

### *Quality assessment*

Although most of the selected literatures correspond to qualitative research, the methods of data collection were prevalently ethnographic methods. However, from the twenty-one selected articles only seven included a detailed description of the methods. The remaining articles provided limited to no information regarding the research methods that were utilised. Considering the specificity of the topic and the limited amount of literature that could be included, no particular low quality exclusion conditions were applied. Therefore, I have considered the reporting of the methods as a standard for quality assessment (Carroll, Booth and Cooper, 2011). I have specified the methods in table 5. Moreover, considering that *“research can be relevant when it either adds to knowledge or increases the confidence with which existing knowledge is regarded”* (Mays, 2000 pg. 52), the literature that was included held significant relevance to the topic and scheme of this research.

Table 5 Quality assessment

| Reference                   | Indication of Methods in the text             | Quality              |                   |                           |
|-----------------------------|---|----------------------|-------------------|---------------------------|
|                             |   | Detailed description | Mentioned in text | No description of methods |
| Berger-González et al. 2016 | Ethnographic fieldwork and interviews         | X                    |                   |                           |
| Pinkoane et al. 2005        | Video-recordings and semi-structured          | X                    |                   |                           |
| Maiello 2008                | N/A   |                      |                   | X                         |
| Lambert 1997                | Ethnographic fieldwork                        |                      | X                 |                           |
| Massé 2002                  | Fieldwork (no further details of the methods) |                      |                   | X                         |
| Thornton 2015               | Ethnographic fieldwork                        |                      | X                 |                           |
| Waldram 2015                | Video recordings and interviews               | X                    |                   |                           |
| Capps 2011                  | Participant observation,                      | X                    |                   |                           |
| *Greenway 1998              | Formal and informal interviews                |                      | X                 |                           |
| *Westermeyer 1988           | Ethnographic field-notes and interviews       | X                    |                   |                           |
| *Cardona-Arias 2012         | Participant observation, field                | X                    |                   |                           |
| *Maher 1999                 | Review of literature                          |                      | X                 |                           |
| *Reeve 2000                 | Interviews                                    |                      | X                 |                           |
| *Risenga et al. 2007        | Focus groups and Interviews                   | X                    |                   |                           |
| *White 2015                 | N/A   |                      |                   | X                         |
| *Turner 1989                | Participant observation and field             |                      | X                 |                           |
| *Yanez del Pozo 2005        | Review of literature                          |                      |                   | X                         |
| *Naranjo 2010               | N/A   |                      |                   | X                         |
| *Valencia 2010              | N/A   |                      |                   | X                         |
| *Mideros 2010               | N/A   |                      |                   | X                         |
| *Jacome 2010                | N/A   |                      |                   | X                         |

\* Literature not focused on the patient-healer relationship, but reconsidered for discussion

## Findings

The literature I used for analysis described TM practices from different Indigenous populations and from various parts of the world. However, as Levers (2006) asserts, “*indigenous healing seem to have much more in common with one another than any one of them has in common with the biomedical paradigm*” (pg. 482). The findings of this literature review reveal the common themes that were identified from the readings. The findings were organised by subjects and are presented as seven main themes from where I will describe and discuss the understandings about Indigenous beliefs and healing practices. Recognising the indigenous concepts of health required the consideration of the contextual background from where the principles of TM come from. For this reason, I firstly introduced a general observation related to the influence of western beliefs on

indigenous cultures that was found throughout the literature. Moreover, the Indigenous conception of health defies most of the rules by which the *western* medical system functions. In this regard, the first three themes are initially presented to contextualise the concepts of indigenous health. I argue that these themes are integral characteristics of indigenous health and TM practices. The narration of findings will evolve into the description of the health-related concepts and the relationships in TM.

### The Christianisation of the spirits

Many indigenous cultures around the world went through different processes of adaptation during the conquest and colonisation periods over many centuries, particularly from European countries. The influence of western beliefs in indigenous cultures that was noticeable in the literature, was frequently revealed through adaptations of Christian religious notions, especially in the American continent (Turner, 1989; Massé, 2002; Waldram, 2015; Berger-González *et al.*, 2016a), though not limited to this part of the world. Several indigenous practices and health-related beliefs emerging from the literature, expressed strong semantic correspondences to the Catholic religion. For instance, some Andean cultures referred to “mal aire” (the exact translation in English is “bad air/wind”) as the spirit of a person that had an unrighteous life or that was not *baptised*; congruently, someone exposed to “bad air” was likely to be detrimentally affected (Yanez del Pozo, 2005). The term “mal aire” was originated in Europe and actually, prompted the nomenclature of the infection we now know as “malaria”. The involvement of religious missionaries in the colonisation process had assiduous intentions, but also had a significant influence on some of the indigenous health-related beliefs. The influence of missionaries on Inupiaq medicine for example, was rationalized by Turner (1989) to the extent that a distinction was made between the before and after the arrival of religious preachers to Alaska. Turner’s (1989) study regards that the possibility to redeem Inupiaq Eskimo culture, depended on maintaining good relations with the church. Not only in Alaska was the introduction of western religious dogmas influential; even the Waoranis, which are the most isolated indigenous community in Ecuador, went through processes of intended conversion to Christianity (High, 2016). Considering the discussion in the previous chapter, I argue the persuasive interest of religious missions in the education and health-care of remote populations, to have an effect on traditional beliefs.

## I. The Animistic and Holistic Cosmos

As I immersed myself in the narratives of indigenous health, I began to distinguish the limitations of my own westernised perspectives. The title of this first theme refers to the distinct way that most indigenous cultures perceived the world around them. The impressions of animal sacrifice, spirit possession and witchery were in most cases, no more than the incomplete understanding of such practices. For many indigenous cultures, *animism* is a natural principle of the universe (Westermeyer, 1988; Yanez del Pozo, 2005; Naranjo, 2010; Capps, 2011; Cardona-Arias, 2012; Berger-González *et al.*, 2016a). *Animism* implies that everything in nature has spirit, which means that life exists in everything and therefore, as how indigenous peoples from the Andes understand, life can never cease (Yanez del Pozo, 2005). As revealed through the study of aboriginal people in the Peruvian Andes, the human body is the manifestation of a universal liveliness that extends to objects and locations in nature and transcends the material realm in spiritual forms (Greenway, 1998). Although not all Indigenous cultures are the same, this idea of life related to the *holistic* understanding of the cosmos, which translated to the concepts of health and illness, sensitises all health-related practices (Turner, 1989; Maher, 1999; Cardona-Arias, 2012; Waldram, 2015; White, 2015). The characteristic of being interconnected that the concept of *holistic* presents, was identified in the principles of Q'eqchi Mayas in Belize, where the unifying force epitomised by the Q'eqchi god was the essence of the Q'eqchi people (Waldram, 2015). The awareness of the animistic feature of all things (living and non-living as western sense would deliberate) set the foundation of relationships in the world of indigenous people.

Although relationships were a crucial aspect in indigenous understandings, I acknowledge that indigenous people witnessed relationships differently from western conceptions. Firstly, I will articulate the strong relationship with nature that was evident throughout the literature. The interaction with animals and plants was distinctive of many Indigenous cultures. An instance of this was seen in the beliefs of Hmong Americans in Milwaukee, who considered that the characteristics in humans and animals were so alike, that a spirit could incarnate either one (Capps, 2011); Likewise, I identified a similar observation in the literature describing the Mayas in Guatemala (Berger-González *et al.*, 2016a). The involvement of animals was observable in descriptions of the treatments of health; regularly in the depiction of sacrifices, but also captured by Greenway (1998) in the way animals reacted during the healing rituals of Quechua indigenous in the south of Peru. Following this understanding, I found the relatedness to nature to be further observed throughout natural settings. Mountains, rivers and waterfalls were commonly considered sources of spiritual

energy and thus, sacred locations (Westermeyer, 1988; Maher, 1999; Yanez del Pozo, 2005; Valencia, 2010; White, 2015). Greenway (1998) described how the *“the medicines in the Andean context often run through the veins of the earth, not through the patient”* (pg. 149). Andean indigenous customarily viewed this universal force as a neutral energy that could enliven but also destroy (Greenway, 1998) and when the relationship with nature was poor, the appearance of disease was predictable (Yanez del Pozo, 2005). Consistently, I found that the health practices of Q’eqchi Mayas (Waldram, 2015) and TH in Ghana (White, 2015) also acknowledged the power of spiritual sites to be a source of illness.

As with nature, the literature also described how relationships within the community were essential to the existence of Indigenous people. The community often had a significant role in the life of the individual, their wellbeing and hence, the healing practices (Maher, 1999; Pinkoane, Greeff and Williams, 2005; Waldram, 2015). In fact, the Mayan healing process was considered a public business, where witnessing according to Waldram (2015), was crucial. Likewise, in the depiction of Sangoma’s healing, Thornton (2015) explained that the healing practice – or as he referred to as *“the magic”* – required the occurrence of the practitioner, the patient and an audience, which was also potentially the TH’s clientele. Frequently, the episodes of illness resembled symbolic meanings where the community was implicated with the deciphering processes (Yanez del Pozo, 2005). Moreover, for the Andean (Greenway, 1998; Yanez del Pozo, 2005), the Gadé in the French and English Caribbean (Massé, 2002) and the Hmong American indigenous (Capps, 2011), the family was usually the first diagnostic instance. In Sangoma’s culture for instance, since the individual was not detached from her family and communal relations, it was not uncommon that family members attended therapeutic consultations without the patient (Maiello, 2008a). Sometimes in active and other times in assistive ways, the participation of family members was actually expected in the healing processes of Alaskan Inupiaq (Turner, 1989), Q’eqchi Mayas (Waldram, 2015) and Andean indigenous (Greenway, 1998). Since the person was considered the product of her relationships, the Q’eqchi TH was even described as a healer of relationships instead of bodies (Waldram, 2015). In general, most Indigenous conceived the human experience in parallel with the ever-changing universe, its elements and networks. I consider this to be meaningful in explaining the difficulty that western medicine has had in comprehending the complexities of the *“indigenous body”* and experiences of illness.

## II. The Spirit World

Expanding on the animistic nature of all things, I also recognised the continuance of life after death to be common amongst diverse indigenous cultures described in the literature. The linkage with ancestor souls was a vital component in the lives of many Indigenous people (Westermeyer, 1988; Turner, 1989; Maher, 1999; Pinkoane, Greeff and Williams, 2005; Maiello, 2008a; Jacome, 2010; Thornton, 2015; Waldram, 2015; White, 2015). I found the distinction between the physical and spiritual realms not so demarcated in indigenous cultures, as it is generally in western viewpoints. In fact, various indigenous cultures viewed the person as being composed of corporeal and immaterial, and the connectedness between both aspects was reflective of good health (Westermeyer, 1988; Yanez del Pozo, 2005; Maiello, 2008a; Jacome, 2010; White, 2015). For example, in Andean (Greenway, 1998; Yanez del Pozo, 2005) and Hmong American cultures (Capps, 2011), there was the credence that the body had multiple souls and the loss of a soul was associated to illness. In this sense, indigenous populations were exposed to a wider range of ailments and determinants that are not usually foreseen in conventional medicine (Thornton, 2015). Although non-physicality is not something that normally concerns western practices, to an indigenous person, not considering its soul features would be comparable to not recognising any other organ or body part. In essence, a person with a lost soul was not only sick, but also less of a person; in Andean cultures, a person with a lost soul was considered nonhuman and consequently, behaved in non-human manners that were not resonant with society (Greenway, 1998).

In my reading of the literature, spirits were described as present in both the aetiology and treatment of disease (Yanez del Pozo, 2005; Naranjo, 2010; Cardona-Arias, 2012). According to Waldram (2015) and Maiello (2008b), the interaction with spirits and energies was far more important than the verbal exchange in the healer-patient relationship. In Q'eqchi Mayan healing, THs did not cure through words, but through energy (Waldram, 2015). Occasionally, the godly power or spiritual knowledge outperformed the ability of the TH in ways that the TH could not quite understand (Thornton, 2015). Cultures such as the Inupiat Eskimos (Turner, 1989), Rajasthani people in India (Lambert, 1997), Hmong Americans (Capps, 2011), Sangoma's in South Africa (Thornton, 2015) and Andean indigenous (Naranjo, 2010), all viewed the skill of the healer and the performance of traditional healing as a cooperating interaction with spirits. In this sense, I understand the healer-patient relationship to be deeply influenced by the spirit world, since in the process of healing there must be a progressive interaction of both the TH and the patient with the spirits and ancestor souls.

### III. The Concept of Balance and Harmony

Compatible with the reasoning that a being was composed of the physical and non-physical and as an expression of a dynamic universal energy, the concept of balance is developed. Of note is that in the identified literature, the terms 'harmony' and 'balance' were recurring words utilised in different studies about indigenous health. The Indigenous narratives revealed how components of the universe were made up of dualities and how they naturally embraced a harmonious coexistence. This was evident to me in the literatures related to Andean (Greenway, 1998; Yanez del Pozo, 2005; Jacome, 2010; Valencia, 2010), Mayan (Waldram, 2015; Berger-González *et al.*, 2016a), Sangoma (Thornton, 2015), and Rajasthani cultures (Lambert, 1997). Likewise, many authors remarked the value that indigenous cultures gave to the maintenance of a balanced and harmonious body and world (Westermeyer, 1988; Greenway, 1998; Yanez del Pozo, 2005; Maiello, 2008a; Waldram, 2015; White, 2015). Although balance was not the only aspect in the maintenance of health, I found it associated to individual and collective wellbeing, as much as to the incidence of disease (Yanez del Pozo, 2005; Waldram, 2015). From my analysis, the interference of balance in earth resulted in what was perceived as natural disasters and illness.

The concurrence of contrasts in everything - equivalent to the positive and negative charges in every atom - underlay the concept of balance. As Thornton (2015) observed, the forces that “[heal] *and harm work in the same way [but] to different effect*” (pg. 357). To some indigenous, destruction was part of creation, thus, the TH embodied both positive and negative energies and through control of this process she was able to restore balance (Turner, 1989; Greenway, 1998). I realised this logic explains why Andean (Yanez del Pozo, 2005), Mayan (Waldram, 2015), Sangoma (Maiello, 2008a; Thornton, 2015) and Creole Caribbean cultures (Massé, 2002), acknowledged the power of witchcraft and accepted it as an ordinary cause of disease. Since, the taboo around witchcraft and sorcery could raise many concerns and debates, before discussing the topic of witchcraft, I will present less contested polarities in indigenous health-related beliefs.

#### *The complementary dualisms*

Yanez del Pozo (2005) described three macro dichotomies in Andean indigenous health-related beliefs: the contrast of “High and Low”, “Hot and Cold” and the “Feminine and Masculine”.

