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**An exploration of the health-related values in traditional healer's practices
among the Amazonian Indigenous people in Ecuador: A critical ethnography
of the possibility of cross-cultural health care**

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Abstract

The process of colonisation has laid the foundation for the encounters between indigenous and *western* cultures. The effects of colonisation have not only been linked to the health status of indigenous populations, but also to the way knowledge of indigenous peoples and their cultures is produced. This includes their health-related practices and beliefs, which in many cases have been misunderstood and misrepresented. Considering the socio-historic context of Ecuador and its constitutional goals, the development of the health system is conditional on a better understanding of its indigenous populations. The aim of this research was to explore the practices of traditional healers in order to develop better understandings of their health-related values and beliefs, as a way to contribute to the possibility of cross-cultural health care. This research particularly looked into the traditional medicine practice of the Kichwa Indigenous people from the Ecuadorian Amazon.

The literature on the topic of indigenous health-related practices was extensive, however it was limited in attention to the relationship between traditional healers and patients, and lacking in the context of Ecuador. My study involved an ethnographic exploration undertaken in the Kichwa community of Rukullacta over a three-month period. I used participant observation in combination with in-depth interviews and photography for the collection of data and thematic analysis to develop the analysis. The findings suggest that the health-related practices replicate the values of Kichwa culture, which were identified as: the importance of collective living, the relationship with nature, ancestors and spirits, enduring strength, and the value of experienced knowledge. I argue that understanding of Kichwa culture, health-related practices and beliefs, required the recognition of the socio-historic context – such as the effects of colonisation – that continue to affect Kichwa people's lives. The findings suggested similarities with the themes identified in the literature review. However, this also suggested an oversimplification of descriptions of indigenous practices, which accentuated the problems in the representation of other cultures. Moreover, general representations of indigenous medicines also depicted fixed notions that differed from the generational changes within Kichwa culture that were identified throughout this study. I conclude that further considerations regarding the processes of representations of other cultures are needed in the production of knowledge related to indigenous cultures.

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List of Abbreviations

CODENPE: Consejo de Desarrollo de las Nacionalidades y Pueblos del Ecuador - Council of Development of Indigenous Nationalities and Peoples of Ecuador.

IDB: American Development Bank

INEC: Instituto Nacional de Estadística y Censos – National Institute of Statistics and Census of Ecuador

ISAGS: South American Institute of Government in Health

MSP: Ministerio de Salud Pública del Ecuador – Ecuadorean Ministry of Public Health

OEC: The observatory of Economic Complexity

PAHO: Pan American Health Organisation

SENPLADES: National Secretariat of Planning and Development of Ecuador

SETECI: Secretaría Técnica de Cooperación Internacional – Technical Secretariat for International Cooperation of Ecuador

UN: United Nations

WHO: World Health Organisation

CYRAE: Consejo de Yachak Runas Amazónicas del Ecuador – Yachak Runas Amazonian Council of Ecuador

AMUPAKIN: Asociación de Mujeres Parteras Kichwas del Alto Napo – Association of Kichwa Women Midwives from the High Napo

Declaration

I, Andrea Alejandra Madrid Menendez, confirm that the Thesis is my own work. I am aware of the University's Guidance on the Use of Unfair Means (www.sheffield.ac.uk/ssid/unfair-means). This work has not been previously presented for an award at this, or any other, university.

Chapter One: Introduction

Introduction

This study explores the values that are reflected within the health-related practices of *traditional healers* (TH); particularly, looking into the values of the *traditional medicine* (TM) practices of the Kichwa Indigenous people of Rukullacta in the Ecuadorian Amazon. Empirically, Indigenous populations have experienced relative adversity and inequalities due to cultural differences and misunderstood behaviours related to health (Menéndez, 1994; Maiello, 2008a; Gracey and King, 2009; King, Smith and Gracey, 2009). Data related to the health status of Indigenous populations is not enough information to guarantee the successful implementation of health programmes within these minority groups (Gracey and King, 2009). Exploring the values, knowledge and health-related beliefs is not only important to support these marginalised populations, but essential to develop policies related to their health (Reeve, 2000; Levers, 2006). Furthermore, most TM involves the awareness of concepts that conventional medicine has only recently begun to embrace (Colomeda and Wenzel, 2000; Charlier *et al.*, 2017); concepts such as community, for example. The World Health Organisation (WHO), as reaffirmed in the Declaration of Alma Ata, defines health as “*a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity*” recognising that social and economic factors influence the attainment of health (WHO, 1978). In order to address the social and economic factors, the community is regarded as a fundamental constituent of *Primary Health Care* (PHC) and the health system (WHO, 1978). However, the community is a fundamental factor for many TMs and indigenous peoples’ customary ways of life (Yanez del Pozo, 2005; King, Smith and Gracey, 2009; Valencia, 2010). In addition, the Declaration of the Alma Ata (1978) recognised the value of including the participation of traditional practitioners in PHC and their role in addressing the health needs of the community (WHO, 1978). While the new Declaration on PHC established at the Global Conference on Primary Health Care in Astana, Kazakhstan in October 2018 asserts the need for comprehensive and inclusive approaches to expand PHC, it no longer evidences the reliance on traditional practitioners within its contents (WHO and UNICEF, 2018). Nonetheless, it does recognise that “*scientific as well as traditional knowledge*” is to be applied for the strengthening of PHC (*ibid*). In this regard, the improvement of PHC also depends on the knowledge of Indigenous people, including their TMs.

The relationship between indigenous and *western* cultures has been frequently characterised as a process of *acculturation* – this process entails that one culture becomes accustomed to the values of the most dominant one – in which the obvious dominant culture originated in Europe. While the European colonisation of the Americas happened around 500 years ago and the process of independence in America started less than 250 years, the effects of colonisation endures in the economic and socio-cultural contexts of indigenous populations (King, Smith and Gracey, 2009). This account extends to the dimensions of health and the health system. As the WHO (2010) has recognised, there are factors that affect the health of individuals and their communities. These factors are identified as the determinants of health and they include in broad terms “*the social and economic environment, the physical environment, and the person’s individual characteristics and behaviours*” (WHO, 2010). In this regard, colonisation itself has been proclaimed as a determinant to indigenous people and their health (King, Smith and Gracey, 2009). Therefore, the understanding of indigenous health cannot be isolated from its socio-cultural and historic contexts; neither can the improvement of health-care for these minority groups be achieved without consideration of indigenous people’s knowledge and health-related beliefs.

Although Ecuador’s cultural diversity upholds the coexistence of traditional and conventional medical systems since its foundation (Pedersen and Baruffati, 1989), the tendency to overlook forms of medicine that are not regarded as conventional is common (Leslie, 1980). As Leslie (1980) notes, health-related practices that are not part of the conventional systems of health are usually disregarded as “*curiosities, or as fringe medicine, quackery and superstition*” (pg. 191). However, as Ecuador’s constitutional reforms aim to recognise indigenous knowledge and work towards intercultural inclusion (Republic of Ecuador, 2008), the interaction between traditional and conventional systems demands a change. Moreover, the current health system reform in Ecuador relies on the successful implementation of PHC as it aims to improve the delivery of health care in rural areas (ISAGS, 2012; MSP, 2013). If, in the past, the recognition of intercultural practices has been inapplicable for the lack of evidence (Pedersen and Baruffati, 1989; Montenegro and Stephens, 2006), Ecuador faces a real opportunity to regain, develop and integrate its traditional medicine practices and knowledge to the health system. The new Ecuadorian constitution provides the grounds that allow the inclusion and recognition of cultural diversity among the dialogues in all-social sectors (Republic of Ecuador, 2008). For these reasons, Ecuador embodies the all-embracing social, cultural, political and legal aspects desirable for a study of indigenous peoples and medicine, making it a suitable setting for this research.

