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Original article

Popular religiosity from the perspective of Popular Health Education: a review of empirical research

No poem about people is genuine IF it lacks the fatigue as well as the hunger and thirst resulting from fatigue.
Simone Weil *The Mysticism of Labor*

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Abstract
This study analyses the studies on Popular Religiosity and Health conducted within the line of research entitled Education, Health and Citizenship, registered as a research group at National Council for Scientific and Technological Development (CNPq). The method adopted in this analysis makes use of elements of systematic review. Two studies were selected for the analysis due to their relevance for the field of Popular Religiosity, from the perspective of Popular Health Education. Both studies have concluded that, by means of religious affiliation, people cope with different aspects of life in violence-stricken unprivileged neighborhoods; they become more resistant to adversity and social inequality and, thus, feel that life is more meaningful and joyful.

Keywords
popular religion; popular education; popular health education; social support; diffuse suffering

This article analyzes studies on Popular Religion and Health conducted within the line of research "Education, Health and Citizenship", one of the lines within the field of Popular Health Education (PHE), organized by researchers and health professionals from several Brazilian universities and health centers. This paper aims to identify the paths and discoveries of a trajectory which started almost 20 years ago.

Apart from some sociological and anthropological studies, little research has been conducted so far about the relationship between Popular Religion and Health. In the field of health, Professor Victor Valla's initiatives have raised noticeable interest in attempting to understand emerging types of popular organization (FLEURI, 2009).

Taking the PHE perspective into consideration, the research group supervised by Professor Valla focused on Popular Religiosity and its relationship with health when conducting their surveys and studies. Their interest in the issue lays the fact that popular religiosity is a constituent of the core of popular culture and, hence, by reinterpreting Marx, carries the possibility to protest against injustice and oppression. Moreover, Victor Valla believed popular religiosity - from the mid to late 1990s – showed features of a historically-determined political phenomenon whose meanings could not be apprehended, at the time, by researchers (mainly those in the fields of education and health).

The newly-observed phenomenon was the rapid

growth of pentecostalism[1] and neo-pentecostalism[2] within the poorest *strata* of the working classes over the years: Catholics, Umbandists and Spiritists converted to different evangelical denominations which started to spread across the poor suburbs of big cities and attracted an increasingly high number of followers. Although such phenomenon could be understood as a response to the aggravated poverty and social violence caused by neoliberal adjustment policies put into effect during the government of former Brazilian presidents Fernando Collor and Fernando Henrique Cardoso, adopting this interpretation of the facts would mean remaining at the level of socio-economic determination, without having the religious dimension as a mediator. Thus, the question yet to be answered was why people in those suburbs identified with neo-pentecostalism.

One approach in order to try to understand and explain this phenomenon, in Valla's opinion, was to look into some of its aspects such as the massive nature of the religious manifestations led by evangelists and the manipulation of people's feelings as they experienced the sacred ("miracles").

By emphasizing the manipulation of followers by religious leaders as the only dimension of massive religious conversion, researchers gave leaders and religious institutions the main role as organizers of communities of believers, hence clarifying the appearance and development of a political trend, elected by the votes of "believers", which is presently consolidated from the perspective of Brazil's institutional and political culture.

The emphasis on the mercantile, financial and electoral aspects of the process has obscured the understanding of how it was experienced and interpreted by the lower classes themselves. In order to understand the process of massive religious conversion from a popular perspective, it is crucial to understand "the righteous path" the poorest ones have always moved along. How can chronic poverty be handled in a society where social identity means being able to buy and show off consumer goods? Drug addiction (alcohol dependence, drug abuse) and crime-related marginalization started to compensate for people's inability to "be just like" the others, causing the destruction of young people and their families. Faced with misery and lacking opportunities to change their status, people found in neo-pentecostalism much more than consolation or a shelter in mysticism. Religious conversion enabled them to transform feelings of impotence into feelings of spiritual superiority, of victory in a hostile world (VALLA, 1995).

Researchers – especially those in the fields of Education and Health - failed to capture these meanings as the knowledge of lower classes that they drew upon was based on the idea of society and politics as representation. Their relative inability to conduct scientific investigations from the perspective of the lower classes (CORRAGIO, 1989) was referred to as *comprehension crisis* by Valla as he reviewed the works of José de Souza Martins (VALLA, 1994). Overcoming such inability required adopting research methodologies that encompassed the way people from the lower classes processed their knowledge of the world and the ambiguity implied by all the oppression and fear they experience on a daily basis.

