

Health and Diversity

Doctors without borders and other health professionals working in Non-Western countries, especially countries in Sub-Saharan Africa have understood the need and the importance of working closely together with anthropologists and other scholars experts in the society they are working in. This interdisciplinary approximation arises from the perception that, having a Western medicine background which is based on another culture and that has another view of the world, they felt very limited in their interventions with the interested societies. That is, they understood that their concepts of health, life, disease, cure, and death were inherited from a Western education and background and that they had nothing to do with the realities of the world and the societies they were dealing with professionally.

They have finally understood that in these diverse African societies, that have anthropocentric cultures, that is, where everything exists: objects, nature, and their contradictions, the Animal, Plant, and Mineral Kingdoms etc. gravitate around human beings and without them they could not exist. In this anthropocentric view, health, life and death are originated in human beings themselves and in their culture. On the other side, diseases, life, and death different from the Western view, are never considered as a natural phenomena, but rather humane and cultural, with their first and essential explanation found in human beings and their culture.

In this perspective of thinking that considers human beings and their culture as the central focus, the main causes of diseases and death are summarized into three factors:

- Out of jealousy or revenge, someone may hire a witch doctor, that is, someone who knows and masters the forces of nature and that can capture and channel them into negative energy, directed against the aimed people, thus making them ill or killing them;
- The sick or dead person may have broken the rules of the group, violated the taboos and offended the ancestors or the family spirits. In this case, the disease or

death is just a punishment for the transgression. The sick or dead person may have also tried to unfairly punish someone for being evil, sending them a spell that gets back to them, leading to the boomerang effect;

- The Gods, Spirits of the family, and ancestors may, when the livings do not worship them as they want, show their dissatisfaction by sending a disease that afflicts or kills one of the members of the group chosen by them. In this case, disease or death is a message or a warning so that actions are urgently taken to regulate the situation. In the case of death of elderly, it is said that the Single God or the Superior Being, that exists in all African societies, call them back when their life agreements expire.

Good health, prosperity, wealth, happiness, and numerous progeny are interpreted as an increase in the vital force, vital energy, or force of the nature. Diseases, death, tragedies, unhappiness, poverty, extreme poverty, etc. are understood as a decrease in the vital force or force of the nature.

In the above mentioned cases, natural origins of the diseases, as for example, insufficient food, accident, bite, several pathogenic agents, etc, are not completely ignored or denied, but they are reduced to conditioning causes. Assuming that a person has an intramuscular abscess; the abscess is a cause, but it is not believed that it would have been formed in a certain person without the intervention of an exterior force: a witch doctor, an ancestor, the victim themselves. If somebody burns themselves with hot water, or is run over by a vehicle, the immediate causes, and those sensible to death are understood. However, the accident would have not occurred without the intervention of a third force that manipulates the vital circular energy. A person with tuberculosis and their family may even admit, after medical examination in laboratories, that the Koch's bacillus caused the disease, but they will make the following observation: as this is the only person in the family or in the group affected by the disease, they must have been searched for and found by the evil sent by a third person. In other words, black-African societies are aware of the natural, material and physiological cau-

ses of the diseases. But their search for explanations starts exactly where the scientific explanation ends, placing the real causes of the diseases in the cultural and humane domain, and the scientific causes are considered only as the materialization and means chosen for the disease to present itself. The question is not “how did it happen?” as the scientist would ask, but rather “why did it happen to that person, and not to the others?” In cultures that are strongly socialized, the social terms are those which appear in the first level. Thus, envy, crime, and revenge should not be limitedly understood in the Western sense.

This is the reason why when we are dealing with: preventive measures and techniques, diagnoses, and therapy, the only way satisfactory and efficient solutions can be offered is when they articulate with the profane and magical-religious within a chain of meanings.

Traditional black-African societies have a dynamic conception of diseases and a holistic view of people, in whom the spirit and the body, the individual and the person, cannot be separated from the telluric environment. This is also the reason why there is no dissociation between the body and the unconscious mechanisms in the therapeutic processes.

A health system and medicine that ignore other forms of thinking, or that consider these forms not scientific or against the progress, reject the cultural bases of the people they are working with. Considering the traditional opposite to the modern is a dual and manicheist view that not always corresponds to the realities. Why is it against the progress for a person to go to church and pray to their God or to their Saints or if they go to Candomblé to make an offer to their Orisha before undergoing a surgery? It is impossible to think human beings without beliefs and religions, just as it is impossible to conceive medicine and therapies of several societies without a fetishistic and magical-religious background.

When we are talking about contemporary modern societies, health systems and scientific medicine do not speak to a single, modern, and universal world. Cultural diversities where religious, educational, and ethnical differences lie; together with differences in gender, age, and social class; somatic, and regional differences, and many others, making health systems and modern medicine face a plural and multifaceted universe that requires different attention and looks.

Intervention proposals, the projects, and health programs must be diverse and differentiated. Despite modernity is the same, it cannot, in practice, ignore these differences, the inequalities existent in modern societies. Likewise, a prevention campaign against AIDS in the African population cannot ignore the African conception of the disease, the same campaign in the Brazilian society, cannot ignore the social class, education, age group and the gender. It cannot fail to ignore the religion of the people it is aimed at. If the same campaign is organized in Western and more aware countries and also culturally different from Africa and Brazil, I believe that the speech elements and the key concepts would also be differently articulated. What is the use of a campaign of food education that suggests changes based on food that is part of the food taboos of a society? How can we talk about women and their social and reproductive rights in general terms without making a distinction between them regarding social class, level of education, not to mention the interference of their religion? In a society such as the Brazilian, where the racist imagination entails consciously and unconsciously all relations, including those between doctors and patients, we must not, when talking about women’s health and reproductive health, level upper class and middle class women with those poorer and of all skin colors; we must not fail to give especial care to indigenous and black women who are more fragile, and who are victims of two kinds of discrimination: racial and economic (race here is understood in the social and political sense as a construction and category of domination and exclusion). We also know that some types of diseases, due to social and even genetics issues, are more frequent and present higher incidence in black or indigenous population than in white population and vice versa. It is the case of Sickle cell anemia that is certainly a genetic disease that occurs more frequently and especially on the populations of the sub-Saharan Africa and their descendents of the Diaspora, even though it cannot be used as a genetic marker and can no longer be classified as racial disease, as it can be less frequently found in non-black population. Should we stop paying attention to this disease in the Afro-descendent population, who are the potential victims of this disease? If we do that would we be racializing Brazil as some Scholars state?

The journal *Saúde e Sociedade* (Health and Society) wants to call attention of Professionals in this issue and to make the population aware on the challenges of health system and of medicine in a plural environment such as the Brazilian one. Some population segments: the black, indigenous, and traditional communities such as Quilombolas, and others, indigenous and black women, economically more deprived social classes, and the population with less education must receive different treatment in terms of health policies, and a special attention by the professionals involved with the health of the population. If we are equal before the law, we must substantially and materially receive different treatments according to our specificities and particularities, according to our differences of gender, “race”, social class, age, culture and education. A democratic society

is a society where its diversities are equally represented in all sectors of national life, including in the system of public health. Certainly we are not living in South Africa before the 90’s, where the black and white population lived in a segregated health system during *apartheid*; or in the South of the United States before the 60’s where the segregation laws of the Jim Crow’s system put black and white people in health systems institutionally segregated. What is our true Brazilian reality? If segregation has not been institutionalized as in the referred countries, we may wonder if we have segregation in terms of health, as we have a Brazilian racism, which is hidden, unspoken and not assumed, but produces victims anyway?

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