Given this understanding, this research explores the practices of TH's to develop a better understanding of Indigenous people, their beliefs and values rooted in their practices of health. Furthermore, considering the relations between indigenous and *western* cultures established through intricate processes of colonisation, this research also explores whether it is possible to understand the health practices of another culture from a Western public health perspective. In order to explore the TM practices and health-related knowledge of the Kichwa Indigenous people of Rukullacta in the Ecuadorian Amazon, I chose ethnographic methods, specifically the method of participant observation. During the three-month period that this ethnography took place I resided with a Kichwa TH and his family in the community of Rukullacta in the province of Napo in Ecuador. Throughout my time with the community, I interacted and participated in the daily activities with the Kichwa people, and through a combination of fieldnotes, interviews and photography I gathered the information for this research. The findings suggest that the health-related practices of Kichwa people reproduce the broader cultural beliefs of Kichwa culture. The core Kichwa values that I identified were five: the importance of collective living, the relationship with nature, ancestors and spirits, enduring strength, and the value of experienced knowledge. I argue that to understand the meanings in the health-related practices of Kichwa people, it was necessary to provide contextual insights that established meaning to the descriptions. The understanding of Kichwa people's practices and beliefs required the recognition of the socio-historic context that continues to affect the Kichwa people. Although the findings suggest similarities in the themes identified throughout the literature review, further considerations – regarding issues of overgeneralised descriptions in the representations of other cultures – were necessary. Moreover, general representations of indigenous cultures tend to portray fixed notions of culture and practice, which contrasted the observation of changes in Kichwa culture, values and beliefs. These issues accentuate the problems in the representation of other cultures that is often not examined in the approaches of research and policy-making regarding indigenous populations.

Structure of the study

This thesis comprises seven chapters from which I will present this research topic. Throughout this first Chapter, I have given an introduction to this research and the general reasons that explain why empirical research on the topic is important.

Chapter two presents the contextual background of Ecuador with the purpose of introducing the geographic, historic, political and socio-cultural aspects that describe the setting chosen for this research. In this chapter I also discuss the effects of colonisation for Indigenous people in the Americas and the current health conditions of Indigenous populations in Ecuador. The discussions in this chapter have the intention to contextualise the development of this research in terms of the setting, but also of the socio-historic conditions that affect the health of indigenous populations, such as the Kichwa people. The chapter concludes with a brief account of my background and the motivations for the development of this study.

Chapter three discusses the literature review related to TM. The literature review includes the findings across a comprehensive search of both empirical and non-empirical publications, drawing on examples from various indigenous cultures. Although there were a wide number of publications that present evidence and insights into TM, studies undertaken in Ecuador that were focussed on traditional practitioners and the values that define their relationships, were limited. Following the literature review and on the basis of its conclusions, in this chapter I examine the identified research gaps and introduce the relevant theoretic framework addressing the contrast between western and non-western cultures identified throughout the literature review. I conclude by presenting the research questions, aims and objectives of this study.

Chapter four presents the methodology and ethnographic methods I used to carry out this investigation. In this chapter I discuss the qualitative nature of this research and the rationale for the methodology and methods used to collect, analyse and interpret the data. This chapter also addresses the ethical issues raised and my positionality regarding this research. Finally, I discuss the challenges, strengths and limitations of the ethnographic approach used in this study.

Chapter five introduces the results from my observations of the Kichwa people and their practices. I discuss the importance of the *context* from which the descriptions of Kichwa traditional healing come as fundamental to their understanding. More specifically, I present the setting and key

interactions within the community and argue that these are central to understanding the resulting values of Kichwa culture including those related to health. The general cultural values constitute the basis to the health-related practices of the Kichwa people, which are organised into five main themes: i) the importance of collective living, ii) the relationship between people and nature, iii) relationships with ancestors and spirits, iv) enduring strength, and; v) the value of knowledge that comes from experience.

Chapter six presents an account of the TM, health-related practices and beliefs of the Kichwa people of Rukullacta. In this chapter I discuss the general values of Kichwa culture with relation to the health-related practices and beliefs of Kichwa people. The findings I present in this chapter concentrate principally on the data collected through the in-depth interviews with healers and patients, supported by the visual data and fieldnotes from my exploration.

Chapter seven discusses the findings of this ethnography in comparison with the literature review and the relevant theoretic framework. I continue with the discussions focussed on three further considerations to the findings related to the health-related practices of indigenous people: i) The developing Kichwa culture, ii) Cleanliness and wholeness in Kichwa TM as definitions of cultural identity, and iii) The representations of TM in Western public health. Finally, in this chapter I review the implications and limitations of this study.

Having introduced the research topic and thesis structure, in the following chapter I will provide the contextual background to the setting of this research and the health and socio-historic contexts for Indigenous populations in Ecuador.

Chapter Two: Contextual Background

To provide a contextual background and introduce the geographic, historic, political and socio-cultural aspects that describe the setting of this research, this chapter presents the general situation of Ecuador. In like manner, I introduce the health and socio-historic contexts for Indigenous populations in Ecuador and the effects of colonisation for Indigenous people worldwide. This chapter intends to contextualise the development of this research in terms of the setting, but also of the socio-historic conditions that affect the health of various indigenous populations. To conclude, I will explain the reasons that motivated me to develop this study.

Background to Ecuador

Ecuador is a relatively small nation with 283,520-km² of territory that is bordered at the north with Colombia and at the east and south with Peru. Although small in size, Ecuador's diversity is vast. Ecuador's national territory comprises twenty-four provinces that cover its four main regions and a variety of tribal boundaries (Republic of Ecuador, 2008). Ecuador's environmental diversity features the rainforest neighbouring the Amazon, the Cordillera de los Andes highlands with its eastern and western slopes, the shores of the Pacific Ocean and the Galapagos islands. The diversity of cultures is wide-ranging as well. Although Ecuador's ethnic diversity dates back to prehistoric ages, the socio-historical context was largely marked by the Spanish conquests in the 15th and 16th centuries (Pareja Y Díez Canseco, 1979; Crosby, 2003; Montenegro and Stephens, 2006). Ecuador was a Spanish colony until 1820 when it gained independence as part of the Gran Colombia – constituted by the current countries of Ecuador, Colombia, Panama and Venezuela, and parts of Peru, Guyana and Brazil – but it became a sovereign country ten years after. Currently, Ecuador is constituted as a sovereign and democratic republic with a population of 14'483,499 people (INEC, 2010). In present-day, Ecuador is considered a middle-income country predominantly grounded on the exploitation of oil that represents the majority of the exports. Ecuador's economy is also reliant on agricultural production and exports, such as banana, cacao, flowers and shrimp (Simoes and Hidalgo, 2011).

In 2017 Lenin Moreno was elected President of Ecuador, after the three-term presidency of his predecessor. Under the former administration in 2008, Ecuador approved a constitutional reform with the main purpose of re-establishing the rights of Ecuadorean people and the environment (Republic of Ecuador, 2008). The Constitution of Ecuador (2008) is the supreme law of the country,

defining the fundamental principles for its administration, regulation and organisation. The new set of principles were mostly retrieved from the Indigenous perceptions of respect and harmony between humans and nature, which are gathered in the concept of “*Sumak Kawsay*” or “Good Living” (Republic of Ecuador, 2008; SENPLADES, 2013). The principles of “Good Living” are also present in the National Development Plan, which guides the organisation of Ecuador’s territory and its people (SENPLADES, 2013). Additionally, the new Constitution (2008) regards Ecuador’s cultural and historic heritage as an ancestral treasure and throughout Articles No. 21, 27 and 340, designates the recognition, protection, promotion and inclusion of cultural diversity and the acknowledgement of *interculturalism* as a principle for its administration.

