The Black Population's Health and Social Control), had been organized and paid for by the state health department of São Paulo. The course was meant to encourage active community members to "monitor" (*monitorar*) the implementation of a new race-tracking system at the hospital. All hospital employees had taken the course and had been trained to ask patients, "What is your color or race?" (*Qual é sua cor ou raça?*) at intake and during medical consultations.

The course instructor, Arlene, was a black health activist and nurse's assistant. She and the students, who were mostly adults in their forties and fifties, lived in low-income neighborhoods scattered around the impoverished Zona Leste (East Zone) of São Paulo. Arlene had very light brown skin and identified as *negra* (black), while the students represented many different phenotypes and racial identities. The class took place in a hospital meeting room with flimsy-looking white walls that resembled particleboard. Around nine in the morning, when most of the students had arrived, Arlene called the class to order. She stood in front of the raised platform, on the same level as the students, who sat at student desks in a semi-circle formation. First, Arlene reviewed the question that she had assigned as last week's homework: "Why is the black population's health important?" ("Saúde da população negra: para quê?") In other words, she was asking why public healthcare providers should pay special attention to black patients' health issues. She formulated the question in a way that affirmed blacks' health as an ontological entity, distinct from the health of non-blacks. Arlene asked them to go around in a circle and share their responses.

Gilda, a petite white homemaker, answered that it is important "to recognize the black race's specific illnesses" (*reconhecer as doenças específicas da raça negra*). The next student, a middle-aged white woman, responded that "blacks are discriminated against a bit, but then, so is everyone. I am also discriminated against as a white woman [*branquela*]." Others nodded in agreement. She finished with the phrase, "health is for everybody—not just for blacks." Next, a light brown-skinned woman named Zelda commented, “each person should be respected as unique.” Another light brown-skinned woman echoed her white classmate in stating that “health is for everyone—people of all colors, not just for blacks.” Finally, a young black woman with plaits in her hair cited some statistics stating that black men and women die earlier and receive less anesthesia during surgery than whites. She referred to “black people’s illnesses” (*doenças de negro*) and stressed the importance of early detection for diseases like sickle cell anemia.

As shown by this sample of their comments, the students expressed a wide variety of reactions to the idea of a special area of health care devoted to blacks. Three students of about twelve were in favor of public clinics and hospitals devoting special attention to blacks’ “specific” health issues (*doenças específicas*). Only one man, an elderly white Spiritist, believed that race-conscious health policy was warranted due to racial discrimination within the clinics. About half of the students opposed the idea of paying special attention to blacks’ health issues, and several even found it racist. They interpreted it as exclusionary toward non-blacks, even though Arlene had taught them that blacks had in fact been excluded from quality health care in Brazil.

Furthermore, the students who expressed resistance to the new policies seemed to believe that public clinics would henceforth prioritize black patients over non-black patients. This belief emerges in the oft-repeated phrase, “health for all” (*saúde para todos*), and reveals the students’ view of public health as a limited good. “Health for all” had been a rallying cry of the Popular Health Movement (Movimento Popular da Saúde) during the 1980s, when citizens fought for the right to universal public health care in Brazil. Now, when students were faced with the prospect of race-conscious health care, they revived their slogan but imbued it with a slightly different meaning—whereas before, they uttered “health for all” to protest the exclusion of the non-employed from public health care, they now used it to mean “no special treatment for certain groups.”

The fact that students framed their opposition in this way also evokes the wider debate within Brazil over affirmative action quotas in public universities and government employment. Although race-conscious health care practices do not involve quotas or prioritizing black patients over non-blacks, the Brazilians with whom I spoke over the years often assumed that they did. More often than not, they would articulate their disapproval of race-conscious health care by denouncing affirmative action quotas in university admissions, thereby conflating the two issues.

I recount these stories not only to illustrate the immense variability of narratives on race and health expressed by Brazilian citizens, but also to highlight the extent to which the idea of race-conscious health care remains a strange concept to many Brazilians. Having grown up in the United States, where minority health initiatives blend relatively easily into the fabric of racialized “common sense”, I was particularly aware of Brazilians’ discomfort with the idea. For most Brazilians, the practice of making racial distinctions between citizens—even with the goal of combating inequality—smacks of racism.

In this chapter, I present ethnographic data from research with patients and health care providers in Brazilian public health clinics and low-income neighborhoods. I show that a majority of patients and healthcare professionals who participated in my study do not perceive health inequalities along racial lines. Rather, they tend to attribute health inequalities to social class. Moreover, my informants tended to categorize racial identity in ways that challenged the race categories deployed by the National Health Policy for the Black Population. Finally, I show that, in response to the disjuncture between politicized versus “commonsense” discourses on race and health in Brazil, both patients and providers routinely circumvent the new race-conscious health measures being implemented in public clinics throughout the nation.

My overall goal in this chapter is to give the reader an idea of how non-activist Brazilians think about race and health. Although it seems plausible that recent shifts in Brazil’s official discourse on race could have a “trickle-down” effect on the Brazilian people’s racial ideologies, this is speculation that lies outside the scope of this dissertation. Instead, I will focus on the following question: to what extent do Brazilians still view race as fluid and situational? Researchers who have studied Brazilians’ everyday uses of discourses on race and color present varying results. Twine (1998) found that white middle-class Brazilians tended to identify both light- and dark-skinned Brazilians of African descent as black (*pretos*). Although whites in the small town where she conducted her fieldwork expressed the discourse of *mestiçagem* (race-mixing) to claim that there was no racism in their town, they consistently discriminated against both light- and dark-skinned African Brazilians when it came to marriage and hiring practices. People of color, on the other hand, tended to “whiten” their racial identity by identifying as *moreno*.

In her ethnography of a Rio de Janeiro favela, Sheriff (2001) argues that residents actually classified race in terms of black and white (*negro* and *branco*), although they used a plethora of terms such as *moreno* and *mulato* to describe people’s phenotypic features. Sheriff draws a distinction between her informants’ conception of race as a deeper, immutable condition, on the one hand, and their understanding of color as a superficial configuration of physical features, on the other. In addition to essentialist (bipolarized) racial discourses and descriptive color discourses, Sheriff identifies a "pragmatic discourse" that serves to soften references to blackness by substituting them with such terms as *moreno*.

Many scholars observe that Brazilians tend to avoid mentioning race or color (e.g., Twine 1998, Goldstein 2003). According to Sheriff, Brazilians' conspicuous silence regarding these topics indexes a collective public denial of racism, although she argues that privately, Brazilians are painfully aware of its prominence in their daily lives. She reads this silence as both a public capitulation to racism and a private, though shared, form of resistance. Brazilian anthropologist João Costa Vargas (2004) contends that Brazilians' reluctance to discuss race actually stems from their hyper-consciousness of unequal racial dynamics within their society. Their silence around issues of race, according to Vargas, serves to reinforce and maintain white supremacy in Brazil.

Patients' Narratives on Race and Health

These features of Brazilian popular race ideology were illustrated repeatedly over the course of my own fieldwork with public health patients in São Luís and São Paulo (see Table 1).[15] I conducted 159 short interviews, each lasting between 10 minutes and one hour, with patients in public clinics and low-income neighborhoods served by the public health system. I focused on public health patients—who tend to live in lower-income areas—rather than wealthier Brazilians with access to private health care, in order to capture the discourses of the population directly affected by the shift toward race-

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[15] Due to practical circumstances, my sample was not randomized, and because of the small data set my results would not be considered statistically significant. Nevertheless, I believe these descriptive data reveal some important trends that shed light on my research questions.

conscious public health policy. I realize, however, that my analysis provides only a partial picture of Brazilians' racial discourses.

In both São Luís and São Paulo, I accompanied community health workers on their routine neighborhood rounds. At each household in São Paulo, I obtained consent and administered the interview to any adult family member who answered the door. Several of these visits stretched into longer conversations, with additional family members and neighbors drifting in and out and contributing to the discussion. I conducted most of the São Paulo interviews in a recently incorporated urban community of Taboão da Serra, a town located in the western periphery of Greater São Paulo. A handful of the São Paulo interviews also took place at a neighborhood association in the Campo Limpo subdistrict. In São Luís, I interviewed clinic patients waiting to be seen in the lower-income neighborhood of Cruzeiro do Anil. I was careful to conduct the interviews on several different days of the week and in various specialty as well as general departments. As Table 1 shows, most of my patient informants were women. This was because clinic directors authorized me to conduct interviews during weekdays, when many men were out either working, or looking for work.

Table 1. Characteristics of Sample Population.

CITY	% MALE	% FEMALE	YEARS OF AGE (avg.)	YEARS OF SCHOOL (avg.)
São Paulo & São Luís	18	82	46.5	6.7
São Paulo	12	88	45.4	5.7
São Luís	23	77	47.8	7.5

Jardim Solidário, the community where I conducted the São Paulo interviews, had an estimated population of 5,000 residents as of May 2009.[16] The community had only recently been urbanized when I began to do fieldwork there. As a result, residents were now receiving regular garbage collection, water, electricity, and mail service. However, there were still occasional water shortages that lasted for four to five days. There were no banks in the area, and only a couple of public telephones. The community had begun roughly thirty years earlier as an *invasão* ("invaded" community) when three migrants from northeast Brazil seized the land and claimed it as their own. They subsequently divided the land into lots and sold them to families, most of whom were also northeastern migrants. The prices varied from 500 *reais* (about US$300 in mid-2009) to a television set.

Although the community had problems with marijuana and cocaine dealers and gangs, the violence had quieted down considerably by the time I did fieldwork there. Two of the community health workers I accompanied on rounds, Alice and Elisa, giggled that there used to be *presuntos* (corpses) in the streets every weekend when they were young. Elisa remembered her mother making everyone lie down on their living room floor while she listened to bullets whizzing past the roof tiles. At the time of my fieldwork, residents reported that there was only about one "presunto" per month on the neighborhood streets. They attributed the decrease in violence to the fact that members of the community's rival gangs had killed each other off.

Jardim Solidário lies flush against a large grocery store, a massive cemetery, and a medical waste repository. There are several evangelical churches and one large Catholic

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[16] Place names have been changed to protect the communities that participated in my study.

church in the area. Flooding is a big problem in the community, since many houses are balanced precariously on sloped dirt lots and many of the roads are unpaved. Residents often lose their homes during the rainy season and are forced to rebuild. The houses vary widely in appearance. Many are bare brick or “Madeirite” (a synthetic wood-like material) with “Brasilit” roofs (sheets of corrugated iron), but others are concrete block and some are painted in bright pastels. When I was there, there were very few cars parked on the streets. Satellite dishes sprang from the tops of many houses, and between the houses were dark, narrow alleyways with tiny steps leading up or down the hill to the next level. Next to many of these alleyways were tiny yards where miscellaneous building scraps had been piled up and abandoned. Lampposts were few and far between, and many of the posts sported a crazily threaded array of “gato” (illegal) wires plugged into the main power line. Several families ran small bars, *lanchonetes* (snack bars), and dry goods stores from their garages.

Although I did fieldwork at three clinics in São Luís, I conducted most patient interviews at an *ambulatório*, or walk-in clinic located within the urgent care facility in Cruzeiro do Anil. In mid-2008, the facility drew a little over 300 patients per day from Cruzeiro do Anil, in addition to many other neighborhoods located in the periphery of São Luís. The clinic offered both emergent and non-emergent general medical care, as well as specialized care on certain days. The clinic’s services included dermatology, gynecology, cardiology, and pediatrics as well as vaccinations and patient education and monitoring groups for diabetics and hypertensives. Since the clinic had lost funding, no dental services were available. The clinic was precariously stocked and staffed, which often sparked outrage among the patients. Each morning, beginning about 6 AM, a long line would form around the block. The line would persist all day from 7-8 AM, when the clinic usually opened, until 6-7 PM, when it was closed to non-emergent cases. It was commonplace to see posted signs declaring “no bandages today” on the clinic’s front wall. Specialists were present for only a few hours on one morning or afternoon per week, thus forcing patients to wait long hours in the hopes of obtaining an appointment slot. My first impression of the clinic was that it resembled a prison; the reception area was protected by a barred door and a full-time security guard. The lone receptionist worked from inside a cage, complaining loudly to his co-workers about the impatient, desperate people in line and scribbling down vital statistics when patients thrust their ID cards through the bars, trying to get his attention. The receptionist, security guard, and custodial staff often referred to the clinic among themselves as a prison (*presídio*) or “loony bin” (*colônia de doidos*).

Although I conducted patient interviews in two disparate cities of northeast and southeast Brazil, the patients’ responses demonstrated a remarkable uniformity. When I asked patients to identify their “color or race” (the format used by Brazilian Census takers), more often than not they would respond with self-conscious laughter, glance at the skin on their own forearms, and ask me what I thought. Similarly, when they answered the question, they would often present their responses in the form of another question, for instance, “I don’t know, *moreno*?” Only fifteen percent of patients referred to themselves as “negro” or “negra,” even when they had very dark skin and prominent African features. Those who identified themselves as “negro/a,” however, tended to pronounce the term in an emphatic way that indicated its charged nature. Only two people referred to themselves as "preto/a," the more traditional term for "black."[17]

Table 2. Self-Identified Race or Color.

CITY	% MORENO	% BRANCO	% NEGRO	% PARDO
São Paulo	33	22	15	19
São Luís	54	14	15	5
São Paulo & São Luís	45	18	15	11

Table 3. Beliefs Regarding Health Outcomes between Blacks and Whites.

CITY	% "NO HEALTH DIFFERENCE"	% "WHITES = WORSE HEALTH"	% "BLACKS = WORSE HEALTH"
São Paulo	54	42	3
São Luís	49	43	4
São Paulo & São Luís	51	43	4

Although 45% of my sample identified as *moreno/a*, indicating their subscription to the idea of racial mixture, 47% expressed the idea that blacks and whites were essentially different at a physical level (Table 3). This was in response to questions about health-related differences between blacks and whites.[18] Additionally, in both cities, interviewees repeatedly told me that blacks are healthier than whites. A striking 43% stated that whites actually have worse health outcomes than blacks. Many people commented that blacks age more slowly, have a lower incidence than whites of diseases ranging from skin cancer to leprosy to AIDS, and generally enjoy better overall health

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[17] In Table 2, I have listed only the four most commonly listed race/color categories.

[18] The color terms were phrased in the respondent's preferred terminology, elicited earlier in the interview. However, many of them answered health outcomes questions using "black" or "white" (*negro* or *branco*).

than whites. Their responses often invoked the trope of blood. Here are some examples of this type of response:

"Whites (*brancos*) suffer more; blacks (*negros*) are stronger. White people are weaker in terms of their blood and cardiovascular health. This comes from their nature."

--64-year-old homemaker, 4 years of school, identified as *branca*

"Blacks (*negros*) are stronger than us and have better health than ours. Their blood has a stronger power and their skin is firmer."

--66-year-old homemaker, 0 years of school, identified as *clara* (light-skinned)

"Blacks (*negros*) have stronger antibodies and hemoglobin (*glóbulos*). The [black] race is stronger, although this also depends on diet. Blacks have more capacity to heal. My mother survived a cardiac arrhythmia. If she were white, she would no longer be alive."

--43-year-old unemployed woman, 12 years of school, identified as *morena*

Other responses asserted blacks' superior tolerance for pain, illness, and childbirth:

"Blacks are stronger than whites. I am diabetic, but I don't feel the symptoms that other diabetics have. I also have high blood pressure, but it's controlled with medication."

--74-year-old homemaker, 11 years of school, identified as *negra*

"People of color (*a cor morena*) are stronger than white people (*a cor branca*). If a *moreno* complains, it means s/he is already very ill."

--71-year-old retired woman, 0 years of school, identified as *morena*

"Whites get sick more often, people of color (*a cor negra*) are more resistant. White women who have had one child look like they've had ten, while black women with four or five children look as if they haven't had any."

--48-year-old college-educated housewife, identified as *morena*

The stereotype of blacks as more physically resistant to pain and suffering is echoed in many countries that participated in the Atlantic slave trade. Harriet Washington illustrates this point powerfully in her book *Medical Apartheid* (2006), which recounts the long history of African-American research subjects' abuse in the name of medical science. When I asked them why blacks would be more resilient (*resistentes*) than whites, several people responded that blacks' ancestors had been slaves and therefore had to be strong and healthy in order to perform slave labor. They implied that these traits were passed on to their descendants.

In contrast, only 4% of respondents stated that blacks suffer from more health problems than whites. Significantly, many of these responses, like those that affirmed the opposite, relied on the trope of blood. For instance, a 50-year-old *negra* homemaker with six years of formal schooling told me, "Blacks have thicker blood. They have more diabetes, cholesterol, and heart attacks. They suffer more." The theme of blacks having "stronger" or "thicker" blood was recurrent. Once, during a visit to a neighborhood association in Campo Limpo, São Paulo, I was interviewing two black women who identified as *negra*, and an elderly man who identified as *branco*. The man was the father-in-law of one of the women, Maria. The other woman, Carol, said, "the black race has more health problems...it's in the blood." When I asked what kinds of illnesses blacks experience disproportionately, Carol responded, "strokes and sickle cell anemia." Maria added that "arthritis and osteoporosis are more prevalent in [people of] our color." When I asked why blacks would suffer more strokes, she replied, "Their blood is stronger. It clogs their veins (*entope as veias*)." Carol and Maria's father-in-law agreed with her.

A few people also mentioned that blacks suffered more from skin diseases, and one person specifically mentioned vitiligo. Of the respondents who claimed blacks have worse health outcomes, few offered non-essentialist explanations for the perceived disparity. For instance, as a 41-year-old *branca* female shopkeeper observed, "blacks do not have good living conditions. When they do not have a clean living environment, their social milieu produces more illness...especially due to [poor] diet." Two other respondents noted that blacks have less time to seek treatment for health problems because they work so much, and that they have less financial resources to seek "quality" (i.e., private) health care.

Overall, however, essentialist explanations for perceived physical differences between blacks and whites dominated respondents' answers about unequal health outcomes according to race. This finding was surprising, considering the affirmation by many scholars (i.e., Skidmore 1993a, Silva 1998) that Brazilians do not believe in separate races, but rather in one Brazilian race with many "colors" (*cores*) or phenotypes. In fact, when I asked my informants to define "race," many replied either that they did not know how to define it, or they rejected the concept outright. A common response was, "race is for dogs. There is only one human race." Whether this was an example of the public denial of race in service of the ideology of racial democracy that Sheriff proposes, I cannot say. But it is difficult to reconcile informants' discomfort with, or rejection of, the race concept with their perception of physical differences between blacks and whites that are significant enough to cause obvious health disparities.

Most surprising of all, however, was the assertion by 43% of respondents that whites have worse health outcomes than blacks. This, combined with the 51% who believed there were no racial health disparities, would most likely constitute a significant obstacle to their acceptance of a health policy to address worse health outcomes among black Brazilians—although, at the time of my research, virtually none of my informants were aware of the new policy. While they were aware that they were now being asked to identify their race or color in SUS clinics, they did not know why (and even that was done on a haphazard basis, as I will discuss below).

My informants' responses corroborate Sheriff's arguments that Brazilians 1) often experience discomfort in discussing race openly; 2) tend to prefer euphemisms for blackness, such as *moreno*; and 3) at times, express a discourse of race (as opposed to color) as an essential biological quality. As my informants' responses showed, Brazilians articulate competing and malleable concepts of race and color. Sometimes they naturalize race, while other times they portray race as a flexible part of one's identity that can fluctuate according to factors such as relative socioeconomic status. Their responses reveal, as Sheriff found, "a profound ambivalence about concepts of race, color, and racialized identity" (2001: 31). Nevertheless, Brazilians live comfortably with these seeming contradictions, negotiating them with humor and euphemisms, as Sheriff discusses.

I did not get the sense, as Sheriff did in her study, that most of my informants shared a bipolarized model of race. When I elicited interview respondents' race and/or color schemes, the average number of colors listed by each was 3.5. Respondents self-identified their color/race using the following terms: morena, branca, preta, parda, negra, clara, morena clara, escura (dark), mulato/a, branquela (really white), índio (Indian), afro-descendente (Afro-descendent), misturada (mixed), and amarela (yellow). When I asked respondents to list all the possible human races or colors they could think of, they listed many additional categories.

As I mentioned in the Introduction, recent epidemiological studies show that black Brazilians have higher rates of maternal and infant mortality, and die in greater numbers than whites from HIV/AIDS, homicide, alcoholism and mental illness, heart disease and stroke, hypertension, diabetes, and tuberculosis (Araújo et al. 2009, Batista 2005, Batista et al. 2004, Chor & Lima 2005, Cardoso et al. 2005, Fonseca et al. 2007, Lessa et al. 2006, Lotufo et al. 2007, Martins 2006, Santos et al. 2007). If we are to accept these findings, how can we explain my informants' widespread belief to the contrary? Are these subjects misrecognizing (Althusser 1971) the racialized configuration of power relations and how they affect black Brazilians' bodies unequally? If so, from what sources could this misrecognition have originated?

The trope of whites as having "weaker" blood, and African Brazilians having "stronger" blood, also appears in Gilberto Freyre's *Casa Grande e Senzala*. In his seminal work, Freyre argues that the Portuguese were better able to withstand life in the tropics because they had intermixed with Moors; when they came to Brazil and intermixed with enslaved Africans, their ability to adapt to life in the colony improved dramatically. It appears that the tropes recorded by Freyre in 1934 have long inhabited the collective Brazilian race imagination (if we can speak of such a thing) and are continually reproduced through Brazilians' *habitus* (Bourdieu 1977).

Pierre Bourdieu (1977) defines habitus as "a system of lasting, transposable dispositions which, integrating past experiences, functions at every moment as a *matrix of perceptions, appreciations, and actions* and makes possible the achievement of infinitely diversified tasks..." (82-83, emphasis in the original). Bourdieu argues that social reproduction occurs constantly through habitus, which in turn is constituted through an iterative feedback loop between social actors' subjectivity and the objectivity of the social field. In other words, individuals in a given society continually and unconsciously adjust their thoughts and actions to comply with the unstated collective norms of their social environment. A key aspect of this process is that social actors, according to Bourdieu, learn to expect only what the social field teaches them is possible. Bourdieu argues further that social actors are incited by the social order to misrecognize systems of inequality as natural or self-evident.

How does Bourdieu's theory apply to the case at hand? Again, if we accept the statistics generated by the Brazilian epidemiologists cited above, there is a significant mismatch between my informants' perception of blacks as having equal or even better health than whites, on the one hand, and the statistical picture of blacks' worse health outcomes, on the other. Up until recently, these statistics were not available; they are still not publicized widely, beyond the occasional newspaper article.[19] Prior to the Brazilian government's acknowledgement of racism and endorsement of race-conscious public

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[19] E.g., *Folha de São Paulo*, June 26, 2009. Negros fumantes têm cinco vezes mais risco de câncer. Available at: http://www1.folha.uol.com.br/folha/equilibrio/noticias/ult263u586716.shtml. Last accessed December 16, 2010.

policies, then, Brazilian citizens had little basis for generating an alternative ideology to the myth of racial democracy. That is not to say that Brazilians are unaware of racial inequalities in their daily lives, but rather that their habitus of denying the existence of race-based inequalities in the field of health is so strong that alternative accounts are effectively discouraged—at least, most of the time. Part of their dominant habitus, as I mentioned above, draws on colonial narratives about the physical strength of blacks versus whites in the tropics. Another important aspect of their habitus involves attributing observable inequalities to class rather than race per se.[20] The working-class Brazilians I interviewed do not misrecognize their socioeconomically subjugated position in society; to the contrary, most were adamant that health inequalities lie between rich versus poor citizens, but not black versus white citizens. Rather, if the aforementioned epidemiological studies are reliable (and many of them claim to have controlled for socioeconomic status), then my informants misrecognize the additional health costs of being nonwhite in Brazil (see Silva 1985).

Health Care Professionals' Narratives on Race and Health

I observed a similar range of racial discourses expressed by public health professionals enrolled in a course called "The Black Population's Health" ("Saúde da População Negra") in Maranhão in October 2007. The course took place in a small town called Chapadinha, located about four hours by collective van from São Luís. In contrast to the course I observed in São Paulo, which was organized by the state health department, the course in Chapadinha was organized by AKONI, a São Luís black

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[20] But is there such a thing as race "per se" in Brazil? Or anywhere else, for that matter? Under Brazil's new biopolitical regime, the state increasingly pinpoints racial discrimination as the cause for observed inequalities between blacks, browns, and whites in measures of health, education, employment, and a host of other quality of life indices.

movement association working for the empowerment of African Brazilians. In this case, the state health department of Maranhão sponsored the course, since AKONI had received state funding along with other NGOs with community health projects geared toward "specific populations" (*populações específicas*). The goal of the Chapadinha course was to educate public health workers from *quilombo* areas (former maroon communities) about "black health."

The course was held in an old, dusty meeting room within Chapadinha's city hall. Due to the scorching heat outside, the improvised classroom's lights were kept off throughout the course. AKONI activists had decorated its walls with Ministry of Health posters about institutional racism and the *quesito raça/cor* (the race/color item now included on patient charts). One poster featured a white *pai-de-santo* (priest of Afro-Brazilian religion) in full ceremonial dress along with the phrase, "Consult the *búzios* [oracle], but take the [HIV] test."

The students, who included SUS nurses and community health workers, sat in a circle in the center of the room. They ranged in age from about twenty-five to forty, and all had either white or light brown skin. Many of them wore clinic uniforms or SUS T-shirts. The instructors were both black movement activists from São Luís. In addition to being the founder of São Luís' oldest and most famed black movement organization, Dr. Lucas is a physician and professor of medicine at the Federal University of Maranhão. At the time of the course, he was also serving on the Technical Committee in charge of drafting the National Health Policy for the Black Population in Brasília. Glória is an occupational therapist who, at that time, had just defended her undergraduate thesis on the racial identities of sickle cell anemia patients in São Luís.

Dr. Lucas began the class by asking, “Why is black health an important issue?” He then answered his own question by explaining that the public health section of the Brazilian Constitution guarantees the three principles of “equity, universality, and comprehensiveness (*integralidade*).”[21] However, he added, since there is no real equity within SUS, the black population is rendered “vulnerable.” He went on to recount events in Brazilian history during which the government had shown preferential treatment toward European immigrants and white landowners by using land quotas.

At this point, I looked around the room and noticed that the students’ eyes were glazing over. Dr. Lucas held up a SUS book titled *SUS from A to Z* and pointed to the array of ethnically diverse, smiling people on the cover. “When we mix, we become more beautiful,” he told the class. “We want each population group to receive adequate health care. We need identity to form communities and a country with diversity. SUS providers need to recognize the particular features of each group.” Next, he reviewed elements of the National Health Policy for the Black Population and observed that “negros” and “Afro-descendants” accounted for fifty percent of the Brazilian population. He explained to the class that the Policy is important because blacks have special health concerns such as sickle cell anemia and hypertension. Hypertension, he explained, is elevated in blacks both due to “social conditions” and because their higher levels of melanin cause them to “absorb more salt” than whites.

After Dr. Lucas finished his presentation, Glória told the class about her research with sickle cell anemia patients. She had interviewed countless patients who self-

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[21] Actually, the three principles of Article 196 are *equality*, universality, and comprehensiveness. “Comprehensiveness,” or *integralidade*, refers to the full array of health services, both preventive and curative, provided by SUS. It also indicates the principle of holism in health care, or defining health as general well-being, rather than merely the absence of sickness.

identified as "moreno" even though, as Glória exclaimed, "*I* knew they were black (*negros*)!" She then spoke about the unconscious racial discrimination manifest within the Portuguese language, for example within popular phrases such as "a coisa tá preta!" [the situation is looking "black," or unfavorable].

Next, the instructors opened the floor for student discussion. An environmental health specialist named Marcos recalled instances of discrimination that he had observed in the SUS clinic where he worked. Almost always, he said, a beautiful (*bonita*) female patient is treated differently than a dirty one (*mulher suja*). A female community health agent spoke of a black friend of hers who had experienced discrimination during their graduation. "She is black, but she is a marvelous person!" she exclaimed. Marcos pointed at Glória and said, "if I were to call her 'black' (*negra*), she could sue me!" Glória responded that it is not even easy for blacks to identify as *negro*. A young *morena* nurse named Soraya then posed the following question: "if we want equality, then how can we have university quotas for blacks?" She added quickly that, despite her light skin and straight hair, "I'm not racist—I have black ancestors." Her comment sparked a flurry of debate among the students, most of whom agreed that the quotas were racist and/or insufficient to solve the deep-rooted causes of racial inequality in educational access.

Soon, it was time to break into small groups. We had to answer questions such as, "why is it important to study black health?" In my group, the students began by discussing the "typical health problems of underserved populations" [*doenças típicas das populações menos assistidas*]. Marcos mentioned that schistosomiasis was brought to Brazil by Africans. Dr. Lucas, who was listening in, confirmed this. Soraya then asked Dr. Lucas if blacks are more physically "resistant" or hardy than whites, and Dr. Lucas replied that whites and blacks present the same degree of resilience. He added that elevated rates of hypertension and diabetes in blacks are due more to unfavorable life conditions than to genes, although genes also play a role. The following group question, “how do you work with the black population?” was met with mystified silence. “I’ve never thought about it before,” admitted Soraya. “You treat the patients’ differences in order to bring equality to everyone,” prompted Dr. Lucas.

When it was time for each of the four groups to present, our group’s presenter, a male community health worker, surprised us by devoting most of his commentary to affirmative action in higher education. “Often, blacks are discriminated against not by whites, but by other blacks,” he stated. “If we already have university quotas, why not have a health policy for the black population? However, this policy cannot be a long-term solution, otherwise it will become harmful (*prejudicial*). You can’t have different programs for different groups.” He then spoke briefly about women’s health programs, but did not seem to find those problematic.

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I chose to recount the Chapadinha class here because it provides a window into the various models of racial identity currently circulating in Brazil. While the activist-instructors conveyed a bipolarized model of racial identity, and global discourses on the relationship between race and health, their students’ responses varied considerably. Unaccustomed to “seeing” patients in terms of race, the students grasped for a common denominator. They came up with university quotas, which are the prototype for formalized racial difference in contemporary Brazilian society. As evidenced by their remarks, students’ opinions of university quotas ran the gamut of tentative acceptance to strong opposition. Overall, they seemed to feel the quotas were at best unnecessary and at worst, discriminatory.[22]

At the same time, the students expressed fundamental discomfort with the prospect of openly acknowledging someone’s race. This point was made most powerfully when Marcos expressed his fear of being sued simply for referring to someone as *negro*. Over the course of fieldwork, I would hear this idea repeatedly from non-activists who seemed to misunderstand the Brazilian law that criminalizes racist speech, or the 1989 Caó Law (*Lei Caó*).

Although the instructors articulated a bipolarized model of racial identity, both they and the students also expressed mixed models of racial identity. Consider Dr. Lucas’ comments, for instance, about the multi-colored people on the cover of *SUS from A to Z*. While he praised their obvious mixed heritage, he also extolled the value of group identity and stressed the need for doctors to recognize and treat the specificities of each racial group. Meanwhile, several of the students were reluctant to utter the term “negro” or even to make direct references to race. Marcos, for example, contributed to a discussion of racial discrimination in the clinic by recounting the differential treatment he had witnessed of “beautiful” versus “dirty” women. He seemed to be discussing race in the coded way I often observed during my fieldwork. Non-activists, in relating hypothetical instances of discrimination between blacks and whites, would often refer to the black person as “disheveled” [*menos arrumado*] or even “ugly” [*feio*] and to the white

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[22] Here, I mean “discriminatory” in a negative sense, as opposed to the term “positive discrimination” which Brazilians and members of other nations such as Britain often use to describe affirmative action.

person as "beautiful" [*bonito*] or "well put-together" or "well-dressed" [*arrumado* or *bem-vestido*].

Additionally, the class revealed varied attempts by both instructors and students to theorize racial health disparities and their causes. Dr. Lucas, for instance, affirmed that genetic predisposition to salt sensitivity is linked to blacks' higher rates of hypertension. Although this theory has been debunked by several prominent scientists (e.g., Cooper et al. 2005), researchers still wrestle with nature-nurture hypotheses in their attempts to explain disparities in hypertension between blacks and whites (e.g., Brewster et al. 2000, Kaufman & Hall 2003). Like them, Dr. Lucas acknowledged that "social conditions," by which he seemed to mean the consequences of poverty, probably play a significant role in these disparities.

The students also struggled to explain the connection between race and health outcomes. Recall Soraya's question about blacks being more physically resilient than whites. This belief was quite common among the non-activists with whom I interacted over two years of fieldwork in northeast and southeast Brazil. Some of the students also demonstrated an interest in the origins of diseases such as sickle cell anemia and schistosomiasis, which in both cases were traced to Africa.[23]

Finally, Dr. Lucas effectively reinterpreted the Brazilian Constitution when he substituted "equity" for "equality." This choice of language can be traced to the current vogue of the word "equity" in health disparities research and activism on a global scale, not to mention race-conscious policies in general. The idea that "unequal groups must be

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[23] In subsequent research of the literature on schistosomiasis, I found no data to support an African origin for this disease. Incidentally, the schistosome *S. mansoni*, which is the vector for the variant of the disease that is endemic to Brazil, was discovered by Bahian physician Manuel Augusto Pirajá da Silva in the early twentieth century.

treated unequally" to achieve justice is ubiquitous in the sphere of affirmative action in Brazil and abroad. I discuss this in detail in Chapter 4.

Although no SUS administrators or providers were willing to go on record saying they were against race-conscious health programs, several administrators reported working with colleagues who questioned the need "behind the scenes" for such programs. Similarly, SUS administrators reported that many patients had expressed confusion or discomfort when asked to declare their race or color in public health clinics. Some patients, they told me, interpret the question itself as racist, and voice the fear that SUS will use this data to discriminate against them.[24] Others simply do not see the need for these programs.

My interview with Dr. Karen, the director of a Campo Limpo public health clinic in the periphery of São Paulo, brought forth several of these issues. Tall and blonde, Dr. Karen is actually a nurse from the southern Brazilian state of Santa Catarina.[25] Even though most would identify her as white, she self-identifies as *parda* due to her indigenous ancestry. When I told her about my project, she shrugged and commented, "for us, color is totally irrelevant. In our day-to-day work, color does not matter at all. The black population is only different in terms of hypertension. For us, the relevant patient categories are age and sex." I asked her who "us" was, and she replied, "the Ministry of Health." Then, I proceeded to ask her about the differences between blacks and whites in regard to hypertension. She told me that blacks are more likely than whites

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[24] Various providers and administrators of public health clinics in São Paulo reported incidents with patients over the race/color question. In São Luís, none of the clinics I visited were collecting race/color data from patients.

[25] In Brazil, people with bachelor's degrees are commonly addressed as "Doctor." Also in keeping with established social etiquette, health professionals are addressed by their title and their first name, rather than their last name.

to have higher blood pressure readings and medication-resistant hypertension. She did not know why this was the case; although she thought it could be genetic, she could see no "structural" (physical) differences between blacks and whites. In terms of hypertension treatment, she affirmed that all SUS patients receive ACE inhibitors such as Captopril or Enalapril, since these medications are the only ones provided by the Ministry of Health.

When asked about the National Health Policy for the Black Population, Dr. Karen commented that it is nothing more than political maneuvering that allows the state to say it has done something for blacks. Next, I asked about race statistics and recordkeeping in the clinic. Although according to the law, doctors and nurses must mark the patient's race on certain patient records, and the patient is supposed to declare his or her own race, Dr. Karen revealed that in her clinic no one does this. When health professionals do note a patient's race, they just look at the patient and decide what color she is. That way, patients never become upset, because they are never aware their race is being recorded. Seeing that the form for pap smears had only "black" (*negra*) and "white" (*branca*) categories, I asked Dr. Karen which category doctors and nurses checked when faced with a brown patient. She answered, "white. They only check *negra* when the patient is *really black* (*é negro mesmo*)."

Dr. Karen's comments reiterate several features of popular race ideology in Brazil. By identifying herself as *parda*, she asserted her own disbelief in the bipolar model of race. She also asserted that color is not an important factor in the medical encounter, except in relation to higher rates of hypertension in blacks—and even then, there is no difference in treatment. Importantly, Dr. Karen affirmed health professionals' tendency (like other Brazilians, according to their traditional race ideology) to whiten their patients' racial identities.

What struck me most about our interview, however, was Dr. Karen's revelation that health professionals do not conform to the Ministry of Health directive to ask patients to self-declare race. Whether it is due to their own lack of conviction in the importance of this metric, or to their reluctance to ask their patients to identify their race, health professionals were quietly disregarding the directive. During my fieldwork in six other clinics in São Luís and São Paulo, I heard time after time from doctors, nurses, nurses' aides, community health workers, and social workers that they either did not record patients' race, or else they simply marked down whatever they perceived the patient's race to be.

This pattern was also reported by Dr. Daniel, a primary care physician in Capão Redondo, near Campo Limpo in the southern periphery of São Paulo. Dr. Daniel identifies as *pardo* due to the mixture of black, white, and indigenous ethnicities in his family. He hails from Santarém, Pará, in the north of Brazil. Similar to Dr. Karen, Dr. Daniel did not think Brazil needed a separate health policy for blacks. He told me, "'Black health' (*saúde da população negra*) is a false argument because there is no discrimination against blacks in SUS, and whites also present with sickle cell anemia. When a white baby is diagnosed with sickle cell disease, no one talks about 'black health'!" He likened the new race-conscious health policy to an infamous episode involving race-based admissions quotas at the Federal University of Brasília. About two years earlier, identical twins had made the news when one was classified as black and admitted under the quota system, while the other was denied entry through the quota system because he was classified as white. “[Black movement activists] complain that there needs to be health policies for blacks, and they think they are helping themselves this way, but really they are asking for a worse situation,” added Dr. Daniel. He felt, like Dr. Karen, that the Lula administration had implemented the new health policy to improve Brazil’s image on the international human rights scene. “It’s populism,” he remarked. “It’s not a ‘mea culpa’ from the Brazilian government for years of oppression against blacks; it’s image control.”

Dr. Daniel agreed with Dr. Karen that blacks suffer disproportionately from hypertension. Unlike her, however, he attributed this fact to a structural difference in blacks’ and whites’ physical makeup. Since blacks have more smooth muscle than whites, he explained, they produce more of a particular enzyme that causes muscle contraction, which in turn causes higher blood pressure. This has been proven through research in Africa, he said. For this reason, they must take ACE inhibitors. I recalled that when I had visited hypertensive patients on neighborhood rounds with community health teams in São Luís, São Paulo, and Recife, everyone seemed to take Captopril. Dr. Daniel confirmed that it is prescribed to everyone, regardless of race. I expressed surprise; hadn’t he just identified ACE inhibitors as a “black” drug? He responded that they must be given to blacks, because “genetically they are better for blacks,” but they can be given to whites as well with no adverse effects.

To illustrate his point further, Dr. Daniel related a *House* episode in which a black patient refuses to take the congestive heart failure drug, BiDil, which is marketed to blacks in the United States. In response, Dr. House rips up the prescription he was writing, writes the exact same one (the patient had not read the first one) and tells him this “new” drug is for everyone, irrespective of race. House’s black staff doctor becomes angry when he discovers what House has done, but House maintains that he tricked the patient for his own good. Dr. Daniel told me he often has to resort to this type of white lie with his own patients.

I asked whether Dr. Daniel’s clinic collected patients’ race data, and he said, “No—it’s not important to us.” On referral forms, he sometimes fills it in, but only if he can check “black” or white” for a racially “unambiguous” person. Occasionally, he checks “pardo” (which is present on some forms but not others), but only if the person has indigenous or “Latin” features—not “cabelo duro” (hard hair) or a “nariz achatado” (flat nose). If the patient has brown skin and “mixed” features, it is only possible to check “white” or “pardo” because they will get mad if you label them *preto*, he said—especially older women. To avoid confusion and problems, he avoids filling it in most of the time. And nobody seems to care.

