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Health: Sculptured by the Hands of Culture

Exploring the Ecuadorian Worldview of Health

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Abstract

Worldview is at the core of our being, providing the filter that gives form to our beliefs, values and behaviour. Each culture and country has its unique perspective in such vital areas such as health and wellbeing. In the global context, where 'health for all' is more a dream than reality, the challenge is to grasp the conceptual understanding of health in each context, to dialogue with the culture, and look for creative ways of meeting health needs. This thesis is part of my journey to achieve an understanding of this, in the context of Ecuador. The essence of this study is an exploration of the Ecuadorian context. How is health conceptualised within the culture? Is there a worldview of health? Are there areas of commonality of beliefs and practices in health? What are some of the historical events and processes that have formed this way of understanding? What has the ways of seeing health in Ecuador's current context?

This thesis presents the experiences and knowledge collected during five months of focussed research and two years of lived experiences in Ecuador. It is very much a journey of discovery for the researcher and participants. The research methodology gives voice to the stories of four participatory groups and five in-depth interviews, which allowed the participants to share their knowledge and experience of health. Through the process of reviewing literature on the beliefs and practices throughout various non-western systems of healing, a number of elements were found common to all. These include: the interrelated nature of the physical and spiritual realms; the concept of self and community; origins of unwellness and health seeking practices; food and food practices; syncretism and the concept of body image.

The stories of the participants reveal some of their beliefs and practices of health. Despite the wealth of cultural origins, climatic and contextual variety presented in Ecuador, nine themes emerge from the participants' stories, as common to their beliefs and practices of health: nature's healers, traditional sicknesses, the path of tradition, common sicknesses and causes of death, the therapeutic route, you are well if you look happy, of divine descent but humanly frail, no health without money, the path of tradition, and an acute awareness of the state of health. Together these portray a fascinating insight into part of the Ecuadorian worldview of health.

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Glossary and List of Abbreviations

<i>aguita</i>	herbal infusion of a herb made with boiling water
<i>colada</i>	a smoothie made with a variety of cereals eg oats and fruit
CONAIE	Confederation of Indigenous Nationalities of Ecuador
<i>cosmovisión</i>	worldview
<i>criollos</i>	Spaniards born in Latin American
<i>cue</i>	guinea-pig
<i>curandero/a</i>	one who heals
<i>fanesca</i>	a special soup eaten during the Easter week
<i>hechicero</i>	one who casts spells or makes magic
<i>hierba buena</i>	good herb/plant
<i>machica</i>	barley flour
<i>mal de aire</i>	evil air
<i>mal de ojo</i>	evil eye – sickness from being looked at enviously
<i>mestizo</i>	name of a person of mixed Indian and Spanish blood
<i>mulatto</i>	name for a person of mixed African and Indian blood
nervios	nerves or uneasiness of being from a bad experience
<i>niño</i>	child
NGO	Non-Governmental Organisation
PAHO	Pan- American Health Organisation (South American branch of the World Health Organisation)
<i>partera</i>	mid-wife or one who helps to give birth
<i>pérdida de la sombra</i>	dream loss
PR	Participatory Research
<i>quinoa</i>	a high protein cereal found in the Andean highlands
<i>rezandero/a</i>	one who recites
RRA	Rapid Rural Appraisal
RCC	Roman Catholic Church
<i>susto-espanto</i>	fright sickness
<i>trago</i>	local home-brew alcohol
<i>tierra</i>	land
UN	United Nations
WB	World Bank

Chapter One: Introduction

Cosmovisión

A wall stands overshadowing us
Of what my grandmother told me
Of what the priest said, and then did
Of how my father treated my mother

A filter fills the space between us
What society says it means to be a man
Of twenty years of accumulated media images imprinted on my brain
Of being given the same foods to eat every day
and the same white tablet when I am sick

Black clouds of assumption swirl foggily around us
I listen to your words but I don't hear their message
I take 'the cure' but it doesn't change the way I live my life
I will pay for your solution, but the voice inside shouts louder and demands allegiance

Perhaps now stepping stones stretch out between us
Pools of commonality now that we have heard and lived a little of each others reality
Asking to be crossed over, learning to step together
The dance that brings health and life

(Hicks 2001)

Introduction

Health is a gift from God.

A good doctor will give me vitamin drips and expensive tablets.

If you don't have money you can't have health.

Our ancestors were healthier because the food they ate was less processed.

Each of these quotes shared by different participants in this study represent a collection of concepts, beliefs and realities that reveal how they understand health. This complex conceptualisation of an area such as health, could be described as their worldview. The reality that we are human beings created with emotions, intellect, body and soul, means that each of us has a worldview, the core of which shapes our thoughts, actions and perceptions of the world around us. Ideas that are expressed, attempt to provide a synthesis of the limited human understanding describing a particular phenomenon or worldview. This knowledge is not like a landscape photo that is still, but is alive and moving, like a river flowing in a dynamic process (Smith et al 1997:169).

Health is one such phenomenon, fluid and constantly evolving, reflecting the needs and experiences within an individual and community context. While keeping in mind that this body of knowledge is complex and dynamic, this study hopes to capture a glimpse of the moving panorama of Ecuadorian people's beliefs and practices about health. It is simply part of a worldview, because the study focuses on the knowledge and experiences of a relatively small number of participants over a limited time frame.

There is a great deal of research focussing on the bad state of health, malnutrition, and analysis of why internationally directed programmes implemented to solve these problems have had limited success in Ecuador. For example, Teekens (1988) who reviews theory and policy for basic needs planning, Berti and Leonard (1998) who look at deficiencies in the nutrient intake in an Andean community, and Stansbury et al (1999) who discuss growth failure in the Ecuadorian highlands. This study does not attempt to provide a critical analysis of Ecuadorian health structures, or to present an exhaustive collection of traditional health beliefs and practices. Rather, it is an opportunity to hear and try to understand the beliefs and experiences of a group of Ecuadorian people in the area of health. In doing this, I hope to increase my understanding of their culture and how it affects

their beliefs and practices of health. My experience working in the area of health has been a continual challenge, to consciously put aside my ideas of health, to listen to, respect, and take into account the unique context presented by each individual and country. As researcher, my search is to understand the whys and wheres of these beliefs and practices, has led me to explore some of the history and culture of this country and the influence on the current experiences of health. I hope this study will provide a different and complementary perspective to the existing body of knowledge about health in Ecuador. The sharing of participants occurred both formally and informally, in both individual and group environments. These stories are combined with a selection of relevant literature, and some of my observations and experiences from living in Ecuador over the last two years.

The central aim of this thesis is to explore the worldview held by Ecuadorians in relation to health. To reach this goal, the following areas are explored: the concepts of worldview and culture; how an understanding of health can be shaped by historical patterns; what the key elements in a worldview of health are; and an overall understanding of the Ecuadorian context. For the purposes of this study, common themes are a collection of ideas, concepts, phrases, words and experiences which were repeatedly expressed either throughout the reviewed literature or shared through the stories of the participants. If patterns of repeated ideas and practices do exist it would appear to reflect an underlying way of understanding health – a worldview.

To help create a structure from which to study the Ecuadorian perspective of health, common themes were noted from reviewing literature about non-western systems of healing. Some of the principal themes found throughout the literature reviewed are: the interrelated nature of the physical and spiritual realms; the concepts of self and community; origins of unwellness and health seeking practices; food and food practices; syncretism; and the concept of body image. These themes provide the frame of reference for the participatory research groups and interviews, which produced the findings for this thesis.

A lifetime of experience and study would fail to capture the entirety and complexity of an Ecuadorian worldview of health. However as researcher, this study has provided an important starting point in my personal hearing and understanding of how health is

conceptualised and experienced in Ecuador. I feel satisfied and enriched with the quality and value of the experiential knowledge gained through this research.

Health as an Integral Part of Development

In the study of health, whether from a 'scientific', social or individual perspective, the wider cultural and historical context in which health is a daily reality, must be acknowledged. Therefore, as a foundation for exploring the concept of health in the Ecuadorian context, it is important to have a brief overview of the history and origins of Development Theory. This theoretical framework will be of assistance in responding to the question "What is development?" and therefore facilitate a better understanding of the integrated nature of health within the development discipline. We will begin by reviewing the three principle schools of thought as to what is the cause of underdevelopment and poverty, and consequently their respective policy directions: Modernisation, Dependency and People Centred Paradigms.

Modernisation

Modernisation traces its origins to early economic and social theory that developed during the age of industrialisation in Europe. The social development theories of sociologists such as Durkheim (1858-1917) and Weber (1864-1920) identified what they considered basic steps in the process of a societies development. The theory was further developed by social scientists such as Parsons during the 1950s and 60s, who taking the ideas of the economist Rostow, formed the theoretical foundation for modernisation theory (Webster 1991:49). Rostow's Stages of Economic Growth Theory (1960) outlined his key formulations of the five stages through which any society would need to pass to achieve economic growth. These began with a traditional society, the precondition to take off, the drive to maturity and the result, that was a high mass consumption society. The assumption was then, that any society who passed through these stages of economic and social transformation could become developed (Todaro 1997:706).

The modernisation school of thought sees development as a process of moving from a traditional to a modern society, modern being in nature industrialised and capitalist (Leslie 1996:12). This was to be achieved through a process of social transformation and

economic growth. Once the goal of sustained economic growth and a secure consumer base is achieved, the benefits will 'trickle down' to the whole of society, automatically bringing about a better quality of life for the affected population (Todaro 1997:82).

Post World War Two, the international climate was one of decolonisation, nation building and the threat of communism during the Cold War era. The modernisation policies implemented by the United States (US) to meet these perceived threats also provided the US with economic benefits (Leslie 1996:11). If the modernisation way of development had proved successful there would now be no poverty or inequality in the current global context. Today's reality could not be further from the truth. Despite the glaring limitations of economic growth to bring about real development, because of vested power interests of the western capitalist world, modernisation remains the dominating policy influence within multilateral 'development' agencies such as the World Bank, United Nations and the International Monetary Fund (Knippers Black 1999:25). In the last decade, the basic tenets of modernisation have re-emerged through the influence of neo-liberal economic policies that have had serious implications for many developing countries. Some of these policy directions include:

The stimulation of free-market trade, privatisation of national assets and reduced national spending on areas such as health and education (School of Global Studies 2000:9).

Examples of the outworking of these policies are described in the Ecuador chapter.

Dependency

The dependency or underdevelopment model is described by Todaro as a paradigm that grew out of Marxist theory, within the context of social upheaval in Latin America during the 1960s and 70s. It provided a strong critique for the apparent failure of modernisation policies, as inequality seemed to be increasing, with the expected trickle down benefitting only a small percentage of the population (Todaro 1996:82). The cause of underdevelopment was seen as a result of the continuous impact of colonialism, which created systems of external and internal exploitation. Although the era of colonialism was said to be over, less obvious forms of economic and media dominance have reinforced these dependence-creating patterns (Schuurman 1996:5). While providing a comprehensive critique of the capitalist economic system, Underdevelopment theorists failed to provide workable policy alternatives to improve the social, political and economic

realities in developing countries. Therefore as a theory, it has been limited in its long-term impact (Frank 1966 and Cardoso 1979).

The People–Centred Paradigm

After a relative vacuum of viable development theory during the 1980s, a collection of fresh approaches have recently been changing the face of development. Participation, empowerment, post-modernism, gender issues, environmental sustainability and a respect for indigenous cultures and forms of living, are some of the key ideologies which have informed the new way to 'do development' (Schuurman 1996:21). Within this perspective, the development practitioner is seen fulfilling the role of facilitator and information broker, rather than decision-maker or teacher. It aims to focus on the needs of the community through understanding and respecting local values, knowledge and experiences (Knippers Black 1999:21).

Although not considered a grand theory of development, this new wave of thought and practice challenges the development 'industry' to return the focus of development work back to people's genuine needs and wellbeing. Instead of embracing the external solution, this bottom-up approach searches for the way forward that is local, recognising the value of the community's experience and culture. While this aim is commendable, the philosophical changes are often limited to a change in rhetoric, without a transformation of the underlying top-down structures (School of Global Studies 2000:18). For example, within many government and non-governmental organisations in project planning and funding proposals, vocabulary such as 'participatory' or 'sustainable' are utilised because they are the current development 'trend', and will be treated favourably by donor agencies. However, there is frequently a limited understanding, ability or willingness by development practitioners to adequately translate these concepts into development practice (Chambers and Guijt 1995:11).

Development theory is particularly useful in this study of the worldview of health in Ecuador for a number of reasons. Firstly, because the health policies of Ecuador are a model case study of the limitations of modernisation theory; secondly, because the participatory methodology utilised in this thesis is a reflection of the recent trends in development theory; and thirdly some of the patterns of colonial exploitation critiqued by

Dependency Theory are present in Ecuador. Before completing this theoretical section, it is important for the reader to be aware of the researcher's bias in defining development. Despite the difficulty in providing a definition for a complex and multi-faceted word such as development, the following are two broad definitions that attempt to include the essential elements of development. The first reflects my personal perspective as researcher, combining parts of my life experience, faith and elements of the definitions given by development practitioners such as Chambers (1997) and Smith et al (1997). Development is a process that facilitates holistic transformation at an individual and social level. This process aims to create internal harmony in people, between humanity and between people and nature. It works toward creating choice, empowerment¹, participation², justice³, and the meeting of people's basic needs.

Another suggested definition of development is:

A multidimensional process that involves changes in social structures, popular attitudes and institutional frameworks, which brings about a reduction of inequality, and encourages economic growth. It facilitates an improvement in appropriate life options and the eradication of absolute poverty (School of Global Studies 2000:3).

My hope then, is that this thesis in its aims and methods will reflect these principles of development outlined here.

Health is life, if I don't have health I can't live and work. So simply stated by one of the participants in this study, good health is a non-negotiable necessity in the reality of being human. Therefore, it is a logical progression to see that health is integral to development, because if people are unwell in any way, it compromises their participation at an individual and communal level in providing for themselves, and in the decision-making processes of daily life. In fact, the individual and communal level of wellbeing within a people group, is

While the following words are common in the context of development literature, since the above definition to which they refer is my own, I have chosen to use the following more general definitions with which I agree, along with my own brief explanation.

¹ Empowerment is to enable or give power to (Collins Dictionary 1992:511) In this context it refers to people being able to have reasonable life choices in decision-making processes and the ability to meet basic needs such as food, security, employment, and human rights.

² Participation is having the ability and responsibility to take part in, or be actively involved in a process or activity (Collins Dictionary 1992:1137, Rahnema 1999:116). In this context this refers to individuals, families and communities in numerous spheres. For example: decision making, economic, political, education, health and social.

³ In this context I am thinking of justice as the fair administration of law according to the prescribed and accepted principles (Collins Dictionary 1992:841).

often an indication of the problems, paradoxes and practices of development in that context. As Helman describes:

Metaphors of illness are created in all cultures reflecting traditional beliefs about the moral nature of health and illness. These are often created to symbolize what is wrong in the wider society (Helman 1990:99).

This next section focuses on illustrating that health is an essential part of development. Health is affected by the economic, political, social, and educational structures of our society. A recent issue of the *New Internationalist* demonstrated this interconnected relationship, when it suggested that the reasons some people are more prone to illness are not surprising: inequality, poverty, pollution, the type of employment people are engaged in, and a system that values money too much and people too little. Of course a person with severely limited employment options will take work in an industrial chemical factory despite highly negative health risks and low wages, if it means providing for a family that would otherwise starve. Important energy has gone into creating and maintaining a profit focused medical system, and not enough energy into fighting against the structural causes of illness (Turner 2001:30-1).

This idea is further reinforced with a description of the close links between certain illnesses and 'development':

Sicknesses of development are in the air, water, air and noise pollutants from industrialisation, urbanisation, social dislocation, changes in nutrition and housing, media impact, cancer, hypertension, compromised mental health, drug and alcohol abuse, STDS/AIDS, traffic accidents and violence (School of Global Studies 2000:40).

Further evidence of this trend is shown by Griffen in the following Pacific example, which could well be in any developing country of the world. Government policies that cause social and economic changes are affecting people's health. Past generations either grew or hunted their food. However, today in agriculture, less food is being produced as people turn to cash cropping to earn a living. This creates a dependence on imported foods, many of which are processed, such as tinned fish, rice, flour, and sugar. These provide less nutritional value than many traditional foods and are contributing to an increase in diseases such as diabetes, anaemia, high blood pressure, heart disease, and malnutrition. In addition, as the influence of global marketing increases, more of the family budget money is spent on consumer items rather than food for the family (Griffen 1983:3,154-5).

Jones (1997:3) expands further on this connection between health and development in her social model of health. She adopts a multi-causal theory of health, which acknowledges the influences of political, economic, social, psychological, cultural, environmental and biological factors. The practical outworking of this model focuses on the transformation of the structural inequalities that undermine health, while simultaneously meeting the immediate, expressed needs of the people. This example reminds us that health is much more than simply immunisation, sanitation and family-planning campaigns, or even providing basic drugs and treatment to a population. Health is implicitly dependent on and part of the wider challenges of development, such as a reduction of inequality and poverty, empowerment, participation and sustainability.

Often the belief systems within indigenous cultures have been treated as an impediment to the modernisation of health, without being given the opportunity to share and utilise their own systems of healing that have sustained their communities for generations. For example, in Ecuador, within the bio-medical model that currently dominates the health system, little acknowledgement has been given to the many traditional remedies successfully used for centuries. Rather than making assumptions or analysing right or wrong practices, this study aims to listen to and value local knowledge and experiences of health. Perhaps by understanding the beliefs and practices of health, health care and education services in each unique context can be formulated to meet the needs of the people.

Voices of This Study

The Spanish word for knowledge is *saber*, which comes from the Latin *sabor*, meaning flavour. We have the ability to absorb knowledge, savouring it and being nourished by it. It is an act of creation and re-creation (Smith et al 1997:19). This thesis presents the opportunity for an interactive journey between the knowledge and experiences of the participants, researcher and reader through the common medium of communication: written language.

Participants

Each of the participants is represented through their stories, quotes, themes, drawings, photos and contexts, described predominantly in the methodology and findings chapters.

The Reader

Each reader comes with his or her own personal history, experiences and interpretation of what is read and felt. These affect how the information in this thesis is interpreted and understood. While reading this thesis you, the reader, are simultaneously processing, interpreting and relating the new information, to your existing frame of reference. This is an important and valuable form of interaction. I ask you to remain conscious of your own cultural filters as you read this study.

The Researcher

Because worldview underpins how and what we as humans communicate, as researcher, this study reflects my choices, experiences, culture and form of communication. Two particular experiences in my life have provided particular inspiration for this study, in challenging and stimulating me to think about the interaction of health, culture and worldview.

While working in India, my job description was to provide a module of basic health and nutrition education to a group of semi-literate Indian women affected by HIV/AIDS, and to the staff who worked in this community. Mostly due to my lack of being able to directly communicate with the women, I spent most of my time observing, participating in the daily activities of community life and asking questions. Through this process I began to discover the wide gap between the worldview of these women and mine, in relation to health. That is, their explanation of simple things, such as the choice and preparation of some foods over others, revealed a completely different underlying explanation. Other beliefs involved specific rituals for healing and a very strong social dictation of food choice, related to status. It was at this point, my consciousness in the differentness of our worldviews began to take shape, and I felt the challenge of how I could interact and offer something appropriate and positive to their reality.

The second learning experience, has been over the last two years in Ecuador. I have sat, observed, heard and participated in the life of an HIV/AIDS support group run at a local government hospital. I began to notice that the 'education' involving medication, food and hygiene practices given by doctors, nutritionists and health professionals, although with the best of intentions, was a discourse which had little to connect it to the everyday social, economic and physical reality of the members of the group. Suggestions and treatments that fitted with perfect textbook technique, had little relevance in the understanding and daily practices of these people. I became fascinated with exploring what was the worldview of the people in this context; where did these differing beliefs and practices come from, and how could these contrasting realities be connected?

Each person's worldview is constructed through particular family, societal and cultural structures, and by conscious decisions and life experiences. This creates the dynamic and constantly evolving nature of a worldview. While my cultural heritage and education are essentially European, I have been strongly influenced by living my formative years in the Melanesian culture of Papua New Guinea, and continuous travel and interaction with other cultures throughout my life. An additional influence shaping my worldview, is that my age, culture and education situates me within the postmodern generation. There are a number of characteristics found more commonly in a post-modern approach to research that are to some degree reflected in this study. Grbich (1999:48) describes some of the relevant traits of research in a post-modern environment in the following way:

It is common to observe a rejection of meta-narratives that are presented as providing complete answers, rather approaching a research topic with a particularly critical eye to self-biases and the socially constructed realities to be investigated. Based on the fact that 'truth' is multifaceted and in a state of constant transformation, multiplicities of perspectives are called upon to refract images from different aspects of the topic. Multiple voices are heard including that of the researcher. The researcher is de-centred, prediction is not so valued, and reflexivity and a continual questioning of the text are favoured.

Long describes postmodernism by contrasting it with a scientific perspective originating as part of Enlightenment philosophy:

While the Enlightenment era emphasized truth based on human reason, the autonomous self, scientific discovery, and human progress, post-modernism is characterised by preferences based on multiple truths, community, and virtual reality (Long in Rawson 1996:54).

Factors such as a reluctance to give boxed definitions of concepts, the acknowledgement and integration of multiple voices and the searching for common themes rather than 'concrete' results, are all reflections of post-modern influence in the way this topic has been approached.

Language

Written language is limiting because each word allows for multiple meanings and interpretations, which, if there is not some degree of consistency could allow for misunderstanding and confusion. Vocabulary such as 'indigenous', 'developing' and 'alternative' are in themselves labels that have been defined from a Euro-centric perspective (Department of Social Anthropology 1995:1). This in itself can create erroneous mental images that can reinforce unfair stereotypes and disrespectful generalisations. Janes (1999:1803) comments that the word 'traditional' invokes the idea of unchanging systems as compared to knowledge that is scientific and modern. Therefore, because of ethnic and political connotations, there is no satisfactory term in referring to non-Western medical systems. While acknowledging that language is problematic, it is necessary to communicate clearly and therefore terms such as 'third world', 'developing country' and 'traditional medicine' are briefly noted below in order to create consciousness of the researcher's perspective.⁴ Finally, it is also important that we do not create in our minds an extreme polarisation using the terms western and non-western. This is because in the reality of today's global environment there is a significant overlapping and borrowing of languages and values between culture, and influencing of worldview at previously un-heard of proportions.