One of the major reasons for the pursuit of a new route in this line of research was the fact that researchers realized the increasing importance of Popular Religiosity while they collected data to produce the *Catálogo de Iniciativas Sociais* ("Catalog of Social Initiatives", 1999), a document depicting the increasing religious affiliation of *favela* dwellers in the investigated area: *Zona da Leopoldina*, in the north zone of the city of Rio de Janeiro. Such a realization was validated by studies, as well as initiatives, to provide advice and support to popular groups and movements, conducted from a PHE perspective. Also in 1999, the Centro de Pesquisas de Energia Elétrica ("Research Center for Electrical Energy" - CEPEL) helped setting up the Rede de Solidariedade da Leopoldina ("Leopoldina Social Support Network"). The participants in the Rede met health professionals and researchers at Fiocruz to discuss issues related to health and living conditions in Zona da Leopoldina (STOTZ *et al.*, 2009). Concurrently, researchers also observed that the health care professionals were astonished at the users' religiosity while promoting Health Education and performing clinical practice, whose resolutiveness should also entail patients' acceptance of the proposed treatment. These observations revealed the need to urgently conduct research so as to understand the meaning of this movement as regards people's health and way of living.

This effort is part of a choice by Victor Valla related to the PHE perspective, especially when made from a place situated between "the academy and the streets", summarized as a quest for

> *practices that expand and recreate interlocution fields which involve participation in loci non-polarized by rules, values and forms of academic prestige; the reconstruction of ways to see and hear the unknown; and the quest for ways to speak and write which do not restrict scientific production to a field of the initiated* (ALGEBAILE, 2009).

Concepts which are present in all the studies

In order to aid the comprehension of the aforementioned perspective which underlies studies on Popular Religiosity and Health, some relevant concepts are described below. In addition, a few concepts were coined within the Line of Research entitled "Research in Education, Health and Citizenship". These concepts are the basis of all the studies conducted by the researchers and are a type of heritage passed on to advisees and collaborators of the project. In order to avoid repetition and to facilitate the comprehension of this paper, the following concepts are highlighted: Popular (Health) Education; Popular Religiosity and Health; Co-construction of Knowledge; Diffuse suffering; and Social Support.

Popular (Health) Education

The PHE movement started in the early 1990s and was rearticulated at the end of this decade by displaying features of a social movement. PHE is organized by means of a virtual network of discussions but also holds specific face-to-face meetings at venues which are made available in different health events. This movement also produces reference material.

According to Marteleto *et al.* (2003), such diverse initiatives have formulated some common, similar principles and practices which characterize a new way of rendering public health services and a new relationship between health professionals and the population. This represents a breach with the authoritative and normative tradition of health education (MARTELETO *et al.*, 2003).

These principles and practices have shaped Popular Health Education and are considered by the very participants in PHE as

> *a unique 'social movement' comprised of researchers, professionals and technicians of the so-called health sector, as well as activists, technicians and leaders of social organizations and movements engaged in contributing to the emancipation efforts of the Brazilian working classes* (STOTZ, 2005).

The proposal of PHE is based on the configuration of popular participation practices which can contribute to making access to knowledge more readily available and bringing science closer to people's everyday lives. It should be noted that PHE has intrinsic, complex relations which contain diverse and often conflicting speech forms in a symbolic arena "which reveals the polyphony of voices by science, the State, the market, civil organizations, community groups, leaders of social movements" (MARTELETO *et al.*, 2003). This polyphony, revealed by means of dialogic processes, can contribute to making public health services more efficient in dealing with the complaints of the users.

Popular religiosity and health

The definition of Popular Religiosity seems to be as multifaceted as its expressions. Overall, it can be understood as a set of resignified beliefs and rites of official religions which are added to elements of the ancestral traditions in the local culture. In Brazil, popular religiosity is comprised of elements of indigenous and African cultures. This is a very particular way of relating to typical signs of the major religions in light of the needs and understanding of those whose insecurity and fear are a part of everyday life. Reinventing the relations with symbols, characters and God himself becomes crucial to bring closer together such religious elements and the need to foster faith itself, as a matter of survival of those *who go ahead but have no one to rely on*[3] and who can state that *if luck exists, I do not know it, for I have never had it*[4].

Religiosity can be possibly defined as the way whereby people most often express and process the integration between the rational, emotional, sensitive and intuitive dimensions. Another possible definition is the articulation of the conscious and the unconscious dimensions of people's subjectivity and their social imaginary.

Popular religions play several cultural roles:

> *They create a more cohesive identity among the lower classes; they help people cope with threats by offering them new energies to struggle for survival and strengthening cultural resistance that, in itself, reinforces the quest for religion as a solution* (VALLA, 2001b).