Dr. Daniel’s comments reproduced several of the same themes as Dr. Karen’s, such as confusion over how to classify patients according to race; denial of the existence of racial discrimination within SUS clinics; the view that the new Policy amounts to political lip service; and the identification of hypertension as the only legitimate area of special concern for black patients. However, Dr. Daniel differed from Dr. Karen in his affirmation that blacks suffer more from hypertension due to racial differences in their physical makeup. Regardless of their diverging etiological theories, Drs. Daniel and Karen echoed their colleagues’ and patients’ questioning of race-specific health policy, and reiterated their subtle rejection to race-specific health measures.

Health professionals' reluctance to ask patients their race is so pervasive that in 2009, the São Paulo State Health Department produced a 106-page guide addressing the problem, titled, "It's Not Offensive to Ask (*Perguntar Não Ofende*)!"[26] Other studies indicate that an unwillingness to discuss race is also common among health professionals in other parts of Brazil. In Rio de Janeiro, for instance, Araújo et al. (2010) found that most health professionals they interviewed expressed significant discomfort (*constrangimento*) with the new norm of having to ask patients their race. Many reported, furthermore, that their patients found it not only awkward but also difficult to choose a single race category. The health professionals also revealed that some of their patients did not want to declare their race because they feared the information might somehow be used to discriminate against them in the future. The researchers express their surprise at discovering that so many health professionals were uncomfortable asking about patients' race, since most of the professionals thought it was important for identifying patterns of discrimination and health inequalities. The authors conclude that, "there is more here than meets the eye. Something that is silent in Brazil; that is not discussed, but that we feel in everyday relations" (245). The researchers' assessment lends support to Sheriff's (2001) contention that silence is a significant feature of racial dynamics in Brazil.

Patients and Providers: A Counter-Biopolitics

There are significant continuities between the narratives of patients and health professionals that I have recounted here. Although they tend to perceive one another as representing different interests, patients and health professionals are united in their

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[26] Available at: http://www.crt.saude.sp.gov.br/resources/crt_aids/pdfs/livro_quesito_cor.pdf. Last accessed March 25, 2011.

rejection of the state's attempts to implement a new and foreign regime of racial classification within SUS clinics. By complaining when asked to identify their race, giving counter-normative answers such as *moreno*, or otherwise refusing to identify themselves as black, patients subvert the Ministry of Health's efforts to register and calculate a black population that will become the object of the new Policy. Similarly, by either neglecting to supply the racial data requested by the Ministry of Health, or whitening their patients' racial identities, health professionals circumvent the race-specific health initiative. Whether they do it based on their objection to the Policy's premises, their fear that racial separation will intensify if they collaborate with the black/white classification scheme, or simply their reluctance to "talk race" with their patients, health professionals quietly resist the state's newly adopted biopolitical paradigm.

Patients and providers, of course, do not perceive themselves as complicit. Rather, they tend to see one another as adversaries. Patients complain that doctors do not fulfill their required hours in the clinic, thereby causing patients to wait weeks and months before they are seen. Once in the office, patients claim that the doctors scribble on clipboards and prescription pads, rarely even pausing to look at the person sitting before them. Doctors, meanwhile, censure patients for non-compliance with prescribed therapeutic regimens and for missing appointments. Most of all, they criticize the patient-members of their clinics' participatory management boards for complaining so much. Patients and providers, then, are often locked in a near-constant face-off. Nevertheless, they have become strange bedfellows amidst the implementation of the National Health Policy for the Black Population.

Given their unspoken complicity and subtle circumvention of racial tracking in the clinics, patients and public health professionals have become, paradoxically, purveyors of a “counter-biopolitics” vis-à-vis the state’s new regime of race-conscious medicine (Comaroff 2007). Now that the state has adopted global discourses of racial categorization and of the association between race and health outcomes, it has instituted a new mode of biopolitics that seeks to track black Brazilians and, at least according to the new Policy, to maximize their health. The moment of race tracking during the medical encounter becomes a site for altered rituals of interpellation between state and subject (Althusser 1971). In the process, the state concedes that blacks have been categorically excluded from equitable health care and proposes to redress their exclusion through an ideological makeover of the public health system, its employees, and their practices. In response, patients and providers have resisted the new practices and insisted on maintaining the old status quo of Brazilian popular race ideology. Ironically, therefore, the supporters of the former status quo become counter-biopolitical subjects. Reports of patient and provider resistance to the newly instituted system of race-tracking in public clinics and hospitals indicate that the state’s interpellation of subjects as either *negro* or *branco* has not yet taken hold.

PART II: THE BLACK HEALTH AGENDA

Chapter 3: The Birth of the Black Health Agenda in Brazil

> Today in Brazil, public health policy includes a variable called "the black population's health"….We have this specific variable because in the past, no one admitted that the black population had specific features. Citing the principle of universality, [the Ministry of Health] assumed that everyone was included without considering their differences… [but] a universality that does not recognize difference is not universal. It is oppressive.
> – (Cláudia, Brazilian public health administrator and black health activist)[27]

In the last several years, Brazil has become a prominent site for health activism and medical intervention directed toward citizens of African descent. It is now one of the few nations in the world with race-specific health policies and programs (others include the United States and Britain). How did this happen in Brazil, a country that historically avoided formulating policies based explicitly on race? My objective in this chapter is to examine the social, political, and cultural conditions that gave rise to the black health agenda in Brazil.

By "black health agenda," I mean the set of political objectives and strategies aimed at the creation of a special area of public health care and policy for black Brazilians. My use of the term "black health" to qualify areas of activism, policy, and practice should not be read as an affirmation that blacks necessarily experience health care or health issues in a separate way; rather, it is an emic term drawn from my Brazilian informants and translated roughly into English.[28] As I discuss the ways in which the concept of "black health" is brought into being within the Brazilian context, I will use the

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[27] Interviewed by the author on September 8, 2005. All informants have been given pseudonyms. The Brazilian "black movement" (*movimento negro*) refer*s* to a diverse array of civil society and governmental organizations at the municipal, state, and federal levels devoted to combating racism and celebrating black identity.

[28] Whereas in the original Portuguese, the term is *saúde da população negra* ("the black population's health"), I have simplified it to "black health" in my writing.

emic term due to a lack of comparable alternatives. However, throughout my analysis I strive to problematize the concept itself, much like Paul Rabinow problematizes the concept of “French DNA” in his ethnography of proprietary genomic struggles between the United States and France (Rabinow 1999).

Although the discursive network I describe here came into being through transnational channels, the black health agenda is now a “cottage industry” in Brazil owing to a critical mass of activists, researchers and policymakers who are invested in it. The domestication of the Brazilian black health agenda rests on the alignment of racial categorization and various medico-racial discourses between government officials, scientists, and activists. As Steven Epstein describes in the case of U.S. biomedical research, Brazil has now adopted an “inclusion-and-difference” biopolitical paradigm wherein citizens are able to access certain public goods by being identified as, and by identifying as, a racial minority (Epstein 2007: *passim*). These include both educational goods, such as admission to higher educational institutions under a quota system, and health goods, such as being screened for certain diseases considered more prevalent in blacks.

Black Health Activism in Brazil

Feminist segments of the black movement have occupied a vanguard role in promoting black health interests in Brazil from the 1980s up to the present (Fry 2005). During the 1980s, activists from the black women's movement began to raise awareness about reproductive health issues that they perceived as affecting black women in a distinct way. They asserted that black women suffered disproportionately from maternal mortality, uterine fibroids, sexual and domestic violence, complications arising from septic abortions, and sexually transmitted diseases. They also claimed that black women were subjected to hysterectomies and invasive sterilization procedures more often than white women, and attributed this fact to racial discrimination in public health services (Pinto & Souzas 2002, Oliveira 2004).[29] This early mobilization by black women activists occurred mainly in São Paulo. As a result, São Paulo was the first Brazilian city to mandate the collection of epidemiological data by race in 1990. However, until recently these data were collected sporadically and only in the form of birth and death statistics.

Black health activists first pressured the state to address racial health disparities on a national level at the 1986 National Health Conference. National Health Conferences bring together citizens and state health care providers and administrators every three years for participatory planning. The final report from the 1986 Conference recommended increased public funding for the study of illnesses believed to affect certain "racial-ethnic groups" in a disproportionate manner (Oliveira 2002). Despite activists' efforts, however, there were no significant national policy developments concerning black Brazilians' health until 1995, when President Fernando Henrique Cardoso convened an Interministerial Working Group (GTI) for the Valorization of the Black Population. Although the GTI's Subgroup on Health concluded that specific health programs for blacks were unnecessary, its participants endorsed the creation of a special

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[29] At that time, their sterilization claims were based on anecdotal evidence due to the lack of epidemiological data by race in Brazil. More recent studies, however, indicate either that white, black, and brown women obtain sterilization in equal measures (Berquó 1999) or that black women actually encounter more obstacles than white women in obtaining sterilization via the public health system (Vieira 2004). These data, however, are based on patients who specifically requested surgical sterilization. Black women activists often assert that black women receive more hysterectomies for uterine fibroids or endometriosis, while white women are offered less radical treatment options. Epidemiological data at this level of specificity do not currently exist.

program for sickle cell anemia. The 1996 founding of the Sickle cell Anemia Program (PAF) marked the first time the Ministry of Health had instituted a program targeting an illness associated with the black population (Oliveira 2004, Fry 2005).

Another significant contribution by the Subgroup on Health was a report listing illnesses that were more prevalent in the black population. The report conceptualizes the illnesses in two main ways: first are "genetically determined" illnesses with a "hereditary, ancestral, and ethnic point of origin" (sickle cell anemia, hypertension, diabetes, and glucose 6-phosphate dehydrogenase (G6PD) deficiency); and second are illnesses arising from adverse socioeconomic conditions (e.g., malnutrition, substance abuse, AIDS and other STDs, septic abortions, work-related illnesses, and mental health problems). The report attributes hypertension and diabetes, heart disease, renal failure, cancer, and uterine fibroids both to "genetic determinants" and to adverse socioeconomic conditions. The report also states that even normal life processes such as growth, pregnancy, giving birth, and aging can become pathological processes within the black population due to "unfavorable socioeconomic and educational conditions."

While the report acknowledges that these illnesses (with the notable exclusion of sickle cell anemia) also occur in other "racial/ethnic groups," it stresses that they affect the "black population" in a more aggressive fashion due to "economic, social and cultural deficiencies (*carências*)."[30] A similar statement in the report attributes blacks' higher rates of hypertension both to genetic makeup (including increased sensitivity to sodium) and to their supposedly higher salt intake, which is explained as a function of their different palate (*paladar*) as compared to whites. Such statements are tantamount to

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[30] Ibid.

blaming not only socioeconomic conditions, but also cultural differences for the exacerbation of certain health problems among black Brazilians.

The blanket characterization of certain illnesses as genetically determined among the "black population" has the unintended effect of naturalizing race as a biological fact rather than a social construction. I will discuss this point in more detail in the following chapter. The point I want to make here is that the authors of the report mix genetic and environmental models to explain higher rates of disease among black Brazilians. According to Krieger & Basset (1993), the genetic model affirms the existence of inherent biological weaknesses in socially defined "racial" groups, while the environmental model blames material deprivation as well as certain health-related behaviors for the higher incidence of disease among certain groups in society. Neither model takes into account the *social* dynamics that create oppression along "racial" lines in the first place.

Although the Round Table report does not recommend the creation of specific government programs for "black" health issues, it does encourage the portrayal of the "black population" as a discrete racial group with specific health needs. The report recommends that health professionals take continuing education courses on the black population's "specific ethnic conditioning factors and socioeconomic-cultural aggravating factors." It also incites the "black population" to recognize its "problems" (*sua problemática*) and "take preventive measures and seek medical care in time, demanding their rights from public health authorities."[31] This portion of the report

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[31] Ibid.

identifies the “black population” as a special-needs group in relation to health care while calling on its members to become an active, organized community.[32]

Despite its avowed reluctance to implement black health programs, the GTI Round Table played a significant role in legitimating the construction of the “black population” as a discrete population group with clear-cut associated health risks. The GTI health report projects a series of strategies that Fry (2004) calls “intense proselytism for the specificity of the black population’s health in Brazil” (125). These strategies include research initiatives, publications about black health issues “in popular language” for distribution in black communities, and the implementation of PAF throughout the national territory.[33] The GTI Subgroup on Health also recommends the inclusion of a race/color item on public health documents. This measure was implemented nationally in 1996, although, as I discussed in the last chapter, health care providers often fail to comply with it. Black health advocates (i.e., activists, researchers, policymakers, and health professionals who promote the black health agenda) claim that statistics from these records continue to underestimate the number of births and deaths within the “black population” by as much as fifty percent (UNDP & PAHO 2001:9). In spite of problems with implementation, however, the GTI’s recommendations and actions in the area of black health were significant forerunners to proposals for the National Policy for the Health of the Black Population.

Finally, the Subgroup on Health recommended the inclusion of a race/color item on patient information documents. In 2001, activists and policymakers adopted the ideas

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[32] Fry (2005:358) discusses the creation of the rhetorical figure of the “responsible black community” in his analysis of PAF.

[33] Ibid.

set forth in the Subgroup's report as the basis for the incipient National Health Policy for the Black Population (UNDP & PAHO 2001). The final version of the Policy would retain some, but not all of the target illnesses; significantly, it would also make no explicit etiological claims about biological versus social causation.

The formation of the GTI occurred within a larger political context of deepening human rights discourse in Brazil, signaled most clearly by the 1996 launch of President Fernando Henrique Cardoso's National Human Rights Program (Fry 2005). The National Human Rights Program committee set the stage for affirmative action policies in Brazil when it recommended measures to increase equal opportunity for blacks, especially within higher education and public-sector employment (Htun 2004). The Program committee also recommended that IBGE, the Brazilian Census bureau, alter the race categories on the national Census by combining *preto* and *pardo* into a new term, *negro*. Although IBGE declined to change the categories on the Census itself, it began to present some data in terms of "black" and "white," where "black" (*negro*) represented the sum of pretos and pardos.

These shifts within Brazil were powerfully influenced by trends abroad. The 2001 Third World Conference against Racism, Racial Discrimination, Xenophobia, and Related Forms of Intolerance in Durban, South Africa was crucial to the implementation of affirmative action in Brazil; in fact, by the end of the Conference, the Brazilian state had instituted the first race-based quotas in federal employment. The Durban Conference's Plan of Action also incited national governments to create public health strategies for communities of African origin as a key component of affirmative action.

Shortly after the Durban Conference, Brazil began to craft partnerships with the Pan-American Health Organization (PAHO), the United Nations Development Program (UNDP), and the British Department for International Development (DFID) to help guide the creation of a national policy directed toward the health needs of black Brazilians. These international organizations provided both financial and ideological support to cohorts of black movement activists and state healthcare policymakers through workshops, conferences, and seminars.

In 2004, the Brazilian Ministry of Health, along with the country's Special Secretariat for the Promotion of Racial Equality (SEPPIR) and PAHO, signed a declaration expressing their intent to develop "saúde da população negra" (SPN), or the black population's health, as a special area within the Brazilian public health system (SUS). At that time, the Ministry of Health appointed a task force of black movement activists, researchers, and health professionals to formulate the National Health Policy for the Black Population.[34] For simplicity, I will refer to the Policy throughout the remainder of this chapter as "the SPN Policy." "SPN" stands for "saúde da população negra" (the black population's health) and often appears in writing by black health activists.

The declaration marks a critical transition in the Brazilian state's discourse on the relationship between race, racism, and health:

> [We recognize] that the principle of equity within SUS, to be effective, requires consideration of the different degrees of vulnerability to which diverse sectors of Brazilian society are exposed, and that the black population (*população negra*)—representing nearly half of the Brazilian population—possesses specific demands and problems in relation to health; [we recognize] that the lack of scientific knowledge concerning the health of the

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

> Afro-descendant Brazilian population stems from the misconception that Brazil is a racial democracy….(Ministry of Health 2004)

In this excerpt, for the first time, the Ministry of Health officially recognizes black Brazilians as a vulnerable population that warrants separate consideration within health policy. At the same time, it conceptualizes the "black population" as single group comprising all "preto" and "pardo" individuals, which totaled around fifty-one percent of the Brazilian population as of 2008.[35] The endorsement of lumped race categories within an official document is noteworthy considering the state's continuing reluctance to include a "negro" category on the Census (see Telles 2004). This discussion began during the late 1980s and early 1990s, when social scientists also began to publish data showing that "negros" and "não-negros" (blacks and non-blacks) had drastically different socioeconomic indicators and life chances (e.g., Hasenbalg & Silva 1988, Wood & Carvalho 1991). Although the idea of collapsing the categories initially drew little support outside of intellectual and black movement circles, in 1996 the Cardoso administration endorsed it as part of the National Program on Human Rights (Nobles 2000). Nevertheless, IBGE, the Brazilian Census bureau, opted to retain the categories "preto" and "pardo" as distinct items of the Census color question.

From its very inception, the SPN Policy broke with the status quo of Brazilian health policymaking by virtue of its transnational and citizen-participatory governance. As cited above, the Policy was crafted by a coalition of Brazilian and non-Brazilian activists, scientists, and public health officials. The Policy is also unique because it is the only Brazilian health policy that links race and institutionalized racial discrimination to

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[35] Source: www.ibge.gov.br. Last accessed March 1, 2011.

health outcomes. Although a specific health policy exists for indigenous Brazilians, that policy attributes their unfavorable health outcomes to the rough environmental conditions in which they live, rather than to discrimination or inherent biological tendencies.

The SPN Policy was approved by a participatory National Health Council in 2006, and it became official on May 13, 2009.[36] The Policy opens with discussions of the principles of social control (*controle social*), or citizen participation, and equity. Specifically, it asserts, "the principle of equality...should entail the principle of equity, which is based in the promotion of equality through the recognition of inequalities and strategic action to overcome them."[37] The Policy thus establishes equity, or compensatory justice, as a necessary pre-condition for the fulfillment of equality.

After establishing these principles, the Policy asserts the following main directives:

1. Inclusion of the themes "racism" and "the black population's health" in medical education for public health professionals;
2. More substantive opportunities for the black movement to participate in policymaking and policy monitoring (*controle social*);
3. State subsidization of scientific research concerning black health issues;
4. Official recognition of popular health knowledges and practices, including those of Afro-Brazilian religions;
5. Increasing the black population's access to health services;
6. Improving epidemiological data through the systematic collection of patients' race/color data;

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

[37] *Diário Oficial da União*, 90, 14 May 2009, p. 31.

7. Creation of health education materials geared toward the black population that respect diverse knowledges and values, especially those of Afro-Brazilian religions;
8. Establishment of international cooperation with the goal of improving the black population's health;
9. Establishment of partnerships between the government and non-governmental organizations in order to strengthen the implementation of black health initiatives within SUS;
10. Earmarking funds within state and municipal health care budgets to implement the Policy.[38]

The Policy changed significantly over the decade that passed between its initial drafts and its final version. The most striking change is its target illness list, which in the final version includes the following health problems: infant and maternal mortality, violent deaths, sickle cell anemia, sexually-transmitted diseases and HIV/AIDS, tuberculosis, Hansen's disease (leprosy), cervical cancer, breast cancer, and mental health issues (in that order). In a major departure from earlier proposals (e.g., UNDP & PAHO 2001, Ministry of Health 2001), the Policy avoids classifying these health problems according to genetic versus social etiology.

Most surprising is the complete disappearance of hypertension and diabetes, both of which had been classified in earlier proposals as having a genetic component. At some point between the April 2007 version of the SPN Policy and the final version of May 2009, these diseases were summarily discarded. This may be due in part to the growing doubt in international medical literature regarding the genetic basis for hypertension and diabetes in people of African descent (e.g., Cooper et al. 2005, Green et al. 2003). However, given the existence of Brazilian medical research that indicates higher rates of diabetes and hypertension in "pretos" (e.g., Chor & Lima 2005) and "negros" (e.g.,

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[38] *Diário Oficial da União*, 90, 14 May 2009, p. 31-32.

Batista 2005, Lessa et al. 2006, Santos et al. 2007, Horta et al. 2008) as compared to whites, it is not clear why these illnesses disappeared from the Policy.[39]

The Black Health Agenda in São Paulo

At the time of its passage, many of the Policy's elements had already been partially in effect since the early 1990s. This was due to the efforts of civil society organizations, especially in São Paulo. As mentioned above, many of the early black women's health activists were based in São Paulo. Their chief concern was the apparent imbalance in sterilization rates for black versus white women. According to Leonardo, the coordinator of black health initiatives for the state of São Paulo, former Mayor Luiza Erundina de Souza (1989-1992) was largely responsible for getting black health issues on the city's political agenda. Souza was a member of the socialist Workers' Party, and her cabinet was the first to designate a seat specifically for a representative of black movements in São Paulo. In 1990, with Souza's support, São Paulo's Municipal Health Department instituted a race/color item on SUS patient records.[40]

Around this time, several civil society organizations in São Paulo were also mobilizing around black health issues. One of the first was Geledés Black Woman's Institute (Geledés Instituto da Mulher Negra), formed in 1988 by a group of black women activists who felt that black women's health issues were not receiving proper attention from either the feminist movement or the black movement. From the beginning, Geledés activists focused on raising awareness about disproportionately high rates of sterilization,

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[39] Follow-up interviews with policymakers who had collaborated on the SPN Policy yielded no information on the reasons for the disappearance of hypertension and diabetes from the Policy.

[40] The legislation is: Portaria nº 696/90, Prefeitura de São Paulo. Available at www.saude.sp.gov.br. Last accessed March 15, 2010.

domestic violence, and septic abortions among black women, in addition to diseases such as uterine fibroids, hypertension, and sickle cell anemia, which they identified as prevalent among blacks.[41] The activists held seminars on these health issues for community leaders in areas of the city with particularly high concentrations of blacks, such as the east and south sides of São Paulo. The activists also produced literature for the public on black women's health issues. From Geledés' founding, its members strived to cultivate partnerships with international organizations and the United Nations. For instance, Geledés activists attended UN conferences where they denounced the alleged eugenics project of the Brazilian state by virtue of the mass sterilization of black women.[42]

In 1997, a faction of Geledés members left the organization and founded their own NGO, Fala Preta, which also focuses on black women's health issues. Fala Preta has conducted health education seminars for black women and youth on reproductive health. Additionally, the organization has held conversation groups (*rodas de conversa*) where black women congregate and speak about their experiences of racial discrimination in all areas of public life, including the healthcare system.[43]

Although Geledés and Fala Preta are the two of the most well known NGOs in the sphere of black women's health activism, several other civil society organizations have been instrumental in getting black health issues onto the political agenda of São Paulo. One of these, OGBAN, arose from its founder's direct experiences with racism in the public health system. Arlene, a black movement activist and former SUS nurse's aide in

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[41] Interview, S.C., Geledés, July 2009

[42] Ibid.

[43] Interview, E.P, São Paulo Municipal Health Department, 2009.

the eastside district of Guaianazes, has very light brown skin and long, wavy black hair that is usually tucked into a bun. She was in her fifties when I interviewed her and was living in a housing project in Itaim Paulista, a low-income neighborhood in the east periphery of São Paulo, with her adult children and grandchildren. At that time, Arlene was commuting to the hospital daily by bus to help care for her husband, who was suffering from advanced alcoholism. She confided that she had received criticism over the years from fellow black movement activists for being married to a white man.

Arlene's activism began in the late 1980s, when she was working at a SUS clinic in Guaianazes. She remembers feeling angry at work when she witnessed nurses cuddling white babies while treating black mothers and their children "as if they were contagious." She also noticed that doctors and nurses often complained that black people smelled bad, and that black men were drunks. During patient exams, she observed that doctors and nurses often avoided touching black patients, even when necessary in order to make a proper diagnosis.

When Arlene complained to her supervisor Beth about racism in the clinic, Beth told her she was imagining things. Beth, an African Brazilian nurse with light brown skin, added that she had never experienced racial prejudice and doubted it was taking place in the clinic. According to Arlene, Beth did not identify as *negra* back then; during our interview, Arlene joked that Beth must have considered herself Japanese (*japonesa*) since she was married at the time to a Japanese-Brazilian.

As the months went by, Arlene began to speak more and more with Beth about the racial discrimination against black patients. As a result, Beth gradually began her own entrée into black health activism. In 1993, Arlene founded a black health organization called OGBAN. Beth served as its Health Director, and other black women's health activists occupied the remaining leadership posts. The group began by providing HIV/AIDS education for samba schools, whose members were mostly African Brazilian. Later, through a partnership with the Municipal Health Department, OGBAN members trained health professionals to collect race/color data from patients. The group also formed partnerships with São Paulo blood centers and conducted seminars and workshops for sickle cell anemia patients and healthcare providers.

Beth remained Health Director for OGBAN until 1997, when she founded the Sickle Cell Anemia Association of São Paulo State (AAFESP). According to Beth, she became devoted to the cause after meeting her first young sickle cell anemia patient in the early nineties. AAFESP provides support and health education for sickle cell anemia patients and their families. Several years ago, Beth designed a patient education booklet that uses cartoons to illustrate the origins of sickle cell anemia centuries ago in Africa. It also explains in lay terms the genetic basis for sickle cell anemia, in addition to its symptoms and treatment. The booklet has been adopted for use all over Brazil and distributed internationally in English and Spanish. Beth remembers that during the 1990s, many black movement activists were concerned that conducting public health campaigns on sickle cell anemia would lead to increased discrimination against black Brazilians. They drew comparisons with the employment discrimination and the generalized stigmatization suffered by sickle cell trait carriers in the U.S. during the 1960s and 1970s.

In the early years of her activism, Beth traveled to Jamaica on a MacArthur Foundation fellowship to study how other countries were diagnosing and treating sickle cell anemia. There, she learned that both Jamaica and the United States were using electrophoresis to test newborn infants for the genetic mutation. When she returned to Brazil, she leveraged this information to convince São Paulo's Municipal Health Department to implement neonatal testing for sickle cell anemia. The electrophoresis technology eventually spread to other cities and states before it was implemented at the national level in 2001. Similar to subsequent Brazilian black health initiatives, sickle cell anemia programs in Brazil were informed from their inception by a transnational network of organizations, actors, technologies, and concepts regarding race and health.

As demonstrated by Beth's influence on the crafting of health policy, citizen participation in policymaking and monitoring is a central component of the Brazilian public health system (SUS). As I mentioned in the Introduction, this participatory process is called "social control" (*controle social*) in reference to the ideal of citizens' agency over public policy. Many of the activists whom I interviewed affirmed that the state did not simply "give" them black health programs; rather, activists forced the implementation of these programs through their demands.

In 2003, a coalition of black health activists, health professionals, and health administrators came together in São Paulo for the first Municipal Conference on the Black Population's Health (Conferência Municipal de Saúde da População Negra). In Brazilian Portuguese, this type of "conference" is actually a political meeting in which civil society actors pressure the government to institute specific changes. The Conference's final report states that its goal was to "insist that the Municipal Health Department of São Paulo implement public policies for the black population in order to create equity between diverse ethnicities/races, thus promoting affirmative action..."[44] The activists' insistence eventually paid off. By 2005, São Paulo's Municipal Health Department had instituted a participatory policymaking body, called the Commission on the Black Population's Health (Comissão de Saúde da População Negra). In 2006, the Department gained a special sector devoted to black health issues.

São Paulo's State Health Department created a similar division in 2007, known simply as the Technical Group for Strategic Actions (GTAE). The GTAE is responsible for developing health programs for special-needs groups, including black and indigenous Brazilians, women, disabled people, laborers, children, and the elderly. It also focuses on specific health issues experienced disproportionately by some of these groups, such as hypertension, diabetes, and mental and oral health problems. When I was conducting fieldwork in São Paulo in 2008-2009, the GTAE was training public health professionals on Afro-Brazilian culture, black health issues, and the importance of providing race/color data on patient records. At that time Leonardo, Black Health Coordinator for the GTAE, was also producing print and television PSAs and lecturing about black health issues on public TV and radio stations.

Concrete changes, however, were slower in the making. It was not until 2007 that the Ministry of Health mandated the collection of race and color data at all stages of patient care in the SUS—not just for births and deaths—and even then, compliance with

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[44] Secretaria Municipal de Saúde de São Paulo. 2003. *I Conferência Municipal de Saúde da População Negra: Controle Social e Inclusão Étnico-Racial no Sistema Único de Saúde/SUS: Relatório Final*. Electronic document, available at: http://www.prefeitura.sp.gov.br/cidade/secretarias/upload/saude/arquivos/cms/PopulacaoNegra.pdf. Last accessed February 9, 2011.

the mandate remained spotty due to a lack of enforcement.[45] In addition, the Municipal Health Department's black health division was crippled by limited funding and internal resistance from administrators who thought it was unnecessary.[46] Despite these problems, São Paulo is widely considered the vanguard in public programs and policies around black health issues.

The Black Health Agenda in São Luís

When I was in São Luís, Maranhão in 2007-2008, the contrast with São Paulo could hardly have been more dramatic. Although there were some efforts to implement the race/color question, especially within state-level HIV/AIDS services, epidemiological data disaggregated by race were sorely lacking. There were no black health programs in effect at either the municipal or the state level, aside from state-funded civil society initiatives. This situation seemed somewhat strange considering São Luís's large black population: in 2000, the sum of *pardos* and *pretos* totaled 68% of the population of São Luís, while in São Paulo they constituted a mere 30% of the city's population.[47] However, municipal and state health administrators whom I interviewed in São Luís explained that there was little need to implement black health policies, given that blacks are not a minority there. They reasoned that targeted policies were only necessary for numerical minorities such as indigenous citizens.[48] In addition, Maranhão is a much poorer state than São Paulo, which significantly limits its ability to channel resources into group-specific health initiatives.

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[45] This data comes from various visits to clinics and interviews with health administrators in São Paulo.

[46] Interview with E.P., São Paulo, November 2008.

[47] Source: www.ibge.gov.br. Last accessed March 1, 2011.

[48] Interviews with S.V. and C.C., São Luís, June 2008.

Instead, in São Luís black movement activists were entirely responsible for carrying out community health projects aimed at the black population. The State Health Department of Maranhão and the Municipal Health Department of São Luís both reserved funds for civil society organizations to deliver health education and, in some cases, preventive services, to populations considered “vulnerable” (*vulneráveis*). These groups included black and indigenous Brazilians, LGBT people, sex workers, drug users, and transvestites. At the beginning of each three-year budget cycle, the Health Departments invited local civil society organizations to compete against one another for funding.

The most active group on black health issues was AKONI, a black women’s organization founded in São Luís in 2004. In 2007-2008, AKONI was training SUS providers about blacks’ specific health needs and participating in citizen health councils, as well as engaging periodically in direct action negotiations with public health officials. Laura, one of the founders, explained the status of NGOs as informal health services contractors in the following way:

> We know that we are training health professionals, and that this is not our role, but rather the role of the state. So why do we do it? Because we have long-term experience [with black Brazilians]. And what is the political role of AKONI and the black movement....? [We] do the work, and then [we] negotiate with the government to take over and continue the training [of health professionals].[49]

At the time of my fieldwork, the Health Departments had no plans to take over the health education services provided by civil society groups. However, Laura explained that sensitivity training (*sensibilização*) to change SUS professionals’ perceptions of

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[49] Interview with L.P., Feb. 21, 2008.

marginalized groups represented the first step toward convincing them that these groups required specialized health care. She added that the National Health Policy for the Black Population had generated significant resistance among SUS administrators and providers who refused to comply with its stipulations. Civil society organizations, therefore, needed to convince them not only to record patients' race/color data, but also to give specialized care to "vulnerable" groups.

Additionally, Laura explained that civil society actors often play an instrumental role in bringing health professionals into certain communities that may harbor mistrust of the public health system, such as members of Afro-Brazilian religions or quilombos (rural maroon communities). Since activists are often members of these communities, they can facilitate SUS professionals' entry into these spaces. Within SUS, the National STD/AIDS Program has been the vanguard in reaching out to groups deemed "vulnerable;" the Program accomplishes this by employing cultural insiders as mediators between SUS and reclusive communities. Perhaps for this reason, many of the SUS/civil society black health partnerships that I encountered involved municipal, state, or national STD/AIDS programs.

Like the black health NGOs in São Paulo, AKONI maintained ties with international organizations and with Brasília. In addition to receiving state and municipal funding, AKONI received support from UNICEF and the Brazilian Ministry of Health. In October 2007, AKONI brought Ana Costa, Coordinator of the Ministry's Black Health Technical Committee, to São Luís for a lecture on black health issues. The event coincided with the release of AKONI's UNICEF-funded project to help improve health outcomes among black children in quilombos of rural Maranhão.

Important ideological shifts were also taking place in São Luís at the level of scientific research during the period of my field research. In 2008, the Federal University of Maranhão (UFMA) was initiating a new Master's degree program in Black Women's Health. The Department of Community Health (Saúde Coletiva) that housed the new program was also spearheading efforts to implement the race/color question throughout HIV/AIDS services in Maranhão. By conducting a major research study funded by the National STD/AIDS Program, Principal Investigator Jean, a European Brazilian medical researcher at UFMA, hoped to demonstrate that black HIV/AIDS patients had unequal treatment experiences that led to their worse health outcomes as compared to non-blacks. Jean collaborated on the study with colleagues from state and municipal STD/AIDS departments in São Paulo. These colleagues traveled to São Luís periodically to attend research meetings and to assist with research design and implementation. In addition, the study took methodological cues from Harvard's University's Enhancing Care Initiative, thereby incorporating transnational influences although data were collected solely in Maranhão.[50]

Jean's study deployed interviewers to HIV/AIDS clinics in São Luís, where they asked patients to self-identify their race or color according to Brazilian Census categories (i.e., white or *branca,* brown or *parda*, black or *preta*, Asian/yellow or *amarela*, and indigenous or *indígena*). Following data collection, Jean's research assistants tallied results by dividing participants into two categories: *negro* and *não-negro*, or black and

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[50] The ECI aims to improve care for AIDS patients in resource-poor nations, including Brazil (http://www.eci.harvard.edu).

non-black; the “negro” category included those who had identified as either “preta” or “parda” when asked by interviewers.

According to the research team’s final report, the study concluded that, although “black” patients reported worse socioeconomic status and overall living conditions than “non-black” ones, their data “did not indicate significant differences in their experiences...as people living with AIDS.”[51] In fact, Jean’s team found that twice as many “non-blacks” as “blacks” reported feeling discriminated against by public health care providers. Furthermore, Jean’s final report questions the validity of combining “preto” and “pardo” into a “negro” category, for two reasons: first, respondents who self-identify as “pardo” (or another intermediate term, such as “moreno”) might not identify with the term “negro,” in which case researchers are imposing an inaccurate category; and second, “pardo” and other intermediate terms can imply a mixture of indigenous and white ancestry, rather than African ancestry with either or both of these. The report thus questions two principal tenets of the black health agenda, namely, the imperative of the combined “negra” category, and the idea that black (or brown) patients necessarily receive worse health care. Of course, it is possible that the black and brown patients interviewed by Jean’s team either misrecognized their experiences of discrimination, or were too proud to admit to them. In the report, the researchers do not speculate about this possibility.

Regardless of its conclusions, Jean’s study provides an example of the networks of expertise formed by advocates of the black health agenda. Jean has been heavily involved in minority health policy (minority in terms of relative access to social goods,

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[51] “Relatório Técnico Final de Pesquisa Financiada pela PN DST/AIDS.” 2008.

not population percentages) since his days as a postdoctoral researcher in São Paulo (2002-2003). There, he worked for the state of São Paulo's Centro de Referência e Treinamento (CRT), an HIV/AIDS prevention and treatment center. Based on his reading of U.S. literature concerning health disparities between racialized groups, Jean helped the CRT to collect self-declared race data from all of its patients (previously, staff members had recorded patients' race based on their own impressions). Jean informed me that the CRT was the first institution in São Paulo, and possibly Brazil, to collect systematic race data from patients. According to Jean, self-classification is particularly important in Brazil because Brazilians rely heavily on social cues, such as how a person is dressed, to determine racial identity; for example, he added, a doctor might classify a shabbily dressed patient as "preto" (black) whereas the patient might self-identify as "pardo" (brown).

After concluding his postdoctoral fellowship at the CRT, Jean moved to Maranhão. There, he continued to collaborate with colleagues in São Paulo, frequently bringing them to São Luís for joint research projects and lectures at the Federal University of Maranhão. He also worked closely with local black health advocates, such as Dr. Lucas and Glória, whom I mentioned in Chapter 2. Dr. Lucas was raised by his indigenous mother and black father on a former quilombo in rural Maranhão. His interest in black health issues stems from growing up among communities of African Brazilians, who lived in abject poverty in areas where there was often no potable water. After moving to São Luís and studying medicine, Dr. Lucas completed his residence in pathology at the University of Ribeirão Preto, in São Paulo state. Between his experiences in São Luís and São Paulo, Dr. Lucas became increasingly aware of the large gap in living conditions between black and white Brazilians. When he returned to São Luís in the late 1970s, he founded the Centro de Cultura Negra (Black Culture Center), the first black movement organization in São Luís. In 2007-2008, Dr. Lucas was teaching courses on black health issues (especially sickle cell anemia) at the Federal University of Maranhão and traveling frequently to quilombo territories throughout the state to provide health care. He also made occasional trips to São Paulo, where he networked with fellow black health advocates and brought back literature on black health issues. One of his mentees was Glória, whom he provided with state of the art medical textbooks on sickle cell anemia, since she could not find adequate literature in São Luís.

Glória is a tall, thin, dark-skinned woman in her mid-twenties. She has an infectious smile and shining dark eyes. When I met her at the class in Chapadinha, she had just finished her undergraduate thesis in occupational therapy. Her research topic was treatment for sickle cell anemia in São Luís. In addition to receiving informal mentorship from Dr. Lucas, Glória was mentored by Leonardo, the coordinator of the GTAE in São Paulo. Additionally, I saw Glória on a regular basis at the home-based *terreiro* (temple) of Mãe Letícia, who became my key informant concerning Afro-Brazilian religion and healing in São Luís. Glória's story illustrates, once again, the interconnected web of black health activists throughout Brazil in general, and between São Luís and São Paulo in particular. Due to the personal biographies and social networks of the black health advocacy community in São Luís, São Paulo was the main point of reference within Brazil for them regarding black health politics.

Like most of the black health advocates in São Luís, Glória had become involved with the black health agenda following her introduction to black movement activism.

Through her activism, she came to see sickle cell anemia as a black health issue with social justice implications based on the state's failure, in many cases, to provide adequate diagnosis and patient care. Although Brazil has a well-established Sickle cell Anemia Program (Programa de Anemia Falciforme or PAF), its implementation varies widely from state to state. Glória told me that during her research, she found that Maranhão's Program existed on paper, but that it suffered in practice from severe resource shortages. This meant that infants were not routinely tested for sickle cell anemia at birth (one of the PAF's stipulations) and that patients had to fight to access adequate treatment. Furthermore, Glória was incensed by her finding that HEMOMAR, the treatment facility in São Luís for blood-borne diseases, provided no patient education on the African origins of sickle cell anemia. For Glória, as for many black health activists, a diagnosis of sickle cell anemia, or even of one's status as a carrier, logically implied the adoption of a black identity.

Glória told me that her phenotypically white cousin had recently discovered, at age thirty, that he was a carrier of the genetic mutation for sickle cell anemia. Although Glória tried to explain to him that his diagnosis made it impossible for him to be white, he resisted adopting a black identity, telling her, "I love black people, Glória, but I'm not black, I'm white. Can't you see that my skin is white?" In response, Glória reminded him that their grandfather was black, and therefore he was, too. In so doing, she invoked an ancestral model of racial identity, similar to the rule of hypodescent utilized in the United States (the "one drop" rule). Her cousin, however, upheld the traditional Brazilian mode of phenotype-based racialization by insisting he was white.

