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Primary Health Care and *Candomblé Terreiros*: approaches and distances in the provision of care

Atenção Primária à Saúde e Terreiros de Candomblé: aproximações e distanciamentos na produção do cuidado

Atención Primaria de Salud y *Terreiros de Candomblé*: aproximaciones y distancias en la prestación de cuidados

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ABSTRACT
Objective: to describe the convergence and divergence between Primary Health Care and *Candomblé Terreiros* in the provision of care.
Method: qualitative, descriptive study conducted in two health units in Camaçari, Bahia, with the

participation of priests from *Candomblé Terreiros*, health professionals, and family health team managers. Data were collected through semi-structured interviews between September and October 2024 and submitted to Thematic Analysis, with the support of NVivo®.
Results: the exclusion and delegitimization of the knowledge of the *terreiros* was observed, influenced by cultural and religious barriers, prejudice, and gaps in professional training. Spiritual practices in the *terreiros* demonstrate a comprehensive care approach that articulates physical, emotional, social, and spiritual dimensions. Although limited, there are institutional initiatives to build closer ties through actions at specific events. In the *terreiros*, the limits of spirituality in health are recognized.
Conclusion: The relationship between Primary Care and the *terreiros* is marked by advances and gaps. Partnership between these entities can overcome barriers and promote more comprehensive care. The current model of health care is still exclusionary and discriminatory.
Descriptors: Spirituality; Primary Health Care; Traditional African Medicines; Health Personnel; Comprehensive Health Care; Nursing.

RESUMO

Objetivo: descrever a aproximação e o distanciamento entre a Atenção Primária à Saúde e os Terreiros de Candomblé na produção do cuidado.
Método: estudo qualitativo, descritivo, realizado em duas unidades de saúde de Camaçari-BA, com a participação de sacerdotes de terreiros de candomblé, profissionais de saúde e gestores da equipe de saúde da família. Os dados foram coletados por meio de entrevistas semiestruturadas entre setembro e outubro de 2024 e submetidos à Análise Temática, com apoio do NVivo®.
Resultados: observou-se a exclusão e deslegitimação dos saberes dos terreiros, influenciadas por barreiras culturais, religiosas, preconceito e lacunas na formação profissional. As práticas espirituais nos terreiros evidenciam uma abordagem de cuidado integral, que articula dimensões física, emocional, social e espiritual. Apesar de limitadas, existem iniciativas institucionais de aproximação com ações em eventos pontuais. Nos terreiros, reconhece-se os limites da espiritualidade na saúde.
Conclusão: a relação entre a Atenção Primária e os terreiros é marcada por avanços e lacunas. A parceria entre essas instâncias pode superar barreiras e promover cuidados mais integrais. O modelo atual de atenção à saúde ainda é excludente e discriminatório.
Descritores: Espiritualidade; Atenção Primária à Saúde; Medicinas Tradicionais Africanas; Pessoal de Saúde; Integralidade em Saúde; Enfermagem.

RESUMEN

Objetivo: describir la proximidad y distancia entre la Atención Primaria de Salud y los *Terreiros de Candomblé* en la prestación de cuidados.
Método: estudio cualitativo integral, realizado en dos unidades de salud de Camaçari-BA, con participación de sacerdotes de templos de Candomblé, profesionales de salud y gestores del equipo de salud de la familia. Los datos fueron recolectados a través de entrevistas semiestructuradas entre septiembre y octubre de 2024, y analizados con el apoyo de NVivo® y Análisis Temático.
Resultados: este estudio cualitativo y descriptivo se realizó en dos unidades de salud de Camaçari, Bahía, con la participación de sacerdotes de templos de candomblé, profesionales de la salud y gestores de equipos de salud familiar. Los datos se recopilaron mediante entrevistas semiestructuradas entre septiembre y octubre de 2024 y se sometieron a análisis temático con el apoyo de NVivo®.

Conclusión: la relación entre los *terreiros* y la Atención Primaria está marcada por avances y brechas. La asociación entre estas entidades puede superar barreras y promover una atención más integral. El actual modelo de atención sanitaria sigue siendo excluyente y discriminatorio.
Descriptores: Espiritualidad; Atención Primaria de Salud; Medicinas Tradicionales Africanas; Personal de Salud; Integralidad en Salud; Enfermería.

INTRODUCTION

In recent years, there has been a growth in research investigating the relationship between spirituality and health, especially in the context of coping with illness and rehabilitation. In this scenario, the spiritual dimension has proven to be an important source of support for patients and families during illness. Similarly, the interface between *terreiros* (Afro-Brazilian religious centers) and health has become a growing and challenging field of research, as these spaces preserve traditional knowledge with significant potential for promoting care and well-being[1,2].

Thus, the incorporation of the spiritual dimension in healthcare has gained relevance, as studies point to its benefits in coping with diseases, promoting health, and rehabilitation. In this context, Primary Health Care (PHC) is presented as the first level of care in the health system, with the development of integrated care and management practices, aimed at the population of the territory under its health responsibility, acting in accordance with guidelines established by the National Primary Care Policy (PNAB)[2-4].