Alves (2005) claims that humans have the same kind of hunger for art as they do for religion, and both types complement each other in the way people analyze reality. Religious affiliation in the lower classes seems to be more and more important. This phenomenon was observed by means of the studies conducted by CEPEL and the assistance it offered to popular groups; as a result, a new field of research was created within the scope of Popular Health Education.

As mentioned previously, health professionals and educators have been increasingly interested in religious beliefs. However, no changes are expected in the short term because science and religion have always been placed in opposing sides. This conception or preconception is currently being challenged, and the way towards convergence is being paved, although theologians are more favorable to convergence than

scientists (PAIVA, 2005). It is consensual that the types of knowledge sought by both fields are often different; religion converges more to subjectivity, while science, to objectivity. However, one cannot ignore the fact that as complex beings, humans are comprised of both sides simultaneously.

Several issues have been currently raised within the health education system: the lack of a "holistic" view"; the fragmentation of teaching, approached in the discussions by Edgar Morin (2002); the re-liaison of different types of knowledge. Paulo Freire (1996) has also raised awareness of issues such as the need to recognize and assume the cultural identity of the learner, and showed that every educational practice involves the historical, political, cultural and social experience of human beings. These concepts were reinforced by Briceño-Leon (1996) in his seven theses on the importance of popular participation in health education campaigns. He emphasized that the individual should be known as a whole, that is, by considering his social context, his job or remunerated activity, dwelling place, habits, and beliefs - which have great influence over his life, often by determining it.

Co-construction of knowledge

Co-construction of knowledge is a methodology systematized at ENSP-Fiocruz which results from a participative investigation developed by the *Núcleo de Educação, Saúde e Cidadania* ("Education, Health and Citizenship Center") in the early 1990s. This methodology is seen as a conception which takes into account the daily experience of the social actors involved in health education practices and whose purpose is to offer individuals and popular groups more power for them to intervene in social relations that can influence the quality of their lives. This proposal implies a communicational, interactive, cooperative and intentionally pedagogical process among *people or groups with different experiences, interests, wishes, collective motivations* (CARVALHO *et al.,* 2001).

The principles of the co-construction of knowledge are based on Popular Education, and the reference for the conception of learning comes from constructivism, where the subject is conceived as constructor of knowledge as he observes and analyzes the experiences in a very specific way when trying to understand the world. The problematizing pedagogy is a matrix, from the methodological perspective, which criticizes educational practices centered around the transmission of knowledge (CARVALHO, 2007), which Paulo Freire has called "banking education" (FREIRE,1987).

Carvalho (2007) identifies the following principles of co-construction of knowledge in educational practices: dealing with issues considering the interest and view of the world held by the groups involved; fostering a relation with dialogue, listening, processes to build conceptions, values and attitudes, cooperation; enabling the dialectic methodological practice, the interaction among subjects, processes that build autonomy; using multiple languages as methodological tools; keeping an investigative attitude towards reality, articulating the process of action-reflection-action (CARVALHO, 2007).

Marteleto *et al.* (2003) point out that for knowledge to produce meaning and guide decisions and actions concerning the population's health, it is important to establish and organize processes of co-construction of knowledge (CARVALHO, 2007), which can yield "third knowledge" derived from different, temporary and renewable combinations between the scientific (or informational) knowledge and the popular (or practical) knowledge (MARTELETO, 2001).

Diffuse suffering

Given the current scenario where there are not enough opportunities to generate income and where social relations are fragile, more and more people are showing signs of illness (LIMA, 2006) expressed as unspecific somatic complaints, for example: headaches and sore muscles, insomnia, nervousness, gastric disorders and discomfort whose classification challenges medical or psychiatric diagnosis (FONSECA *et al*., 2008). In general, health professionals are not prepared to deal with such a demand and tend to identify those people as *overcomplaining or feigning patients* (SAVI *et al.,* 2009).

There can be a multitude of reasons for these complaints when one takes into account the social context of users of public health services (VALLA, 1999, 2001). Surveys show that, on average, 60% of the people who sought public health centers report these complaints, whose solution requires more time, resources and more comprehensive paradigms to understand the health-disease process and how they relate to people's living conditions (LIMA *et al.,* 2003, 2005). Although the lack of evidence of a specific disease can cause some health professionals to render the suffering of these patients as relative (LACERDA, 2002), some authors consider these issues as relevant for public health (VALLA, 1998). A large number of health professionals usually classify such patients as *overcomplaining, psychosomatic, functional, psychofunctional, hysterical, feigning.* Reflection upon unspecific somatic complaints is relevant for primary health care professionals because they can gain deeper understanding of users of the health system who require care, despite the lack of any disease described in diagnosis

manuals. A great challenge for health professionals and their work processes is to avoid previously established or biased categories to classify the users and to perceive the needs of users as regards care and shelter (FONSECA, 2008).