In addition to the personal benefit of having a clearer understanding of the Ecuadorian perspective of health on the completion of this study, it is my hope that:

- Through taking the opportunity to share their knowledge and experiences of health in this study each participant would feel affirmed in their knowledge and practice of health within their own culture.

⁴ *The words ethnomedicine, non-western or non-Eurocentric health system, and traditional are used to describe any system of healing which is not based on an European ethnic origin

*Developing country or third world is used to describe lower-income countries while the term western or European is used for 'developed' more economically stable countries.

- That through participating, each participant might pass through a process of conscientisation⁵ regarding the state of their own health and health care options. This in turn may assist in reducing in some small way the dependence on western medicine and expensive health treatments.
- This study has facilitated an improved understanding between different ways of understanding health. By exploring the concepts of worldview, culture and health in this specific Ecuadorian context, perhaps health workers in a cross-cultural context will also become conscious of the extreme differences in worldview. If this recognition fuels action, maybe those facilitating health education would have greater relevance, appropriateness and effectiveness in improving the wellbeing of communities. Freire talks about this idea of respectful dialogue and conscientisation as being important for development:

Revolutionary leaders cannot sloganise, but should enter into dialogue with peoples so the peoples empirical knowledge of reality, nourished by the leaders' critical knowledge gradually becomes transformed into knowledge of the causes of reality (Freire 1972:104).

- This research will help to broaden the perspective of health in Ecuador. In doing this, perhaps a greater awareness amongst health professionals of the prevailing concepts of health will be raised, and relevant connection points between this prevailing worldview and the western based professionally educated perspective can be found.
- I, as researcher will gain a more insightful understanding of the history and culture of Ecuador, especially in how this impacts on the area of health.
- As a researcher, it is an opportunity for me to put into practice participatory research methods, and see how effective they are as tools for research and community development.

The Path to Follow – Outline of the Thesis

This thesis begins with an introduction to the concept of worldview and culture, why health is a key development issue, and goes on to create an awareness of the interacting voices represented throughout the study. Chapter Two is intended to provide the frame of reference by reviewing the literature related to the themes of worldview, culture, health and

⁵ Conscientisation is the process of becoming conscious of something (Rahnema 1999:125, Freire 1972). Here it is generally used in reference to becoming aware of existing ideas, beliefs or practices in relation to health.

Ecuador. Chapter Three situates the study within the context of Ecuador; its people, culture and history of health beliefs, policies and structures. The fourth chapter seeks to explain the origins and philosophy behind participatory research, why it has been chosen for this study, and how it worked in practice as a methodology. In Chapter Five we hear the voices of Ecuadorians sharing their knowledge and experiences of health as revealed in the common themes, sayings and a case study. Finally Chapter Six is dedicated to the relevant reflections and conclusions of the common themes revealed in this study.

Chapter Two: Literature Review

Introduction – Creating the Frame of Reference

The literature search for this study is focused in three main areas. The first area of interest is Ecuador, an exploration of its social history, culture, and some of the existing beliefs and practices of health. Part of this review of Ecuador is found in the second half of this chapter, however the main part is described in the following chapter. The second area of literature focuses on the concepts of worldview and culture. What do they mean and why they are important for this study. The third area is that of health, in itself an extensive and complex topic. I look at the origins and outworking of the bio-medical model of health and some of its limitations. Then some of the common patterns reflected in non-European systems of healing are explored. In addition a brief mention is made of how the bio-medical model of health has come to be dominant in today's global context. The aim of this chapter is to provide a frame of reference for this study in the light of existing literature. I hope it will facilitate a relevant understanding of worldview in the context of health in Ecuador.

I begin by exploring the concept of worldview, its place within and relationship to the concept of culture. This is followed by a historical review of global health patterns, which help to explain how the biomedical model of health has become dominant. The next part is an exploration of literature that describes the beliefs and practices of health and wellbeing within non-European environments. There are six themes that appear to be common in many non-western health systems, and I consider that they reflect part of a worldview of health. These themes are: the interrelated nature of the physical and spiritual realms, the concept of self and community, origins of unwellness and health seeking practices, food and food practices, syncretism and the concept of body image. These themes are illustrated using examples from a variety of cultures. The final part is a more in-depth study of some common health beliefs in Latin America, and how Ecuador is represented throughout literature.

Worldview and Culture

The aim of this thesis is to explore a worldview in the area of health. Winthrop (1991:324) comments that interest in the concept of worldview is a relatively recent (twentieth century) phenomenon. In my search for literature focused on the concept of worldview, I noted an absence of awareness and consideration of the concepts and effects of worldview and culture within the health science disciplines. Recent studies in the field of health-science undertaken in Ecuador, while numerous, were of little assistance as they did not in any way refer to worldview (for example Berti 1998 who looked at the demographic and socio-economic determinants of variation in food and nutrient intake in an Andean community, or Stansbury et al 1999 who studied caretakers, child care practices, and growth failure in highland Ecuador).

At this stage I broadened the search to include the closely related concept of culture and how culture shapes every area of human communication and interaction. Here I found an extensive range of fascinating literature within a variety of disciplines such as anthropology, psychology, ethno-medicine, cross-cultural communications, and sociology. As the concept of worldview is closely related to that of culture, firstly the concept of culture, its characteristics and role will be discussed, followed by a look at worldview and how the two are related. This is to provide a clearer understanding of how these terms are used within this study.

Culture

Culture is a complex concept, which has a variety of meanings for different people. The concept is utilised widely at times in imprecise and unclear ways (Tucker 1997:1). Winthrop (1991:50) in his dictionary of concepts in Cultural Anthropology gives eight varying definitions and discusses at length the complexity of the concept. He outlines the origins of the word as being from the Latin word *colo*, which means to foster, cultivate or honour. During the nineteenth century the notion of culture came to include a set of ideals capable of guiding social life. From there it became more commonly associated with the study of people groups, ethnology and anthropology. The following are a range of definitions, which I have judged as helpful for this study:

Culture is the distinctive patterns of thought, action and value that characterise the members of a society or social group (Winthrop 1991:50).

The Collins English Dictionary (1992:387) defines culture as:

The totality of the inherited ideas, beliefs, values and knowledge, which constitute the shared bases of social action. These are transmitted and reinforced by members of the group.

Ember and Ember (1995:166) define it as:

The learned behaviours, beliefs and attitudes that are characteristic of a particular society or population.

Lee, McCauley and Dragons (1999:5) view culture as:

Common patterns of human behaviour. Originally the term was limited to an ethnic group or geographical location, but more recently the word has been used to describe sub-groupings within or between societies such as 'youth and punk culture'.

O'Sullivan (1994:2) describes culture as:

The way we choose to be.

Most authors seem to include in the characteristics of culture that it is: learned, transmissible, dynamic, selective, ethnocentric and its various parts are interrelated (Samovar and Porter 1997: 13). In addition, there is no denying the social nature of culture. It is something learned consciously and sub-consciously from being part of a collective body where there is a basis for common understanding. This acts as a guide for behavioural patterns of the group. Important elements of culture include: language (verbal, written and body), concepts of space and time, relational behavioural patterns, and the more visibly external features such as music, dress, food and religion (Samovar 1997:19). One of the important functions of culture is to provide a highly selective screen between the individual and outside world. This helps to determine what a person pays attention to and what is ignored, giving structure to how we see the world and providing protection from information overload (Samovar and Porter1997:45).

For example, my experience has shown me, that in New Zealand, people are encouraged to be direct and efficient in their communication. This is a cultural characteristic. In Ecuador however, I have found that being direct is often offensive. It is much more important to maintain the harmony with whom you are communicating, rather than be logical and efficient. This reflects a number of underlying values present in each culture regarding time and the importance of maintaining good relationships.

As will become evident, Ecuador has a rich cultural heritage from a number of distinct sources including Indian, Spanish and African. Each people group that has become a part of Ecuador's history has brought with it their inherited ideas, beliefs, values and knowledge regarding how they see the world. Elements of these have joined and mixed to give certain characteristics that can be described as Ecuadorian. This range of beliefs, common conceptual understandings, social expectations, patterns of dress, speech, music and food to me represent Ecuadorian culture.

While the two concepts of culture and worldview are closely linked, they do not mean the same thing. Now we turn to explore the concept of worldview.

Worldview

Winthrop (1991:324) explains how the word worldview originally appeared in English as a translation of the German *Weltanschauung*. *Welt* refers to the universe, people, society and humanity, while *Anschauung* describes a way of understanding combined with an act of contemplation. Philosophers such as Dilthey (1833-1911) and anthropologists like Redfield (1897-1958) explained the term as a person's overall perspective on life. Worldview is conceptual and philosophical, there is no tangible object called worldview, yet it permeates our daily actions and reactions. While culture generally refers to a communal characteristic or societies' behavioural and belief patterns, each individual can have their own worldview in a certain topic area within a culture. These following definitions I hope will help to explain what worldview is.

Worldview is the underlying logic and guiding assumptions of a culture regarding such categories of experience as time, causality, nature, society and the self (Winthrop 1991:324).

Samovar and Porter (1995:68) say that:

Worldview provides the construct for a culture's orientation toward philosophical issues such as God, humanity, nature, the universe and those matters concerned with 'being'. It is reflected in and intrinsically linked with culture, which is consequently shown in systems and institutions in the functionality of a society.

Kraft gives the definition as:

Worldview is the culturally structured assumptions, values and commitments or allegiances underlying a people's perceptions of reality and their responses to these perceptions (Kraft cited in Rawson 1996:6).

Hoebel and Frost (1976:324) describe worldview as:

The human beings inside view of the way things are coloured, shaped and arranged according to personal cultural perceptions.

Figure 1 is a visual representation of how worldview is at the core of our being, providing the filter that permeates and shapes our beliefs, values and external behaviour.

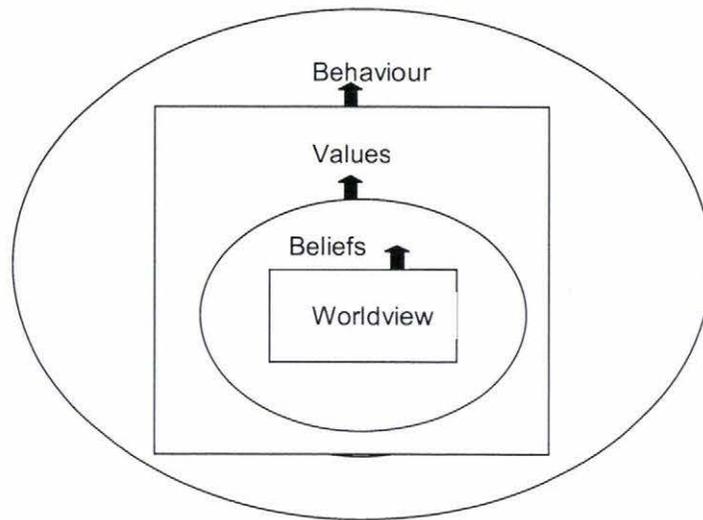


Figure 1 Worldview and the Layers of our Being (Chew 1990:5)

The Core of Worldview

Samovar and Porter (1995:114) describe worldview as the core, subconscious part of our being which helps us to locate our place in the universe. For example a child learns its place in a family both by how it is treated, what it is consciously taught and by the models seen in the surrounding society. Therefore two children from the same family who experience different educational structures could develop a distinct way of seeing the world. Worldview is complex, timeless, and dynamic, representing the most fundamental basis of a culture. It is related to and shaped by the history of a specific context. People learn to become members of a group and follow the norms, rituals, values and expectations that lead to appropriate outward conduct (Levinson and Ember 1996:1381).

The Second Layer – Beliefs and Values

An important function of a belief system is forming the basis of our values. These values then produce different choices and reactions in people's daily decision-making processes. Values are social guideposts that disclose to us the guidelines of our society and measure the way we should behave. They represent what is expected, required or forbidden. For example, a person who believes that humans are responsible for caring for the environment will display different behavioural patterns to someone who does not hold this belief. Whether this belief is held or not relates back to the core of the worldview. When values are internalised, they are used both consciously and subconsciously as a set of standards for directing actions, also developing and maintaining attitudes toward relevant objects and situations (Samovar and Porter 1995:115).

What is Seen – Behaviour

Behaviour is the external demonstration of internal beliefs and values. As human beings we each possess the same physiological sensory mechanisms of perception i.e. sight, touch, hearing, taste and smell. However, the next level of interpretation and evaluation of these perceptions, which is then translated into behavioural patterns, presents itself with the hues and colours of our world-view (Samovar and Porter 1995:81). For example, the viewing of a violent image on television could trigger two completely different reactions in children who have been exposed and formed by different beliefs and values regarding violence. Our conscious and sub-conscious behavioural reactions to events in the universe are a result of our social, educational and cultural conditioning by the core of our worldview. People generally behave and communicate responding in accordance to their interpretation of the external world (Levinson and Ember 1996:1381).

In trying to describe the relationship between culture and worldview, I like to imagine a weaving which represents the totality of the internal and external human being. The weaving has two sets of threads, one going length-wise, and the other width-wise, which form the base colours of the weaving. These two threads form the background for all the other colours and textures that are woven in and around them. Therefore these two dominant colours determine to a large extent the flavour and design of the finished product. Culture and worldview could be likened to these two fundamental threads that are interwoven, the interrelation of which gives form and identity to us as people.

Rawson (1996:65) in her study on the worldview changes of Asian students studying in the United States describes how people within the same culture can have distinct worldviews depending on the life influences they have experienced. I have seen clear evidence of this in India. Here, two people who both display Indian cultural characteristics can hold a significantly different worldview in the area of religion. In this example, each person although reflecting the same culture on many levels (such as dress, language and food), their worldview of faith has been formed by a specific life experience, and is distinct such as that of a Hindu and Christian. Levinson and Ember (1996:1381) talk about how a person's worldview in a particular area can be shaped by their material living conditions, social and historical influences and cultural knowledge passed on by past generations. The phrase worldview can refer to a particular area of cultural knowledge (Winthrop 1991:325). While culture defines wide, general characteristics, worldview can be related to a specific area, such as health. For example, I would define myself culturally as being a New Zealander, where a bio-medical model of health is dominant. However, most of my views about health are not dominated by, or restricted to the bio-medical model. This is a result of my individual life decisions and cross-cultural experiences. Therefore the broader characteristics of culture can be a defining influence of worldview, but not necessarily everyone from the same culture will have the same worldview in a particular area. While a person is generally aware of their culture, worldview is often more sub-conscious. It is the lens through which a person gives meaning or explains a particular concept or experience. External actions and behaviour then, can be traced to a particular worldview.

Samovar and Porter (1997: 235) make the comment that worldview can be reflected through common sayings or proverbs used within a cultural context. These can capture what is deemed important, and have a tendency to repeat the assumptions on which the culture operates. For example, a common saying in Ecuador is *Despues el gusto viene el susto*, which translates to, following the things I have enjoyed will come the shock or the bad thing. This was explained to me by a participant, as representative of part of a common worldview of faith in Ecuador. It is expressing the idea that people should never take for granted the good moments because something bad is sure to follow. There is a sense that people do not have control over difficult circumstances, because perhaps God willed this hard time, or the person is un-deserving of the good things in this life. Consider the language used in sayings, the images they portray, and the assumptions underlying

the understanding of it. All represent a way of being. Sayings can provide a valuable connection between the past, present and future, being both universal and specific. Encased in the 'truths' are values handed down by tradition from one generation to the next (Samovar and Porter 1997:236).

Having explored the definition of worldview, the following section gives some examples of how health is viewed in another culture. This different understanding could be described as a reflection of this groups worldview of health. Cornwall (1992:69) shares her experience in exploring the understanding of the bodies of a group of Zimbabwean women. After doing a body mapping exercise with a group, Cornwell, the project facilitator, noted that the anatomical portrayal of the women's own reproductive systems was completely different to what is illustrated in western textbooks. The Zimbabwean women's perception of their own bodies was completely different, thus reflecting a distinct way of conceptualising health – a different worldview. Theirs was an understanding unrelated to or affected by western education and 'scientific' knowledge.

Cornwall goes on to explain how this presenting of a different understanding of anatomy, could create a situation where a clash of worldviews arises. Here, a Western trained professional is being challenged to take seriously a person's body map when it is clearly 'wrong' from a bio-medical point of view. This requires a big attitude change on the part of the western trained health professional. This reveals that 'scientific' knowledge is not really objective, rather is also a product of its own worldview. Therefore in a cross cultural situation such as this, it makes little sense to 're-educate' people using the metaphors of an unfamiliar worldview, which has nothing in common with their existing knowledge base (Cornwall 1992:74).

As we see in the following section, a bio-medical perspective of health is often restricted to pain alleviation or a managing of observable symptoms. A person's physical state is generally considered quite separate from the spiritual or emotional arenas. The way of understanding what sickness is, appears to be quite different in the following experience described by a Honduran community health worker:

Entering university at twenty I was so smart and beautiful. I came out at twenty-seven ugly and dispirited. I know now that the greatest sickness is that of the spirit, and it is possible not to notice you are weak in spirit (Smith et al1997: 164).

Here, sickness seems to be more about the state of spiritual wellbeing, rather than a physical ailment. To me this reflects a different way of understanding health, where the physical and spiritual are inextricably linked. This characteristic of non-western cultures is explored later in the following section.

Although modern science has carefully excluded the 'unexplainable' spiritual realm from its reality, in many cultures disbelief in a spirit world is a striking abnormality. Helman (1990:217) describes how the difference of worldview depends on the construct of a person's norm in the Haitian context:

To a western psychiatrist the behaviour of a traditional healer involved in a healing trance closely resembles that of a schizophrenic in a mental institution. What is normal for one worldview of health is treated as illness in another. Each culture provides its members with ways of becoming ill, of explaining its causes and treatment for the state of un-wellness (Helman 1990:230).

It appears that each culture has a group of beliefs and practices that could be considered their worldview of health.

To summarise why the concepts of culture and worldview of health are important in this study, there are two assumptions I am making. Firstly, that each participant, by nature of being an Ecuadorian in today's context, will share elements of Ecuador's diverse cultural history. This means that by being in the same geographical area, while the participants may have had different class or gender experiences, significant areas of culture are shared. However, as described above, culture refers to the entirety of behavioural patterns in a people group, while the word worldview can be used as a way of exploring the way a particular area of culture, that is health and how it is understood. In exploring worldview I want to see if there are areas of commonality in how participants understand and conceptualise health. If there are areas of commonality throughout the experiences and beliefs of the participants, this to me in a general sense describes a worldview.

Secondly, that if some degree of commonality is shown in this group of participants perhaps it would be true for Ecuadorians in general. I would like to see if the diverse cultural influences throughout Ecuador's history have formed any common ways of understanding health that could be described as a worldview. This is reflected in their beliefs, values and practices of health. Therefore for this study, a worldview of health could be described as

common patterns of beliefs and practices shared by the participants. The next section outlines different ways in which health can be understood.

Constructs of Health

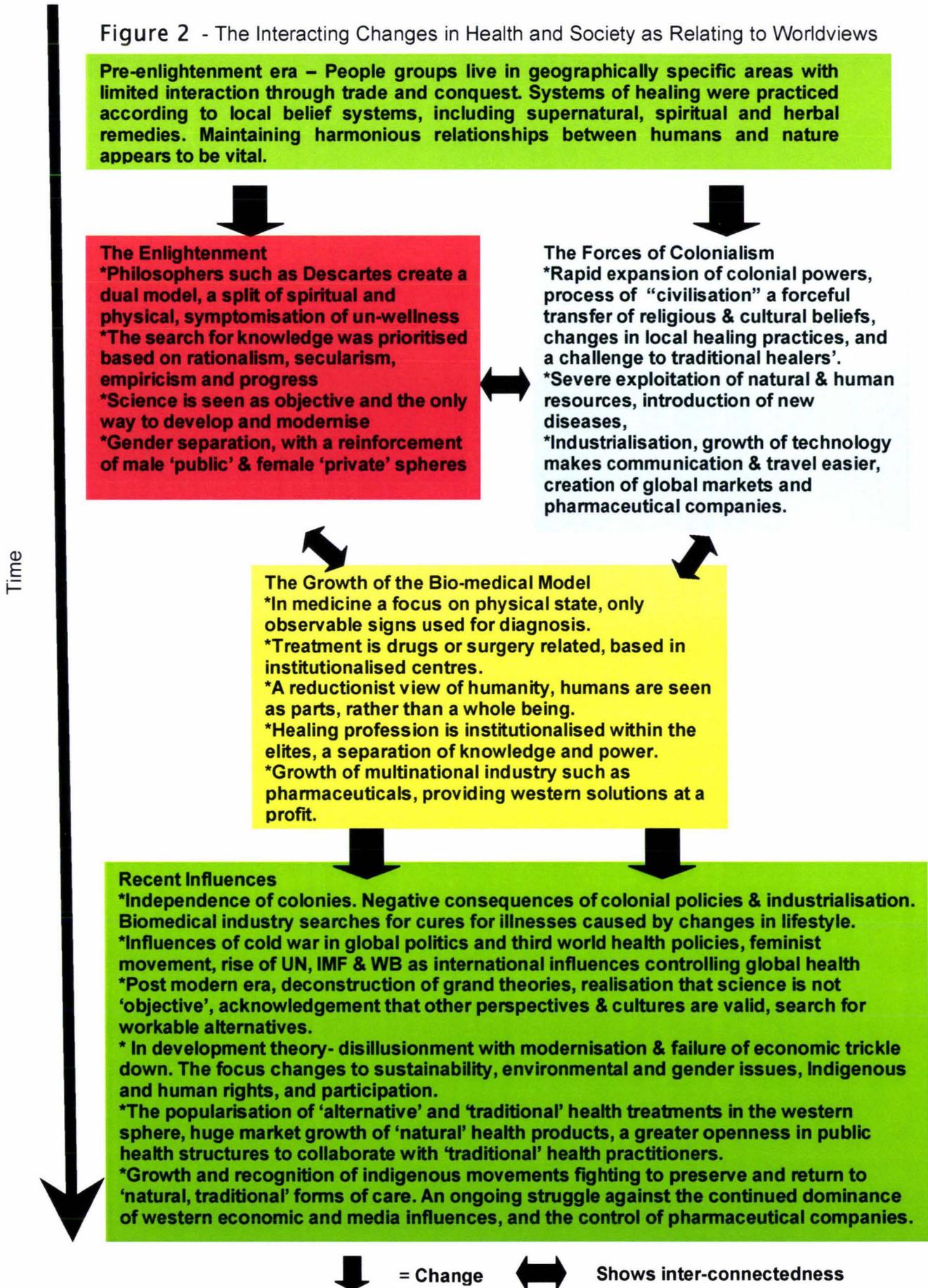
As human beings, we experience health through the filters of our sex, gender, class and culture. The resulting set of beliefs and practices held by a person or community could be described as their worldview. Explanations of health and illness are embedded in people's life experiences, influencing their attitudes and actions (Jones 1997:3). In reviewing a variety of health related literature, I have noted that two main perspectives of health seem evident: that which is predominantly **Euro-centric**, scientific and modern, and that based on the reality of **non-European** belief systems. Unfortunately, this generalisation is limited in that it does not allow for the complexity of perspectives revealed through and within each culture on earth. We should remember that even the notion of west and the rest has limitations; because it gives the impression that the west is the centre of the universe and therefore the norm (Department of Social Anthropology 1995:1). This is certainly not the case. However, in the present global environment it is not hard to see that the Euro-centric model of health dominates. This is largely a result of the historical patterns of colonisation, modernisation, globalisation, combined with economics, power and exploitation, which have paved its way.