When I asked Glória why she felt it was important for sickle cell anemia patients to identify as black, she replied, “To take care of themselves, I think they have to become aware [of their racial identity] (*se conscientizar*)...when someone finds out they have this disease that originated in Africa... they begin to think, ‘then who am I?’” Glória’s response indicates that for her, a diagnosis of sickle cell anemia provides fundamental information about one’s ancestry and racial identity that is related to self-care. For Glória, as for other black health activists, diagnosis has the potential to become a “technology of the self” (Foucault 1988).

According to Michel Foucault, technologies of the self are discourses and practices that “permit individuals to effect...a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (ibid: 18). Whereas Foucault was preoccupied with technologies of state and institutional domination during the earlier part of his career, he later began to focus increasingly on “the technologies of individual domination...how an individual acts upon himself, in the technology of the self” (ibid: 19). As Burchell (1996) notes, government for Foucault was the point at which techniques of domination and techniques of the self came together (20). He emphasizes that the relationship between the two is not unidirectional or one-dimensional; rather, techniques of domination may be “presupposed by, or are conditions for the possible existence of” techniques of the self (ibid: 21). In the Brazilian black health agenda, there is a constant feedback loop between the National Health Policy for the Black Population and its associated programs, on the one hand, and the re-crafting of racial identity that individuals undertake in reference to a medicalized conception of race, on the other. These two elements of governance are intimately intertwined.

In this chapter, I have examined the sociopolitical conditions that set the stage for the birth of black health agenda in Brazil. Although much of my analysis refers to collectivities such as “black health activists” and “health professionals,” it is important to remember that these groups comprise individuals who engage with the black health agenda in their own personal ways. Drawing on the ideological material embedded in the black health agenda, they construct particular identity discourses and practices. These techniques of the self enable individuals to re-define themselves in accordance with new norms of governance, which in turn present new possibilities for subject making.

Chapter 4: The Black Health Epistemic Community in Brazil

In this chapter, I examine how the Brazilian black health agenda is produced discursively by an epistemic community of activists, government officials, scientific researchers and intellectuals in Brazil and beyond. I use the term "epistemic community" in the sense that Haas (1992) has defined it, as a group of individuals with "recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area" (3). These individuals produce a range of discourses that constitute the Brazilian black health agenda in particular ways.[52] Each member of the epistemic community is responsible, to varying degrees, for the circulation and naturalization of specific knowledge and truth claims about the relationship between blackness and health in Brazil. I argue that black health activists in particular utilize these claims to formulate not only a biologically based politics of difference, but also a new kind of biopolitical citizenship in Brazil. In response to political influences from abroad, as well as activists' citizenship claims at home, the Brazilian state has institutionalized a biopolitical paradigm that affirms race as a primary determinant of health inequalities in Brazil.[53]

It is important to note that the discourses of the black health epistemic community in Brazil do not go unchallenged. In fact, they are vociferously debated by a group of scientists and researchers who argue that the black health agenda racializes medicine and promotes unncessary racial division (e.g., Fry 2004, Laguardia 2005, Maio & Monteiro

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[52] Briggs and Hallin (2007) describe "biocommunicability" as the process through which health discourses and practices are communicated to citizens in ways that confer authority and power to certain kinds of information while obscuring or disqualifying others.

[53] Epstein (2007) defines biopolitical paradigms as "frameworks of ideas, standards, formal procedures, and unarticulated understandings that specify how concerns about health, medicine, and the body are made the simultaneous focus of biomedicine and state policy" (16).

2005, Pena 2005, Maggie 2007). Government officials also challenge the black health agenda in both direct and indirect ways. In 2008, black health activists were outraged by the mysterious disappearance from the federal budget of funds earmarked for black health programs.[54] In 2010, the Brazilian Senate approved the Racial Equality Statute (Estatuto da Igualdade Racial) but eliminated provisions for black health programs based on a lack of conclusive genetic evidence for diseases considered more prevalent in blacks.[55] Demóstenes Torres, the senator who demanded the removal of the health provisions, explained his position in the following way: "I'm not going to contribute to racial divides. There are [also] poor whites, Indians, and browns [*pardos*]."[56] Like the researchers and intellectuals cited above, Torres interpreted health disparities as a consequence of poverty rather than of race *per se*. Meanwhile, black health activists attribute blacks' worse health outcomes to a variety of factors, including an unequal distribution of wealth between blacks and whites, racial discrimination in medical settings, and blacks' biological predisposition to certain diseases.

The data I present in this chapter are based on narrative analysis of interviews with, and texts produced by, members of the black health epistemic community in Brazil. My objective is not to evaluate whether my informants' discourses accurately describe the reality of racial health disparities in Brazil. That is exceedingly difficult to do, given that epidemiological data by race in Brazil are still relatively scarce and ethical research standards impede the observation of medical encounters between patients and health

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[54] "27 de Outubro-Dia Nacional de Mobilização Pró-Saúde da População Negra." Electronic document, available at: http://redesaudedapopulacaonegra.blogspot.com/2009_08_01_archive.html. Last accessed February 9, 2011.

[55] "Senadores aprovam Estatuto da Igualdade Racial, mas retiram cotas." Electronic document, available at: http://correiobraziliense.com.br. Last accessed June 18, 2010.

[56] Ibid.

professionals. Rather, I am interested in how discourses on healthcare inequalities and unequal treatment become naturalized and institutionalized, especially in the midst of considerable ambiguity surrounding the causes and lived reality of health disparities in Brazil.[57]

Here, I examine the discourses of key figures in São Luís and São Paulo who create and disseminate the black health agenda, both locally and nationally. Although I separate them analytically into the categories of activist, government official, scientist, and intellectual, many of my informants occupy more than one of these categories simultaneously. For example, several of the activists with whom I worked also held public health posts. Over the course of our interactions, it became clear that many activist-officials felt uneasy about occupying both roles simultaneously. Their activist colleagues often intimated that they were "sell-outs" who had been co-opted by the government. Some also expressed frustration with the bureaucratic limits imposed on their work by the realm of public service. Nevertheless, the activist-officials often conceded that their posts afforded them greater influence on health policy outcomes. As my informants often articulated during interviews and political meetings, the increasing entry of activists into public service reflects a changing relationship between the state and civil society since the 1990s. Whereas in the past activists' role was primarily one of opposition and protest vis-à-vis the government, civil society and the state increasingly fuse and form "partnerships" (*parcerias*).

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[57] See Rouse (2009) for an incisive analysis of how health care providers and patients manage the uncertainty surrounding racial health care disparities in the United States.

Most of the health researchers and health administrators whom I interviewed were white, middle-class Brazilians with advanced academic degrees. The activists whom I interviewed were middle or lower middle-class Brazilians who identified as *negro* or *negra*. Nearly all had begun their activism within black movement organizations (*movimentos negros*) that focused on eradicating racism in many areas of society, and subsequently moved into black health activism. Many activists held advanced academic degrees, and several were employed in the medical field as doctors, nurses, nurses' assistants, laboratory technicians, or clinical social workers. As such, the activists constituted an elite group in comparison to the masses of low-income black Brazilians they purported to represent. Burdick (1998b) argues that the socioeconomic chasm between elite black Brazilian activists and their non-activist constituents produces an enormous ideological gap and limits non-activist black Brazilians' support for black movement initiatives. This ideological gap is also responsible in large part for the circumscription of the black health agenda to the epistemic community I discuss here.

As an elite group, black health activists have access to national and transnational channels of communication and information via internet technology and their attendance at conferences on racial health disparities. In general, the activists I worked with in São Paulo had greater access to financial resources than the activists in São Luís. These resources, which they obtained from Brazilian government agencies and from international NGOs and foundations, afforded them the mobility to be in more frequent contact with colleagues in distant locations. Easy access to national and transnational activism networks meant that activists in both cities were constantly exposed to globally-produced discourses on race and health. They, in turn, disseminated these discourses locally through internet blogs and sites, print media, and presentations at meetings and conferences. Many of their discourses on health outcomes in the black population resemble those produced in countries such as Britain and the United States. Meanwhile, most non-activist Brazilians are unfamiliar with such concepts as "racial health disparities" and "health equity."

The activists, officials, health professionals and researchers who co-create the Brazilian black health agenda are a diverse group with varying discourses, but they share a few key beliefs. First, they tend to define "black" as *negro*, a category created through the collapsing of the Census categories "brown" (*pardo*) and "black" (*preto*). Members of the black health epistemic community also claim that black Brazilians need culturally sensitive health care. To this end, they recommend that the state provide health professionals with training on aspects of Afro-Brazilian culture, particularly Afro-Brazilian religion. Furthermore, they accept the idea that *negros* suffer disproportionately from a number of health problems including sickle cell anemia, hypertension, diabetes, maternal and infant mortality, substance abuse, and others. My informants differed, however, in their accounts of what causes these health disparities. In the following section, I draw on my ethnographic research to analyze in detail the major discursive themes that constitute the black health agenda. These include the politics of categorization, the imperative of self-declaration, etiological claims, medicalizing racism, and discourses of difference.

The Politics of Categorization

Categorization is the *sine qua non* of contemporary debates about race and health, and it suffuses discussions of racial/ethnic identity and disease etiology in Brazil. As

Bowker & Star (1999) have noted, systems of racial and ethnic classification embed "ethical choices" with significant political and social implications, in part because "each standard and each category valorizes some point of view and silences another" (5). For this reason, it is important to examine the choices underlying schemas of racial categorization, and to consider the alternatives that were either discarded or not chosen—and their consequences. In his analysis of health disparities research in the United States, Epstein (2007) argues that the static race categories used by biomedical researchers obscure the "complex sociopolitical processes" that shape individuals' racial identities (228). Similarly, Brazilian scholars contend that race is a particularly problematic variable for health research and policymaking in Brazil due to the multiple ways in which Brazilians construct racial identity (e.g., Pena 2005, Laguardia 2005, Monteiro 2004, Grin 2004).

Since the topic of black health first began to circulate within Brazil in the 1980s, activists have defined the black population as the aggregate of Census-identified pretos and pardos. They have done so based on their conviction that pretos and pardos experience similar social and biological tendencies that produce poorer health outcomes. Defining the black population in this way increases the total number of black Brazilians, and represents a marked contrast to the Census bureau's traditional definition of the black population as the total number of pretos. This statistical tactic serves to bolster activists' claims for special health resources for blacks; after all, how can the Brazilian government ignore the needs of over half of the population?

According to the 2008 nationwide household census (PNAD), pretos represent 6.8% of the total Brazilian population, pardos 43.8%, and brancos, 48.4% (IBGE 2009).

When IBGE released these figures in 2009, black health activists took to their blogs and web sites to proclaim that the black population (pretos + pardos) now constituted the majority of the Brazilian population.[58,59] In comparison to the 2000 Brazilians Census, the 2008 PNAD figures indicate a 5% increase in pardos, a 0.3% increase in pretos, and a 5% decrease in brancos. Although the reasons for this shift are not clear, one contributing factor could be that increasing numbers of young Brazilians are identifying as brown or black in order to compete for affirmative action quotas in public universities (e.g., Schwartzman 2007).

Activists' bipolar mode of racialization mirrors the traditional U.S. practice of hypodescent. It defines blackness based on ancestry rather than primarily phenotypic features, as is the case in Brazilian popular racialization practices. In other words, this model encourages even light-skinned individuals to identify as "negro" based not only on their skin color and facial features, but also on the presence of African Brazilians in their family trees. Although black movement activists were the ones who propagated this model initially, many public health professionals and biomedical researchers adopted it following the Ministry of Health's endorsement of it in 2004 (see previous chapter).

Of course, the process of adopting a new racial ideology is not seamless. New activists undergo a process of attitudinal change (*conscientização*), in which they make contact with black movements and learn to conceptualize race in new ways. Many of my activist informants described their own experiences of learning to identify as *negro* or *negra* and beginning to recognize racism in various social contexts, including medical

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[58] One example is black women's health organization Geledés' web site: http://www.geledes.org.br/noticias/pnad-conclui-que-maioria-da-populacao-brasileira-e-de-negros-2.html. Last accessed June 22, 2010.

[59] Source: www.ibge.gov.br. Last accessed June 16, 2010.

encounters. Several of them told me that racism had not been a salient issue in their lives prior to their entrée into activism, which often occurred when they entered university and met black student activists.

Activists who have adopted new ways of perceiving race and racism, in turn, disseminate these ideas through engagement with various publics. Sônia, for instance, is a sociologist and black health activist at Geledés, one of the most prominent black women's health NGOs in São Paulo. In 2007, Geledés began to partner with Conectas, a local human rights organization, to teach low-income women about black women's health concerns and how to report discriminatory treatment in public clinics. Sônia said the women only realized they had been the victims of racial discrimination after their activist instructors encouraged them to reinterpret their experiences with doctors and nurses through the lens of race.

Mariela, a light-skinned black health activist and public health administrator in São Paulo, related a similar story. When São Paulo's municipal and state health departments first began to require the collection of patients' self-declared race data in public clinics and hospitals, Mariela led state-sponsored workshops on racial discrimination and cultural sensitivity for public health employees.[60] She recalled that employees in the workshops were unaware of the role of racial dynamics in their daily interactions. As a result, Mariela had to teach them to "see race."

Concomitant with these shifts in race ideology, black health activists develop fluency in biomedical language and concepts as well as in the language of citizenship and

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[60] The term in Portuguese for these sessions is "oficina de sensibilização," (literally, "sensitization workshop").

rights. During my fieldwork, I attended several workshops given by SUS administrators to groups of black health activists. The content of these workshops was remarkably consistent; they usually reviewed the 1988 Constitutional articles affirming health as a universal citizen's right; described the bureaucratic layout of SUS; and explained the procedures for filing formal complaints about public health services. The workshops used the language of active citizenship and encouraged participants to "fazer valer seus direitos," or to make sure their rights were upheld, by participating in planning meetings and serving on public clinics' governing councils (*conselhos gestores*).

In addition to attending SUS-sponsored workshops, activists also read scientific articles about black health issues. Gaining knowledge in these areas equips them to communicate with government officials, health care providers, and biomedical researchers as they make claims for improved treatment and research for diseases that affect blacks disproportionately. In the process, many activists acquire (or at least find the language to articulate) genetic understandings of race that are based on ancestry rather than phenotype alone.

Beth, President of the São Paulo Sickle cell Anemia Association, described to me how black health activists from the Association teach non-activists about race and genetic risk for disease via community outreach activities. For instance, the Association provides health education classes to newly diagnosed sickle cell patients and their families. Beth explained that about 10% of these patients initially identify as white, but they usually adopt a genetic model of racial identity after attending the Association's classes:

> If you have light skin, and all of a sudden you are diagnosed with a black disease, you gain a new identity... [our patients] begin to look at their families and notice they're not so white. And sickle cell anemia demonstrates

> that...On the last day [of class] we ask people to identify their own color. Nobody can call themselves white anymore—they all end up [identifying] as pardos! [laughs]

It is striking that Beth refers here to sickle cell anemia as a "black disease," since earlier in our interview she had stated unequivocally that it affected people of all colors. Specifically, she had explained that her own patient manual was titled, "Sickle cell Anemia: *Our* Problem" (*Anemia Falciforme: Um Problema* Nosso) because sickle cell anemia was not exclusively a black disease (emphasis mine). How does one account for this discursive ambiguity? A bit of probing revealed that Beth was aware of the discrepancy between the Association's racial politics and the diverse geographic origins of sickle cell disease (which are not exclusively African). Beth admitted that she purposely emphasizes the African roots of sickle cell anemia to patients in order to promote antiracism: "...socially people are perceived [as white], but we want them to understand the wider context [of ancestry]. Within this wider context, it is impossible to be racist."

Beth assumed that if phenotypically white Brazilians believe they have a common heritage with phenotypically black Brazilians, they will be less likely to discriminate against them. This assumption, however, is a slippery slope. The characterization of sickle cell anemia as a "black disease" could end up perpetuating the misconception that only phenotypically black Brazilians need to be tested for the genetic mutation. Although Brazil's Sickle cell Anemia Program mandates screening in all Brazilian-born infants, my informants reported that this goal is far from being realized. In fact, during my research I heard many stories of (and met several) phenotypically white Brazilians who had only discovered they carried the trait in their twenties or thirties.

Although the statistical correlation between sickle cell anemia prevalence and African ancestry is rarely challenged in the United States, it is more tenuous in Brazil due to blurry racial distinctions. Regarding this point, Fry (2005) observes that "even though it is recognized that the illness is disseminated to the four corners of the country through miscegenation, sickle cell anemia is associated increasingly with the 'black population'" (358). As I stated above, members of the black health epistemic community operationalize the "black population" as over fifty percent of the Brazilian population, which represents the sum of "pardos" and "pretos" counted by IBGE. But when activists conflate genetic markers for sickle cell disease with African ancestry, this number would seem insufficient. To put it crudely, how much African ancestry must one have in order to be considered at risk for inheriting the sickle cell trait?

Based on genetic samples collected across Brazil and analyzed for markers of geographic origin, Pena and Bortolini (2004) estimate that eighty-seven percent of Brazilians possess more than ten percent African ancestry. They calculate that approximately half of this eighty-seven percent self-identified as "white" on the 2000 Brazilian Census. The authors thus conclude that genetically-based "racial" distinctions are problematic for identifying policy beneficiaries because, in addition to the fact that race does not exist from a genetic standpoint, phenotype is an unreliable indicator of geographical ancestry in Brazil. In their study of perceived versus genomic ancestry among residents of Rio de Janeiro, Santos et al. (2009) also found a significant mismatch between research subjects' classification of their own and each other's ancestry, on the one hand, and their actual genetic markers for European, African, and Amerindian ancestry, on the other.

During my fieldwork, it became clear that black health activists were well aware that their political discourses sometimes contradicted existing scientific data. André, a longtime black health and labor activist in São Paulo, conceded that activists' discursive association of sickle cell disease with African ancestry is a deliberate political tactic. Without any probing, he characterized this tactic as "subterfuge" (*um subterfúgio*). Here is an excerpt from our interview:

> **Anna**: Why was it subterfuge?
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> **André**: Because there is sickle cell anemia in North Africa, but also...I think it's also in the Mediterranean. There's a part of Europe that has it too, and a part of Asia too, the Syrians, look how many Syrians have sickle cell anemia.[61] And not all Syrians are black, actually Syrians aren't black.
>
> **Anna**: Yes. In Iran, [sickle cell anemia] is endemic too.[62]
>
> **André**: Right. It's endemic, so it's not an issue. So it's subterfuge. A subterfuge that worked....Because we didn't have a [specific] disease. We had no way to complain about a [specific] disease, so we used sickle cell anemia.
>
> **Anna**: Why didn't you have any way to complain about a disease?
>
> **André**: Because here in my country, mental illness is something a drunk has, it's a black thing....You couldn't say that you had [a mental illness]... So we said that [sickle cell anemia] is a black problem. That was it. It's subterfuge that enabled us to discuss all the social diseases we have.
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> **Anna**: Beginning with sickle cell anemia.
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> **André**: Yes. From there, I can speak about uterine fibroids [in black women], about mental health, from there I can speak about the kind of working conditions I have.

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[61] There is a substantial population of Syrian-descended Brazilians in São Paulo (called *sírios*), where this interview took place.

[62] This comment might seem idiosyncratic. I have followed sickle cell epidemiology in Iran due to my own ethnic background.

In this excerpt, André described the strategic discursive process through which sickle cell anemia became the most visible black health issue in Brazil. As Beth and André's comments show, even though activists know sickle cell anemia is also endemic to geographic areas outside of Africa, they purposely emphasize the association between sickle cell anemia, Africa, and blackness. They do so in order to support their argument that blacks have fundamentally different health needs, despite their awareness that this argument might not be scientifically or medically justifiable. Their approach is strategic because scientific discourses carry a unique legitimacy; they have the aura of "hard" facts that allegations of diffuse structural racism tend to lack. Moreover, activists know that sickle cell anemia is considered a "black" disease in the United States, and that the Brazilian state has a vested interest in maintaining its international reputation as a protector of human rights and promoter of racial equity. Therefore, it behooves the state to implement policies that demonstrate its dedication to the diverse needs of its multiethnic population.

André's revelation recalls Fry's argument (2005) that Brazilian black health activists have leveraged sickle cell anemia as a political tool in their efforts to transform Brazil into a "black-white" society based on the supposed genetic difference of African Brazilians. Fry views this tactic as an extension of the Brazilian black movement's efforts to convince Brazilians who identify as "pardo" to assume a black identity. He does not clarify, however, why black movement activists might want to portray African Brazilians as incommensurably different from European Brazilians in the first place.

In 2007, a leading Brazilian public health journal (*Cadernos de Saúde*) featured a debate over whether it makes sense to categorize the black population as a vulnerable group in relation to HIV/AIDS, as the National STD/AIDS Program and the Ministry of Health have done since 2005. In that issue, Fry and colleagues from the Oswaldo Cruz Foundation (FIOCRUZ) argue that black health activists and the Ministry of Health are racializing AIDS and homogenizing epidemiological data in order to serve a political purpose, namely, the ideological construction of Brazil as a racially bipolarized society where blacks and whites have distinct physical characteristics and health needs. The authors point out that epidemiological data from Brazil's National AIDS Program show a steady increase in AIDS cases among "pardos" since 2000, but relatively stable rates among "pretos." The authors thus critique the use of the category "black population" (*população negra*) on the grounds that it masks the differences between the epidemiological profiles of pretos versus pardos.

In response to Fry et al.'s arguments, Paixão & Lopes (2007) assert that pretos and pardos should occupy a single category since their epidemiological profiles resemble one another more than either resembles that of whites. They arrive at this conclusion by comparing the ratio of new AIDS cases in 2005 between pretos and pardos and between negros (pretos + pardos) and brancos; the first ratio is considerably smaller than the second. Paixão & Lopes also cite AIDS mortality statistics to argue that pretos' rates of AIDS deaths are much higher than the percentage of pretos in the total Brazilian population, while pardos' and brancos' shares of AIDS deaths are markedly lower than their representation in the total population.

The journal issue also includes debate papers by several other researchers (Chor 2007, Guimarães 2007, Barata 2007, Camargo 2007, Travassos 2007), who echo Fry et al.'s concern that classifying AIDS as a black health issue is not only scientifically unsound, but also racializes the epidemic in a dangerous way by identifying blacks as a risk group for HIV/AIDS. The common thread uniting the arguments of these other researchers is that the data are too ambiguous to make straightforward claims about the black population's vulnerability to AIDS. Travassos illustrates this point when she asks, "Why highlight race/skin color as the expression of the pauperization of AIDS in the country? Why leave out the multiplicity and complexity of the social factors involved in the process?" (2007: 518). Only Paixão and Lopes argue that AIDS should, in fact, be classified as a black health issue.

This debate exemplifies the level of ambiguity that surrounds the attribution of diseases to specific racialized groups. It also shows the extent to which the same statistical data can be manipulated to serve opposing political agendas. Peter Fry and his co-authors are among the most vocal opponents to the black health agenda, while Marcelo Paixão and Fernanda Lopes are staunch supporters of it. In fact, Lopes directed the now-defunct national Program Against Institutional Racism (Programa de Combate ao Racismo Institucional), a bilateral initiative between the British and Brazilian governments that was key to introducing the black health agenda into Brazil (discussed in Chapter 3).

Given the interests of the researchers involved in this debate, it is important to examine the discursive and practical effects of epidemiological ambiguity. As other anthropologists have argued (e.g., Rouse 2009, Whitmarsh 2008), uncertainty surrounding the causes and expression of health inequalities among racialized groups can end up weakening attempts to denounce and counteract those inequalities. Health activists, therefore, strive to reduce epidemiological ambiguity so that their claims appear authoritative and self-evident. The framing processes described by André and Beth are examples of ambiguity reduction—both described how black health activists framed sickle cell anemia as a black disease, in spite of the highly ambiguous correlation between racial identity and the distribution of the sickle cell trait throughout the Brazilian population.

Another form of ambiguity reduction deployed by Brazilian black health activists is their claim that pardos and pretos constitute a uniform epidemiological population of *negros*. In collapsing the two populations, activists attempt to create a "black and white" system of racial classification in Brazil. In addition to their claims of genetic continuity between pardos and pretos, activists argue that the two categories should be collapsed into one because black and brown people suffer similar effects of racism, such as employment discrimination and low socioeconomic status—which ostensibly affect health outcomes (Figueroa 2004). However, as I mentioned in the Introduction, recent epidemiological studies indicate that although pretos fare dramatically worse than brancos (whites) on most mortality and morbidity indexes, pardos' rates of disease and death from a variety of causes are either similar to those of brancos (Chor & Lima 2005, Cardoso et al. 2005) or fall somewhere between those of pretos and brancos (Lotufo et al. 2007, Fonseca et al. 2007). The major outlier is the rate of violent deaths for pardos aged 15-29 years, which resembles that of pretos and is much higher than that of brancos (Chor & Lima 2005). In addition, both pretos and pardos have a lower life expectancy than whites do—which, at least for "pardos," is likely due in large part to the spike in violent deaths within the 15-29 age range. These data suggest that collapsing preto and pardo categories for health policy makes the most sense when addressing health issues with a social etiology (e.g., violence), rather than complex chronic diseases such as diabetes and hypertension.

Besides the issue of differing epidemiological profiles between pretos and pardos, some Brazilian researchers question claims of genetic continuity between the two categories. Recall Jean's (the European Brazilian medical researcher in São Luís) observation that "pardo" does not necessarily connote the presence of African ancestry, but can also apply to individuals with mixed indigenous and European ancestry for lack of a more precise Census category. Despite this observation, Jean affirmed during our interview that pardos and pretos with African ancestry exhibit higher rates of hypertension that is more severe and harder to treat than hypertension in whites. Thus, although he questions the accuracy of the category "pardo," he believes there is a common genetic basis for at least one disease between light- and dark-skinned African Brazilians. Telles (2004) also argues that "pardo" is a problematic Census category if lumped together with "preto" to form a single "população negra." Since the Census registers self-reported racial identity, and the National Health Policy for the Black Population utilizes these numbers, its target population may capture individuals without African ancestry (e.g., indigenous Brazilians) who are phenotypically brown while excluding individuals who have African ancestry but lack a black phenotype.

The Imperative of Self-Declaration

The imperative for patients to declare their own racial identity, rather than permitting health professionals to declare it for them, is a particularly salient issue within the Brazilian black health agenda. Over the last few years, the Ministry of Health has conducted a widespread campaign to encourage patients to declare their own "race or color” (*raça ou cor*) on medical forms. In São Paulo, the state health department often contracts black health activists (many of whom are psychologists or sociologists) to conduct training sessions for hospital staff on appropriate procedures for collecting patients’ self-declared race and color data. According to many of the health administrators and activists whom I interviewed, self-declaration is important because, in a context of significant interethnic mixture, health professionals must rely on patients’ knowledge of their own ancestry rather than trying to guess their ancestry through phenotypic clues. This claim indicates their belief that race is a reliable proxy for ancestry, and that ancestry can provide important clues regarding patients’ health vulnerabilities.

Prior to the early 1990s, epidemiological data by race were rarely collected in Brazil; only birth and mortality statistics featured a race variable. In recent years, however, the Ministry of Health has invested increasingly in the production of epidemiological data by race in order to get a clearer picture of racial inequalities in health. The Ministry’s shift in data collection policy occurred as a result of pressure from black health activists and new legislation. As Mariela, a black health activist and SUS administrator, explained:

> The color question [on patient records] serves to reveal race relations and how they interfere in the process of health care.... People get sick and die as a result of their social conditions, which are due to race relations and social inequalities. But when they enter the clinic, those relations are reproduced there. That’s why [health professionals] end up treating their patients differently. And they don’t even realize it.

Mariela’s comments reflect the importance that advocates of the black health agenda place on collecting patients’ race data. In essence, they rely on the color question (*quesito cor*) to provide proof that racial health disparities exist in Brazil. Although still inadequate due to spotty recording practices in many areas, epidemiological data by race have been instrumental in persuading the Brazilian government to approve black health initiatives. Mariela's statement also posits social factors, including blacks' relative socioeconomic disadvantage and racial discrimination in health care, as the primary cause of racial health disparities in Brazil.

Another element that emerges in Mariela's comments is the claim that blacks are treated differently (i.e., unequally) from whites in health care settings. Black health activists both denounce and demand differentiated treatment in health care using the same language, i.e., *tratamento diferenciado* (differentiated treatment). This seems at first glance to be contradictory. Activists denounce worse treatment for blacks but they do not reject discrimination *per se*; in fact, they make political claims for "positive discrimination" (*discriminação positiva*) in the form of culturally sensitive treatment for blacks, as well as treatment that takes into account their specific physical features and biological tendencies.

Although Mariela's statement reveals her understanding of the utility of the color item, she still does not explain why it is so important for the patient, rather than the health professional, to declare the patient's race. If the objective were to provide evidence of racial health disparities stemming from racism, wouldn't hetero-classification (i.e., classification by the health care provider) constitute a more reliable measure of how others in society perceive the patient? Patient self-declaration makes it possible for a person with African or Indian ancestry to identify as white, thereby obscuring any correlation between her health status and her status as a disenfranchised minority. In addition, the color question does not take into account the race of the health care provider. If the objective of the question is, as Mariela states, to reveal how racial dynamics influence medical encounters, wouldn't that information also be useful?

Recently, Bastos et al. (2009) conducted a large-scale study of self-declared racial identity. They found that the way respondents identified their own race shifted significantly depending on the interviewer's phenotype. Specifically, respondents tended to identify themselves as one shade lighter than their interviewer. This study demonstrates the considerable influence of relational dynamics in constructing racial identity in Brazil. In a practical sense, it shows that racial identity is not stable even when self-declared, and that it can shift considerably according to context.

Nevertheless, the public health professionals I interviewed all stressed the importance of self-reported race on patient records. Miriam, a European Brazilian health educator at the CRT in São Paulo (see Chapter 3), recalled the significant changes in patients' race statistics that ensued when the CRT first instituted a self-declaration policy in 2004. At that time, Miriam and her colleagues re-classified their current patients' race data according to self-declared racial identity, then compared those data with the race data that had previously been recorded by staff. The largest increase was in "pardos," followed by "pretos." To the staff's surprise, they suddenly gained about twenty-five indigenous patients, all of whom had previously been classified by health professionals as "pardo" or "preto." Based on these results, the staff concluded that they had been "whitening" their patients' racial identities.

Given the highly contingent nature of both self- and hetero-classification of patient race in Brazilian public health settings, both methods are problematic if the goal is to generate consistent epidemiological data that reflect racial identity. During fieldwork, however, it gradually became clear that activists were more concerned about the patient's right to self-determination than with the quality or consistency of epidemiological data. An episode from my fieldwork illustrates this point. On October 27, 2008, a group of black health activists gathered at the radio and television workers' union in Bixiga, a neighborhood of downtown São Paulo. The occasion was the third annual Black Health Mobilization Day, and activists from black movements (*movimentos negros*) all over Brazil were commemorating the day with special meetings and events. Early that afternoon, I was down at the union headquarters helping the activists to hang posters and organize the auditorium for a debate to be held in the evening. The posters we were hanging, which came from the Ministry of Health, encouraged patients to self-identify their race when accessing health care in public clinics and hospitals. Each poster featured the slogan: "HEALTH: What is your color/race/ethnicity? You are the best person to declare your color. With this information, the public [health] service can better serve you." Underneath the slogan was a photographic lineup of seven faces, each one cropped below the nose and representing a different ethnicity.

I turned to Pai Cesar, a fervent black health activist and priest of Afro-Brazilian religion, and asked him why self-declaration is so important. He looked at me quizzically and replied, "It's an issue of the right to declare your own identity, rather than allowing the state to dictate your identity to you." I then asked him about the possible pitfalls of self-declaration, such as white people identifying as black and vice-versa.[63] Tentatively, I

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[63] The way I framed this question demonstrates the extent to which I was using North American racial ideology at this point in my fieldwork.

added that it seemed as though self-declaration could misrepresent both racism in health care and the correlation of certain race categories with risk for genetic illnesses like sickle cell anemia. Pai Cesar quickly replied, “genetic makeup is irrelevant in Brazil due to miscegenation,” adding that black health activists were much more concerned with black Brazilians’ unequal access to health care and with racial discrimination in the clinics. He skirted the issue of data quality.

In his explanation, which was echoed by other black health activists during fieldwork, Pai Cesar affirmed that one of the fundamental issues underlying self-declaration is the right to self-determination. Rather than allowing the state to impose a racial identity upon its citizens, as it routinely does on infants’ birth certificates, activists and many health administrators believe citizen-patients should have the right to decide how they want to present themselves during a medical encounter. This ideology of self-declaration/determination of one’s racial identity comes from the Brazilian Census, which also requires citizens to declare their own race.

Earlier, I stated that Brazil’s current regime is closer to a social democracy than a liberal democracy due to its focus on social welfare policies. During the 1990s, however, Brazil, like many Latin American nations, implemented structural adjustment policies meant to help curb its mounting debt and staggering inflation. Like its Latin American neighbors, Brazilian governmentality still bears traces of neoliberalism that have endured from this time. As Burchell (1996) argues, neoliberal governance

> constructs a relationship between government and the governed that increasingly depends upon ways in which individuals are required to assume the status of being the subjects of their lives, upon the ways in which they fashion themselves as certain kinds of subjects, upon the ways in which they practice their freedom” (29-30).

In the context of post-neoliberal Brazil, the imperative of racial self-declaration within health care represents a technology of the self that constitutes citizens' relationship to the state in a particular way. Through the act of declaring one's racial identity within the public clinic, citizens are (in theory) given the freedom to choose how they want to be viewed and treated. Within Brazil's new biopolitical mode of governance, citizens who identify as "parda" or "preta" are tallied and entered into national epidemiological databases as such. From there, data on their health outcomes join those of other citizens and are used to produce scientific knowledge and to formulate health policies. Thus, in declaring their race, citizens enter a complex cycle of interaction with the state that both begins and ends by reinforcing particular rationalities of government. In this case, citizens participate in a form of governance that utilizes their self-declared vital statistics to create health policy, care, and research that aims to fulfill a compensatory logic. This form of governance reinforces the idea that some citizens are more vulnerable than others, and thus require specialized health care.

Furthermore, as is often the case with neoliberal governmentality, the state appears to entrust citizens with certain aspects of governance (sometimes called "responsibilization"), while simultaneously circumscribing their choices (e.g., Ong 2006). In the case of race/color data collection within SUS, the state purports to give citizens the freedom to choose their own racial identity, but limits this freedom by requiring them to choose from a list of state-provided categories that may or may not reflect how they actually identify themselves racially. In theory, citizens would become co-responsible for their treatment, health outcomes, and, ultimately, the health policies they help to create by declaring their race in the public clinic. In practice, however, this idealized scenario often breaks down due to provider and/or patient resistance.

Etiological Claims

Many scholars have questioned the validity of utilizing race variables in epidemiological research (e.g., Root 2003, Shim 2000, Fullilove 1998). Specifically, they question research designs that purport to measure the prevalence of genetically determined conditions by referencing socially defined “racial” populations. They also problematize the use of “race” as a universal variable, given that race categories differ according to social and historical context. Many of these scholars, however, support the use of a race variable to measure the effects of racism as a causal factor for health disparities between racialized groups.

Jean, the medical researcher in São Luís, criticized some Brazilian epidemiologists’ blanket attribution of certain diseases to the entire black population without taking into account regional differences. Having researched black health issues in both São Paulo and Maranhão, he pointed out that blacks in Maranhão suffer disproportionately from diseases such as malaria, tuberculosis, and Hansen’s disease (leprosy). Blacks in urban São Paulo, by contrast, do not often present with these illnesses, as they are tend to be more prevalent in poverty-stricken regions like Northeast Brazil.

Jean’s comments raise the question of whether illnesses defined as black health problems in Brazil merit this special category, or whether they are, in essence, diseases of poverty. In other words, what is it that distinguishes black Brazilians’ suffering from that of Brazil’s impoverished masses? This question is hotly debated between supporters and opponents of the black health agenda. In their recent book *Divisões Perigosas* [Dangerous Divisions] (2007), Peter Fry and colleagues from FIOCRUZ, Brazil's premier public health research institute, dismiss the need for a separate area of public health focused on blacks. They argue that low-income blacks suffer from the same health concerns as all impoverished Brazilians. While Fry and his colleagues do not dispute the existence of racism, they contend that creating separate policies for black Brazilians will end up creating racial segregation in Brazil in a manner similar to the United States or South Africa. According to them, public policies based on a bipolar conception of race represent a North American solution to racial inequality that does not match Brazil's cultural context. Rather, they assert that only universalist policies to improve health and living conditions for *all* Brazilians are capable of counteracting racism.

According to black health activists (e.g., Lopes 2005), positions like that of Fry and colleagues reduce racial inequality to class inequality. Activists argue that black Brazilians not only constitute the majority of the country's impoverished masses, but also endure additional suffering provoked by racism in all social structures and institutions, including the clinic. They claim further that black Brazilians' suffering is qualitatively different from that of poor whites due to both physical and social factors. Activists' explanations of health disparities between black and white Brazilians run the gamut of genetic/biological, social, and combinations of these. Furthermore, they often classify diseases believed to have a genetic origin in African Brazilians as "ethnic illnesses" (*doenças étnicas*).

Laura, the black health activist in São Luís mentioned in Chapter 3, identified sickle cell anemia, uterine fibroids, hypertension, and diabetes as "ethnic illnesses" affecting the black population. She distinguished these from diseases such as HIV/AIDS, which she said were more prevalent in socially "vulnerable" populations (*populações vulneráveis*) such as the black population, but have no connection to blacks' genetic makeup. Laura attributed blacks' social vulnerability both to socioeconomic disadvantage and to unequal access to HIV/AIDS prevention and treatment services. When I asked her about the origin of ethnic illnesses, Laura speculated that the hostile conditions of slavery, combined with artificially engineered contact between enslaved Africans from diverse geographic areas, had produced genetic mutations in blacks. These mutations, she explained, were then expressed as ethnic illnesses.

The idea that an individual's acquired traits can be passed onto his or her offspring is a key tenet of Lamarckism. During my research, I encountered many activists and non-activists that invoked the duress of slavery to explain black Brazilians' present-day health patterns—regardless of whether they considered them better or worse than the health outcomes of non-blacks. Perhaps the frequency of Larmarck-inspired etiological narratives is no coincidence, considering the popularity of Larmarckian or "soft" eugenic theories in Brazil during the late nineteenth and early twentieth centuries. Brazilian intellectuals favored Galton's brand of "positive eugenics," which earned that moniker through Galton's recommendation that governments should encourage fitter individuals to reproduce, rather than limiting the reproduction of individuals assumed to be less fit. Brazilian eugenicists often combined Galton's ideas with Lamarckian theories that stressed the heritability of acquired traits, thereby engendering an even "softer" form of positive eugenics in which public sanitation and hygiene were stressed over and above restrictive mating practices (Stepan 1991).

Although it may be a stretch to connect Brazilians' present-day racial narratives to turn-of-the-century eugenic discourses, Lamarckian understandings of racial inheritance figured prominently in my informants' accounts—often in combination with discourses drawn from biological and biomedical sciences. Laura, for instance, combined a Lamarckian explanation with a narrative based on population genetics (i.e., genetic drift). What is interesting about the second part of her explanation, however, is the idea that enslaved Africans in Brazil represented an isolated mating population. She claimed that the forced contact between Africans from different continental areas had produced genetic mutations, as if enslaved Africans were not also reproducing with Portuguese and indigenous Brazilians. This kind of narrative challenges an important tenet of Gilberto Freyre's theory of racial democracy, namely, unrestricted sexual mixing between African, Portuguese, and indigenous Brazilians during colonial and post-colonial times.