When the PNAB was created, it emphasized the appreciation of diverse knowledge and practices, determining that teams also work in homes, schools, daycare centers, squares, and other spaces[3]. Therefore, we understand that *terreiros* can be an important space for family health teams (eSF), since in this place actions can be promoted that respect and value the local culture, particularly that of the black population, in addition to representing an opportunity to consolidate the link between the *terreiro* and the health units.

However, in practice, the relationship between PHC and *terreiros* is marked by fragility and instability, with an interaction that is often timid and with scarce bilateral linkage, compromising and reducing the potential for coordination between the two contexts[1].

Some authors point out that the lack of knowledge of religions of African origin contributes to negative stereotypes and a stigmatized identity, reduced to pejorative terms such as the segregating use of the term "macumbeiro," which causes suffering and exclusion from society. Thus, the religion is demonized and the participants stigmatized, and this is one of the reasons for the distancing from the *terreiros*[5].

On the other hand, followers of *Candomblé* resist seeking health care due to their own views of health and illness. For health care, the *terreiros* (religious centers) use different therapeutic

devices, producing resistant subjectivities and corporealities, ways of caring for oneself, for others, for ways of being and existing in the world, which allow the production and recovery of the health of individuals and the community[6].

To foster closer ties between primary health care and *terreiros*, the National Health Council (CNS) published Resolution No. 715, recognizing *terreiros* as spaces that promote health and healing, complementary to the Unified Health System (SUS), legitimizing non-traditional medicine as a space for care[7].

In a preliminary literature review, which sought to identify the interactions between *Terreiros* and Primary Health Care, carried out in 2023, significant gaps were found in the scientific knowledge on the subject. The research was conducted on the Virtual Health Library portal, using the descriptors "Candomblé" and "Health". Only five studies addressed the health of people of African descent, but did not mention concrete practices of rapprochement between *Terreiros* and Primary Health Care. Initiatives originating from health units were described as sporadic and based on the biomedical model[1,8-11].

We start from the premise that understanding the interconnection between *terreiros* and health is essential, as it underpins the doctrinal and organizational principles of the SUS (Brazilian Unified Health System), in addition to promoting an accessible and equitable management model. Furthermore, we understand that ancestral knowledge is part of a people's cultural identity and traditional medicine. It plays an important role in care, and it is necessary to advance scientific knowledge on the subject. Therefore, this study aimed to describe the convergence and divergence between Primary Health Care and *Candomblé* religious centers in the provision of care.

METHOD

Descriptive qualitative study conducted with CT priests, health professionals, and managers working in primary health care in the municipality of Camaçari - BA. To ensure transparency and rigor in reporting this study, the criteria established in the *Consolidated Criteria for Reporting Qualitative Research* (COREQ) protocol[12] were considered.

The municipality's primary health care network is distributed across two districts, the city center and the coast, and is composed of 38 Family Health Units (USF) where professionals with different backgrounds and specialties work[13].

This study took place in two health units, one in the city center and the other on the coast, in an attempt to obtain a sample from both districts, chosen based on the following criteria: being the oldest units implemented in the municipality's primary health care system, having a team composed of a doctor, a nurse, a nursing technician, a dentist, and a Community Health Agent (CHA), and

having a CT scanner in their coverage area.

Participants included professionals with higher, middle/technical level education, managers of selected health units, municipal managers of reference for the topic in the municipality who were approached in person by the authors and invited to participate in the study, and TC priests linked to the territory of the Family Health Strategy (eSF), indicated by the Community Health Agents (ACS). Inclusion criteria required that managers and health professionals had to be involved in the primary health care work process in the municipality for a minimum of six months, and that priests were active in their religious centers at the time of the study. All participants had to voluntarily agree to participate in the research. Professionals and managers who were on leave, vacation, or absent during data collection, and priests who were not performing their duties during the data collection period, were excluded.

The study included 14 participants: two municipal managers, two local managers (health unit managers), six primary health care professionals (two mid-level, two higher-level, and two community health agents), and four priests of *Candomblé terreiros.* There were no refusals or repeated interviews. The sample size was intentionally determined, seeking individuals who knew or directly influenced the phenomenon under study. A larger number of professionals was included due to the heterogeneity of roles in primary health care and the need to capture different institutional perspectives on care. Among the priests, given the centrality and relative homogeneity of their role in the temples, the number of four interviews corresponds to the number of people practicing this activity in the territory.

Data was collected between September and October 2024, through semi-structured interviews, following two scripts: one for *Candomblé* priests and another for health workers and managers. The choice of different scripts was due to the need to encompass the different roles, responsibilities, and contexts of action in situations involving health care in the *terreiros* and in primary health care. The first part of the instrument was dedicated to the sociodemographic characterization of the participants, and the second consisted of open-ended questions that allowed participants to freely explain their answers. For the priests, the questions involved the perception of health in the *terreiros*, the care practices existing in the *terreiros*, the experience with activities proposed by health units, and the ease, difficulties, or benefits of the interaction between the health center and *Candomblé.*

For healthcare professionals, the following were addressed: perception of the relationship between *Candomblé* priests and primary healthcare professionals; the proposal of activities by health units; perception of work process management; and the possible benefits and difficulties in the interaction between health centers and *Candomblé*. For managers, the question of including the

need for coordination with social services, especially *Candomblé* services, in the management plan was added. The instruments were pre-tested with one participant from each group mentioned, and no adjustments to the initial script were necessary.