Figure two is a diagram that attempts to provide a visual overview of these historical trends on a global scale. While there are too many influencing factors to cover each in detail, the aim of the section following the diagram is two-fold. To briefly explain the approach to health within each era and, trace how the western bio-medical model has dominated health through the processes of colonialism and global change. It is the interrelation of these themes with health, and the changing trends in a world context that we consider next.

Pre- Seventeenth Century European Concepts of Health

Helman describes how medicine practiced throughout Europe in the Middle Ages was based on the theory of Hippocratic medicine. This humoral theory, which has its roots in ancient Indian and Chinese systems of healing, was developed into a medical system by

Figure 2 - The Interacting Changes in Health and Society as Relating to Worldviews



Hippocrates, born in 460 BC. It was elaborated further by the Greek physician Galen during the second century AD, and in time diffused throughout the Roman and Islamic world (Helman 1994:21). This medical system was based on the idea that the body consists of the four bodily humours, phlegm, blood, yellow bile, and black bile, each corresponding to a natural element. A unity was thought to connect the humours of the person - or microcosm, with the elements of the universe - the cosmos or macrocosm. Health resulted from these humours being correctly balanced. To maintain this balance, external factors such as diet and environment were important, as well as internal causes such as personality (Samson 1999:3-5). A similar balance of energy theory remains the basis for many non-Western systems of healing today, for example India, Puerto Rico, Morocco and China (Kurup 1984, Helman 1994, and Kim 1996).

Changes Brought by The Enlightenment

Frohock (1999) describes how the significance of a biomedical worldview as it is currently practised, researched and conceived is based upon the changes in the philosophical underpinning of the world that took place during the Enlightenment. These changes were engaged in overturning the culture of the 'dark' or middle ages, which were considered to be suffused with superstition, primitivism and unreason. Throughout Seventeenth and Eighteenth Century Europe, scientists, medics and philosophers were focused on a 'new' search for knowledge and 'truth', promoting the values of rationalism, empiricism, secularism and progress (Samson 1999:3). The key assumptions developed in this era include the creation of mind-body dualism, the machine-body model, and the creation of 'objective' knowledge (Kleinman 1980, Helman 1994, Jones 1997, Senior and Viveash 1997, Freund and McGuire 1999). These beliefs, which continue to form the basis of the current bio-medical worldview are outlined below, along with some of its practical consequences.

The Biomedical Model of Health

The dualism between the mind and body had its roots in the theory of the French philosopher Descartes. He believed that the body was profane; the public space, and clearly separated from the soul that was sacred (Samson 1999:4). This resulted in the physical symptoms of unwellness being treated in isolation without the consideration of the

soul and spiritual dimension (Doyal 1995:15). This physical reductionism helped to create the compartmentalisation of health into separate specialist areas such as mental, physical, social and spiritual, each of which is dealt with by a different specialist (Freund and McGuire 1999:6). Therefore, diagnosis and treatment is based on a symptom or malfunctioning body part rather than taking into consideration the whole person with his or her physical, emotional, spiritual and social context.

Influenced by fast developing science and technological models, the body began to be described, using a machine metaphor. The form and function of the human body was likened to a bio-chemical machine (Martin 1994:29). Consequently sickness or pain was seen as the breaking down or malfunctioning of the machine, that must be fixed. Helman (1994:25) describes another analogy based on the same assumptions, as the 'plumbing' metaphor of the body. Here the focus is the maintenance of the 'normal' body function ('normal' being based on a European middle aged male), which excludes a vast majority of the world's population.

The consequence of this machine image being so dominant is that both nature and human life are defined solely in cause and effect terms (Samson 1999:3-5). While a level of systematisation of sickness was useful, this cause and effect mentality failed to allow for the complexity of human characteristics and function that exist on our planet (Mackay et al 1998:6). The aim has been to 'fix the broken parts of the machine'. For this reason we see a machine like drug and surgery treatment of sickness, often removing the symptoms without dealing with the background causes (Martin1994:29).

Research into human physiology, anatomy, new diseases, cures, viruses and anti-biotics were forging ahead during this era. Because of its supposedly unbiased 'scientific' nature, this knowledge was considered to be 'objective' (Freund and MacGuire 1999:6). Therefore the assumption that sickness is always caused by something scientifically explainable such as bacteria or a virus became entrenched. This along with the concept that disease can be localised in particular organs became the basis for an 'objective' diagnostic process (Senior and Viveash 1998:10). Therefore, identification of illness is dependent on the doctor. As this body of medical knowledge has continued to expand, the gap between those with the knowledge (the professionals) and those without (the patients) has grown, creating a greater imbalance of power. A parallel growth in technology has provided the

endless products and machines such as pills, X-rays, heart-monitors, and uniforms which are associated with the maintaining of this distance (Freund and McGuire 1999:206). There is almost an unquestioned dependence on scientific knowledge, meaning that those who do not share this worldview or knowledge are either excluded from, or become dependent on the system.

In making these generalisations, it is important to recognise that not all professionals trained in this model necessarily reproduce its limitations. There is considerable variation in how this basic model is outworked in the professional arena. However the basic assumptions of this worldview remain firmly entrenched, as the basis within the bio-medical model of health. The next section turns to some of its limitations and critiques, before focusing on some of the recent trends that are impacting this set of beliefs and practices.

Critique of the Biomedical Model

One of the main critiques of the Bio-medical model is that health care services have lost their people focus. What was once a healing service has become a moneymaking industry designed to benefit those who produce the cures (Senior and Viveash 1998:14). Aided by powerful media and marketing influences, a system focused on high-tech, institutionalised, curative care health centres and hospitals, rather than preventative care has been created. Illich (1976) describes how human behaviour is medicalised, turning health concerns into medically 'curable' problems, therefore creating a self-sustaining industry. Turner adds his critique of some of the current trends in biomedicine:

The history of medicine tells us the key to improving human health is providing a greater quantity and quality of health professionals who receive higher salaries. However with more highly paid medical 'professionals' in the world today than ever before, the overall health of the world's population doe not appear to be improving. The emphasis of financial and human resources being focused on trivialisation, hair transplants or a boob-job, which reflects the individualist and image conscious west that sucks health resources away from the truly needy. The reality is that people would rather go for a 'cure it' visit to the doctor than begin to deal with the social problems of bad eating habits or lack of daily exercise. In March of 2000 the number of overweight people was equal to those underweight in the world. Between them, hunger and overeating account for more than half of the world's diseases (Turner 2001:32).

This critique alludes to the complex array of factors that have interacted to create this industry: multinational companies looking for profit, changing lifestyle and eating patterns, and a culture that searches for immediate solutions.

Another longstanding critique is the presence of a strong gender bias in the bio-medical worldview (Senior and Viveash 1997:17). From its birth during the enlightenment, where the dominance of male philosophers and scientists was unquestioned, this pattern has not changed significantly. Although the majority of health care professionals such as nurses and midwives are women, there continues to be a numerical dominance by men in the higher paid and prestigious positions of the medical profession (Helman 1994:154). This often results in an imbalance of power and a biased understanding of women's needs within health services. The realities of pregnancy, contraception and the predominance of women's role in childcare means that they form the larger proportion of health care users. These natural processes become medicalised in a system where the underlying model is based on a male 'norm' and understandings (Doyal and Elston 1998:79). It is also the narrow biological orientation of medicine and health research that limits its capacity to deal adequately with women's health problems (Doyal 1995:17).

Throughout the next two critiques it can be seen how technological and lifestyle changes made through global patterns of colonialism, industrialisation and capitalism have affected epidemiological patterns. While in many countries serious basic health needs still exist, a new list of sicknesses is becoming a greater threat. The acute is being replaced by the chronic illnesses of industrialisation (School of Global Studies 2000:37).

On the one hand the positive benefits of technology, economic growth, industrialisation and western influenced education can be seen in areas such as: more people with access to safe water, improved sanitation, immunisation, contraceptives and a greater variety of foods. However the negative impact can be seen in the greater inequality within resource distribution, more of the health budget is spent by fewer people, growing pollution, and changed lifestyle patterns. These in time lead to an increase in the risk of heart disease, diabetes and cancer. Stacey (1998:54) outlines that although it is difficult to claim the health 'consumer' model is the direct cause of changes in epidemiological trends, the critique remains that the industry and underlying assumptions of the medical model are an integral part of these global pattern. In doing so, it has generally failed to create space for alternative ways of understanding and treating health.

Samson (1999) discusses how a crucial factor in the perpetration of illness in many contexts, results from the changes brought about by the colonial era. Many ethnic groups

are suffering from apparently 'unexplainable' physical illnesses and serious social problems such as suicide and alcoholism. He believes that an important contribution to these patterns has been the undermining of native cosmologies, spirituality and ways of viewing the world, resulting from colonialism (Samson 1999:275). The diffusion of diseases which are caused by, and can only be cured through the use of biomedical treatment, have played a part in the undermining of many cultural realities. This has compromised human ability to manage and remedy unwellness in their own way (Illich 1976:128).

A further critique related to the input-output machine like assumptions of the bio-medical system, is the limitations in the way health is measured. Quantitative measures of mortality or life expectancy fail to take into account either the experiential element of illness or the level of quality of life (Doyal 1995:10). In reality a lowering of morbidity often has little to do with the improved health of families and communities. This is evidenced in Ecuador where despite an improvement in health statistics the general health of the population, health services and quality of life have not improved (INEC, OPS 2002, and Olmedo 2001). These are some of the critiques of this essentially western worldview of health. The next section goes on to mention some of the recent influences having some effect on the bio-medical model.

Recent Changing Trends Impacting the Bio-medical Worldview

While built on a series of key assumptions, the practice of bio-medical science and health cannot be categorised simply as an unchanging, homogenised, Euro-centric, curing industry (Doyal 1995:15). Nor is it denied the tremendous positive impact this health system has provided to some sectors of the globe. The dynamic nature of medicine and culture can be seen in the acknowledgement and growing popularity of non-western perspectives of health. This is demonstrated by the acceptance and availability of professionals in the areas of acupuncture, homeopathy, and naturopathy, and in the growing range of 'alternative' health literature. In addition to the growth of areas such as ethno-medicine, it is common to read publications that present a broader multi-cultural lifestyle approach to health. In his popular lifestyle health book, Ford focuses on the importance of environmental and emotional factors in maintaining health:

The immune system mirrors our mood and self esteem. Some of the principle causes of immuno-suppression are smoking, unresolved emotional stress and depression (Ford 1998:7).

Diamond the author of another self-help health manual also promotes a more holistic approach to health:

The best way to manage stressful lives and prevent un-wellness is by opting to change your lifestyle, as intervention with drugs or surgery are only bandaid solutions. Living healthfully is not an art that we must learn; it is an instinctive way of life to which we must return (Diamond 1987:8).

Over recent years, within the research field there has been a growing focus on the study of the social and environmental elements of health. An example of this is Brown, who explains that although illness is located in the body, it is a profoundly integrated social experience that goes far beyond physiology. It is considered that social roles, power, conflict, networks of family and friends, bureaucracies, organisations, social control, ideas of moral worth, and aspects of work are all interlocking factors affecting health. Therefore what we actually experience as illness is a change of our social lives, disturbing our normal patterns of pursuits (Lorber 1997:1,4). This perspective moves away from the strictly cause- effect type model, and takes into consideration the wider human context and how this impacts on our health.

On the global health stage, there have been significant moves by dominant influencers such as the World Health Organisation (WHO) to recognise 'traditional' health practices and practitioners within other cultures. In 1977 the WHO urged government health providers to acknowledge and utilise traditional practitioners within national health systems (Durie 2000:9). The outworking of these policy directions has been seen in the four main types of relationships between western trained health professionals and traditional health service providers throughout the world that are described by Bannerman et al (1983). The first is where western trained practitioners have the sole legal right to practice medicine, and other types of healing are outlawed. Secondly, a relationship of tolerance, where traditional healers can work, but are not recognised by the government as official health service providers. This applies in countries like the United Kingdom, Indonesia, Egypt and some Latin American countries. This would appear to be the case in Ecuador, where a homeopath told me of the struggle to be officially recognised and registered as health providers within the existing Ministry of Health, by members of his profession. Thirdly, is where western and traditional systems work alongside each other, both being given equal recognition and value for the service they provide. This is the official policy in Zimbabwe, Thailand and Swaziland. The final system is truly integrated, where modern and traditional structures work in an integral and complementary way, being equally resourced and

valued. For example this can be seen in China where traditional and western medicine are taught and practised side by side (Bannerman et al 1983:10). These changes have been followed up by the WHO organised Hong Kong conference in 1995 that focused on traditional medicine, and working groups focused on the health of indigenous peoples (PAHO 1997:361). This acknowledgement of 'traditional' health practitioners reflects the growing influence of non-western worldviews, and its impact within the biomedical system.

Throughout this section some of the key assumptions of the bio-medical model and its limitations have been described. As we move on to explore some of the beliefs and practices of health within non-European cultures it is worthwhile reflecting on the contrast between Euro and non-Euro centric worldviews as presented by Samovar and Porter (1995:127):

Biomedicine is essentially mechanistic, where the universe is a physical system operating in a determinate manner set by discoverable scientific laws. Humans can change or redesign the system as they gain knowledge and improve their techniques. The other is holistic, where the world is a unit, continuously creating and intimately infusing every aspect of the cosmos from its smallest detail to its grandest feature. Human beings in this orientation are at once body, mind and spirit.

Non Euro-Centric Cultural Perspectives of Health

In every culture healing is governed by established (although generally unwritten) codes of practice, which draw on ethical, cultural and philosophical principles as well as use of plant materials. Therefore the rationale for healing activity is found in physical remedies offered along with the traditions, beliefs and cultures of the client and practitioner (Durie 1996: 9,10).

The scope and wealth of literature exploring traditional systems of healing from around the world is both fascinating and endless. In reading a selection of this literature, my aim was to see if there were any recurring patterns or themes in the beliefs and practices of non-western contexts. The reasoning behind this was that although each culture is unique, if there were patterns expressed in how health is conceived found in a variety of cultures, perhaps these same patterns could be found in Ecuador. The patterns that I noted form something of a framework for what I have described as a worldview of health. These common themes are: the inseparable nature of the physical and spiritual realms, the concept of self and community, the origins of unwellness and health seeking practices, the presence of a multi-sectored healing system, the significance of food and food practices,

the concept of body, and the existence of syncretistic beliefs. This next section traces these themes, giving examples from a range of cultures and systems of healing.

The Inseparable Nature of the Physical and Spiritual Realms

Some of my earliest memories as a child living in rural Papua New Guinea involve having my friends explain that someone was sick because the spirits had been used to put a curse on them. In that context it was unimaginable either for me, or the local people to see the physical and spiritual world as something separate. Frohock (1999:150) describes non-western systems of healing as tending to regard the human in holistic terms. People are seen as wholes, constituent parts of a wider reality that is not expressed as being divided into 'physical' and 'spiritual' compartments. Evidence of this is seen in many cultures.

Pere (1987) describes how Maori, the indigenous people of Aotearoa/New Zealand view health as encompassing *wairuatanga* (spirituality), *wairoa* (total wellbeing), *hinengaro* (the mind), *taha tinana* (physical well-being), *whanaungatanga* (family), *whatumanawa* (the emotions), *Mauri* (life ethos), and *Ha A Koro Ma a kui Ma* (the breath of life from their forebears). The all-encompassing nature of wellbeing is clear in this description. If any one of these parts is out of balance or broken down a person is not considered to be healthy (Pere 1987:45-47). Kim Le (1996: 3) describes how in the ancient Chinese philosophical way of being healthy, is seen as a balanced relationship between body, mind, emotions, spirit and the universe at large. Rather than sickness being limited to a physical pain or symptom in a body organ, it is related to the interactions between the physical and spiritual realms. There is a mutual dependence between *xing* (the body) and *shen* (the spirit) (Huihe 1995:2).

The interaction between the individual's physical state and their surrounding spiritual realm is fundamental to this worldview. Goldwater (1983:41) describes how this is seen in traditional sicknesses in Latin America where physical symptoms of vomiting and listlessness are a result of activity in the spiritual realm such as a curse. Consequently, the cure for unwellness must be facilitated by someone who moves between the physical and spiritual realm. Roseman (1991:30) explains the role of the traditional healer, who as a medium must activate benevolent spirits to combat the activated malevolent spirit that has

caused the sickness. Here, the direct connection between the activity of the spiritual and physical realms is clear. (This whole area of interaction between the causes and cures of disease will be addressed further in a later section.)

Nature is accepted as a living, being, part of this physical-spiritual relationship. It is something to be respected, to be kept in harmony with the physical and spiritual realm (Katz 1997:17). Lewis (1976) confirms this lack of differentiation between physical and cosmic realm in his study of the Gnaou tribe of New Guinea. In this culture, there is no specific word for physical pain; rather the concept used for unwellness expresses a wider sense of things not being right in the cosmic realm (Lewis 1976:53). Kleinman (1980) in his studies of a number of Hispanic communities describes the most common causes of disease as being natural and supernatural forces. Whitten (1976:146-7) describes the experiences of the Canelos, a group of Amazonian Quichua in Ecuador. In this belief system nature, the spirit world and their daily lives are all one and the same. Illnesses that cannot be cured by herbal remedies are regarded as the result of spiritual attack. Dentan (1968:82) describes the Semai tribe of Malaysia, where a person is understood to be the result of a number of interlocking spiritual and physical elements. Each of these examples reinforces the inseparableness of the physical and spiritual realms in a non-western worldview of health.

The Concept of Self and Community

In my experience being strongly influenced by a western culture, I have been taught to see myself as an individual placed in the here and now. Of course my identity is related to my being a daughter, female, student etc, but essentially when it comes to making decisions, society has taught me that my current state of individual wellbeing is the most important thing. Brown (1989:257) describes the understanding of personhood, that is how a person sees themselves in non-western systems of healing, is essentially relational. Here, the essential definition of an individual is derived from the web of relationships that includes the family, community, ancestors and spirit world. It is a change in this relational network that affects a person's state of wellness. As the worldview of health reflects patterns in its cultural context, this defining of self in a relational way is a reflection of the strong sense of family and community ties found in most non-western countries (Helman 1994:77).

Katz (1997:23) describes how the healing dance of the Jul'hoansi tribe is a communal affair. In this culture, unwellness is explained as a break in relationships, either between families, community, ancestral or the spirit world. Healing can be brought by a dance, where a spiritual power that heals, protects and gives wellbeing to all the community is shared. This healing ceremony is not generally done for an individual but in relation to the whole family and community. The healers are the stewards of the healing energy who guide it toward the service of the wider community. Similarly, Dentan (1968) talks about the importance of kinship links, and how illness can be caused by unreturned love or a breakdown in existing relationships. Helman (1994:17) also describes how in Japan, the group is considered to be more central than the individual. This 'collective' sense of self can include the wider family, clan, community or ethnic group.

Origins of Unwellness and Health Seeking Practices

Foster (1983) in his introduction to ethno-medicine outlines how each society has its own way of explaining the origins of disease. In addition, the origin of unwellness directly relates to how health can be restored. The form of the cure relates directly to the origin of unwellness. For example, illnesses caused by natural causes are treated with the natural realm, such as a cleansing herb. In contrast, to cure a sickness caused by an ancestral spirit, the offending spirit must be identified and appropriate antidote sought (Foster 1983:21). Katz (1997) describes the origins and healing practices in the Jul'hoansi tribes of the Kalahari Desert in Africa. In this tribe, sickness is explained as being caused by a break in relationships either between family, communities or in the ancestral and spirit world. Therefore the healer must carry out a healing dance to restore these broken relationships. The healing has three main parts: seeing properly, pulling out the sickness and arguing with the gods. *N'om* is the invisible spiritual energy which fills the dancers in their trance like state during the ceremony (Katz 1997:23).

This similar relational plane can be observed between the cause and cure in the Chinese worldview of health. Each body has a life force called *Qi*, which has two sources: genetic or ancestral, and postnatal from the environment, air and food (Kim Le 1996:30). As part of nature, humans carry internally the same five elements that form the earth: earth in the flesh and skin, water in blood and mucus, wood in bone, fire in body heat, and metal in cell composition. Each of these are subject to the polar laws of *yin* and *yang*, with the energy

network of the body being made up of channels with twelve major meridians corresponding to the twelve major organ systems (Huihe 1995:59). It is the interaction of these energies, and a person's emotional state, which affects the overall state of balance in the body. Consequently, disease can originate two ways: as a result of reaction to outside forces that deplete the body's ability to protect itself, or through unbalanced forces within the physical body that cause a breakdown in its coping mechanisms. A good practitioner will be able to determine whether the cause is external or internal, and assist the patient to restore balance to the body (Ru-shu 1983:79).

Roseman (1991) gives a detailed account of the way Temiar (a Malaysian indigenous group) have a similar phenomenological plane for the conceiving and curing of illness. In this culture, when rules that constitute 'normality' are broken, for example incorrect food preparation, the souls of the spirits are awakened from their state of suspended animation, freeing them to act as disease agents. Therefore, since this worldview sees spirits as causing illness, it is logical that the spirit world must also be called upon to help in finding a cure. The healer or medium that provides communication between the human and spirit realm is the key. Songs are the way Temiar communicate with the spirit world, through singing in a dance-trance ceremony. As a healer sings tunes and texts given to them by spirit guides, the healing process takes place. The direct relationship between the cause of unwellness and process of healing is clear (Roseman 1991:130).