The discourse of ethnic illnesses is not confined to activists; it has been used by Brazilian medical researchers and endorsed by the Brazilian Ministry of Health. In 2001, the Ministry of Health published the *Manual of Most Important Illnesses, for Ethnic Reasons, in the Afro-Descendant Brazilian Population* (*Manual de Doenças Mais Importantes, por Razões Étnicas, na População Brasileira Afro-Descendente*). The manual sought to educate health care providers about diseases observed to be more prevalent in African Brazilians. Although "ethnic reasons" could refer to anything from customs to diet to residential patterns, the manual operationalizes Afro-Brazilian ethnicity as genetic predisposition to a host of diseases. These include sickle cell anemia, G6PD deficiency, hypertension, diabetes mellitus, and pre-eclampsia. Although the manual deems it "unacceptable" to divide the Brazilian population into "black" and "non-black" categories given its high level of miscegenation, the authors simultaneously affirm the existence of "white genes" and "black genes" (Ministry of Health 2001: 46).

Many researchers argue that human races do not exist, at least not in the sense of discrete biological entities that correspond to socially constructed race categories such as "black" or "white." Brace (2005), for instance, asserts that biologically adaptive traits are not distributed along the lines of perceived racial boundaries, but rather along genetic clines. Clines differ substantially from race because, while "cline" refers to the distribution of a particular trait throughout a species, "race" designates a population group (sometimes understood as a subspecies) on the basis of shared phenotypic traits such as skin color and the shape of facial features. Similarly, Templeton (2003) argues that race is nonexistent from a genetic standpoint because subspecies do not exist in human populations. Clines, however, do exist and often cross so-called racial boundaries. For instance, clines for the sickle cell trait occur in several regional populations throughout Africa, the Middle East, the Mediterranean area, and southern India; the high degree of phenotypic variation across these populations demonstrates the trait's discordance with the traits normally used to designate race, such as skin color (ibid.). Genetically determined variation in drug response is another example of clinal patterning that defies the socially constructed boundaries of race (Wilson et al. 2001).

Nevertheless, a number of biomedical researchers continue to assert the validity of using U.S. Census race categories as a proxy for genetic variation in epidemiological studies of health issues such as diabetes (e.g., Karter et al. 2002) and hypertension (e.g., Brewster et al. 2000) as well as drug response (e.g., Exner et al. 2001). Similarly, most of the Brazilian activists and health professionals I interviewed accepted at least some degree of health-related genetic specificity among blacks as a group. Sickle cell anemia and hypertension were the two diseases that respondents most commonly invoked as proof of this specificity—even though some, like André, were clearly aware of the contingent nature of "black" health problems.

Jéssica is a black health activist and the director of a public clinic in Taboão da Serra, São Paulo. As one of the only black clinic directors in São Paulo, she was keenly aware of racism within the clinics and recounted how her colleagues had given her the cold shoulder when she first became director of a nearby clinic. By night, Jéssica worked as a nurse at the public Campo Limpo Hospital, and she was completing a master's degree in organizational management at the time of my research. She is in her fifties and has medium-brown skin and straightened hair.

Due to her simultaneous positions as health provider, health administrator, and black movement activist, Jéssica had a unique perspective on issues of race and health. Like most of my informants, she presented a mixed account of etiological explanations for black/white health disparities. For instance, she stated that blacks' higher prevalence of diseases such as hypertension, diabetes, and uterine fibroids may have arisen from their enslaved ancestors' emotional trauma. She also claimed that black women have more problems with reproductive health because they have "hotter bodies." Additionally, she affirmed that the ACE inhibitor captopril is ineffective in blacks and causes more side effects for black cardiovascular patients than for white ones, although she could not explain why.

In spite of her biomedical training and experience, Jéssica's comments indicate that she subscribed to several medical beliefs that contradict basic tenets of biomedicine and evolutionary biology. Her belief in the heritability of diseases with psychosomatic origins resembles the Lamarckian model of inheritance, as I discussed above in relation to Laura's etiological explanations. Jéssica's statement that black women have hotter bodies invokes elements of both humoral pathology and scientific racism. According to Foster (1987), some tenets of humoral pathology have lingered in Latin America as a result of Spanish and Portuguese colonizers introducing the topic into medical education and practice in the New World. Although humoral pathology seems to have retained more popular influence in Spanish-speaking Latin American countries than in Brazil, Jéssica's idea that black women have hotter bodies could be influenced by remnants of humoral pathology in Brazilian medical culture. At the same time, the idea of black women having hotter bodies than white women is reminiscent of the scientific racism that was in vogue across Europe and the Americas during the late nineteenth and early twentieth centuries. During the interview, however, it was clear that Jéssica was expressing hypotheses rather than convictions about the causes of worse health outcomes in blacks.

Jéssica also identified racism in health care as a powerful contributor to worse health outcomes in black patients. In her role as charge nurse at a public hospital, she claimed she had often witnessed her colleagues verbally abuse black women in labor:

> A white woman comes in and screams, screams, screams, and no one says anything. But normally with black women—even nurses do this, unfortunately, I have seen this—[they say] "when you were getting laid you didn't cry out for your mother or for God." They make these vicious comments that they don't make to other women [patients]. When a [black] woman yells, "oh my God!" [the nurses] tell her to shut up.

Jéssica also observed that black women in labor were given anesthesia less often than white women in labor. She attributed this practice to the widespread belief that blacks could withstand pain better than whites.[64] Additionally, Jéssica had seen doctors recommend hysterectomies more often to black women with uterine fibroids than for white women with the same problem.[65] To Jéssica, it seemed that the doctors wanted to sterilize those women in order to prevent the birth of more blacks.

Jéssica's account of unequal treatment of black versus white patients in Brazil is supported by several recent studies. For instance, in a large-scale survey of women who had recently given birth, Leal et al. (2005) found that nearly twice as many white women as black women (pretas) had received anesthesia during normal labor. Pardas' rates fell between those of black and white women. Similarly, brancas were nearly three times more likely than pretas, and nearly twice as likely as pardas, to receive pre-natal care.

Although these findings could reflect service differences between private and public health care, the authors argue that this should not matter since SUS, Brazil's universal health care system, provides both pre-natal care and anesthesia during labor. However, during my fieldwork in public clinics, many working-class women reported having significant difficulty accessing pre-natal care through SUS. Many of these women, though not all, were brown or black. Also, several of them reported difficulty getting to the hospital when they went into labor because they could not afford taxi fare. If these women arrived at the hospital in an advanced stage of labor, it is possible that

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[64] See also Washington (2006) on how the popular belief in the United States about blacks' superior pain tolerance impacted the disproportionate use of blacks as subjects in medical research during the 19th and 20th centuries.

[65] Jéssica implied, but did not state, that the doctors to whom she referred were white. Physicians in both private and public practice in Brazil are overwhelmingly white.

epidural anesthesia was no longer an option. At the same time, these data could reflect racist stereotypes that black women either are able to withstand pain better than whites, or are less deserving of scarce resources like anesthesia than whites. It is impossible to know.

Despite the significant ambiguity surrounding claims of racial discrimination in health care, the Brazilian Ministry of Health has in recent years launched a prominent campaign against institutional racism (*racismo institucional*). This campaign consists of sensitivity workshops for health professionals, and print media such as booklets, posters, and videos that encourage patients to declare their own racial identity. The campaign is rooted in the now-defunct national Program for Combating Institutional Racism (Programa de Combate ao Racismo Institucional-PCRI), the bilateral initative between the Brazilian government and the UK's Department for International Development (DFID) that I described in Chapter 3.

In emic terms, the phrase "institutional racism" denotes the unequal treatment of blacks and whites in public spaces such as clinics and hospitals. It also refers to health professionals' unconscious discrimination against black patients. Following the creation of the PCRI in 2001, official discourses on racial health disparities shifted from emphasizing genetic etiology to privileging institutional racism as a primary causal factor. This shift is somewhat curious, given that nearly all of the activists I interviewed between 2005 and 2009 posited genetic differences as an equally important cause of health inequalities between blacks and non-blacks. The shift may be due to the Pan-American Health Organization's influence on the Brazilian black health agenda; PAHO has conducted workshops in Brazil focused on "ethnic equity" and the elimination of "institutional racism" in health care since the early 2000s.[66] Reducing ethnic health disparities in the Americas is the main focus of PAHO's "Millennium Development Goals" (MDG), which were established in 2000.

During my fieldwork, it became clear that transnational discourses on institutional racism had begun to filter into SUS clinics. In some cases, new antiracist institutional norms caused discomfort and confusion among employees. One day, for instance, I was sitting in the computer room of Jéssica's clinic in Taboão da Serra —the de facto employee lounge—when Dr. Miguel walked in. He was a tall, white *paulista* of about fifty-five with salt-and-pepper hair and dark, twinkling eyes. When Jéssica told him I was studying race and ethnicity in Brazil, Dr. Miguel remarked that in Brazil, most people do not see color in terms of black and white; rather, they perceive many intermediate colors, such as *mulata*—"like Jéssica here," he joked. Jéssica smiled but replied firmly, "Eu sou negra" (I am black). Dr. Miguel reacted with surprise, and responded, "Oh, really?" Jéssica explained to him that *mulato* is a pejorative term because it comes from *mula* (mule). Dr. Miguel had never heard that before. "Well," he said, "I have nothing against *negros*—at least, not most of them!" He playfully slapped Jéssica on the upper arm when he said this, and she grinned. Dr. Miguel then commented that it was difficult to know when to call someone *negro*, because so many people find the term offensive.

A few weeks earlier, Dr. Miguel had jokingly asked a child he was treating, "Why are you so dark (*escurinha*) if your mother is white?" The mother became very upset. The next day, her husband lodged a complaint against Dr. Miguel, calling his behavior

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[66] See, for instance, a 2004 PAHO publication titled "Working to Achieve Ethnic Equity in Health: Ensuring that the Millennium Development Goals Include an Ethnic Perspective in Latin America and the Caribbean." Electronic document, available at: http://www.paho.org/english/ad/ge/torres-ethnicequity.pdf. Last accessed March 28, 2011.

"racist." Dr. Miguel thought this was going too far. "I joke around with Japanese children too, asking why their eyes are squinty (*puxados*)," he added. Jéssica asked me if doctors made these types of comments to their patients in the United States, and I responded that doctors, like most Americans, tend to avoid joking about people's racial identity because it is not considered politically correct. "See?" said Jéssica, raising her eyebrows and nodding approvingly.

When I entered the employee lounge the following week, Dr. Miguel was seated at the table, looking rather down. He told me that earlier that day, he had asked a female patient why she has a white baby if she, the mother, is so black (*preta*). The mother had responded angrily, "I'm not black, I'm *morena*—don't you see that my hair is straight?" Virginia, the office manager and a self-proclaimed *negra*, snorted with laughter and remarked that many patients who are *negros de cabelo duro* (black with hard hair) claim to be "moreno" when asked to declare their race on patient forms. Dr. Miguel laughed too, adding, "These *mulatinhos* (little mulatos) always say they're *morenos*!" He glanced sideways at Jéssica to gauge her reaction, and she smiled tightly.

This example is emblematic both of the conflicting norms on how to deal with race in clinical settings, and of the way Brazilians tend to use humor to defuse potentially uncomfortable situations involving race. The exchanges between Dr. Miguel and Jéssica revealed their contrasting stances on racial etiquette, and their divergent models of racial identity. Although Jéssica did not openly censure Dr. Miguel for teasing his patients about their skin color, she used my response about U.S. norms of race talk to suggest that this was the proper way for doctors and patients to interact. As clinic director, Jéssica was Dr. Miguel's supervisor, and he was aware of her participation in the city's black health committee. Nevertheless, he was confident that she and Virginia would take his racial commentary as good-natured ribbing rather than an expression of racism. He had not received any formal training on *saúde da população negra* at that point, and thus still felt comfortable using racial epithets like "mulatinho" to describe his patients.

This episode also shows that not only health professionals, but also patients are becoming increasingly vigilant about racial discrimination. Dr. Miguel's patients had received no training on how to recognize and report racism at the doctor's office. It is possible, though, that the child's father had noticed a Ministry of Health poster posted on the clinic wall with the words, "Racismo Institucional—DENUNCIE" (Institutional Racism—Denounce it). In the last couple of years, SUS has implemented complaint boards (*ouvidorias*) to receive patients' feedback on clinic services. Despite the Ministry's good intentions, I heard from many patients that they had never been contacted after lodging a complaint with an *ouvidoria*.

None of the healthcare administrators I interviewed admitted to opposing the implementation of race-specific health measures, although several doctors and nurses did; I discussed some of their reactions in Chapter 2. The most vehement opposition to activists' charges of institutional racism in SUS, though, comes from researchers at FIOCRUZ. In their article "O SUS é racista?" ("Is SUS racist?"), Maio, Monteiro, and Rodrigues argue that the racist attitudes and actions of some SUS professionals simply reproduce the same tendencies that exist within society and do not, therefore, constitute pervasive institutional racism, but rather reflect the idiosyncrasies of particular individuals (Maio, Monteiro, & Rodrigues 2007).

In addition to blaming health disparities on institutional racism, black health activists attribute black Brazilians' worse health outcomes to everyday experiences of racism. They connect these experiences to hypertension and to higher rates of mental health problems among blacks. Arlene, for instance, reported feeling unwelcome in many public places in São Paulo before she became involved in black movement activism. According to Arlene, she used to confront daily bouts of insecurity when doing the most mundane things because she expected to be treated badly. As she explained,

> You enter [an establishment] without knowing ...how you will be received. Restaurants, for example—I can't tell you how many times I walked by a restaurant, hungry, with money in my pocket, and a thousand times I didn't have the courage to go in.

Whether or not Arlene's discomfort was justified by the way she was actually received in public places is irrelevant. The point is that she believed she would not be treated well, and her belief caused her to experience stress and to avoid certain places and situations.

Many of the activists in my study—women in particular— reported exceptionally stressful life situations, and they often seemed anxious or depressed when we spoke. Edileusa, for example, complained about the high degree of job stress she experienced due to racial prejudice and belittlement at work. Raquel and Arlene lived in the urban periphery and battled disintegrating financial conditions. Jéssica worked double shifts to support her household as a single mother. Perhaps not surprisingly, most of these women suffered from high blood pressure. Although Arlene felt that her involvement in black movement activism helped her to confront racial discrimination in her own life, it did not appear to diminish the stress she experienced on a daily basis. She reported that her doctor had advised her to "stop this black movement business" if she wanted to live to see her grandchildren grow up. Many studies have demonstrated the correlation between perceived prejudice and high blood pressure (e.g., Williams 1998). Although my sample was relatively small, the women activists who participated in my fieldwork brought this correlation to life. Their narratives indicated that being aware of racism, and possessing strategies to respond to it, did not necessarily abate the stress of experiencing it.

Medicalizing Racism

By positing racism as a key causal factor for mental and physical health problems in the black population, activists and other supporters of the black health agenda medicalize racism. The National Health Policy for the Black Population presents urban violence as a public health problem for the black population and calculates health damages in terms of productive years lost for black men. Many activists attribute black Brazilians' lower life expectancy (as compared to whites) to socioeconomic disadvantage caused by racism in various sectors of society.

What are the implications of medicalizing racism? Medicalization, or framing a social problem in terms of its health impact, transforms an obvious but diffuse social problem into an empirical pathology located in the body of an individual patient. If medicalization is a top-down phenomenon, it could serve to neutralize a politicized response to social suffering (e.g., Lock & Scheper-Hughes 1996, Rhodes 1996). In the case of the Brazilian black health agenda, however, the medicalization of racism can be understood as an agentive strategy to garner health resources for black Brazilians. It thus constitutes a strategic response to a social problem that disrupts individual bodies. This argument becomes more evident if one situates the black health agenda within the corpus of affirmative action programs in Brazil. Viewed in this way, medicalization represents another strategy to redress inequalities stemming from racism. There is one important caveat, however: this kind of medicalization associates race and racism with the concept of "vulnerability," a discursive move that, in my assessment, can have negative side effects.

In an article presented at the First National Seminar on Black Health in Brasilia, activist Fernanda Lopes identifies the black population's "vulnerability" as a leading cause of poorer health outcomes (Lopes 2004). She defines "vulnerability" as "a set of individual and collective factors related to the degree and mode of exposure to a given situation and, undeniably, to unequal access to the resources necessary to protect oneself from the undesirable consequences of that situation" (49). She links black Brazilians' heightened vulnerability to their higher rates of preventable diseases such as AIDS.

What are the consequences of labeling a racialized group as vulnerable? Does this language empower or stigmatize the group in question? On the one hand, asserting that social exclusion renders black Brazilians more vulnerable to illness could mobilize resources toward addressing the physical results of entrenched structural inequalities. On the other hand, "vulnerability" discourses resemble the language of risk employed in the epidemiological identification of "at risk" populations. Glick Schiller (1992) critiques the identification of race, ethnicity, or culture as risk factors for illness because this language can shift the locus of blame from society onto excluded groups themselves. Epidemiologists' blanket characterizations of certain populations as "at risk" may reinforce the image of these populations as culturally distinct from the rest of the nation, or what Glick Schiller terms "contagious cultural others" (239). Finally, she argues that the "racial and ethnic categorization of risky behavior" can result in misguided health policy (239).

How does this argument apply to the Brazilian black health agenda? The Brazilian case is slightly different because members of the excluded group are promoting their own characterization as a vulnerable population. Overall, activists' discourses of vulnerability do not seem to obscure social factors such as racism. Being labeled "vulnerable," however, may be unpalatable to individuals who do not wish to be associated with weakness or heightened predisposition to illness. As for Glick Schiller's argument that "at risk" populations are often constructed as "contagious cultural others," this could be a danger for the Brazilian black health agenda as well if the focus is on contagious diseases such as HIV/AIDS. Even identifying black Brazilians as more likely to experience septic abortions, substance abuse, or mental illness could have a stigmatizing effect. When asked about vulnerability discourses and the potential for stigma, however, black health activist Cláudia responds that "everything we do [related to black health] is risky….We run the risk of negative stereotypes, but on the other hand, they are based in reality." She adds that, although the general population might interpret health "vulnerabilities" as stemming from essential characteristics of the black population rather than from racism, this risk is necessary in order to denounce racism and reduce health disparities.

Discourses of Difference

As I mentioned previously, black health activists often make reference to different treatment for blacks and whites in medical settings. These statements can be somewhat confusing, since they simultaneously demand and denounce different treatment (*tratamento diferenciado*). On the one hand, activists often complain that health professionals discriminate against black patients in various ways. Sônia, the activist from Geledés in São Paulo, expressed this idea in the following way:

> Let's say we both go to the doctor's office. The doctor will ask you about your medical history. "What illnesses run in your family?" "How old are you?", etc. Then I come in. He's going to ask, "Since when [have you had this]?" "What's going on?" "OK. Take this [medication]." My appointment won't last as long because he is less interested in identifying the origin of [my] illness. So, something that's really common is for them to ask a black patient if he's an alcoholic. "Have you been drinking?" "Do you drink?" "Are you an alcoholic?" "Do you use drugs?" With you, he tries to get your medical history. With me, no—he goes directly to his assumptions...even today, black women's illnesses are often seen as being related to sexually transmitted diseases....they invoke the idea that black women are promiscuous, that black women are prostitutes...that they are unhygienic.

In this excerpt, Sônia describes a hypothetical doctor's discrimination against her, a black woman, as compared to me, a white woman. She attributes the doctor's neglect of his black patient to racism and suggests that doctors often misdiagnose black patients based on their belief in negative stereotypes about blacks, for example, that they are more prone to substance abuse and sexual promiscuity. During our interview, Sônia added that doctors' misperception of the causes of black patients' symptoms ends up delaying correct diagnosis until the patient's original complaint has become more complicated and difficult to treat. In her view, this lag between initial presentation and correct diagnosis in black patients is one of the most significant contributors to health inequalities between blacks and whites in Brazil. The discriminatory practices Sônia described fall under the rubric of "institutional racism" (*racismo institucional*) within black health activists' narratives. Virtually all of my activist informants reported similar discriminatory practices against black patients (in reference to themselves and/or to their friends and family), including health professionals' spending less time with them as compared to white patients and assuming that they engage in unhealthy behaviors.

The same activists who denounce different treatment often demand, in the same breath, that health professionals recognize and attend to black patients' special needs. These activists urge doctors and nurses to see black patients as a qualitatively different group than white, indigenous, or Asian patients. They argue that health professionals should take "a differentiated view" (*um olhar diferenciado*) of black patients. When I asked Sônia whether activists are ultimately seeking equality or different treatment, her answer was "both":

> [We're] asking for equality. But [treatment] has to be differentiated because the same headache may have a different cause between—between you and me. Let's say we go to the doctor with the same complaint. But that symptom in me should put the doctor on higher alert. Because I might have an illness which is prevalent in blacks, and you might not. You might be temporarily indisposed....so this initial moment which is equal ends up producing illness [in me]. So we ask for equality, but a different view (*um olhar diferenciado*) is also necessary.

Here, Sônia was referring specifically to hypertension. Although her suggestion that doctors should take headaches in black patients more seriously than headaches in white patients may seem like bad medicine, it is important to remember that Sônia is not a health professional—she is a sociologist. In her assessment, doctors should not only view black patients as a special group, but they should also follow a different treatment protocol when diagnosing them. In this example, Sônia did not say that blacks and whites have unequal access to public health care, but rather that their treatment *becomes* unequal if the doctor uses the same treatment protocol to diagnose everyone. The logical corollary of this statement is that blacks and whites are different before they ever enter the clinic. It was not clear from Sônia's narrative whether she believed this difference arose from unequal living conditions or from intrinsic physical specificities.

Furthermore, Sônia was making a case for "positive" discrimination between black and white patients, as opposed to the status quo in which negative discrimination (described in her first example) or even benign neglect (described in her second example) prevails. I asked her if that was what she meant, and she confirmed it:

> A *positive* differentiated view. That's it. Because today's differentiated view causes [blacks] to be neglected...This differentiated view of you and me prevents the doctor from requesting a specific exam, an EKG. It leads him to instead prescribe a simple analgesic, and to ignore my symptom.

Many of my activist informants similarly articulated the need for doctors to treat black and white patients differently in a way that would improve their health, rather than in a way that would misdiagnose and demoralize them.

Insofar as they confirm the existence of intrinsic differences between blacks and whites, Sônia's comments provide an example of "difference discourse" (Ford 2005: passim). Difference discourse is a reaction to racism that ends up reinforcing the idea of incommensurability between racialized groups (ibid). Whereas racist discourse "insists on racial difference and then punishes it as deviance," difference discourse retaliates against the racist "punishment of difference" by claiming respect for differences (ibid: 35). In the process, argues Ford, difference discourse "describes social identities such as race as a manifestation of underlying differences—a racial culture—while at the same time generating those very differences" (28). This is also Peter Fry's argument in relation to the black health agenda; he contends that, by treating the "black population" (*população negra*) as a "pre-discursive category," black health policies and programs "produce what they claim to exist" (Fry 2004: 133). In addition, Fry predicts that difference-based policy agendas, such as the black health agenda, will lead to increased divisions and racial hostility in Brazil (ibid, Fry et al. 2007).

It is too soon to say whether Fry's predictions will materialize. It seems plausible, however, that the black health agenda could significantly affect clinical practice in Brazil. While its focus on awareness of racist behavior within the clinic appears to be useful, the race-medicalizing component of the black health agenda could negatively affect health care decision-making. By following race-specific diagnostic and treatment protocols, medical practitioners may end up misdiagnosing and mistreating certain patients. This is especially the case when the health condition in question is linked to genotype, as with hypertension. Kaufman & Cooper (2010) show that, if physicians follow current guidelines to treat white patients with ACE inhibitors or beta blockers, and black patients with calcium-channel blockers or thiazide-type diuretics, they have a probability of mistreating patients roughly 45 percent of the time (197). Similarly, clinical studies of treatment response by race demonstrate more variability within racialized groups than between them (e.g., Nguyen et al. 2009, Sehgal 2004). Furthermore, Kaufman & Cooper warn that focusing too much on supposed racial differences can intensify racial stereotyping within clinical practice. For instance, physicians may undertreat minorities in response to the stereotypical belief that they are less compliant with prescribed regimens (199).

Kaufman & Cooper acknowledge, however, that the recognition of social categories such as race or ethnicity may be useful in clinical practice when treating health conditions with a social etiology. Krieger (2010) also makes this point, arguing that an "ecosocial" perspective enables policymakers and providers to address the health effects of racist social exclusion. She refers to both early-life and latent health consequences of growing up in impoverished and violent conditions. Krieger thus invokes the substantial overlap between racialized identity and socioeconomic inequalities in the United States, rather than race itself. She argues, nonetheless, that the only way to approach health problems that arise from racial discrimination is to take into account individuals' race.

Given the high correlation between skin color and life conditions in Brazil (e.g., Lovell & Wood 1998), it may be of practical value to consider racial identity in certain research and policy contexts. There are two caveats to this statement, however. First, stratifying data by race appears to be most useful in relation to diseases with socially produced etiologies. These might include diseases that arise from malnutrition, environmental toxins, or domestic violence, for instance. Second, in my view, it makes more sense to employ race as a (highly contingent) variable within epidemiological research and policymaking, as opposed to clinical practice. If a medical practitioner relies primarily on a patient's racial identity to diagnose and treat her, the practitioner may become blinded to important details about the patient's case, as asserted by the literature on race and response to hypertension treatment cited above.

Implications for Citizenship

The black health agenda raises the issue of the legitimacy of group-differentiated citizen rights. But are black health activists asking for special treatment? The National Health Policy for the Black Population calls for an increase in the black population's access to health services, the creation of health education materials geared toward the black population's particular "knowledges and values," and the creation and implementation of black health initiatives.[67] Its language is sufficiently vague as to make unclear the extent to which the black population will actually receive special treatment, as opposed to being *recognized* as a different group, but not necessarily treated differently within public health care.

James Holston (2008) argues that the uneven distribution of rights and obligations according to citizens' social characteristics is the rule, rather than the exception, of citizenship regimes around the globe. He observes that the extension of certain privileges to specific groups of citizens has historically been endorsed in Brazil, a regime he calls "differentiated citizenship" (passim). As I noted earlier, in Brazil women are permitted to retire five years earlier than men, and college graduates who are convicted of a crime have the right to a private jail cell. Since the end of the military dictatorship in the 1980s, Brazilians have increasingly used the language of citizenship to demand not only equal rights, but also special treatment for specific groups.

Black health activists, as I have shown, demand special medical attention for the particular health needs of black Brazilians, but they also make these claims on the basis of their exclusion from the right to quality health care, which is a universal citizenship right. In so doing, activists often cite the article from the Brazilian Constitution that defines health as a universal citizen's right and the State's obligation, and guarantees citizens "universal and equal access" to health care (Title VIII, Ch. II, Art. 196). Activists argue, however, that this Constitutional article and the Organic Health Law (8.080/90), which guarantees the provision of equality in health care, can only be fulfilled by adjusting medical treatment to suit different patients' needs. Rather than "equality,"

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[67] *Diário Oficial da União*, 90, 14 May 2009, p. 31-32.

activists invoke the principle of "equity." Equity has been defined in Brazilian public health literature as "equal opportunity of access" to health care (e.g., Almeida et al. 2000). My informants repeatedly defined equity as "treating different populations differently." In other words, theirs is a redistributive logic that aims to "level the playing field" (*anivelar o campo*) by giving special care to segments of the population deemed "vulnerable" by SUS—and especially by Brazil's National STD/AIDS Program—such as blacks, indigenous Brazilians, and homosexuals.

In recent years, "equity" has become a buzzword among black health activists and SUS administrators who are sympathetic to the black health agenda. They often argue that it is more important to provide equitable, rather than uniform, services because different patient populations have different needs and degrees of vulnerability that place them at greater or lesser risk for disease. They claim that if SUS provides uniform services to all patients, it will end up perpetuating unequal health outcomes. Although the term "equity" does not appear in the Constitutional articles related to SUS, or in the Organic Health Law that implemented SUS, it does appear in the new National Health Policy for the Black Population.

Black health advocates' definition of equity reflects a classic Aristotelian argument: "the nature of the equitable [is] a correction of law where it is defective owing to its universality."[68] Equity adapts the law to fit extenuating circumstances, and thus ensures justice by allowing, for example, less strenuous punishment for criminals who exhibit vulnerabilities in relation to other citizens. Equity in Aristotle's definition legitimizes unequal treatment of citizens in consideration of their particular needs. This

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[68] *Nicomachean Ethics*, 5.10 (1908, trans. W.D. Ross. Oxford: Clarenden Press).

conception of proportional or relative justice has been endorsed by scholars such as Young (1989), who argues that equal treatment actually produces and maintains social inequality since some groups in society are more privileged than others.

In Brazil, intellectual and politician Rui Barbosa famously articulated the Aristotelian conception of equity.[69] In a 1920 commencement address to law students in São Paulo, Barbosa reiterated the idea that true equality could only be achieved by treating "unequals unequally, according to the measure of their inequality" (*Oração aos Moços*).[70] More than once during fieldwork, I heard black health activists quote Barbosa directly in their claims for equity within SUS. Their use of Barbosa surprised me, since the quote naturalizes inequality between groups of citizens. Nevertheless, the quote often merely served to reinforce the activists' own naturalization of physical differences between blacks and non-blacks. For instance, at a black health rally in Bragança Paulista (a small town in São Paulo state), activist Pai Cesar made the following comments to an audience of terreiro health activists and black movement activists, local SUS administrators, and medical students:

> Ever since Rui Barbosa, we have been equal but different (*somos iguais porém diferentes*)...we must understand difference not as difference before the law, but between our bodies—and these differences create social differences between us....SUS tells us we are all equal, but there are pre-existing factors of inequality [among us].

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[69] James Holston discusses Rui Barbosa's definition of justice, and his own informants' engagements with it, in *Insurgent Citizenship* (2008). He also observes the Aristotelian origin of the compensatory justice argument.

[70] "A regra da igualdade não consiste senão em quinhoar desigualmente aos desiguais, na medida em que se desigualam. Nesta desigualdade social, proporcionada à desigualdade natural, é que se acha a verdadeira lei da igualdade." [The rule of equality only exists insofar as the unequal are treated unequally, according to the measure of their inequality. Within this social inequality, which is proportionate to natural inequality, one finds the true law of equality"] (my translation). Available at: http://www.culturabrasil.org/aosmocos.htm. Last accessed June 22, 2010.

In this excerpt, Pai Cesar made two discursive moves: he reaffirmed the principle of equality-in-rights, and he deployed a politics of difference by naturalizing biological incommensurability between black and non-black Brazilians. His narrative posited inherent physical differences as *a priori* ones that establish the basis for social differentiation. Even though he did not specifically mention racial identity in this excerpt, he invoked it throughout the remainder of his speech. This kind of essentializing discourse was commonplace at black health meetings and events I attended, and it was usually couched within proclamations of Brazilian citizens' universal right to health care through SUS.

Holston (2008) asserts that the Brazilian formulation of equity not only naturalizes the existence of inequality among citizens, but also ends up creating more inequality: "...it accepts that social inequalities exist as prior conditions of either disprivilege or privilege and treats them differently by distributing resources accordingly" (29). Although black health activists make claims for equal access to quality public health services, they simultaneously demand official recognition of their health-related differences. In so doing, they uphold the status quo of Brazil's "inclusively inegalitarian" citizenship, which combines universal inclusion with a politics of difference (Holston 2008: passim).

What are the implications of the black health agenda for citizenship equality in Brazil? At least in its present form, the black health agenda does not advocate giving black Brazilians special treatment to the detriment of citizens who do not identify as black. The National Health Policy for the Black Population does not stipulate, for instance, that black patients should be seen before whites in public clinics. Meanwhile, elderly patients are routinely moved to the front of the line in SUS clinics. Moreover, while there is some redistribution of human and financial resources in the form of training materials and workshops on black health issues, the Ministry of Health also funds special health programs for other citizen groups, such as women and indigenous Brazilians. For these reasons, while I see the black health agenda as an example of differentiated citizenship, I am not convinced that it will create more inequality than already exists in the Brazilian public health system.

At the same time, however, some of the differentiated citizenship claims embedded in the black health program naturalize incommensurability between blacks and whites. As such, one could conclude that the black health agenda represents a more dangerous form of differentiated citizenship than the kinds that already exist. Although the black health agenda maintains the status quo of differentiated citizenship in Brazil, its politics of difference goes further since it formalizes racial difference at a deeper level than is currently the case with affirmative action quotas in education. University quotas, at least in Brazil, are based on the premise that blacks have been excluded from higher education due to socioeconomic disadvantage. They exist alongside quotas for students who attended the inferior public school system and therefore do not impute any innate differences in scholastic ability to black citizens. Black health programs and policies, by contrast, attribute blacks' worse health outcomes to innate physical differences, in addition to structural factors such as socioeconomic disadvantage and institutional discrimination. In this aspect they differ from indigenous health policy, which highlights environmental and cultural determinants of indigenous health concerns, rather than alleging indigenous Brazilians' intrinsic biological susceptibility to certain diseases.[71]

Race-based legislation is particularly controversial in Brazil because, between abolition in 1888 and the implementation of the first affirmative action quotas in 2001, the state avoided distributing citizenship rights on the basis of race. Although the ideology of Brazilian racial democracy has now been widely debunked, many Brazilians retain the idea that public recognition of race equals racism. That is one reason that they become so inflamed by affirmative action quotas for blacks in public universities; they view the meting out of different treatment by race not only as unfair and unproductive, but also as a negation of the country's racially harmonious self-image.

Brazil, like many nations, faces the dilemma of how to promote the values of multiculturalism and antiracism without sacrificing fundamental civil rights and formal equality. According to many liberal theorists, the protection of individual rights automatically safeguards group-specific rights because individuals have the freedom to pursue group-specific goals in their private lives without fear of discrimination. They argue that benign neglect of particular interests and cultures is vital to maintaining a non-normative public sphere that remains neutral on the "good life" (e.g., Rawls 1971). Theorists who support group-differentiated rights, however, counter that in practice not all individuals possess equal access to the resources necessary to pursue the good life as they understand it (e.g., Taylor 1994, Kymlicka 1995, Benhabib 2002).

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[71] Source: National Indigenous Health Policy (Política Nacional de Atenção à Saúde Indígena), p. 9-12. Electronic document, available at: http://www.funasa.gov.br/internet/arquivos/biblioteca /sauInd_politica.pdf. Last accessed March 31, 2011.

But in the present case, I repeat, are black health activists really asking for different treatment? The answer is both yes and no. Some activists argue, like Sônia, that doctors need to treat their black patients differently based on their greater vulnerability to certain health problems. Much of the time, however, activists stress the need for blacks to have equal *access* to public health care. When I first heard black health activists say this, I was confused. Wasn't SUS open to everyone? Even I, a non-citizen (albeit a white one), had accessed health care at various public clinics and hospitals during my years in Brazil. In response to my query, my informants stated that two factors impede blacks' access to public health care: distance and the way they are treated by doctors.

Mariela, who is both a black health activist and a SUS employee, pointed out that in São Paulo, the majority of the black population lives in areas that are poorly served by public health facilities. To what extent is her theory accurate? On the next page, I have juxtaposed maps showing the distribution of health services and of the population by color within the city of São Paulo (Figure 3). The health services map utilizes differently colored dots to indicate various types of public health facility (e.g., primary care clinics, specialized clinics, etc). The race/color map combines pretos and pardos into one "população negra;" the darker the area, the higher the concentration of pardos and pretos. It seems that Mariela was correct in her assertion that the *zona sul* and upper north and northwest areas of the city have fewer health facilities. The *zona leste* (eastern zone), by contrast, appears to be relatively well served by the public health infrastructure. This is likely due in part to the fact that the zona leste was the epicenter of the Health Reform Movement during the 1970s and 1980s.

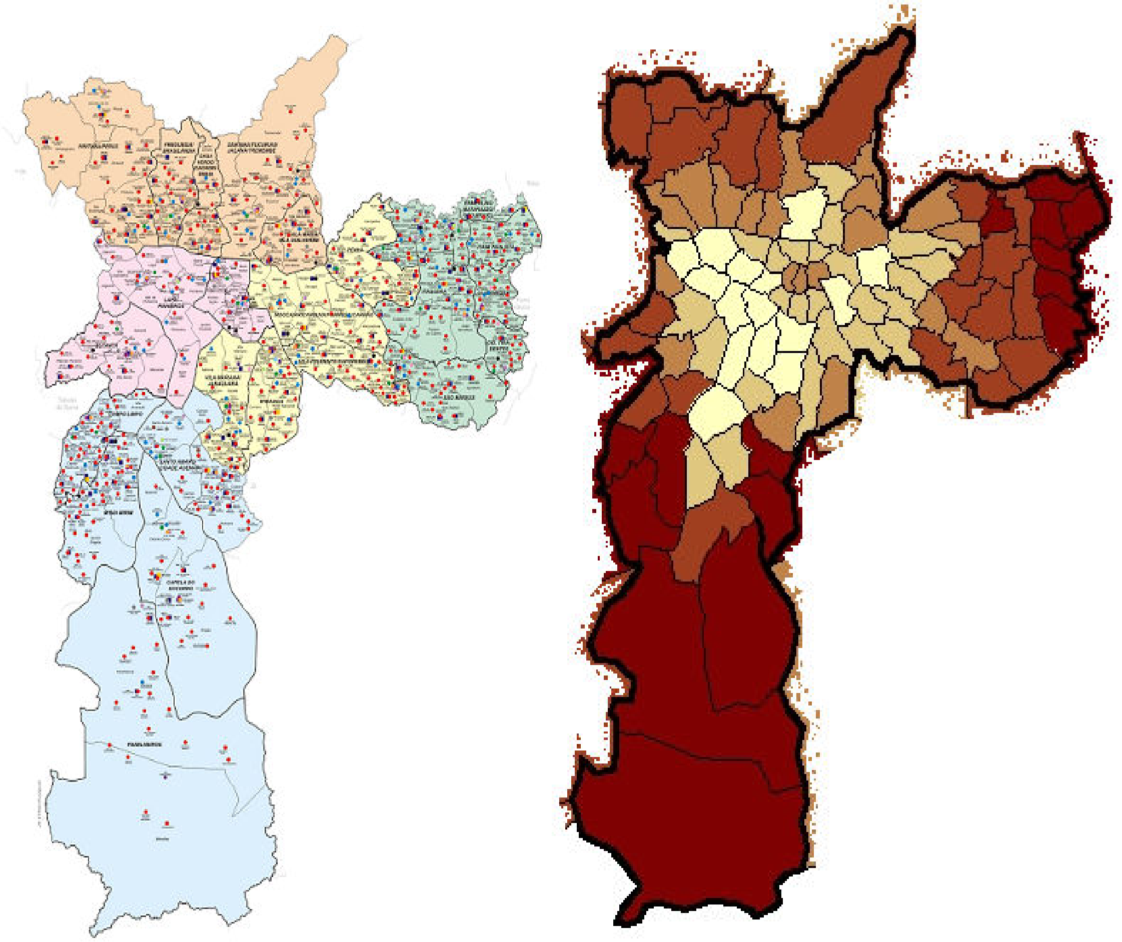

Figure 3. Public Health Facilities and Distribution of Population by Color in São Paulo, 2000.[72]

At the same time, however, it is important to consider population density when judging how well served an area is vis-à-vis its population's needs. As Figure 4 shows, the recently incorporated southern *bairros* of Marsilac, Parelheiros, and Grajaú (95, 58, and 30 on the map) have an exceptionally low population density, as do Anhangüera, Perus, and Tremembé in the north (2, 63, and 81 on the map). *Zona leste*, meanwhile, is densely populated. Therefore, it makes sense that there would be more health facilities in

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[72] Sources: Secretaria Municipal da Saúde de São Paulo (map on left) and Fundação SEADE (map on right). Map on left available at: http://www.prefeitura.sp.gov.br/cidade/secretarias/upload/saude /arquivos/organizacao/crs_sp_sts_munic.jpg. Map on right available at: http://www.seade.gov.br /produtos/idr/dem/mapa_popula_01.pdf. Both last accessed March 19, 2011.

the populous zona leste than in the less populated northern and southern parts of the city. When considering these factors, it becomes more difficult to affirm the accuracy of Mariela's statement that "black" neighborhoods lack health facilities.