Social support

One of the premises considered here is the social support theory which relates the source of diseases and emotions, which would be the solution for health problems. The core proposal of the theory is that when someone can rely on a group of people for support, their health will improve.

The Social Support Theory became an important reference in studies on Popular Religiosity and Health in order to understand emerging forms of popular organization. Valla (1999b) associated the beginning of the debate on social support with the debate on public health in the United Sates in the 1980s and proposed interpreting the term in light of the Brazilian reality. Valla defines social support as any piece of information whether spoken or not and/or material aid offered by groups or people who know one another, which can result in positive emotional effects and/or behaviors (VALLA, 1999b).

This support usually happens among people who know one another and meet regularly. This is why it usually takes place when people go to an institution (LACERDA *et al.*, 2002). In the Brazilian context, this theory would encompass solutions found for the state of "continuous stress" the lower classes are subjected to, referred to by Valla *et al.* (1999) as *state of permanent emergency*.

According to the theory of social support, material, emotional and informational support offered to people on a regular basis can have a positive effect over their health (LACERDA *et al.,* 2003). An example is the assistance provided by religious institutions.

One possible explanation for the fact that people look for evangelical churches and attend them regularly is that the "theory of social support" relates the source of diseases and emotions, and signals that the solution to health problems is associated with the latter. The core proposal of the theory is that when someone can rely on a group of people for support, their health will improve.

Method

This study makes a review of the literature and uses explicit, previously defined methods to identify, select, and critically analyze studies that are relevant (ARAÚJO, 2008). Two particular studies were selected for our analysis because of their relevance in the field of Popular Religiosity from the perspective of Popular Health Education. They were conducted along the research line entitled "Education, Health and Citizenship". The first study is called "*Situação de Pobreza e Saúde: a busca de recursos pela população na periferia do município do Rio de Janeiro*" (Poverty and Health: people's quest for resources in the peripheral neighborhoods of the city of Rio de Janeiro)(1999/2002). The second study is named "*Religiosidade, Sociedade Civil e Saúde: um estudo sobre redes e apoio social no cuidado integral à saúde*" (Religiosity, Civil Society and Health: a study on networks and social support in health care) (2007).

Results and Discussion

This section shows the results of the two selected studies and discusses them. A table summarizing the studies is included at the end of the section.

Study 1 – "Poverty and Health: people's quest for resources in the peripheral neighborhoods of the city of Rio de Janeiro"

Lima *et al.* (2005) analyzed aspects of this research, which started at the end of 1999 with the collection of data used to create a catalogue of social initiatives in the *Leopoldina* area, which covers about 10% of the city of Rio de Janeiro. The study was completed in 2003. Known as one of the most violent areas in Rio, *Leopoldina* is comprised of four sets of favelas: *Maré, Manguinhos, Alemão, Penha,* and *Vigário Geral*. While the social initiatives were mapped, a large number of religious institutions were seen to develop some kind of assistance to the population. They often performed roles that the State, which had long been absent from low-income communities such as the favelas in the Leopodina area, was supposed to perform, however.

One of the major objectives of the study was to discover whether people going to religious institutions favored alternative forms of organization, over traditional forms - such as membership to residents' associations and affiliation with political parties – in their struggle for life. The study also aimed to understand why there had been such a big increase in people's participation in religious institutions in those communities and neighborhoods.

An initial hypothesis was that problems regarding people's access to the public health system and its resolutiveness caused a significant part of the lower classes to seek for religion to soothe their pain. Given the different types of predicaments, different coherent responses were observed: consumerism, active or passive violence, drug abuse and religious affiliations or disease. The increase in religious

affiliations was thought to be proportional to the increase in the predicaments identified in the routine of lower classes living in poor, dangerous neighborhoods. Examples of such predicaments include the search for medical assistance vs. the difficult resolutiveness of the treatments due to poverty; restrictions to basic rights, such as freedom to come and go; lack of access to the judiciary system and to quality public services; in summary, the predicaments can be associated with the idea of dignity.

The main objective of the study, according to Lima *et al.* (2003), was to raise discussion on the importance of religiosity for the life and health of people from lower classes across different segments of society, for example: health and education professionals dealing with these people, local religious leaders, organized groups, local leaders, middle-class left-wing leaders (who are normally skeptical and resistant to the issue).