Background to Ecuador’s Cultural and Ethnic Diversity

Interculturalism is a term that acknowledges the complexity of the cultural and ethnic diversity in Ecuador (Ayala Mora, 2010; CODENPE, 2011a, 2011b). According to the national census carried out in 2010 (See figure 1), the majority of Ecuadorians consider themselves *Mestizos*.

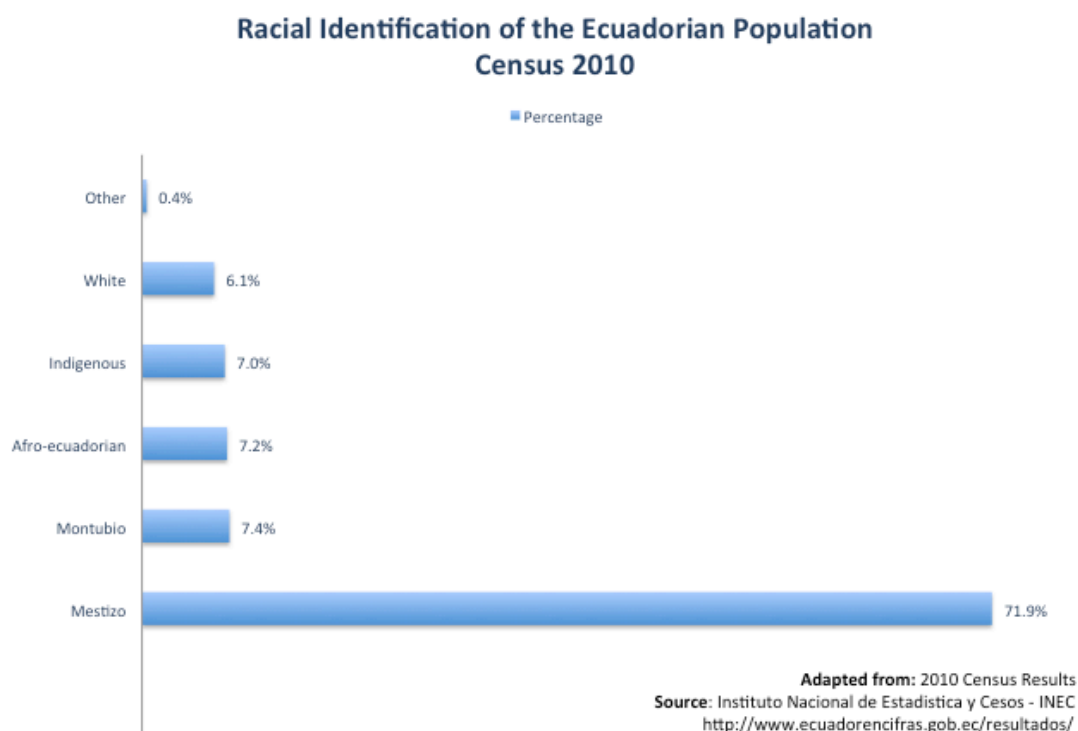


Figure 1 *Racial identification of the Ecuadorian Population*

Mestizo is an ethnic identity and the most common in Latin America. The term refers to the mixed-race ancestry of white European and Native Indigenous Americans that originated during the Colonisation period. While *Mestizo* is the most common ethnic identification, other mixed ethnic groups such as the Montubios – descendants from the coastal region of Ecuador – have preferred to be identified as independent ethnic groups. As a result, the ethnic diversity in present-day Ecuador's population is distributed as follows: Mestizos 71.9%, Montubios 7.4%, Afro-Ecuadorians 7.2%, Native Indigenous 7%, White 6.1% and a 0.4% that have been categorised as belonging to 'other' various ethnic backgrounds (INEC, 2010).

Ecuador is one of the four Latin American countries with the highest percentage of indigenous population (PAHO, 2012). From the 14'483,499 Ecuadorians, there is a total of 1'018,176 indigenous people belonging to one of the 14 aborigine nationalities or 18 indigenous groups recognised in the country (Montenegro and Stephens, 2006; INEC, 2010; CODENPE, 2011a). Since indigenous people inhabited the territory before Ecuador was constituted as a country, aborigine nationalities are ethnic groups that in addition to the shared characteristics that define them as an ethnic group, e.g. their history, culture and language, they occupied a specific territory (CODENPE, 2011a, 2011b). For this reason, in Ecuador some indigenous groups are recognised as an indigenous or aborigine nationality, while others are recognised as indigenous groups. In fact, indigenous groups are part of the aborigine nationality of their origin, but since they have developed distinctive ethnic characteristics, they are sometimes recognised as a different group (CODENPE, 2011a). The Kichwa peoples are the largest indigenous group in Ecuador, since they originally occupied the majority of the Ecuadorean territory (CODENPE, 2011a). Furthermore, most of the currently recognised indigenous groups are actually part of the Kichwa nationality (CODENPE, 2011a). Although in general Ecuador's urban areas are densely populated, the rural population is mostly made up of indigenous communities (See figure 2), with nearly 80% of the indigenous people having preserved their rural living (INEC, 2010).