However, I also identified comparable dualisms related to health across other indigenous cultures. I will firstly discuss the duality of “High and Low”, followed by the notions of “hot and cold” and finally, the distinctions between “feminine and masculine”. The duality of “High and Low” was related to the perception that there was a physical sphere and a higher ethereal dimension. As I recognised in the literature, the allocation of spatial dimensions also extended to parallelisms throughout the human body. To explain this notion, some indigenous cultures perceived the human body as divided from the navel to an upper and lower body; from these two dimensions of the body, energy and disease could flow (Lambert, 1997; Yanez del Pozo, 2005). For instance, TM in India determined the type of illness and treatment by the way the sickness flowed through the body, it could move from upper to lower body or contrariwise (Lambert, 1997). In Andean TM this duality manifested in the individual’s body as contrasts between each intake orifice and a matching releasing output; for instance: mouth and anus, nerves and sexual organs, and the breathing system with the urinary tracks (Yanez del Pozo, 2005). The second dichotomy was between the “Hot and Cold” that was believed to have parallelism in foods, medicines and environments; and thus, these elements were used under this logic to restore balance in the person’s body (Lambert, 1997; Reeve, 2000; Yanez del Pozo, 2005). The third great dualism was the dyadic existence of feminine and masculine qualities. Many indigenous cultures in Australia (Maher, 1999) and throughout the Americas (Yanez del Pozo, 2005; Naranjo, 2010), were reported to have the male and female characteristics and roles noticeably defined. In Andean cultures male and female aspects were present and entwined in every form; every man was both male and female, as well as every woman was female and male (Yanez del Pozo, 2005). This view not only affected the way indigenous people perceived sexual relations and sexual health, but the maintenance of good health also depended on balances in sexual activity (Yanez del Pozo, 2005; Mideros, 2010). Notwithstanding the dichotomies presented, dualisms were visible in terms of general contrasts between things. Representational elements of them were present in Quechua indigenous’ healing practices (Greenway, 1998). In this sense, the human body was healthy when balance was maintained among the dualities of the body, the interactions between them, and a balanced relationship with the universe and all of its parts (Greenway, 1998; Yanez del Pozo, 2005; Maiello, 2008a; Mideros, 2010; Cardona-Arias, 2012; Waldram, 2015; Berger-González *et al.*, 2016a). In this awareness, many indigenous’ descriptions presented a dynamic interplay between health and sickness in the search of universal equipoise.



#### IV. Versions of Health and Illness

Consistent with what I have previously described from this literature, the human body was composed of complementary elements. Predominantly, there was the merged synchronicity of the physical and energetic body (Westermeyer, 1988; Yanez del Pozo, 2005; Capps, 2011). Although types of souls were commonly described amongst indigenous views, I could only identify hierarchical elements in the descriptions of the Embera-Chami indigenous in Colombia (Cardona-Arias, 2012). Divergent from the notions of harmonised connectedness, the ranking of elements was something that was not prominent in other literatures.

##### *The “Indigenous” human body*

In relation to the notions of balance and dualities that I have presented, for some cultures the balanced body had equal distributions of dualities. For instance, in Andean cultures, while soft organs were considered to be feminine, hard tissues were considered masculine; in consequence, the body’s consistence was made of both (Valencia, 2010). Likewise, the head was analogous to the male aspects and logic, as the heart was to the female and emotion (Yanez del Pozo, 2005; Valencia, 2010). One important distinction to western thought was that to an Andean indigenous, rationality was achieved when both aspects were consciously merged: rational thinking was reliant on memory and memory was linked to emotions (Yanez del Pozo, 2005). Furthermore, symbolic manifestations of the universe were seen throughout the corporeal fluids and body parts (Yanez del Pozo, 2005; Valencia, 2010). For example, according to Andean Indigenous views, the body was divided in three sections representing the cosmos: the head was a representation of the celestial domain, the trunk of the mundane, and the abdomen and pelvis of the underworld (Yanez del Pozo, 2005). Similarly, blood represented life, fat denoted energy, and the skin exemplified the perception of reality (Valencia, 2010). The correspondence between earth and body was particularly recognised in South American indigenous cultures (Reeve, 2000; Yanez del Pozo, 2005; Valencia, 2010). Thus, the equilibrium in the body held greater complexity as it resembled the functions of their universal counterparts.

##### *The meaning of health*

The meaning of health for many indigenous cultures showed a greater comprehensiveness and

optimism (Lambert, 1997; Yanez del Pozo, 2005; Jacome, 2010; Valencia, 2010; Cardona-Arias, 2012), than the western understanding of it. Health meant being good with the self and with the environment and in fact, the word for health in Quechua – the Andean native’s language - is “Allikai” that meant wellbeing (Yanez del Pozo, 2005). Generally, health was a result of wholesome relationships with the self, the family, the community, the environment, the cosmos and the spirit world (Westermeyer, 1988; Lambert, 1997; Yanez del Pozo, 2005; Maiello, 2008a; Valencia, 2010; Cardona-Arias, 2012; Thornton, 2015; White, 2015; Berger-González *et al.*, 2016a). However, the uniqueness of every combination of interactions was what made every patient different from the other. According to Thornton (2015), this underlies the discrepancies between traditional and conventional medicine. TM sees everything holistically, but treats the patient specifically; while conventional medicine is indifferent to the particularities, as it sees the person like a random example of a specific biological condition or population (Thornton, 2015). Although there have been recent attempts in conventional medicine to focus on the individual, the approaches were mainly in the area of pharmacogenetics rather than the holistic and psychosocial aspects of the person. The specialisms of biomedical systems focussed treatments on the expertise of maladies; hence, the patient may require health-care from numerous specialists. In contrast, traditional systems focussed less on the illness and more on ways to restore equilibrium to the patient’s life. Consequently, a common aspect I identified in the literature about indigenous health and healing was the relationships within the individual (Maiello, 2008a; Thornton, 2015), which in many cases were restored in order to regenerate health in the patient (Maher, 1999; Yanez del Pozo, 2005; Maiello, 2008a; Capps, 2011; Cardona-Arias, 2012). Furthermore, Lambert (1997) complements, that in such, a healed person was restored to her society. Proportionately, the rebound of an individual to society balanced the environment.

### *The meaning of illness*

Alternatively, in many of the works I reviewed the concept of illness was described as an external factor that could be removed from the body (Turner, 1989; Lambert, 1997; Yanez del Pozo, 2005; Naranjo, 2010). I identified similar terminologies for illness in different cultures and for instance, “soul loss” and “evil eye” were described in literature relating to very geographically distinct cultures such as Hindu (Lambert, 1997) and Andean TM (Greenway, 1998; Yanez del Pozo, 2005). The loss of soul happened when a person had been shocked by an exposure to negative energies and in that frighten state, the soul left the body (Lambert, 1997; Greenway, 1998; Yanez del Pozo, 2005). Likewise, the occurrence of bad energies from people or spirits, were referred to as “evil eye”

(Lambert, 1997; Yanez del Pozo, 2005). In Rajasthani society, maladies were also seen as temporary, where treatments were not focused on eradicating the disease, but on allowing the malady to flow out of the body with minimal pain (Lambert, 1997). Moreover, when the malady moved in a natural flow (from head to feet) the person naturally healed, but when it moved in opposite direction it required the TH's intervention (Lambert, 1997). The outward property of sickness, exemplified the earthly representation of impurities and in doing so, deliberated the notion of the body as a pure form (Turner, 1989; Lambert, 1997; Yanez del Pozo, 2005).

Although the aetiology in Andean medicine has been organised into three types, namely of earth, god and human origin (Yanez del Pozo, 2005), I noticed that many other cultural definitions of illness could also follow this logic. Firstly, the "earthly" diseases that were those caused by imbalances in the individual or by disruptions in the relationships within the environment (Yanez del Pozo, 2005). Examples of this type of ailments were described as related with spiritual, human and environmental interactions - such as temperature changes - in the accounts of: South African cultures (Pinkoane, Greeff and Williams, 2005; Risenga, Botha and Tjallinks, 2007; Maiello, 2008a; Thornton, 2015), Rajasthani people in India (Lambert, 1997), Hmong populations in America and Southeast Asia (Westermeyer, 1988; Capps, 2011), Mayan (Waldram, 2015), Caboclo (Reeve, 2000) and Embera-Chami populations in Latin America (Cardona-Arias, 2012), the Creole Caribbean people (Massé, 2002) and in the literature of Aborigine Australians (Maher, 1999). Secondly, there were those ailments considered of "god" and it referred to illnesses caused by trespassing cultural boundaries (Yanez del Pozo, 2005). In Andean cultures, for instance, the inexplicable manifestation of communicable diseases was perceived as a punishment from god in relation to the consequences of the colonial memoir (Yanez del Pozo, 2005). The ascription of certain diseases to the insertion of the western culture was also observed in Australian aborigines (Maher, 1999). However, these types of diseases were not restricted to relations with western culture; indigenous people in Peru (Greenway, 1998) and in Ghana (White, 2015) referred them to a loss of identity resulting from the adoption of manners foreign to their own cultures. Similarly, in South Africa sorcery was credited to foreign THs, in evidence of the cultural confrontations that marked its history (Thornton, 2015). The third aetiological group conferred illnesses to "human" causes and they differentiated from the ailments triggered by human relationships, in the sense that they were stirred by "sorcery" (Yanez del Pozo, 2005). Although it was considered a different type of aetiology, it held a relational aspect rooted in the motives of a person to conjure over another.

### *The good against evil*

In relation to the aforementioned three areas of illness construction, there was a more normative account of the “human” aetiology of illnesses, as being caused by “evil”. The taboo around witchcraft and sorcery can be attributed to the “evil” depiction of those practices. Although witchcraft is a combination of words deriving from old English, the ambiguous use of the term was interesting when it came to health. The arbitrary use of “witchcraft” and “pharmakeia” in different versions of the Bible did not only set the basis to promote witch-hunting, but it also disoriented the following descriptions of curative practices that differed from the customary medicines based on orthodox religious beliefs, as they were known at the time. Along with “balance” and “harmony”, “sorcery” and “witchcraft” were very common expressions when recounting indigenous health practices among the literatures I reviewed (Westermeyer, 1988; Maher, 1999; Massé, 2002; Yanez del Pozo, 2005; Maiello, 2008a; Capps, 2011; Thornton, 2015; Waldram, 2015; White, 2015). As I mentioned earlier, many indigenous cultures recognised “sorcery” as a cause of illness (Westermeyer, 1988; Maher, 1999; Massé, 2002; Yanez del Pozo, 2005; Maiello, 2008a; Capps, 2011; Thornton, 2015; Waldram, 2015; White, 2015); however, the associated “evil” in the descriptions was questionable. While western conventional medicine endures the fight against the evilness of disease, TM focused on sustaining a balance.

Witchcraft was described as a “work” enacted over another, which in consequence withheld the ailing’s liability and positioned her in a role of victim (Massé, 2002; Thornton, 2015). In contrast, many more authors emphasised the conscious responsibility that the indigenous patient had over her own health and care (Westermeyer, 1988; Maher, 1999; Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005; Cardona-Arias, 2012; Berger-González *et al.*, 2016a). Andean indigenous people understand that a person in a state of balance was not susceptible to any affection, including maladies directed through conjuring (Yanez del Pozo, 2005). Although the person’s vulnerability was greater when exposed to “magic” and “mystical” causes (Thornton, 2015), the personal relations with spirits and others (who may conjure an illness) fell back on the individual’s undertakings. Contending the conflict between good and evil, Indigenous cultures seemed less resistant to the notion of “evilness” because they seemed to understand it in a different way.

### *The death experience*

Expanding the definition I introduced in Chapter Two, TM perceived wellbeing as part of a wholesome life, of which death is just another part (Thornton, 2015). Comparing indigenous and western beliefs, the comprehensiveness of western health-care was quite narrow. Arguably, the ceaseless quality of the soul in TM complicated the management of illness. Unlike the lifesaving ventures of conventional medicine that are fuelled by the perception of life ending at the moment of death, the indigenous notion of life was exempted from the need of being saved. Generally, life was understood as a set of relationships that remained after death; either through the interaction with ancestors or by reincarnation (Yanez del Pozo, 2005; Risenga, Botha and Tjallinks, 2007; Maiello, 2008a; Capps, 2011; Thornton, 2015). Furthermore, the notion of reincarnation held other implications related to health-care. For example, in Hmong (Capps, 2011) and Andean cultures (Yanez del Pozo, 2005; Valencia, 2010), since a soul reincarnated a body as long as the body was well preserved (including different species), the risk of damage by surgical procedures triggered resistance from indigenous people to these type of techniques. Likewise, the opportunity of a soul to continue its re-embodiment required a set of conditions, such as soil contiguity, which conflicted with the prospect of dying in a hospital bed (Valencia, 2010). Evidently, the indigenous patient had a different deathbed experience, which is frequently unrecognised when attempted by western doctors with the certification of the person's death.

### **V. Indigenous' healing practices**

The emphasis on balance explained the commitment of TM to overlook disease. Unlike western medicine, TM was not so concerned with the details that have caused the illness; instead, the therapies focussed solely on the desired result (Lambert, 1997; Maher, 1999; Yanez del Pozo, 2005; Waldram, 2015). For instance, in Mayan (Berger-González *et al.*, 2016a) and Andean cultures (Yanez del Pozo, 2005), the patient's natural state was always one of wellbeing and illness was only an interruption caused by disharmony in her relationships. Therefore, the selection of therapies for her recovery were not dependent on the conditions of her illness - as it would happen in western health-systems – but on the conditions in her relationships (Yanez del Pozo, 2005; Berger-González *et al.*, 2016a). Other narratives interpreted the healing ritual as a process of conversion, either as a transformation from one state to another or as the transference of energies between bodies (Turner, 1989; Lambert, 1997). While western medicine is based on the transference of verbal information, both for the purpose of diagnosis and care; from my readings of the literature,

indigenous therapies limited the word exchange to procure permission from the patient (Waldram, 2015). Thereafter, the therapeutic consultation became an intercessional restoration of energy, where the patient was mostly allowing - in faith - things she did not necessarily understand or question (Massé, 2002; Waldram, 2015). For example, in Waldram's (2015) account of the treatments as they were explained by Queqchi TH, he narrates:

*"One said: 'I ask God and the blood jumps' when you call the correct name of the sickness during the prayer. If he mentions a river, for instance, and the 'blood jumps,' then he knows he is dealing with a fright-related problem. [Additionally], the healers also see little need to explain their treatment procedures to patients or family members. 'No, it is not necessary,' explains the healer. 'It is us that prepare the treatments.' 'They are not really told,' adds another" (pg. 283).*

Moreover, the success of the therapy depended largely on the trust and acceptance of the patient (Massé, 2002; Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005; Cardona-Arias, 2012; Thornton, 2015; Waldram, 2015; Berger-González *et al.*, 2016a). Nonetheless, comparable to conventional medical systems, TM also embraced both curative and preventive treatments of health (Lambert, 1997; Greenway, 1998). While the literature described various treatments, I identified a common pattern of differentiation between diagnostic and therapeutic care.