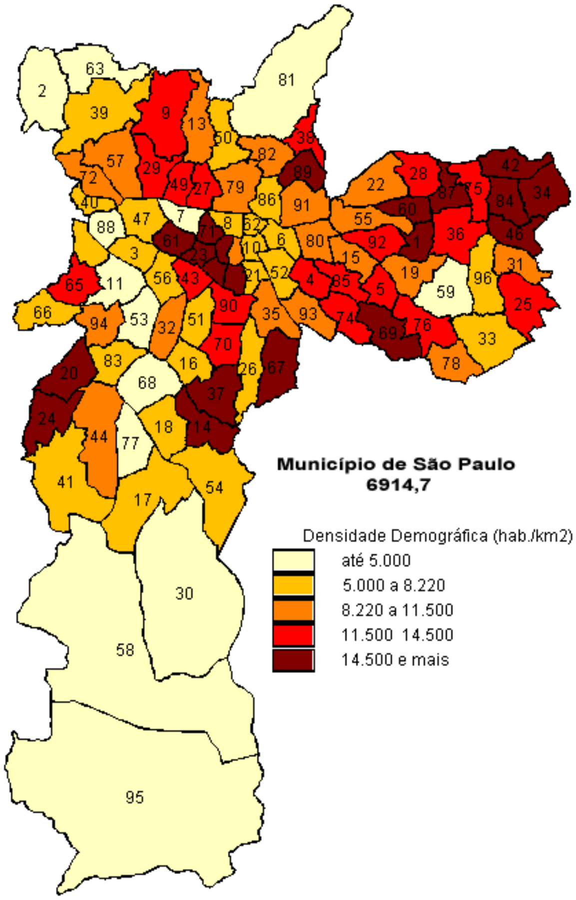

Figure 4. Population Density of São Paulo, 2000.[73]

As I stated earlier, it is also difficult to evaluate claims of unequal treatment by race because medical encounters are usually private. Additionally, patient care protocols differ from case to case, making it nearly impossible to assess the quality of individual treatment plans. Further complicating this issue is the generalized precariousness of SUS. It is commonplace for SUS patients of all phenotypes to complain about long waiting

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[73] Source: http://www.seade.gov.br/produtos/ivj/index.php?tip=map&mapa=2. Last accessed March 21, 2011.

lines, rushed appointments, and dismissive doctors and nurses. Although the Brazilian state similarly has no basis for evaluating claims of institutional racism in the clinic, besides a few studies of patients' own assessments of their health care (e.g., Barata et al. 2007), the Ministry of Health has seen fit to implement programs and policies to counteract institutional racism. This fact attests to the power wielded by activists' claims.

Conclusion

In this chapter, I have examined how researchers, public health administrators, and, above all, black health activists discursively enact the black health agenda. Through specific ways of defining blackness and its relationship to health, this epistemic community posits African Brazilians as a separate category of citizens that have special health needs and require equitable (not necessarily uniform) health practices. By claiming citizenship rights based on membership in a racialized group, black health activists are forging a new kind of racially informed biopolitical citizenship in Brazil. As part of this process, activists are demanding compensation from the state. This compensation takes the form of adjusting healthcare practices to address health damages sustained by the black population through social exclusion. By providing this compensation, the state has endorsed black health activists' biologized politics of difference. This fact signals the new wave of Brazilian governmentality that interpellates black citizens as a special class of citizens that can increasingly access reparatory resources through affirmative action programs in education, employment, and now, health care. At the same time, African Brazilians are enjoined to participate in their own interpellation as members of this special citizenship group by declaring their race as "preto" or "pardo" on the patient information forms utilized by public clinics.

The scenario I describe here is similar to what Epstein (2007) terms the "inclusion-and-difference paradigm" adopted by U.S. social movement activists, scientists, and the state in reference to the use of racial categories in U.S. biomedical research. In that case, minority activists demanded to be included in biomedical research in a way that defined them as different. Their simultaneous demands for inclusion and public recognition of their differences were successful, argues Epstein, due to the alignment of "the enhanced classificatory practices of modern democratic states, the assertive self-naming practices of identity-based social movements, and the new segmenting techniques of the biosciences" (342).

I perceive a similar alignment of factors in the Brazilian case. For over a decade, the state has endorsed the collapsing of "preto" (black) and "pardo" (brown) categories in order to constitute "the black population" (*a população negra*) numerically. As a result, affirmative action policies such as the National Health Policy for the Black Population are able to define the "black population" as over half of the total Brazilian population. Brazilian black health activists regularly adopt this definition of the black population in their discourses, although non-activist Brazilians usually do not. Also, due to the increasing availability of health statistics on the Brazilian population by race, Brazilian scientists are conducting more and more studies of differences in health outcomes between "white" and "black" Brazilians. The black health epistemic community utilizes these scientific data to fortify their political campaigns for race-specific health policy, which the state, more often than not, approves. And the cycle repeats itself. Thus there is, in Brazil, an intertwinement of state, civil society, and science that mirrors the situation described by Epstein in the United States.

At the same time, the case I analyze here differs from Epstein’s in that there is substantial categorical *mis*alignment between Brazilians who do and do not participate in the black health epistemic community. Whereas the majority of U.S. citizens would likely formulate racial categories in the same way as the U.S. Office of Management and Budget (OMB), which dictates the categories to be used in U.S. public health research and policy, most Brazilian citizens do not classify all people of African descent as “negros.” Yet, this composite category is increasingly gaining purchase within the realms of research and public policy in Brazil.

Part III: AFRO-BRAZILIAN RELIGIONS AND HEALTH

Chapter 5: Health and Healing in Afro-Brazilian Religions

In Part II, I discussed the ways in which the black health epistemic community brings the Brazilian black health agenda into being. In Part III, I examine how health activists from Afro-Brazilian religions establish the ethnic component of the black health agenda. By bridging their causes, activists from black health movements and from Afro-Brazilian religions co-create the image of an essential black body with an essential Afro-Brazilian culture. Within the black health agenda, Afro-Brazilian religion becomes the diacritical marker for Afro-Brazilian ethnicity, and thus for the black population's cultural difference vis-à-vis the rest of the Brazilian population. This is a strategic political choice on the part of activists, and does not reflect the diverse demographics of Afro-Brazilian religions. All over Brazil, and particularly in the southeast, phenotypically white members fill the ranks of Afro-Brazilian religious temples (*terreiros*). As I will show, the introduction of race-naturalizing health discourses becomes a significantly divisive factor among health activists from Afro-Brazilian religions.

The construction within the black health agenda of black Brazilians as culturally unique reflects a growing trend toward the institutionalization of multiculturalism in Brazil.[74] The National Health Policy for the Black Population becomes a key part of this process by enjoining the state to recognize Afro-Brazilian religions' healing model as a valid complementary therapeutic system. The Policy also calls for culturally competent medical treatment and health education materials that reflect the health-related beliefs

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[74] By "multiculturalism," I mean a state policy that endorses the ideology of distinct cultures co-existing with a single polity.

and practices of Afro-Brazilian religions. Due to the participatory nature of SUS, members of civil society organizations are largely held responsible for creating this new brand of culturally competent health care.

The people whose work I describe in this part of the dissertation are members of various Afro-Brazilian religions all over Brazil. Through diverse life trajectories and pathways, they have become involved in black health activism. Although I refer to “terreiro health activists” and “black health activists” within the dissertation, these are analytical constructs and do not reflect how the activists define themselves. Unlike black health activists, who often refer to themselves as *militantes do movimento negro* (black movement activists), health activists from terreiros identify themselves by their ritual post and the divinity or orixá to whom they belong. Some ritual posts include *iaô* (female or male initiate who receives divinities), *ekede* (female initiate who does not receive divinities), *ogan* (male initiate who does not receive divinities), *babalorixá* or *pai-de-santo* (priest), *iyalorixá* or *mãe-de-santo* (priestess), etc. Thus, for example, a terreiro health activist might introduce herself as “Silvia, *filha* (daughter) of Xangô and *ekede* of Mãe Lídia.”

In his study of ritual healing and identity politics among the Navajo, Csordas (1999) proposes a three-tiered analytical framework that comprises the following elements: processes of representation between subaltern and dominant societies; internal negotiation among different sectors of the subaltern group; and transformation that occurs within individual members of the subaltern group. In order to understand terreiro health activists’ construction of identity politics based on claims of expertise in ritual healing, it is vital to examine each of these layers. Chapter 6 will focus on activists’ external representations of their religiosity and on terreiro members' historical use of ritual healing as a currency for negotiating with elite sectors of Brazilian society, including the state. Chapter 7 addresses activists' internal negotiations of racial and ethnic identity. In this chapter, I begin by examining the third layer, individual transformation vis-à-vis encounters with collective identity politics. First, I provide an overview of Afro-Brazilian religions. Then, I acquaint the reader with my two key informants in São Luís and São Paulo, respectively: Mãe Letícia and Pai Cesar. Their stories are meant to help introduce the complex world of Afro-Brazilian religiosity. Finally, I describe some of the health-related beliefs and practices of members of Afro-Brazilian religions.

Afro-Brazilian Religions: A Brief Background

Afro-Brazilian religions are a variety of syncretic, African-based, spirit-possession religions with diverse pantheons, ritual registers, and ritual practices. Afro-Brazilian religions arose through an amalgamation of several different African religious systems during the transatlantic slave trade to Brazil. They are syncretic and comprise elements of Catholicism and Kardecist Spiritism, to varying degrees. While there are many different forms of Afro-Brazilian religion, the most prominent are Candomblé, Umbanda, Xangô, Tambor-de-Mina, and Batuque. Their pantheons and practices vary according to geographic region—although the boundaries are becoming more tenuous due to migration—and by supposed ethnic origin. Candomblé, for instance, is divided into three main ethnic "nations" (*nações*) : Nagô/Ketu, Angola, and Gege.[75] These are associated with ritual registers based on Yoruba, Bantu, and Fon, respectively.[76]

The terreiro health activists whom I describe in this section belonged to Candomblé (Ketu, Gege-Nagô, and Angola nations), Umbanda (traditional and Omolocô nation), and Tambor-de-Mina. In Candomblé of the Ketu or Gege-Nagô varieties, initiates receive into their bodies divinities called *orixás* (in Angola, they are called *nkisis*). In Tambor de Mina they are called *voduns*. Each orixá, nkisi, or vodum represents a particular aspect of nature. For instance, Iemanjá is associated with the sea. Each divinity is also associated with a specific day of the week, color, number, and so on. Each initiate, in turn, has one principal divinity that is said to preside over his or her head, or *ori*, as well as two adjunct divinities—one on the left side and one on the right side, so to speak. In Afro-Brazilian religions, the head is the seat of spirituality and the point of entry for communion with the spirit world.

Aside from orixás/nkisis/voduns, which are African divinities, many initiates of Candomblé, Umbanda, and Tambor-de-Mina receive *caboclos*. In standard Brazilian Portuguese, "caboclo" designates someone who has mixed indigenous and Portuguese heritage. It can be somewhat of a derogatory term, since it can also mean a simple or rustic person. In Umbanda and some forms of Candomblé, caboclos are portrayed in religious images (i.e., portraits and statues) as traditional Indian figures who wear feathers. When an initiate receives a caboclo, that spirit usually speaks and/or sings, whereas orixás/nkisis/voduns normally utter no more than short calls or sounds. Caboclos

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[75] Nagô and Gege are sometimes combined into a single "gege-nagô" nation.

[76] Although Bantu is actually a language family, within Afro-Brazilian religions it refers to a ritual register for the "Angola" nation of Candomblé.

speak “hillbilly” Portuguese and often invent words, to the hilarity of terreiro members and attendees. In addition to indigenous-style caboclos, however, initiates receive a whole range of other spirit figures; although there are stock figures, pantheons vary from terreiro to terreiro. For instance, in Tambor de Mina, initiates receive caboclos called *encantados*. Encantados are believed to be the spirits of mortals who entered the spirit realm without having died a physical death. The category of “encantado” actually comprises several different sub-categories, such as *princesas* (princesses), *turcos* (Turks), and *gentis* (noblemen). Most of the terreiros I visited in São Luís were either solely Mina terreiros, or a combination of Mina and Candomblé. Most of the terreiros I visited in São Paulo, by contrast, practiced Candomblé.

Aside from their ritual and linguistic differences, Afro-Brazilian religions share some common characteristics. They are all spirit possession religions with a pantheon of divinities associated with aspects of the natural world, and they all have complex ritual features such as intricate ceremonies and periodic ritual obligations that initiates must observe. Members of many Afro-Brazilian religions practice animal sacrifice, since blood is believed to be an important source of *axé*, or life force, which facilitates communion with divinities. Additionally, all Afro-Brazilian religious denominations contain significant bodies of therapeutic knowledge that includes herbal remedies and ritual healing. Although in recent decades these therapies have begun to be disseminated widely through print media and the internet, in the past they were transmitted verbally from generation to generation by priests and priestesses (Silva 1995).

Mãe Letícia

I first visited Mãe Letícia in July 2006, during the final games of the World Cup. She was a corpulent woman of fifty-five with deep brown skin and long braids that were usually pulled back into a bun or ponytail. She was often clad in a brown shapeless shift with the insignia of her employer, mining giant Companhia Vale do Rio Doce, printed on the right breast. On weekends, however, she would don a *raçao*, or a strapless, shapeless white cotton garment held up by a piece of cloth tied at the chest.

Due to her intense involvement in the local politics of black health and terreiro health, Mãe Letícia was perpetually stressed. She angered easily, laughed loudly and often, and had a fiercely protective streak that appeared whenever one of her family or friends was threatened or hurt. Like other members of Afro-Brazilian religions, Mãe Letícia drew no line between her ritual family and her biological one. In short, Mãe Letícia took care of everyone but herself. She battled diabetes but kept eating sweets and chain-smoking, despite experiencing frequent thirst and urination as well as blurry vision (symptoms of poorly controlled diabetes). She had also undergone a hysterectomy several years earlier due to complicated uterine fibroids. Once, when I asked her whether her religion influenced how she treated her own health problems, she chuckled and admitted that she did not practice what she preached. At the same time she lobbied SUS for greater recognition of the terreiros' traditional healing practices, Mãe Letícia used her employee health policy to access private medical care. She explained to me that she saw no point in taking up another patient's space within SUS clinics if she could utilize another source of health care. Rather than using herbal medicine to treat her diabetes, Mãe Letícia relied on pharmaceuticals.

Mãe Letícia and her twenty-five year old son, Vicente, lived in a working-class neighborhood near Cruzeiro do Anil, where her pai-de-santo's terreiro was located. Vicente's own six-year-old son also lived with them much of the time. The family's wooden house sat at the end of a long street near a wide-open, grassy lot where children sometimes played soccer. Their neighborhood was both residential and commercial, and loud *serenata* music often blared from an informal bar down the street. Right next door to their house was a three-story, unfinished brick building that was supposed to have been a private clinic before construction was halted due to a funding shortage.

Mãe Letícia's two-bedroom house was unkempt and chaotic; nearly every cent of the wages she earned as a clerical worker went to support her religious obligations. She had given up battling the huge nests of termites that had settled among the exposed wooden rafters of her living room and bedroom. Like most *maranhenses* (residents of Maranhão), Mãe Letícia was accustomed to living at close quarters with nature. She would calmly watch lizards race up and down her walls, devouring the ever-present ants and flies. Her backyard was home to several chickens, guinea fowl, tortoises, and a constantly barking golden retriever. Her plumbing rarely functioned, but none of this seemed to faze Mãe Letícia. She would lie in her hammock or sit on her faded couches in the living room, smoking cigarettes and talking. Often, she would simultaneously watch television or idly accompany the video game her small grandson and his cousins were playing on the screen.

Mãe Letícia had decided several years ago to become celibate and devote herself entirely to her religion. Mãe Letícia did not yet have her own terreiro, but was slowly paying the installments on a piece of land she had acquired for that purpose in the nearby municipality of Paço do Lumiar. At the same time, she was building a two-room brick-and-mortar structure in her backyard where she could receive clients during the week and hold meetings with her filhos-de-santo. Until then, she had dedicated a small wooden shed in her front yard as the *casa de Exu* (the messenger divinity) and used the small room off her front parlor to *jogar búzios* (a divination ritual) for clients and conduct monthly *obrigações* to her *orixá*, Oxum.

Mãe Letícia's parents, grandparents, aunts, and uncles all participated in Tambor de Mina, the local variant of Afro-Brazilian religion in Maranhão. Her mother had resisted her own spiritual calling, only dancing in rituals and receiving her caboclos whenever she became very ill with asthma. According to Mãe Letícia, her mother's asthma would disappear after these rituals, and then return gradually during the periods that she avoided the terreiro. The young Letícia also resisted attending the terreiro, although she experienced periodic unexplained blackouts and a generalized sense of anxiety throughout her youth. As a teenager in São Luís, she attended a center for Kardecist Spiritism. She enjoyed studying the doctrine of reincarnation, but had no reprieve from her symptoms. Eventually, her blackouts and anxiety became so troublesome that she went to her aunt's Mina terreiro for spiritual treatment. There, she received caboclo spirits for the first time. She "danced" at, or became a member of, her aunt's terreiro until she moved to Rio de Janeiro with her family during the late 1970s, when she was around twenty years old.

In Rio, Letícia stopped attending terreiros and her spiritual unease returned. Her younger sister was experiencing similar difficulties; according to Letícia, since she was not fulfilling her spiritual calling, her spirit entities would "grab" her out of nowhere and leave her to return to consciousness hours or even days later, with no idea of what had transpired. One day, when Letícia was feeling particularly disoriented—she described not being able to feel the ground beneath her feet, as if she were floating—some friends brought her to the Messianic Church. The Messianic Church is actually the Brazilian branch of the Church of World Messianity, a Japanese religion founded in the 1930s. Using their hands, qualified members strive to heal others by emanating "divine light" or *johrei* into the person's energy field. When a few members applied this treatment to Letícia, she blacked out. When she awoke later in the Minister's chambers, he diagnosed spiritual illness and prescribed regular johrei treatments at her home. Letícia had the treatments and became involved with the Church for some time.

In 1984, she moved back to São Luís and joined the vibrant black movement that had formed there. She described herself prior to her entry into the movement as a "poor bourgeoise." She was working three jobs and focused on making money, rarely pausing to think about social inequalities. When she returned to Maranhão after several years of absence, however, she was struck by the grinding poverty of the mostly black and brown population, which she had forgotten during her years in Rio. That shock led her to join the local black movement, where she acquired a new perspective on the ways in which racism structured social inequality.

One day, she and fellow activists from the Black Culture Center of Maranhão (Centro de Cultura Negra or CCN) attended a famed terreiro called Casa Fanti Ashanti. It had begun solely as a Tambor de Mina terreiro, but after its pai-de-santo became initiated into Candomblé, he built a separate *barracão* (ceremonial house) for Candomblé rituals. Letícia began to visit the terreiro more regularly, and on one of these visits she first received the divinity Oxum. She recalled feeling devastated when she awoke from her trance and discovered that she would need to become initiated into Candomblé. From her family's experience within Afro-Brazilian religions, she had learned that one had to devote one's life to the spirit entities, or suffer the consequences. Reluctantly but obediently, Letícia became initiated into Candomblé at Casa Fanti Ashanti. Seven years later, she received her *deká*, a ritual step that confers the ability to initiate others, and became Mãe Letícia.

During my fieldwork in São Luís, I saw Mãe Letícia at least once per week, either at her home or at one of the many social movement activities with which she was involved. I often attended religious ceremonies at Casa Fanti Ashanti, as well as at the terreiros of Mãe Letícia's extended *família-de-santo* ("saint family," or initiates of Casa Fanti-Ashanti). At these rituals, which routinely lasted all night long, I would wear all white and sit with the *assistência* or audience, listening to the drumming and sung prayers in Yoruba or Portuguese (depending on whether the ritual was Candomblé or Tambor de Mina). We would watch the filhos dance in a circle until most of them received their spirit entities, and then we would watch the spirit entities dance. After the ritual, I would either sleep at the terreiro or, if I was lucky, hitch a shared taxi ride home with other people who had attended the ritual. For the annual festival honoring Mãe Letícia's Oxum, I stayed at the terreiro for most of the weekend and helped with the preparatory work—e.g., washing clay dishes and pots at an outdoor sink, "catando" or removing the bugs and pebbles from dry beans and corn, and sweeping the kitchen floor. That December weekend was the point at which I felt most integrated into the bustling life of the terreiro.

Gradually, her close friends and filhos-de-santo, and Letícia herself, began to describe me as Letícia's "filha" (daughter, or initiate within Afro-Brazilian religions). I actually went through the initial ritual steps toward becoming her filha, although we both knew that I would have to leave São Luís at the end of the year. I started with a ritual divination ceremony known as the *jogo de búzios*, and eventually went through an *ebó*, or ceremony in which ritual foods are offered to one's orixás. I received a *fio de contas* (string of beads) with the mark of Mãe Letícia's orixá, Oxum, on it. Mãe Letícia even allowed me to accompany her and some *irmãos-de-santo* ("saint brothers/sisters") on a trip to the Bahian island of Itaparica, to attend the centuries-old *egungun* ancestor rituals. Within Candomblé, egunguns are the spirit figures of collective family ancestors who have passed on. Whereas orixás are mythical spirit entities associated with the natural elements, egunguns are anonymous representations of ordinary mortals who walked the earth before passing into the *orun*, or afterlife. The egungun rituals are secretive, and I could only enter as Mãe Letícia's filha. This is just one example of the many ways in which Mãe Letícia welcomed me into her life.

Pai Cesar

When I arrived in São Paulo in mid-2008, Pai Cesar was a fiery activist whose schedule of political meetings and events left me dizzy. He identified as *negro*, which was not surprising given his dark brown skin and unequivocally African features. His tall, solid build and firm, frank manner of speaking amplified his imposing presence. At age thirty, Pai Cesar was one year younger than me, but he always seemed much older due to his considerable accomplishments and responsibilities.

Pai Cesar grew up in a working-class neighborhood of São Paulo's *zona norte*. He was brought up within Candomblé, with his grandmother's terreiro located right overhead the family's home. When he was a child, he suffered from kidney problems and from a generalized feeling of restlessness and anxiety. From an early age, Pai Cesar was a wanderer; he left his family home as a young teenager and moved from terreiro to terreiro, being cared for by the pais- and mães-de-santo at each one.

Pai Cesar interpreted his kidney problems as "a motive to reaffirm my commitment to my ancestors" through participation in Afro-Brazilian religion. He became a *iaô*, or initiate, at age seven. Around age fifteen, he received his deká, which authorized him to initiate his own filhos-de-santo. This is an unusually young age for someone to become a pai-de-santo; in fact, Pai Cesar recalls that he was somewhat renowned within the São Paulo Candomblé community at that time for being the youngest pai-de-santo. Again, health concerns motivated his decision to perform the deká at such a young age. Iaôs are supposed to undergo this ritual obligation exactly seven years following their initiation. Pai Cesar was late, however, and his health problems were growing steadily worse. According to him, his worsening health was a sign from the orixás that he urgently needed to perform the ceremony. He describes his condition around the time of his deká:

> I was limping from kidney disease, because the doctor couldn't cure me, the medication wasn't working anymore, and I was becoming addicted to Voltaren. I was becoming famous in the [public] clinic, but they weren't helping me and I was so swollen my clothes didn't fit....Sometimes I managed to walk normally, sometimes I walked kind of dragging my feet. All because of my kidneys and circulation.

It is not clear exactly what kind of kidney and circulation problems Pai Cesar was experiencing. He was probably medicating himself, because Voltaren is a prescription-strength NSAID, or non-steroidal anti-inflammatory drug, that is available over the counter in Brazil and is contraindicated for patients with kidney problems. However, these details are less important than Pai Cesar's interpretation of his illness and its cause (his own failure to fulfill ritual obligations). Pai Cesar's orixá is Oxaguian, and according to Candomblé cosmology, Oxaguian's children are vulnerable to kidney problems. Members of Afro-Brazilian religions believe that illnesses occur due to a loss of spiritual, mental, and/or physical equilibrium (*equilíbrio*). Such a loss can occur through an initiate's neglect of his or her relationship with the orixá. To this day, when something is wrong, Pai Cesar claims he can feel his kidney pain returning. If he does not *jogar búzios* to check in with his orixá, his kidneys begin to throb as if his heart has taken up residence there.

Pai Cesar dropped out of high school early on and worked his way up from a delivery boy to a cook for the supermarket chain Pão de Açucar. Around age twenty, in response to the AIDS-related deaths of several of his initiates, he became an activist for HIV/AIDS prevention within Afro-Brazilian religions. He also began to attend black movement meetings, which had a profound effect on the way he viewed racial dynamics. Prior to his involvement with the movement, he had never been aware that racism existed. Growing up in the *zona norte*, he told me, children and families of all colors lived, worked, and played together. After attending black movement meetings, however, Pai Cesar began to re-interpret the circumstances of his own life. He came to see his disagreements with white supervisors as tinged with racial prejudice. He noticed that in the terreiros he attended, filhos-de-santo with darker skin were often in charge of behind-the-scenes “dirty” work, such as killing animals for ritual sacrifice, while whites did less work and were often given more prestigious ritual posts.

When I met him in 2008, Pai Cesar was working at the office of a state Representative (*deputado*) from the Worker’s Party who spoke out against the religious intolerance suffered by members of Afro-Brazilian religions. He lived in a cramped kitchenette located in the center of São Paulo. He had neither the time, nor the financial means to have his own terreiro, but he presided over the terreiro of a fellow pai-de-santo who had suffered a stroke and was on extended convalescence. At the beginning of my fieldwork, Pai Cesar always wore ritual clothing. This consisted of a *dashiki* with loose, white linen pants; a *pano*, or length of printed fabric, thrown over one shoulder; and a long string of heavy, wooden beads that he was constantly tugging backwards so that they hung down the slope of his back as well as his chest.

Most of our deeper conversations took place at Café Vermont, his favorite LGBT *barzinho* in downtown São Paulo, where he smoked tobacco from a pipe and downed espresso after espresso. He often observed that his love of cappuccino and lasagna did not fit the image of a traditional pai-de-santo. After all, a pai-de-santo was supposed to eat African foods with his hands, his bare feet planted firmly on the beaten-earth floor of his terreiro. By contrast, Pai Cesar identified strongly with the concrete and the skyscrapers, the frantic pace, and the tangled ethnic spaghetti of São Paulo. He was constantly attending meetings, writing manuscripts, and making Skype calls to Brasília from his laptop. Once, he even gave a virtual lecture on HIV/AIDS prevention in Second Life. São Paulo’s STD/AIDS Program maintained an HIV education center in the virtual interface, and in December 2008 the director invited Pai Cesar to create an avatar and deliver a lecture to other people’s avatars about HIV prevention in terreiros. So much for the image of the elderly pai-de-santo passing down secret knowledge to generations of filhos from his high-backed wicker chair!

Although Pai Cesar had not quite finished high school, he was an autodidact, and his knowledge of anthropological and sociological texts on race in Brazil and Afro-Brazilian religions was superior to my own. Despite his biting criticism of what he viewed as inaccurate and essentializing anthropological discourses on Afro-Brazilian religions, Pai Cesar agreed to let me shadow him. He often jokingly referred to me during meetings as his *anjo da guarda* (guardian angel)—more for my ubiquitous presence than for any concrete form of assistance I may have provided him.

In January 2009, Pai Cesar accepted a technical appointment at the São Paulo Municipal Health Department. Over the years, he had established ties with the AIDS Program through his participation in the AIDS Commission and other participatory citizen councils related to HIV/AIDS and black health policy. Although he suspected he was a token hire that allowed the Program to boast of its equitable employment practices and tolerant attitude toward members of Afro-Brazilian religions, he took the job in the hopes of continuing to pursue his ideals from within the system.

Pai Cesar’s transformation from activist to state employee was abrupt and remarkable. His African-style clothing gave way to more mainstream slacks or jeans and dress shirts or T-shirts. Although he still wore his beads most of the time, his *pano* disappeared. He was forced to give up many of his activist involvements and, as a result, many AIDS activists labeled him a sell-out. Pai Cesar countered, however, that his motive for taking the job at the AIDS program was self-preservation; he needed to earn a living:

> I won't exchange my *abadá* [religious garment] for a suit, but my closet needs to have both of them. My place of work is the terreiro. I put a [white] cloth on the table and wear white on Fridays. But I'm practical, and I'll do what I need to in order to get along [in society].

As he felt the anchor of his former identity slipping away, however, he decided to live full-time in his former terreiro in Perus, a remote area on the northeast periphery of São Paulo. By the time I left São Paulo in August 2009, he had reduced his activist commitments considerably, although he was still involved in black health and terreiro health movements.

Healing in Afro-Brazilian Religions

Healing rituals take many forms within Afro-Brazilian religiosity. They can be collective, personal, or client-based. They can arise from programmed celebrations of health-related orixás, or visits from a healing *caboclo* that the pai- or mãe-de-santo receives with or without prior notice. Alternatively, they can consist simply of taking ritually prescribed herbs and perhaps reciting some sung prayers to specific orixás. As shown in the cases of Mãe Letícia and Pai Cesar, conversion to an Afro-Brazilian religion represents, in itself, a significant mode of spiritual and, often, physical healing.

After making a religious commitment to one's orixás, devotees must maintain constant vigilance over their health. This is because, as Pai Cesar explained, the body is the primary medium through which the spirit communicates. In addition to interpreting manifestations of illness as signs that something is amiss in one's relationship to his or her orixá, members of Afro-Brazilian religions must follow a number of preventive measures to preserve their bodies as adequate vessels for spirits to enter.

The terreiro health activists I came to know over the course of fieldwork spoke frequently of the various foods they had to avoid; they call these *kisilas*. For instance, Pai Gerônimo, a São Paulo Candomblé priest, never eats honey. For him and other children of Oxóssi, the orixá of forests and hunting, honey is a ritually proscribed food; if he eats it, he ends up with diarrhea and indigestion. Additionally, according to Pai Gerônimo, eating the food can "close his pathways" (*fechar meus caminhos*) or interfere with his daily objectives, as well as disrupting his communication with Oxóssi. The same consequences apply if he eats pork in August, because the particular "quality" (*qualidade*) or type of Oxóssi that he receives is related to the orixá Omolu. Omolu, also known as Obaluaiyê, is the orixá of epidemics, and his ritual month is August. Pork is a kisila for children of Omolu. As a child of Oxum, Mãe Letícia could eat fish with scales, but had to avoid fish with smooth skin (*peixe de couro*). Whenever I brought whole fish to her house for our lunch, I would have to be careful not to buy a smooth-skinned variety. Similarly, Pai Cesar could not eat the Bahian cuisine he adored because of its main ingredient—palm oil, or *dendê*. His orixá, Oxaguian (a quality of Oxalá), preferred white foods and abhorred the thick, red palm oil. Pai Edson, another Candomblé priest in São Paulo, had to avoid all ground-growing fruits and vegetables (*comidas rasteiras*) because he belonged to Obaluaiyê, who is associated with the earth (and more specifically with returning to the earth upon death). Ingesting foods such as watermelon or pumpkin, he said, could land him in the hospital.

In addition to observing kisilas, devotees of Afro-Brazilian religions must pay careful attention to certain areas of the body that they believe are particularly vulnerable in children of certain orixás. For example, children of Oxalá are believed to have problems in their kidneys (like Pai Cesar) and bones. Children of Xangô are thought to be especially prone to coronary problems. Obaluaiyê is associated with contagious diseases such as smallpox, AIDS, and leprosy, and members of Afro-Brazilian religions believe his children are more at risk for developing these illnesses. As in Pai Cesar's story, the manifestation of a particular health problem can be an early sign of one's vocation as a *filho* of the corresponding orixá.

One night, as we were riding home on the bus, Mãe Letícia's filho-de-santo Jorge told me he had first come to the terreiro in search of healing for Hansen's disease (leprosy). He seemed a bit ashamed to tell me he had suffered from *hanseníase*, because the disease is still highly stigmatized in Brazil; as in other places around the world, it is associated with poverty and contagion. As Jorge became more involved in Afro-Brazilian religion, he discovered he was a devotee of Obaluaiyê. When he accepted his religious vocation and began to fulfill his ritual obligations to the orixá, his symptoms dissipated. At the time of my fieldwork, Jorge was an accomplished choreographer and dancer. Sometime after our conversation, I witnessed Jorge incorporating Obaluaiyê during a ceremony at Mãe Letícia's house. Immediately, he fell to the ground and curled into the fetal position with his muscles twitching and his hands gnarled up like claws. Subsequently, I saw many devotees of Obaluaiyê assume this position when they received the spirit. My informants explained that the posture represents affliction with advanced leprosy, when the limbs curl in on themselves and the appendages dissolve into the body.

Due to their association with certain parts of the body, orixás have the power not only to harm, but also to heal. For instance, Oxum, the orixá responsible for fertility, is associated with the uterus and ovaries. When a woman has trouble conceiving, or any other gynecological problem for that matter, she can make a ritual offering to Oxum and obtain healing, regardless of whether she is a devotee of the orixá. Iemanjá, orixá of the ocean and ruler of the *ori* (head), is linked to mental health issues. Iançã, the orixá of the wind, is associated with respiratory illnesses. When devotees (and their clients) suffer from these afflictions, they often seek healing by making a special offering to an orixá. They call this offering an *ebó*.

During my time in São Luís, I dealt with a recalcitrant chronic pain problem. Mãe Letícia performed the jogo de búzios to discover whether my illness had originated from spiritual or organic factors. The búzios indicated that my problem was medical, and Mãe Letícia recommended I see a doctor. When I replied that I had seen many, to no avail, she offered to perform an *ebó de saúde* (health ebó). She instructed me to buy several ingredients, including dry white corn, popcorn kernels, white “seven-day” candles, cornstarch, coconut milk, condensed milk, and several different plants and herbs. As Pai Gerônimo later explained to me, ebós de saúde utilize white foods because Candomblé devotees believe they fortify the body. According to him, ebós de saúde are not meant to cure a medical problem, but rather to “strengthen” the individual and help his or her doctor discover the root of the problem.

The day of the ebó, I wore a lilac flowered skirt and a white tank top. I also brought a white dress, as Mãe Letícia had instructed me to do. When I arrived at her house, Mãe Letícia gave the materials to her housekeeper Juliana and instructed her to make the "comida de Iemanjá" (Iemanjá's food). Although Juliana did not practice Candomblé, she had learned to prepare ritual foods in the decade she had worked for Mãe Letícia. I also learned to prepare several of them, since I participated in monthly rituals with Mãe Letícia and her *filhos-de-santo*. "Iemanjá's food" is a sweet, white corn pudding. Mãe Letícia had chosen Iemanjá's food because she had discovered during a jogo de búzios that I was a *filha de Iemanjá* (daughter of Iemanjá). Juliana used the white corn to make *acaçá*, a grainier, insipid paste wrapped in a banana leaf. Acaçá accompanies all food offerings to orixás, since practitioners believe that all orixás eat it. She then popped the popcorn and placed it in a bowl. Popcorn, explained Mãe Letícia, is for *limpeza* (cleansing) and represents *doença e saúde* (illness and health). At this point, Mãe Letícia instructed me to stop asking questions, and to remain quiet for the remainder of the ritual.

Next, Mãe Letícia took the herbs I had brought and crushed them into a bowl, simultaneously singing in Yoruba. She enlisted Juliana's help to grind some of the leaves in a blender with water, then strained them and added them to the bowl. Together, she and Juliana made two large batches of pungent, sweet-smelling *banho* (an herbal bath). Then, Mãe Letícia ripped off three sections of newspaper and filled them with *pólvora*, which is a black flammable powder. Finally, she broke up chunks of pungent charcoal and filled her rustic *defumador* (censer).

Mãe Letícia led me out to her large, grassy backyard. First, she had me remove my bra and underwear so they would not get wet. She stood in front of me, waved some long-leaved herbs around me, and brushed them down my outstretched hands and upturned palms. All the while, she prayed to the orixás in Portuguese, asking them to make me healthy. Then, she poured white corn over my head, followed by popcorn. Her tortoises (*jabotis*) became excited and ambled over to eat the fallen corn. All the while, Mãe Letícia's golden retriever, perpetually tied up near the back door, barked; she grumpily scolded him. Next, she instructed me to jump up and down three times, then forward. After I did so, she made me repeat it, telling me to jump higher this time. Finally, she took a broom and swept up the fallen food from the ground, disappointing the jabotis.

Next, Mãe Letícia and I walked over to her outdoor concrete laundry area, complete with a large washing tub, a ridged washboard, a spigot, and a rustic showerhead mounted on the wall. She had me kneel down in front of her, then proceeded to bathe me with the dark green banho. She poured it over my head, rubbed it down my shirt and over my breasts, then lifted my shirt and rubbed it onto my stomach. All the while, she prayed to the orixás in Portuguese. After she finished bathing me, Mãe Letícia directed me to wash myself off first with water, then with the remaining banho that she had placed on the laundry counter in a plastic two-liter soda bottle with the top cut off. I stripped off my clothing, feeling slightly self-conscious. Mãe Letícia took my fio de contas and dropped them into the bottle of banho. As I bathed myself, Mãe Letícia went inside to get my white dress. She brought it out and hung it on the clothesline with my white bra. I reminded her that I had worn that bra on the street that day (which usually renders clothing inappropriate for ritual use), but Mãe Letícia said it was OK, as long as I did not put on the same underwear I had worn in the street. She waved her defumador around my clothing to purify it as she spoke. Next, she had me squat down in front of her and rubbed more banho on my body, concentrating especially on the area afflicted by pain. Afterward, she told me to rub the green droplets off my body and to don the white dress. I wiped off my skin as best I could, and wrung out my hair, but when I put on my dress there were still tiny green rivulets flowing from my hair down onto my chest and staining the front of my dress. I could smell the sweet scent of the herbs on my skin and in my hair.

Mãe Letícia then instructed me to stand on the concrete sidewalk leading up to the front patio. She placed one piece of balled-up newspaper on my left, one on my right, and one in front of me. She then lit each of them one by one, and told me to jump three times as each ball exploded, then to rub my hands over my limbs and torso in order to brush away all negativity. She lit the defumador and waved it all around me, directing me to "bathe" myself with the smoke. When that was finished, we returned to the kitchen and Mãe Letícia had me sit on a small stool (*banquinho*) in front of the table. She rubbed a fragrant stone on top of my head and behind each ear, praying aloud all the while. Then, she took red, sweet-smelling liquid from a tiny bottle and drew crosses with it on my chest and back. I bowed my head to inhale the scent, and Mãe Letícia commented wryly, "this stuff is better than French perfume!" After this part of the ritual was finished, she led me into a small room off the front door, to the left. This was her "saints' room" (*quarto do santo*), where she conducted her monthly rituals. It was filled from floor to ceiling with yellow candles for Oxum, and wax and ceramic figurines and portraits of various orixás. There were also several altars with ritual objects, such as baskets of eggs (once again, a symbol of Oxum) and stones. The door leading from the room out into the living room remained closed at all times.