Urban and Rural Populations by Ethnicity Census 2010

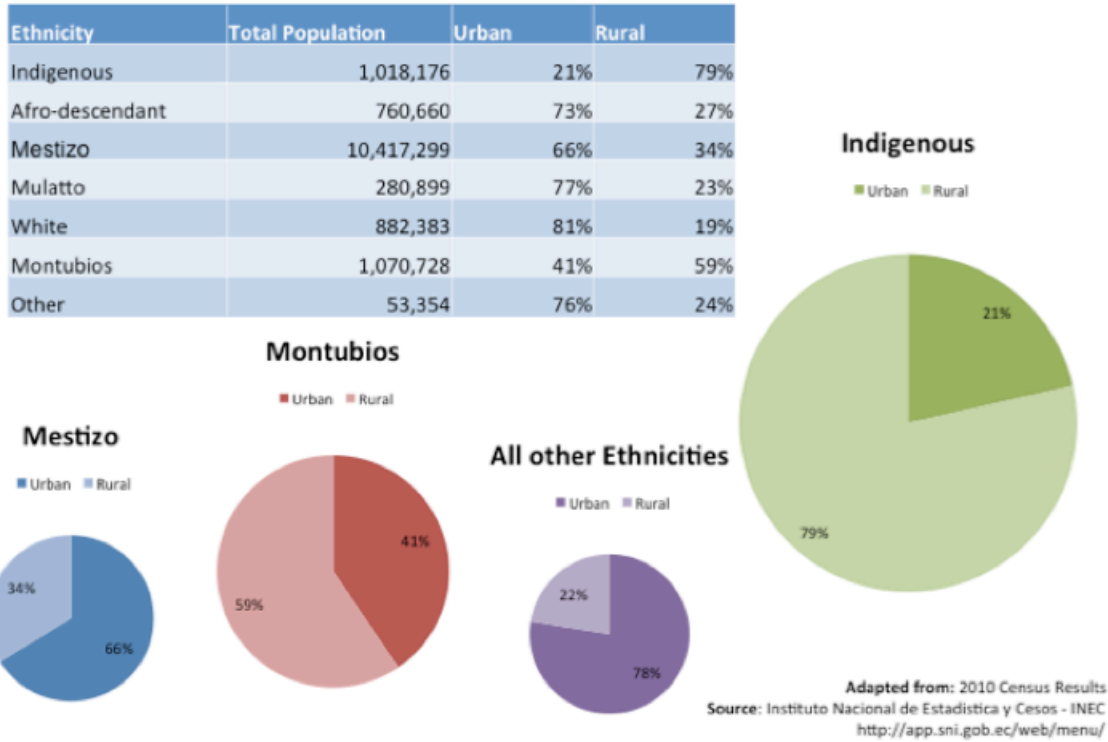
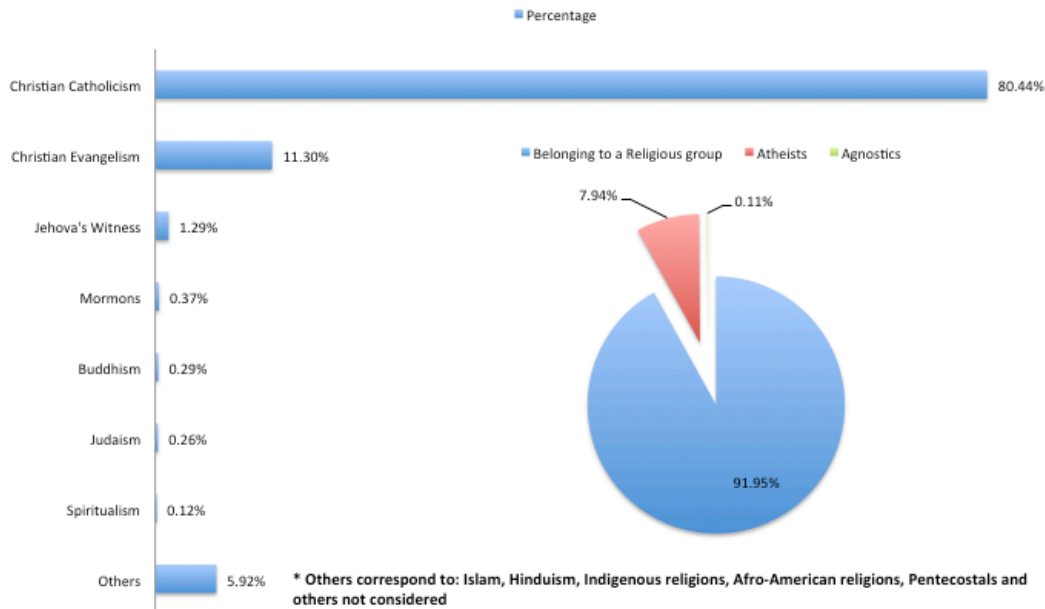


Figure 2 Urban and Rural Populations by Ethnicity

First Official Statistics about Religious Affiliation in Ecuador August 2012



Adapted from: 2012 First Official Statistics about Religious Affiliation in Ecuador
Source: Instituto Nacional de Estadística y Censos – INEC
Sistema Integrado de encuesta de hogares www.inec.gob.ec

Figure 3 Religious Affiliations in Ecuador

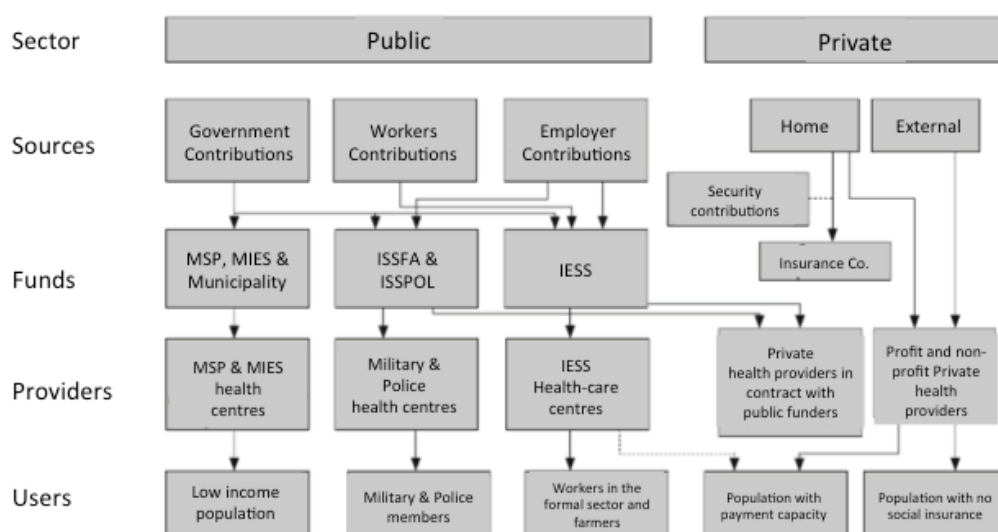
Apart from the ethnic diversity and referring to the first official religious statistics (See figure 3), most Ecuadorians considered themselves as religious. While Catholicism is the main faith in the country, to a lesser extent, a variety of different religions and beliefs coexist as well (INEC, 2012).

Background to health care and the healthcare system in Ecuador

The main focus of the Constitutional reform (2008) – as previously noted – was the repossession and acknowledgement of Ecuador's people and environmental rights, which marked a turning point in Ecuador's health history and development (PAHO, 2008; De Paepe *et al.*, 2012). Ecuador's policies have historically alternated from state-oriented to neoliberal schemes that are "*characterized by reduced state spending, privatization, international exposure, foreign investment, export orientation, labour code reductions, and market-determined prices*" (Hey and Klak, 1999, pg. 67). The impact that the political changes had in the history of the Ecuadorean health system is directly related to the sources of funding, but implicitly affecting the governance of the health system. The new Constitution re-established the role of the Ecuadorian State as a guarantor of rights, with an explicit recognition of the right to health (PAHO, 2008; Republic of Ecuador, 2008; ISAGS, 2012; Malo-Serrano and Malo-Corral, 2014). As a consequence, the Ecuadorian health system initiated an integral reform process aimed at the strengthening of governance and coverage of health-care services (MSP, 2011, 2013). Ecuador's institutionalised health system is a mixed system that comprises both private and public sectors (see figure 4), with an influential involvement of the Social Health Insurance, a smaller contribution of private insurance companies (only 3%) and a significant participation of the National Health Service (Lucio, Villarcrés and Henríquez, 2011; ISAGS, 2012). Though Ecuador's public expenditure incremented over the last decade, private expenditure still accounts for 60.5% of health-care financing (Lucio, Villarcrés and Henríquez, 2011). This outlook reflects the predominance of neoliberal policies that debilitated the public health sector, even when the public services deliver health-care to more than 70% of the Ecuadorian population (PAHO, 2008; Lucio, Villarcrés and Henríquez, 2011; MSP, 2013; Malo-Serrano and Malo-Corral, 2014). Furthermore, though the dependency of the Ecuadorian health system on international aid has recently lessened, international cooperation is still essential to the development of the health system. Currently, the main partnerships in health are: the Pan American Health Organization PAHO/WHO and other United Nations (UN) organisations, the Inter-American Development Bank (IDB) with an important influence though financially, stakeholders like the United States, Germany and Spain among others (See Table 1), also provide assistance (WHO, 2009, 2013; SETECI, 2014).