On the other hand, it became gradually apparent that the study should help health professionals understand the therapeutic alternatives sought by users of the Unified Health System (SUS). By reflecting upon the prejudice of the middle class (where most professionals come from) as regards SUS users going to church, it was possible to raise awareness of the fact that people's initiatives may signal feasible and effective ways to implement public health policies without resorting to a great deal of financial resources.

While the study was conducted, there was little evidence to support the conception that the so-called miraculous healing (usually spectacular) was the major reason why people looked for and attended churches on a regular basis. Most churchgoers did not seem to have been awarded with miraculous healing. However, the fact that people continued going to church may signal that their attendance had some beneficial results to their health. The environments observed in Pentecostal and neo-Pentecostal churches are full of enthusiasm right from the entrance – smiling hosts who shake hands with people; songs whose rhythm and lyrics try to encourage people to trust God and trust themselves, as they were created in His own image.

Parker (1996) suggests that the modernization process of Latin America should be reinterpreted if we are to understand how popular religiosity is expressed by lower classes. The author points out that religion is a part of popular culture, hence people are born in a culture that is religious in itself and where religion is deeply connected with everyday life. Most people are catholic and believe there may be solutions within the religious perspective even when they do not go to church. This can explain why religious institutions are sought as an alternative by lower classes.

All those interviewed for the study acknowledge that people from lower classes search for religious institutions especially because of their hardship, exemplified by unemployment, diseases and broken family structure. Salvation and the possibility of life in heaven after death do not seem to be factors that attract believers. Cesar *et al.* (1999) argue that the religious experience takes place in the daily lives of people lacking a life project, as life holds nothing in store for them.

Bonfatti (2000) observed that at church the importance of the mere act of listening is commonplace. He points out that it is common knowledge in psychology that this procedure brings almost immediate results to the person who is listened to.

Machado (1996) developed his investigation around two hypotheses, basically. The first hypothesis is that "there are different consequences of religious affiliation to family relationships, depending on whether the converted person is a man or a woman". The second hypothesis is that women who affiliate with Pentecostalism tend to reproduce patriarchal standards. Male conversions tend to yield more symmetrical relationships between genders due to the more radical change to a lifestyle which tends to favor the interests of wife and children.

Corten (1996) claims that it is typical of Pentecostalism to prioritize emotion. According to Valla (2002), the great contradiction found by many middle-class observers is that although those people are often very poor and sick and live in violence-stricken environments, they experience a huge joy of living. Such joy could be observed in liberation cults in a neo-Pentecostal church by means of informal conversations, where people reported being healed from depression.

While the study was conducted, there was no confirmation for the hypothesis that people chose to attend church regardless of participation in community politics. Many religious leaders claimed to have started their militancy in community projects after converting to Pentecostal or neo-Pentecostal Chistianity. They envisaged new horizons for themselves and their communities after they quit drugs, alcoholic drinks and sexual adventures, and increased their self-esteem. Their self-confidence and the belief that they were chosen and "empowered" by God can be seen as propelling forces that take those men to a leading role as a person and member of their community.

Although one cannot ignore the fact that some pastors manipulate the donations offered by believers in order to foster their own richness, it should be noted that most churches in the investigated area are managed by simple people who care about the situation in their communities. Several of them do their best to help improve the living

conditions of the unprivileged who suffer because they are still illiterate, because young people lack job opportunities, because many people live in extreme hardship, among other predicaments.

Leaders of a traditional protestant denomination located in one of the most dangerous communities within the Leopoldina area claim that unemployment is the main source of diseases, even though they believe there are diseases of spiritual nature. They also see drug dealing as a consequence of people's living conditions. In their opinion, the role of the church is to fight for better living conditions for the population.

Although there are other collective *loci* where people can "relieve daily stress", evangelical churches – located in communities and neighborhoods like the Leopoldina zone – have been a privileged locus for the lower classes. Results seem to show that people from the lower socio-economic strata do not usually find an interlocution channel for their subjective needs in institutions where the official knowledge health prevails. This shows that even a more inclusive view of the world like the Pentecostal Christian one - with plenty of experiences of healing and replenishment of physical and emotional well-being, as well as a feeling of belonging which is often unprecedented - fails to fully satisfy the health demands of their followers. In spite of that, some authors denominate these religious institutions as public health apparatuses and classify religious cults as therapeutic agencies (RABELO, 1993).

The main purpose of the research was to foster reciprocal understanding among technicians (health and education professionals), researchers and the lower classes so that they could find alternatives to end with the poverty and unemployment that affect the latter. The studies aim to shed light on the logics found in the speech and the actions of the lower classes so as to bridge the gap between the actions performed by public health services and the popular initiatives to fight diseases, especially the chronicle ones (VASCONCELLOS, 1998).