Several candles were burning in the saints' room as we entered. Mãe Letícia placed the bowl containing Oxalá's food on my right, and the bowl of popcorn on my left. I held the bowl of Iemanjá's food, and Mãe Letícia told me to set it down and then pick it up again three times, slowly. After the third time, she clapped with cupped hands a 3-7-3 sequence three times, as Candomblé members often do to mark communion with the deities during rituals. She then told me in a kind voice, "it's up to you now" (*agora é com você*) and directed me to sit on the floor in front of the bowls. She placed a white seven-day candle in front of the bowls and then poured honey over each of the bowls, telling me to ask Oxalá and Orixalá (the supreme Candomblé deity) to bring me health "and a great love, because this is important too." She lit two sticks of white-rose scented incense and then closed the door, leaving me alone to pray in silence for the next hour.

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In addition to healing rituals like the one described above, practitioners of Afro-Brazilian religions also rely upon medicinal plants to help resolve health problems. I met no one, however, who relied exclusively on ritual healing (*ebó*, *limpeza*, or *sacodimento*), herbal teas (*chás*), or medicinal potions (*garrafadas* or *meizinhas*) to get well. Rather, these were complementary measures to biomedical treatment. When I asked Mãe Letícia whether she relied more on biomedicine or herbal medicine from her religion to treat her own illnesses, she replied:

> It's funny....We [members of Afro-Brazilian religions] go to the doctor more often than we use our own secular tradition of making herbal teas...We usually take medication from the doctor. We dope ourselves up with pills....In the old days there was no doctor, so naturally people healed themselves with herbs and leaves....We also go more often to the doctor because of the exams they do, their diagnoses. You have more options...to see what kind of problem [you have]. So, due to the diseases that we have today, that are very different from the diseases of the past—there are lots of diseases today that need a more precise diagnosis. Not that the spirits don't have knowledge. They do. But it's simple compared to today's advanced medicine.

In this part of our interview, Mãe Letícia struggled with the issue of authenticity and tradition versus practicality and rationality given the present context. In her study of Australian multiculturalism, Povinelli (2002) examines Aborigines' internal battles with similar issues. She argues that "multicultural domination" works "by inspiring subaltern and minority subjects to identify with the impossible object of an authentic self-identity" (6). Similarly, in order to garner special recognition as a traditional group from the state, members of Afro-Brazilian religions (and other "traditional populations," as they are called in Brazil) have to perform a certain kind of identity that has been deemed authentic. In the case of Afro-Brazilian religions, members perform this identity by wearing sacred clothing at public meetings and events, displaying their knowledge of medicinal herbs, and generally showing state officials that they are the authentic custodians of a vital piece of Brazil's cultural history that merits promotion and preservation. These, however, are public performances; on their own time, Mãe Letícia and other terreiro health activists availed themselves of pharmaceuticals to treat their illnesses.

Although terreiro health activists in both São Luís and São Paulo spoke frequently about Afro-Brazilian religions' unique and effective corpus of traditional medical knowledge, I observed terreiro members utilizing herb-based medicine much more often in São Luís than in São Paulo. This was not surprising, given the drastically different lifestyles and socioeconomic conditions of the terreiro members I met in each city. In São Luís, many of the plants needed to make herbal remedies were readily available near the terreiros; due to the humid climate and incomplete urbanization, they were literally growing everywhere. In São Paulo, by contrast, where concrete dominated the landscape and terreiros rarely had space for gardens, it was more difficult and expensive to find the right ingredients for herbal concoctions.

During my time in São Luís, several terreiro leaders (e.g., pais- or mães-de-santo) and their caboclos offered me herbal remedies for my chronic pain condition. They would give me a list of herbal ingredients to buy, I would bring the ingredients to the terreiro on a specified day, and then I would leave with a smelly potion and detailed instructions for how and when to imbibe it. Although none of the potions resolved my problem, the process helped me to learn about the folk pharmacology practiced in terreiros. Many terreiros grew herbal ingredients in their gardens, and their leaders took great pride in showing me the various plants. Additionally, many pais- and mães-de-santo in São Luís held public healing services for clients once a week or so, and I often attended these sessions in order to observe how healing worked in the various Afro-Brazilian religious traditions present in the city.

As I mentioned before, Tambor-de-Mina dominates the religious landscape in Maranhão. Mina terreiros, however, tend to be highly syncretic, incorporating elements of Catholicism and a local religious tradition called *pajelança*. Since Pajelança is primarily concerned with ritual healing, participants usually refer to it simply as “cura” (cure). It comprises ritual elements from indigenous religions and Catholicism. Pajelança and Mina rituals often take place on different days within the same terreiros. Mina rituals are structurally similar to those of more characteristically "African"-based religions, such as Candomblé. They consist of members dancing around the terreiro in a circle to drum beats, receiving their spirits and then dancing in distinctive ways individually, depending on the spiritual entity they have "incorporated." The main differences between Candomblé and Mina, at least to the casual observer, are the different ritual languages used in each (a Yoruba-based ritual register in Candomblé, and a Fon-based one and Portuguese, in Mina); the absence of elaborate ritual costumes in Mina; distinctive rhythmic structures and instruments used in ritual drumming; and the greater presence of Catholic elements in Mina ritual practice.

Meanwhile, the Pajelança ritual centers on *passagem*, in which the terreiro leader receives a number of different spirit entities in relatively quick succession. Each transition is marked by the terreiro leader trembling, eyes closed, and frantically rattling a maraca. Some spirit entities stay a longer time than others, and each one has a particular personality. They can include many of the same types of entities from the Mina pantheon, such as caboclos and encantados; but pajelança often includes animal spirits, while Mina does not. The spirit entities in Pajelança are often comedic, and thus provide great enjoyment for the clients waiting to consult with them. As I mentioned earlier in the chapter, caboclos use rustic Portuguese and invent curious names for common items. For example, they often refer to coffee as "água preta" or black water. They might call a telephone a "fuxicador" in reference to a popular term in Northeast Brazil for chatting or gossiping, "fuxicar." Since caboclos are illiterate, they rely on a terreiro member (appointed by the terreiro leader prior to his or her trance) to write down the ritual prescriptions they dictate after examining clients. During healing sessions, caboclos tend to drink a great deal of sugarcane rum (*cachaça*) and smoke lots of cigars. Terreiro leaders often point out, apparently to bolster their credibility, that they suffer no ill effects from their caboclos' many hours of drinking and smoking, even though they do not drink or smoke when "unincorporated" or without a spirit entity inside their body (*puro/a*).

During Pajelança sessions, caboclos would often call me over to watch what they were doing to clients, stating that I needed to see it in order to believe that their healing was authentic. Often, the caboclo would begin by walking around the client, blowing cigar smoke all around him or her. After asking the client questions about his or her health problem, the caboclo would often place his mouth on the afflicted body part and suck the skin, as though trying to extract something. Then, the caboclo would straighten up and start gagging, eventually vomiting something into an outstretched bowl or jar held by filho-de-santo. Sometimes this would be a green liquid, while other times it was some noxious object. In the sessions I witnessed, I saw caboclos regurgitate everything from nails to spiders to centipedes (*lacraias*). Sometimes, the caboclo would stand with his back to the client's back, link his elbows through the client's, and then lift him or her up into the air, jumping a few times. Jumping is important in healing rituals from Candomblé to Umbanda to Pajelança because it represents a liminal state between the ground and the sky, both of which are sacred in Afro-Brazilian religions. To achieve healing, the client must pass metaphorically from a state of sickness to a state of health, and the *sessão de cura* (healing session) occupies the liminal space between the two. The same applies to the caboclo, who hangs suspended between the spirit world, where he resides, and his temporary presence in the human realm.

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The examples of individual healing considered above rely on the healer-client dyad and address specific health concerns. Besides these individual healing practices, collective and more generalized health-related rituals also constitute a central part of Afro-Brazilian religiosity. These are usually preventive in nature, and tend to pay homage to the orixá Obaluaiyê/Omolu, also known as the *vodum* Akossi in Tambor de Mina. Rituals for Obaluaiyê usually take place during the month of August in Candomblé, whereas Mina terreiros often celebrate Akossi in May. In May 2008, I attended a multi-day ritual for Akossi at the terreiro of Pai Juninho in São Luís. It began with a late-night public ceremony on May 29. The filhos-de-santo dressed in white clothing and danced in a large *roda* (circle) to the rhythm of *abatá* drums (tall drums with cowhide stretched over the top, laid down horizontally and beaten with the hands). As the filhos began to receive Akossi, they dropped to the ground and assumed contorted postures, their limbs trembling in continuous spasm and their hands gnarled like claws. An attendant went around covering the body of each incorporated (*incorporado*) filho with a white cloth. I was only allowed to photograph them while they were covered, although no one could explain exactly why this was the case. Normally, I was not only permitted, but actually encouraged to take pictures of incorporated filhos-de-santo. This was only the case in Mina terreiros, however; in Candomblé terreiros, photography was strictly prohibited. Often, caboclos at Mina terreiros would pose graciously for my camera, then request a framed portrait of themselves.

Akossi, by contrast, seemed to provoke a mixture of adoration and fear in members of the terreiros I visited. Mãe Letícia explained to me once that this was because Akossi/Obaluaiyê represents not only protection from illness, but also suffering and death. He is thus a liminal figure, neither here nor there. In many Afro-Brazilian religious traditions, he is associated with the spirit ancestors (*egunguns*), who are also simultaneously feared and revered due to their "betwixt and between" status; according to practitioners, egunguns lived on the earth one day, but are now part of the spirit world. In this respect, they are different from orixás and voduns, who always resided in the spirit realm.

The second day of the Akossi celebration began at noon with a large banquet for a group of dogs. The banquet took place in the terreiro's front room, which had been set up with long tables bearing figurines of Saint Lazarus and large clay bowls of popcorn. Dogs are Akossi's symbolic animal due to his association with Saint Lazarus, the figure portrayed within Catholic imagery as a beggar/leper, accompanied by a dog that is licking his leg wounds. Since Akossi plays such a central role in Tambor-de-Mina, terreiros often treat dogs with special reverence. I visited many Mina terreiros in São Luís where dogs had the run of the house. They frolicked about the various saints' rooms, in addition to areas from which they would normally be banned within Brazilian households, such as the kitchen. After the dogs finished their meal that day, the human guests were allowed to eat (children were served before adults).

That day, the filhos-de-santo were dressed in yellow and white, which are Akossi's ritual colors. The feasting gave way to another roda with drumming, similar to the previous night, in which filhos received Akossi and were draped with white cloth sheets so that, I was told, we would not see their "ugliness." The white cloth used in Tambor-de-Mina corresponds to the head-to-toe costume of straw worn by filhos-de-santo who receive Obaluaiyê in Candomblé terreiros. In Candomblé lore, Obaluaiyê is said to have contracted smallpox as a child. As a result, he was left with lesions so disgusting that even his mother, Iemanjá, could not lay eyes on him. Thereafter, he always wore straw to cover his deformity.

The third and final day of the Akossi ritual at Pai Juninho's house featured a procession from the terreiro to the small leprosy hospital located about a mile away, down by the inlet. The air was hot and heavy that day, and the sky was pregnant with rain clouds. We set off for the clinic around ten o'clock that morning, May 31, in a long line of about thirty people. We wore yellow and white, and many people carried umbrellas to shield themselves against the unrelenting sun. We carried bowls of food and cakes for the patients at the clinic, and the *abatezeiros* beat their drums while the filhos-de-santo sung prayers to Akossi. When we reached the hospital, the staff was expecting us; this ritual had become a neighborhood tradition. They helped us bring in the food and set up the large cake bearing the words "São Lázaro" on the front. Then, they led us to the patient wards where we visited men and women of all ages, in advanced stages of deformity from the disease, who were lying in beds or sitting up in wheelchairs. Most had gnarled hands and feet with missing digits; some were also missing noses or lips. These were inpatients from distant towns in rural Maranhão who were forced to reside at the hospital because they had no access to adequate treatment at home. Over the years, a village of patients and their families had grown up around the hospital. The terreiro members made a point of hugging the patients and holding their hands, so I followed suit. The patients seemed quite happy to receive our visit.

After about an hour, we left the hospital and returned along the same red, dusty path from whence we had come. On the way back, we stopped at the Bonfim Cemetery, where Pai Juninho jumped over the locked gate and then had a filho hand over a bowl of Akossi's ritual food. Pai Juninho placed part of the food offering on top of a tombstone, then wiped off his hands and feet (later I would learn that this symbolized the dusting off of negative energy). Next, he placed the bowl on top of his head and disappeared from sight among the concrete slabs. Cemeteries are symbolically associated with Akossi and Obaluaiyê due to the deity's connection with sickness and death.

As we waited for Pai Juninho to return, three filhos (two women and a man) suddenly received Akossi and fell to the ground, writhing. As the vodum arrived, people called out his ritual greeting, "Atotô!" One of the filhas grunted repeatedly, while the filho lay completely stiff and unblinking, as if catatonic. Just then, Pai Juninho climbed back over the gate with help from his filhos. He "suspended" (*suspendeu*) or dispatched Akossi to the spirit realm by placing his hands over the head of each filho-de-santo who had received the spirit, and then incanting a few words. As he did this, the filhos returned to normal and got up, blinking dazedly. Next, Pai Juninho picked up a bowl of popcorn and tossed handfuls of it over all of our heads while pronouncing words in the ritual Fon register used in Tambor de Mina.

Several minutes later, we all exited the cemetery yard, walking backwards to protect ourselves from the dangerous energy of the eguns. Back at the terreiro, the ritual concluded with Catholic prayers and hymns. The filhos-de-santo sat in a large circle on the tiled floor of the *barracão*, the enormous room where public ceremonies took place. The terreiro's many resident dogs circulated freely among the filhos and the community members who lined the edges of the room, singing along with the filhos. During the prayers, a couple of filhas received Akossi again, but an attendant quickly "suspended" the spirit by placing a white cloth over each of them and pronouncing a few words in the Mina ritual language.

After the prayers concluded, everyone went outside, and several filhos-de-santo distributed hot lunches to community members in foil and cardboard containers (*quentinhas* or *marmitas*). Children rushed to the front of the line and were the first to receive food. While the community members ate, a filho and filha climbed the great *mangueiras* (mango trees) outside the barracão and broke off large bunches of leaves, which they tossed down to their *irmãos-de-santo* (saint brothers and sisters) who were waiting below. After they brought them inside the barracão, I joined the filhos in spreading the leaves all over the floor of the barracão, and then sprinkling popcorn over the leaves. After this was finished, I sat for a while in the darkened barracão. The shutters were open and candles burned in each corner. The smell of incense filled the air, and outside the wind rustled the leaves of the mangueiras. It was peaceful.

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In this chapter, I have described the various healing modalities that I witnessed over two years of fieldwork in terreiros of São Luís and São Paulo. My intent was to provide the reader with some idea of the substantive practices that underlie terreiro health activists' claims to a culturally distinct assemblage of healing knowledge and a different way of understanding the body, health, and illness. Although the traditional forms of healing from Afro-Brazilian religions are more salient in some areas of Brazil than others, and despite the fact that members usually turn first to biomedicine when treating their own afflictions, this traditional corpus of health knowledge is a powerful source of identity for members of Afro-Brazilian religions. Within the context of black health activism, traditional health knowledge becomes a currency with which terreiro members can claim specialized resources and recognition from the state. In the next chapter, I substantiate this argument through an examination of historical and contemporary relations between Afro-Brazilian religions and the Brazilian state.

Chapter 6: Afro-Brazilian Religions and the State

As I established in Parts I and II, special rights for certain kinds of citizens are nothing new for Brazil; what *is* relatively new is the state's extension of special rights and/or recognition to black Brazilians and, as I describe in this chapter, to religious groups. The second issue is just as contentious as the first, given the separation of religion and state in the Brazilian Constitution.[77] In the following pages, I examine how the Brazilian state handles the dilemma of extending special protections and recognition in public policy to members of Afro-Brazilian religions. I identify three key strategies. The first is equating Afro-Brazilian religions (as well as other religions, in some cases) with civil society organizations ("NGOization"). The second strategy is treating terreiro members as a vulnerable group in relation to health issues such as HIV/AIDS ("vulnerabilization"). The third strategy is the conflation of religious affiliation with racial/ethnic identities (i.e., Afro-Brazilian religion as culture, rather than religion per se). The discourse of cultural competence is an instrumental part of this strategy. Together, these strategies serve to de-sacralize Afro-Brazilian religions within the public sphere and thus render them a legitimate object of public policy.

Terreiro health activists, I contend, are co-conspirators in this process; they participate in their own ethnic othering, vulnerabilization, and NGOization. At the same time, however, they critique Brazil's *estado láico* ("lay state") policy by claiming that the separation of religion and state does not mean that the state should ignore its citizens' religions, but rather that it cannot favor any particular religion; and that since the

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[77] Prior to the formal separation of church and state in 1890 under the first Brazilian Republic, the Crown had maintained a relationship of open patronage with the Catholic Church.

Brazilian state favors Catholicism in practice, separation of religion and state does not truly exist in Brazil.

I also make a third kind of argument in this chapter. Situating the interactions between Afro-Brazilian religions and the Brazilian public health apparatus within a historical context, I argue that terreiro health activists' political struggle represents more than a push for medical pluralism. Rather, these activists seek symbolic reparation for the historical criminalization of these medical practices and for the historical association of Afro-Brazilian religions with poor hygiene, contagion, and charlatanism.[78] At the same time, activists carve out a unique Afro-Brazilian cultural identity through references to a culturally specific body of knowledge concerning health and illness. In the process, they re-imagine the relationship of their traditional healing practices to biomedicine, as well as the relationship of Afro-Brazilian religions to the nation itself.

Partnerships between Terreiros and SUS: Rehabilitating History

Since the late 1980s, members of Afro-Brazilian religions have actively sought out and organized formal and informal partnerships with SUS. These partnerships began as community-based efforts to promote awareness and prevention of HIV/AIDS within terreiros. Early educational campaigns promoted condom use as well as "biosecurity" (*biosegurança*), or making ritual practices safer (Mott & Cerqueira 1998). From top-down initiatives that instilled public health education within terreiro communities, however, partnerships slowly became more democratic as terreiro health activists began to assume the role of educators in regard to their own cultural and religious beliefs

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[78] See Johnson (2001) and Maggie (1992) for historical accounts of the criminalization of Afro-Brazilian religions' healing practices.

concerning health, illness, life, and death (e.g., Silva & Guimarães 2000). They began to organize internally around issues such as experiencing prejudice in public clinics due to their religious and racial identities.

Throughout my fieldwork in northeast and southeast Brazil, I followed the activities of the most elaborate partnership between Afro-Brazilian religions and SUS to date: the National Network for Afro-Brazilian Religions and Health. A meta-social movement, the Network comprises terreiro members, black movement activists, and public health workers in over 25 Brazilian cities who are interested in the official valorization of Afro-Brazilian ethno-religious identity and health knowledge. The Network is an outgrowth of an earlier terreiro health initiative called "Ató-Ire," which was funded by the Ford Foundation and based in São Luís and Rio de Janeiro. Ató-Ire trained members of Afro-Brazilian religions to be HIV-prevention educators in their own terreiros. When Ató-Ire's funding ended in 2003, its participants decided to create the Network in order to maintain the initiative's activities and expand them to a national level.[79]

The Network has smaller chapters called "nuclei" (*núcleos*) that operate in seventeen Brazilian states, and each nucleus has both state- and city-level coordinators who organize political meetings and health education events in their communities. Health education events take place in terreiros and usually take the form of health fairs, workshops, or lectures. Network activists also work with public health departments to create health education materials that incorporate concepts and symbols from Afro-Brazilian religions. Although their internal newsletter became defunct following the end

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[79] For more information about Ató-Ire, see Silva (2007).

of the Ató-Ire project, Network activists have continued to circulate information among themselves through a collective blog. The Network's national coordinator, José Marmo da Silva, has also published articles in academic journals such as the *Journal of Health Communication* and *Saúde e Sociedade* (Health and Society) (Silva & Guimarães 2000, Silva 2007). He is a public health dentist and a member of Candomblé in Rio de Janeiro.

The most salient topics raised in Network publications and meetings are religious intolerance and institutional racism in the public health system, as well as the benefits of the traditional medicine practiced in terreiros. Like members of the black health epistemic community, terreiro health activists define institutional racism as a form of racial discrimination that is so dispersed throughout societal institutions that people practice it unconsciously. As I discussed in Chapter 4, black health activists claim that health care providers discriminate against black patients and thus contribute to health disparities between racialized groups. Terreiro health activists extend this claim to members of Afro-Brazilian religions, asserting that they are often mistreated for belonging to a marginalized religion, regardless of their race.

In practice, the Network channels the conflict between public health norms and Afro-Brazilian ritual practice into routinized public dialogue. Its main goal is to promote "knowledge exchange" (*troca de saberes*) between SUS and terreiros. Many Network activists claim, however, that the intended exchange continues to flow mostly from SUS to Afro-Brazilian religions. In other words, SUS disseminates public health information to members of Afro-Brazilian religions and financially supports some of the Network's activities, but does not yet fully recognize traditional Afro-Brazilian medicine as a complementary healing practice.

Nevertheless, the proliferation of partnerships between public health departments and terreiros is significant, given that the Brazilian state once repressed Afro-Brazilian ritual practices through infamous public health codes. At many points throughout Brazilian history, the figure of the black *feiticeiro* or *curandeiro* (witch doctor) has been imagined and appropriated in varying ways to serve both dominant and subaltern interests. In his study of religion and culture in Brazil and other Portuguese colonies up to the eighteenth century, Sweet (2003) observes that colonizers often associated African slaves' healing and divination practices with witchcraft (*feitiçaria*). Indeed, as he states, "race and culture became fused, as Africans became the receptacle for all things savage" (187). Simultaneously, however, many colonizers were aware of their slaves' curative powers and sought ritual healing from them.

From early on, the figure of the black healer/sorcerer encoded ambiguity and liminality between Christian notions of good and evil. As enslaved Africans became aware of their masters' belief in their powers, they began to derive economic benefit and greater agency by selling their healing services. Historian Ubiratan Castro has observed that Afro-Brazilian ritual healing constituted an "important currency with which blacks could insert themselves into the wider society."[80] That is, many African Brazilians appropriated the essentializing race-culture fusion created by their oppressors and transformed it into a source of power.

Throughout much of Brazil's colonial period until the consolidation of Western medicine in the mid-1800s, African and Afro-Brazilian ritual healers provided primary

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[80] Conference presentation, Fifth National Seminar on Afro-Brazilian Religions and Health (João Pessoa, Paraíba, Brazil, April 18-20, 2006).

health care to various sectors of the Brazilian population, including elites.[81] After the first public health department was instituted in 1850, proponents of the biomedical model expressed decreasing tolerance for alternative forms of healing. As abolition drew nearer, public opinion also turned against Afro-Brazilian healers and they were viewed with increasing distaste and suspicion.

While slavery lasted, Afro-Brazilian religions were not systematically persecuted. Despite occasional police raids on terreiros, enslaved Africans were considered the responsibility of slave-owners (Reis 1989). Although existing terreiros were maintained by freed Africans, they were relatively few in number and were so carefully hidden that the state rarely bothered to persecute them. With abolition in 1888 and the formation of the First Republic the next year, however, came a shift in dominant society's perceptions of Afro-Brazilian culture. For the first time, all blacks were officially incorporated into the Brazilian citizenry. Influenced by themes of positivism and scientific racism, Brazilian intellectuals agonized over how to protect civilized society against the supposedly degenerating, barbaric influence of Afro-Brazilian customs and people (Borges 1995).

Johnson (2001) argues that public health codes constituted the most powerful mode of state oppression of Afro-Brazilian religions during the First Republic. In 1890, the new republican government created a Penal Code with three new articles that were used to persecute Afro-Brazilian healers, among others: 156 (prohibiting the practice of illegal medicine such as homeopathy), 157 (prohibiting magic and sorcery), and 158 (prohibiting "curandeirismo" or the practice of false or questionable ritual healing). These

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[81] See Sampaio (2001).

articles were instituted at a time when elites were troubled by Brazil's seemingly limited capacity for progress and its reputation among developed nations; after all, Brazil was a predominantly black nation whose population engaged in cultural practices viewed by many as backward and unsanitary. Given this context, Johnson argues that the articles introduced by the 1890 Penal Code allowed the state to continue controlling African Brazilians, who were now citizens rather than slaves.

Persecution of Afro-Brazilian ritual healing through the public health codes reached an apex in the early twentieth century but declined somewhat with the regime of populist dictator Getúlio Vargas. During the 1930s and 1940s, Vargas' populism elevated the status of Afro-Brazilian contributions to the national culture (Davis 1999). Johnson (2002) avers that during the Vargas regime, state policy toward Afro-Brazilian religions shifted from "unpredictable house arrests and general harassment" to "accommodation and co-opting" (94). Umbanda became the most celebrated Afro-Brazilian religion due to its combination of elements from Catholicism, Amerindian religions, and African religions. This religion fit well with Vargas' promotion of mixed-race Brazilian nationality since it represented the amalgamation of the three "founding races" of Brazil: Portuguese, indigenous, and African. Brown (1994) observes that the de-Africanized character of Umbanda made it acceptable for state promotion at this time, whereas many other, more explicitly "African," religions continued to be persecuted.

Despite Vargas' promotion of Umbanda, in 1934 he passed a decree requiring Afro-Brazilian religious temples to register with the recently created Polícias de Jogos e Costumes (Police of Gaming and Customs) prior to engaging in any public ritual activity. Registering with these police stations meant that Afro-Brazilian religions were not only denied recognition as legitimate religious institutions, but they were also placed on a legal par with casinos and brothels. In 1937, however, Vargas passed a presidential decree recognizing a few designated “traditional” Candomblé terreiros as legitimate and protecting them from police disturbance of their ritual practices or objects. Vargas’ protection of those few terreiros represented more a strategic move to preserve the cultural patrimony of Brazil in a museum-like fashion, than an actual recognition of their status as legitimate temples of worship (Johnson 2002).

During Brazil’s military dictatorship (1964-1985), the regime continued to encourage Afro-Brazilian cultural manifestations as a way of justifying Brazil’s connection to Africa (Santos 2005). As a result of this political stance and the regime’s focus on economic modernization, state tourist boards began to promote Afro-Brazilian religions in advertisements for international travel. This phenomenon was most visible in Salvador, traditionally deemed Brazil’s “Black Rome” due to its high proportion of African descendants and practitioners of Afro-Brazilian religions (Bastide 1978). State promotion of Afro-Brazilian culture continued upon Brazil’s return to full democracy in 1985 and has increased ever since (Johnson 2002). State support for Afro-Brazilian culture reached an all-time high during the administration of Luís Inácio “Lula” da Silva (2003-2010). Global trends that influenced the Brazilian state’s increasingly tolerant attitude toward Afro-Brazilian religion and culture include the UN’s World Conference on Racism in 2001 and the World Health Organization’s campaign to promote popular medicine and healing knowledge, which intensified around the same time.[82]

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[82] World Health Organization, 2002 (http://www.who.int/mediacentre/news/releases/release38/en/). Last accessed August 30, 2010.

Razor Blades and Comic Strips

Despite the improving relationship between Afro-Brazilian religions and the Brazilian state, the practice of ritual cutting within some Afro-Brazilian religions has remained a sticking point, so to speak, for SUS. This was especially true during the late 1980s, when the Ministry of Health identified members of Afro-Brazilian religions as a risk group for HIV/AIDS due to this practice, as well as to the large proportion of homosexual terreiro members. To make matters worse, Brazilian media outlets picked up the story and broadcast it widely (Mesquita 2002, Silva & Guimarães 2000, Galvão 1991).

In response, terreiros and civil society organizations in Rio de Janeiro collaborated to create HIV prevention campaigns for local Candomblé terreiros. In the early 1990s, the Institute for Religious Studies (ISER—Instituto de Estudos da Religião) and local terreiro leaders launched an initiative titled "Odô-Yá" (Galvão 1991, Silva & Guimarães 2000). "Odô-Yá" is the greeting called out by terreiro members when the orixá Iemanjá descends into someone's body. The sector of ISER that carried out the project was ARCA, or Apoio Religioso Contra a AIDS (Religious Support Against AIDS). Odô-Yá received funding from several international NGOs, including the World Health Organization. The Network's national coordinator, José Marmo da Silva ("Marmo"), was actively involved in the project.

In 1991, ARCA, in consultation with Marmo and a few other terreiro members, produced a manual titled *Odô-Yá!* The manual included three Candomblé parables in comic strip form, and related them to HIV prevention. It discussed the tradition of using the "navalha da casa" (a ritually blessed razor belonging to a specific terreiro) on multiple initiates, and recommended modifications such as using disposable razors or disinfecting them with bleach before using them on another person (1991:18).

The Odô-Yá project was followed by "Arayê," a similar initiative carried out by the Interdisciplinary Brazilian AIDS Association (Associação Brasileira Interdisciplinar de AIDS, or ABIA). Like Odô-Yá, Arayê's goal was to produce culturally competent HIV prevention materials for terreiro members. Mesquita (2002) observes, however, that Arayê went further than Odô-Yá in "superimposing *négritude* onto Candomblé" (119). For instance, Arayê materials used the terms "povo-de-santo" (terreiro members), "povo afro-brasileiro" (Afro-Brazilian people), and "povo negro" (black people) interchangeably, as if each term described the same population. This fusion of racial and ethnic identity would endure and grow stronger, culminating in the National Health Policy for the Black Population.

The Rio de Janeiro initiatives gave way to similar projects in Salvador and Recife. In Salvador, the Bahian Anti-AIDS Center (Centro Baiano Anti-AIDS—CBAA) promoted an HIV prevention campaign in the mid-1990s by holding educational meetings and distributing public health literature in terreiros. Like Odô-Yá and Arayê, the CBAA campaign called for ritual modifications such as disposable razors (or disinfection of a common razor) and the use of rubber gloves during ceremonies. In Salvador, however, CBAA's campaign was met with outrage by Candomblé practitioners who did not wish to be labeled a high-risk population for HIV/AIDS.[83]

When I questioned pais- and mães-de-santo in Salvador, São Luís, and São Paulo about ritual cutting, all of them insisted that they used individual, disposable razors on

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[83] Personal communication, D.R., SUS administrator; Salvador, 2006.

their initiates. However, the coordinator of the CBAA project, who is also a terreiro member, told me in 2006 that he continued to witness shared-razor ceremonies in many Salvador terreiros. Nonetheless, a large survey conducted by the CBAA in 1998 revealed that 87 percent of priests and priestesses approved of using disposable razors. As for the use of rubber gloves, however, nearly half the leaders felt it would compromise the ritual (Mott & Cerqueira 1998: 18-21).

In 2001, the Health Department of Pernambuco undertook a similar campaign against ritual cutting by producing and distributing a booklet titled *Atotô*. As I mentioned in the last chapter, "Atotô" is the greeting called out to Obaluaiyê during Candomblé rituals. The pamphlet was co-authored by a SUS administrator and a Xangô priest in Recife. It aimed to teach readers how to protect themselves from contracting HIV through blood transfusions, sexual contact, and ritual cutting. The text of *Atotô* enjoins ritual practitioners to use disposable razors during healing and initiation rites that require ritual incisions in multiple people. The booklet includes a comic-strip depiction of a religious parable involving Obaluaiyê, who is the divinity or *orixá* of infectious diseases. *Atotô* calls for a "partnership" between "us, health professionals" and "members of Afro-Brazilian religions." Healing practices in Afro-Brazilian religion are depicted as complementary to official medicine with the following phrases: "When we are ill it is very important that we seek the protection of Obaluaiyê….However, we cannot neglect to seek out medical assistance, because the orixás help with the suffering of the soul, but the medical professional is in charge of healing the wounds of the body." White health care providers are portrayed using the trappings of modern medicine (e.g., a stethoscope and blood pressure equipment) in hospital settings, while black *filhos-de-santo* (initiates) are drawn wearing African-style clothing and surrounded by foliage—thus invoking a sharp difference between biomedical/scientific and traditional African religious spaces. Although *Atotô* was conceived as a culturally sensitive tool for HIV prevention, it provoked a negative response among local practitioners who felt it reproduced stereotypes.[84] Many of them bristled at being characterized as potential vectors for HIV transmission.

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These stories of razor blades and comic strips reveal an enduring tension between terreiros and the state that is frequently obscured by official representations of Afro-Brazilian culture as an integral element of Brazilian nationhood. There is a fundamental conflict between the state's exaltation of Afro-Brazilian tradition, on the one hand, and its desire to regulate ritual practices it deems dangerous or barbaric, on the other. This conflict illustrates Paul Christopher Johnson's argument (2005) that in many African diasporic religious contexts, the state endorses freedom of belief but not necessarily of practice.

Discussing the Brazilian case, both Johnson (2001) and Yvonne Maggie (1992) have shown that the state relied historically upon public health codes to regulate Afro-Brazilian religious practices. I argue that although these codes are rarely enforced nowadays, the regulation of "risky" practices such as ritual cutting and animal sacrifice continues more subtly through the application of public health norms by new actors and coalitions. These norms are applied using new techniques such as the language of health

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[84] Personal communication, various, Fifth National Seminar for Afro-Brazilian Religions and Health (April 18-20, 2006, João Pessoa, Brazil).

education. In the process, certain members of Afro-Brazilian religions receive the Ministry of Health's stamp of approval, but only on the condition that they modify their risky practices and cooperate with the public health apparatus. Terreiros are only recognized publicly as health-promoting institutions if they demonstrate their commitment to complying with public health norms, for example, by inviting SUS health educators to deliver HIV-prevention lectures within their terreiros.

This scenario is somewhat similar to the one Hale (2002) describes in his analysis of neoliberal multiculturalism in Guatemala. He argues that neoliberalism entails a cultural project in which the state extends cultural rights and recognition to marginalized ethnic groups while simultaneously denying them substantive citizenship equality. This situation creates the "índio permitido," often an elite member of the marginalized group who performs cultural authenticity for the state in exchange for recognition and resources. Postero (2007) documents a similar process that occurred within the context of neoliberal multiculturalism in Bolivia. She shows that, by engaging civil society organizations in the implementation of local projects with limited impact, the state was able to channel indigenous activists' energies away from demanding a more extensive redistribution of resources.

In the case I describe here, practitioners of Afro-Brazilian religion who comply with the state's ideals of healthy religiosity receive recognition in the public sphere. According to Pai Cesar, this recognition comes at the expense of systemic health care reform. The state keeps terreiro leaders happy, he said, by occasionally sponsoring seminars where they can orate about the value of their traditional medical practices. In this way, the state can avoid making more sweeping healthcare reforms, such as implementing more health care services within terreiros' communities, or taking serious measures to counteract the discrimination faced by terreiro members in public clinics.

For most terreiro health activists, however, a little recognition apparently goes a long way given the history of state persecution under public health codes. For many of my informants, recognition was an end in itself, rather than a means to obtaining better public health services. I realized this only after many frustrating months of trying to ascertain the Network's ultimate goal. Repeatedly, terreiro health activists would tell me that they wanted the state to "recognize the terreiro as a health-promoting institution" (*reconhecer o terreiro como instituição promotora da saúde*). This phrase came to sound like a broken record as I interviewed more and more terreiro health activists and attended seemingly endless meetings. Indeed, most activists seemed content with the state's increasing sponsorship of their events, as well as its mention of Afro-Brazilian religions and their healing knowledge within state- and national-level health policies. Given their tortured history with the state, it seemed, they were content with gaining the human right to dignity.

Other Sources of Conflict

Although the razor-blade controversy is the most dramatic example of conflict between Afro-Brazilian religions and public health norms, other examples abound. For instance, in 2003, practitioners of *batuque* (an Afro-Brazilian religion practiced widely in the state of Rio Grande do Sul) and black movement activists successfully lobbied the state legislature to get Afro-Brazilian religious worship exempted from the Animal Protection Code. The event provoked impassioned reactions from both animal rights and human rights activists, the latter of who defended the right to full religious freedom.

Similar animal sacrifice/public health legal struggles have been documented in other Afro-diasporic religious contexts, including *santería* in Miami (Johnson 2005).

Alongside these widely publicized controversies between Afro-Brazilian religions and public health are others that rarely make their way into the media. For instance, terreiro health activists in the four cities where I conducted fieldwork between 2005 and 2009 complained that community health workers routinely avoided visiting their terreiros when making neighborhood rounds. Many primary care clinics send teams of community health workers, and sometimes also doctors and/or nurses, on household visits in the neighborhoods surrounding the clinics. These teams monitor pregnant women, the elderly, and patients with serious chronic and infectious diseases (e.g., diabetes, hypertension, leprosy, hepatitis). There are also specialized dengue fever workers who inspect people's homes for risk factors such as uncovered containers of water.

Since terreiros in northeastern Brazil are often located on relatively large land tracts with multiple family compounds, this means that many people living in the compounds, especially the elderly and disabled, may not receive primary health care if heath workers avoid terreiros. In Salvador, activists partnered with the city's health department to organize a project called "Saúde nos Terreiros" (Health in the Terreiros). The project was implemented with ease since the health department had a special office for black health programs, and a Network member directed the office. The project consisted of public debates and community health fairs held in terreiros all over the city. At these events, terreiro members and public health workers came together and discussed their areas of conflict. The goal was to find solutions that would be acceptable to both parties, such as placing anti-mosquito tablets in the water of ritual preparations rather than requiring terreiro members to cover the containers.

In São Paulo, by contrast, terreiros are often squeezed into narrow, concrete urban dwellings or improvised from rented spaces within a large Umbanda Sanctuary (Santuário da Umbanda) located in the "ABC" periphery of the city.[85] Almost none of the pais- and mães-de-santo who participated in the São Paulo city branch of the Network actually lived in their terreiros. They frequently spoke of the challenges involved in carrying out rituals and offerings that required certain natural settings, such as waterfalls or forests, or certain key plant ingredients that were difficult to find in the city's concrete sprawl. The Umbanda Sanctuary therefore represents a practical solution for many terreiro leaders. When I visited a friend's rented terreiro there, soon after my arrival in São Paulo, I was astounded at its innovative organization.

The Sanctuary is divided into sections devoted to each orixá; for instance, in the "Oxum" section, there is a waterfall and a large colorful statue representing Oxum. The day I was there, Oxum's section bore the remnants of multiple ritual offerings, such as burnt-out thick yellow candles resting on saucers, covered porcelain bowls, and clay pots (which, I assumed, contained preparations of Oxum's foods such as fish, eggs, and honey). Near the entrance of the Sanctuary, there is a large store selling snacks as well as ritual objects and implements, such as incense, candles, and statuettes of various orixás. In my view, the Sanctuary's organization was reminiscent of theme parks in the United States. My visit there came just after I had spent a year in São Luís, where most terreiros

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[85] The ABC comprises the neighborhoods of Santo André, São Bernardo, São Caetano, and Diadema. These neighborhoods are mix of residences and industrial complexes.

are situated in areas of abundant foliage. As such, I was struck by the creativity required to practice a nature-worshipping religion within the physical constraints of a mega-city.

Terreiro health activists attribute community health workers' avoidance of their terreiros to religious intolerance. According to them, many of these workers are evangelical Christians and therefore believe Afro-Brazilian religions are diabolical (*coisa do diabo*). Pai Arnaldo, a Network member in São Luís, reported that he returned to his terreiro one day to find a dengue inspector trying to destroy his statue of the *orixá* (deity) Exu:

> My mother was in the terreiro. When I arrived, I found this scene unfolding. [The inspector was saying] that it was the devil, that it belonged to the devil, that it was Satan, and he wanted to take [the statue] out of my house. Then, he wanted to evangelize us, so I got mad and threatened him with four or five stones in my hand, I nearly threw them. I thought he was out of line, since he was there to work and not to tell me what's right and wrong with my life.