The data were collected by a specialist nurse, a municipal employee and main investigator of this study, during her professional master's degree in Nursing. Data was collected in health units, *terreiros*, and the municipal health department, in a quiet location suggested by the respondents, respecting the participants' availability and privacy, and on a day and time convenient for everyone.

After the participants were selected, telephone and email communication was carried out with the unit managers to facilitate contact and scheduling with the professionals. The Community Health Agents contacted the priests, scheduling the best day and time for the in-person meetings, and the data collection took place at the *terreiro*.

The interviews were conducted individually and recorded using an application installed on a cell phone belonging to the researcher, with an average duration of 25 minutes, the shortest being 12 minutes and the longest, 38 minutes. During the interviews, when a vague answer was obtained, the initial question was restructured in order to clarify and delve deeper into the topic.

With the use of intentional participant selection, data collection was ended during data analysis when researchers determined that saturation of meaning has been reached[14]. The coded material allowed for an understanding of the interactions between PHC and CT, and no additional information was needed, in addition to the repetition of themes raised by the participants.

After recording, the interviews were transcribed by the main researcher and made available to the respondents for reading and validation. No modifications were requested from the researcher following this procedure. Participants were identified by letters corresponding to their profession or role in the territory: NS - professionals with higher education, NM - professionals with secondary education, G - managers, ACS - Community Health Agents, and S - priests. A sequential numbering system was also used to indicate the order in which the interviews were conducted.

The textual material was organized in NVivo® 15 *software* and the analysis followed the assumptions of Bardin's Thematic Content Analysis[15]. The 14 documents, which correspond to the number of interviews conducted, were entered into the software, and the first coding was carried out, referring to the approaches taken by the participants regarding approach and distancing.

A total of 14 core meanings and 214 citations were obtained. During the in-depth analysis, the codes were revised and rearranged to arrive at the four categories that were presented. The groupings were defined *a posteriori*, according to the meanings that emerged in the analysis.

The codes related to spirituality, health and healing practices, and the care model were grouped into the category "Models of health care and traditional practices in *Candomblé* temples";

the codes related to prejudice, cultural and religious barriers, discrimination, lack of information, religious racism, administrative limitations, and professional practices were grouped into the category "Practices of distancing between health units and *Candomblé* temples"; the codes related to activities, specific groups, referrals to medicine, and the limits of spirituality constituted the category: "Practices of rapprochement between health units and *Candomblé* temples"; and finally, the category "Potentialities and implications of practices of rapprochement between health units and *Candomblé* temples" was added, bringing together the codes that dealt with the benefits of interaction and the possibilities of articulating practices between health units and *Candomblé terreiros*.

The research was previously approved under Protocol no. 6,987,222 and CAAE 78297224.0.0000.0053, by the Research Ethics Committee of Universidade Estadual de Feira de Santana. The ethical aspects stipulated by Law 14874/24[16] were observed. Contact with the professional and managerial participants was made by text message on *WhatsApp*, and an invitation was sent to participate in the study and schedule the interview. The research and its procedures were explained in person to the participants, requesting the signing of the Informed Consent Form in duplicate, followed by the recorded interview. The priests were contacted through the ACS to schedule the interviews.

RESULTS

The participants were predominantly female, married, and of mixed race or Black. The predominant age range was 45-54 years for professionals and 75-84 years for priests. Most managers and professionals had a higher education level, while the priests were illiterate or had incomplete primary education. The length of service ranged from 5-32 years for professionals and 38-54 years for priests. The dominant religion among health professionals and managers was Christianity, with a majority of Evangelicals and Catholics.

The analysis and interpretation of the content obtained through the interviews generated four categories, entitled as follows: Models of health care and traditional practices in the CT; Practices of distancing between health units and the CT; Practices of approximation between health units and the CT; Strengths and implications of practices of approximation between health units and the CT.

Models of healthcare and traditional practices in *Candomblé terreiros*.

This category addresses healthcare models in Primary Health Care (PHC) and *Candomblé*, and the systematic exclusion of traditional knowledge, highlighting the challenges and gaps in the recognition and appreciation of these practices within the context of the Brazilian Unified Health

System (SUS). Issues related to medical training and practice were raised by two managers, who emphasized the deconstruction of this traditional knowledge and a technological approach to user care, resulting in invalidation, discrimination, and weakening the relationship between *Candomblé* religious centers (*terreiros*) and PHC. In *Candomblé*, on the other hand, the holistic approach goes beyond curing diseases, promoting quality of life, and encouraging healthy habits. Managers and priests highlight spiritual practices in *Candomblé* and the connection between body and spirit. Table 1 exemplifies these findings:

Table 1 - The biomedical model in practice and professional training, and spiritual practices in CTs. Camaçari, Bahia, Brazil, 2025