Lewis (1976) in his study of the Gnau tribe of New Guinea also observed this clear relationship. In this tribe, those who are sick choose to make themselves isolated, unkempt in their appearance and withdraw from regular communal life. The explanation given for this is to deceive the spirits who have caused the sickness. Once the spirits are deceived they will leave the person alone to recover (Lewis 1976:72). Brown in her study in Haiti noted that diagnosis of unwellness occurred by the healer looking for the point where a breakdown in relationships or offence has occurred. Because the concept of wellbeing is embedded within a relational network, health is maintained or regained through ritual adjustment or a restoring of these relationships, with the living, the dead or divine (Brown 1989:256). The healing ceremony of the Semai also involved the going into a trance in the context of a communal 'sing-sing'. This provides a suitable environment for the help of the spirit realm in diagnosis and treatment of illness (Dentan 1968:89). It is at this point we can see the importance of the traditional healer in non-western systems of

healing. Healers are generally those who have the key role of communicating between the wider community and the spirit world. This they undertake by using specialist knowledge of healing plants or by asking for special knowledge from the spirit realm.

A Multi-Sectored Healing System

Read, in her study of health practices in Ecuador, describes three common classifications of unwellness: a daily pain that can be cured at home, western introduced sickness that can be cured only by western medicine, and traditional sicknesses only cured by the specialised knowledge of a traditional healer, for example evil air and evil eye (Read 1968:46). It appeared to be common that these three levels of health care are found in most cultures: those that are popular, non-specialist or self-treating, treatment by a local healer with specialised knowledge, and the biomedical public or private health services (Helman 1990:55). Some knowledge and cures are available to everyone, whereas others belong to those with specialised gifting, an ancestral role, or those with extensive training.

Katz describes the different levels of treatment in the Jul'joasnsi tribe. The popular level of healing is with herbs that are used to cure minor un-wellness, while a specific healing dance is done for a seriously ill person (Katz 1997:17). The Temiar also have a multi-layered healing system, which includes self or family elders application of herbal remedies for minor un-wellness. Then there is a more specialized herbal knowledge held by mediums and midwives for the more complicated cases, and western treatment if judged necessary (Roseman 1991:130). Dentan also describes these different sectors of healing amongst the Semai people. Some cures are reliant on the use of known plants or food, while others need the intervention of the spirit world. There is also a respect for the knowledge of other peoples in that when a foreign disease is evident, it must be treated with the foreign cure (Dentan 1968:94). Bell, in describing the medicine of the Maori, says that many plants provided cures for the wounds of the people. Some cures however, were known only by the *tohunga* (traditional healer). Later with the introduction of new diseases through colonisation, the use of western medicine was necessary to provide healing (Bell 2000:34). This pattern reflects how a worldview changes dynamically according to the needs of the people. The introduction of western diseases has brought about the need for western solutions. This multi-sectored approach to healing also reflects syncretism in the

beliefs and practices of health. This phenomenon is described in more detail later in this chapter.

Food and Food Practices

Food is deeply imbedded in social, religious and economic aspects of everyday life. It plays a significant role in defining a culture and affecting human health. Helman (1990:32) outlines three ways food reveals the worldview of a culture: sacred and profane foods, food as medicine, and social foods. For example, in Ecuador guinea-pig is considered a delicacy revealing the social status held by the consumer. Archetti (1997) describes how in some parts the meat of the guinea-pig and is believed to have medicinal value. If however, guinea-pig was suggested for a New Zealand menu or as a tool for a healing ceremony I am sure the resounding response would be non-acceptable. This reflects the different significance guinea-pig holds in Ecuadorian and New Zealand culture.

The importance of food practices, are also demonstrated within the traditional community structures amongst the Maori. Within the *pa* structure, which is the centre of Maori community life, are inbuilt systems that regulate food use such as the concepts of *tapu* (the sacred) and *noa* (the common). Rituals involved in collection and storage of clean water, systematic disposal of waste, building of shelter, and food storage all facilitate community health (Durie 1996:7.) In the Chinese culture, rather than focusing only on chemical components of foods, the energy value of food and how they interact are considered. Just as there are five natures of energy, there are four movements (inward, outward, upward, downward) and five flavours: sour, bitter, sweet, pungent, and salty (Kim Le 1996:23).

Within the belief system of the Temiar people, definite cultural patterns of behaviour exist, which when ignored or broken cause a state of unwellness. For example, when food is incorrectly prepared, consumed or named, the spirits are offended and begin to cause disease (Roseman 1991:130). Lewis (1976:69) outlines how food practices have great significance in the Gnao tribe where there are many taboo foods. If one of these taboos is broken, the consequence will be illness with symptoms such as feeling heavy, breathless, weakness and limb pain. This pattern reveals that food is not only important for physical sustenance; it also forms an essential element of social interaction and maintaining health.

The Concept of Body

This pattern is to do with how the body is conceptualised within a culture. Because the body is where health and wellbeing is most important, how a body is seen is a vital part of the worldview of health. Helman (1990:12) describes body image as:

The entirety of ways an individual or society conceptualises and experiences the body. This includes a set of beliefs about its social, spiritual and psychological significance, its structure and function. In all societies the human body is the focus of a set of beliefs, including social and psychological significance, its function and structure. This includes the conscious and subconscious.

Helman goes on to say that the concept of body image has four important elements: beliefs about optimal size and shape of the body, including the amount and type of surface decoration and image, beliefs about the inner structure, beliefs about the boundaries of the body and beliefs concerning function. This body politic exerts a powerful influence on behavioural patterns in sickness, diet and overall health (Helman 1990:11). In the previously described example of Cornwall's (1992) study in Zimbabwe it was clear how the anatomy of the reproductive system was conceptualised quite differently by the group of women, as compared to a western understanding. It is most likely that if the anatomy is viewed differently, the function maybe too.

Martin (1994) talks about how images of the body have been portrayed, specifically in the area of the immune system, strongly affects how people experience health. This in turn affects how health is conceptualised. In many cultures fatness is seen as being healthy and strong. In parts of West Africa daughters of wealthy families are sent to be fattened before their marriage because to be plump and pale is an indication of wealth and fertility (Helman 1990:15) My experience in Ecuador is similar, in that in some rural areas being fat is seen as a sign of strength, vigour and health. While the concept of body image appears to be important in all contexts, I was curious to see if this area would be revealed throughout this study in Ecuador. These are the six patterns observed throughout the literature about non-western systems of healing reviewed. While not strictly limited to only these six themes, they helped to guide in the participatory activities and questions used in the game that I undertook in the research groups. For example, that is why the idea of body mapping was tried with participants, and a whole section of questions in the participatory game related to food and food practices. Before moving on to look at health in the context of Ecuador and South America, the next section looks briefly at some of the limitations of traditional healing systems.

Limitations of the Traditional Systems of Healing

Perhaps people would like to believe that traditional health models and practices are more integral, effective and have remained unchanged for centuries. While it would be fair to say that many indigenous systems are more holistic, in that the whole person's (physical, spiritual, social) context is treated, rapid changes in the global environment means that few cultures are untouched, neither traditional worldviews nor their realities have remained static or 'pure' (Bannerman et al 1983:9). As seen above, in many contexts another layer has been added to the traditional system of healing, one that provides for western diseases and cures. Likewise, the practices of traditional healers have in many contexts changed with the face of society. Phillips (1995:81) outlines a number of studies of what he calls the urban healers phenomenon. This is where traditional healers have accommodated elements of modernity into their philosophy. Treatment has become impersonal, synchronistic and market orientated where the healers are driven more by the worst elements of western health practices, than their own culture. These are some of the current challenges facing traditional healing systems.

South America and Ecuador

Ecuador by nature of its geography is part of the South American region. While there is significant cultural, ethnic and geographical variation within this region, there are some general historical and social patterns that this region has in common. This section will briefly explore some areas of health that have been shaped by its shared history. A more detailed exploration of the nature of Ecuador's regional identity and history is given in the following chapter.

A Shared Colonial History

The population of this region before its European conquest consisted of aboriginal (Indian) populations (Morris 1979: 55). Although each country in South America has its unique dates, people and characteristics of colonisation, because the Spanish and Portuguese were the dominant influence, much of the lasting impacts are common throughout. For example, the predominance of a common language (Spanish and Portuguese) and the control of the Roman Catholic Church (RCC) in the political and social life. Bethel

(1998:18) comments on the strong nuclear family structure and ongoing influence of the RCC in marriage and fertility trends throughout the region as being one result of this.

Ethnic Origins

Ethnicity is one of the areas in which there is a degree of commonality throughout Latin America. Bethel (1998:27) traces the four main groups that have contributed to the regional identity. The first is the indigenous Indian population that was disastrously lowered by the impact of disease and conquest. The second is the *criollos*, those of Spanish descent born in Latin America who by the end of the colonial era dominated the wealth and political power of the region. This also includes the classification more commonly used today which is *mestizo*, those of mixed Spanish and Indian blood. The third group are those of African descent bought as slaves; and fourthly, the migrants of European and Asian descent who arrived in response to demands for labour after 1850. This ethnic mix brings with it the wealth of cultural beliefs and practices that form part of the regional identity. In the case of Ecuador, examples of this are described both in the Ecuador and Findings chapter.

Urban Development

The pattern of urban development is another shared element in this region. Historically Latin America has a strong urban tradition, because of its dependence on coastal cities and ports to sustain economic and trade links (Morris 1979:57). A classic example of this is Guayaquil in Ecuador, the country's major port, centre of industry and largest city. However the real urbanisation trend became noticeable in the post World War Two drive for industrialisation. Bethel (1998:30) describes how by the 1980's up to two-thirds of the region's population was considered urban compared to thirty percent in Africa and twenty-four percent in Southern Asia. Changes in government policy, moving from an agricultural to predominantly industrial economy played an important part in facilitating this internal migration. These phenomenal rates of growth have had obvious social consequences, such as inadequate housing, basic sanitation and water services, and the breakdown of communal and family structures, violence, and growing economic inequality between classes. The long-term effects of this trend are an ongoing challenge (Mesa-Lago 1992:8).

Political and Economic Similarities

In addition, there are parallels in the recent political and economic directions taken in the region that have had similar outcomes. Bethel (1998:272) outlines some of these policies aimed toward industrialisation and modernising of the agricultural sector, which have aided in the growth of unemployment and the informal sector. Combined with large fluctuations in the price of export products and increasing privatisation, the need to repay foreign loans has often replaced spending on the provision of health and education services. To a large degree these economic policies and internal problems such as corruption, have resulted in high levels of political instability, repressive military dictatorships and social uprisings. These in turn have fuelled migration both to 'better' off neighbouring countries and to places such as the United States and Spain (Bethel 1998:46).

One of the direct consequences of these policies is the inequality of resourcing within the health sector. While there are a number of providers such as the military, social insurance organisations and NGO's, because of the cost involved the only access to health care for the majority of the population is through the government run public health sector. However public hospitals and health centres struggle constantly with under-staffing and lack of resources (Mesa-Lago1992: 15). These patterns of high urban growth, economic and political instability and a shared colonial history are areas of commonality in the region that have affected the area of health.

Literature based on the health beliefs and practices in Latin America, particularly that of indigenous tribal groups is extensive (Goldwater 1983). Because of its extensiveness, I have chosen to focus on two areas noted in the literature that seem to be common throughout the region. These are the influence of humoral theory, and syncretism in health practices. One of the evidences of syncretism is the ongoing importance and role of traditional diseases and traditional healers in Ecuadorian culture and society.

Humoral Theory

Kleinman (1980), Foster (1983), Helman (1990), and Archetti (1997) among others describe the humoral theory of disease as being common throughout Latin America. Humoral theory is a belief system that understands that health is lost or maintained by the effect of the heat and cold on the body. This does not refer to physical temperature, rather

to the symbolic power contained in foods, herbs, medicines, and mental states (Goldwater 1983:37). A state of harmony between hot and cold is what maintains health, with imbalance bringing sickness. A person is exposed to hot and cold through either internal (such as a genetically weak disposition), or external elements such as the environment, diet or supernatural forces. The origins of this theory and its influence in South America are debated, although its similarities with Hippocratic theory seem clear. The theory is said to have its origins in ancient China and India (Helman 1994:21).

Archetti (1997) in his fascinating book on food, symbol and conflict of knowledge in Ecuador, talks about how in some highland communities of Ecuador the concepts of health appear to include parts of the humoral theory. The body is made up of humours, cold and hot, humid and dry. Health is maintained by keeping a correct balance of these humours, and moderating the outside influences such as sun, water, and food intake. He describes the causes of illness being categorised as either 'naturalistic' from food, people, and nature or 'supernatural' involving the spirit realm and ancestors. He explains that food and health are part of a wider frame of reference fundamental in both social practice and as a reflection of wider cultural patterns (Archetti 1997:91-97).

Archetti spends a significant amount of time exploring the significance of *cue* (guinea-pig) as hot meat used for its healing properties. This is based on the idea that food is seen as a source of energy that helps maintain the body's internal equilibrium. For example, menstruating women are forbidden to eat guinea-pig because it is thought to interrupt the cleansing process, and can produce irritation or a greater loss of blood (Archetti 1997:91). However guinea-pig soup is recommended for women after giving birth to help regain strength. He also describes how guinea-pig is used in ritual cleansings by traditional healers for diseases such as fright and bad air. The guinea-pig is rubbed over the person in a process of diagnosing the sickness. Then, by the ongoing rubbing until the animal dies, the disease is transferred to the animal leaving the person well (Archetti 1997:96).

It is interesting that in my observation of diet, questioning both formally and informally as part of this thesis, I did not find specific evidence of humoral theory in the explanations of participants. Guinea-pig was described as the favourite meat used for celebrations in some highland populations. It also represented a degree of status, the more guinea-pig a person owns the richer they are considered. Never in my discussions with participants

were guinea-pigs referred to as being significant in maintaining health. Perhaps Archetti's findings are specific to the particular community that was studied. In regard to humoral theory, while not assuming these beliefs would be present, I remained conscious in my fieldwork that this idea of balance may appear. However, throughout my study this hot and cold explanation did not appear, but sickness being a result of curses or bad spirits did. This will be explained in the discussion of traditional illnesses in the following section.

Syncretism

The Collins English Dictionary (1992:1563) describes syncretism as:

The combining of differing philosophic or religious systems of beliefs and practices.

In this case it is referring to how people can simultaneously hold and practice significantly different ways of maintaining health, particularly between traditional beliefs and a western science dominated model of health. I have seen evidence of this occurring many times during conversations with friends in Ecuador with them picking and choosing between the scientific knowledge they have gained through university training and existing traditional beliefs. For example, friends explained to me that they 'know' that a speech defect is generally caused by a genetic or physiological fault, but also hastened to tell me that one must not cut the hair of a child before the age of one, because it will cause a speech defect. To me this reflects that the two systems of understanding and explaining sickness exist side by side, depending on what explanation or cure best suits the circumstance.

I observed further evidence of syncretism in religious practice during my first few months in Ecuador, in a small rural community. A parade of people, led by the Catholic saint for the local area, were going to present a sacrifice to the god of the nearby mountain. The purpose of this was to plead for the safety of the community, by stopping the volcanic activity. Here, I observed a mix of traditional belief in the god of the mountain, and the use RCC prayer ritual with a saint in response to a crisis in the community. Roos and van Renterghem (1997) describe this syncretism as being a normal part of community life in Ecuador. There are a number of ways syncretism is reflected in the literature of both South America and Ecuador. These include: the presence and function of the traditional healer, the presence of traditional diseases, and how a mix of western and traditional health beliefs are used in the promotion of health products. These are discussed below.

The existence and role of traditional healers throughout South America and Ecuador are described in extensive studies by authors such as Eliade 1961, Hermida Piedra 1979, Goldwater 1983, Hanratty 1991, Matteson Langdon and Baer 1992, and Moffit Cook 1997. This indicates that the belief in, and use of traditional healers is important in this region. However, in this study, participants while acknowledging their existence and function did not appear to place a significant emphasis on the importance of the traditional healer. In one group they were even heavily critical of the local healers, complaining that they simply work to charge big prices instead of providing a real healing service. In the light of this, I would like to focus on some of the common names used to describe traditional healers, briefly define what a traditional healer is, and then move on to describe some of the traditional illnesses cured by them.

What I am referring to in this study as a traditional healer has many titles depending on the respective tribal group and culture. Some of these include folk healer (Helman 1994:113) *payé* (Evans 1992:5), *shaman*, *spirit-medium* (Roseman 1993:53) *curandero/a*, *sobadore*, *partera*, and *resandera* (participants in this study). Others also include those who practice the areas of spiritism and voodoo magic under this title (Goldwater1983: 47). For the purpose of clarity, I am using the word traditional healer to describe a person who has the ability to heal in a way that conforms to their own belief system, rather than being based on an understanding of the western bio-medical model. This commonly includes a mixture of reliance on herbal remedies and being in touch with the spiritual realm. Phillips (1995) also comments on the changing nature of traditional healers, and how western models of diagnosis and treatment in health are affecting them.

A major area of interest in Latin American studies of health is the description of sicknesses that have a spiritual or psychological origin. These sicknesses such as *susto or espanto* (fright), *mal de aire* (evil air), *mal de ojo* (evil eye), *pérdida de la sombre* (dream loss), and *nervios* (nerves), are described in details by Adams 1952, Gillins 1948, O'Neil & Selby 1968, Whitten 1976, Uzzel 1977, and Helman 1990. Each author gives a varying definition and explanation for the illnesses, reflecting their Andean, Afro or Caribbean regional variations. I have chosen to describe three of these traditional sicknesses that were most common in the experience of the participants in this study: evil eye, evil air and fright. Specific examples of these sicknesses are described later in the findings chapter, while a general definition provided by other authors is outlined below.

(Helman 1994:274) describes fright sickness as what occurs in the physical body when one or more of the material soul/spirits contained within each person becomes detached, and wandering free. This most commonly affects children and occurs after they have experienced a fright, shock or unsettling experience. For example a child who has been lost or left with a sense of abandonment could get fright. They are then affected by physical and emotional symptoms such as depression, listlessness and loss of appetite. It is explained that the only way to restore the dislocated soul is by a ritual cleansing, sometimes undertaken by a mother, grandmother, or local healer. A wide variety of items are used in the cleansing ceremonies, ranging from an egg, herbs, guinea-pigs or frogs being passed over the body while reciting and painting crosses of ash on the child's forehead (participants from this study).

Evil eye is another common sickness, described by participants in this study and found throughout literature. It is described as a look full of envy or jealousy that brings harm to the person who is looked at. It most commonly affects children, especially those who are cute or attractive. The results of this envying look include physical symptoms such as listlessness, vomiting, diarrhoea and loss of appetite. Often children are seen with a red cord around their wrist, which is said to protect them from this sickness. The cure for this is a ritual cleansing and chanting by a traditional healer or in some cases the child's mother or grandmother (Helman 1994:127).

Whitten (1976:146) describes how evil air can be caught when a person passes near a cemetery or something that is closely associated with death. It is explained that passing near something associated with death allows exposure to a mystical danger linked with the spirit world. This then affects the physical body with negative physical symptoms such as vomiting, listlessness, diarrhoea and loss of appetite. This can affect both children and adults. A traditional healer, who passes an egg or special plant over the body while chanting, undertakes curing. Uzzel (1977:402) explains at times diagnosis occurs when all other curing strategies have failed. These illnesses are explained as a way of providing a culturally acceptable form of expressing frustration, receiving sympathy or managing stress in difficult circumstances.

In my experience the mixing of bits of western knowledge with existing belief patterns in Ecuador was common. It is almost like the two systems are held side-by-side and

available to be referred to whichever one is most appropriate at any one time. Cavender and Alban (1998:1938-42) describe the existence of syncretistic beliefs in Ecuador's population. They comment on the experience of recently graduated health professionals who find an eclectic mix of western and traditional ideas of health amongst rural populations. These professionals describe how what they have been taught as professionals' contrasts strongly with local practices. In some areas people are quick to take on 'western' health ideals, but in many cases changes never occur because the 'traditional way' is stronger. For example people are quick to ask for vitamins that make them feel stronger, but if they are affected by diarrhoea and vomiting are more likely to blame evil eye than bad hygiene.

This whole idea of accepting the western and traditional was reinforced to me when talking to some of my participants who were medical students. They said:

Even the lecturers who teach us about how disease is spread through bacteria and viruses will send their children to a traditional healer if they think it is affected by evil eye or evil air. The different systems do not seem to be conflictive for them.

In this way, syncretism is revealed in what I have earlier described above as a multi-sectored healing system. The multi-sectored response to health needs described how in many non-western contexts, some sicknesses are considered curable at home, while others require the intervention of a traditional healer or western trained doctor. Here there is a clear demarcation between diseases, their cause and consequent cure. This reflects the existence of both the western and traditional forms of healing. For example, at the same time a person may seek treatment from a local health centre for back pain, and go to the local healer for a cleansing to be performed to cure evil eye. This does not appear to cause any sort of internal confusion or conflict between the two systems.

A further area of syncretism in Ecuador is seen in how part of western concepts of health have been combined with traditional beliefs, in the production of natural health products. A study by Miles (1998) explores the discourse created in order to market pills, lotions and liquids created from 'natural' substances. The syncretism is between a belief in the traditional plants and remedies of generations to heal, and the benefits of scientific progress in creating better health. Medicines, like other commodities, are both economic and symbolic, reflecting and reinforcing understanding about the moral condition of individuals and relations between people. The radio broadcasters who promote these

products are subtly appealing to the traditional systems of healing but in the packaging of a western scientific discourse (Miles 1998:2127-28).

Miles explains how advertising is based on the ideas that a) the Ecuadorian body is susceptible to illness because the modern world has forgotten the laws of nature, and b) illness is an unnatural condition caused by societal problems and the economic crisis. For example, cleansing of the body is constantly recommended. This reflects the familiar concept of ritual cleansing ceremonies carried out by traditional healers. In many cases the heart and blood are paid particular attention, as dirty blood, which is said to be caused by bad nutrition, can result in bad circulation and sexual dysfunction. The solution is presented as a return to nature, encouraging the population to grasp for their identity and control in a world where they have been left feeling helpless. Paradoxically the other main selling point of these 'natural' products is that science and technology has improved nature, by turning known plants into medicines that are scientifically prepared and thus more reliable. This new range of 'natural' health products has become another way in which syncretism between traditional and western systems are reflected (Miles 1998:2131-3).