Following this incident, Pai Arnaldo went to the police and pressed charges against the dengue inspector. He even began to file a lawsuit, but dropped both the charges and the suit after the inspector apologized.

Episodes like this one have prompted Network activists in many Brazilian cities to hold "sensitivity training" (*sensibilização*) sessions with public health care providers. Such activities took place within selected terreiros every few months during my fieldwork in Salvador (2006), São Luís (2007-08), and São Paulo (2008-09). During these sessions, members of Afro-Brazilian religions strived to "demystify" (*desmistificar)* their religious beliefs and practices by teaching the health professionals basic facts about orixá worship and about how they treat spiritual and physical health problems in the terreiro. They also encouraged health professionals to openly discuss their own fears and prejudices concerning Afro-Brazilian religions during the workshops. During a sensitivity training session in São Paulo in 2008, a mental health employee admitted that she had furtively prayed three rosaries before entering the terreiro that day in order to seek spiritual protection from the demonic forces that she was certain of encountering there.

I heard many other such fears and fantasies about Afro-Brazilian religions from health professionals during fieldwork. Once, I was seated in a dingy but air-conditioned waiting room at São Luís's Municipal Health Department, waiting to obtain permission to conduct research at a local clinic. Having overheard my conversation with the secretary, two white, middle-aged female employees approached me and asked about my research. When I told them I was studying Afro-Brazilian religions and health, one woman nodded knowingly and said, "Yeah, those people don't like to get vaccines, and during their rituals they all use the same razor blade which can spread HIV. They do whatever the pai-de-santo commands them to do. Plus, they sacrifice animals." I kept quiet, hoping she would say more, but just then the secretary returned with my documents and the women went back to work.

This kind of exchange was more common in São Luís than in São Paulo, where the public health employees I met seemed more concerned with political correctness. Over the course of fieldwork, only one employee, Rosana, expressed her own negative impressions of Afro-Brazilian religious practices during a taped interview. Even so, she kept asking me to stop the recording so she could think carefully about her responses to my questions before taping them. At the time, Rosana was a 55-year-old project administrator at São Luís' municipal STD/AIDS department. She identified as white and was an evangelical Christian. I interviewed her at her family's home in the middle-class neighborhood of São Francisco. When Rosana stated that the municipal HIV/AIDS Program had classified terreiro members as a vulnerable group, I asked her why. She replied that the members' rituals, which she had heard involved cutting, expose them to HIV. She added that members of these religions have no access to public health information regarding, for instance, how to avoid contracting HIV.

Rosana's comments led us into a discussion about her perception of the public health implications of other Afro-Brazilian religious practices. She was dubious about the safety of the herbs, teas, and "those mixtures" that members ingest. "Nobody's in the laboratory testing to see what products they use," she remarked. Rosana also echoed the employee at the municipal health department who had told me that terreiro members refused vaccines.

> Members believe that their rituals guarantee their own immunity. They have this idea. Therefore, they negate [public] health. They negate everything that's outside [the terreiro]. So when Public Health goes there...[health professionals] can't just show up and impose things, can they? They have to go peacefully, sensitively. It's like taking the Indian out of the woods where he lives...he has a whole lifestyle, customs, values, that are totally different.

Although Rosana was trying to emphasize the need for public health employees to be mindful of terreiro members' cultural specificities, her comments revealed the extent to which she viewed terreiro members as fundamentally "other" vis-à-vis the general Brazilian population. She also presented an image of Afro-Brazilian religions as a kind of counter-culture, especially by opposing their beliefs about immunity to the germ theory of disease. By contrast, the terreiro health activists whose work I followed in various cities were adamant about the fact that the ritual healing practiced in terreiros is not a "cure-all" medicine; they claimed to advise members and clients (*clientes*) who sought out the terreiro for healing to consult a medical doctor as well. During my own fieldwork in terreiros, I also witnessed mães- and pais-de-santo counseling filhos and clients to go to a *posto de saúde* (SUS clinic) while they were undergoing ritual healing. Often, the mãe- or pai-de-santo would be "incorporated" (*incorporado/a*) at the time with a healing caboclo. Since caboclos use distinctive language characteristic of rural populations, it is customary for them to refer to medical doctors as *o homem de bata branca* (the man in the white coat). On the three occasions that I sought ritual healing for a chronic pain condition, the mãe- or pai-de-santo told me to visit a doctor because my problem was physical, not spiritual—but they also gave me herbal concoctions to drink and, in one case, conducted an *ebó*, or offering, to my orixá (described in Chapter 5).

Of course, it is likely that the leaders of the terreiros in which I conducted fieldwork were more careful to recommend simultaneous biomedical treatment to clients, because the leaders were terreiro health activists. In addition, years of persecution as charlatans have presumably rendered terreiro members more apt to characterize their healing as complementary to biomedicine, rather than as a substitute for it. It follows that my presence as an outsider also could have influenced terreiro members' behavior in this regard.

Over roughly three years of fieldwork in terreiros, I met only one pai-de-santo who claimed to have cured a client of cancer through ritual healing. No one claimed to have cured HIV/AIDS. I met terreiro members who said they had been cured of leprosy and epilepsy, as well as a host of chronic pain and mental health disorders, through spiritual treatment and development in the terreiro. As for Rosana's idea that terreiro members believe their religion confers immunity, there is a concept of the "corpo fechado" (closed body) within Afro-Brazilian religions. When a member's spiritual obligations are up to date, and/or when she undergoes a special ritual, her body is said to be "closed" to external threats. In some cases, these threats might include illnesses that manifest physically. However, this belief generally does not preclude terreiro members from getting vaccines—in fact, in most cities I visited, a few terreiros served periodically as community vaccination posts (*pólos de vacina*). At certain times of the year, members of the terreiro and its surrounding community would line up to receive various vaccines from SUS nurses. Furthermore, my observations and interviews with terreiro members indicated that they rarely, if ever, chose ritual healing in place of biomedical treatment.

Finally, Rosana compared terreiro members to indigenous Brazilians, another population labeled "vulnerable" and targeted by HIV/AIDS programs throughout Brazil. Her comparison is useful to the present discussion. After all, both indigenous Brazilians and terreiro members have been targeted as objects of public health policy. Both have been constructed by the public health system as culturally different and in need of culturally competent health practices. Unlike indigenous Brazilians, however, the public health apparatus has only recently begun to formally recognize terreiro members as a culturally separate group.

As terreiro members increasingly push the boundaries of their relationship to the public health apparatus, additional sources of conflict appear—particularly when terreiro members attempt to bring their practices into biomedical spaces. In São Paulo, terreiro health activists protested frequently that public hospitals would not allow them to attend to their faithful. Most hospitals in Brazil offer chaplain services and routine patient visitation (called *capelania* or *assistência religiosa*) from Catholic, Protestant, and

Spiritist chaplains or lay members. At designated times throughout the week, lay members make bedside rounds, offering unsolicited prayer to patients (many of whom are in no condition to protest). Chaplains call on patients by request to provide religious rites. However, members of Afro-Brazilian religions are not included in chaplaincy and lay visitation programs. Terreiro health activists frequently complain about their exclusion from patient visitation programs, as well as the fact that they are not allowed to conduct rites for their own ailing faithful in the hospital.

In *Orixás da Metrópole* (*Orixás of the Metropolis*), Silva (1995) discusses the conflicts that ensue when mães- and pais-de-santo attempt to conduct healing rituals for their members at public hospitals in São Paulo. He views these conflicts as symptomatic of fundamental differences in conceptions of health, illness, life, and death between Afro-Brazilian religions and medical science. He observes that Christian rites do not produce conflict in the biomedical setting because they are "aseptic" and bring only words to patients, rather than herbs or ritual incisions (238).

During fieldwork, however, I found a significant disconnect between terreiro health activists' public and private claims of discrimination during hospital visits to religious "family" members. Mãe Cíntia, for example, a Candomblé priestess in São Paulo, told me during an interview that although *sacerdotes* (priests) declare they do not have access to their hospitalized faithful, this is not true: they simply do not go to the hospitals dressed in their ritual clothing because they believe they will be barred from entering. Similarly, Pai José and Mãe Denise, both Candomblé leaders in São Paulo, gave firsthand reports of having visited their *filhos* in the hospital and conducted religious rites. In Pai José's words, he simply used the good old "jeitinho brasileiro" (roughly, "Brazilian way"). Brazilians often use this phrase to describe a situation in which the rules are bent. Pai José paid an attendant at the Heliópolis Hospital ten *reais* to ensure that he would not be disturbed while conducting funereal rites for his filho who had just expired from AIDS-related complications. When he told me this story, I assumed it must have been easier to get persuade hospital staff to let him conduct rites on a dead body than would be the case with a live patient. Mãe Denise's story, however, made me question my assumption.

When her own pai-de-santo ended up in the Ibirapuera State Employees' Hospital following a massive stroke, Mãe Denise and some other members of his terreiro visited him regularly, unbeknownst to his disapproving family. At first, they only dared to sing prayers to orixás whenever they found themselves alone at his bedside. Eventually, however, the orixá told them they needed to give him *banhos* (ritual herb baths), perform an *ebó* (ritual offering to the orixás), and feed him the ritual foods of his own orixá, Obaluaiyê—coincidentally, the orixá associated with health and illness. They decided to approach the nurses and explain the situation. To Mãe Denise's surprise, the nurses did not say no. Instead, they sent in a psychologist and a social worker to ask Mãe Denise and her *irmãos-de-santo* exactly what would ensue, and to decide whether any of the rites could harm the patient. They settled on involving the nurses in the whole process. The nurses administered the herbal baths to the patient using a sponge, spoon-fed him the herbal concoctions (after obtaining a list of the ingredients and making sure they had been prepared with filtered water), and incorporated his orixá's ritual foods into his hospital meals.

Mãe Denise’s experience, however, appears to be the exception rather than the rule. Most of the terreiro health activists I interviewed told me the more usual scenario is to conduct rituals in secret *(às escondidas*), or not to conduct them at all inside the hospital. They believe, however, that skipping the rituals jeopardizes the patient’s health and relationship to his or her orixá. Meanwhile, despite some individuals’ success with negotiating hospital norms, terreiro health activists continue to be excluded from patient visitation programs in hospitals.

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As the examples above show, the Brazilian public health apparatus continues to regulate the bodily practices of members of Afro-Brazilian religions. Although some SUS employees are blatant in their attempts to normalize the terreiros’ ritual space, like the dengue inspector in São Luís, they are now the exception rather than the rule. Indeed, the state’s new *modus operandi* is a rewards system that encourages terreiro practitioners to regulate each other. The state can apply this technology seamlessly, since it corresponds so well to the value placed on citizen participation and “social control” (*controle social*) within SUS. The Brazilian public health system is a prime example of a contemporary biopolitics that engages citizens as “active participants in the drive for health” (Rose 2001: 6). Terreiro members who agree to become health education disseminators (*multiplicadores*) in their communities are rewarded with recognition in the public sphere. The state is thus able to rationalize Afro-Brazilian ritual practices and keep terreiro bodies docile without overstepping the bounds of a new Brazilian multiculturalism that is endorsed by the international human rights community.

Although the new Brazilian multiculturalism emerges in various legal domains such as land rights, public education, and cultural policy, I contend that nowhere is it more essentializing than in the domain of health policy and health care. As a semantic field, health mixes claims to cultural difference with assertions of biological difference in a uniquely authoritative way due to the hegemonic status of medical science. When multiculturalism enters the hospital or clinic, it translates activists' and healthcare administrators' political discourses on particular patient identities and needs into a set of cultural symbols which are then inserted into healthcare practices. In the case of health activism and policymaking for the Brazilian black population, Afro-Brazilian religious symbols become the diacritical markers of Afro-Brazilian ethnic difference, writ large. They also become the main ingredients for sensitivity-training workshops and health education materials as part of a growing cultural competence movement in Brazil.

Cultural Competence and the Terreiro

Although they rarely use the term "cultural competence," terreiro health activists and SUS professionals employ the concept when they advocate for health care strategies that reflect the worldview and health/illness beliefs of Afro-Brazilian religions. Cultural competence in health care refers to the practice of "tailoring health care services to the needs of particular populations whose difference is understood in cultural, ethnic, and sometimes biological terms" (Shaw 2005:292). Cultural competence aims to counteract the biomedical tendency to individualize patients by reinserting them into a more familiar cultural context. The goal, typically, is to increase marginalized groups' utilization of health care services and compliance with prescribed treatment.

Brazilian black health programs portray members of Afro-Brazilian religions not only as the custodians of ancestral healing knowledge, but also as a cultural minority in need of special health care. The inclusion of provisions for the terreiro population within the National Health Policy for the Black Population makes it seem as though the terreiro population is a subset of the black population, when in reality many terreiro members do not identify as black, and the majority of black Brazilians do not profess Afro-Brazilian religions. Activists' and policymakers' conflation of the two groups establishes a semantic ambiguity between the "black population" (*população negra*) and the "terreiro population" (*população de terreiro*). This semantic ambiguity, in turn, makes it possible to define the black population as a culturally distinct part of the Brazilian population. The claim to cultural (and biological) distinctiveness is necessary in order to make the case that this population requires special resources and recognition.

SUS-sponsored cultural competence initiatives for terreiro members consist of specialized health education materials and sensitivity training for public health professionals. Like educational materials for the black population more generally, health education for the terreiro population tend to feature an "African" theme with illustrations of items such as cowry shells or West African drums. For instance, a pamphlet titled "Where there's a terreiro, there's health!" ("Tem Terreiro, Tem Saúde!"), produced by the São Luís municipal health department, features cowry shells on the front and all along the borders, in addition to a photo of the woven straw "dish" used during the *jogo de búzios* (a divining ritual that utilizes cowry shells). On the front of the pamphlet, there is also a photo of a ritual garment with strings of beads (*guias*) hanging down from it.

Inside the pamphlet is printed information on various sexually transmitted diseases, as well as illustrated instructions on how to use a condom. The inside flap reads:

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

This language establishes an image of terreiro members as a traditional population with culturally specific and holistic ways of understanding the relationship between the body and spirituality.

In both São Paulo and São Luís, I attended sensitivity-training workshops on *saúde da população negra*. I described some of these in Chapter 2. In São Paulo, I attended another workshop series called "Saúde com Cultura" [Health (care) with Culture].[86] The workshops were organized and financed by the São Paulo state health department, and were taught primarily by black anthropologists and sociologists. They were organized as a lecture series that resembled an introductory course on the anthropology of African peoples; the lecturers began by covering the "out of Africa" evolutionary model and proceeded to teach about different ethnic groups in Africa, focusing on their various religious and health-related beliefs and practices. When I interviewed Leonardo, the SUS administrator who created the workshops, he told me they were intended to give SUS providers an appreciation for the richness of African culture. If they appreciated the cultural background of their black patients, he reasoned, perhaps they would be less likely to mistreat them.

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[86] Within SUS, the word "saúde" is used to refer both to healthcare, and to health more generally.

Cultural competence training also took place in more informal ways during routine interactions between terreiro health activists and SUS officials. For instance, I witnessed an impromptu lesson in cultural competence during a meeting of the Xirê Project (Projeto Xirê) at São Paulo's municipal AIDS department in August 2008. The Project was a cooperative endeavor between municipal HIV/AIDS officials and a group of terreiro leaders in São Paulo; it dispatched health professionals to local terreiros for weekend workshops in which they and terreiro members took turns educating one another about their respective health beliefs and norms. The team included Marília, Janaína, Pai Cesar, Simone, and Mãe Cíntia. Marília was a white, middle-aged administrator and self-described Catholic with copper-colored hair and blue eyes. Janaína was a twenty-three year old policy analyst with olive skin, wild curly black hair, and horn-rimmed glasses. She had grown up in the periphery of São Paulo and identified as *árabe* (Arab) due to her father's Syrian roots. Simone was the departmental secretary; she was also an Umbanda priestess in her mid-forties with medium brown skin and chemically straightened, shoulder-length black hair. Mãe Cíntia was a forty-five year old Candomblé priestess, and good friend of Pai Cesar, who identified as black despite her olive skin tone. Mãe Cíntia's *filhos-de-santo* were mostly white, middle-class *paulistas*. She was a permanent fixture at Network and Xirê Project meetings and events, and always wore Candomblé-inspired clothing: long, billowy white skirts; white sweaters or long-sleeved blouses; and a white head wrap which covered her long, straight black hair. In accordance with Candomblé mores, Mãe Cíntia always wore a long string of beads (*guia* or *fio de contas*) whose colors and pattern indicated her guiding orixás. Because Mãe Cíntia's main orixá was Oxum, her beads were mainly yellow and gold.

The team was seated around a table in a meeting room at the HIV/AIDS department, rehashing the previous workshop when Marília asked Mãe Cíntia what the guia signified for members of Candomblé. In response, Mãe Cíntia pulled her long string of yellow beads out from her sweater neck and explained that the guia transmits the orixá's positive energy and thus protects the wearer from malevolent forces. "It's especially important for members to wear their guias when they go to the hospital, because it strengthens the positive energy of their mind and spirit, which is vital to preserving equilibrium when the body's energy is weakened," she added. Mãe Cíntia went on to explain that in clinics and hospitals, Candomblé members are often told to remove their guias as well as their *contra-eguns* (straw ornaments worn on the upper arms for spiritual protection). Marília nodded, and then asked, "Do doctors have the right to ask patients to remove their *pano de cabeça* (head covering) for a clinical exam? And if the patient does not want to remove his guia, can the doctor push the beads aside to examine him?" Mãe Cíntia replied that it was all right for doctors and nurses to touch the guia, but that they should not ask the patient to remove it, or else he or she will become vulnerable in the absence of its protection. Finally, Marília asked about the function of the pano de cabeça, and Mãe Cíntia explained that it is for protecting the head, which in turn controls the person's equilibrium.

This episode demonstrates the process of constructing a health-related ethnic identity through didactic performances (Shaw 2010). During interactions between SUS administrators and terreiro members during the Xirê Project, terreiro members often assumed the role of cultural experts with the mission of teaching the public health apparatus about the health-related culture of Afro-Brazilian religions. In so doing, this elite group of terreiro members (most of them from Candomblé) with access to the state spoke for all members of Afro-Brazilian religions, despite the significant variations in beliefs and practices among them. Over time, these repeated didactic performances of ethnic identity often end up constructing fixed, static notions of particular cultures, which are then deployed to other members of the target population through cultural competence programs (ibid).

As Shaw (2005) and Santiago-Irizarry (1996, 2001) observe, cultural competence programs presuppose the existence of distinct cultures that merit special consideration within public policy. Through the kind of interaction described above, terreiro health activists reinforced their claim that members of Afro-Brazilian religion were indeed a special-needs group, distinct from the general population. The construction within the black health agenda of terreiro members—and, by extension, black Brazilians—as a cultural minority reflects the rise of multiculturalism in Brazil. Against an ideological backdrop that valorizes cultural assimilation, the language of cultural competence emerges as a counter-process of identity construction deployed by activists. As I discussed in Chapter 4, black health activists are seeking to replace the negative informal discrimination they already experience with positive, formalized "discrimination." The same is true for terreiro health activists.

De-Sacralizing the Terreiro

Pai Cesar often remarks that ten years ago, cooperation between the Brazilian public health system and terreiros would have been impossible in São Paulo due to widespread prejudice against Afro-Brazilian religions. He and a group of Candomblé leaders spent seven years trying to convince the city's STD/AIDS program to collaborate with them on an HIV prevention project for São Paulo terreiros. According to Pai Cesar, the coordinator simply refused to meet with them. In 2007, under mounting pressure to work with vulnerable populations, she finally accepted the group's proposal, and the Xirê Project was born.[87]

Employees from São Paulo's HIV/AIDS Program, however, tell a different story. Janaína, an anthropologist who works at the Program (and Pai Cesar's coworker), informed me that the Program had worked with terreiros in the early 2000s through *agentes de prevenção*, or peer educators. As I stated earlier, STD/AIDS programs in Brazil often hire members of difficult-to-reach communities, such as IV drug users and transvestites, to serve as peer educators. Although the Xirê Project took the SUS-terreiro relationship a step further by having terreiro members educate SUS providers about their own health practices, the Program was reportedly open to working with terreiros prior to 2007. Judging by subsequent circumstances, however, it is possible that the coordinator did not want to devote the kind of resources that the Xirê Project required. I attempted to interview her, but she was never available.

From the start, the Xirê Project encountered difficulty in obtaining funding and convincing SUS to pay providers overtime for attending weekend workshops. The workshops had to occur on weekends because the participating terreiros, like most terreiros in urban centers throughout Brazil, were located far from the city center. The gargantuan traffic jams of São Paulo made transit to the impoverished *zona leste* (east zone) nearly impossible for SUS employees who worked in the city center.

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[87] "Xirê" is the word for "public ritual" or "festival" within Candomblé.

Despite these logistical challenges, STD/AIDS Program administrators agreed to fund the workshops. They put their collective foot down, however, when Pai Cesar and Mãe Cíntia asked them to produce STD-prevention materials that portrayed the orixá Oxum. During a Xirê meeting that I attended at São Paulo's municipal health department in September 2008, Marília, the program administrator who helped coordinate the Xirê Project, told Pai Cesar and Mãe Cíntia that the Program could not produce such materials because they would violate the separation of religion and state. During an administrative meeting the previous day, her colleagues had called the proposed materials "unconstitutional." They had argued further that if they made a booklet with Oxum on the cover, they would then have to make similar ones featuring Jesus, Muhammad, and Buddha in order not to offend any religious group. Marília said she would try to convince her colleagues to produce a small number of Oxum prevention materials, just to hand out in terreiros. After that meeting, Pai Cesar complained bitterly to me that the administrators were hypocrites. How, he reasoned, could Brazil claim to be a "lay state" (*estado láico*) when virtually every public building had a crucifix on the wall? When I left São Paulo a year later, the Program had still not produced the materials.

The issue of the *estado láico* came up many times during my fieldwork with terreiro health activists and SUS employees in São Paulo. I initially found this curious, considering the numerous financial partnerships between the National STD/AIDS Program and Christian churches. For instance, the Catholic Church's AIDS pastoral initiative (Pastoral da AIDS) receives funds from the Ministry of Health for HIV/AIDS prevention and patient services. Clearly, Brazil's National STD/AIDS Program makes little to no distinction between religious institutions and other types of civil society organizations when it funds community HIV prevention projects (Terra 2010).

In São Luís, Recife, Piracicaba and many other cities where I conducted research, municipal and state health departments collaborated with terreiro health activists to create culturally competent health education materials. They also sponsored workshops like the Xirê Project, in which terreiro practitioners taught SUS employees about their religious principles. Furthermore, in the National Health Policy for the Black Population, the Ministry of Health mandates public health departments throughout Brazil to recognize terreiros as health-promoting institutions. Although most Brazilian blacks identify as either Catholic or Protestant, no such mandate exists for other religious institutions or groups. In sum, SUS's myriad financial entanglements with religious institutions reveal the estado láico's permeability to social and political interests.

Meanwhile, the discourse of the estado láico retains considerable currency among SUS administrators, as shown by the episode from the Xirê Project meeting. When I asked STD/AIDS administrators in São Paulo how they could collaborate with terreiros given the separation of church and state, they replied that they were dealing with terreiros not as religious institutions, but rather as cultural or civil society organizations. Pamela, a coordinator at the STD/AIDS Program of São Paulo state, explained that when the Program partners with religious groups, it treats them merely as "communities of citizens." She went on to redefine the concept of the lay state:

> The separation of religion and state does not mean that I have to ignore people's religions. It means I have to respect people's religions and know how to work with them...any [religious collaboration] is part of the lay state because the state gives any religion the opportunity to participate.

Pamela's solution to the problem of the lay state, then, is to ensure equal opportunity for all religions to collaborate with the state. In practice, of course, this does not happen. As I discussed above, chaplain services in Brazilian public hospitals include Catholic, Protestant, and even Kardecist members, but not terreiro members. It is important to note, however, that Pamela's view of the estado láico is likely informed by her own religious affiliation; she is the mãe-de-santo of an Umbanda center.

Pamela's view that the state treats religions as communities of citizens, however, is bolstered by the fact that representatives of religious institutions are permitted to sit on participatory councils that allow citizens to co-construct health policy. In Brazil, these are referred to simply as *conselhos de saúde*, or "health councils." One-third of the councils' members are supposed to be citizens; the other two thirds consist of SUS providers and administrators, respectively. Citizens, however, must represent a civil society organization; they cannot sit on the councils as mere individuals. Similarly, religious groups must sit on the councils as nonprofit organizations, rather than religious institutions *per se*.[88] Up until recently, health councils included representation by Catholic, Protestant, and Kardecist organizations, but not terreiros. As more and more terreiros acquire nonprofit extensions, however, terreiro leaders are increasingly joining health councils. One way in which the state negotiates the restrictions of the estado láico, then, is to conceptualize terreiros, as well as other religious institutions, as NGOs rather than as religious institutions. I will call this strategy the "NGOization" of terreiros.

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[88] The U.S. equivalent would be the concept of the faith-based organization (FBO), which is associated with a religious institution but is a separate entity with 501(c) (3) status. Religious organizations that sit on health councils in Brazil are supposed to have a CNPJ (Cadastro Nacional de Pessoa Jurídica). The CNPJ is a registration number which confers legal personality (*pessoa jurídica*), as opposed to the CPF (Cadastro de Pessoa Física) which confers the status of *pessoa física*, or natural person (i.e., an individual citizen).

Another strategy is to classify terreiro members first and foremost as a vulnerable population that engages in risky practices, rather than members of a religious institution. When I asked STD/AIDS Program employees in São Paulo and São Luís why their department had chosen to implement public health interventions in terreiros, they often responded that the terreiro population (*população de terreiro*) is more "vulnerable" to HIV infection than is the average citizen. When I pressed them on why terreiro members were more vulnerable, most employees cited the practice of ritual cutting, which they had heard often involved shared razors.

Janaína, however, replied that terreiro members are more vulnerable to contracting HIV due to the discrimination they suffer. She stated that the persecution they experience, or anticipate experiencing, prevents them from accessing health care. She added that community health workers, who often speak to the families they visit about condom use, tend to avoid visiting households that also function as terreiros. Therefore, she felt that faith-based discrimination was keeping terreiro members from receiving adequate information about how to prevent HIV. Several other SUS administrators whom I interviewed echoed her comments. The second way, then, that SUS justifies its financial relationship with terreiros is through "vulnerabilization," or classifying terreiro members as a higher-risk group for HIV due to their risky practices and/or to their social marginalization. Either way, the focus is on members' social suffering, rather than on their status as members of a religious institution.

The third way in which SUS de-sacralizes Afro-Brazilian religions is by conflating race with religious affiliation. SUS officials and health professionals do this by accepting and re-affirming the identity claims originated by terreiro health activists. In particular, they reaffirm the terreiro as a strategic place to deploy HIV prevention campaigns for blacks. Célia, the coordinator of São Luís' STD/AIDS Program, explained that Program staff had first reached out to local terreiros in 2005 because they believed they could access the black population through such a partnership. Their decision coincided with the National STD/AIDS Program's campaign to reduce rates of HIV infection in blacks (see Fry 2005). Presumably, Célia and her colleagues could have accomplished their goal more directly by collaborating with one of several prominent black movement organizations in São Luís. Instead, however, they opted to approach the local branch of the National Network for Afro-Brazilian Religions and Health.

Célia's explanation of the logic behind the Program-Network partnership conflates the health agenda of terreiro members with the black health agenda. In so doing, it equates Afro-Brazilian religion with blackness, and terreiro members with the black population. This conflating discourse was present throughout the universe of terreiro health activism that I came to know in Brazil. Although I understood the discourse as a form of identity politics, it stood in sharp dissonance to the variety of phenotypes I saw whenever I attended religious ceremonies at terreiros in São Luís and São Paulo. Although the proportion of phenotypically white members was higher in the São Paulo terreiros I visited, the ones I attended in São Luís had a large share of whites as well.

In São Paulo, likewise, terreiro health activists and their SUS collaborators used the phrases "saúde da população de terreiro" (terreiro members' health) and "saúde da população negra" (the black population's health) interchangeably. During Network meetings and workshops in São Luís and São Paulo, I rarely, if ever, heard anyone acknowledge that the terreiro community was not all black. Questions over the racial makeup of terreiro members, however, did emerge during Network meetings where only terreiro health activists were present. Within the context of the terreiro, this already complex discussion became further nuanced through the introduction of a spiritual component of ethnicity. As I discuss in Chapter 7, phenotype is not the ultimate arbiter of black identity in the terreiro.

Conclusion

In this chapter, I have examined changes in the state's governance of Afro-Brazilian religions over time. I have shown that, although the state has adopted a public discourse of celebrating Afro-Brazilian religions for their cultural cache, the relationship between these religions and the state tends to break down over issues such as healing practices. The climate of political openness to, and state support for, Afro-Brazilian culture reached an all-time high with the regime of Luís Inácio "Lula" da Silva (2003-2010). It is under his regime that the state was most responsive to efforts on the part of Afro-Brazilian religious practitioners to mobilize politically, as seen in the case of the National Network for Afro-Brazilian Religions and Health. At the same time, however, the relationship between these religions and the state is still laden with the tension that prompts such mobilization in the first place. Drawing on historical memory, and availing themselves of the current sociopolitical conjuncture, activists are attempting to rehabilitate the denigrated figure of the Afro-Brazilian "feiticeiro" while at the same time employing its power to negotiate with dominant society, as their ancestors did in the past. The historical "fusion" of race and culture noted by Sweet (2003) has thus furnished the conditions of possibility for contemporary re-imaginings of Afro-Brazilian ethnicity in the Brazilian political arena.

Chapter 7: Afro-Brazilian Religions and Ethnic Identity Politics in the Brazilian Public Health Arena

> The debate about health care within Afro-Brazilian religions raises ethnic/racial issues because it involves spiritual factors that are molded by African ancestrality. This is an ethnic/racial issue...[The Afro-Brazilian priest] does not use academic or scientific knowledge to promote health. He uses ancestral knowledge. He uses the instruments he has gained through his relationship to the sacred. This is an ethnic/racial issue. [Afro-Brazilian religions'] health care model, practices, and instruments are all associated with a worldview that is neither Afro-Brazilian nor Japanese—it's *African*. (Pai Cesar, São Paulo Municipal Health Department, May 2009)

Pai Cesar, whom I introduced previously, is a priest of Candomblé in São Paulo who identifies as *negro*. When he is not presiding over his *terreiro* (temple) or working at the city's STD/AIDS Program, Pai Cesar lobbies the state to secure better health care for black Brazilians and members of Afro-Brazilian religions. With a liberal dose of what Brazilians call "jogo de cintura" (something like *savoir-faire*), he manages to juggle the realms of Afro-Brazilian religion, public health policymaking, and health activism simultaneously.

Pai Cesar's comments in the above quote exemplify how he and other terreiro health activists construct a health-related identity through claims to their own racial and ethnic difference—and in particular, to their African-based health beliefs and practices. In so doing, terreiro health activists challenge the image of the Brazilian universal health care system as color-blind and equally accessible for all citizens. They simultaneously criticize the system for treating all patients the same, arguing that this actually deepens existing inequalities. In essence, they question the value of equal treatment upon which the health care system is based, while maintaining that equal *access* to quality health care (tailored to patients' particular needs) is an inalienable citizen's right. Like black health activists, terreiro health activists speak of individual patients' particular needs, but in practice they apply the concept of "niche standardization" (Epstein 2007: passim). Niche standardization is a way of segmenting the population and recommending strategies or solutions that apply neither to the whole population nor to the individual, but rather to a particular subset of the population. As Epstein shows, within racialized medicine, all members of a chosen subset (e.g., the black population) are assumed to have identical health issues and needs. Niche standardization simplifies the selection of target populations for policy and research, but it also homogenizes the internal diversity of these populations. Therefore, niche standardization ultimately fails in its attempt to deliver health care that is responsive to patients' individual needs. Instead, it ends up replicating the shortcomings of universalized medicine at a level intermediate to the universal and individual levels.

Like the black health activists described in Part II, terreiro health activists represent an elite leadership rather than the rank-and-file membership of terreiros. Prominent terreiro health activists, like Pai Cesar, also belong to the black health epistemic community. That is, they have achieved the status of experts on the provision of culturally competent health care for the *povo-de-santo* (members of Afro-Brazilian religions; literally, "people of the saint"). Within the black health agenda, terreiro members' status as experts of traditional medicine is rarely questioned. Whereas black health activists must cite epidemiological statistics and scientific evidence to bolster their claims of unequal treatment, terreiro health activists need only reference the centuries-old preservation of their traditional healing knowledge (although, as I show in this chapter, terreiro health activists often seek scientific legitimacy as well). Terreiro health activists' demands for culturally competent health measures are seldom singled out for criticism by those who oppose special health programs for black Brazilians. One exception is the critique leveled by Maio & Monteiro (2005), who object to the black health agenda's emphasis on terreiro-based health practices because, they argue, it narrowly recasts Brazilian popular medicine as African cultural patrimony:

> The long tradition of cultural interaction developed during centuries between the Portuguese, the Africans, and indigenous peoples which generated a rich and diverse body of medical knowledge in Brazil—termed 'popular medicine'—ends up reduced to the legacy of the black population. Popular knowledge is thus essentialized in order to affirm an 'authentic' black culture. (429)

Here, the authors argue that members of the black health epistemic community essentialize Brazilian cultural elements by associating them with Africanness in an exclusionary manner. Their argument highlights the fact that the identification of Afro-Brazilian ethnic symbols is contested terrain, rather than a natural or self-evident process.

In the pages that follow, I explore how terreiro health activists deploy racial and ethnic identity politics within the Brazilian public health arena to gain recognition and respect for their beliefs and practices, as well as public health goods for their communities. Through discursive acts of identity construction, these activists negotiate between their desire to be recognized as a special-needs group, on the one hand, and their reluctance to abandon the universal identity of Brazilian citizen, on the other. I show that the resulting tension between particularism and universalism ultimately leads to a breakdown in the group's collective identity.

The following analysis of the group dynamics of terreiro health activists is useful for understanding the dynamics of universalism versus particularism that pervade the black health agenda more generally. In examining the conflicts that arise through the process of negotiating racial and religious identities in relation to health, this chapter highlights the ideological work that goes into constructing Afro-Brazilian religion as an essential aspect of black identity (and vice-versa) in Brazil. Although the black health agenda naturalizes the association between Afro-Brazilian religion and blackness, this link does not exist *a priori*; it must be forged discursively.

Terreiro Health Activists' Identity Politics

Terreiro activists draw on images and language rich in symbology from Afro-Brazilian religion in order to construct a collective public identity, which then becomes a point of departure for making demands on the state. During events and meetings of the National Network for Afro-Brazilian Religions and Health, religious symbols are put to work in various ways. They are used to affirm the specific, collective identity of the group not only as members of Afro-Brazilian religions, but also as Brazilian citizens.

As I entered the room at the Network's national meeting in 2006, which took place at a hotel on the beach in João Pessoa in northeast Brazil, I was greeted by a number of large, full-color illustrations of orixás with their names printed at the top. Other posters featured photos of Network members in ritual dress. In the front of the room was a large statue of Obaluaiyê, the orixá of epidemic illnesses such as smallpox and, today, AIDS. In accordance with the orixá's ritual dress, the statue was adorned with cowry shells and covered from head to toe by a long, thick sheet of raffia. Clay pots and vases decorated the front of the room; some overflowed with popcorn, while others were decorated with fragrant green leaves that had been scattered all over the display. As I discussed in Chapter 5, popcorn is Obaluaiyê's ritual food. It represents the smallpox lesions covering his body, which are believed to be concealed by his raffia costume. During rituals that celebrate Obaluaiyê, the pai- or mãe-de-santo (priest or priestess) often throws popcorn over the heads of terreiro members and bystanders as a sort of good-health benediction. The green leaves and tall-necked vases completing the Network's makeshift altar represented the herbal medicines prepared by Ossain, the orixá who guards the secrets of healing plants in the forest.

This national meeting, like most other Network meetings I have attended over the years, commenced with the singing of hymns to the orixás. On that day, the opening ceremony took place on the shore since it was to be followed by a ritual offering to Iemanjá, the orixá of the sea. Men and women of various ages and ethnicities stood in a circle, dressed in African-inspired ritual garments. They took turns leading the sung prayers while the others in the circle either clapped softly with cupped hands or brushed one hand against another in a regular rhythm. After a few minutes of quiet singing, some Network members began to play *atabaque* drums. Immediately, the circle began to move, and the participants started to perform the prescribed ritual gestures and rhythmic dance steps for each of the orixás in sequence. Since this meeting was taking place in the state of Paraíba, there were several practitioners of *jurema* (a local Afro-Brazilian religion) dressed in black and red; most participants, however, wore white or other light colors. After about half an hour of dancing around the circle, several people received Iemanjá into their bodies. At this point, the crowd greeted the orixá's arrival joyously, took turns embracing her and kissing her hands while she bestowed her blessings upon them, and finally sent her presents off in a small white boat that had been anchored nearby for this purpose.

For passersby witnessing the spectacle in the street, there was no mistaking that this was a group of worshippers from Afro-Brazilian religions. A small, barefoot girl standing next to me kept asking me if anyone else was going to "virar" (i.e., receive a spiritual entity) and reported that her grandmother had fallen sick after a *juremeiro* (practitioner of jurema) had cast a "catimbó" (curse) on her. She then eyed my long skirt and asked if I was a *crente* (evangelical Christian) before snickering that the man in the black turban leading the hymn was almost certainly a *veado* (homosexual).[89]

Although many Network meetings are held in non-terreiro spaces, including hotels, universities, and black movement headquarters, activists prepare these spaces by adorning them with religious symbols that mark them as "Afro-religious." They also wear ritual clothing, and begin and end each daily session with orixá hymns. In their public meeting narratives, Network activists also use language strategically to construct a collective, health-related identity that is distinct from the wider society.

During a Network task force meeting on the HIV/AIDS epidemic in the northern Brazilian city of Belém, for instance, a local pai-de-santo spoke about the special kind of health care practiced in terreiros. Before his talk, however, he pronounced several phrases in Yoruba, which prompted the audience to respond reverently with the word "axé" while clapping slowly several times with cupped hands. Afterward, the pai-de-santo referred to terreiros as "urban quilombos" and praised the "preventive and curative popular medicine" practiced in terreiros. He then positioned the terreiro's medicine in contrast to "official, allopathic medicine" and extolled *rezadeiras, curadores,* and *raizeiros* as

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[89] Ironically, her comments echoed those of many Brazilian adults when I discussed my research with them; even when they did not belong to Afro-Brazilian religions, they tended to believe in members' ability to "curse" others. Many non-members also criticized the high number of homosexual men in the terreiros.

"health agents for black people."[90] Finally, he characterized Candomblé as "tolerant" and "humanist," observing that it involves caring for people without regard to color, gender, or sexual orientation. He contrasted these characteristics with SUS's alleged discrimination against black people and members of Afro-Brazilian religions. He ended his speech with a Yoruba myth about twin brothers (*ibeji*) who outsmart Death with a magic drum.

In this example, the pai-de-santo constructed an image of the terreiro as an alternative ethnic and religious space where an often superior form of health care is delivered to the community. He not only prefaced his speech with phrases in a language that only "insiders" could understand, but also likened the terreiro to the quilombo, or Brazilian maroon community. Historic quilombo sites (*comunidades remanescentes de quilombos*) are often invoked by policymakers and black movement activists as areas where an "authentic" Afro-Brazilian culture has been preserved.[91] They claim that quilombos have managed to retain Afro-Brazilian culture due to their rural, isolated locations and to their status as alternative societies. In fact, terreiros and quilombos are the two "traditional communities" most often cited by black movement activists and policymakers as repositories of Afro-Brazilian culture. In his comments, the pai-de-santo from Belém drew strategically on this association between quilombos, terreiros, and authentic Afro-Brazilian culture. He then described specific healing services, including

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

[91] See French (2006) for an insightful analysis of identity discourses related to quilombos.

herbal baths and medicines provided by ritual specialists in the terreiro. Finally, he selected a story that portrays traditional figures from the Yoruba culture (the elected cultural and religious affiliation of most activists at the meeting) “beating the system,” so to speak. These linguistic devices served to reaffirm Network activists (and, by extension, all terreiro members) as members of a particular culture with its own health-related values and practices that differ from, and are in some ways opposed to, those of general Brazilian society.