Approaches	***Corpus***
Biomedical model	*So, the mind of a newly graduated doctor, who has just finished college, is completely immersed in traditional biomedical thinking. He is supposed to request exams, prescribe medications, and because he graduated from a university, he wants to* ***deconstruct*** *the habit of people who live across from the health center of drinking tea to alleviate some health problem, for example, flatulence, by replacing the tea with pills [...] And the difficulty is in the issue of education itself. In training, in undergraduate studies,* ***this topic is not addressed*** *in the university [...]* (G4)
	[...] I believe that professionals today are still focused on that ***medical-centered model****, on that complaint-based conduct, and then, they tend to prepare themselves to concentrate their actions on the users' illnesses. So, all these dimensions are often not properly addressed.* ***They are not welcomed, they are not valued****. And sometimes the users themselves do not mention that they come from a religious family, or that they attend* a *terreiro (Candomblé temple), because they believe the professionals won't take this into consideration [...].* (G3)
	[...] and in addition, it focuses on the issue of valuing the ***biomedical model [*** *...]* (G3)
Spiritual and health practices in terreiros	***Health in the terreiros should be praised,*** *you know, because people arrive here sick and leave healthy. We pray for headaches, we pray for toothaches, we pray for the wind, we pray for a fallen spine, right? […] These illnesses are often related to the orixás (deities), so we perform a body cleansing, bathe these people with leaves and herbs, go into the woods and bathe them, and thanks to God and the orixás, they get better.* (S1)
	When it comes to spiritual life*, there are baths, there are cleansing rituals, sometimes the client even needs to become a "filho de santo"(initiated son), which involves the birth process of being a buri*[a]*, to undergo a ritual [...], depending on the need they may have in their body, related to the illness, if it is a spiritual illness.* (S2)
	If it's a spiritual matter, we guide *the person, talk to them, make them see that it's necessary to cleanse their health, and then we begin this process, and depending on how things evolve spiritually, we perform a cleansing ritual for Ogum and Exu.* (S4)
	People of the Afro-Brazilian religion see the body as a whole*; they know that if they have any edema or swelling in a leg, they should try to understand what caused that edema or swelling, whether their mental or spiritual side is involved*

	or not. (G4)
	I have many of my spiritual daughters here that I took from the health center, because they were being treated by a doctor, ***but their problem was related to Candomblé****. And I brought them here and cared for them, and they are well to this day. Thank God!* (S1)

Source: Prepared by the authors
The participant refers to Bori or Borí, a ritual that seeks to strengthen the ori (physical and spiritual head) of the *Candomblé* follower.

Social distancing practices between health units and Candomblé *terreiros.*

The practices of distancing between health units and community health centers occur through actions or omissions that marginalize and exclude these spaces from health practices and policies. This process is the result of conscious or unconscious attitudes of individuals, groups, or institutions, and this distancing is manifested and mediated by attitudes of prejudice and intolerance, lack of information, religious racism, and barriers resulting from cultural and religious differences, as shown in the statements below (Table 2):

Table 2 – The distancing between health units and *terreiros* mediated by prejudiced attitudes and religious and cultural barriers. Camaçari, Bahia, Brazil, 2025

Approaches	***Corpus***
Prejudice and intolerance	*Because, you know, I have over thirty initiated children, if they get sick there and go to the health center, there are times when we go there to visit them, and if we need to do anything, we can't because the people there won't let us.* ***The people at the health center won't let us do anything inside*** *[...]* (S1)
	I don't think anyone has proposed this idea; we already have projects aimed at specific groups here, but not at the religious public. Perhaps no one has ever had this idea because of some kind of ***prejudice*** (NS1).
	[...] if I were to mention a difficulty, since these are Candomblé temples, I would say there is a great deal of ***resistance****, a great deal* ***of prejudice*** (NM2)
	Because many times we, who are from Candomblé, seek out the health center, and when we get there, we are ***rejected****. They ignore us, sometimes they even curse us because we are from Candomblé [...]* (S1)
	[...] if they are dressed in the clothing of their sect, of their religion, whether they are priests or just followers of the religion, then these people are ***discriminated against*** *in the health unit environment* (G4)
	[...] ***the health centers don't quite match up*** *with Candomblé* (S3)
	It's about ***lack of knowledge****! They don't want to understand what Candomblé is. It's about prejudice, simply* ***prejudice*** (S4)
	[...] there is a very large, clear ***segregation*** *between what is evangelical and what is candomblé* (NM1)
Lack of information	*[...] The diet of the people who practice Candomblé is somewhat different, [...] Caruru, vatapá, if they were more receptive and we* ***could pass on this information*** *about diet and physical activity, probably the incidence of many diseases that affect people of Candomblé could be mitigated.* (NM1)
Religious	*[...] they are malicious people, who think that Candomblé is* ***the work of the devil****,*

Racism	*and it is not* (S4)
	[...] they are seen as negative people, people who, in a way, are frightening because, in the general context, they say that they are people who might wish ***evil things,****,* ***cast spells*** *, things like that* (NM1)
	Evangelicals [...] they see the people from the Candomblé terreiro, which is another religion, as if it were a ***religion of evil.*** (NM1)
Religion and culture	***People are a bit incredulous****, and think that Candomblé doesn't exist, [...]* (S4)
	Some ***people here have other religions*** *and perhaps they don't have contact with Candomblé,* ***and prefer to avoid such contact*** (NS1)
	[...] there is a very large, very clear ***segregation*** *between what is evangelical and what is candomblé* (NM1)
	[...] because of the issue of ***prejudice****, we know that there is* ***religious intolerance*** (NS2)
	So there is a certain resistance, also because people visually identified as belonging to a religion are treated with suspicion by others who think they are sorcerers or something similar, that they represent something negative, and it is precisely this ***cultural barrier*** *that causes this to happen* (NM1)
	There's also the issue of family upbringing, the beliefs people acquire within their family, and ***that stigma persists throughout life****, so it is difficult to end it* (G4).