Summary

The literature review for this study focuses in three main areas. In this chapter, firstly, is an exploration of the concepts of worldview and culture. What they are and why they are important in this study. The second area is related to constructs of health, both the western bio-medical model, and the areas of common beliefs and practices found in non-European cultures. Included in this section are some of the limitations of each perspective and a brief explanation of how the bio-medical model has gained such influence in today's context. The third part is an introduction to some of the commonalities Ecuador and South America that affect health such as the Humoral theory, traditional sicknesses and syncretism. A more detailed description of Ecuador, its social and health history, the challenges it faces in today's context, and its South American regional identity are outlined in the following chapter. This chapter has provided a frame of reference for the exploration of worldview in this research.

Ecuador – the Land of the Equator

When God was making the western hemisphere, he started out with Alaska and worked south. When he came to South America He went down the east coast with his building materials to the southern tip then worked north again. But when he got almost to Panama He discovered he had too much material, and in a fit of creative energy threw it all down in a great pile and that's how he made Ecuador. Hour after hour you twist and wander through multiple worlds, each separated by a layer of clouds, stretches of valley farmed in patchwork intensiveness, series of mountain peaks, each one higher and more brutal, fading away from baked reds and browns to blue, purple and violet, down to the sparkling aqua of the Pacific. Its people, who are varied and rich in their culture and personality (Thomsen 1969:13).

The aim of this section is for you, the reader, to 'know' Ecuador, to feel, hear, and see a glimpse of the reality, to place this study in its rightful context. This will be presented in two parts; firstly, a brief overview of Ecuadorian history and secondly, a summary of the history of health in Ecuador. These are closely connected because the political and social history clearly affects health policy and the health of the wider population. The Ecuador of today is a cumulative product of its history, shaped by the cultures of its aboriginal people, by the Inca and Spanish conquest, the era of colonisation, and the more recent forces of industrialisation and globalisation. This past is what gives form to the present structures, culture and worldview, all of which are a dynamic reality, re-moulded by their ever-changing context.

Discourses of history form part of a society's collective understanding. Handlesman (2000:3) describes how many of the early interpreters were primarily concerned with political unity and social order, thus their concepts of nationhood in Ecuador reflected the privileged ruling class self-image: European, Roman Catholic and Spanish speaking, excluding those of Indian and Afro origin. Because the use of language, especially written language, is at the centre of this interpretation, those with an oral culture have been dominated by a society that relies on the authority of the written word. Only in recent years have the alternative voices of history begun to be more widely accessible, some of which include writers such as Ayala Mora⁶ and Adoum (2000) who provide a fascinating critique of the growth of their own nation. Ayala Mora (1999:13) explains:

For the coloniser, the conquered population do not have a history, as anything that existed before is called pre-history. The history of Ecuador does not begin with the

⁶ Note that although I have heavily referenced Ayala Mora, authors such as Adoum (2000) and Alchon (1991) reflected many of the same ideas. These books however were only accessible to me for a limited time in Ecuador and without being able to get copies, this left me with limited referencing.

Spanish conquest. Its aboriginal peoples were not passive receivers, but actors in a process that began millenniums before.

Throughout this section I have attempted to be conscious of the conflicts of interpretation, language, and history. In doing so, I have aimed to present some of the paradoxes that have affected Ecuador's problematic struggle for identity. The themes relating to health that emerge from this study should be placed on the backdrop of these historical and cultural realities.

A Historical Review of Ecuador

Situated on the north-west Pacific coast of South America, its 283,520 sq km include three distinct ecological zones on the mainland: the coastal region, the tropical Amazon basin, and the Andean highlands, consisting of eastern and western mountain ranges (Roos, van Renterghem 1997:76). In addition, Ecuador controls the famous Galapagos Islands and has territory in the Antarctica. Most historians divide the country's history into three eras: the Aboriginal, Conquest and Colonisation, and the Republic (Hermida Piedra 1979 and Naranjo 1984).

Aboriginal

In this fertile and richly resourced country the earliest visual records date from the Eleventh Century, while the oldest excavated civilisation is thought to be the Valdivia culture from around 3200BC. Archaeologists' documentation of the various eras include pre-ceramic, formative, regional development and integration (Ayala Mora 1999:13). Abundant archaeological evidence points to the presence of small nomadic groups who were subsistence hunters and gatherers. These records show two dominant tribes; initially the Quitus in the highlands, and later the Caras on the coast. Around 1300 AD, these together were collectively known as the Shyri nation. With the passing of time, agriculture was developed and these communities became more populous. The Valdivia civilisation lasted about 1500 years, predominantly in the coastal area, followed by the Machalilla era from 1500-1100 BC, and the Chorrera-Engoroy from 100-300 AC (Naranjo 1984:2).

The Cañari people lived in the southern Andean region and it is thought that distinct people groups lived throughout the Amazon area. The level of political and economic



Map One: Ecuador's Place in South America

Source: Rachowiecki (1997:11)



Map Two: Ecuador, Including Main Cities and Research Sites

Source: University of Texas Website (2002)

development at this time was diverse, as groups formed alliances through war and intermarriage, which gave some degree of relational stability between regional groups. In addition, some degree of role diversification within communities assisted in the growth of agriculture and trade (Ayala Mora 1999:19).

Conquest and Colonisation

It is often forgotten that the expansion by the Inca kingdom from northern Peru during the 1400s, was the first conquest of Ecuador. Although the Inca system did not destroy existing social structures or the religious and cultural traits, they did insert their own complex system of *Tahuantinsuyo*, that is, the Inca imperial ruling system (Ayala Mora 1999:23). Throughout a significant part of the highland and coastal areas, there was a total imposition of military and social control, by subduing and intermarrying with local inhabitants. Some of the more outlying areas and those deep within the Amazon remained free of direct control of the Incas. The production base and social organisation was in the community, overseen by the traditional chief who was absorbed into the Inca imperial bureaucracy (Ayala Mora 1999:28).

The Inca language (*Quechua*) and religious worship of the sun god became compulsory, with the building of the temple at *Ingapirca* close to the city of Cuenca. Tributes were levied according to the natural resources provided by each region (Meggers 1966:160). Meggers summarises the consequences of the Inca rule:

The accomplishments of the Inca in the Ecuadorian highlands were so impressive, and their re-writing of history so successful, that the conquistadors and many who have followed them have been misled into the belief that prior to their coming, the Indians were little more than savages (1966:165).

When the Spanish began to penetrate the Inca kingdom, it was already in crisis, with internal uprisings and conflicts between brothers, for the right to rule. Therefore, the fact that the Spanish conquest was so rapid, was more of a reflection of existing internal problems, rather than a superior waging of war. The reign of the Incas dominated until 1526, when the death of the emperor Huayna Capac left a divided and weakened kingdom. In September of that same year the first Spanish landed in Esmeraldas, the northern coast of Ecuador, ushering in the era of European conquest and exploitation (Meggers 1966:164). The birth of the Spanish colonial era in 1532 came as a

consequence of the deception of chief Atahualpa by the Spanish general Pizarro, who instead of signing a peace treaty, executed him (Handelsman 2000:3).

Roos and van Renterghem (1997:8) describe some of the features of this period. Colonial control was maintained from Lima until 1563 when the Audience of Quito was created, giving governing rule to Spanish settlers and the newly forming *mestizo* (mixed) class. The Spanish ruling class introduced a system of serfdom and forced labour, with the Roman Catholic Church playing a decisive role in maintaining consolidated power. Complete religious and cultural imposition, a hierarchical class system, exploitation of the wealth of natural resources, and injustices at all levels of society were the hallmarks of this colonial era. However, the establishment of Spanish power did not signify an end to indigenous resistance. By means of protests, non-violent means and the defence of their customs, community celebrations and language, indigenous populations have maintained their presence, in the face of the permanent threat of elimination by those with political power (Ayala Mora 1999:30).

One of the many legacies of this Spanish era was the population of African slaves brought to work the land and mines. Most originated from the west coast of Africa and today their descendants form about ten percent of the population, living predominantly in the northern province of Esmeraldas. While slavery was officially prohibited in 1821, it was not until 1881 that the debt tenancy system that had bound the slaves was abolished (Roos and van Renterghem 1997: 26). Distinctive populations began to emerge in the coastal and highland regions, the influence of which continues today. The mixes of African-Indian (*mulatto*) populations are the hallmark of the coast, with the Spanish-Indian (*mestizo*) being more common in the highlands. The European element on the coast is quite cosmopolitan, including British, American, Italian and German settlers. In contrast, the highland European population is largely of Spanish ancestry (Morris 1979:206).

Despite these colonising eras, remnants of these aboriginal populations such as the Cañari and Amazonian groups have a strong identity in some pockets of Ecuador today, such as the *Shuar*, *Quichua*, *Ashuar*, *Huaorani*, *Siona-Secoya*, *Cofán*, *Chachi* and *Tsachila* (Morris 1979: 206). Another cultural influence notable especially in the coastal region, was the wave of Lebanese immigrants who arrived during the late 1800's and early nineteenth century. Although traditionally shunned by the Spanish-descended elite, their

commercial skills and consequent economic power has been an important factor in the ongoing regional power conflicts. This community has maintained tight links through marriage and business dealings and holds considerable political influence in national circles (Roos and van Renterghem 1997: 24).

A further legacy of the Spanish colonial era is the influence of the Roman Catholic Church (RCC). The RCC became firmly established as part of the colonial state structures due to a papal concession. This gave the Spanish sovereignty the patronage of the RCC, which included the right to name and remove functionaries and control the church's resources (Ayala Mora 1999:43). The Spanish settlers were given the combined elements of economic control and ideological domination. This was achieved through each Spanish settler being responsible for administering the catechism, receiving the taxes and supervising the labour of the people groups in each local area. The church was also responsible for the 'education' of the indigenous population, both in literacy and a 'Christian' worldview. Thus, it is not surprising these deep roots of RCC influence remain strong in Ecuadorian society today (Ayala Mora 1991:32).

The second half of the eighteenth century was an era of intellectual and cultural agitation (Roos and van Renterghem 1997: 10). People such as Eugenio Espejo and Velasco were key figures in the growth of the move for independence. This movement was predominantly led by *criollos* (people with Spanish blood born in Latin America), out of their discontent with the Spanish Crown. These were part of the new *mestizo* generations, for whom the existing Spanish bureaucracy formed an impediment to them having political power. Also for the indigenous peoples, discontent and uprising had become a matter of survival (Ayala Mora 1991:59). Independence then was not so much equal freedom for all, but rather the replacing of one ruling class by another. This is one of the reasons conflictive issues of race, class and identity persist today (Handelsman 2000:7).

The first attempt at liberation from Spanish rule was on the 10 August 1809, but it was not until 1820 under the leadership of Simon Bolivar that independence was first declared. Following a series of drawn out military campaigns, complete liberation was achieved in 1822. Therefore, the state of Gran Colombia was recognised, including part of present day Colombia, Venezuela and Panama. It was not until 1830 that the democratic republic of Ecuador became established. The name Ecuador was given by a group of French

scientists following their geographical 'discovery' of the equatorial line between 1736-1743 near Quito (Handlesmen 2000:4).

The Republican Era

Politically, Ecuador was established as a presidential republic with a democratically elected congress of eighty-two members. Elections are held four yearly, and the President is the head of the armed forces, responsible for appointing cabinet ministers and the twenty-one provincial governors (Rachowiecki 1997:19). From independence to the present day, the Ecuadorian reality has been one of ongoing political turmoil, instability, military coups, dictatorships, border conflicts with its neighbours, especially Peru, and a constant struggle against internal corruption. The Ecuadorian reality is one with a history of oppressive Spanish colonial rule, followed by economic imperialism, in the form of ongoing exploitation of its natural resources. It is not surprising then, that as a country it is striving for identity, and struggling for a wise management of its remaining natural resources (Roos and van Renterghem 1997: 4).

Ayala Mora (1999:72) loosely divides the Republican era into three main periods. The first is from 1830-1900, the era of establishment to the beginnings of the Liberal revolution. Secondly, from 1901-1960's, where the structures of Ecuadorian society underwent major changes; and finally from the 1970's to the present.

Quitero López (1987:4) describes how over the first hundred years following independence a national identity was slow to emerge. The foremost characteristic of the recently birthed nation was the deepening of regional tendencies, a product of a constant 'mirror-dance' between local, regional and national affiliations. Three regional pivots based around Quito, Guayaquil and Cuenca became power centres, with frequently conflicting interests. Each center aimed to maintain a high degree of political and economic autonomy. Ayala Mora (1999:69) elaborates further on the difficulties of the new Republic:

The socio-political reality of the first few decades was one of instability and disjointedness. In reality the newborn republic was based on the social, economic and ethnic exploitation of the indigenous people. Rather than building a national identity, the breaking down of relationships between the dominant classes and the rest of the people was consolidated.

The majority of the population remained without power in the organisation of the new state, due to denial of voting rights to the landless (which included a majority of the indigenous

population) and women. These strong paternalistic traditions and highly structured social relations have been slow to change (Olmedo 2001).

From the 1880s Ecuador was under the rule of the Catholic 'tyrant' Garcia Moreno. Loved by some and hated by others, it was a regime that in the decades that followed, brought a greater integration into regional economic patterns and global markets. Partly as a result of rising cocoa exports, capitalism became the dominant mode of production. This was an era full of drive for modernisation and centralisation, with the development of a banking system, centres for higher education and a re-organisation of the military (Roos and van Renterghem 1997: 13). Following the assassination of Moreno and rise to power of Eloy Alfaro, the period from 1895- 1912 is called the Liberal Revolution. This saw a greater development of power by the industrial elite in the coastal region. This new economic power backed the liberal transformation of Ecuador, which included the removing the control of the church from the official education system, civil registry and social security services. Instead these were placed in the hands of the secularised state (Ayala Mora 1999:87).

Following this revolution was an era that saw the downfall of global export prices, and increasing social agitation. This unrest terminated in the military coup of 1925. It is from this point on in Ecuador's history, that a growth in power of the working class and the influence of socialist ideology can be seen in the political spectrum. Socialist ideology has remained an important influence in areas such as art, literature and culture; an example of this is the art of Guayasamin. The next few decades are marked by the characteristic themes of inter-regional conflicts for power, territorial border clashes with Peru and political instability have been the reality in Ecuador, bringing a serious challenge to the task of nation building (Ayala Mora 1999:94, Rachowiecki 1997:19).

From 1948-60 Ecuador enjoyed a time of relative stability and economic expansion due to the rise in the export market of bananas. Policy direction in Ecuador during the decade of the 60's reflected much of the influence of American foreign policy in its anti-communist nature. This is illustrated in the development of the Ecuadorian national health system that will be elaborated on later in this chapter. This economic expansion in part relied on significant loans by the IMF to facilitate industrial development (Suárez-Torres et al 1997:83). The main exports of bananas, coffee and cocoa were overtaken by the

discovery of oil in 1967, which brought prosperity to a small percentage of the population. This not only meant a change in the predominant exports, but also was an acknowledgement of the limitations of being dependent on the single agro-exporting model, instead of driving for greater modernisation through industrial development (Ayala Mora 1999:104).

At the end of a period of military dictatorship during the 70's, Ecuadorian society began to undergo profound changes. Namely, increasing urbanisation of its population and a re-grouping of both unions and powerful industrial elements actively involved in mobilising protest. A plummeting of global export prices brought a crisis and consequent rise in interest rates on IMF loans, led to the debt crisis of the 1980's (Suárez-Torres et al 1997:83). Ayala Mora (1999:108) comments about the period with the dictatorship ending in 1979:

Modernisation had accelerated and capitalism had penetrated deeply in all the socio-economic structures. In doing so, the dependence on international assistance was accentuated.

The last two decades have been a constant battle to manage external debts payments, social unrest, and resolve the historical border dispute with Peru. Various governments, such as that of Febres Cordero (1984-1988) have faced harsh international criticism for internal corruption and human rights abuses (Ayala Mora 1999:112). The 80's and 90's have seen significant changes in a number of areas such as agriculture and health. The proportion of land used for the production of basic food consumption has decreased from twenty-three percent in 1970 to ten percent in 1980. State backed agrarian reforms have re-distributed only marginal lands to the peasantry. Increased farming of livestock has had profound ecological effects, including erosion and loss of biodiversity. IMF enforced policies have pressured the development of new export products in order to service its international debt. Unfortunately, industrial growth has occurred without regard for its cost to human and environmental health (Suárez-Torres et al 1997: 88).

Deler & Saint-Geours (1986:428) describe some of the changes at a societal level. Class and economic elites have created and maintained their dominance, based on the reproduction of their differences to indigenous groups. Although some improvement has been seen in the representation of women and indigenous minorities at a national level, a higher level of equality is desired. In 1986 CONAIE (the Confederation of National Indigenous Groups) became the first indigenous Indian political movement to be

established (Roos and van Renterghem 1997:76). CONAIE executed their first major uprising for land and human rights in 1990, and more recently played an important part in the overthrowing of president Jamil Mahwat in the coup of January 2000. CONAIE plays a significant part in national politics today, along with Afro-Ecuadorian interest groups who are beginning to take their place in the political playing field. In 1999, a peace treaty was signed with Peru ending the border conflicts of centuries.

Currently the main national income earners are foreign money sent by family members living in the United States or Spain, followed by the export of oil, shrimp, bananas, and cut flowers. Areas such as eco-tourism in the coastal, Andean and Amazon regions and products made of *tagua* (vegetable ivory) are growing in importance (Roos and van Renterghem 1997:47). The 'sucre', which has been the national currency since 1885 was exchanged for the American dollar in the year 2000. This was an attempt to stabilise the deepening economic crisis. Despite promises of improvement, levels of unemployment and the prices of basic commodities have continued to rise (Olmedo 2001). The concentration of capital and wealth in the hands of a few is increasing while the economic wellbeing of the majority is in decline. Immigration (generally illegal) to the United States or Spain is the main aim of much of the population (Roos and van Renterghem 1997:48).

Suárez-Torres et al (1997:83) describes how Ecuador is a clear example of the way development policy can bring a country to the point of social and environmental collapse while simultaneously generating significant economic accumulation for a tiny sector of the population.

State involvement has contributed to the consolidation of dominant monopolistic groups that control financial capital, industrial growth and foreign trade. These groups have experienced significant increases in their profits while the rest of the population has seen its income rapidly reduced. Those of the ruling class have benefited from the exporting of natural resources at the expense of the majority.

She goes on to explain that the current state of economic and social crisis in Ecuador is the result of a complex range of factors including foreign driven, economic focused neo-liberal economic policies, and internal factors, such as natural disasters and corruption.

Item	%	Year of Statistic	Page in WB Development Indicator
Official unemployment	11.5%	1996-98	56
Urban Informal Sector Employment	40%	1993-98	74
Women in Decision Making Positions	20%	1998 (6% in 1990)	20
Population workforce in Agriculture	7%	1998 (40% in 1980)	28
Pop with access to adequate sanitation	59%	2000	102
Pop with access to improved water	71%	2000	102
% GDP annually spend on health	3.7%	1990-98	98
% Tot land deforested in 2000	39%	2000	138
% Total land area protected	43%	2000	138
% Pop below US\$1/day line	20.2%	1995	64
% of GDP in Trade	69%	1999	28

Figure 3: Ecuadorian Social Statistics

Source: World Bank (2000)

Population: 12.4 mill	Population density: 45/sq km (WB1999:29)
Gross National Income:	US \$1360/capita (WB 1998 : 12)
Minimum wage: reduced from US\$136.40/month	US\$41/month (1980-84) (WB1995-9: 60)
External debt/capita	\$1239 (NIGuide 1996:18)
Life Expectancy:	male 67.3, female 72.5 (1995-2000)
Prevalence of Smoking:	male 47%, female 18% (WB1988-99:110)
Fertility births/woman:	3.1 (WB 1998:106)
Literacy Rate	male 90%, female 92% (NIGuide1995:18)

Figure 4: Ecuadorian General Statistics

Source: World Bank (2000) and New Internationalist Country Guide (1995:231-234)

The Ecuadorian Identity

I feel it is important to briefly discuss some of the aspects of the Ecuadorian cultural identity. This is because many of the characteristics that relate to the Ecuadorian identity are reflected in the participants approach to health. Ecuador as part of Latin America

In my experience in Ecuador, while people do describe themselves as Latin Americans, they are very quick to point out the significant differences and strong rivalries between the countries of this region. For this reason, this section focuses briefly on two areas of broad regional similarities, that of trade agreements and cultural expression. Morris (1979:254) outlines the creation of the Latin American Free Trade Association (LAFTA) in 1960, which aimed to facilitate regional trade, and encourage the expansion of internal markets. Todaro (1997:486) discusses the benefits and challenges of these trade agreements in this regional block. There are two major trading blocks, the Mercosur, which includes Argentina, Brazil, Paraguay and Uruguay and the Andean group, which includes Bolivia, Colombia, Ecuador, Peru and Venezuela. Perhaps more significant to Ecuador is the Andean agreement that has aimed to provide a free-trade zone to promote mutual economic co-operation and growth. This has continued with discussions to remove tariff barriers in an attempt to create an Andean Common Market (NI Country Guide 1995:232).

However a combination of factors, such as disputes over land, competition for similar foreign markets and old attitudes of mistrust based on historical disputes, have at times proved difficult to overcome. This often undermines the potential power this regional linkage could provide in the global market (Todaro 1997:486). A recent example of the complexities of these agreements I have noted, are the current border relations between Ecuador and Colombia. While one of the aims of the Andean agreement is to facilitate travel of citizens between neighbouring countries, high numbers of refugees fleeing from the ongoing 'drug' wars in Colombia into Ecuador is creating a strain in relationships between these two neighbours.