### *Rituals of divination*

Diagnostic processes in TM have received the most attention from western interest because of the use of hallucinogens to determine the nature of ailments. However, attention has mainly focused on the active constituents of the psychedelic methods used (Naranjo, 2010). For example, the ayahuasca root that was better known as the "cable of the soul" to Andean Indigenous people, was appreciated as an aid that allowed communication with the spirits (Yanez del Pozo, 2005; Naranjo, 2010). Different cultures, depending on their environmental localities, used different plants or combinations of their active ingredients to reach the same enlightened state. For instance, while ayahuasca was used along the cultures in the Amazonia, the "San Pedro" cactus and coca plant were used by peoples in the Andes (Greenway, 1998; Yanez del Pozo, 2005). Nevertheless, in the identified literature, the use of these plants was never recreational; customarily, they were part of a ritual (Naranjo, 2010) and in most cases only used by the TH (Yanez del Pozo, 2005).

In spite of the emphasis, hallucinogenic insight was not the only way by which TH diagnosed health conditions. Based on the believed animistic feature of nature and the parallelisms with the human body, I found that elements, animals and vegetation were also common instruments for diagnosis in the literature. Diagnostic methods that resembled parallelisms with the universe were seen across Andean (Greenway, 1998; Yanez del Pozo, 2005), Mayan (Waldram, 2015), South African (Pinkoane, Greeff and Williams, 2005; Risenga, Botha and Tjallinks, 2007; Maiello, 2008a; Thornton, 2015), Hmong, Lao (Westermeyer, 1988) and Ghana's TM (White, 2015). The diagnostic practise in TM was crucial (Thornton, 2015). Nonetheless, in some cultures the TH's contribution was essentially confirmatory after the first familial diagnosis (Reeve, 2000; Massé, 2002; Yanez del Pozo, 2005). Though not all the authors acknowledged the afore-wisdom in the diagnostic deeds of the family (Massé, 2002), others recognised that there was always a basic level of health-care knowledge within the indigenous' household (Reeve, 2000; Yanez del Pozo, 2005).

The TH's diagnostic ritual has often been described as a divinatory process (Westermeyer, 1988; Greenway, 1998; Pinkoane, Greeff and Williams, 2005; Maiello, 2008a; Thornton, 2015; White, 2015). However, although the description can be attributed to the triviality of conversational material (Thornton, 2015), I consider that this was also related to the resembling energies of natural elements rooted in the animistic worldviews. Excepting the analysis of human fluids such as urine and pulsing, where the TH determined the malady through the oscillation of the patient's bloodstream (Greenway, 1998; Waldram, 2015), diagnostic techniques relied on the use of animals, elements and plants. For example, one common method in Africa was the throwing of animal bones, which through the arranged settlement of the bones the TH was able to recognise the cause and breakages of the patient's health (Thornton, 2015; White, 2015). Alternatively, Andean cultures detected sicknesses by rubbing a guinea pig against the patient and later analysing the animal's body; the animal's vibratory sympathy with the human body recreated the condition of the patient (Yanez del Pozo, 2005). Similar procedures involved the handling of eggs, candles, tobacco or the combination of different elements (Greenway, 1998; Yanez del Pozo, 2005; Berger-González *et al.*, 2016a). Some diagnostic rituals reconstructed through different objects the vital state of the patient (Greenway, 1998), sometimes not even requiring the patient's presence (Pinkoane, Greeff and Williams, 2005; Maiello, 2008a; Capps, 2011).

## *Magic treatments*

Similar to the diagnostic practices, I found the literature described that symbolic parallelisms were also involved in therapeutic processes. In Andean healing rituals, objects not only symbolised, but actually became the patient (Greenway, 1998; Yanez del Pozo, 2005). Other instance of this symbolic transference was seen in the animal sacrifices of Hmong cultures, where the spirit of the animal was given in exchange for the person's soul (Capps, 2011). Consequently, the patient's malady could be transferred to the object, which was later discharged or given back to nature (Lambert, 1997; Greenway, 1998; Yanez del Pozo, 2005). Offerings were usually godly requests and therefore, there was careful consideration of the time and place where the rituals were carried out (Greenway, 1998; Yanez del Pozo, 2005; White, 2015). Furthermore, since illness was seen as an external factor, the act of healing was generally seen as a practice of extraction (Turner, 1989; Lambert, 1997; Yanez del Pozo, 2005; Naranjo, 2010). Accordingly, Ayurvedic (Lambert, 1997), Andean (Yanez del Pozo, 2005; Naranjo, 2010; Cardona-Arias, 2012) and TM in Ghana (White, 2015) used healing methods that focussed on the imagines of cleanliness and the removal of maladies. Because the body was considered healthy when it was clean from impurities, Sangomas' treatments were even applied for the removal of pharmaceutical residues (Thornton, 2015). Another important characteristic often shared among different traditional healing practices, was the TH's use of her hands (Turner, 1989; Capps, 2011; Waldram, 2015). Turner (1989) described her experience in learning the Inupiaq healing crafts, as follows:

*"The sense perception of the fingers exists, and there is a knowledge, a certain awareness in the human consciousness of a link between oneself and the sufferer empowered by a kind of rushing of one's own consciousness into that of the other, very like 'love' or 'sympathy' but following a palpable path, through the fingers' understanding." (pg. 19)*

Furthermore, the TH was cautious with the ritualised handlings in the transference of energies - directly with her hands or through objects - to avoid harm to her own health (Turner, 1989; Greenway, 1998; Yanez del Pozo, 2005).

Greenway (1998) described two types of therapeutic rituals in Andean medicine: the "healing despachos" that were used to restore health and the "payment despachos", which were protective rituals used to maintain health. Since the ritual represented the person, healing rituals recreated an imbalanced ambiance to restore, while preventive rituals assembled balance from the beginning



(Greenway, 1998). Personal care for the body played an important part in the maintenance of health; however, in contrast to western practices, health-care was not only reflected within the individual's body (Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005). For example, Andean people could identify if an individual was taking care of her body not only by what she ate, but also by the way she treated her environmental surroundings (Yanez del Pozo, 2005). Other preventive measures among Andean (Greenway, 1998; Yanez del Pozo, 2005) and African TM (Pinkoane, Greeff and Williams, 2005; White, 2015), included different forms of rituals and charms, to impede the affection of undesirable energies. Nevertheless, both curing and preventive procedures operated outside the patient's body (Greenway, 1998; Pinkoane, Greeff and Williams, 2005). The follow up consultations for both types of treatments were essentially associated with the provision of medicinal herbs, either for the renewal of dosages or for clarification of their use (Westermeyer, 1988; Pinkoane, Greeff and Williams, 2005; Waldram, 2015). Nonetheless, from the literature I reviewed, there were usually follow-ups to the treatment (Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005), either in review of progress or until there was a confirmation of healing or balance in the person's life.

## **VI. The Power of the Healer**

A further emerging theme I identified in literature was that THs held an overpowering and profound wisdom that transcended the expertise of medicine. The holistic nature of indigenous health required THs to have the ability to surpass the boundaries of physicality. Though primarily, age and experience explained the TH's knowledge (Westermeyer, 1988; Yanez del Pozo, 2005; Maiello, 2008a; Naranjo, 2010), many described the source of the TH's power to be divine (Westermeyer, 1988; Lambert, 1997; Reeve, 2000; Cardona-Arias, 2012; White, 2015). Undeniably, these observations clarified important differences between traditional and western processes.

### ***The role of Traditional Healers***

Recurrently, I found the TH depicted as the conduit between physical and spiritual worlds (Westermeyer, 1988; Yanez del Pozo, 2005; Valencia, 2010; Capps, 2011; Cardona-Arias, 2012; White, 2015). Although every person had a certain relationship with spirits and ancestors; the TH had the ability to move back and forth between ethereal realms, and interpret ancestral wisdoms (Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005; Capps, 2011). Essentially, the role of

THs was to return balance to the person, the community and the universe (Greenway, 1998; Pinkoane, Greeff and Williams, 2005). However, the TH accomplished this role in a half-conscious state, where after invoking the spirits, she allowed supernatural forces to heal through her (Lambert, 1997; Yanez del Pozo, 2005; Capps, 2011; White, 2015). Massé (2002) reasoned that the TH was uncertain of her power and thus, her power was out of her control. Likewise, Cardona-Arias (2012) remarked that in Andean medicine, the TH was the one who knew, but not the one that cured. What I found apparent in the literature was that the TH was aware and respectful of, the overbearing power of the spirits and showed no intention to control the supernatural, but instead to be other-directed. Nevertheless, TH did have an extraordinary power, in the sense that they were frequently considered people of great wisdom and exemplars of their societies (Maher, 1999; Yanez del Pozo, 2005; Naranjo, 2010).

TH were greatly trusted and respected by their communities (Westermeyer, 1988; Maher, 1999; Naranjo, 2010). Since the TH was able to embody the values of the people, she often represented the community in all external dealings (Yanez del Pozo, 2005; Capps, 2011). According to Westermeyer (1988), the relational skills of the TH was one of the sources of her trust and power. Although THs often undertook different occupations, they were commonly the society's leaders and negotiators; in political matters, as much as in relation to the spirit world (Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005; Capps, 2011). Moreover, the TH was a living memoir, with the role to protect the people and guard the culture (Yanez del Pozo, 2005; Naranjo, 2010; White, 2015). Consequently, the TH was considered an intermediate provider of historical information, stability, spiritual and social support (Maher, 1999; Pinkoane, Greeff and Williams, 2005; Naranjo, 2010; Capps, 2011; Waldram, 2015; White, 2015).

### *The traditional medical school*

In spite of the external power to heal that I have discussed, the TH had a thorough and specific process of preparation. The knowledge of THs was extensive and crucial to the people within their respective cultures. For instance, the Q'eqchi TH was a technical expert of the human body and all its cosmological corresponding forces, in physical and spirit realms (Waldram, 2015). The holistic understanding of the TH could be translated to her knowledge of plants and their powers; in fact, the TH's relationship with medicinal plants was a very important aspect of many TH's practice (Yanez del Pozo, 2005; Maiello, 2008a; Mideros, 2010; Capps, 2011). While there was no indication that the TH knew the distinctive chemical components of medicinal plants (Naranjo, 2010), the knowledge of

the curative properties, uses and effects was accurate (Westermeyer, 1988; Greenway, 1998; Capps, 2011; Cardona-Arias, 2012). The varieties of instructional processes were numerous, but fundamentally dealing with mastering the communicational skills to bridge different representations of energy: the symbolisms and ways of consciousness that allowed the TH to receive and decipher the knowledge (Maiello, 2008a; Thornton, 2015). In other words, the TH could only become a healer through the help of spirits (Yanez del Pozo, 2005; Capps, 2011). Although some notions were difficult to understand from a western perspective, I find the processes of acquiring knowledge consistent to the animistic principles and the unseen communication between people, spirits and with the environment.

Furthermore, I found the recruitment process to be frequently described as a supernatural process (Greenway, 1998). Though the path was not always recognised or even desired by the future healer, the vocation to heal was inevitable (Greenway, 1998; Maiello, 2008a; Capps, 2011). The becoming of a TH was a divinely motivated vocation that was usually followed by a prolonged period of preparation (Greenway, 1998; Yanez del Pozo, 2005; Maiello, 2008a; Capps, 2011; Thornton, 2015). The training of a TH was sometimes as the apprentice of another TH and other times on experiences of her own (Yanez del Pozo, 2005; Maiello, 2008a; Thornton, 2015). For example, Australian aborigines recognised that any person could have healing powers, though that was not what made someone a “healer” (Maher, 1999). The Hmong Americans, for example, recounted that healers were selected by the first TH, who in her nonphysical form send spirit helpers to call on others to join and become THs (Capps, 2011). The calling of Sangomas (Maiello, 2008a) and Hmong TH (Capps, 2011) could happen at any moment of the person’s life and it often happened through the experience of illness, which was only cured once the TH accepted her call. Notwithstanding, when the call was rejected, the community got involved (Maiello, 2008a). I consider this example to ratify the significance of the societal role of the TH and the importance of relationships among indigenous cultures.

### *The specialisations of traditional healers*

In the literature I found that THs were frequently categorised according to areas of expertise that distinguished complexities and types of knowledge (Westermeyer, 1988; Reeve, 2000; Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005; Cardona-Arias, 2012; Thornton, 2015). For instance, in South Africa healers were classified into three types: the Sangomas, the herbalists and the faith-healers (Thornton, 2015). Similarly, Cardona-Arias (2012) classified the TH of the Embera

Chami community in Colombia in five hierarchised groups: the “shamans”, the midwives, the faith-healers or “rezanderos”, the bone-healers or “sobanderos” and the household elders, who provided the most basic health-care. However, the approaches of categorisation and hierarchisation seemed unfitting to the cohesiveness of TM and arguably, much influenced by western understandings. Therefore, this area could benefit from further understanding and wider analysis.

Nonetheless, there were two important distinctions in the practice of TM by which abilities could be classified. The first corresponds to the differentiation made between the notions of healing and parturition, and the second to the difference between healing and sorcery. Antenatal, delivery and postnatal care were not even considered within the healing practices, for the reason that there was nothing to repair in nativity (Mideros, 2010). Although concepts such as harmony and balance also applied, the core of the practice was different in nature (Mideros, 2010) and therefore, required specialised knowledge. In a similar approach, the delineation between healing and sorcery was fixed in its core. While the ability of a TH to embody both positive and negative forces (Greenway, 1998) could be misinterpreted as an indistinguishable swiftness of healers to also be sorcerers (Massé, 2002), most cultures demarcated a clear distinction. The TH’s interaction with spirits was always in benefit of the people (Capps, 2011). The TH managed both energies with the sole purpose of maintaining and restoring balance; fundamentally, her purpose was pure (Lambert, 1997; Greenway, 1998; Yanez del Pozo, 2005). In essence, once the spiritual power was used for harm, the TH could no longer be a healer. The use of knowledge was a defining factor between healers and sorcerers; comparable to the way the west views the application of knowledge in drug making.