Source: Prepared by the authors

The participants recognize the need for this approach, but exclusion is present in public policies, health practices, management plans, and health services. The excerpts (Table 3) are examples of this situation:

Table 3 – The invisibility of *terreiros* in health policies and practices. Camaçari, Bahia, Brazil, 2025

Approaches	*Corpus*
Policy	***I've never seen anyone talk about this here, not even the manager****. And I've dealt with all sorts of people, not even from management or the health department,* ***nobody ever suggested this idea****.* (NS1)
	[...] in the Annual Management Report, ***there is nothing****, at least that I have seen, that contemplates it. Nor in the planning documents, nothing is programmed either* (G3)
	[...] ***targeted actions that lack a policy*** *[...] there are no external actions, in the case of the priests, in the terreiros in the region* (G2)
Practices	*[...] we've had actions aimed at professional groups, like motorcycle taxi drivers, we've had actions aimed at them, but this issue focused on religion* ***is not very common*** (NM2)
	So here, especially in this unit, ***very few people show up.*** (NM1)
	[...] ***the family health teams are very entrenched*** *within the unit, [...] this means that these activities are more demanded by the practitioners of Afro-Brazilian religions, priests of these terreiros, than by the health team* (G4)
	[...] regarding the terreiros, as I said, we don't have ***any specific action*** *[...] we don't have targeted, specific actions* (G2)
	I think that the relationship is very weak, so for us, managers, ***no specific demand related to the terreiros has ever come up*** *[...]* (G3)

	I perceive an inertia, ***there is no concern with these people****, perhaps because it doesn't exist, or because there is an* ***invisibility*** *in this regard* (NS2)
Administrative limits	***If we had another team, it would be much easier****, not only for the Candomblé temples, but for the community as a whole* (ACS2)
	Every month I go to my doctor in Salvador, because ***it's difficult to get to the health center in (mentions the location) Camaçari****.* [...] (S2)
	Logistical *issues, regarding availability of* ***resources,*** *because sometimes transportation to a given location is necessary. And also arrangements regarding the* ***duration*** *of internal and external activities.* (NM1)

Source: Prepared by the authors

Practices for fostering closer ties between healthcare facilities and Candomblé religious centers.

The results of the interviews, regarding the practices of rapprochement between health units and the *Terreiros* allowed us to separate the actions into two perspectives: the first, from the health units towards the *Terreiros,* and the second, from the *Terreiros* regarding the services.

The practices originating from the health units are specific and described by one of the managers as positive for the professionals and satisfactory for the priests because they integrate conventional medicine with ancestral knowledge.

The initiatives originating from the *Terreiros* acknowledge the limitations of spiritual practice in health matters, subsequently referring followers to traditional medicine when necessary. This practice demonstrates a more respectful relationship with Western medical knowledge while maintaining treatment using ancestral wisdom. In their testimonies, we perceive guidance provided by the priests regarding seeking care within the formal health system without abandoning their faith. Table 4 below exemplifies these findings:

Table 4 - Practices of rapprochement between health units and terreiros. Camaçari, Bahia, Brazil, 2025

Initiatives from health units	***Corpus***
Specific activities	*[...] when there is any type of action, we activate the ACS, the team meets, defines and passes the date to the ACS, and the ACS go there and* ***call****, and* ***the actions take place*** (G2)
	Here we have already held and occasionally hold the ***Health Fair*** *in Candomblé terreiros... the team from (location) develops some activities with them, but they are one-off things* (G4)
	Also in the Costa District, there is a professional who ***works with the practitioners of Afro-Brazilian regions****, who is (name of the female professional) [...]* (G4)
	They come to get the COVID and flu vaccines because we go to their homes and ask [...]. So they come based on our guidance, because they've always come to the clinic before, you know (ACS1).