Ecuador's Health Care System Structure

Revenue collection, pooling, purchase and health-care delivery



MSP: Ministry of Public Health
MIES: Ministry of Economic and Social Inclusion
ISSFA: Military Social Insurance
ISSPOL: Police Social Insurance
IESS: National Social Insurance

Source: Lucio et al. 2011. Sistema de salud de Ecuador. *Salud pública de México*, 53(Suplemento 2), pp.5178

Figure 4 Ecuador's Health Care System Structure

Ecuador's International Cooperation

Health Sector 2014

Country or International Organisation	No. of Projects	Cooperation Amount (USD)	%
United States	12	\$3,953,060.83	29.86%
Canada	1	\$1,533,721.75	11.59%
South Korea	1	\$1,250,000.00	9.44%
United Nations Organization - UN	4	\$1,123,157.00	8.49%
World Bank	1	\$658,055.25	4.97%
Germany	5	\$654,702.98	4.95%
The Global Fund - GFATM	2	\$607,977.29	4.59%
Spain	8	\$607,160.41	4.59%
Belgium	2	\$486,813.11	3.68%
Switzerland	3	\$486,165.00	3.67%
Italy	7	\$378,719.88	2.86%
Norway	1	\$376,976.00	2.85%
Netherlands	2	\$331,239.00	2.50%
Inter-American Development Bank	2	\$263,204.00	1.99%
Sweden	2	\$203,781.84	1.54%
Japan	2	\$166,227.72	1.26%
Panama	2	\$155,742.81	1.18%
TOTAL	57	\$13,236,704.87	100.00%



Adapted from: Mapa Interactivo de Cooperación Internacional
Source: Secretaría Técnica de Cooperación Internacional – SETECI, 2014

Table 1 Ecuador's International Cooperation in Health Sector

Traditional Medicine and Health System in Ecuador

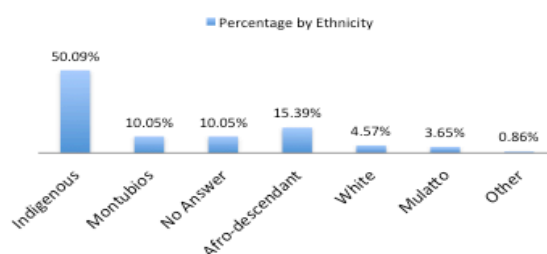
Traditional Medicine (TM) as defined by the World Health Organisation is “the sum total of the knowledge, skill and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness” (WHO, 2019 pg. 8). In Ecuador TM are also generally referred to as ‘intercultural’ medicines or health, in response to the principle of *Interculturalism* defined in the Constitution (Republic of Ecuador, 2008; MSP, 2013). According to Mignone et al. (2007), in Latin American countries intercultural medicine is generally considered a complementary practice to western or conventional medicine, with the intention to bridge cultural differences. However, Ortega (1988) describes TM in Ecuador as a cultural expression that responds to people’s needs. The level of integration of TM and the conventional health system in Ecuador is viewed as fragmented, with few adaptations of intercultural practices (Mignone *et al.*, 2007; ISAGS, 2012; MSP, 2013). Although TM have not been considered part of the Ecuadorean national health system in previous years, developments in the integration of TM and conventional health-care have become more noticeable recently. For instance, the Ministry of Public Health (MSP) as part of the institutional reform that responded to the changes in the constitution of 2008, established the creation of the National Directorate of Intercultural Health (ISAGS, 2012; MSP, 2014b). The National Directorate of Intercultural Health is an instance within the organisational structure of the MSP that is in charge of developing policies and implementing ethnic practices and notions within the health system (MSP, 2014b).

Indigenous Health Conditions

In general, the national health indicators do not reflect the disparities between ethnic groups in Ecuador, or the inequalities in health experienced by minority groups such as the indigenous people (ISAGS, 2012). Furthermore, King, Smith and Gracey (2009) have observed that “*research into Indigenous health has been largely focused on non-Indigenous, rather than Indigenous, notions of health*” (Pg. 76). Since indigenous traditional medicines usually take into account the physical, spiritual and environmental wellbeing altogether (Pedersen and Baruffati, 1989; Montenegro and Stephens, 2006; SENPLADES, 2013), some studies argue that conventional treatments of health could have counterproductive effects to the whole environment and lifestyle of indigenous people (Montenegro and Stephens, 2006). Montenegro and Stephens (2006) consider that while some

indigenous populations have successfully endured the institution of *western* beliefs, the insertion of new health technologies might not be as beneficial as it sounds. However, not having access to those communities and to the information of their health conditions, also represents an issue for the health system (Montenegro and Stephens, 2006; Mignone *et al.*, 2007; MSP, 2013). In spite of the debate, most indigenous communities apply a mixture of their own ancient wisdom with conventional health-care practices, mostly with emergency care (Pedersen and Coloma, 1983; Pedersen and Baruffati, 1989; Montenegro and Stephens, 2006; Mignone *et al.*, 2007). The statistics provided by the Ministry of Public Health (See table 2) demonstrate that from the different ethnic groups in Ecuador and setting aside Mestizos for being the typical ethnic identification, the indigenous people reflect a greater use of conventional health-care services (MSP, 2015). Although official information is limited and frequently found dispersed in individual studies, morbidity and mortality rates are generally higher for indigenous populations (Montenegro and Stephens, 2006). Nonetheless, referring to Pedersen & Coloma’s (1983) findings, the variation of morbidity and mortality rates was insignificant when comparing four indigenous communities with different levels of access to conventional health-care services in Ecuador.

Health-care Provision by Health-care level and Ethnicity Ecuador’s Ministry of Public Health 2014



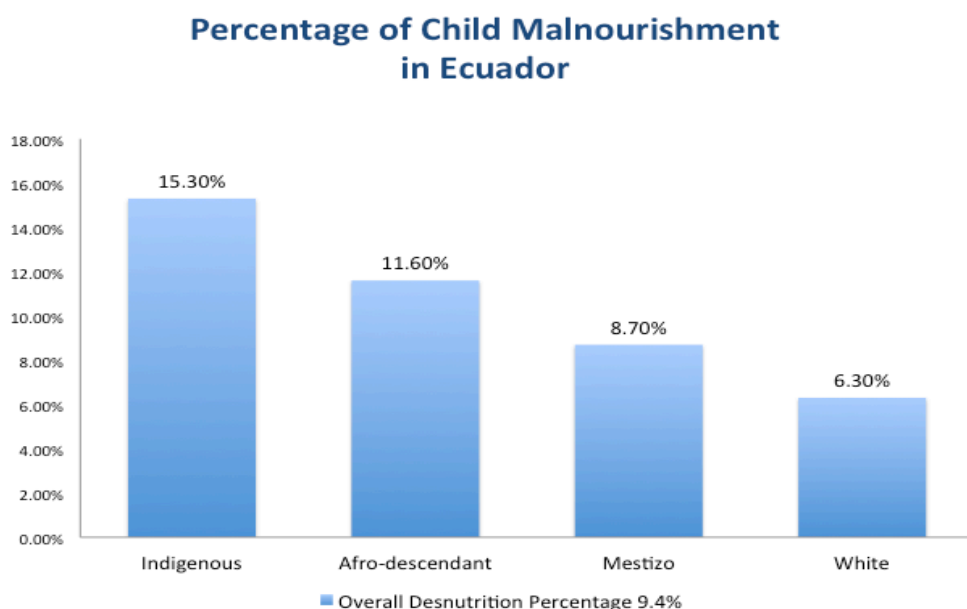
Ethnicity	Health-care Services			Total	Percentage
	Primary Health Care	Secondary-level of Care	Third-level of Care		
Mestizo	24,598,825	3,234,847	925,348	28,759,020	87.66%
Indigenous	1,907,883	116,633	3,558	2,028,074	6.18%
Montubios	502,851	109,250	11,152	623,253	1.90%
No Answer	326,588	69,338	10,955	406,881	1.24%
Afro-descendant	529,487	79,513	14,172	623,172	1.90%
White	138,333	38,134	8,447	184,914	0.56%
Mulatto	116,240	27,298	4,040	147,578	0.45%
Other	15,740	18,197	801	34,738	0.11%
TOTAL	28,135,947	3,693,210	978,473	32,807,630	100.00%