## **VII. The Comprehensive Relationships of Traditional Medicine**

Through this review, I have noticed how the relational aspects constitute an important part of the human experience for various indigenous cultures. In general terms, the literatures construed the being as a sum of complex interactions intended to maintain the equilibrium of the universe (Maher, 1999; Massé, 2002; Pinkoane, Greeff and Williams, 2005; Risenga, Botha and Tjallinks, 2007; Maiello, 2008a; Cardona-Arias, 2012; Waldram, 2015; Berger-González *et al.*, 2016a). Understanding the relationships of indigenous people was essential to comprehend their health and health-care systems. Actually, there were certain principles that guided the manners by which indigenous people interact with each other and the rest of the world (Yanez del Pozo, 2005; Valencia, 2010). For instance, Andean indigenous based their behaviours on four universal principles: the principles of relatedness, correspondence, complementarity and reciprocity (Yanez del Pozo, 2005). Nonetheless,

some of these principles were represented in other indigenous cultures as well. The first principle referred to the interconnection between everyone and everything, where all was relative and thus, no truth was absolute (Yanez del Pozo, 2005). Similarly, Mayan and African traditions considered relatedness and interconnectedness as fundamental elements of health-related practices (Maiello, 2008a; Berger-González *et al.*, 2016a). Secondly, the principle of correspondence that alluded to harmony in relationships (Yanez del Pozo, 2005). For example, a healthy person was able to treat the environment differently and therefore, received a corresponding response from nature (Greenway, 1998). Thirdly, was the principle of complementarity that dealt with the interaction between dichotomies (Yanez del Pozo, 2005). Lastly, the principle of reciprocity that was related to the compensatory means that counterbalanced every action and that was revealed in every therapeutic dealing (Yanez del Pozo, 2005; Capps, 2011). Reciprocity was visible in most descriptions of healer-patient relationships (Lambert, 1997; Greenway, 1998; Yanez del Pozo, 2005; Maiello, 2008a; Capps, 2011; Cardona-Arias, 2012). Accordingly, the ways reciprocity was exemplified were distinctive for each culture; while some traditions rejected the idea of payment for healing (Lambert, 1997; Pinkoane, Greeff and Williams, 2005), others rendered reciprocity through compensation, though it was usually redirected to nature and the spirits (Greenway, 1998; Cardona-Arias, 2012). Evidently, not all indigenous cultures shared the same values or guided their actions over the same principles, but the similarities were noteworthy. In spite of the differences, the values that upheld relationships were consonant to the indigenous concepts of health and wellbeing, revealing the significance of relationships in traditional systems.

### *The healer-patient relationship*

The most important relationship in a therapeutic encounter was the relationship between the TH and the patient. Nevertheless, the health-related concepts of TM unveiled a deeper understanding of this relationship. Although this literature review focussed on the healer-patient relationship, it was clear that for most indigenous cultures, this relationship was non-exclusive and the healing treatment was not limited to a two-way interaction (Greenway, 1998). As Thornton (2015) asserts, the TH can be viewed as a relationships expert. The practice of TM was a collective one, and in many cases, a cultural process that was open to society's contribution and evaluation (Massé, 2002; Waldram, 2015; Berger-González *et al.*, 2016a). The traditional healing practice represented the relationship between the TH and the community. Furthermore, as the relationship with ancestors played a fundamental part in traditional healing (Greenway, 1998; Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005; Risenga, Botha and Tjallinks, 2007; Maiello, 2008a; Capps, 2011), so did

the power or ability to heal rest with the TH's relationship with the spirit world. The relationship between the TH and patient was ultimately a junction of all relationships (Berger-González *et al.*, 2016b).

Apparent in the literature was the claim that trust and a sense of belonging were the values underlying the loyalty to traditional practices and what held the healer-patient relationship together (Greenway, 1998; Maher, 1999; Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005; Mideros, 2010; Thornton, 2015; Berger-González *et al.*, 2016a). While most accounts considered that shared worldviews were an implied reason for patients' preference for TM (Maher, 1999; Massé, 2002; Pinkoane, Greeff and Williams, 2005; Berger-González *et al.*, 2016a), Waldram (2015) recognised that TM was essentially technical and that shared worldviews, language and culture were unnecessary explanations to substantiate the practice. Nonetheless, I found the importance of the cultural context in the understanding of TM to be mostly recognised.

### *Relationships with the west*

Although there are some indigenous groups that remain secluded, there is no doubt of their awareness of the external world.<sup>1</sup> For instance, indigenous cultures such as the Waoranis in Ecuador evidenced how in spite of their deliberate isolation, had ways to maintain contact with other cultures in the region (Robarchek and Robarchek, 1998, 2005). Accordingly, Maher (1999) noticed that the medical practices of Australian aborigines were disappearing and not because of less faithfulness, but because western medicine was now easier to access. The use of both medical systems was a common reality to modern indigenous people (Greenway, 1998; Maher, 1999; Massé, 2002; Yanez del Pozo, 2005; Capps, 2011). While most of these literatures presented a TH not standing in opposition to the use of western medicine, they did recognise disparities; in fact, some considered diseases belonging specifically to western health-care (Westermeyer, 1988; Greenway, 1998; Reeve, 2000; Yanez del Pozo, 2005; Risenga, Botha and Tjallinks, 2007). Nonetheless, there was also the perception that some aspects of western medicine were not favourable; instances of this were the communicational matters in the healing interaction (Waldram, 2015) and the division concerning body and soul (Greenway, 1998). In spite of the criticisms, the stances pointed towards the need to bridge the gap between western and traditional health-care systems (Risenga, Botha and Tjallinks, 2007; Maiello, 2008a; Mideros, 2010; Naranjo, 2010; Valencia, 2010; Berger-González

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<sup>1</sup>One of the discussions in the "I Regional Summit of Ancestral, Spiritual and Intercultural Medicine", was the conservation of ancestral knowledge amongst the youth; younger indigenous generations, that are not only more exposed to western culture, but also more interested.

*et al.*, 2016a). In the midst of these observations, I found there was a broader discussion around pluralistic systems of medicine, which evidently reflected the cultural diversities (Massé, 2002; Thornton, 2015); however, they also emphasised a change in user preferences around health-care.

While the dialogues concerning pluralistic medicine developed in the discussions around indigenous medicine (Massé, 2002; Thornton, 2015), the coexistence of traditional and biomedical systems was noticeable, although not always recognised. In fact, the integration of TM was approached elusively and mainly limited to the area of psychology (Westermeyer, 1988; Maiello, 2008a; Capps, 2011; Waldram, 2015). The hesitant inclusion of indigenous practices was mostly based upon claims that there was a lack of evidence (Cardona-Arias, 2012; Thornton, 2015). Furthermore, Thornton (2015) expands the debate by recognising that although conventional medicine is mostly effective, it is not always and not for everyone, just as TM are. The effectiveness of medical systems depends on judging principles, which need to be understood in awareness that health practices were produced in the context of distinctive socio-cultural values (Lambert, 1997). Additionally, the witchlike depiction of TM continues to stigmatise indigenous practices and it becomes a problem in the attempt to understand other cultures. While the integration of both systems may not even be the desirable goal (Berger-González *et al.*, 2016a), the demystification of these practices is. For the most cases I have reviewed in this literature collection, TM reflected processes of acculturation (Maher, 1999; Reeve, 2000; Pinkoane, Greeff and Williams, 2005; Yanez del Pozo, 2005; Risenga, Botha and Tjallinks, 2007; Berger-González *et al.*, 2016a); where indigenous practices were the ones echoing adaptations of western culture. The differences between indigenous and western cultures were a barrier with breaches associated to worldviews, health-related concepts and even dialectal discrepancies (Maher, 1999; Massé, 2002; Yanez del Pozo, 2005; Maiello, 2008a; Mideros, 2010; Valencia, 2010; Thornton, 2015; Waldram, 2015; Berger-González *et al.*, 2016a). Nonetheless and regardless of the surrounding debates, there were also contact points; indeed, both systems aimed to alleviate the burden of disease and they both had committed specialists with devoted audiences (Risenga, Botha and Tjallinks, 2007; Maiello, 2008a; Thornton, 2015; Waldram, 2015). In addition, patients and practitioners had distinct roles and responsibilities and the wider impact of social and cultural determinants, and personal relationships, were recognised as important.

## Summary of Findings

In this section I have presented a comprehensive account of the empirical literature relating to TM practices along with the role of TH and the various relationships. The broadness of these discussions was not intended to address all of the issues that they uncover. While I have found great varieties of practices in TM amongst the different indigenous cultures, the overall importance of the role of the TH within these communities was evident. Likewise, I have recognised a general dichotomy between western and indigenous understandings in the intricacies of the relationship. I have also identified a consistent relevance of the spiritual features that were not only recognised among the different indigenous health-related beliefs, but that were also a component of the healing practices. Furthermore, I have found a similarity across the different TM in relation to the relationships within the individual and how those various relationships – with the family, the community or the environment – not only affected the individual’s health, but also were essential to the TH and their practice. I started the discussion of the themes within the literature with an observation about the similarities between TM and their contrast with the western medical view. However, throughout the review I have considered the possibility of the likeness across TM, to be the result of a western way of seeing and describing, and of ‘othering’ them. Certainly, western methods of observation cannot capture entirely what TM involves. Nonetheless, some of the language used in the descriptions of TM – such as “sorcery” and “witchcraft” – instead of developing the knowledge and understanding, continue to mystify the health-related practices of indigenous people. I have also found that research regarding TM and indigenous health-related practices was commonly approached through the use of ethnographic methods – presented in tables 4 and 5 – which were often not sufficiently described. Based on this literature review, I found that, whilst potentially more evidence is needed to understand TM practices, the world view of researchers only further goes to dichotomise understandings rather than narrow the gap between conventional and TM.



## Research gaps

The literature review demonstrated that previous research focussed on the relationship between traditional healers and their patients is scarce. In addition, I found little evidence of research focussed on this topic in Ecuador. The findings of the literature review also suggested that ethnographic methods are the most common approach to research related to this topic. The research gaps that I identified throughout the literature review are summarised as follows:

1. Research focused on the relationship between traditional healers and patients is scarce. While this topic was identified in the literature, research focused specifically on this topic has not been carried out in Ecuador.
2. Although the main methods reported throughout the literature review were the use of ethnography, the description of research methods was poor in the majority of readings. Some of the literature not even stated the research methods that were applied.
3. The commonalities in the descriptions of TM and health-related practices across studies from different indigenous cultures, particularly the mystifying language used, demonstrates a generalised representation of indigenous cultures. Not only the descriptions create a fixed and oversimplified representation that assumes that all indigenous cultures are the same, but also places the “Indigenous” and their practices in opposition to the “Western” and their practices of medicine. Considering the socio-historic context of indigenous people and the effects of colonialism, the literature does not address the positionality of the researchers and its relation to the production of knowledge and representation of indigenous practices.

The identified research gaps exemplify a profound concern in the production of knowledge and representation of indigenous cultures. As summarised in point No. 3, the lack of attention to the researcher’s positionality in conjunction with the issues around language, fixed descriptions and the dichotomies between western and non-western, reflect a process imbued with a sense of the “Other”. A process that needs to be evaluated and that stands at the core of the critiques of research related to indigenous and other non-western cultures (Said, 1978; Smith, 1999). The differentiation between indigenous and *western* cultures was a subject that became significantly evident throughout my fieldwork. While I will discuss the iterative nature of this research in the Methods Chapter, it was through reflecting back on the data that the imperativeness of this matter was heightened and turned into an essential aspect to the understanding of indigenous practices. In

light of this discussion and the research gaps, I will now introduce the theoretic frameworks that are relevant to this research study.

## Theoretic frameworks

The main theory I present in this section is Said's (1978) "Orientalism" as a critical framework regarding the representation of other cultures. In order to comprehend the extensiveness of Said's (1978) notions, I discuss the process of representation through the principles presented by Douglas' (1966) classificatory system and cultural categories, and Hall's (1997) theory of representation. These theories address the issues around the descriptions of indigenous cultures from western perspectives that were highlighted in the literature gaps and that will be discussed further throughout this thesis.

### "Orientalism" in Ecuador's "Oriente" region

The awareness of the identified dominance of western perspectives over indigenous views in academic work (Martin-McDonald and McCarthy, 2008) is an issue that underlies and concerns the development of this research. For this reason, the discussion regarding Said's (1978) observations examined in what he terms *Orientalism* is of crucial importance to this study. Orientalism "*is a style of thought based upon an ontological and epistemological distinction made between 'the Orient' and (most of the time) 'the Occident'*" (Said, 1978 pg. 2). As Said (1978) also clarifies, "*neither the term Orient nor the concept of the West has any ontological stability: each is made up of human effort, partly affirmation, partly identification of the Other*" (Preface 2003, pg. xii). The Amazon region – as the setting for this research – is located at the east of the Ecuadorean territory and because of its location, the general Ecuadorean population refers to the Ecuadorean Amazon as the "Oriente" or Orient. While the coincidences may serve this particular research, the concepts in Said's (1978) Orientalism are relevant to most, if not all indigenous populations (Smith, 1999). Orientalism is explained as an established approach to understand "the Other" – for instance, the Oriental or the Indigenous – applied to the knowledge of human societies and cultures, their functioning, their history and languages (Said, 1978). Orientalism is also based on the representation of "the Other" from the standpoint of *Western* civilization, produced by and for the "West" (Said, 1978). In other words, is an ideological discourse and strategy of colonialism, devised to understand the natives

encountered throughout the European conquests, which also resolved how to subjugate the people in those territories (Said, 1978).

As observed by Said (1978) the representation of “the Other” has significant political content. This observation has also been identified in the general descriptions of indigenous populations (Gliozzi, 1977; Said, 1978; Ellingson, 2001; Mora Rodriguez, 2007). As Ellingson (2001) explains:

*“The ‘Savage’ and the ‘Oriental’ were the two great ethnographic paradigms developed by European writers during the age of Exploration and colonialism; and the symbolic opposition between ‘wild’ and ‘domesticated’ peoples, between ‘savages’ and ‘civilization’, was constructed as part of the discourse of European hegemony, projecting cultural inferiority as an ideological ground for political subordination”* (Ellingson, 2001, Preface pg. xiii).

Said’s (1978) analysis of the roots of Orientalism account for the first European descriptions of the cultures in the Orient, that placed the European people and values in a position of power and prestige. The accounts reflected the power that Europeans had to produce knowledge of the Orientals with expertise – something that the Orientals themselves were not able to do – and that were reproduced in works of science, history and art (Said, 1978). As a strategy, Orientalism functions upon the depiction of “the Other” in terms of binary oppositions, for instance between the “East/West”, “Coloniser/Colonised”, “Savages/Civilised”, “Us/Them” (Said, 1978; Smith, 1999; Ellingson, 2001; Hall, 2001; Van Dijk, 2006). In addition, the general representation of the Oriental “Other” assumes that all the Oriental cultures are the same (Said, 1978). According to Said (1978), the Oriental “Other” – in contrast to the Westerner – is frequently stereotyped as irrational, for example *“fail[ing] to understand what the clever European grasps immediately that roads and pavements are made for walking”* (pg. 38). Additional oversimplified descriptions of Orientals are for instance, that they are “gullible”, “mysterious”, “lethargic”, to list a few (Said, 1978). Furthermore, the images representing the Oriental “Other” are timeless, showing no development of the people or their cultures (Said, 1978). In like manner and as identified within the research gaps, the representations of indigenous peoples as “the Other” in academic, historic and artistic literature are as common as the representations Said (1978) examines about the “Orient”.