	*(Regarding the evaluation of the activities carried out jointly) all were evaluated as **positive**, including by the professionals, the workers who acted, who act in these activities, they like them [...] the followers of that house, of that terreiro, they are quite **satisfied**. Including when they begin to associate what they have as laymen, **their lay knowledge, with scientific knowledge**.* (G4)
Initiatives from the *terreiros*	***Corpus***
The Limits of Spirituality	*But if it's a physical illness, **we'll follow up the whole process with the doctor** to help the person get better [...] And if there's a need for a doctor, we'll follow that person and see what can be done on the spiritual side* (S2)
	*Because there are many types of diseases that we cure, when the people arrive here in my house, and when I realize that I'm not unable to treat the disease, I **refer them to health services*** (S1)
	[...] we remove the spiritual, and the material is sent to the health center to remove what is bad (S4)
	*Because Candomblé is Candomblé, **we work in one way and the health center works in another** [...]* (S3)
	*[...] they don't seek assistance., **When they're feeling unwell, they seek assistance as patients*** (G2)

Source: Prepared by the authors

Regarding initiatives stemming from Primary Health Care (PHC), health education campaigns, vaccination programs, and actions carried out in the *terreiros* were mentioned, according to the statements of respondents G2, G4, and ACS1. Activities such as health fairs and home visits are welcomed by *Candomblé* followers, especially when there is integration between "lay" and scientific knowledge.

The Powers and Implications of Practices of Approximation between Health Units and *Candomblé Terreiros*

The collaboration between religious centers and health units allows for the therapeutic potential of practices such as the use of medicinal plants, purification rituals, and spiritual support, which can contribute to the biopsychosocial balance of individuals, as well as enabling adherence to conventional health treatments. Furthermore, initiatives that formalize partnerships between religious centers and health units, including the exchange of knowledge, can help to mitigate barriers such as religious racism and lead to greater access to comprehensive care for the population. These potential benefits and implications are exemplified below (Table 5):

Table 5 – Strengths and implications of practices that foster collaboration between health units and *Candomblé terreiros*. Camaçari, Bahia, Brazil, 2025

Approaches	***Corpus***

Powers	*If we had it, it would be a support for us in Candomblé… because we have our herbs, our leaves, but we also need* ***bandages*** *applied in a health center, a nurse who accesses a Candomblé community [...] but we don't have that* (S2)
	[...] ***everything that is part of the territory****, everything that is part of the beliefs of the families in the assigned territory must be part of the care that will be established* (G3)
	One of the premises of Primary Health Care, especially the Family Health Strategy, is to identify leaders in that territory. Who are these leaders? Political ***leaders****, community leaders, religious leaders, and maintaining a relationship with these leaders.* (G4)
	It is the same process as with the other groups. We would approach the community health workers, ***invite them to an event here at the health unit****, and I think if it's in their interest, which I believe it is, they would come more frequently* (NS1).
	[...] it would be much easier for them to work for the health of the people, to ***interact for the health of the people****, so that they would not suppose they are the only ones that know what is right* (S4)
	[...] we could ***perform activities, discussion rounds, and this would certainly demystify things****, and the people would be more welcoming towards the group, but everyone is generally assisted* (G1)
	[...] we are healthcare professionals and ***we need to deconstruct everything that we hold*** *as religious beliefs and serve the population in general,* ***without prejudice*** *[...]* (NS2)
	[...] I think that the Black Population Policy, in terms of management, is very much focused on this issue of ***sending out reports****, documents, internal communications, things that* ***sensitize health units*** *to carry out these health promotion activities in any space* (G3)
	If we start ***thinking about actions****, it would be interesting because normally they don't do it* (G2)
Implications	*[...] it would be interesting to* ***monitor people's*** *health conditions to see if they have diabetes, high blood pressure* (G2)
	[...] if we get closer there will be a ***dialogue,*** *we will* ***demystify*** *many things and certainly the relationship will be very beneficial because it truly brings the health unit professionals closer to the people of the Candomblé terreiro* (G1)
	[...] there would be mutual learning. Healthcare professionals would have much to learn from the health practices of the Candomblé people, and ***combine it with their scientific knowledge*** *[...]. On the other hand, the Candomblé people would gain more scientific knowledge of the practices they heard from their mothers, that their grandfathers did, that their great-grandmothers did [...]* (G4)
	Because it could very well work out very well, because in any case, both Candomblé and the health workers work for what? To care for the people's health (S4)
	The real benefit would be ***bringing together another people, another group, for our unity to work together*** (G1)
	[...] I think there would be countless benefits for the users, and also for the professionals, because if you monitor the evolution of a user, you'll have access to ***all the dimensions*** *that are part of this care, so you can plan their care, which is a very positive point* (G3)

Source: Prepared by the authors

DISCUSSION

The health system in Brazil has undergone major transformations, such as the Sanitary Movement and the creation of the SUS, consolidating health as a right for all. However, despite its principles of universality and equity, there are gaps in the care model, especially regarding the lack of attention to the specificities of traditional peoples, such as those who frequent the CTs. These spaces play an essential role in physical, mental, and spiritual health, in addition to being places of resistance for Afro-descendant populations, in the face of attacks from the State, conservatism, prejudice, and religious racism, insofar as we understand these cults as predominantly constituted by black people[17].

Participants highlight the difficulties faced by *Candomblé* practitioners in accessing public healthcare due to the prevailing medical care model. Although *Candomblé* values spiritual care, it is understandable that there is no rejection of Western medicine on the part of the priests, who recognize the need for both types of treatment.

The biomedical model, predominant in health systems, excludes subjective aspects such as social, spiritual and emotional dimensions, hindering comprehensive care. This imposes limitations on traditional knowledge, such as that of *terreiro* communities, since health professionals often feel unable to deal with the complexity of human illness, making it necessary to train professionals capable of integrating cultural practices into care[8,18].