Adapted from: Statistic Production MSP 2006-2014
Source: Ministry of Public Health – MSP, 2015

Table 2 Health-care Provision by Health-care level and Ethnicity

Determinants of health

Along with the infectious diseases brought by the European conquerors (Crosby, 2003; Montenegro and Stephens, 2006; Noymer, 2011), the effects of colonisation had an impact on the living and environmental conditions of indigenous populations, which are now acknowledged as being determinants of health (WHO, 2010). King, Smith and Gracey (2009) argue that colonisation is a “*fundamental determinant*” to the health of indigenous people (pg.76). In like manner, Pedersen and Coloma (1983) resolve that a crucial reason of deteriorated indigenous health is socio-economic inequality. Currently, the indigenous populations are among the most deprived in Ecuador (PAHO, 2012). A suitable example of the previous statement, is the high percentage of chronic malnourishment of indigenous children that when compared to the rest of the population (See figure 5), it almost doubles (WHO, 2009; ISAGS, 2012; SENPLADES, 2013). As a whole, Ecuador’s health burden is affected mostly by non-communicable diseases (See Figure 6), which are diseases that are mainly affected by heredities, lifestyle and environmental factors (WHO, 2015). In addition to other conditions related to poverty, sexual and reproductive health and domestic violence are the ones that most affect indigenous people (Montenegro and Stephens, 2006; WHO, 2009, 2015; Lucio, Villarcres and Henríquez, 2011; SENPLADES, 2013; UNFPA, 2013).



Adapted from: WHO Country Cooperation Strategy Ecuador 2010 - 2014
Source: World Health Organization, 2009

Figure 5 Percentage of Child Malnourishment in Ecuador

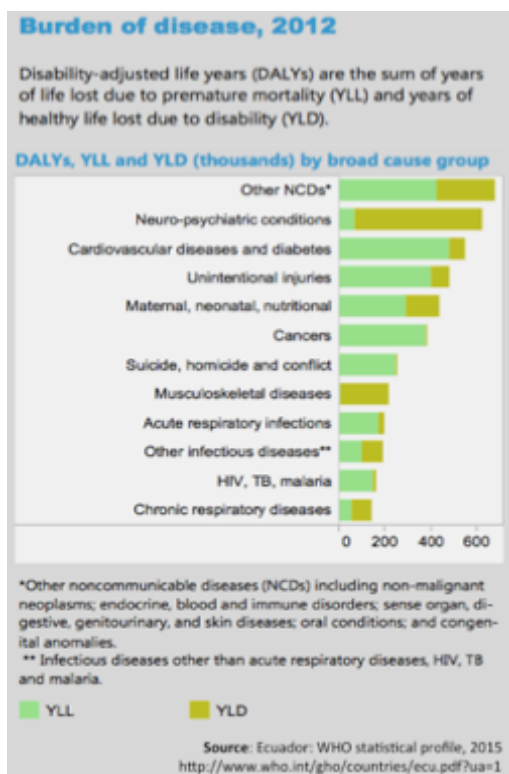


Figure 6 Ecuador's Burden of Disease

As shown previously, most indigenous populations in Ecuador live in rural areas (INEC, 2010). Even though not applied to all of the indigenous groups, as a result of the Spanish conquest and colonisation, some indigenous communities chose to settle in remote places in the deep Ecuadorian jungle as means of protection (Montenegro and Stephens, 2006). While in the past, alienated environments could have protected indigenous people from being in contact with the diseases brought from Europe, now environmental contamination coming from farming, petroleum and mineral exploitation, represent one of the main threats to indigenous health (Pedersen and Coloma, 1983; Montenegro and Stephens, 2006; WHO, 2009; Brisbois, 2014). According to Montenegro & Stephens (2006) the patterns of illness amongst indigenous populations are linked to the contact they have with modern society; while the health of the most isolated groups is affected by environmental hazards, those who have greater contact with society are prone to diseases of lifestyle and poverty.

Colonisation and the socio-historic context of Indigenous populations

The Spanish arrival in 1526 brought countless changes that affected and altered the life conditions of the native indigenous populations. After the conquest, the populations of indigenous people struggled to survive after the introduction of European diseases such as smallpox, measles and other infections (Crosby, 2003; Montenegro and Stephens, 2006; Noymer, 2011). While a large number of indigenous people died after the exposure to the foreign diseases, the Spanish conquest left a debatable ground to account for the lessening of indigenous populations (Hanke, 1966; Muldoon, 1994; Noymer, 2011; Batchelder and Sanchez, 2012; Casanova, 2012). According to Casanova (2012), the Spanish is bestowed as the fairest amongst the European conquests. Since the Spanish Monarchy was strongly influenced by the Catholic Church, the aim of the Spanish conquest and posterior colonisation was the subjugation of the indigenous rather than their extermination (Casanova, 2012). However, the popular accounts of Bartolome de las Casas – a colonist who later became a Dominican friar – about the cruelties and atrocities towards indigenous people during the Spanish colonisation, are the foundation for the opposing argument and the long-lasting debate (Hanke, 1966).

In addition to the expansion of the Spanish empire in the Americas and due to the strong link between the Spanish Monarchy and the Catholic Church during the colonisation period, the Spanish colonisers also had the intention to save the native people from their barbaric ways (Thiemer-Sachse, 2009; Casanova, 2012). As a consequence, the colonisation that took place in the Americas came in parallel to the intention to convert indigenous people to Catholicism (Hanke, 1966; Muldoon, 1994; Casanova, 2012). In this sense, Casanova (2012) argues that the Spanish colonisation allowed Indigenous customs to continue, as long as they did not infringe the Catholic natural laws and rights. However, Thiemer-Sachse (2009) clarifies that because the colonisers perceived themselves as civilized – in contrast to the indigenous – they also adopted an attitude of superiority over the native indigenous peoples. This position eventually transformed into the racial abuses and discriminating attitudes that became even more visible with the latter division of socio-economic classes deriving from the taxing system and ownership of lands taken by the white colonisers (Hanke, 1966; Pareja Y Díez Canseco, 1979; Batchelder and Sanchez, 2012). As some scholars have recognised, the Spanish colonisation was characterised by an hegemonic and forceful insertion of principles, practices and beliefs (Hanke, 1966; Thiemer-Sachse, 2009). The colonisation instigated not only the amalgamation of cultures, but also the fostering of *Mestizos* and other mixed racial groups in Latin America (Montenegro and Stephens, 2006). In like manner, the dominance of

the Spaniards over the indigenous peoples, has been observed throughout a wide range of factors: socio-political aspects, populace migration, forced labour, culture, language, environmental change and with numerous implications to health (Crosby, 2003; Thiemer-Sachse, 2009; Noymer, 2011; Arroyo Abad, Davies and van Zanden, 2012; Belknap and Sandweiss, 2014). Nonetheless, the influence of the Spanish colonisation enabled the religious and cultural diversity that exists in Ecuador today. As it will be seen throughout this thesis – and developed in Chapter seven – the influence of colonialism is still present not only in the current experiences of indigenous people, but also in the ways that indigenous people have and continue to be represented.