Morris (1979:254) discusses how, the similarities of colonial experience and the unifying Spanish language (with the exception of Brazil and the small French speaking territories) has helped to create a sense of identity. The influence of Spanish culture, language and

the Roman Catholic religion has been pervasive. Rachowiecki (1997:38) comments on the regional similarities in areas of cultural expression, such as crafts, music, literature, art and sport. Much of the music is an eclectic mix of traditional instruments, such as the panpipe and conch shell horns, mixed with the rhythms and flavour of Spanish and African ancestry. Another area of commonality is their passion for soccer in each of these countries. This is reflected in the stiff rivalry between them to qualify for the Soccer World Cup. The whole area of art and crafts is another area of similarity. The use of colour and designs in weaving, textiles and ceramics, reflects both the indigenous and Spanish influences (Roos and van Renteghem 1997:66)

Like many of its geographical neighbours who share some of its colonial and ethnic history, the attempt to define a sense of identity was essential to complete its independence from Spain. Handlesman (2000:2) comments on some of the challenges in the formation of the Ecuadorian sense of cultural identity:

Following independence, the early shapers of the discourses of nationhood, who were primarily concerned with establishing political unity and social order were those of the privileged ruling class. That is, Spanish speaking, Roman Catholic and male, tending to exclude women and those of African or Indian origin.

Throughout its recent history, in many ways this privileged class has sought to maintain this exclusion of other voices, which if acknowledged, could signify a threat to their own hegemony and power. The differences between the varying parts of Ecuadorian society are the result of conflicting agendas, that make up much of the country's social history. Ayala Mora (1999:116) comments on the use of art, literature, music and popular culture to encourage a sense of national identity. In the year 2000 the production of the first all Ecuadorian movie called *Ratas Ratones y Rateros* was completed. Artists such as Oswaldo Guayasamin and Kingman, authors, musicians and of course the currently successful national football team have tended to become important in the expression of national identity (Rachowiecki 1997:38). Some of the features suggested by authors as being an important part of the national identity are outlined below.

Race and Ethnicity

With their ethnic diversity and easy ability to laugh at anything, the people of Ecuador are certainly its greatest wealth. While there are as many as thirteen known ethnic minority groups in Ecuador, the approximate mix of its twelve million inhabitants is about fifty

percent *mestizo* (European and Indian) origin, while forty percent is of indigenous Indian ancestry and ten percent of African ancestry (Roos and van Renteghem 1997:79). Hanratty (1991:82) explains that in Ecuador there is little pretence of equality or egalitarianism in ethnic relations. He describes one example of this in the lack of a race or ethnicity question in its census. This indicates a reluctance to acknowledge the presence of ethnic differences that so obviously exists in daily life.

Ibarra (1992:198) goes on to explain how societal structures are designed to maintain the differences and exclude the marginalised. A common saying often repeated to me illustrates this idea. *Allí donde están los indígenas*, which translates to mean over there are the indigenous. This was explained to me as reflecting the fact that Ecuadorians in general are not proud of their indigenous heritage. The indigenous are always the people 'over there' or 'in the rural area'. It is widely considered more attractive and better if a person is 'whiter'. These disparities are the result of conflicting agendas that make up so much of the country's social history. As Handelsman (2000:3) describes:

It has always been the conquerors against the conquered, the powerful against the powerless, the literate against the illiterate, the rich against the poor, and the ruling elite against the masses. These dichotomies are an expression of the deep conflicts at the centre of the Ecuadorian crisis of identity, and have served to maintain the power in the hands of the conquerors, old and new.

Another common saying reflects something of the cultural bluntness and ethnic disparity that is commonly accepted. *Trabajando como negro para vivir como blanco* which translates to mean working like a black to live like a white. Firstly, it is considered quite normal to talk about categories of 'black' and 'white'. The other assumption here is that 'white' is, and will always be better off than 'black'. On the other hand through the centuries the pride and resistance of the marginalised groups has served consciously or subconsciously as a catalyst for cultural survival and ethnic affirmation. There is a growing acknowledgement and expression of this rich cultural heritage (Handelsman 2000:3).

Religion

Some ninety-six percent of the population maintains their links with the Roman Catholic Church, at least in name. However the growth within the evangelical and Pentecostal Protestant Church has been significant over the past few years (Rachowiecki 1997:40). Although the percentage of committed and practicing Catholics is small, beliefs such as fatalism, the importance of charity, good works and recognition of God are deeply

entrenched. A belief system underpinned by the RCC, where rituals and festivities are a synchronistic mix of RCC and indigenous traditions directly influence the daily life of many Ecuadorians. For example the celebration of *pase del niño* or literally, passing of the child is a festivity held to adore the Christ child (Roos and van Renteghem 1997:79). Another is the eating of *fanesca*, a soup made with twelve ingredients which represent the twelve disciples of Jesus is part of the very important good Friday and Easter week celebrations.

A participant in this study spent some time explaining to me the importance of destiny and the role of fate in people's lives. He used a common saying that says:

Me va a pasar algo porque estoy riendo mucho, which translates as, something bad is bound to happen to me because I am laughing a lot, or enjoying life too much.

It was explained that people do not have control over life's events. If bad things occur it is usually explained as being the will of God or that it must be deserved. While expressed as sayings, these beliefs do affect daily decision-making and the life of many people. The list is endless, of daily rituals, food practices and beliefs that are influenced at a profound level by the RCC. Examples of this are seen in the Afro-Ecuadorian case study in chapter six.

Regionalism

In my experience the first important fact asked when introducing a person in Ecuador is which region they were born in. The number of years a person may have lived in another city, or another country is irrelevant. The regional identity of birth is very strong. Roos and van Renteghem (1997:4) describe well the marked regional differences. Guayaquil is the hot, humid cosmopolitan port, the commercial hub, and the home of the entrepreneurs. Quito is the cool, cultured mountain city, the seat of government and home to the country's administrators. The common saying money is made in Guayaquil and spent in Quito, typifies the strong feelings between the regions. The geographical distinctness and diversity of Ecuador's regions has historically provided a challenge to communication and national unity (Handelsman 2000:8). For example, there are different calendars for the countries education system because of the radically different climatic patterns in the coastal and highland region. This makes co-ordination of national events difficult.

Although official discourses and practices of nationhood are explicitly and deeply embedded in state run institutions, they are not entirely uniform or consistent. Dutiful nationalism, such as kissing the flag, weekly singing of the national anthem, and national

holidays are strongly reinforced in the state education system (Radcliffe and Westwood 1996:78). As we have seen in the above historical summary, regional groupings of populations have always been stronger than national identity. It has really only been threats to national security, such as the war with Peru that caused a big enough challenge to overcome regional conflicts and competitiveness that affect the business, political and social arenas. There remains a deep-rooted distrust between the coastal and highland populations (Rachowiecki 1997:20).

Poverty

Handelsman (2000:8) in his analysis of the Ecuadorian struggle for identity brings to light the complex issue of poverty:

The lack of identity manifests itself in many ways: living for the moment, fatalism, an overdeveloped sense of poverty, a desire to leave the country, and always thinking that foreign is better.

I am not so concerned with defining poverty and its effect on Ecuador, but rather want to try and reflect the sense of poverty expressed by Ecuadorians to me in a number of ways. A number of sayings that were repeated by participants in this study assist in reinforcing Handelsman's comment. *Somos pobres* translated as, we are poor, was a claim both individual and collective (in social protests) I heard from many Ecuadorians, irrespective of their class or social position. It seemed to reflect something of how they see themselves as considerably worse off in relation to other countries. Secondly, the phrase *Se fue a Estados Unidos*, which translates as they've gone to the United States. This is the reality for many Ecuadorian families who are in increasing numbers sending their fathers, mothers, sons and daughters overseas in the hope of a better life and to receive economic assistance. However, more profoundly, this reflects the belief that Ecuador has little to offer for the future (Olmedo 2001). The saying *La alegría del pobre dura poco*, which translates, as the joy of the poor does not last, reflects the daily reality of the difficulty of living with economic instability and poverty.

In my experience, the poverty prevalent in Ecuador is rarely one of physical desperation or lack of food, but rather characterised by inequality, and a lack of identity which does not have the energy to value what they have and who they are. Thomsen (1969:261) describes some of the complex factors involved in poverty:

Poverty isn't just hunger, it's many interlocking things: ignorance and exhaustion, underproduction, disease, inequality and fear. It is glutted export markets, sharp

unscrupulous middlemen, and ancestral beliefs spreading their values on your life. It is a dozen irrational Latin qualities, like your fear of making more of your life than your neighbour and thereby gaining his contempt for being overly ambitious.

In contrast, Rachowiecki (1997:14) describes some of the features of Ecuadorian society which have aided their survival:

It is a society that is based around very strong interpersonal and family relational networks. Because of a tumultuous history, protest and political instability are a way of life. These are people who are adaptable and creative survivors.

Perhaps the Ecuadorian historian Ayala Mora best describes the positive side of the complex issues of identity and crisis in the context of Ecuador:

The complex situation we live in, is at the same time a guarantee that we will continue to survive. At the end of more than ten thousand years, our people remain living in our Andean land. That is a demonstration of our capacity to confront the contradictions of life and overcome them (1999:124).

Regionalism, poverty, religion and ethnicity are some of the factors that form part of the complex cultural identity of Ecuador. These cultural factors in turn affect how health is conceptualised by Ecuadorians. Let us now move on to explore some of the historical patterns surrounding the beliefs and practices of health in Ecuador.

The History of Health in Ecuador

Naranjo begins his introduction to the history of health in Ecuador with the following quote:

The conception of health and sickness, of life and death, form part of the worldview of a culture, revealing a development within the social context and the evolutionary change of it (1984:1).

While keeping the overview of general Ecuadorian history in mind, this section seeks to focus more particularly on the beliefs and practices of health in Ecuador throughout its history. Authors such as Hermida Piedra (1979), Naranjo (1984) and Navaro et al (1998) trace three distinct periods of influence and practice in the history of medicine in Ecuador. These are the Aboriginal and Inca, that of Spanish and Arab influence, and the more recent Anglo-Saxon. Following a review of these eras we will explore the development of the current health structures that remain in place today.

Aboriginal

Hermida Piedra (1979:3) describes the medical practices of the aboriginal tribal population, as predominantly animistic in nature. The world of magic and medicine were

inseparable, as healing came from the practice of ritual ceremonies. A firm belief in the spirit world meant that sickness and death were the consequences of supernatural forces that affected humans by means of invisible arrows. Curing ceremonies included localising the magic arrows inside the person and exorcising them. The healer belonging to the local group undertook these healing ceremonies. In different regions these had different names for example *hechicero* (the one who makes spells), *inchuri*, *chupador* (the one who sucks), *shaman*, *rezcandero/a* (the one who recites), and *partera* (the one who helps give birth). The names often reflect the particular role that was played in healing. For example, a sickness that involved poison or venom was typically removed by a *chupador* who sucked it out of the sick person's system (Naranjo 1984:10).

Hermida Piedra (1979:20) describes how archaeological evidence in the coastal province of Manabí indicates the practice of worship of the female god of health, Umiña. Some archaeological finds reveal evidence of stone statues and human sacrifices that are thought to be a part of tribal ceremonies involving magic and healing. Small ceramic containers used to store and carry ash used in trance inducing ceremonies have been found. These trances were a means of diagnosing and treating illness. Other remedies of this era included rest, special diets, the passing of animals over a sick person to suck out disease. This ceremony is based on the idea that in rubbing the animal over the person, the sickness would be transferred to the animal, leaving the person healed. Two of the commonly used animals in these treatments were frogs and guinea pig. Another frequent remedy was to cause sweating in the patient. By means of the sweat being driven out, the sickness also would be purged from the system. Historians also note the practice of primitive forms of surgery, such as setting of broken bones and sewing up of war wounds around this time (Naranjo 1984 and Navaro et al 1998).

Naranjo et al (1984:10) indicates that some nine hundred known plants were used for medicinal purposes in this era. Some of these include *uña de gato* (cat's claw), *sangre del drago* (dragon's blood), quinine, *cocaine*, *curare*, and *las daturas*. Others include for example, *ipeca* that was used to prevent intestinal amoebas, *guayusa* that acted as a psycho-stimulant, and *guayaba*, which functioned as an anti-diuretic. Hermida Piedra (1979:31) discusses how the underlying healing beliefs and practices of the conquering Incas in the fourteenth century were similar to those of the Aboriginal people groups. The Incas however were more accustomed to war and so appeared to have more highly

developed techniques for the treatment of war wounds and of surgery. Over time the Aboriginal and Inca systems of healing have merged, making it difficult to distinguish between the two.

Spanish and Arab Influence

The second era is described as classic medicine with Spanish and Arab roots. This new influence on the population's health was introduced by the Spanish settlers who brought with them the beliefs and practices of health, common in Spain. Navaro et al (1998:2) describes how during this era the dominant influences of healing practices in Spain were based on the Hippocratic and Galenic understanding of the body. In addition there was a strong Arabic influence in the history of medicine, gained over their eight centuries of occupation in Spain. The Arabs are responsible for example, for the development of many commonly used drugs such as alcohol. Due to religious dogmatism, Spain had been slow to experience the significant scientific medical advances brought by the enlightenment to other parts of Europe. Contagious diseases were the focus of most health policy in Spain because of the frequent outbreak of plagues, such as yellow fever, cholera and typhoid fever. Both these positive and negative aspects of the existing health system in Spain, in turn affected the scope of development in medical practices throughout colonial Ecuador (Hermida Piedra 1979:10).

While initially the settlers were more dependent on local knowledge and healing power for survival, a greater exchange of remedies between settlers and local people occurred from the sixteenth Century (Naranjo et al 1984:10). During this time, many previously unknown sicknesses were introduced that seriously affected the local population, such as, sexually transmitted diseases, typhoid fever and measles. In 1565 the first European style hospital was established, and the first faculty of medicine created in 1693 (Hermida Piedra 1979:14).

The Anglo-Saxon Influence

The growing Anglo-Saxon influence is described by Navaro et al (1998:8) as a reflection of England's social and economic influence throughout Europe and its colonies. Some of these advancements in technology and the industrial revolution also brought about the growth of the public health movement. These changes had some impact on Spanish

health policy, such as the sanitary laws of 1855 (Navarro et al 1998: 25). Because the ties with Spain remained strong, this in turn affected Ecuador. After becoming a republic, increasing western influence took place, due to the arrival of scientific exploration teams and both protestant and catholic mission establishments. Doctors from French and Bethlehemite missions (amongst others) arrived to provide health services. English, French, Germans, and Belgian explorers and botanists came 'discovering' the plants with healing powers, such as quinine, that the indigenous people had been using for centuries. As the study of medicine became common at a university level, the texts used were equal to those of England, France and Spain at the time. One of the first famous Ecuadorian scientists was Eugenio Espejo, a doctor who developed the measles vaccine. This is the same Eugenio Espejo who played a significant part in the Independence of Ecuador. It is in this era that we see the establishment of public health structures that exist to the present day.

Ecuadorian Health Structures

From independence up to the 1940s Ecuador had no established health policy or internally recognisable structure that provided health services. The only basic health service provided free at this time was by the General Direction of Health, one of the government departments. This service was administered by the Pan American Health Organisation (which is the south American branch of the World Health Organisation) and UNICEF. This service was seen as charity for the poor, an attitude that characterised medicine throughout the colonial era (Estrella et al 1997:3).

Instability and Global Politics

Sachs (1993) Suárez-Torres et al (1997) and Estrella et al (1997) all describe the influence of global politics on the development of Ecuadorian national health policy. Never in Ecuador's history has there been the opportunity to develop autonomous health policies, or a system that is appropriate within its culture and context. The development policies implemented in Latin America following World War Two, were dominated by the economic, political and philosophical ideology that suited the military cold-war policies of the United States (US), and its aim to attain global hegemony (Sachs 1993:3). In the early sixties the triumph of the Cuban communist revolution caused a backlash of fear, that was in turn reflected in US foreign policy. The fear that communist influence would spread around the

South American continent led to policies that aimed to retain influence in this region. As Ecuador was politically unstable and needed the financial backing, these policies were accepted. This marks the beginning of dependence on external health and finance structures (Estrella et al 1997:9).

The policies created were a clear reflection of modernisation theory. Estrella (1997:19) outlines how the country's health policies were inseparable from the drive for economic development. The Pan-American Health Organisation was responsible in its influence, firstly to increase economic growth and social wellbeing, secondly to establish the priority of needs and intervene with planned programmes, and thirdly to improve the human conditions in their capacity to create, produce and consume. In practice this included the formation of the top-heavy and bureaucratic department of health, and establishing health programmes under the direction of the sub-secretary of health (Estrella et al 1997:17). For example, the general department of health included the following sub-areas: epidemiology, environmental health, maternal-infant services, medical attention, national institute of hygiene, and the personnel and administrative division. Advisors provided by the WHO were crucial in the formation and institutionalisation of health policies. Because funding was external and government controlled, the state was to be responsible for the health of the population (Estrella et al 1997: 16).

Steps in the Creation of a National Health System

During the late sixties inflowing foreign aid through IMF loans and income from the petrol boom facilitated the process of modernisation and industrialisation. Estrella et al (1997:22) outlines some of the characteristic modernisation policies that affected the country at this time. These include: (a) a re-organisation of economic policy through the stimulation of local industry, (b) stimulating growth in internal markets, (c) stimulation of foreign capital in public spending, (d) greater participation by the middle classes in the distribution of wealth and political power (e) accelerated urbanisation, (f) and the tendency to strengthen the relative autonomy of the state. However, the social consequences of these policies were also evident. These included: patterns of unequal regional development, internal migration, abandonment of traditional agricultural lifestyle and an increase in the difference between social classes (Suárez-Torres et al 1997: 95).

In June of 1967, the national assembly created the Ministry of Health, closely followed by the implementation of two important health policies in 1970 (Estrella et al 1997:25). Firstly was the implementation of the compulsory year of rural service for all graduating health professionals, and secondly, the unrestricted entry of students into medicine at state universities. Cavender et al (1998:1938) explains the significance of the rural service policy. This compulsory year of service fulfilled three main goals of the Ministry of Health. It was part of a national strategy to improve the country's health by providing basic health services for all rural areas. The rationale being, that the presence of more doctors would improve the general health of the population. In addition, the low wages received during this year were seen as compensation by the students who had received an almost 'free' education from the state. Thirdly, it was a way of encouraging health professionals to work in the rural areas that are generally less popular than the large urban centres. Estrella (1997:34) comments that the rural service scheme, rather than extending health cover, instead seemed to produced a greater number of disillusioned professionals, and lesser degree of efficiency in a more centralised and bureaucratic health system. Establishment of the rural service year is an example of modernisation health policy common throughout Latin America at this time (Cavender et al 1998:1937).

The second policy removed financial and social barriers to students wanting to enter the medical profession. This was an attempt to raise the number of doctors per head of population with the assumption that more health professionals would mean a healthier population. This however resulted in a decline of the quality of education, as student numbers rose significantly without any increase in funding for teaching resources. This in turn lowered the quality of graduating professionals (Estrella 1997:102). These policies however did serve the purpose of increasing the number of health professionals (see figure five).

Year	No of Doctors per 10,000 people	No of Dentists per 10,000 people	No of Nurses per 10,000 people
1967	3.3	0.2	0.8
1973	3.6	0.4	1.1
1980	7.8	1.0	1.8

Figure 5: Number of Health Professionals per 10,000 people 1967-1980.

Source: National Institute of Statistics and Census cited in Estrella et al (1997:179)

Also at this time, consistent with modernisation theory, the Ministry of Health programmes focused on birth control campaigns concerned with excessive population growth, on mother-child services, vaccination campaigns, primary attention, and control of epidemics such as polio (of which there was an outbreak in 1967). Estrella et al (1997:29) comments that these policies similar to those in other parts of Latin America where the philosophy behind the health system was one of providing charity and assistance. This left the population as passive receivers of foreign driven initiatives.

The design of the health system was reliant in its function on a significant level of infrastructural development such as roads and water being in place. In many cases, particularly in rural areas, these did not exist. Often the services offered occurred in an inconsistent manner, due to lack of medical and human resources (Estrella et al 1997:52). Suárez-Torrez (1987:70) outlines how 1979-88 was a period of crisis in the international economy with the implementation of neo-liberal policies such as privatisation and extension of free market policies. Under the government of Febres Cordero, Ecuador struggled with rising inflation and to meet debt repayments. As a result, the trend of diminished spending on areas such as health continued and the coverage of basic services provided diminished. A greater percentage of the population was becoming urbanised. (see figure six).

Year	National Health Budget (in millions of sucres)
1962	12.7
1970	10.5
1978	7.3
1985	5.4

Figure 6: Changes in National Health Budget 1962-1985

Source: National Institute of Statistics cited in Estrella et al 1997:178

Suárez-Torres et al (1997:95) outlines how the combination of a growth in industrial pollution with a lack of basic infrastructure such as water and hygiene in the urban centres, affected the health of the population. A greater percentage of unwellness relates to poverty, resulting from the concentration of wealth and the reduction of the productive base of the country. A rising trend of heart problems and traffic accidents took over from diarrhoea and epidemics, as the leading causes of death.

Present Health Structures and Services

In 1987 the Ministry of Health was regionalised, as part of Ecuador's policy to provide a national free health service. This involved the creation of small sub-centres of health based in rural and marginal urban communities. Cavender et al(1998:1939) describe the function of this Ministry of Health strategy. Depending on the population the centre serves, it usually consists of a few small rooms where a doctor, dentist, nurse or obstetrician can be found. Staffing for these centres is usually dependent on recently graduated professionals completing their rural service year. The health professionals in these centres are also responsible for providing regular check-ups, and basic health education to the primary and secondary schools in the surrounding region. While the essential idea provides a necessary service to often quite isolated communities, lack of adequate equipment, medicine, staffing and even water and electricity, frequently prevents the providing of essential services. In addition, the frustrations of excessive paperwork and internal corruption within the bureaucratic ministry of health, are a further challenge to the rural professional (Olmedo 2001).

Of the health budget \$117/person is available for the 20% of the population that have the government social security insurance (IESS), leaving only \$17/person for the remaining 80% (Estrella et al 1997:94). Figure nine shows the comparative proportion of people served by the private and public health systems. We see that the largest proportion of the population is served by the public health sector, which is under-resourced. Unfortunately, health services have become the monopoly of the elite, technology being simply another way to differentiate between the haves and have-nots. Two-thirds of medical professionals are concentrated in the urban centres of Quito and Guayaquil (Estrella et al 1997:95).