The early accounts of indigenous populations after the discovery of the Americas, reflect the relationship that European colonisers had with the native indigenous that were encountered (Gliozzi, 1977; Mora Rodriguez, 2007). Gliozzi (1977) analyses the first accounts of American

indigenous people as explanations produced by the Europeans – mainly the Spanish – in order to understand the origins of these populations. In general, the explanations that were produced by Europeans had no real scientific purpose or epistemological validity, but rather an intention to justify the European domination over the American continent (Gliozzi, 1977; Mora Rodriguez, 2007). For instance, the first explanation linked the Spanish monarchs with the right over the American continent, under the assumption that the lands where the Hesperia's Islands, that associated by name, belonged to an ancestor King (Gliozzi, 1977; Mora Rodriguez, 2007). The second main representation assumed the indigenous in America as descendants of one of the ten Israelite tribes that according to the Biblical texts, were punished by God – for adoring foreign gods – and sent away from the promised lands (Gliozzi, 1977; Mora Rodriguez, 2007). According to Mora Rodriguez (2007), this account had the most influence over indigenous populations, since under the idea that indigenous populations could be “saved”, it justified the abused punishments for not adopting the Roman Catholic or European ways. The third main representation of the American indigenous was in relation to the assumption that the American continent was the abundant region described in the Bible as Tarshish and Ophir; in which the Andes were represented as "Mount Sephar", described in the Bible as “the mountain of the East” (Gliozzi, 1977; Mora Rodriguez, 2007). The last two descriptions placed the indigenous as descendants of the Hebrews, revealing a contrast between the discovered knowledge and the knowledge accumulated until then that came essentially from the Bible (Mora Rodriguez, 2007). However, as Gliozzi (1977) explains, these descriptions were formulated by Europeans for their own interests and rather than to understand the living conditions of the indigenous, were produced to justify the subjugation of the people and appropriation of the land and riches found in the American continent (Mora Rodriguez, 2007).

From these representations a variety of discussions have developed. One of them is related to the point I discussed in Chapter Two that assumed the Spanish Colonisation as “fair” (Casanova, 2012). As opposed to the colonisation process in Africa, for example, where it was assumed that the native Africans were descendants of Ham who was not only punished, but cursed by God, not only justified the colonisation, but also the slavery of African people (Hall, 2001). Through parallelisms with the Bible, the descriptions of the Americas and its populations concluded that just as God had given the Canaanites to the Jews, the Americas were given to the Spanish; and following the logic, that as God had told the Hebrews to subjugate the Canaanites peacefully and if they opposed to go to war, upon the resistance of the indigenous, the Spanish colonisers imposed a "fair war" (Hanke, 1966; Gliozzi, 1977; Mora Rodriguez, 2007). Nonetheless, Gliozzi (1977) reasons that the early descriptions of American indigenous were also a reaction to the disruption of the knowledge paradigm of the time,

based on Biblical historic accounts. Because of the inconsistency and diversity of the new discoveries, the descriptions of Indigenous people gradually developed into a generalised understanding of indigenous as "good savages" (Glozzi, 1977). However, the notion of the "savage" developed from the same binary opposing strategy described by Said (1978), where rather than describing the indigenous, the descriptions stated what the "westerner" was not (Glozzi, 1977).

Accentuating the description of Indigenous peoples as "savages", Ellingson (2001) furthers the notion and the issues around it in what he terms as the "myth of the noble savage". The "myth of the noble savage" refers to the representation of the indigenous peoples as uncorrupted and living in perfect harmony with nature (Ellingson, 2001). In Africa, the association with nature was usually portrayed in terms of barbarism – as the description of everything that was found to be monstrous or repulsive in nature – and the "primitive" as opposed to the "civilised" (Hall, 2001). While the "myth of the noble savage" (Ellingson, 2001) has been directly linked to environmental studies (Rowland, 2004), as identified in the literature review, descriptions of indigenous medicine were also frequently associated with nature and the relationship with the environment. This representation of indigenous cultures is present in various academic studies (Ellingson, 2001). The representation of African people as "primitive" holds a similar feature as the indigenous portrayed as "savages" in the sense that both descriptions are fixated in time (Hall, 2001; Rowland, 2004). This constitutes the main criticism around the representation of indigenous people as "noble savages", since it fixes these cultures in the past and places them in a position where their knowledge has nothing to contribute to the developments of humanity (Hall, 2001; Rowland, 2004). This critique matches Said's (1978) observations regarding the representation of Oriental cultures as timeless, static and thus, incapable of development. Not only the representation of indigenous people as "noble savages" establishes a contrast between indigenous and non-indigenous, but as Rowland (2004) explains, it also places a contrast between indigenous peoples in the past and today.

### *The 'Othering' process*

As described by Said (1978), the undercurrents of Orientalism come from the distinguishing process where the Other is identified and defined. In order to explain this process, I will firstly discuss the importance and significance of 'difference' which is subsequently addressed within Douglas' (1966) cultural categories and system of classification. The repeated delineations between western and non-western cultures – particularly present in the knowledge produced through western viewpoints – emphasise the significance of the "other". The importance of difference or 'otherness', as Hall

(2001) argues, is set in the way that the differences are interpreted and thus represented; *"Difference signifies. It 'speaks'"* (Hall, 2001 pg. 326). The process of differentiation is therefore, also intrinsically a process of meaning production (Hall, 1997, 2001). Hall (2001) examines the utilisation of difference or 'otherness' from four different approaches. The first two are linguistic approaches where language is seen as the means used to give meaning to the world around. In the first approach, difference is explained as essential in the production of meaning because without the contrast, it is not possible to define (Hall, 2001). For instance, 'the savage' exists only as it is contrasted with 'the civilised' and as Hall (2001) exemplifies:

*"We know what it is to be 'British', not only because of certain national characteristics, but also because we can mark its 'difference' from its 'others' - 'Britishness' is not-French, not-American, not-German, not-Pakistani, not-Jamaican and so on" (pg. 328).*

The second explanation approaches 'difference' as a requisite in the process of producing meaning, considering that meaning arises from dialogue where the participation of the 'other' is indispensable (Hall, 2001). In both approaches meaning is relational. However, the second approach – that is based on the linguistic studies of Mikhail Bakhtin – reveals a limitation in the process of meaning production, since based on its relational characteristic it establishes that meaning cannot be fixed (Hall, 2001). Moreover, this limitation stresses the issue with the 'other' because it states firstly that meaning does not belong to how one or another culture understands it and secondly, that one cannot know what it means to be the 'other' (Hall, 2001). These issues are directly related to the representation of other cultures. According to Hall's (1997) definition, representation comprises two iterative processes and purposes. The first part of representation involves the depiction of the object, event or person; this process entails that there is a meaning out there to be re-presented (Hall, 1997). However, representation also refers to the process of symbolisation (Hall, 1997). The concept of representation brings together both processes and thus, representation can be defined as the process of assigning meaning to the things that are being described (Hall, 1997). Consistent with Geertz's (1973) definition of culture that describes it as a system of shared ideas and meanings, culture can also be understood as a "system of representation" (Hall, 1997).

Considering culture as the way humans make sense of and give meaning to the world, the meanings produced are the consequence of shared concepts (Geertz, 1973; Hall, 1997), which in relation to each other can be understood as frameworks or conceptual maps (Hall, 1997). Conceptual maps – which are in essence organising tools – enable the classification of the world around us and

therefore, classification becomes a process in which meanings are produced (Hall, 1997). In this regard, Douglas (1966) reasons that people give meanings to the world around them by ordering things into classificatory systems based on particular conceptions of purity. According to Douglas' (1966) approach, 'difference' is needed to maintain order, to classify what is symbolically considered "pure or whole" and identify what is not:

*"Ideas about separating, purifying, demarcating and punishing transgressions have as their main function to impose system on an inherently untidy experience. It is only by exaggerating the difference between within and without, about and below, male and female, with and against, that a semblance of order is created" (Douglas, 1966 pg. 5).*

In Douglas' (1966) explanation, the opposition of differences - binary opposition – is central to the process of classification because in order to categorise things, clear distinctions must be demarcated. The classificatory systems are established by the symbolic boundaries that keep things "pure"; and those symbolic boundaries not only delimit the way cultures order their behaviours, things and practices, but also are defined differently by the diverse concepts of purity (Douglas, 1966). Furthermore, Douglas (1966) argues the transgression of those symbolic boundaries and when something fails to fit to any one category or it is out-of-place, it becomes a disturbance to the normal order of things. As a result, the ambiguity of the behaviours, things or practices that do not fit into the established categories, represents a danger to the stability of the culture (Douglas, 1966). In the natural process of maintaining or restoring order, the 'difference' defines what needs to be 'cleaned', 'removed' or 'expelled' (Douglas, 1966; Hall, 2001). Nonetheless, Douglas (1966) also deliberates on the power of things that are "out-of-place", specifically when they stand in the middle of the categories defined through differentiation. The power of what is different or which does not belong to the established categories, lies on the attractiveness of the taboo and its unexplainable characteristics that make it either belong to diverse categories or to none (Douglas, 1966). In particular, taboos protect the consensus of how a culture perceives and gives meaning to the world (Douglas, 1966). The cultural categories or the classification system defined by any culture, is fundamentally what maintains order within the culture (Douglas, 1966; Hall, 2001); in other words, it defines it.

Therefore, *"the marking of 'difference' is thus the basis of that symbolic order which we call culture"* (Hall, 2001 pg. 330). Related to Douglas' (1966) notions, the fourth approach discussed by Hall (2001) addresses 'difference' as a psychological necessity to establish contrast with the 'other' in

order to constitute, define and establish the self. The 'otherness' in this case, presents the opportunity to recognise, define or redefine our own identity (Hall, 2001). Hall (2001) exemplifies this approach through the experience of a child identifying him or herself by comparing and contrasting the characteristics found in the mother or father. Like the limitation in the linguistic approaches, identity – comparable to meaning – cannot be fixed, it is rather a continuous process of interaction with the 'differences' we encounter in life (Hall, 2001). Fanon's (1967) rationalisation of racism is also linked to this model of difference and identity, since the antagonism develops from the refusal of the White, the Westerner, the European, to recognise the identity of the black person. Nonetheless, under these considerations the significance of difference is fundamental to *"the production of meaning, the formation of language and culture, for social identities and a subjective sense of the self"* (Hall, 2001 pg. 332). In conclusion and not without its issues, the 'Othering' process is a process of differentiation, categorisation and identification.

### *The power of representation*

Orientalism is centred on the representations of the "Other" from western standpoints and as Said (1978) argues, the concerns regarding western positionality are fundamentally related to power. The relational characteristics of the 'Othering' process – according to Jacques Derrida's thought – regularly entail relations of power within its binary oppositions (Hall, 2001). As Hall (1997) argues, *"representation is the production of meaning through language"* (pg. 2) and the crucial aspect of it has to do with 'who' has the power to represent. The power of representation deals with who says and decides what is said; in other words, who has the power to give meaning (Hall, 1997, 2001). In this regard, binary language has been recognised as an effective discourse strategy for the manipulation of accounts (Van Dijk, 2006). The strategy works by the depiction of the 'other' through language that facilitates the emphasis of what needs to be persuaded – for instance, the 'good/positive' in "Us" and the 'bad/negative' qualities of the other – and likewise, obscure what needs to be discouraged – e.g. the 'good/positive' aspects of the "Other" together with the 'bad/negative' of "Us" (Van Dijk, 2006). Van Dijk (2006) argues that what groups of people believe is actually *"controlled and organised by underlying ideologies"* (pg. 123) and that at the core of biased ideologies and beliefs, are the exaggerated polarisations applied through strategies such as binary opposition. Moreover, opposition strategies are also used to legitimise specific ideologies and actions, and within its course, delegitimise the actions and ideologies of others (Van Dijk, 2006). As Said (1978) observes, western representations of other cultures contrasted the prestige of European



position, culture, knowledge, values and people with the lowliness of the “Others”, which enabled and justified the undertakings of Colonialism.

Furthermore, the normalisation of a particular representation is also a tactic to maintain power (Hall, 1997). Therefore, not only the entitlement to give meaning, but also the dissemination of meaning involves issues of power (Hall, 1997). These observations for instance, have been also highlighted in the analysis of colonial historians who have commonly generated accounts that overstate the histories of Europe and too often dissipate the history of native people, to the point of portraying a world history where indigenous prior to the Europeans, have no history at all (Zimmerman, 2010). Considering that meaning is relational and thus cannot be fixed, Hall (1997) argues that ‘true’ meanings are not only complicated, but also lie on the dubious. That is to say that context matters, because as things can have variable meanings, representations can be easily manipulated or placed out of context (Hall, 2001). Bearing in mind Douglas’ (1966) framework, I argue that the undefined quality of ‘meaning’ is also at the core of the power of representation.

### Summary of theory discussion

In this section I have presented the theoretic frameworks that address the subject of representation and the contrast between western and non-western cultures. I introduced the principles of Said’s (1978) “Orientalism” and discussed how they apply to the studies of indigenous populations. I also explained the process of “Othering” as an essential practice of Orientalism and the representations of other cultures. Finally, I reviewed the issues of power that are imbedded in the process of representation, which also constitute the problem in Orientalism and its approaches. As it was considered in the introduction to the theories that I have presented, the issues around representation and the “othering” process surfaced after my experience in the field and from the analysis of data. Nonetheless, the relevance of these subjects was undeniable and crucial to my understanding and the overall research process. On this account, I will now introduce the research question, aim and objectives of this research with a brief discussion explaining the re-framing of my research process.