Biomedical knowledge dominates medicine, valuing the culture of others only when its methods are accepted, as it considers religion to be an interference in care, thus reserving the decision about patients' lives to the health professional[6]. Religions of African origin, in turn, were born from resistance to racism and oppression during the period of slavery, offering health practices based on ancestral knowledge, with a holistic approach to problems that integrate body, spirit and relationships with nature and the sacred[19].

Medicinal plants are frequently cited as an important therapeutic resource in popular health practices and in *terreiros*, often being the last option for care[20]. These care practices, cited by the participants, reflect the integrality of the CT approach in relation to the body and spirit that takes place under the guidance of the priests.

The statements show that therapeutic practices in the *terreiros*, such as prayers and baths, are often not recognized by health professionals, resulting in communication barriers and disrespectful reception. Thus, the practices are not valued, the practitioners are not welcomed, and the care provided devalues traditional knowledge, which makes it difficult for these people to be assisted and stay for as long as necessary in the health services. The lack of recognition of these practices perpetuates the invisibility of the *terreiros*, creating cycles not only of exclusion, but also

of human rights violations[21].

Regarding the possibilities of collaborations between traditional medicine and health professionals, a study carried out in Ghana, Africa, identified a different practice, in which health professionals tend to recognize the expertise of healers and the different possibilities of approaches to the healing process, seeking partnerships that were understood as a collaboration and not as a competition[22]. In the same experience, the healers also recognized that some things that are not of a spiritual nature required a biomedical intervention, expressing appreciation for the specialized intervention of health professionals.

Regarding *Candomblé,* we observed situations of exclusion from healthcare facilities in the priests' statements, while health care professionals acknowledge the presence of prejudice and rejection from colleagues, which has hindered the production of information that could contribute to the prevention of illnesses and diseases.

Prejudice has a negative impact on the relationship between religious communities and primary health care units, excluding these communities from comprehensive care, and manifesting itself in subtle and explicit ways, such as a lack of initiatives and the perpetuation of stereotypes. The absence of a "unique perspective" reflects that the organization of care is still marked by historical discrimination and misinformation, which was frequently reported by participants, added to the demonization of religious centers and lack of knowledge about this religious practice.

Although Brazil is considered a secular country, many contradictions persist, as not all religions can fully experience their spirituality, or practice their liturgy freely, and they face prejudice and intolerance, as is the case with religions of African origin, which have historically been the target of persecution[23].

Prejudiced and discriminatory behaviors on the part of health professionals and managers can directly impact the quality of care provided; in this regard, it is worth noting that none of the professionals interviewed belong to religions of African origin.

Personal, cultural and religious barriers end up reinforcing this prejudice, hindering dialogue between health units and the leaders of the *terreiros*, with health teams frequently neglecting the uniqueness of *Candomblé,* such as its dietary practices and their health implications. To overcome these barriers, it is necessary to train health teams on cultural and religious diversity, as well as create spaces for dialogue with the leaders of the *terreiros,* recognizing their practices as legitimate and essential for comprehensive care.

Paradoxically, one study illustrated a privileged situation of collaboration between health professionals and traditional medicine, suggesting that this interface can also be established in other contexts. The factors that contributed to the success of the experience emerged precisely from the

individual characteristics of the participants, the relationships established between the social actors, the support of the communities, and the health system[22].

Public health policies must address the demonization of *Candomblé* as symbolic violence, promoting educational actions to demystify its practices and value its cultural and health contributions. According to some priests, religious intolerance hinders the recognition of ancestral practices in healthcare, especially in the spiritual aspect. Some study participants, such as G4, NS1, NM1, and NS2, point out that religions contribute to strengthening this intolerance, hindering dialogue between healthcare professionals and those attending *Candomblé terreiros.*

Cultural stigmas make it difficult to recognize the care practices of *terreiros* as complementary to traditional approaches; similarly, religious barriers exert a direct influence on health services. Religious discrimination, especially against Afro-descendants, is still intense in Brazil and contributes to the stigmatization of its adherents, characterizing a structural racism that certifies this exclusion[24].

Furthermore, the lack of interfaces between public policies and traditional knowledge in the SUS hinders the use of the potential of this knowledge in health promotion. The marginalization of traditional knowledge is the result of a history marked by prejudice and structural racism that negatively impact African-based practices and these communities' access to the right to health[17].

The creation of specific health policies for the TC is essential to recognize these spaces as producers of care. Although religious issues are addressed with more respect, few documents directly address care for this community. The PNAB suggests the inclusion of the *terreiros*, but indirectly, while the PNSIPN recognizes racial inequalities as social determinants of health. The CT are fundamental in the fight against oppression, representing historical and cultural resistance, as each *terreiro* is a *quilombo*, symbolizing resistance to prejudice[8].

Representation in the National Congress can guarantee the defense of the worldviews of traditional communities, but the rise to power of certain neo-Pentecostal groups in different public instances hinders the creation of public policies for people of African descent. This contributes to the invisibility and exclusion of their health practices[23].