In this chapter I presented the contextual background to this research in order to contextualise the development of this study. Not only to provide understanding of the setting where this research took place, but also to introduce the socio-historic conditions that continue to affect indigenous populations. As discussed in this chapter, a limited understanding of indigenous cultures challenges the approaches in regulations and policies related to traditional medicines and the health of indigenous populations. Moreover, it establishes a limitation in the access or “cultural access” of indigenous people to health-care. Although the use of traditional and biomedical systems is common in Latin American countries (Pedersen and Coloma, 1983; Pedersen and Baruffati, 1989; Montenegro and Stephens, 2006; Mignone *et al.*, 2007), it also reflects a rather complex history in the relationship between *western* and non-western cultures. Considering that the effects of colonisation have been linked to the health status of indigenous populations (King, Smith and Gracey, 2009), throughout this thesis I will explore how colonialism continues to affect the lives and health of indigenous populations.

Background and motivation for this study

My interest in the field of health and particularly health systems, evolved from my experience of working with the Ecuadorian Ministry of Public Health (MSP). I worked in the MSP in Ecuador for over 4 years, where I had the opportunity to work on the institutional reform of the MSP and the Ecuadorian health-care system. My particular interest in TM, however, developed during my Master's degree in Public Health (MPH) while residing in the United Kingdom (UK). Since I live in the UK, I have grown a profound awareness of my cultural background and with that, a deeper appreciation of the cultural diversity of my country, an empathic recognition of the challenging conditions of the ethnic minorities, but also of the extraordinary knowledge behind these cultures. Through my focus on health systems, my interest in exploring the integration between indigenous and conventional systems of health developed. In addition, after reviewing the literature around this topic I began to realise that not only was there limited research that explored the perspectives of indigenous populations on health, but also that my personal knowledge of indigenous cultures was narrow. There are more than 15 native languages in Ecuador and I don't know any of them. The reason I bring this into account, is because as I reflect on what it means to be *Mestizo*, I realise that I have not been aware of the aspects that make up half of my own ethnic heritage. The critical ethnographic methods and the symbolic interactionist stance that I have chosen to approach this research, have given me the opportunity to reveal my own preconceptions about indigenous cultures. The interactions with the Kichwa people of Rukullacta have not only given answer to the question this research states, but also to the personal queries of my own identity. The reflexivity required throughout this study was an essential part of the interpretation process and for this reasons this thesis is written in the first person. Through this thesis I aim to present a different account about the realities of indigenous people and their health-related practices, surely not the rightest account nor an absolute one, just the account of what I witnessed. Therefore, the value I provide to this work is the value of my authentic perspective.

Summary

This chapter has presented the contextual background for this research. The background introduced in this chapter has provided an overview of Ecuador's context and explained the socio-political and historical implications in Ecuador's health system. I have also described the conditions and socio-historic background of indigenous populations, their practices and beliefs and discussed the effects of colonisation. Lastly, I have presented and reflected on the reasons that motivated the development of this study. The thesis will now go on to give a more detailed account of existing empirical and theoretical insights into traditional healers and associated medical practices.

Chapter Three: Literature Review

The aim of this chapter is to present a comprehensive narrative account of the relevant literature related to the topic. This chapter includes the findings across a broad bibliographical exploration of both empirical and non-empirical publications, drawing on examples from various indigenous cultures. The literature I included in this review was not limited to the Ecuadorian context, because of the limited number of studies taking place there. Thus, the empirical research I present in this chapter comes from a range of international settings. Using a narrative approach to analysing the literature, seven main themes emerged relating to:

- [*The Animistic and Holistic Cosmos*](#)
- [*The Spirit World*](#)
- [*The Concept of Balance and Harmony*](#)
- [*Versions of Health and Illness*](#)
- [*Indigenous' healing practices*](#)
- [*The Power of the Healer*](#)
- [*The Comprehensive Relationships of Indigenous Medicine*](#)

As will be shown, this reflects key orientating ontological concepts related to traditional medicine such as the recognition of a world linked to, but beyond corporeal human embodiment (Westermeyer, 1988; Yanez del Pozo, 2005; Maiello, 2008a; Jacome, 2010; White, 2015), to the imbuing of many objects and places with power (Westermeyer, 1988; Yanez del Pozo, 2005; Naranjo, 2010; Capps, 2011; Cardona-Arias, 2012; Berger-González *et al.*, 2016a), the role of healers in locating and using such power, and of the way in which health and illness are viewed. Central to all these is the idea also of *holism* (Turner, 1989; Maher, 1999; Cardona-Arias, 2012; Waldram, 2015; White, 2015), and of the need to understand the world as being interconnected and with humans and their associated constructs of health, illness and wellbeing as being but one part of this. I will recapitulate the research gaps that were identified within the literature, and introduce the related theoretic framework. Finally, I present the research question, aims and objectives of this study.

Narrative Literature Review

In this section I present the literature search and findings that surround the topic of traditional healers (TH) and their medicine practice. The initial exploration of the literature consisted of a broad

search to help narrow the scope of interest (Hart, 2001). Originally, the use of a systematic approach to search for publications related to traditional medicine (TM) practices was intended. However, the retrieved results for this topic were exceedingly broad in number, but unsatisfactory when evaluating the content of the articles. Although many articles mentioned TH or TM, the topics of the studies were not relevant to the topic of this research. Likewise, the focused approach of a systematic review limited the diversity of themes that are related to TM and the health-related practices of indigenous people. I concur with Collins & Fauser (2005) that *“for some review topics, however, the strengths of the systematic review may turn into weaknesses”* (pg. 103). In this sense, a narrative review was a more suitable approach to undertake this literature overview. The narrative review allowed a wider search, retrieving articles that discussed the topic within the context of a broader range of research. In order to find relevant articles, I carried out a citation search and reference list checking as contrasting strategies to complete this review. Furthermore, resulting from my attendance at the “First Regional Summit of Ancestral, Spiritual and Intercultural Medicine” that took place in Ecuador (2016), I was introduced to people with similar interests who recommended some specific literature describing TM. I also contacted two expert researchers that have been studying indigenous cultures in Ecuador and they suggested other related writings. While the previously mentioned strategies are mostly used to complement a systematic review (Papaioannou *et al.*, 2010), the application of these techniques was imperative for retrieving literature that was significant to the topic of interest, especially for literature that was not digitalised. Considering the diversity of indigenous cultures, the literature review I present in this section is based on a narrative literature review that brings together scattered and varied data into comparable conclusions about existing research regarding TM and the healing practices of indigenous people.

Search Strategy

The bibliography used to generate the background knowledge for this research was mainly located through the application of a citation search, reference list checking and expert recommendation. As a result, the literature includes a variety of empirical work and grey literature that relates to the healing practices of indigenous people. The search was primarily focused on finding articles that would resemble the type of investigation that this research question aims to answer. In that respect, the terms I used for tracing related literature were the following: “traditional healer” and “patient” or “health seeker”. Terms like “traditional systems” and “Indigenous medicine” were also scoped. Truncation devices (such as \$ and *) were applied in each case, depending on the database that was used. Likewise, according to the topic area and type of research, my selection of databases included

the following: Sociological Abstracts, Applied Social Sciences Index and Abstracts (ASSIA), International Bibliography of the Social Sciences (IBSS) and Web of Science. Google Scholar was used as a secondary database to locate specific citations and related articles.