## Re-framing the research process

Informed by the gaps found in the literature review, I initially elaborated a research question, aim and objectives that were focused on the values present in the relationship between Kichwa THs and their patients; with the further aim to understand patients' use of how this relationship worked as a way to contribute to the identification of bridges between traditional and biomedical health systems. Nonetheless, as this research developed, the issues around representation that began to surface became fundamentally significant to the understanding of the Kichwa people, culture and health-related practices. Contrary to the idea that the Kichwa people maintained their practices unchanged and that through my meticulous observation I could isolate the links to my western influenced knowledge, my observations and reflexive remarks began to point out that in my forethoughts I was mistaken. To begin with, the research question that originated my exploration assumed that Kichwa THs only interacted with Kichwa patients. As I will detail in the Methods chapter, it was not long into my fieldwork before I witnessed that nearly half of the people seeking the treatment of Kichwa THs were not Kichwa. Therefore, focusing on the relationship between THs and their patients was not conducive to an accurate understanding of Kichwa culture. Secondly, as it will be discussed throughout the findings, Kichwa people interact widely with mainstream culture; indicating that bridges between cultures were already part of current Kichwa practices. In order to have an accurate understanding of Kichwa culture and their traditional medicine, it was fundamental that I asked a rectified research question. As I have mentioned and will develop further in the next chapter, the undertaking of this research has been a continuous process of adjustment. Considering that the elaboration of the research question has also been part of my iterative process of developing knowledge about Kichwa people, the initial research question was revised in order to reflect the true focus and scope of this study.

## Research question

- What are the values that are reflected within the practices and health-related behaviours of the Kichwa Indigenous people from the Amazonian region in Ecuador?

## Research Aim

To explore the values present in the TM of Kichwa indigenous people and whether it is possible to understand and represent the health practices of another culture from a Western public health perspective.

## Objectives

1. Through the use of ethnographic methods identify the key people and events that relate to the traditional healing practices of the Kichwa people of Rukullacta
2. Use participant observation and in-depth interviews to explore the traditional healing practices and health-related beliefs of the Kichwa people of Rukullacta
3. Explore the views of Kichwa people in relation to western cultures and conventional medical care
4. Discern the values that influence the Kichwa traditional health-related practices
5. Develop an account of Kichwa health-related practices and beliefs
6. Discuss the implications from a Western public health perspective

## Summary

This chapter has sought to offer an account of the empirical literature related to the TM of different indigenous cultures, the beliefs and health-related practices. I have discussed the role of THs and importance of relationships in the understandings of health and illness of the studied indigenous people. I also presented the common ethnographic methods used across the empirical studies. Based on this literature review, I identified the research gaps and concluded that more evidence is needed to understand TM practices, that ethnography is the most common approach to research related to this topic and that further considerations of the positions of western researchers perceiving indigenous TM are necessary. In this chapter I have also presented the theoretic frameworks that address the subject of positionality and representation in Western produced knowledge. I discussed the principles of Said's (1978) "Orientalism" and its relevancy to indigenous cultures. Likewise, I described the process of "Othering" and discussed the issues of power in representation. Additionally, informed by the research gaps from the literature review and the iterative considerations throughout the development of this research, I have presented the research question, aims and objectives of this study that were focussed on the Kichwa indigenous people of Rukullacta. In the next chapter I will describe the methods that were used to explore the identified issues and answer the research questions.

## Chapter Four: Methodology

This chapter explains the methodology used for this investigation. Following the recurrence of ethnographic approaches in the studies that were examined in the literature review, this chapter presents the rationale for the use of qualitative methodology and ethnographic methods. The qualitative nature of this research compels discussions regarding the influences of western perspectives and the misrepresentations of traditional medicine. In this chapter I describe the functionality of the multiple methods of data collection encompassed in this research. I also review the methods of analysis. Likewise, this chapter addresses the ethical issues and concerns that surrounded this study, and the significance of the positionality I hold as the researcher. Finally, I discuss the challenges of doing ethnographic research and the strengths and limitations of this approach of investigation.

### Philosophical foundations and methodology

In terms of understanding health and medicine, assuming that the meaning of health is the same amongst all cultures is a problem, fundamentally, because cultures are diverse. The different worldviews identified through the literature exploration, indicate how indigenous cultures could be misunderstood in western outlooks and thus, the importance of the philosophical foundations of this research. Carter & Little (2007) recognise that:

*“in the health sector, qualitative research is often conducted without attention to methodologies or epistemologies, reflecting the dominant research culture, which tends to take epistemology for granted and to use the terms method and methodology interchangeably”* (p. 1325).

While the prevailing scientific methods commonly used in biomedical research have produced significant knowledge about people’s health, the underlying ontology assumes that the values between indigenous and western cultures are the same. Conversely, the distinctive definitions of health by which traditional medicines (TM) perform, suggest that before addressing health among indigenous cultures there are still meanings that require further understanding. TM practices cannot be understood outside of the exploration of the meanings - for instance of health – within their respective cultures. Geertz (1973) reasons the study of cultures as a semiotic process that is not

quintessentially experimental, but from which meanings are derived. The question this research aims to answer is in essence a search of meanings; meanings embedded in the practice of TM. The philosophical considerations are fundamental; not only in justification of the ethnographic approach I have chosen to undertake this research, but also on behalf of understanding different cultural practices and of the implications of this study.

### Ontology, epistemology and Indigenous research

The majority of scientific knowledge is based on objective views that have evolved from the associated positivist approaches to research. Positivism argues in favour of an observational language, which can be straightforwardly judged as true or false as it is juxtaposed to previously proven realities (Hughes and Sharrock, 1997). However, the complexity occurs in the definition of these realities or social truths between different social contexts; not only in terms of what they comprise (ontologically) and how we come to understand them (epistemologically), but also in terms of the implications these definitions have beyond western social conventions and norms. In light of the various descriptions of indigenous views, I argue that positivistic approaches may not allow us to make sense of these cultures. Positivistic reasoning privileges the objectivity of science as being dependent on a theoretical, neutral and independent “*observational language*” (Hughes and Sharrock, 1997); counter-arguments related to the limits of language and the unobservable (spiritual) features of TM warrant consideration (Westermeyer, 1988; Turner, 1989; Maher, 1999; Pinkoane, Greeff and Williams, 2005; Maiello, 2008a; Jacome, 2010; Thornton, 2015; Waldram, 2015; White, 2015). The predefined truths that sustain much of western thought have been profoundly criticised and argued to be central hindering factors in understanding different cultures, in some cases even inducing detrimental repercussions (Said, 1978; Smith, 1999). While realities in the *natural* sciences are possibly easier to agree upon, agreement about such realities in the *social* sciences is not so evident and is reliant on “*the fact that social actors already live in a world which has meaning for them and it is out of this that many of the puzzles for social research arise*” (Hughes and Sharrock, 1997, pg. 43).

The perceptions of reality vary so profoundly between western viewpoints and most of indigenous worldviews that even the facts of nature (animate and inanimate) are not in full agreement. Mason (2002) emphasises the importance of consistency between the philosophical postures and the course of research by clarifying how:

*“... it is only once it is recognised that alternative ontological perspectives might tell different stories, that a researcher can begin to see their own ontological view of the social world as a position which should be established and understood, rather than an obvious and universal truth which can be taken for granted” (pg. 14).*

Certainly, indigenous cultures have captivated much research and although the purpose is arguably to develop knowledge, the truth about indigenous people ultimately becomes a subject of how researchers tell the story (Said, 1978). In this sense, Kant’s (1781) consideration about knowledge being limited to perception is crucial, since the understanding of indigenous cultures begins with the philosophical stance the researcher takes.

### ***Social Constructivism and Interpretivism***

Contrasting positivism and aligned to empiricists’ views, social constructivism deals with the construal of reality, involving a collective and active process of knowledge production (Berger and Luckman, 1967; Collin, 1997). The constructivist discussion regarding the nature of reality has developed in two branches that fundamentally diverge in the acknowledgement of elemental facts; however, social constructivism appeals to the less radical view (Collin, 1997). While radical constructivism finds the agreement of truths or social facts to be inconsequential, social constructivism regards elemental truths in the midst of their distinctive properties. The recognition of bridging points (shared values) between western and indigenous cultures requires a perspective that finds value in the meeting points of diverse experiences. Social constructivists regard interaction and agreement to be essential in the process of reality construction (Berger and Luckman, 1967; Collin, 1997), and it is through these practices that interpretivism interrelates. In particular, interpretivist approaches:

*“... are concerned with understanding the social world people have produced and which they reproduce through their continuing activities. This everyday reality consists of the meanings and interpretations given by the social actors to their actions, other people’s actions, social situations, and natural and humanly created objects” (Mason 2002 citing Blaikie 2000, pg. 56).*

The epistemological principles of interpretivism harmonise with both the social constructivist paradigm and the character of this research. Although the difficulty of interpretivism derives from the ways the researcher gives meaning to such realities, as quoted by Collin (1997):

*“once brought to scrutiny, the ‘orderly structure’ of the social world is no longer available as a topic in its own right (that is, as something to be described and explained) but instead becomes an accomplishment of the accounting practices through and by which it is described and explained” (Collin 1997 citing Zimmermann and Wieder 1971, pg. 4).*

Interpretivism approaches meaning in two different ways based on the conceptual frameworks of ethnomethodology and symbolic interactionism (Sanchez-Jankowski, 2002). Ethnomethodologists view the researcher as capable of portraying accurately other realities; on the reasoning that through engaged interaction it is possible to see through other people’s eyes (Sanchez-Jankowski, 2002). Alternatively, symbolic interactionists consider that the way the researcher understands the meanings of other people’s reality, also through interaction, is what it is ultimately represented in the study (Sanchez-Jankowski, 2002). While my positionality is later discussed with more detail, the conceptual framework presented by symbolic interactionism is representative of my philosophical stance for this research process.

## Qualitative Methodology and Ethnography

The congruence between the philosophical positions and the nature of this research brings into careful consideration the selection of a suitable methodological approach. Based in interpretivism and focussed on understanding the values present in the practices of Kichwa traditional healers, the question this research seeks to discover, I argue to be answered best using qualitative approaches (Mason, 2002). Methodology not only justifies the methods of research, it represents the juncture where the choice of methods align to the epistemological stance (Carter and Little, 2007). This explains the confusing use of the term, as it sometimes describes theories of knowledge and in other situations refers to the methods of research (Carter and Little, 2007). The descriptions of ethnography fall into a similar misunderstanding. Hammersley & Atkinson (1995) introduce ethnography as either a *“particular method or set of methods”* that consist in the researcher being involved in daily interactions with people and from where information is gathered in order *“to throw light on the issues that are the focus of the research”* (pg. 1). For the purpose of this research,



methodology is to be understood as the qualitative approach that explains and justifies the choice of ethnographic methods, in relation to the epistemological foundations that I previously discussed.

### Why Ethnography?

Although the critiques regarding the deficiency of research methods in understanding indigenous cultures have been explicitly directed to anthropologist and ethnographic accounts (Smith, 1999), fundamentally, the argument is centred on the representation of indigenous cultures instead of the actual research procedure. In this sense, the hindrance seems to be a problem related to the philosophical theories that delimit the observations rather than the methods themselves. In spite of the criticism, I consider that among the qualitative methods of investigation, ethnography provides a constructive course for understanding different cultures. Baszanger & Dodier (2004) consider that ethnographies are meant to fulfil three needs of social research:

*“the need for an empirical approach”, “the need to remain open to elements that cannot be codified at the time of the study” and the need for “grounding the phenomena observed in the field” (pg. 10).*

As the literature review revealed and disclosed in the critiques of scientific representations of indigenous cultures, the understanding of TM demands an approach that can accomplish all three of these aspects. Additionally, other important characteristic of ethnography is the generation of data in the particular setting of interest (Mason, 2002; Silverman, 2013). Though attentive to the philosophical influences, ethnographies accentuate the qualitative capacity to understand and explain how things in particular settings work (Mason, 2002) or as Hammersley (1992) emphasises, the feature of “understanding events in context” (pg. 23). This research is focussed on understanding the practice of health in a very distinct context from the most ordinarily known. The flexible and unstructured features of ethnographic methods simulate the natural ways in which people perceive the world around them (Hammersley and Atkinson, 1995). Although these characteristics can and have been considered elemental weaknesses of ethnography, when other methods of investigation fail to capture a truth, ethnographic methods become a strength (Hammersley and Atkinson, 1995). This method is convenient to generate detailed descriptions of TM practices (Hoey, 2014) and from them, develop new principles from the data observed (Hammersley, 1992; O’Reilly, 2005). Ethnography opens the opportunity to produce, understand and

portray the knowledge related to the practice of TM in more natural ways (Hammersley and Atkinson, 1995).

### *Critical Ethnography*

This research began to take the shape of a *critical ethnography* the moment I set foot in the field. However, it was not until the final stages of this research that I have come to realise that in my sensible endeavour to understand, interpret and truthfully represent the Kichwa people, what I have actually done is a *critical ethnography*. Critical ethnography is defined as “*a type of reflection that examines culture, knowledge, and action. It expands our horizons for choice and widens our experiential capacity to see, hear, and feel*” (Thomas, 1993, pg. 2). Critical ethnography questions the notion of objectivity, but also the notion of subjectivity and this is done through a reflexive examination of the researcher’s positionality and way of interpreting her own observations (Madison, 2004). As Madison (2004) explains, on reflecting back the researcher brings to light and becomes accountable for her own research paradigms, positionality and the production of her representations. In revealing her vulnerabilities, the researcher summons an “ethics of accountability” because she places herself in a position where she assumes the risk of being wrong (Thomas, 1993; Madison, 2004). In essence, critical ethnography recognises and evidences the iterative process, the inevitable continuous dialogue that has been crucial to this research process.

Through the acknowledgement of the reflexive and continuous dialogue, critical ethnographies enable an interaction between the researcher, the reader and the people being studied (Madison, 2004), and “*offer vantage points for generating new understandings*” (Hart, 2006, pg. 982). This opens the frame of representation, exploring how the observations in relation to the Other, were produced (Madison, 2004). Quintessentially aligned to the theoretical frameworks discussed in the previous chapter, critical ethnography recognises the issues of representation that I have endeavoured to address. As Madison (2004) reasons:

*“It is the dialogic relationship with the Other, this ongoing liveliness and resistance to finality that resist the connotation of timelessness commonly described as ‘the ethnographic present’, that has adversely haunted traditional ethnography” (pg. 9).*

As I have introduced in Chapter Three and will continue to discuss in Chapter Seven, the representation of indigenous people as static and timeless (Said, 1978; Smith, 1999; Rowland, 2004),

is also the product of *“the ethnographic present”*, which *“refers to the representation of a timeless account of the culture or people being studied”* (Madison, 2004, pg.9). In opening up the reflexive process, critical ethnographies enable a dialogue that as Hart (2006) argues, aims to generate new perspectives that allow a *“critical rethinking”* of the available knowledge. Critical ethnographers aim to identify and elucidate the cultural processes that limit their understanding and through the reflexive analysis of the origins of those limitations, foster ways to change them (Thomas, 1993). As Madison (2004) describes it, critical ethnography is *“critical theory in action”* (pg. 13). In other words, critical ethnography is a critique of the social constraints in my own perspectives that have been normalised in the culture and environment that I live in, and that through the experience of this research I have dared in various ways.