Another conclusion is that the alternatives found by the population may offer feasible possibilities which do not require a great deal of funds to define public policies that can actually meet the needs and rights of the lower classes.

Study 2 – "Religiosity, Civil Society and Health: a study on networks and social support in health care"

Lacerda *et al.* (2008) analyzed the religious affiliation of community health agents (CHAs) who participate in the groups of Community Therapy because they showed greater resistance to the predicaments in their personal and professional life.

Community Therapy is a group technique which translates into a health care practice dealing with human suffering. The community therapist acts as a mediator who seeks to encourage and facilitate experience sharing, thus helping to build networks of social support.

Some researchers from the *Escola Nacional de Saúde Pública Sérgio Arouca* (National School of Public Health Sergio Arouca) created Community Therapy groups with CHAs so that they later could share their life experiences to maximize individual and collective resources which could help them find solutions to the problems they had reported.

These Community Therapy groups put the researchers in closer contact with CHAs, a lot of whom were revealed to followers of Pentecostal and Neo-Pentecostal churches. As a result, it becomes crucial to discuss the religious affiliation of the agents and the impact of that on their own work.

Qualitative empirical research was hence conducted within this perspective. Open interviews around particular themes proposed by the researcher were conducted to collect the ideas freely produced by the agents. Open interviews were chosen because according to Montenegro (1992) they offer the interviewee a wide range of stimuli that can foster involuntary processes of association and reminiscence. A dialogic relationship was established between interviewer and interviewee where the different types of knowledge were acknowledged (MARTINS, 1989).

Seven CHAs - six females and one male - who go to Pentecostal and neo-Pentecostal churches were interviewed. They all live in communities in Maré (in the Leopoldina area) and work in health centers there.

The objective of the interviews was to understand why they had affiliated with religion. The research confirmed that the agents affiliated with Pentecostal and neo-Pentecostal churches at difficult moments in their lives. The religious affiliation of the interviewed CHAs was driven by several circumstances. Some of them had been going to evangelical churches since their childhood because of family tradition. However, most of them started going to church after they experienced some kind of crisis, or suffering and anguish caused by a feeling of emptiness – as if they were in "very hot water". They had very difficult lives, with situations involving poor living conditions, sick family members, alcohol and drug dependence, family members involved in drug dealing and other illicit activities. In other words, they had *a stressful, fearful and very unfortunate life*.

One of the major conclusions is that social ties have become stronger. Some CHAs reported making friends and establishing relationships of trust with other members of

church. People established relationships of solitude as they shared common problems. Faith is a crucial value for these believers and is considered one of the intangible assets that are a part of social networks and provide guidelines for the search for health care. From the moment they affiliated with church, they started to realize and resignify, in a very particular way, the situations they experienced. By means of codes shared with other CHAs and a feeling of belonging, their work gained another meaning as well. It was possible to observe that their work was an intrinsic part of their lives and thus acquires a sacred, supernatural sphere.

For the interviewed CHAs, spiritual preparation by means of praying before they leave for work is a prerequisite for good work performance, because they are aware that they deal with different subjects and their suffering. CHAs felt stronger when they went to religious cults and prayed, and thus felt more prepared to deal with the diverse and complex nature of their job.

At first, some health technicians were worried about the fact that the CHAs were Pentecostal and neo-Pentecostal evangelicals because they thought the religious beliefs of the agents could cause problems - for example, the CHAs might refuse to visit homes which hosted Umbanda or Candomblé rituals. However, the interviewees participating in this study did not show any signs of prejudice in this sense.

The evangelical CHAs distinguish the corporal (material) disease from the spiritual disease, which affects the soul. They seemed to bear these conceptions in mind when they paid home visits. They understand that corporal diseases can also be caused by other types of problems: psychological or spiritual ones; they sometimes sought solutions they labeled as 'supernatural', such as praying to heal people, which are expressed in a popular conception of etiology.

Health professionals have long been "astonished" at the apparently eclectic therapeutic alternatives sought by users, who refer to biomedicine but also to treatments considered to be spiritual. For the lower classes, which look into the health-sickness process in an ecological, holistic manner, the supernatural domain as an etiological explanation implies visits to venues with religious cults, duties and healing practices. They can explain the process of illness with a multitude of factors; the supernatural is associated with explanations of a psychosocial nature, and although it refers to the 'metaphysical' sphere, its place is the body (MINAYO, 1998).