Inclusion and Exclusion Criteria

The inclusion and exclusion criterion was principally based on the outcomes of interest. Essentially, I took into consideration the research question and the comparability of settings, populations and the analogy of methods that were described. The search was not limited to the Ecuadorian context due to the limited number of studies about the topic in this geographical area, resulting from the initial scoping search that was undertaken. For this same reason, I did not consider the date of publication as an exclusion criterion for this literature search. The detailed inclusion and exclusion criteria are presented in table 3.

Study Considerations	Inclusion Criteria	Exclusion Criteria
<i>Population</i>	Traditional health practitioners (shamans/ healers) and patients (users, ill)	Medics and Allopathic medicine practitioners and policy makers.
<i>Setting</i>	Traditional medical systems (Folk and popular models). Fieldwork carried out within the local environments of indigenous populations.	Western medical systems (Professional models). Observations of traditional practices in western contexts, such as hospitals, PHC and other conventional health-care services.
<i>Outcomes</i>	<ul style="list-style-type: none"> - Research focused on the observation of social and cultural aspects of traditional medicine practices. - Explanation of health views and practices of Indigenous people. - Focused on the role of the practitioner. - Explanation of the sociocultural roles of traditional healers and patients. - Exploration of the relationship of traditional healers and their patients. - Comprehension of sociocultural beliefs of Indigenous people. 	<ul style="list-style-type: none"> - Ethno-botanic research and research focused on the effects and efficacy of traditional medicines. - Focused on the health outcomes of Indigenous people. - Description of the role of traditional medicine/practice within the western medical system. - Exploration of the roles of traditional healers in the allopathic health system. - Concentrating on the interaction between Indigenous and Western - Account of policy implementation and its consequences on indigenous people.
<i>Language</i>	Studies available in English and Spanish language	Studies that are not available in English or Spanish language

Table 3 *Inclusion and Exclusion Criteria*

According to Martin-McDonald & McCarthy (2008), the influence of western culture on research carried out on indigenous populations is notorious. Understanding the intricacies and comprehensiveness of Indigenous beliefs can be a challenge to more western-influenced perceptions. For this reason, the criteria I applied to select the literature that would be useful for this research excluded settings and outcomes that because the nature of the research, would observe indigenous practices within westernised frameworks. For example, studies focussing on the effects of contemporary medicine in traditional practices (Bhatia *et al.*, 1975; Wolffers, 1989) or the training of TH in primary health care - PHC (Hoff, 1992). Martin-McDonald & McCarthy's (2008) awareness of the influence and assumed superiority of western over indigenous people in their academic search, was my motivation for this approach. This is a topic of important debate, not only present in the scholarly understandings and interpretations of non-western cultures, but extending to claims that support the view that western colonisation continues (Said, 1978; Smith, 1999). Although I will address this discussion in later Chapters, the literature selected for this review considered this argument and with the purpose to acquire a proper comprehension of TM, research that was not focussed on understanding the indigenous views of health-related practices was excluded.

Study selection

After the selection of publications based on the search of key terms on the titles or abstracts, an evaluation of the contents took place. There was limited existing literature that matched the same focus of this research question. Although the search yielded a total 2,480 articles, only 50 met the inclusion criteria (see figure 7). Through diverse literature that matched the inclusion criteria, I was able to draw a clearer perspective of the health-related beliefs of different indigenous people. Thus, I evaluated the complete texts of the selected literature and 13 related articles that after reconsideration substantiated specific points for the discussion. The bibliography suggested by experts was utilised in this same way. Consequently, all the literature that discussed the practice and beliefs of TH and TM that would help draw conclusions, although presented in diverse forms, was included in this narrative review (Baumeister and Leary, 1997; Hart, 1998; Green, Johnson and Adams, 2006). A total of 21 texts were reviewed and discussed. Duplicates and unrelated contents were identified and disregarded.

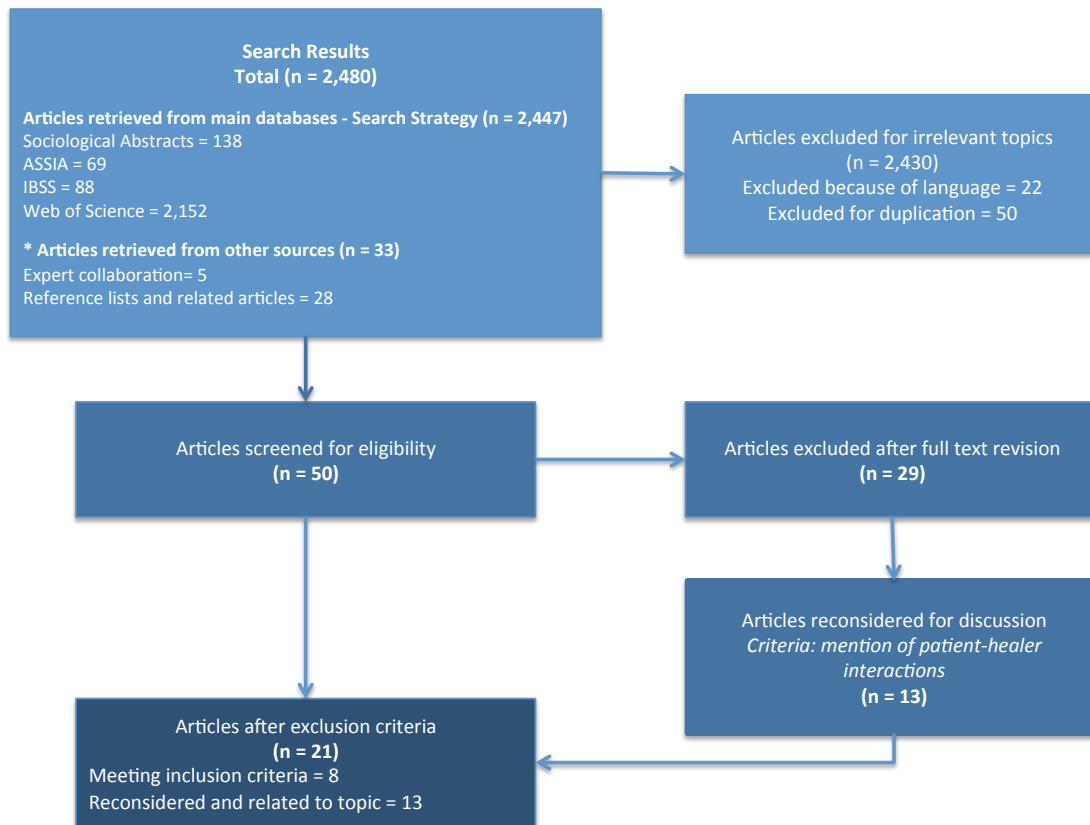


Figure 7 Literature review's search results

The unrelated topics about TM that were excluded dealt with ethno-botanical research – focused on the medical uses of plants – or with the implementation of health policies on indigenous populations. Since the aim of this review was to understand the exercise of TM and specifically, the relationship between TH and their patients, I narrowed the selection to literature that would at least refer to these processes of interaction. A detailed summary of the empirical literature – the methods used and findings for each study - is reflected on table 4. As it can be seen, the most utilised method to approach research related to TM was ethnography, which in some cases was combined with interviews, video-recordings or photography.