### **Ethnography and participant observation**

Ethnographic research is not prescriptive and does not have set instructions as to how it should be carried out and how researchers should immerse themselves in the research setting (Mason, 2002; Silverman, 2013). However, irrespective of how *“unstructured or inductive”*, the researcher *“comes to fieldwork with some orienting ideas, foci and tools”* (Silverman, 2013, pg. 85). Although there is no formula on how to undertake ethnographic research, an essential part of ethnography consists in the researcher’s involvement with the setting that is being explored (Hammersley and Atkinson, 1995; Silverman, 2013). For this reason, I approached the generation of data for this study through the method of *“participant observation”*. Participant observation relates to the method of observation that involves the participation of the researcher in the setting and through which she experiences and observes the situation at *“first hand”* (Mason, 2002; Silverman, 2013). In this sense, participant observation allows the researcher to connect directly her *“ideas, foci and tools”* to the generation of data. Expressed in a different way, participant observation situated me as a tool of data collection (see Figure 8); a tool by which data was produced through my participation in the context, rather than just outwardly observing it. The role the researcher undertakes in the fieldwork (see figure 9) is another aspect of importance, as it may also influence the field relations (Hammersley and Atkinson, 1995) and outcomes. While it is not uncommon that the researcher assumes different roles for the benefit of acquiring data (Hammersley and Atkinson, 1995), the role I undertook during the fieldwork was principally based on the *“participant as observer”* model (May, 1993). This model acknowledged my learning about the environment, culture and values of the Kichwa people, while openly maintaining my role of researcher within the group.

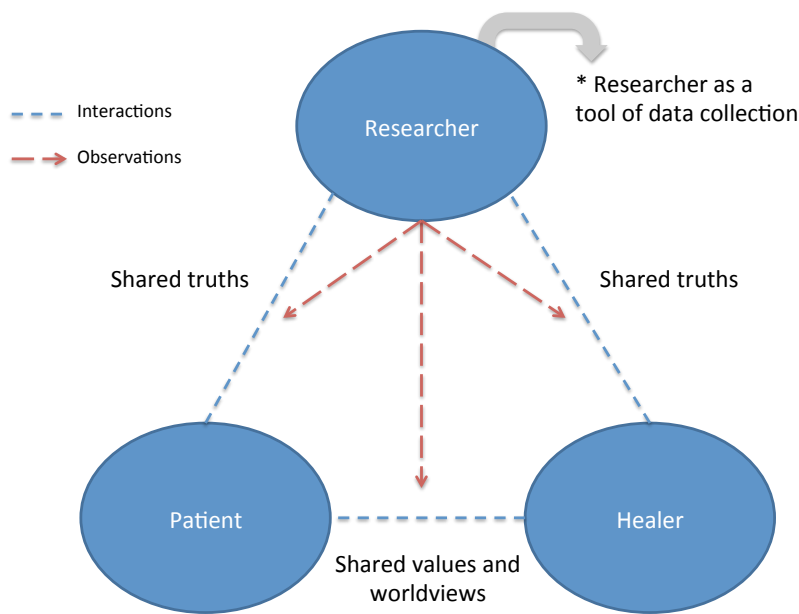


Figure 8 *Researcher as a tool of data collection*

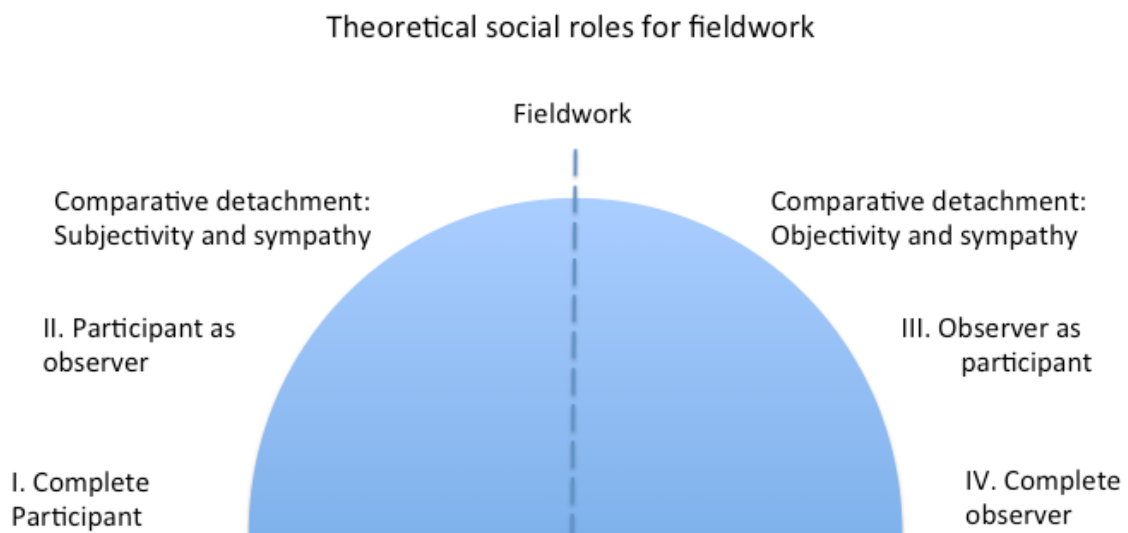


Figure 9 *Theoretical social roles for fieldwork, adapted from Hammersley & Atkinson 1995 (original source Junker 1960).*

In order to capture the practices occurring through my interaction with the Kichwa people of Rukullacta in the Ecuadorian Amazon, this investigation was observational and descriptive; where I used a set of multiple and interrelated methods of data collection (Silverman, 2013).

### *Fieldwork arrangements*

Since this ethnographic research is focussed on the interaction between TH and patients in a particular community, population representativeness was not a matter of concern (O'Reilly, 2005). However, as it is generally for ethnographic research, the setting and context of the community to be studied were taken into consideration (Hammersley and Atkinson, 1995; O'Reilly, 2005). The choice was also dependent on the respective entry offered through the gatekeepers (Hammersley and Atkinson, 1995). Different indigenous cultures in Ecuador were considered in order to choose the most appropriate population to study. As mentioned earlier, Ecuador is a multi-ethnic country and many indigenous nationalities have settled since the colonisation in the remoteness of the Amazonian region (Lu, Bilsborrow and Oña, 2012). My search for an indigenous community that would agree to take part in this research began on July 2016. In May 2017, I had established four potential opportunities. After attending the "First Regional Summit of Ancestral, Spiritual and Intercultural Medicine" that took place in Napo in August 2016, I met two Kichwa TH that were potentially willing to participate in this study. The Kichwa is the largest indigenous population in Ecuador and while groups have settled in the highland region, the Amazonian Kichwa population is composed of approximately 60,000 people dispersed through different settlements along the provinces of Napo and Pastaza (Lu, Bilsborrow and Oña, 2012). Another option derived from one of the expert researchers I contacted for the purpose of the literature review. The contact is a recognised Ecuadorian ethno-botanist that has worked with different indigenous groups and is the founder of an Ethno-botanical research centre located in the Amazon region. The centre is in proximity to Shuar, Waorani and Kichwa settlements. The Shuar is the second largest indigenous group in the Ecuadorian Amazon, with a population of more than 40,000 people (Lu, Bilsborrow and Oña, 2012). The Waorani population reaches almost 1,400 people and are known for being the last indigenous group to be contacted by westernised culture (Lu, Bilsborrow and Oña, 2012). The Waorani is still one of the most isolated indigenous groups in Latin America and renowned for their warrior traditions; though for these same reasons, they are one of the most researched indigenous populations in the region (Davisa and Yostb, 1983; Robarchek and Robarchek, 1998; Cardoso *et al.*, 2012). Finally, there was an option to undertake this research with the Secoyas, one of the other ethnic groups that inhabit the Ecuadorean Amazonian region.

After consideration of the settings and safety, the entry offered by one of the Kichwa THs that I had contacted was the most opportune and accessible. In July of 2017, I regained contact with Marcos

Ramirez, one of the TH of the Kichwa community of Rukullacta in the province of Napo. Unlike the other contacts, Marcos was my direct intermediary with the Kichwa community of Rukullacta. Marcos also spoke Spanish, which was an advantage to the development of this research considering Spanish is my first language. In addition, he offered me a room in his house and the opportunity to accompany him to his healing sessions. During the three months of fieldwork, I mainly followed Marcos throughout his daily activities and shared with his family and acquaintances, while we both waited for occasions to visit his patients. During the time I was there, he performed a total of eight healing sessions, from which only four were for Kichwa patients. Three of the remaining sessions were carried out for people from Quito – Ecuador’s Capital city – and one session for a couple that came from the United States and Russia. As I was told, it was common to have foreign visitors that wanted to have a healing session or experience ayahuasca. However, in Kichwa culture the drinking of ayahuasca was always done within the context of a healing ceremony. Although I will discuss the particularities of ayahuasca and its relation to the Kichwa healing practices in Chapter 6, it was important to note that not all the healing sessions were performed with a particular healing purpose. Nonetheless, I attended six of the eight healing sessions and assisted Marcos with the healing session for the foreign couple. The reasons I did not accompany Marcos to all the healing sessions were: firstly, because he had to travel to Quito to visit a non-Kichwa patient and this research was focused on the context of Kichwa people, and the second session I could not attend was a follow up session, to which he said it was better if he went alone. Apart from the healing sessions I attended, Marcos performed three healing ceremonies for me: one upon my arrival and two more when he took me to visit a cave and a waterfall that were considered to be sacred sites. In addition to that, one of the other healers I interviewed performed two different healing sessions on me and asked me to assist him with a foreign English-speaking group that had visited him from the United States.

The Ramirez family were not only my host family, they were also intermediaries between me and the participants of this research and as mentioned, Marcos was one of the six healers I interviewed for this study. In addition to the six interviews with healers, I also interviewed six of Marcos’ patients. This ethnographic study was in large part dependent on my interaction with Marcos. Not only was I able to follow him closely in his practice of Kichwa healing and knowledge of medicinal plants, but also throughout the three-month fieldwork period I had the advantage to experience Kichwa culture in all of my undertakings by living with his family who have managed to maintain so many of the traditional practices of the culture. Needless to say, within a few weeks the people in the community of Rukullacta knew that I was staying with the Ramirez family. This opened

opportunities for me to talk to other people and participate in various events as a member of the Kichwa community, including the official visit of the Ecuadorean Vice-president to the community of Rukullacta on the 26<sup>th</sup> of October and a TH's gathering on the 25<sup>th</sup> of November of 2017. Marcos' contribution to this research has been extraordinary as he not only offered me access to the Kichwa community of Rukullacta and the opportunity to participate and explore the health-related situations, but also to experience the relational characteristics of THs and observe at first hand what life for a Kichwa TH was like.

## Methods of data collection

Central to the participant observer's role is the awareness of what required observation, when to record the observations and how to record and explain them (Silverman, 1985; Hammersley and Atkinson, 1995; Mason, 2002). Considering the interactionist framework, the way reality is witnessed by the researcher, is as important as the way it is perceived by the studied culture (Hoey, 2014). Among the aspects questioned and considered throughout the fieldwork were: the details of the settings where Kichwa medicine practice happened, the occurring events (specific healing rituals), the objects, activities and actors involved in these proceedings, the relations between actors and my feelings surrounding these situations (Silverman, 2013; Hoey, 2014). In order to gather sufficient data that enabled a comprehensive understanding of Kichwa culture and medicine, I used a combination of the following methods of data collection: 1) ethnographic accounts that described details of the settings, events and interactions related to the health-related practices of Kichwa people and a reflexive diary; 2) Interviews with Kichwa healers and patients, and; 3) photography that captured elements of the Kichwa healing practices and the associated environments, which complemented the observations and dialogues recorded through the aforementioned methods of data collection.

The data was collected throughout three months of fieldwork – from the 29<sup>th</sup> of September to the 20<sup>th</sup> of December of 2017 – in the Kichwa community of Rukullacta in the province of Napo in the Ecuadorean Amazon. During this period I lived in a Kichwa household with Marcos, one of the traditional healers who participated in this research.

## Ethnographic Fieldnotes

Fieldnotes are the most customary way of ethnographic recording (Hammersley and Atkinson, 1995). The purpose of field notes as Geertz (1973) understands, is to convert the experienced occurrences into tangible records that can be accessed and revisited over and over again. Essentially, ethnographic writing has two main intentions: the first is related to the researcher's need to express the experience she is perceiving and the second is focussed on describing the settings, people and events (Hoey, 2014). However, ethnography recognises the interrelation of these two observational processes, and actually requires a dialogue from where conclusions are drawn (Geertz, 1973; Hoey, 2014). For these reasons, I kept four different sets of notes to record my observations: 1) brief notes taken at the time of events, 2) expanded annotations after specific sessions (e.g. a healer's consultation, particular rituals, etc.), 3) journal reflections that collected thoughts and identified problems throughout the fieldwork, and 4) on-going registers of analyses and conclusions related to the research question (Silverman, 2013). The first set of fieldnotes documented specific details such as names of people, things and places, dates, Kichwa words and their meanings, quotes and contact details of potential participants. These notes were recorded in small notepads that I was able to keep in my pocket and write at any given time. The second set of notes was kept in a notebook that I used during and after every interview and after specific conversations or events. The notes I kept in this notebook were based on details regarding the Kichwa healing rituals and medicines, the elements and explanations of the practices, and the forms in which they took place. It also included details of the interviews, such as details of the settings where the interviews occurred, details of the person, specific spelling of Kichwa terms and thoughts that occurred during the interview. In cases, such as trips to sacred locations or rituals where it was not convenient to take a large notebook, I recorded details in the pocket-sized notepads and later rewrote the notes with an extended explanation of the events. Third was my reflexive diary, where I recorded the way I felt about the experience. I took time almost every day to reflect and write upon the things I had experienced that day. I kept record of things I had witnessed, thoughts around dialogues and interactions that in first stance had nothing to do with the topic of this research, but after reflexion some did. The reflexive diary was also a personal account of my feelings, which I will discuss later in this chapter, since it revealed an important key to the analysis of the meanings this research answers. Keeping a reflexive diary was a cathartic process that helped me throughout the fieldwork and that continued throughout the analysis period of this research. Finally, I kept a separate notebook where I recorded assessments and conclusions specific to the research question, which served the development of the interview questions and subsequently, the iterative process of analysis.