Because they have a comprehensive, holistic view of human beings, evangelical CHAs can interfere in the user's therapeutic choices. By means of dialogue and a tailor-made approach to each visit, they can sometimes affect the therapeutic process by encouraging the user to reflect

Chart – Overview of studies on Popular Religiosity

Research Period	geographical scope	Method	Some results	Conclusions
"Poverty and health: people's quest for resources in the peripheral neighborhoods of the city of Rio de Janeiro". 1999 - 2002	*Zona da Leopoldina (Alemão, Penha, Vila da Penha* and *Manguinhos*)	- Participant observation. - Semi-structured interviews.	- Notion of no political affiliation following religious affiliation: not confirmed. - They stopped drug abuse and alcohol dependence and increased their self-esteem after converting to . - Pentecostal or neo-Pentescostal Christianity. - Churches have been a privileged locus for the lower classes.	- Alternatives found by the population suggest public policies may meet the needs and rights of the lower classes.
Study: "Religiosity, Civil Society and Health: a study on networks and social support in health care." 2007	Complexo da Maré (Zona da Leopoldina)	- Open Interviews.	- Agents' affiliation to Pentecostal and neo-Pentecostal churches at difficult moments in their lives: confirmed. - Stronger social bonds; some CHAs reported making friends and establishing relationships of trust with other members of church. - Greater closeness with users; influence over their therapeutic choices. - Respect for other users' religions prayers complement the work of CHAs.	- Dimensions: emotions, affection, engagement of CHAs with users' problems has been more effective than the logical dimension of words. - While doing their job, the religious CHAs foster reflection upon users' moral, affective and psychological conflicts that can be the root of their health problems.

upon their illness and seek for the root causes of their health problems. In a way, this complements the doctor's assistance offered by the public health system, because it is not restricted to the physical dimension of the illness. Rather, it aims to provide holistic care to satisfy the needs of each visited individual. Thus, CHAs develop a therapeutic project together with the user to cater for the health needs of their clientele, in tune with the particular context of each visit and each subject (MATTOS, 2004).

Moreover, the religious view in general – and the Pentecostal and the neo-Pentecostal views in particular – have an optimistic approach to life and encourage believers to have control over their lives and search for solutions to their problems.

Religious affiliation was seen as a strategy employed by CHAs to cope with health problems and predicaments in life, since lower classes live in a permanent state of emergency (VALLA *et al.*, 2005). While sharing experiences with other Christians, CHAs feel strong and able to do their job.

There are some initiatives that incite direct dialogue between the technical-scientific and the religious fields in primary health care services, as, for example, the work of "rezadeiras" (praying women) in health centers in the state of Paraíba, northeastern Brazil (SILVA, 2004).

According to Brandão (2007), studying religion may be the best way to understand popular culture, as

> it *exists in a straightforward state of constant fight – either for survival or for autonomy – amongst profane and sacred wrestles between the erudite domain of the dominating and the popular domain of the dominated* (p. 19).

While reorienting health care, it was possible to realize that the dimension of emotion, affection and engagement of CHAs with users' problems has been more effective than the rational and logical dimension of words (VASCONCELOS, 2006). Through genuine sympathy, faith and the feeling of presence of God, the believer has a different perspective of his own life (CORTEN, 1996). When the religious CHAs take a holistic approach while providing health care, they look beyond the physical aspects of the illness by placing it in a new dimension where illness is seen as an ordeal inciting the user to reflect upon the moral, affective and psychological conflicts (MARIZ, 1994) that may be the root of the health problem in question.

Although studies on popular religiosity started in the field of Psychiatry, they are mainly found in Sociology and Anthropology. The health sector as a whole, and especially health education, have neglected the importance of studies on this topic, which is very meaningful for poorer populations living in big cities (DALGALARRONDO, 2007). Such populations have died more often of chronicle diseases than infectious and parasitic diseases which, not infrequently, "scare them to death".

Including diversity and heterogeneity is one of the greatest challenges faced by educational processes, as their universality has been questioned historically (STOTZ, 2005). FASHEH (2004) reinforces the need to rethink anything claimed to be universal; diversity constitutes the nature of life, where each person is a source of understanding that creates, observes, constructs owns a reality. Moreover, every experience has a value to be shared.

It is the "power" that religions exert over people that we should learn about, understand and respect. We should change our view, as Silas Guerreiro (2005) suggests, that many beliefs only exist because there is no explanation for many things happening in nature. Thus, it is important to consider science and religion as two different pillars of human knowledge, each encompassing a facet of human existence. When science makes itself available to investigate, discuss and respect religious phenomena, learning about the knowledge of "the other", who can be the user of the system, for example, can benefit both health students and health educators as they approach issues such as cloning, artificial insemination, test tube babies, surrogacy, research on human embryonic stem cells, evolution and theories on the origin of life.