Current Challenges to Health

Coming into the last decade, Ecuador is affected by the diseases facilitated by inequality and poverty, combined with the worst effects of industrialisation and modernisation. Estrella (1997:57) reviews these changes. In highly populated marginal urban areas, lack of basic hygiene and water services assist in creating the high rates of diarrhoea, parasites, malaria and dengue fever. The struggle for economic subsistence and changes in eating patterns has brought about malnutrition, heart disease, high blood pressure, and cancer. Greater levels of stress, and industrial contamination, leave in their wake growing

Population Distribution in Ecuador

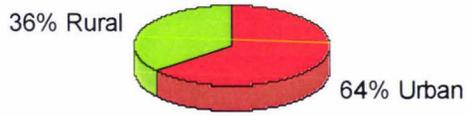


Figure 7: Population Distribution in Ecuador

Source: World Bank (1998:18)

Population Distribution By Gender

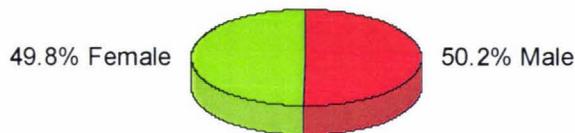


Figure 8: Population Distribution By Gender

Source: World Bank Guide (1998:18)

Health Providers in Ecuador

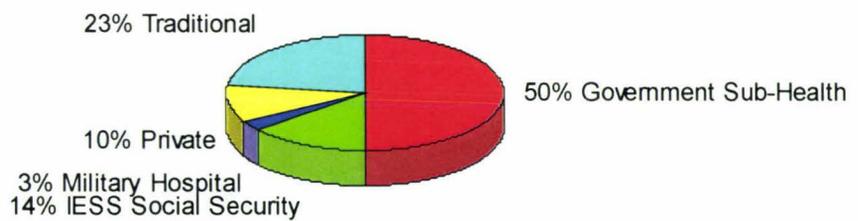


Figure 9: Health Providers in Ecuador

Source: Estrella et al (1997:93)

rates of respiratory problems, traffic accidents, and suicide. Refer to figure seven for the rural to urban population ratio in Ecuador, and figure eight for the gender distribution of its population.

Environmental contamination and degradation generated by exploitation of petroleum is one of the greatest challenges to health. The tendency has been for multi-national companies to impose modern methods without establishing the infrastructure and capacity to manage and control the implementation of extraction processes (Suárez-Torrez1997:93). The consequences have been disastrous socially and environmentally. For example, for many of the Amazonian indigenous populations it has generated violence, sickness and death. A further example is found in agricultural production, where there has been an imposition of the use of pesticides, many of which are prohibited in countries like New Zealand. This leaves a residual contamination of food, water and soil, negatively affecting the health of the wider population (Estrella 1997:92). The section concludes with a description of Suárez-Torres et al (1997:99) of the challenges faced by the ministry of health in the country's recent state of economic crisis:

The expanding effect of neo-liberal policies has brought about the worsening of the social, cultural and moral state of the country, resulting in a better provision of goods and services for an ever-decreasing proportion of the population. The majority of people were relegated to be observers in the gift distributing of the great market with an alarming gap between the quality of services provided by private and public health facilities.

Summary

This section began with a brief overview of Ecuador's general history. This describes its Aboriginal peoples, the conquest of the Inca and Spanish civilisations and the more recent era with a democratically lead government. Through this we gain a sense of the country's identity and some of the challenges it currently faces, such as regionalism and poverty. This is followed by a description of the eras of Aboriginal, Spanish and Anglo-Saxon influences in the beliefs and practices of health in Ecuador. Each of these eras brought with it a distinctive conceptual understanding of health, for example the strongly animistic beliefs system held by the Aboriginal and Inca populations. This was impacted, challenged and in some areas replaced by the later Spanish and western influences in Ecuador's history.

The next section outlined how the currently existing health service system came into being under the influence of foreign direction and funding. A complex interplay of global politics and internal instability, has not perhaps provided Ecuador with the most appropriate health structures to deal with the country's needs. Despite four decades of health services and education, serious questions have been asked as to why health remains such a glaring need. Estrella (1997:105) notes that the health and health education structures that have been consistently used, lack recognition of the ethnic and cultural diversity of Ecuador. The beliefs and realities that form the existing worldview have not been taken into account. Therefore while information is received and actions are produced responding to a need, there is very little change in the underlying patterns of beliefs and behaviours. Ayala Mora sums up the challenges of the Ecuadorian reality of health:

We are the protagonists in a time of great change. There is: the accelerated pattern of urbanisation, the rise of social unrest, the demands of the workers and indigenous peoples' groups, the initiatives of modernization that extend throughout the whole of society, the increasing influence of the global multi-media. We are forced to reflect on the process of globalisation whose reality is neither neutral nor irreversible. Rather it is a phenomenon that facilitates interchange, communication and access to knowledge, but also accentuates the existing inequalities and also threatens the survival of different identities (Ayala Mora 1999:121).

Chapter Four: Methodology

If an item of clothing is needed for a particular event, it is only sensible that a garment of the appropriate size, style, appearance and purpose be chosen, thus allowing the wearer to be presented to their fullest potential. Similarly in designing a research project, the way the information is gathered should serve the aim of the study. The methodology gives the theoretical and practical guidelines for the 'how' and 'why' of research in practice.

My attitude in coming to this research project was one of a learner, to learn about Ecuador, its people, culture and the realities of health for them. However, I also wanted my learning to take place in a manner that was respectful to the participants, and enabled them to enjoy and gain something from the research process. I was looking for a methodology that enabled the creation of an environment where I could listen to and observe the beliefs and practices of health of the participants. In a relaxed and people centred way, Participatory Research (PR) enabled these aims to be fulfilled. PR also provides me as researcher and participant, the opportunity to interact within the context of this study. PR however, is not a methodology that stands alone, as it has both clear philosophical underpinnings, and practical out workings.

This chapter begins by outlining the two predominant schools of research, then narrowing down to look at some of the characteristics of qualitative methodologies, and finally to an explanation of the origins and meaning of participatory research. The second part of the chapter focuses more on the practice of PR in this study, how it worked with its strengths and limitations. This part describes the participants, places and research tools used in this study.

Contrasting Research Paradigms

To understand the variety of options available when considering a research methodology, and why perhaps one set of tools is more appropriate than another, it is worth reviewing the alternative theoretical approaches by the differing schools of research. The two main philosophical underpinnings of research are the positivist and interpretive paradigms. Leslie (1996:85) outlines how positivist research generally focuses on quantitative methodologies, emphasising explanation, prediction and control of research subjects

within a clearly defined scientific framework. This way of researching seeks 'exact' measures and 'objective' analysis by the researcher. The assumption behind it suggests that there is only one logic to science (Neuman 1997:63).

In contrast, the interpretive tradition originates within the social sciences, focusing on human beings and their way of interpreting reality. It has its roots in the fields of philosophy, history and anthropology, where participants are approached as part of the whole context of their lives, rather than as scientific 'subjects' (Bryman 2001:12). Interpretivism relies on the researcher's understanding of the socially constructed nature of the world, and an acknowledgement that values and interests subconsciously form part of the research process. It has a more practical orientation in its focus on human behaviour, interaction and communication (Neuman 1997:68). It also recognises that language itself is context bound and shaped by the researchers' and participants' values and social location (Holloway 1997:93).

Out of these two dominating theories of knowledge, interpretivism allows for the expression of beliefs and practices that are unique to a specific social context such as Ecuador. Within this paradigm, qualitative methods are the common medium for research. These allow a form of social inquiry that focuses on the way people interpret their experiences and the world in which they live (Holloway 1997:5). These tools, based on exploring the variety of human experiences, allow for the creation of an adequate space to hear the traditions, perspectives and practices of the participants.

Holloway (1997:5) outlines the following as some of the ideal characteristics of qualitative research:

- The researcher's focus is on the everyday lives of people in their natural settings, rather than a contrived and controlled environment (also in Neuman 1997:331).
- The theoretical framework of the study is not predetermined, but rather derived from the information gathered.
- The context of the study is of crucial importance. This means the researcher needs to be sensitive to this, and immerse his or her self in the context. An example of this, is to participate in reflexive critique. This is when the researcher reflects critically on his or her interaction and participation within the research context,

considering the implications of their chosen methods, values, and biases (also in Bryman 2001:470).

- The aim is to try and share from an insider's perspective. This seeks to present the views of participants, their perceptions, meanings and interpretations of knowledge, rather than relying on, or assuming, the accuracy of an externally imposed framework.
- The data collection and analysis proceed together as an interactive process. The process is parallel and interactive, rather than being strictly linear.
- The researcher provides detailed contextual description throughout the study. This aims to expand the contextual understanding of the reader, thus providing the tools to interact with the story.
- The research is a joint effort, where participants and researcher are equals, participating in a creative process.

Qualitative research allows for the flexible and valuing study of a complex social phenomenon (Leslie 1996:86). Peoples' beliefs and practices that come out of an existing worldview are certainly complex. The characteristics described above, that reflect the underlying philosophy of qualitative research, are directly applicable to participatory methodology. PR is considered a qualitative methodology because at its core, the focus is on human interactions within a socially constructed context. The value is placed on the quality of each participant's involvement in the research, and allows for a mutual sharing of knowledge.

PR is one qualitative method used to create a comfortable space for the participants to share their experiences and knowledge of health. By creating this opportunity for interaction, I aimed to observe and reflect upon some of the themes related to health, shared by the participants. Using participatory tools allows the sharing of knowledge in a variety of ways. For example: small research groups, formally arranged individual interviews, and the informal gathering of information through observing, questioning and participating in life. Each is a valuable way of research.

In addition, in the reading of this thesis, a multifaceted interaction is required between the participants, researcher and reader. Through the quotes and themes, participants are telling the stories which reveal part of their reality. Simultaneously, the researcher is

noting, observing, participating and interpreting in each research context. Then as the thesis is read, a further understanding and interpretation by the reader is taking place. It is a glimpse into another world shared by the participants.

Participatory Research – its Genesis

A person cannot plan to “teach” another person, but they can live a process together. Knowledge is not transmitted, it is constructed (Smith et al 1997:145).

Chambers (1994:954) outlines some of the key ‘streams’ of influence in the birth of what is today called Participatory Research. Much of the underlying philosophy is attributed to the work of the Brazilian educationalist Paulo Freire. In his book *Pedagogy of the Oppressed*, Freire expressed his belief that the poor should be empowered to participate in their own needs assessment, thus becoming the key players in facilitating transformation within their own realities. His main emphasis was in transforming the pedagogy, from a one-way reception of information, to a process in which ‘teachers’ and ‘students’ could discover knowledge together through the sharing of their experiences (Freire 1972). It is from here that the strong sense within PR originates, of research being a shared learning experience, rather than simply an extractive one-way process.

A further key influence was the experience of development practitioners in countries such as India and Latin America, and the field of applied anthropology. In an attempt to better appreciate the wealth of local knowledge being shared, new or re-discovered forms of undertaking research were being experimented with. These included: unhurried participant observation, the valuing of participants existing knowledge, acknowledging the importance of attitudes and behaviour and a greater quality in researcher-participant rapport (Chambers 1994:955).

Rapid Rural Appraisal (RRA) evolved in the late 70’s from the sense of disillusionment of rural development practitioners who became frustrated with the limitations of existing research tools such as questionnaire surveys. It was felt that previously used methods reinforced a western bias, and instead searched for a more people centred solution. Tools that emphasised multi-disciplinary teams, careful observation, semi-structured interviews and focus groups were developed. This was an attempt to practice less exploitive and western biased forms of assessing rural development projects (Chambers 1994:956). These converging strands, formed part of the changing trend in development theory and

practice towards becoming a more participatory and empowering process, focused on people.

Participatory Rural Appraisal (PRA) became recognised in the late 1980s, as a more inclusive form of planning, implementing and evaluating projects in rural areas. It focused on behaviour, attitudes and sharing of knowledge, rather than only quantitative output. This was revolutionary in a development world dominated by modernisation and trickle down economic policy (Leslie 1994:88). Many of the tools of PRA such as mapping, ranking and trend lines, continue to be useful in the wider field of participatory development and research. Since its humble beginnings, the body of participatory methodology has grown, developed and retained its clear, uncompromising philosophical base and creative body of methods for use in both a research and project context. A variety of names have been used to describe its application, such as Participatory Learning Approaches (PLA) and Participatory Action Research (PAR). It is to the explanation of these key elements that we now turn.

Participatory Research – Its Philosophy

There are two characteristics that give PR a level of distinctiveness compared to more traditional research methodologies. Firstly, it was born from the contexts of development practice in the third world, or the 'south' as described by Chambers (1994:958). PR was 're-discovered' as a way of exploring the felt needs of real people, in a way that potentially could facilitate empowering change. In addition, much of its spread and growth has been through the sharing of experiences between practitioners in developing countries, rather than from western academic circles. Secondly, there is little rigidity in the use of PR. It is a dynamic and continually evolving methodology. This encourages the creativity and contextualisation of those utilising its techniques, according to the expressed needs of each situation. While its menu of methods facilitates the sharing of information in a participatory and empowering way, the underlying philosophy is un-compromisable (Chambers and Guijt 1995:9). It creates the opportunity for a partnership between researcher and participants, where the knowledge and experiences of the participants are valued and shared, to facilitate a process of individual and social transformation. What this means in practice, is outlined later in this chapter.

Cornwall and Jewkes (1995:1667) go on to elaborate some of the key principles in participatory philosophy. Firstly, local knowledge is paramount. Compared to traditional research, a role reversal occurs, where the local participants are the experts, sharing about their own life's reality and context. The aim is to engage local people as active contributors, to explore their own knowledge and perceptions. It is a joint process. The participants, together with the outside facilitators (who are learners) aim to work together in a transformational process. PR centres on the concept that people have a right to determine their own development and recognises the need for local people to participate meaningfully in the process (Attwood 1997:2). It is where theory and practice are constantly challenged through experience, where the methods cannot be used simply as techniques, without the fundamental awareness that all people are creative, capable and can best share their own wisdom, knowledge and experience in their own ways (Chambers & Guijt 1995:13).

Secondly, Smith et al (1997:8) explain how PR is not simply a static data collection exercise, that happens to involve humans. Rather it is a shared journey between the researcher and participants. A journey in which time, energy, experiences, and knowledge are respectfully shared. It is about movement – movement from the way things are, to the way things could be. PR can bring about the possibility of facilitating transformation on a personal and social level. This involves reflecting on the needs, resources, and constraints of the present reality, examining the possible paths to be taken and consciously moving in new directions.

The journey is marked with signposts: shifting questions and doubts, points of critical awareness, moments of celebration, and connections that demonstrate a deepening understanding of lived and transformed realities (Smith et al 1997:11).

It is a journey that allows the researcher and participants collectively to enter into a living process. In doing this, the purpose is to examine their reality by asking questions, reviewing assumptions related to their everyday circumstances, and to deliberate on the alternatives for change and take meaningful action (Smith et al 1997:173). This is where concepts such as empowerment are important. Through the process of PR, it is hoped that participants on a variety of levels feel that their knowledge and experiences are valued and they are capable of facilitating positive change within their own environment, in their own way. This is the process of empowering.

Furthermore, Participatory Research encourages diversity and flexibility through its range of tools (Cornwall and Jewkes 1995:1668). Instead of relying on one questionnaire, a variety of creative ways can be used to share knowledge. For example: researcher observation, case-studies exploring the stories of individuals, small group activities such as mapping, seasonal calendars, transect walks, describing trends, matrix scoring and ranking exercises, drama and presenting visual representations of the participants daily reality (Chambers and Guijt 1994:9). Some of the tools of PRA are outlined in figure eleven (Chambers 1994). The tools of PRA and PR come from the same origin and philosophy. More detailed examples of the specific tools used in this study will be described below.

Cornwall and Jewkes (1995:1667) argue that the key distinctive in PR is the attitude of the researcher. The control of the process of sharing of knowledge must be in the hands of the participants. For the participants, the creative act of presentation and analysis is often a pleasure. The process of thinking through, learning and expressing their knowledge, form part of the process of empowerment. This kind of empowerment is based on their own value systems, with knowledge being created and shared, thus enhancing the quality of life, however informally it is dispensed. PR is action oriented, community based, and emphasises empowerment of the participants to control and sustain their own development (Smith et al 1997:61). Because PR tools allow for the sharing of knowledge in a number of different ways, it provides a creative and multi-disciplinary approach to explore such a complex topic as the beliefs systems and practices of health.

The Participant Researcher

Choosing PR methodology has a number of implications for the researcher. One of these is that the researcher has the dual role of participant and investigator, whose job is to facilitate the sharing of knowledge between participants. An important starting point for fulfilling this role is a willingness to listen to, and acknowledge the validity of people's stories, windows into their reality. This required me to be in a constant state of reflection, and critically self-aware of my behaviour and attitudes. Also being willing to embrace error, adopt a learning attitude, and be relaxed and openly inventive in how the research was carried out (Smith et al 1997:143). While taking the initiative to facilitate the PR activities, I did not control the sharing of knowledge throughout the process. In practice this meant the

research went at the pace and form directed by the participants. We would meet where, when and however long the participants felt comfortable. This often meant that I struggled with the physical limitations such as the lack of adequate time, limited energy and being dependent on human inconsistency. Another example, was my consistent and repeated attempts to communicate with a contact in the Amazon area, to arrange for a research group and possible interview. However, I was never able to talk to them. I will never know why, but I simply had to accept this and focus on the positive aspects of the study that I had. Each test of my patience and culturally different response was a reminder that PR is a time consuming and emotionally costly experience (Chambers and Guijt 1994:11).

Another aspect of PR is the element of reflection and observation, to observe and be conscious of both the participants and my feeling and reactions, is essential. For example, in each of the research contexts I noted in the participants' feelings; sometimes of pride, pleasure, interest, dignity, anger, being resigned to the inevitable, or a sense of helplessness. An example was the strong sense of pride in one eighty old participant who shared the following comments during a group activity:

Our ancestors had control over their food production. They did not have to use artificial pesticides and fertilisers. The food was not processed and their health was generally better. We didn't have sicknesses like cancer and diabetes.

In turn, I too was conscious of the range of feelings that at times engulfed me during the research process. These included: feelings of solidarity, hope, fascination, frustration, pain, gratitude, depression, friendship, surprise and being the outsider. Overall however, my role as participant-researcher collecting these stories, was an immensely interesting and satisfying experience. One of the participants commented after a group exercise:

I expected in the group time, to sit and listen to a talk. Instead it was a lot of fun to participate. I learnt a lot about health as I listened to the women in our group, and I really enjoyed sharing my own beliefs and experiences of health too.

This leaves me with the sensation that PR methodology can, for both the researcher and participants, be an enjoyable and learning experience. An experience that is part of a process that allows each participant to feel valued, while also building on the knowledge that already exists.

The Synergistic Effect

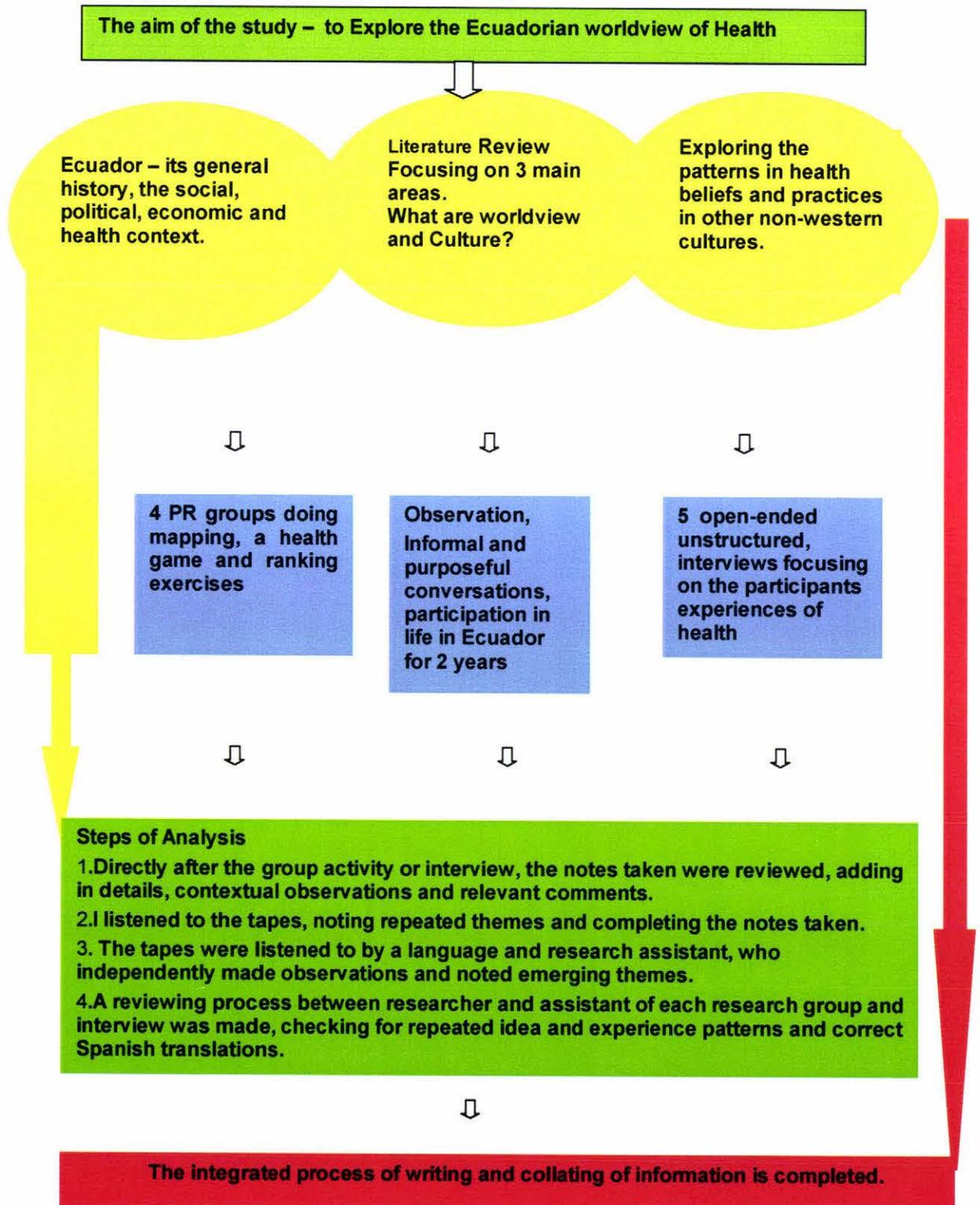
While the research methodology focuses on PR, in reality the process of learning for this study involved interaction between three sources of knowledge and story gathering. The most concentrated knowledge gathering exercises were the small research groups and personal interviews carried out during the months of fieldwork, June to September. The repeated ideas, beliefs and experiences shared by the participants form the main body of knowledge outlined in the findings of this study. The second source of knowledge was through informal observation and participation within the life and culture in Ecuador over a period of two years. This involved consistently observing local practices and attitudes relating to health and living with the reality of health limitations in the research context.