Fieldnotes are fundamentally where the experienced patterns appear, and as Hoey (2014) puts it “*if it isn’t there... you do not have it*” (pg. 6). This method of recording the experience and observations of my participation in the research field facilitated my continuous and developing process of understanding the Kichwa culture. As Hoey (2014) anticipated, I developed a cherished relation with my fieldnotes and more than actual final words, the process of recording constituted a personal dialogue with myself (Geertz, 1973). The facility to have a continuous dialogue with my notes and developing thoughts was fundamental and the reason why I consider this method to be of greatest advantage to this ethnographic research. The internal dialogue is why fieldnotes seem to be extremely personal, unrevealing and valuable, though they are the sources of publicly acknowledged evidence (Hammersley and Atkinson, 1995) and I assent that certain ideas had to be processed before they made any valuable sense. Although no expertise was needed, the ability to record relevant data in a clear and quick manner (Hammersley and Atkinson, 1995; Hoey, 2014) is a skill that has naturally developed through my work experience, but improved throughout the fieldwork. While I took a laptop to the setting, the note taking process relied on manuscripts that were stored manually. Fieldnotes were written in English, Spanish and Kichwa. The reason for this was that sometimes my thought process automatically expressed in either English or Spanish, e.g. the idea came to me in English and I wrote it down in English. Although notes were mainly taken in Spanish with a few terms and expressions in Kichwa, the reflexive diary was written in English since it collected my unrefined personal reflections and as a method of discretion and confidentiality, I felt comfortable to write in English. While it was planned to translate the notes to English for analysis, the interchangeable mix of languages in my fieldnotes fostered a further complexity that I will discuss later, but that required the data to be analysed in its original language. Additional to the written records, I sketched graphs, streets and organisational maps as supplementary data in my fieldnotes. Given the conditions of the setting, during the 3-month period of fieldwork the manuscripts were physically stored in a suitcase secured with a lock to which only I had access.

## Visual data

Considering the identification of different objects used in traditional healing rituals (Greenway, 1998), the animate nature of things in many indigenous worldviews (Westermeyer, 1988; Yanez del Pozo, 2005; Naranjo, 2010; Capps, 2011; Cardona-Arias, 2012; Berger-González *et al.*, 2016a) and the nonverbal forms of interaction in indigenous healing practices (Maiello, 2008a; Waldram, 2015); I

collected photographic material to complement the observations recorded through my fieldnotes. Photographs were studied in order to build more thorough conclusions of the elements and environmental aspects that were part of Kichwa healing practices, and to analyse the effects these elements had on the healer-patient relation. I mainly took photographs of sacred sites, healing tools and medicinal plants, preparations of rituals, remedies and other important brews such as ayahuasca. While I had planned to photograph the interaction between patients and healers during the healing rituals, these generally took place in the evening and using flash photography would have interfered with the healing process. However, I had the opportunity to take photographs of some Kichwa healers performing healing rituals at a public healer-gathering event that took place while I was there. In addition to that and considering the emphasis on the relevance of the research setting in ethnographic research (Hammersley and Atkinson, 1995; Mason, 2002; Silverman, 2013), I also took photographs of Rukullacta and the nearby locations where I was taken by the Kichwa people. Photographs of people interacting were verbally consented and in various occasions I was asked to take photographs with and for some of the people I interacted with.

Although sometimes multiple forms of data collection could complicate the analysis process (Silverman, 2013), for this case, the combination of images and textual data has added value to the representations this research produced (Rose, 2012). Rose (2012) considers that images present an opportunity to think about how images look, but also about the ways they are seen. I also consider Berger's (1972) remark on the way things are seen to be conditional to the eye of the beholder. Visual data in this context was helpful for clarification, interpretation and exchange of meanings that environmental features and particular health-related objects had (Rose, 2012; Silverman, 2013). I deliberate over the use of images to be of benefit for this research, since it opens my perceptual framework to the external audience who is broadly also part of the construction of meaning. Additionally, because of the value that western culture gives to visual images (Rose, 2012), the use of visual material presents the opportunity to narrow the understanding gaps between indigenous and western cultures. The photographs were taken using a digital camera and the photos were stored in an encrypted laptop and deleted from the camera's memory-card. The camera and laptop were kept in a safe place along with other data forms.

### **Unstructured interviews**

Interviews were applied to counterbalance the observations recorded through my fieldnotes. The in-depth interviews were unstructured and based on open-ended questions; which I agree is the

advantage of qualitative interviews (Kvale, 1996). While ethnographic unstructured interviews are not predefined, they are not exactly ordinary conversations (Hoey, 2014). Ethnographic interviews provide more targeted data, allowing the space to generate dialogues about more specific topics (Hoey, 2014). The interviews were conducted using an interview guide with specific topics of interest and questions that developed in-situ from the topics of conversation. Although semi-structured interviews could have been used in this study, I considered the importance of emphasising the need to approach the understanding of indigenous cultures from their own narratives. The interviews were based in interactionist theories (Silverman, 2013) and following the social constructivist approach of this study, the interviews were seen as an encounter between the interviewer and interviewees, where knowledge was actively constructed (Holstein and Gubrium, 2004). The “active interview” as Holstein & Gubrium (2004) define it, develops the concept of the interview from a tool that conveys knowledge from the respondent, into a participatory space that includes the researcher in the process of construing knowledge. The process of “active interviewing” not only focuses on the “what’s” of the conversation, but also on “how” the interaction unfolds (Holstein and Gubrium, 2004). In this sense, the situation that was examined not only focused on what was enquired, but also on how the information was presented and understood. Moreover, in reference to the previously discussed role of “participant observation”, treating the interview as an active process allowed my engagement with the activity. This interviewing approach addressed two key aspects of my methodological stance: a) the process of reality construction between the respondents and me, and b) the opportunity to attend to the way indigenous people see the world through and in their own accounts. The interviews were focussed on exploring the ways Kichwa people saw and recount the healer-patient interaction and health-related situations. Nonetheless, the development of topics depended on the particular stories that the participants shared with me and on the situations that required elucidation.

A total of twelve interviews were carried out, but only eleven were audio-recorded. I interviewed six healers: three men and three women, but one of the women refused to let me record our interview. Although she gave no explanation to why she didn’t want our conversation to be recorded, I have considered two reasons; the first reason I presumed was because she did not trust me enough at the time, given the fact that I was living with one of the male healers in the community. The second reason was based on her situation or position within the community, considering she was the only female *Yachak* I was able to access. The other two women were healers, but *Yachaks* as I will explain in Chapter 6, have particular abilities to heal. In addition, I interviewed six patients: three men and three women all of them were patients to the same healer. The lengths of the interviews varied

from 29 minutes to 153 minutes. However, the average time for the interviews with healers was of 107 minutes and for the interviews with patients was of 47 minutes. The place where the interviews took place was negotiated with each participant, usually taking place in each participant's home. From the twelve conversations only one required the assistance of a translator. The remaining interviews were undertaken in Spanish. Apart from the previously mentioned case, the interviews were audio-recorded and verbally consented before each interview took place. In addition to the audio-recordings, I took notes for each interview session. The audio-recordings were transferred onto the encrypted laptop I took to the field and deleted from the audio-recorder after each interview session. The interviews were transcribed once the fieldwork period concluded and stored in an encrypted USB data stick. Back-ups of the audio-recordings were also made to the encrypted USB data stick and used together with the transcripts for analysis.

## Participants

A large part of the knowledge for this ethnographic research was acquired through the participation and interaction with the entire community of Rukullacta, but particularly through the relationship with Marcos Ramirez, the elder Kichwa TH who was my host, gatekeeper and a main participant of this research. Although it was not possible to identify the exact population of Rukullacta, an estimate of 160 people lived in the community. I was introduced to people in the community of Rukullacta through my gatekeeper and his family. The Ramirez family are renowned in the community for their health-related knowledge and their musical talents, which opened opportunities for me to get to know other people. The identification of key participants took place by carrying out initial conversations within the community (O'Reilly, 2005). With the help of my gatekeeper's son who was also my translator, I talked to eight Kichwa healers from whom six were participants in the interviews. I also interviewed six Kichwa people, who were all Marcos' patients at some point in their lives. In addition to the data collected through my participant observation, there were a total of twelve interviews undertaken for this study. However, only eleven interviews were audio-recorded and thus, transcribed. One of the healers that accepted to participate and take part on the interview did not consent for the interview to be recorded. The eleven-recorded interviews correspond to the following participants:

- Five traditional Kichwa healers: three male and two female TH.
- Six patients: Three male and three female Kichwa participants.

## Recruitment strategy

The recruitment of participants for the interviews was based on my initial observations and conversations related to the health-related practices of the Kichwa community. Nonetheless, it was through Marcos – my gatekeeper – and his family who introduced me to the people within the community of Rukullacta and the interviewed participants of this study. In my interest to learn about how Kichwa people live, I accompanied Marcos and several of his family members throughout their daily activities, which led me to meet the people in Rukullacta and participate in communal activities with them. Marcos' daughter introduced me to the *Kuraka*, the leader of the Kichwa people. As a result of presenting my research to him, he invited me to attend the *Yachak* gathering that took place while I was there. As I discovered with time, being trusted by Marcos and his family was a gateway to speaking to the people in the community and especially with the healers that participated in the interviews. The identification of key informants took place through conversations with the people in the community, but it was Marcos' eldest son who facilitated the interviews with all the TH's that participated in this study. Actually, it was only because I was with him that some of them agreed to talk to me. That was particularly the case of the TH who did not agree to record the interview and stated that the only reason she had accepted to talk to me was because Marcos' son was with me. As a non-Kichwa it was not easy to engage in conversations with the people, it was only through my association to the Ramirez family that I had access to insightful dialogues with many of them. Although every individual in the community of Rukullacta could have been a potential participant for the patient interviews, in order to keep consistency, I focused on people who were patients to the same TH. In the first stance, I had planned to interview Marcos' patients after the healing sessions that I attended. While it was not possible to predict the number of people that required Marcos' healing assistance, the recruitment of patients to interview was planned to ensue from each healing session that took place during the 3-month period that I stayed there. Since I lived in Marcos' home it was feasible to be ready when I was given the opportunity to accompany him to a healing session. In order to have access to the patients that participated in the interviews for this study, I requested Marcos' agreement and presented him examples of the type of questions I wanted to ask. Although in our conversations he agreed to help me find a time to talk to his patients, he was not actively involved in creating opportunities for the interviews. However, with the help of Marcos' youngest son I managed to interview two of the Kichwa patients for whom I had witnessed their healing ceremonies. As for the other patient's interviews, it was towards the end of my fieldwork that I already knew my way around and was able to identify Kichwa people who were treated by Marcos in the past. Though the initial plan was to interview Marcos' patients after the

healing sessions, my misunderstanding of the process of healing post-ceremony – that will be explained in Chapter 6 – was the limitation for which I had to find the alternative approach. The selection of participants for the interviews was opportunistic and given the ethnographic nature of this study, it was based on a snowball strategy. In order to capture different experiences and perceptions of health-related practices, I considered diversity in the characteristics – such as gender, age, etc. – for the identification of participants. However, the Kichwa patients of each TH are usually in some way related to them, this is because of how the Kichwa traditional medicine system works – I will discuss the details of this topic in the following chapters. In the case of the TH's that I interviewed, it was after speaking with Marcos' eldest son about my research and asking if he knew other healers within the community, that he introduced me to them. While I had asked a few people the same kinds of questions before, it was Marcos' eldest son who actively helped me find the Kichwa healers I spoke with. Marcos' eldest son had hosted a couple of students in the past and worked with one research student before. Thus, my request for help was not strange to him and he was dynamically involved in assisting me with my research.

### *The Kichwa healers*

The TH participants were three men and three women ranging from 35 to 69 years of age, though the average age was 57. The age difference is related to the level of knowledge each TH had. All three men were considered *Yachaks* and while the three women were all TH, only one was considered a *Yachak*. However, she refused to call herself a *Yachak* and instead called herself “Ajajyo”, a term also referring to wisdom. From the other two female TH's, one was a midwife with many years of experience and knowledge of women's health and the other was an expert on herbal medicine. Although there were additional casual conversations with other THs, these were only recorded through my fieldnotes. The interviews with TH's were all prearranged and although one of the interviews was not audio-recorded – upon the TH's request – I have maintained our prearranged conversation as part of the interviews for two reasons: the first, because she was the only female *Yachak* I was able to contact while I was there and secondly, because in spite of the limitation of not having an audio recording of our conversation, the information she shared and the unexpected interaction were valuable contributions for this research. A summary of the main characteristics of each TH participant and the details of their interviews is presented in Table 7.

### *The Patients*

The participants for the patients' interviews were all Kichwa people and as noted earlier, they were all patients to the same TH. There were two reasons for this approach in the selection of participants for the patient interviews. The first motive was to have consistency in the perspectives of Kichwa patients about Kichwa traditional medicine. The second reason was because in Kichwa tradition the elders of the family are usually people with great knowledge of medicine and the healing practices; thus, the patients of Kichwa THs are frequently related to them. This is a topic that will be discussed in the following chapters. There were a total of six participants in the interviews with patients: three men and three women. The ages of the participants varied from 22 to 38 years old. The participants were treated for different conditions, ranging from spiritual cleansing after the death of a family member to epileptic seizures. All the participants were patients and treated for their conditions by Yachak Marcos, the TH I lived with during the three-month fieldwork period. The following table (Table 6) presents the details of each patient and the interview session with each.

Table 6 Details of patient participants

| Pseudonym Name  | Age | Background Information   | Time and date of interview | Place of Interview |
|-----------------|-----|--|----------------------------|--------------------|
| Miguel Ramirez  | 22  | Miguel suffered from health problems throughout his late childhood and adolescent years. He had not presented any health problems for over 10 years. Miguel lived with his family and was completing his training to become a paramedic under the Red Cross training programme.  | 09/11/2017<br>75 min       | His home           |
| Raul Huango     | 33  | Raul was recently married and lived with his wife at his parent's home. Raul had recently lost a family member in a road accident, which was the reason his family requested Marcos' assistance.   | 21/11/2017<br>49 min       | Plantation         |
| Dolores Morales | 30  | Dolores was Raul's wife and the link between Raul's family and Marcos. She was a distant relative of Marcos that moved from a different region to the studied community after her marriage. Dolores was mother of two children.  | 21/11/2017<br>51 min       | Plantation         |
| Noelia Huaman   | 30  | Noelia suffered from severe illness and was hospitalised two times before seeking the help of Marcos and treating her illness with TM. Noelia was married and a mother of two children.  | 28/11/2017<br>44 min       | Fire log           |
| Ismael Quishpe  | 27  | Ismael worked part time as a tourist guide with an agency in the city town. He was married and a father to one child.  | 18/12/2017<br>29 min       | Fire log           |
| Elsa Lanchama   | 38  | Elsa was a mother of three and grandmother to one child. Most of her health-related interaction with Marcos was because of her children's health. She suffered from minor health issues for which she had regular cleansing rituals and other TM treatments. Elsa had little knowledge of medicinal plants that she learned from her mother and grandmother. | 18/12/2017<br>34 min       | Her home           |

\* Identifying details of the participants have been anonymised for the purpose of this thesis.