Network publications also contain many examples of claims to the terreiro population’s unique medical model and culturally influenced health needs. In general, these publications are concerned primarily with portraying Afro-Brazilian religion as a health-promoting institution. This is a self-conscious attempt to reverse the historically stigmatized image of terreiros as unhygienic places. For instance, an article titled “Afro-Brazilian religions as a protective factor for mental health” argues that a terreiro’s “sacred family” (*família-de-santo*) counteracts psychosocial consequences of the breakdown of the family following rural-to-urban migration (Ató-Ire 2003). The article also refers to trance behavior, adepts’ identification with the divinities, and ritual practice as modalities that promote stress alleviation and overall mental health. Various Network publications also praise Afro-Brazilian religious expertise in phytotherapy (herbal medicine) and psychosocial adjustment.

As a corollary to emphasizing the health benefits of participation in Afro-Brazilian religions, Network publications also strive to demarcate practitioners of Afro-Brazilian religion as a medically specific population in its own right, and attribute the religion's persistence to its followers' health expertise, as demonstrated in an excerpt from *Tambores de Axé* (Axé Drums):

> Devotees of the Afro-Brazilian tradition have a peculiar way of understanding and caring for health….The principle and practice of caring for those who seek out the terreiro…is what makes this religion resistant and active through the present day, representing one of the great manifestations of the culture and belief system of the Afro-descendant population" (National Network 2004:4).

Here, the authors invoke an aura of absolute difference. They not only praise Afro-Brazilian religions' medical model, but also attribute the terreiros' practice of popular medicine to the religions' historical survival. In statements such as these, traditional health care becomes a primary metaphor for political and social survival.

While they emphasize the authenticity of traditional terreiro medicine, Network publications also reveal activists' preoccupation with establishing the scientific legitimacy of ritual healing practices. For example, as an article in *Ató-Ire Bulletin* proclaims, "After long years of the predominance of allopathic medicine and synthetic remedies of the laboratory, the world turns its attention to natural medicines" (Ató-Ire 2003: 4). The article is written by a Tambor-de-Mina priest in São Luís who states that, for *maranhenses* (inhabitants of Maranhão state), illnesses "always" have supernatural causes. His contribution is a striking example of how Network activists negotiate between discourses of "universal" scientific legitimacy and affirmations of local and regional models of illness causation and treatment.

A similar example comes from an article titled "Caminhos da Cura" (Paths of Healing) (Ató-Ire 2002). Its author states that the "relations between religion and health, which society viewed with disdain until recently, are beginning to be recognized scientifically today" (6). He adds that laboratory research has proven the efficacy of herbal medicines used in the terreiros for both organic and emotional illnesses. In a similar vein, an article written by a psychologist in *Ató-Ire Bulletin* (*Boletim Ató-Ire*) asserts that the medicine practiced in terreiros is holistic and in line with the World Health Organization's stipulation that health is "a state of complete well-being in physical, mental, and social terms, and not just the absence of illness" because terreiros offer "cuidados" (preventive care) as opposed to just "tratamentos" (treatments for existing illnesses) (Ató-Ire 2003: 6). These articles incorporate markers of scientific discourse, such as allusions to laboratories and medical procedures, in a way that lends an aura of legitimacy to Afro-Brazilian ritual healing and herbal medicine. Rather than simply stressing the ancestral wisdom and traditions present in these healing practices, these articles reveal a strategic engagement with biomedicine as a means of claiming external legitimacy vis-à-vis the paradigm of global public health.

At the same time, Network publications often present Afro-Brazilian religion as a key essence of black identity in Brazil. In the May 2002 issue of *Ató-Ire Bulletin*, for example, physician and activist Fátima Oliveira characterizes terreiros as ideal spaces for black health education and promotion because they are "trusted by the black population" (Ató-Ire 2002: 5). In Oliveira's portrayal of Afro-Brazilian religious temples as normative cultural spaces for "the black population," she invokes the cultural competence principle of patient-provider resemblance; in other words, she assumes that black Brazilians will feel most comfortable receiving healthcare advice from a terreiro because its traditional practitioners and Afro-Brazilian cultural setting is most familiar to them. However, Oliveira glosses over the significant proportion of black Brazilians who do not frequent Candomblé terreiros, and in particular, those who belong to evangelical Christian denominations that vociferously condemn Afro-Brazilian religion—thereby engendering a strong *mis*trust of terreiros.

In their analyses of various postcolonial and religious contexts, scholars have identified ritual healing as a way of engaging modernity (e.g., Holston 1999) and confronting the sequelae of colonial and post-colonial domination (e.g., Taussig 1985, Comaroff 1985). Csordas (1999) argues that ritual healing constitutes a complex form of identity politics, and should be treated as more than just an "opiate of the masses" or a kind of symbolic "subaltern resistance" in anthropological evaluations. I agree with this assessment and have tried to follow suit with my analysis of the politics of ritual healing discourses in Afro-Brazilian religions.

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The Brazilian state's new biopolitical project has repercussions that go far beyond the realm of policy. In this section, I connect the re-racialization that is currently taking place within some sectors of Afro-Brazilian religion to Brazil's burgeoning black health movement. By "re-racialization," I mean a revival of normative discourses about the kinds of bodies considered most authentic within Afro-Brazilian religious spaces and practice. As more and more members of Afro-Brazilian religions join the black health movement, its re-biologized discourses of race circulate into the *terreiro* (temple) and reinforce a racialized politics of religious authenticity.

Although enslaved Africans brought Afro-Brazilian religions to Brazil, increasing numbers of European Brazilians began to participate in them in the decades following abolition. This occurred above all in south and southeast Brazil, where there is a high concentration of Italian, German, and Portuguese descendants. Reginaldo Prandi (1991) has observed that the influx of European descendants into Candomblé in São Paulo over the last several decades complicates the identification of terreiros as ethnically "African" spaces.

During the 1980s, the incursion of whites and Catholic liturgical elements into Candomblé spurred a "re-Africanization" movement among many prominent terreiros, especially in Salvador. The movement began officially in 1983, during the II World Conference of the Orixá Tradition and Culture in Salvador, when a group of famous priestesses issued a manifesto against syncretism within Candomblé. In Jim Wafer's words, re-Africanization was "based on the idea of throwing off white domination" through an attempt to recover and reinstate ritual elements assumed to be purely African (1991:56). Although it was focused on syncretism, the re-Africanization movement had the general effect of valorizing "Africanness" to the detriment of "Europeanness."

Even during the height of the re-Africanization movement, however, white members were never prevented from participating, rising up through the hierarchical ranks of sacred leadership, or opening their own terreiros. To do so would represent a rupture with the religions' universalist spiritual orientation, which ostensibly is colorblind. Within the context of Afro-Brazilian religion, African ethnicity is available to members of all skin tones. As Cruz (2008) has noted, phenotypically white terreiro members often make the discursive leap between claiming spiritual "Africanness" and identifying as black. I also found this to be the case during two and a half years of fieldwork in Brazilian terreiros. As Mãe Cíntia explained to me, even I would be considered "negra" if I were to become an initiate of Afro-Brazilian religion:

> Because you would be joining a religion that comes from Africa...don't you believe in the spirit?...That's the big issue that people don't understand, that there's much more there than meets the eye. Your soul definitely passed through Africa. If we look historically—at your spiritual history—it must have. Otherwise, you would never choose a research project like this one.

Mãe Címtia's comments indicate the connection members make between participation in Afro-Brazilian religion and spiritual African-ness. Her last sentence also suggests the extent to which Afro-Brazilian religions are still marginalized in Brazil. The priestess assumed that no one would want to study them unless they had a direct spiritual connection to Africa.

Regardless of white members' access to an African spiritual identity, the re-Africanization movement contributed to many whites' feeling marginalized within the religion based on their skin color. Since terreiros began to participate in black health activism during the late 1990s and early 2000s, white members' sense of exclusion has increased. This is the case, I argue, because the black health movement imposes a biologized conception of race by linking blackness to a variety of health concerns and physical tendencies. Furthermore, as I have established, the black health movement naturalizes the symbolic connection between blackness and Afro-Brazilian religion. This is a symbolic and politically mediated choice, and does not reflect the reality that most black Brazilians are Catholics or Protestants.[92]

The framing of Afro-Brazilian religion as a synecdoche for black culture is consistent with the Brazilian black movement's exaltation of it as the most tenaciously "African" cultural artifact in Brazil. This choice, however, produces palpable tension due

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[92] Here, I refer to 2000 Brazilian Census data by race/color and religion, reproduced in Prandi (2005). By "black," I refer to those Census respondents who self-identified as *preto* (black).

to the drastically different race ideologies embedded within black movements versus Afro-Brazilian religions. In the black health movement, race is “skin deep.” In Afro-Brazilian religions, by contrast, African ethnic identity is based on the spirit inside. With the growing participation of members of Afro-Brazilian religions in the black health movement, however, boundaries between these ideologies become increasingly blurred, and tensions skyrocket.

During my fieldwork, I witnessed many examples of conflict between phenotypically white and black terreiro activists over issues of racial identity. Within the context of the black health agenda, white terreiro members’ claims of ethnic “African-ness,” as well as Afro-Brazilian religions’ ideal of spiritual colorblindness, are called into question more than ever. During a 2008 convention of the National Network for Afro-Brazilian Religions and Health in São Paulo, race/color tensions reached a flashpoint. It started when Mãe Renata, a newcomer to the Network, complained to the group that she had been feeling excluded. Mãe Dilma, a priestess with dark skin and African features, responded: “Don’t give up on the group. Your ancestors need you, despite the fact that you have white skin.” Her remark drew sharp criticism from Pai Edson, a European Brazilian priest who complained that Mãe Dilma was being racist. He added that the Network’s focus on black health issues was exclusionary. “Creed has no ethnicity,” he added. “I came here to see *axé* [spiritual life force] in action, not to look at people’s skin color!”

At that point, Mãe Verônica, a phenotypically black priestess, attempted to revive the discourse of spiritual universalism. She pointed out that “the same orixá that enters Pai Edson’s head enters mine.” She meant that she and Pai Edson receive the same spirit entities into their bodies during religious ceremonies. The issue was resolved temporarily when Mãe Dilma apologized for her remark about Mãe Renata's skin color. However, a similar episode occurred at another meeting a few months later and Pai Edson resigned from the Network in protest.

In spite of the symbolic work done to create a shared identity among activists from terreiros, there are moments, like the one recounted above, when this identity visibly splinters according to differences in racial and even intra-religious identities. At these moments, the group's unified platform of identity narratives and political demands is threatened by a lack of frame resonance.[93] As Burdick (1998a) observes in his study of the Brazilian black movement and popular Catholicism, "every ideological position is, at once, an articulation and a marginalization" (103). Thus, while some of the Network's identity frames resonate with all members, others fail to do so. When this happens, the group's collective identity "breaks down," so to speak, and conflict flourishes.

The conflict I recounted above arose from a lack of frame resonance among light-skinned Network members. In a process similar to what Snow et al. (1997) refer to as "frame bridging," the Network combines the "ideologically congruent but structurally unconnected frames" of *terreiro health* and *black health* and includes both causes on its banner (238). Due to the historical association between terreiros and African descendants in Brazil, and to black movements' support for the preservation of terreiros, these two causes are bridged within the Network. The result is, in some cases, member attrition. To put it simply, many Network members of European descent, like Pai Edson, identify

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[93] See Goffman (1974) on the concept of framing experience, Gamson (1997) and Snow et al. (1997) on frame alignment and resonance. For excellent discussions on frame resonance between the Brazilian black movement and different religious groups, see Selka (2005), Burdick (1998a, 1998b), and Clarke (1993).

strongly with the Network's frame "we are terreiro members" but not with the frame, "we are black." Even though Pai Edson identifies as *negro* due to his involvement in Candomblé, in his daily life outside the terreiro—and within the domain of an increasingly racialized health care system—he is considered white.

Up to this point, I have presented white members' perceived exclusion from a racialized politics of authenticity within Afro-Brazilian religions. There is, of course, a range of perspectives regarding this issue. During my fieldwork in terreiros in southeast Brazil, many dark-skinned terreiro members described subtle, everyday patterns of racial discrimination against blacks within the terreiro. Pai Cesar, for instance, a black health activist and Candomblé priest, recalled his own pai-de-santo's preferential treatment of white filhos-de-santo. According to him, it is still quite common in terreiros to see darker-skinned members washing dishes, cooking, and slaughtering animals for ritual sacrifice, while many white members come to the terreiro only on the day of the *xirê*, or public ritual. (I also witnessed this pattern.) He also remarked that when pais- and mães-de-santo (priestesses) send filhos-de-santo to represent them at other terreiros' xirês, they often send white filhos.

The same members who complained of racial discrimination within the terreiro, however, also expressed the idea that blacks have more spiritual capital in Candomblé. Pai Wilson, the Network coordinator for the state of São Paulo, offended some white members when he stated at a meeting that he would never allow a white priest or priestess to initiate him because "blacks and whites have different ways of doing axé." No one missed his implication that blacks are more spiritually authentic when it comes to Afro-Brazilian religion.

Consider, also, Pai Cesar's comments during an interview: "I don't know whether Ogum is stronger in blacks versus whites. What I can say is that I can visualize someone's orixá much more easily if that person has black skin...So, I'm not racializing the divinity. For me, the divinity *is* black." In other words, Pai Cesar contemplated whether phenotypically black members of Afro-Brazilian religions are somehow closer to the spirit entities they incorporate. He concluded that black members look more authentic when they receive their orixás. In other words, they present less cognitive distortion for him than a white member might when dancing as Ogum, the orixá of steel, because Pai Cesar envisions the orixás as black.

It is useful to contrast Pai Cesar's comments with Pai Edson's remarks on the issue of racial politics within Candomblé. During an interview at his terreiro in Piracicaba, Pai Edson said, "I think that religion has no ethnicity, race, or color. God has no color...The moment I start to perceive differences, I am no longer any good as a religious leader." In essence, Pai Edson rejected the idea that spirit entities "look" a certain way, and implied that religious leaders should be colorblind. At the same time, he also implicitly rejected the differential distribution of spiritual capital according to phenotype.

Contrary to academic assertions that the universalist ethos of Afro-Brazilian religions minimizes members' recognition of racial differences among them (e.g., Segato 1995, 1998; Prandi 1991, 2005), my ethnographic data suggest that race is as alive within the sacred confines of the terreiro as it is in the profane world outside. In addition to everyday patterns of racial discrimination that accompany members into the terreiro, an inverse racial ideology accords greater spiritual capital to darker-skinned members. It is important to note, however, that race becomes an especially salient issue among the terreiro members involved in the black health movement. These members are exceptionally aware of racial dynamics within the terreiro because they spend their days discussing racism and healthcare.

The tendency of white Candomblé members to identify as black or African indicates that a racialized politics of authenticity is not new to the terreiro. White members have long desired the greater spiritual capital assigned to blackness within Afro-Brazilian religions. What is new, however, is the intensification of biological authenticity based on the growing medicalization of race in Brazil. Hypertension is not just hypertension anymore; for many Brazilian health care providers, it is now an "ethnic illness" that affects black patients in specific ways due to their genetic characteristics.

For terreiro members who participate in black health activism, the spiritual capital accorded to blacks thus gains a new layer of biological capital; black members can embody the black health cause in a way that white members cannot, regardless of their immersion in spiritual African-ness. Whereas in the past, white terreiro members could achieve considerable public recognition by virtue of their adopted ethnic identity, they are now pre-empted by phenotype from participating fully in the public sphere spawned by black health activism. Culture is expedient, as George Yúdice (2000) argues, but only to a point. After that, re-biologized race, genomic discourses, and the influence of global health governance conspire to transform authenticity into a commodity that is increasingly essentialized.

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In the case of the Network, racial identity was not the only factor that challenged the group's collective identity; religious differences also came into play. Since most Network activists belonged to the Ketu "nation" or ethnic group of Candomblé, those activists who practiced Umbanda or another form of Candomblé often complained of feeling excluded. For instance, a group of activists from the "Angola" nation of Candomblé argued with the rest of the group over the language to be used in the 2009 theme. Every year, the São Paulo Network chose a theme around which to focus their activities. For 2009, they selected "women's and family health." Initially, the group had decided to include the Yoruba word "axé" in the theme in order to emphasize its connection with Afro-Brazilian religions. This inflamed the "Angola" group, who wanted to use the Bantu word "gunzó" instead of "axé" (a synonym). The episode prompted an in-depth discussion of how the Network tended to privilege Ketu/Yoruba references when creating public health materials and planning public events. Mãe Renata, an Umbanda member, also complained that the Network did not actively recruit "kardecistas." She was referring to members of Umbanda, but "kardecista" usually designates someone who belongs to Kardecist Spiritism.[94] Her comment prompted Pai Cesar to remind the group, "The Network is a movement of Afro-Brazilian religions. Kardecism is not an Afro-Brazilian religion." In this case, Pai Cesar interpreted Mãe Renata's comment as a breach in the movement's collective identity frame and moved quickly to correct it.

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[94] A religion created by Allan Kardec in France during the late 19th century. Like Afro-Brazilian religions, Kardecism is a mediumship religion with a strong emphasis on healing.

The preference accorded to Ketu/Nagô cultures within the Network reflects a wider tendency among Afro-Brazilian religions all over Brazil. Commonly assumed to be the “purest” form of Candomblé, the Ketu/Nagô model has long enjoyed a high level of prestige both among terreiro members and among academic researchers of terreiros. Beatriz Góis Dantas (1988) links this prestige to the progressive transformation of terreiros over several decades from Umbanda to “Angola” to “Nagô” nations. Many of my informants told me they had followed this trajectory in their own religious lives.

In 2006-2008, there were no Network activists in São Luís from the Angola nation, but there the story took another interesting turn. Candomblé is rare in Maranhão, and the principal Afro-Brazilian religion there is Tambor-de-Mina. Nevertheless, over the last decade, a handful of Candomblé terreiros in the Ketu/Nagô model have appeared. All of these terreiros belong to filhos-de-santo of Casa Fanti-Ashanti, a Tambor-de-Mina terreiro whose pai-de-santo was himself initiated in Candomblé during the 1980s. Although Candomblé is still a minority religion on the Afro-*maranhense* religious scene, the most active members of the São Luís Network all practice Candomblé. This could be due to a lack of frame resonance among Mina members, since the activists from Rio who made the initial contact with São Luís also belonged to Candomblé. Although Mina terreiros were initially selected to participate in the Ató-Ire project (which led to the creation of the Network), by the time I conducted fieldwork in São Luís, those terreiros were no longer active in the Network. The pai-de-santo of one of the original Mina terreiros recalled that Ató-Ire had focused primarily on HIV transmission through initiation and healing rites involving the use of razors. He pointed out that this issue was not salient in São Luís because “[in Tambor-de-Mina] we don’t shave or cut [members]—terreiros that do this transmit the virus through the blood." He added that in São Luís, no one ever discusses this mode of transmission; according to him, it is more relevant in states where Candomblé is more common such as São Paulo, Rio de Janeiro, Pernambuco, and Bahia. As for the other Mina terreiros, I was told that their elderly mães-de-santo were uncomfortable with Ato-Ire's proposal to distribute condoms and hold safer sex lectures within the terreiro.

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Like black health activists, terreiro health activists' discourses often reveal a tension between universalism and particularism. In other words, they often alternate between identifying foremost as Brazilian citizens, on the one hand, and identifying primarily as a different, vulnerable group vis-à-vis SUS and Brazilian society more generally, on the other. This tendency emerged in the comments of Pai Cesar at a São Paulo Network meeting:

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

In his comments, Pai Cesar drew a distinction between general issues that concern all Brazilians who use SUS, and specific issues that concern black Brazilians and terreiro members in particular. He conflated the two populations, as do many Network activists and publications. He also placed emphasis on the unique "codes, values, and principles" that structure the ways in which terreiro members relate to health and illness. In so doing, he reaffirmed the existence of significant cultural difference between members of Afro-Brazilian religions and the Brazilian population at large. All of these linguistic devices served to mark the former as a culturally distinct population with culturally specific health beliefs and practices.

At the same time, Network activists often utilize religious symbols to reinforce general SUS and citizenship values, such as "social control" (*controle social*), discussed above. During the São Paulo statewide meeting last November, the Network's national coordinator (an ogan and SUS dentist from Rio de Janeiro) told the following story about the orixá Oxum:

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

In this example, the national coordinator used the religious story as a reference for terreiro members to model the behavior of active "citizen" Oxum.

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

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

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

In his commentary, Pai Edson rejected the tailoring of health care to patients' particular racial and religious groups. In so doing, he reaffirmed the principle of equality-in-rights that is upheld by the Brazilian Constitution. Similarly, Mãe Cintia told me during our interview that the 1988 Constitution made a significant difference in terreiro activists' ability to negotiate with the state:

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

Like Pai Edson, Mãe Cíntia cited Article V of the Brazilian Constitution, which states: "Everyone is equal before the law, without any manner of distinction."[95] In this excerpt, Mãe Cíntia emphasized her status as a Brazilian citizen with full equality of rights before the law. She articulated a changing relationship between citizens and the democratic state, a relationship in which citizens have the right to demand their rights. At the same time, she acknowledged citizens' obligation to know the law and to be aware of their state-granted rights, which she implied are not automatically protected by the state. Rather, in her view, citizens are responsible for holding the state to its promise of protecting citizens' full rights. Mãe Cíntia brought this up right after telling me about the discrimination she has faced when going to public clinics or hospitals dressed in her religious regalia (e.g., a head covering, "African" dress, and sacred beads). Many Network activists also told me, and expressed to each other during meetings, that citizens are responsible for ensuring that the state protects their rights. They saw this "watchdog" role as the primary function of their activism, although they perceived their rights to include not only equal treatment, but also the adjustment of health services to accommodate their special needs (equity).

Most of the time, terreiro health activists' discourses centered on a politics of difference. Occasionally, however, the discourse of citizenship equality reared its head.

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[95] Constituição da República Federativa do Brasil de 1988. Electronic document, available at: http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm.Last accessed April 4, 2011.

During my fieldwork, this usually occurred when a phenotypically white or middle-class activist, like Pai Edson and Mãe Cíntia, felt excluded from the group's collective black identity. At that point, the activist would reiterate the principle of citizenship equality, perhaps in an attempt to revive some semblance of a common purpose with his or her fellow activists.

It is important to note that many terreiro health activists saw no contradiction between upholding the universalist, egalitarian model of SUS *and* tailoring public health services to reflect different populations' characteristics and "vulnerabilities." Activists and SUS administrators who argued that substantive equality can only be achieved through group-differentiated health care appeared to discard the logical snafu that accompanies claims for "equal but different" treatment. They seemed to interpret equality not as uniformity of treatment, but rather as the equal right to be recognized as different (see Taylor 1995).

Pai Cesar's comments during an interview illustrate this point well. First, he stated that institutional racism prevents black Brazilians (*negros*) from receiving equal access to public health services. When I asked him to clarify, he explained that health services are often delivered in a substandard way to blacks versus whites. For instance, the doctor might spend less time with black patients, and consequently miss important diagnoses. His argument was similar to Sônia's, the black health activist from Chapter 4. Like Sônia, Pai Cesar's proposed solution was to institutionalize "equity," which he defined as "treating different people unequally...and giving more attention to those who need it more" (*tratar de forma desigual as diferentes pessoas…e dar maior atenção para quem precisa de maior atenção*). He compared this strategy to affirmative action quotas in the university, describing it as a temporary measure to "level the playing field" (*anivelar o campo*). This is the only way, he said, to achieve the goal of equal health for all Brazilians.

There is a debate in Brazil between maintaining the universalist-egalitarian model of SUS and creating health programs that take into account the particular characteristics of patient populations. This debate filters into the discourses of Network activists, although much of the internal debate within the Network concerns *which* specificities should take center stage (i.e., racial/ethnic versus religious), as opposed to whether specificities should be recognized within health policy to begin with. The latter question is largely taken for granted by activists. When faced with this question, they tend to voice the "equity" argument, as I discussed previously.

Conclusion

In this chapter, I have examined the ways in which terreiro health activists engage the debate on incorporating attention to racial and ethnic differences into the logic and practice of SUS. The debate rages on in Brazil regarding the best strategy for eradicating black Brazilians' disadvantages in the labor market, the university, and the public hospital. While social movements like the Network advocate for the creation of health policies for specific population groups, many non-activist Brazilians and the popular media denounce these strategies as racist and claim that universalist policies are the only effective way to address the consequences of racial inequality.[96]

In the midst of this controversy, Network activists continue to wage their politics of difference alongside appeals for egalitarian inclusion in public health services and

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[96] For example, see Veja (2006).

protection against religious intolerance and racism. The Network provides a fascinating context within which to observe terreiros members' negotiation of universalist and particularist claims because, as Segato (1995, 1998) has noted, Afro-Brazilian religions' universal, expansionist ethos often does not accommodate fixed, essential categories of gender and color, or even recognize the dichotomy between "us" and "other," but rather blends and incorporates. She argues that Afro-Brazilian religions' "cultural codex...resists racialization because it perceives itself as bigger than race and aspires to universality" (143). But what happens to this ethos when members leave the terreiro, so to speak, in order to participate in mundane public debate with SUS officials? This public sphere, located somewhere at the interstices of religion and politics, takes on debates and schisms from the wider society. Terreiro members cease to be "religiosos" above all and activate the political aspects of their identities. In this aspect, the Network provides an important counter-example to the image of terreiros as apolitical, or "close to magic, far from politics" (Prandi & Pierucci 1996). However, in keeping with Segato's characterization of the terreiro as "encompassing the other," Network activists engage SUS officials in political debate on their own terms, insisting that their particular worldview and health practices in the terreiro be taken seriously.

The problem of delimiting a population of policy beneficiaries arises constantly within the Brazilian black health agenda. There is constant tension surrounding the definition of this population and its chief health concerns. As a case in point, the terreiro health agenda exists sometimes as part of, and sometimes separate from, the black health agenda. The phrases "saúde da população negra" (the black population's health) and "saúde da população de terreiro" (the terreiro population's health) are often used interchangeably among terreiro health activists. However, there comes a point where they diverge from one another, since many terreiro members are not black in appearance. Although phenotypically white terreiro members may consider themselves spiritually and ethnically African, and even though they may have phenotypically black parents or relatives, within the realm of black health activism they are not considered black. Despite the geneticizing discourses embedded within the black health agenda, and the spiritually-based African ethnicity that is available within the terreiro, among themselves activists continue to invoke a racialized politics of authenticity that is decidedly skin-deep.

Chapter 8: Health in Black and White

Throughout this dissertation, I have examined the tension between universalism and the politics of difference that pervades Brazil's new biopolitical paradigm of formalizing citizens' racial and ethnic differences in order to promote health equity. I have attempted to convey the complexity of this process, especially given SUS's rootedness in a paradigm of radical equality—equal health care for all. Although black health activists and terreiro health activists mainly express a politics of difference, and an argument of equity, the principle of citizenship equality occasionally emerges and complicates their cause. Likewise, although many SUS administrators and providers are amenable to the equity argument, when it comes to implementing group-differentiated policies they tend to question their validity on scientific as well as legal bases. In Chapter 2, I discussed SUS providers' reluctance to collect patients' race data; in Chapter 6, I recounted how São Paulo's municipal HIV/AIDS department invoked the principle of the lay state to express their opposition to creating health education materials for members of Afro-Brazilian religions. In these ways, agents of the state quietly resist implementing key aspects of the black health agenda.

I have argued that the black health agenda, for the most part, constitutes a politics of recognition, rather than redistribution. Although the Ministry of Health has re-allocated some funds for activists' conferences and for scientific research on black-white health differences, these are, in my assessment, ultimately legless demonstrations of the state's ideological commitment to multiculturalism. That is, its benefits have mostly remained confined to an elite group of activists and researchers, rather than being distributed to black citizens outside these circles. At the heart of the story lies activists' desire for official recognition of blacks' racial and ethnic specificity, and their attempts to institutionalize a more inclusive definition of the black population, rather than their struggle for systemic social change. Accordingly, the state has obliged these activists' politics of difference but so far has done little to address the systemic roots of sickness and suffering experienced disproportionately by the millions of *pretos* and *pardos* in Brazil. As I mentioned in Parts I and II, epidemiological studies show that black Brazilians have a lower life expectancy than whites, and endure higher rates of myriad health problems including HIV/AIDS, hypertension, and infant and maternal mortality (Batista 2004, Barata et al. 2007). However, in the last decade the Brazilian state has substantially improved health care delivery in general to disadvantaged neighborhoods.

In her study of quilombo legislation in Brazil, French (2009) argues that law and social identities are mutually constitutive. Likewise, in this dissertation I have examined the processes by which Brazil's new health policy for black citizens has shaped, and been shaped by, activists' adoption and propagation of a black (*negro/a*) identity. Rather than a neutral term for "black," *negro* has come to signify, within the black health agenda, a special kind of patient with particular health risks. Concomitantly, the identity of terreiro member has come to signify a culturally distinct patient who practices traditional medicine and requires culturally sensitive health care.

In tracing the genealogy of how these once-foreign ideas rapidly became institutionalized within Brazil, I analyzed the black health agenda's ideological ties to transnational entities such as the Pan-American Health Organization and the UK Department for International Development. Through their early partnering with civil society organizations and the Ministry of Health, these international agencies helped to introduce language and policy models for discussing and addressing health disparities by race into Brazil. Based on these ties, I argued that the black health agenda displays elements of transnational governance (e.g., Ferguson & Gupta 2002). Through contact with transnational organizations and foundations, black health activists were able to import discourses concerning the "vulnerability" and special health needs of blacks and of traditional healers from Afro-Brazilian religions. Moreover, they were able to convince the state to implement policies recognizing these groups as distinct from the general population, and defining race according to a bipolarized, "black-white" schema. Once the idea of separate racial and ethnic groups with special needs entered the logic and practice of SUS, it joined an already-existing debate over universalism and the politics of difference within Brazilian public health care. This debate crystallizes around the following question: to what extent should SUS, which is based on equality of access and health services for citizens, accommodate the particular identities and claimed health needs of different citizen groups?

It is important to understand what the tension between the politics of equality and the politics of difference has produced in this case. What does it mean for Brazilian citizenship? Furthermore, what does the emergence of the black health agenda in Brazil indicate about biopolitical governance? First, the Brazilian state's ratification of the black health agenda demonstrates its increasing permeability and responsiveness to citizenship claims regarding racial and ethnic inequalities. I contend that the state's increasing willingness to entertain the demands of racial and ethnic minorities stems from its desire to promote a global image of Brazil as a tolerant, socially progressive, multicultural nation. My data also indicate that while special treatment for specific kinds of citizens may be “business as usual” for the Brazilian state, it is not necessarily so when it comes to race. Health care providers’ and patients’ resistance to new norms of racialized medicine substantiate this point. Brazilians’ tolerance for special treatment seems to break down over race-based differentiation in a way that does not occur when elderly SUS patients are automatically moved to the front of the line, or when women retire five years earlier than men with full social security benefits.

Thus far, Brazil’s new mode of biopolitical governance has produced increased essentialism in the public sphere and increased strife over the perceived divisiveness of affirmative action policies—the latter is particularly visible in SUS clinics and hospitals when patients resist racial classification. Amplified racial and ethnic essentialism emerges in state publications about the special vulnerabilities and health needs of black Brazilians and members of Afro-Brazilian religions. Racial essentialism also pervades the discourses of black health activists, and it underlies the recent surge in Brazilian biomedical research that presupposes the existence of genetic “racial” differences. The black health agenda has begun to alter Brazilian scientific research agendas by providing public incentives for studies that emphasize race as an independent variable and classify research subjects by “black” (*negro*) and “white” (*branco*). This shift in scientific policy is demonstrated by, for instance, the Ministry of Health’s increasing calls for sponsored research on issues pertaining to “saúde da população negra.”

Over time, this new mode of biopolitical governance will likely affect the way Brazilians understand and define race.[97] By propagating a bipolarized scheme of racial

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[97] See, for example, Evans’ (1997) account of the South African apartheid regime’s (and specifically, the Department of Native Affairs’) utilization of a series of administrative and bureaucratic practices that gradually normalized the idea of racial separation among the population. Evans shows how administrative

classification and endowing it with an aura of scientific authority, the black health agenda may encourage Brazilians to see racial differences in terms of black and white. To date, it has already produced subtle changes in the way many health care providers perceive their patients' identities and health care needs. This is particularly true for providers who have undergone cultural sensitivity training (*sensibilização*), but is not limited to them. For black health and terreiro health activists, Brazil's new biopolitical paradigm has produced increased prestige and public recognition, not to mention increased legitimacy in the public sphere, for the traditional healing knowledge of practitioners from Afro-Brazilian religions. The black health agenda has also generated a new area of technocratic expertise that, in turn, has provided employment for some black health activists—although posts are often temporary and reportedly under-funded. According to several of my informants, the black health agenda has resulted in co-optation of black health activism by incorporating activists into the government, and thus neutralizing their ability to express opposition to the state. These activists report joining the state both for pragmatic reasons (i.e., to make a living) and based on their conviction that they could bring about more change from the inside. All too often, however, they have found that being part of the state machinery limits their power due to the entanglements of bureaucracy and the vicissitudes of state budgetary planning.

For individuals engaged in black health activism, the black health agenda often provides the raw ideological material for constructing an essentialized black identity. Black health activists (and perhaps other Brazilian citizens who are not activists but identify as *negro*) develop new technologies of the self in relation to changes in

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technologies can convey ideas of governance that, through repetition, eventually become accepted as routine and self-evident.

governmentality. Whereas in the past these citizens might have located black identity primarily in phenotype or in Afro-Brazilian cultural expressions, they can now reference a biological layer of black identity that lies below the surface of the skin. By claiming recognition for specific health issues that affect the black population, especially sickle cell anemia, activists can invoke another source of specificity related to blackness in Brazil. As discussed in previous chapters, this has been a significant challenge for black movement activists in Brazil due to the primacy of *mestiçagem* ideology.

While it is undeniably important to remedy health disparities arising from structural racism, the reinforcement of essential racial differences may have unintended consequences. In this dissertation, I have examined these pitfalls and presented a number of arguments. First, I argued that the Brazilian black health agenda is strongest where it proposes to correct health disparities caused by structural racism, and weakest where it applies a genetic model to explain morbidity patterns among black Brazilians. Since many studies have demonstrated that the darker one's skin, the worse his or her life chances in Brazil (e.g., Lovell & Wood 1998), it is not unreasonable to target brown- and black-skinned people for a health policy that proposes to address the health effects of racism. When black health advocates introduce a genetic model to connect race and illness, however, I argue that they commit the correlation-causation fallacy. The net effect of employing a genetic model to explain higher rates of illnesses such as hypertension and diabetes among black Brazilians is to divert blame from social factors such as exclusion and to place it on a "black" genotype. Another potential consequence is to cast black Brazilians as inherently more vulnerable to these illnesses when higher prevalence rates may reflect environmental stressors related to racism.

The main problem I perceive with black health advocates' geneticizing discourses, however, is the way they use race categories, including the mapping of U.S. "black-white" racial distinctions onto the Brazilian population. Following Graves (2001), I suggest that the important question is not whether disease-related gene frequencies vary between clinal populations—they obviously do—but instead "whether genetic variation for disease incidence can map the socially defined categories of race" (186). Graves concludes, as I have, that it cannot; the two are incommensurable. A comparative framework destabilizes claims about biological "race" and health outcomes even further. How can "race" be a robust independent variable when systems of racial classification vary substantially from one context to another?

A related objection to the genetic approach is that black health activists' genetic discourses are incompatible with their reliance on self-declared phenotype to define who is black. Studies have shown a weak correlation between phenotype and ancestry in Brazil, prompting Brazilian geneticist Sérgio Pena to deem the correlation "practically non-existent" (2005:341). It thus becomes difficult for activists and policymakers to specify how much African ancestry one must possess in order to be considered "at risk" for target illnesses. I have argued that activists' calculation of the black population (over fifty percent of the total population) may not adequately capture genetic markers for illnesses such as sickle cell anemia. This point loses significance, however, when one realizes that activists are not trying to be scientifically accurate. As I stated in Chapter 4, activists are aware that there is no such thing as a "black" disease. Their classification of sickle cell anemia as a black health concern was a calculated political move. Although there are clear indicators that *pretos* and *pardos* have worse health outcomes in a number of areas, it is much more difficult to pinpoint the cause. Thus, at least in the beginning of the black health movement, activists found it more expedient to claim sickle cell as a black disease. Politically speaking, genes tend to be less problematic than allegations of diffuse structural racism—particularly in a nation that once prided itself for being a racial democracy.

I also argued that cultural competence strategies within the black health agenda strategically reinforce the idea of essential cultural difference between blacks and non-blacks by imputing ownership of Afro-Brazilian religion to citizens who are phenotypically black. Cultural competence materials and projects for the black population end up distilling black culture to one main ingredient—Afro-Brazilian religion. I suggested that the black health agenda's emphasis on defining the parameters of Afro-Brazilian culture indicates a rejection of cultural assimilationism and an attempt to carve out a distinct cultural identity for the black population within public policy. This effort reflects the ideological orientation of the Brazilian black movement, whose cultural platforms have often celebrated Afro-Brazilian religion as an emblem for black identity in Brazil (Burdick 1998, Pagano 2002). Within the black health agenda, Afro-Brazilian religion becomes the metonym for a holistic, authentic, and autonomous Afro-Brazilian culture, with its own medical knowledge that is complementary in some ways (e.g., phytotherapy, or plant medicine) and superior in others (e.g., its psychosocial component) to the dominant biomedical orientation of SUS.

I have therefore identified several problems of the black health agenda relating to bioreductionism or cultural reductionism. I view the black health agenda as an example of strategic essentialism that aims to ameliorate health disparities produced over time through social stratification along racial lines. The problem with strategic essentialism, however, is that it can backfire by reifying biological and cultural differences among social groups (see Conklin 1997). Black health activists attempt to harness and transform existing patterns of racialization and exclusion. In striving to define and delimit a black population whose needs and modes of suffering differ from the masses of impoverished Brazilians, they end up reinforcing the idea of essential racial difference.

I do not mean to suggest that the state should take no political action to combat health inequalities between people from different racialized groups. To the contrary, I believe that discrimination based on social race categories can dramatically affect health outcomes, and that state policies are necessary to address them. What I am problematizing here are the possible unintended consequences of Brazil's black health agenda, such as increased polarization between people identified as black (*negro/a*) versus white (*branco/a*). Although the black health agenda purports to apply only to those who self-identify as *negro/a*, I have shown that many health care providers neglect to give patients this choice. Consequently, patients identified as *negro/a* often have no freedom of association with, or exit from, the black health agenda.[98] Some aspects of the black health agenda, such as its focus on reducing unconscious racial discrimination in health care, are helping to reduce health disparities in Brazil. Others, as I have shown, tend to reduce the complex interaction in Brazil of racial identity, socioeconomic status, and biological processes to oversimplified accounts of health in black and white.

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[98] See Kymlicka (1995) on the importance of the freedoms of association/exit for maintaining fundamental individual rights within the context of group-differentiated policies. See Doppelt (1998) for an incisive critique of these aspects of Kymlicka's theory.

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