Conclusion

Both studies have concluded that by means of religious affiliation, low-income individuals cope with different aspects of life which make them more resistant to adversity and social inequality and, thus, make life more meaningful and joyful.

The rationalizing potential offered by religious affiliation and popular religiosity as a whole seems to be one of the great forces producing resistance and hope, as observed at several moments during the conduction of this study by means of procedures such as one-on-one interviews, participant observation of religious cults, and forums of group discussions.

Such an affiliation is a crucial part of the efforts to heal illnesses and soothe pain. These attempts are an inherent part of human nature, but the poorer someone is, the harder their human condition. Pain seems harder to endure when one considers public health services in a country with one of the greatest economies in the world but also one of the greatest rates of social inequality. Desperation for healing seems to be

proportional not only to the size and seriousness of the illness but also to the level of misery one finds oneself in.

The results of both reviewed studies showed that, on the one hand, people attending Pentecostal and neo-Pentecostal churches, including CHAs, have not found miraculous healing. On the other hand, the studies revealed different types of reports on social support meetings, fewer complaints related to diffuse suffering and the appearance of "forces to go ahead".

Pentecostal and neo-Pentecostal churches are usually joyful environments where one can dance, sing, clap, smile and weep. For the socially 'unaffiliated", being called brothers and sisters by dozens of people who share the same social situations, often family and personal situations too, can be lenitive to their pain. Finally, they have a feeling of belonging.

The religious perspective is always present in people's daily life, which enables dialogue to take place with those who do not attend church. However contradictory, the respect "non-believers" show for those who commit illicit acts seems to make it less conflicting for them to live in the same community. For those who admittedly have an improper lifestyle, being approached by religious neighbors that show interest in their lives is a sign that they are not totally left on their own and perhaps have a chance to change.

In the analyzed studies, the speech of the religious participants seems to suggest solutions to daily problems, especially the ones involving health of their family members or their own. Although afterlife is associated with transcendental causes, it does not seem to be a concern. For the ones who attend church and use the Unified Health System (SUS), the longing for living healthily is what prevails.

SUS represents great advancement towards providing universal health care but it cannot either cater for the whole amount of miserable people or reach the resolutiveness levels satisfactorily. The choice for favelas in the Leopoldina area was made because they are representative of Brazil's reality.

It is important to establish truly dialogic practices in order to increase resolutiveness of the demands faced by health services. Acknowledging the culture of those in pain is a possible path that is up to health professionals to take. Thus, by understanding the living conditions of a population, and especially its religious context, health professionals can take a crucial step towards dealing with such complex challenges.

Notes

1. Pentecostal evangelical churches appeared in black neighborhoods in the United States in the early 20th century. In Brazil, the first Pentecostal churches appeared in 1910, when the *Congregação Cristã do Brasil* (Christian Congregation of Brazil) was created in São Paulo. Then the *Assembléia de Deus* (Assemblies of God) was created in 1911, in Belém, Pará. These churches differ from other protestant evangelical churches (known as historical or traditional) because they added manifestations known as "gifts of the Holy Spirit" to their cults - individual experiences strongly characterized by emotion – like those expressed by the disciples of Christ on the Day of Pentecost, as described in the Bible (LIMA et al., 2003). Such gifts include speaking in tongues (glossolalia), interpreting those tongues, evangelizing, healing, making prophecies, dispensing words of wisdom, distinguishing spirits (reading thoughts) and working miracles (CORTEN, 1996).

2. In its turn, neo-pentecostalism as a religious movement is considered to have appeared in a period of serious economic crisis in Brazil. It was pioneered by the *Igreja Universal do Reino de Deus* (Universal Church of the Kingdom of God), which was created in 1977. Other churches followed, for example: the *Igreja Internacional da Graça de Deus* (International Church of God's Grace) in 1980 and the Igreja Cristo Vive ("Christ Lives") in 1986. After that time, it became harder and harder to quantify the number of smaller churches that have been created, especially in lower-income neighborhoods and communities, (LIMA et al., 2003) spreading across the lowest strata of the population. Such churches make use of mass media and focus on individual prosperity, family values and exorcism (RAMALHO, 2000).

3. Translated from the Brazilian song "Gente Humilde" (Humble People), by Garoto, Chico Buarque and Vinicius de Moraes.

4. Translated from the Brazilian song "Romaria" (a type of religious procession), by Renato Teixeira.

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