The analyzed statements reveal a vicious cycle in health management, where professionals and managers justify the lack of specific actions for people of African descent due to the absence of clear regulations and the lack of coordination between health units and the community. Although some managers acknowledge the existence of actions in other contexts, the absence of organized policies that consider the cultural and religious specificities of people of African descent keeps the population underserved, highlighting flaws in strategic planning and the implementation of inclusive practices.

The lack of clear guidelines and dialogue with local leaders reflects this institutional negligence and constitutes a form of violence that fragments actions, while the lack of planning generates a scenario of marginalization and discrimination.

Regarding the administrative limitations mentioned by professional NM1, concerning the time available for activities, resource availability, and lack of logistical support, these are factors that limit integration with the *terreiros*, resulting in the exclusion of these communities from health policies and practices.

The partnership between the SUS and the *terreiros* is a current demand and, as long as it does not remove the autonomy of Afro-religious communities or colonize them, it can provide the SUS with learning strategies for welcoming and caring, which are already established in the context of the practices of these religions[19].

Considering the therapeutic itinerary of people seeking attention and healthcare in *Candomblé,* all priests cited the limitations of spiritual treatment for issues of physical illness. Although health units and *Candomblé* follow different paths, the management of illness in the terreiro (*Candomblé terreiro*) and in the health unit, for the priests, should occur in parallel, and the pursuit of traditional medicine is encouraged by them.

The *terreiros* carry out intersubjective work with their attendees that perceives healing as a process of general transformation in people's lives[8,21]. Thus, we can see that the *terreiros* are more prone to recognizing the complementarity of systems than the health system itself, as demonstrated in this study based on the participants' statements.

The construction of public policies that enable the integration of *terreiros* into the SUS, starts from the principle of recognizing racism in the process of illness among the black population in Brazil, because what is being fought in these practices is the African origin of these religions, and their demonization makes them an enemy to be fought[19].

There are many factors that can be considered in the effective integration between traditional and conventional medicine. A study that explored the facilitators and obstacles of this integration in mental health services in West Africa identified the need for policies that clearly define the directives, regulations, planning, coordination and implementation of this integration, providing those involved with clear and coherent guidelines on the involvement of professionals and organizations, as policies are the basis on which health systems are built[25].

It is also necessary to understand that the process of illness and healing, for religions of African origin, is deeply related to the balance between body and spirit, and healing is understood as the reestablishment of this lost harmony. In this context, the search for traditional therapeutic practices aims not only to alleviate illnesses, but also to promote well-being and overcome suffering

resulting from various imbalances[26].

Due to its strong religious ties, traditional medicine challenges Western paradigms centered on rigid scientific proof, which hinders its full acceptance. Even so, recognizing its relevance and cultural influence is fundamental to broadening the understanding of health in its biological, psychosocial, cultural, environmental, and spiritual dimensions. Therefore, integrating such knowledge into public health policies requires respect for the specificities of this tradition and openness to more comprehensive care models[26].

The closer relationship between Candomblé and eSF through joint activities can also help to demystify the image of the terreiro community, promoting holistic and continuous care, integrating knowledge, and enabling the monitoring of health conditions.

The main limitations of the present study are the scarcity of current studies discussing the topic, since most articles report on issues concerning health practices in the *terreiro* environment, with few references discussing the interaction/interrelation of *terreiros* with health services. The present study highlights the transformative potential of collaborative actions, such as community engagement and continuing education, and recommends that managers, health professionals, and educational institutions strengthen intersector strategies that broaden social participation, promote spaces for continuing education, and incorporate culturally sensitive practices into the daily routine of health services. Measures such as promoting discussion groups, home visits, prioritizing listening to historically silenced groups, such as the *terreiro* community, and building authentic bonds can contribute to expanding equitable access and consolidating a more inclusive care model, with positive impacts on health in Camaçari that can be adapted to other locations.

FINAL CONSIDERATIONS

The study revealed that the interface between *Candomblé* religious centers and primary health care presents both elements of convergence and divergence in the provision of care. The dynamics of these relationships highlighted both advances and gaps in the integration of knowledge, demonstrating the complexity of operationalizing this interface. Although there are some specific instances of convergence, such as health fairs and other jointly developed activities, the absence of robust public policies, adequate professional training, and an inclusive management model hinders effective integration, perpetuating discrimination and exclusion.

Prejudice, lack of information, religious racism, and cultural practices hinder the recognition and appreciation of traditional knowledge, resulting in poor coordination between traditional communities and primary health care. Such disconnection is expressed in the absence of formal partnerships, the exclusion of these communities from health promotion policies, the lack of

referrals, and the non-recognition of religious leaders as care providers.

The integration of traditional knowledge with scientific knowledge is essential for a more effective care model and for overcoming these historical barriers, which requires structural changes in the health system, focusing on interculturality. Recognizing the *terreiros* as legitimate spaces of knowledge and care can contribute to achieving comprehensiveness and equity in health care.

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AVAILABILITY OF DATA AND MATERIAL

Access to the dataset may be obtained by requesting it from the corresponding author.

AUTHORS' CONTRIBUTION

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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