Complementing this was the literature review focusing on some of the beliefs and practices within non-western worldviews of health. This helped me to gain a more global perspective, become conscious of my own worldview, and extend my knowledge about life and culture in Ecuador. Figure ten provides a visual representation of how the overall research process functioned in this study. The process of collating relevant literature, fieldwork, analysis, writing up and my lived experiences, all occurred in a simultaneous and integrated manner. So far, I have focussed on how the knowledge was collected. This next section focuses briefly on what was done with the stories, recordings, maps and observations that had been collected. The practicality of what occurred with the gathered information is outlined in the box below.

Steps in the Analysis Process

1. Immediately following each group activity or interview, notes taken during the group time were reviewed filling in the details, contextual observations and relevant comments.
2. The recordings of each activity were listened to, noting repeated ideas and responses to similar activities. This helped to fill out the notes already taken.
3. Each recording was listened to by the language and research assistant who independently made observations and noted recurring ideas and experiences.
4. Finally a reviewing process took place between researcher and assistant of each group and interview, checking through the common themes and for correct Spanish translations. The research assistant was an Ecuadorian friend who is a health professional with a good understanding of English.

Figure 10 The Research Process



Analysis could be described as the process of ordering the stories to rediscover pre-existing experiences and knowledge (Moses in Walsh 1996:19). Neuman (1997:420), comments that a qualitative researcher's analysis often involves searching for patterns and relationships, and exploring the world of concepts and multiple meanings. The main form of analysis for this study involves looking for themes and patterns in the knowledge shared by participants. That is through the noting of repeated words, phrases or experiences in their stories. Also strong senses of feelings, which appear repetitively in the interview texts or visually in the PR exercises, are of importance. As it is vital that the experiences and stories of the participants are foremost in my research, direct quotes are used in presenting the findings.

While PR is the predominant influence in the methodology of this thesis, the reasoning behind the analysis process reflects to some degree my interest and experience with another qualitative research methodology, called Heideggerian Hermeneutical Analysis (HHA). I used this methodology in a research project that involved the exploring of the experiences of students from another culture, during their time at Massey University. HHA is a research methodology based on the philosophy of Martin Heidegger (1956/1996) who explored the concept of being in the world. Manley (1995:67) describes HHA as descriptive and interpretive, where the participants are asked to share their story in an in-depth way. Through this sharing of participants' reality, a sense of what it means to be human is explored. Key steps in the process of analysis involve identifying themes and patterns in the stories of participants.

However, the searching for, or use of patterns and commonality in information gathered during research is by no means exclusive to HHA. It is very common in anthropological methodologies such as conversation or discourse analysis (Bryman 2001:355). The logic is, that if there are experiences, ideas, beliefs and practices repeated by participants in a variety of contexts, there must be some significance in what is shared. Both PR and HHA place importance on the experience of the participant shared through their story. Therefore, while the philosophy of PR and the flexibility and creativity of its tools served the purpose of gathering information for this study better, HHA influenced in a complementary way, that significance was given to the stories.

Validity and Ethics

Before seeing how PR functioned in reality, the important issues of validity and ethics need to be addressed. Chambers and Guitj (1994:5) discuss how the use of a variety of tools and informants in Participatory Research provide tri-angulation. For example, exploring the same basic question in a variety of different ways and contexts. The observations and information collected from these different sources are noted and compared. In this study, different the PR tools such as the game, ranking and mapping exercises were used to explore common sicknesses in each of the research contexts. From this, it could be determined if common patterns of illness existed throughout all the participants. Within each of the four groups in urban coastal, urban highland, rural highland, Afro-Ecuadorian (each with distinct geographical and ethnic influences) six to ten activities were carried out. The individual interviews were also carried out in these different geographical areas.

In addition, the individual interviews provided a further exploration of the same theme within a different context. Therefore, if consistent themes appear from the use of a number of the research tools, it affirms the presence of the common themes. A further check against researcher bias in interpretation of the participants stories was achieved through the contribution of the research and language assistant. My assistant reviewed each of the group activities and interviews, which independently noted areas of commonality in the participants' stories.

In considering ethics, it is important to take into account the potential impact of this research on the participants, and their right to have control over the research process. An important part of the initial development of research methodology included an interview with the departmental ethics committee. Through this I was questioned as to the impact of this study on the participants, and my responsibility to protect their anonymity. The ethics committee consequently approved this study. Although participation was completely voluntary, it was important to discuss the issues of confidentiality and ownership with the participants. Each time spent with an individual participant or group, began with a personal introduction, followed by a general explanation of the research, and a time for questions and dialogue. Each participant had the opportunity to give both verbal and written consent through the signing of a form. This affirmed the confidentiality, respect and ownership of the research (see appendices). This sheet also outlined my responsibility to each

participant during and following the research. It was interesting that most of the participants were keen to receive feedback and wanted me to write of their experience in Spanish.

Participatory Research: the People and Practice

One of the important aspects of the facilitator's role in PR is the fostering of mutual confidence and trust, both amongst participants, and between participants and researcher (Chambers and Guijt 1995:6). This can be accomplished through spending time and building personal relationships with the participants in their own context. Most of the participants in this study were people with whom I had an established contact. I felt this was particularly important, as in Ecuadorian culture the participation and utilisation of relational networks in every day life is very important. For example, an Afro-Ecuadorian friend took me along and introduced me to the Afro-Ecuadorian group with whom I ended up working. I was able to spend time with individuals and the group in their own community before, during and after the research activities took place. One night I ended up involved in the planning meeting for an up-coming African pride parade. Another time I shared a meal and celebration of one the African saints in their community.

Although this study does not claim to be completely representative of Ecuadorians, within those participating, my aim was to include the most balanced representation possible based on age, gender, class, ethnicity and rural/urban population. These two reasons (relational and balance) influenced the choice of location for the research groups. I was able to organise to spend time with these participant groups and their communities through the help of friends and contacts who knew about my research topic. I then followed this up by numerous phone calls and visits to confirm their participation. Some participants were friends who were interested in my research, and wanted to participate. By the end of the study, all participants had become friends.

The first research group was with the members of the community in Pindilig. Please refer to the map of Ecuador to locate the research sites. This is a small rural Andean village in the province of Cañar, two and a half hours drive from the city of Cuenca. The population is of mixed Cañari and Quechua descent. The second group was based in Cuenca, Ecuador's third largest city. While being a highland city, the group of university students included participants from coastal, Amazon and highland regions. The third group was

METHOD	PROCEDURE	RATIONALE
Secondary sources	search for books, maps, articles, reports, aerial photographs, satellite images	provides basis from which to start
Semi-structured interviews	mental or written checklist of points, but open-ended and non-confrontational	allows the follow-up of the unexpected, cross-checking information
Key informants	seeking out 'experts' in the community to provide specific information	Provides in-depth information on particular aspects of local life
Focus groups	using groups of people to focus on a particular aspect of local life to determine a consensus of opinion	Allows for a more broad analysis of local knowledge and the reality of local life
Do-it-yourself	Ask to be taught how particular tasks are carried out within the local area	provides a deeper understanding of local activities and capabilities
Participatory mapping and modelling	local people design maps and make models of the local community and environment	Provides valuable information on local communities and resources, and allows local people to assess their own situation
Transect walks	local people walking through an area and noting, drawing and discussing local features, resources and problems	Provides additional information of local environment, community, problems and potentials
Time lines and trend and change analysis	construct chronologies of local events, resource availability and use using local informants	allows the analysis of change over time, and indicates what local people consider to be important historical events
Seasonal calendars	construct seasonal calendars showing key seasons, months, and cyclical events	elicits information on cyclical processes within a local area, eg. crop rotations, planting, harvesting, rainfall.
Daily time-use analysis	construct time-use analysis including time spent on activities, degrees of drudgery, may also indicate variation over weeks, months etc.	Provides information on the relative importance of particular activities in relation to the amount of time spent on them
Institutional diagrams	use 'chapati' or venn diagrams or other diagrams to indicate the relative importance and location of institutions such as government, local councils or village level authority.	indicates local and broader structures of authority, power and control.
Matrix scoring and ranking	Use seed or some such other material to indicate the relative importance of resources, social groupings, assets, soils, crops, and differences in wealth etc.	indicates differences between people and relative importance of local resources, facilities and problems

Figure 11: The PRA Methodology Tool Box (Chambers 1994)

based at an Afro-Ecuadorian centre in Ecuador's largest city, Guayaquil. All of these participants originate from the northern province of Esmeraldas. The final group was based in a low-income area of Guayaquil. Contact with this group of women was made through a local NGO. I had hoped to include a group based in the Amazon region but time and finances did not allow it.

These four groups, of six to eight people, met over a period of two to four hours (some groups met two or three times), to participate in a combination of participatory activities. Although the same varieties of tools were used in each group, the combination and order varied, depending on the time and response of each group. I spent a considerable amount of time with both local and foreigners, with many years experience in Ecuador, thinking and talking about what would be the most appropriate form of knowledge sharing in the Ecuadorian context. The central idea of using a variety of participative and exploratory activities is to provide an indirect and non-threatening way of gaining knowledge. My experience in the Ecuadorian culture leads me to believe that a direct asking of questions can often create discomfort in the respondent. However by creating a comfortable environment in which stories and knowledge can be shared in a more indirect way, the participants appeared happy to share of themselves.

Mapping

Mapping is a PR tool where participants use the ground, paper or any available surface to draw a map or diagram that represents an element of their reality. The idea is that people can present information in a way that is understandable and relevant for them. Common in PR are maps of peoples' bodies, communities, farms or natural resources (Chambers 1994:960). Examples of body maps drawn during a PR study in a southern Zimbabwe PR are shown in figure twelve (Cornwall 1992:71). This is followed by some examples of the body maps drawn by participants in this study in figure fifteen. I chose to try body mapping because it provided another way to find out what sicknesses affect the participants, and also could reveal something of how they perceived their own bodies. Mapping simply provides the participants a visual form of representing their reality. This put together with their oral contributions creates a more holistic sharing of knowledge.

In most of the groups we began by drawing a map of either the participant's family or community. The community map was a group exercise with participants discussing and

BODY MAPS - some examples from Southern Zimbabwe.

① INDIVIDUAL MAPS

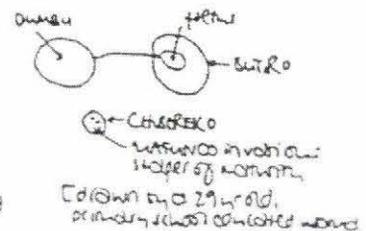
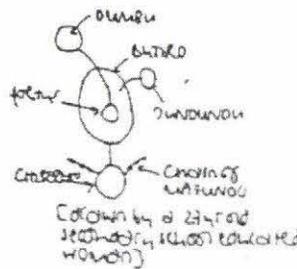
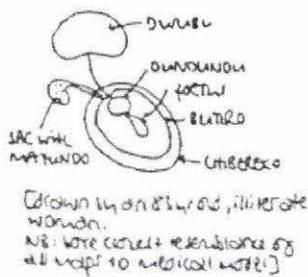
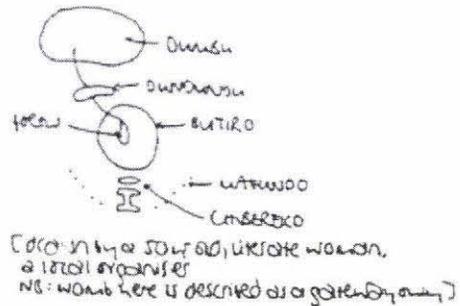
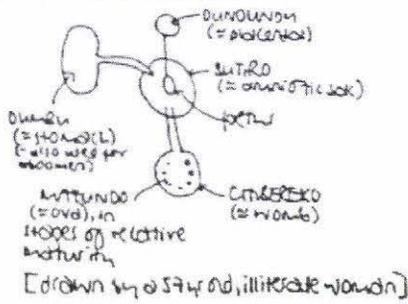


FIGURE ② GROUP MAPS - drawn first to explore processes of conception and pregnancy, then used to discuss oral contraception

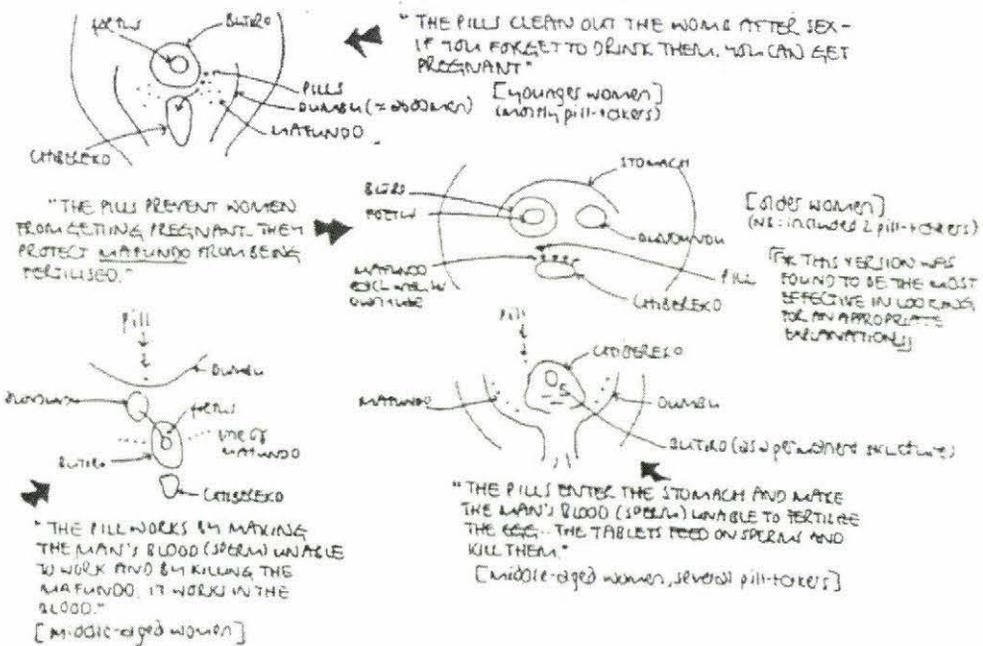


Figure 12: Example of Body Mapping in Zimbabwe (Cornwall 1994:71)

SOCIAL MAP OF KABERA VILLAGE IN KABALE DISTRICT

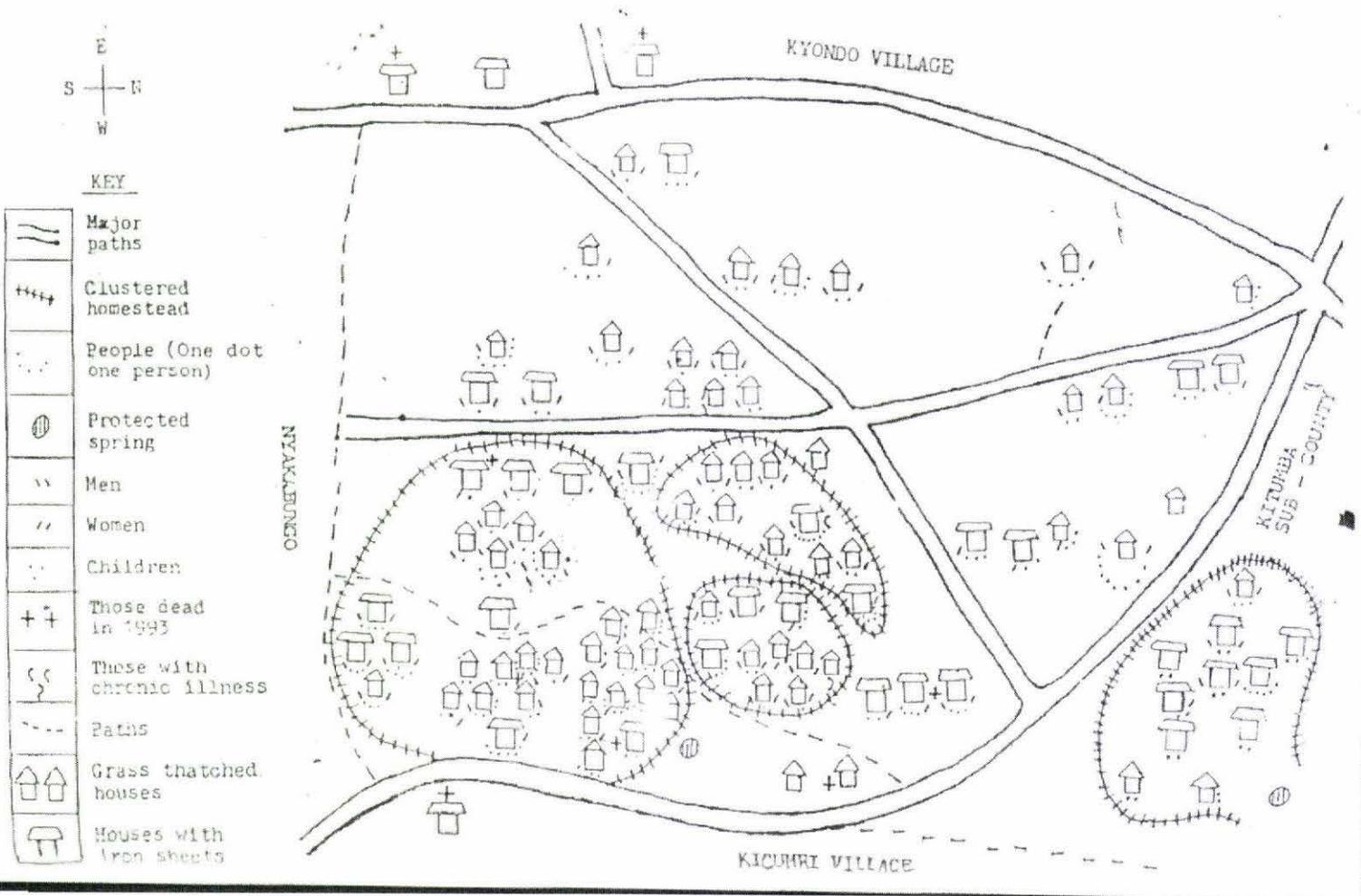


Figure 13: Example of a Community Map (Osuga and Mutayisa 1995:5)

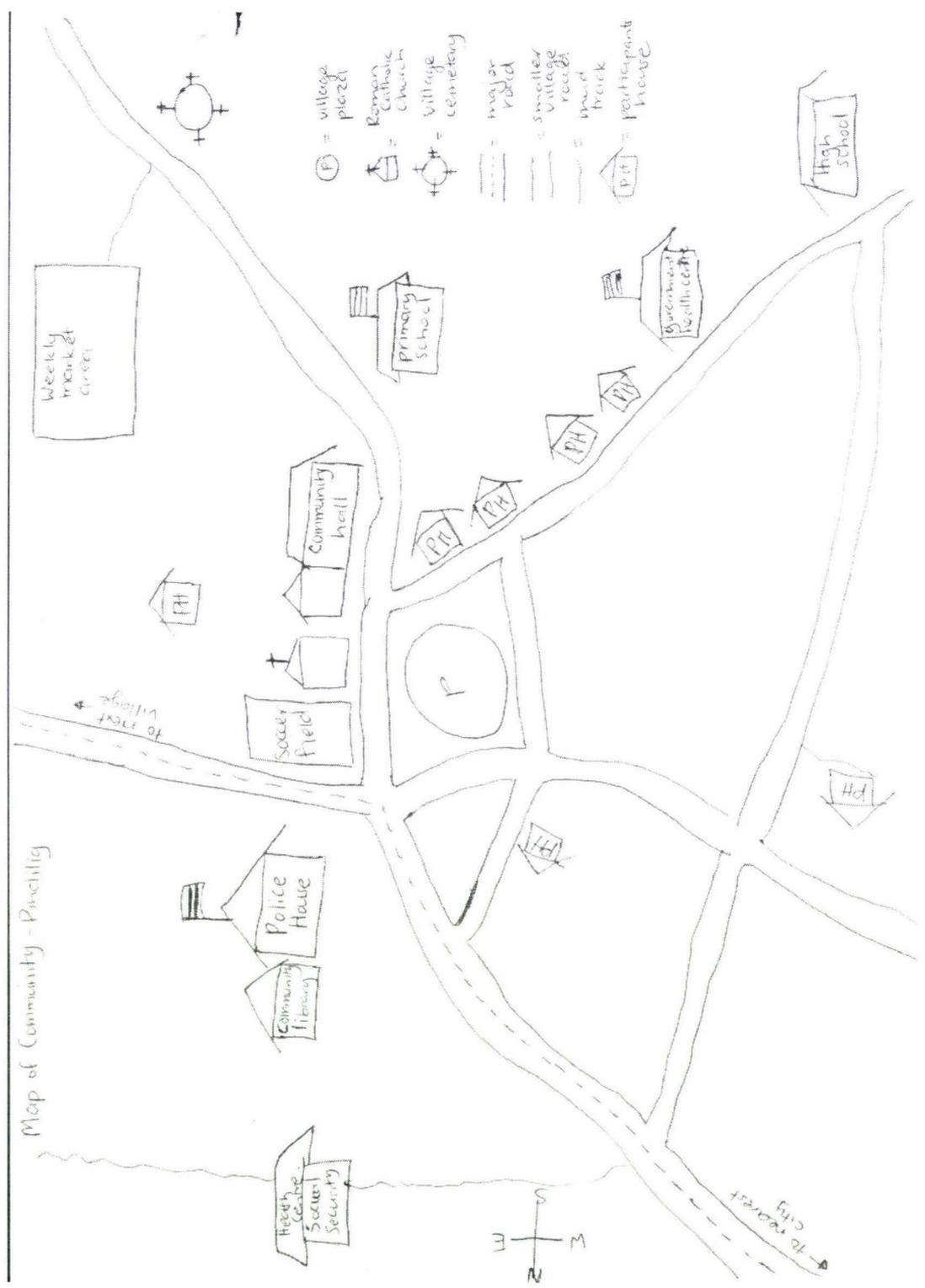
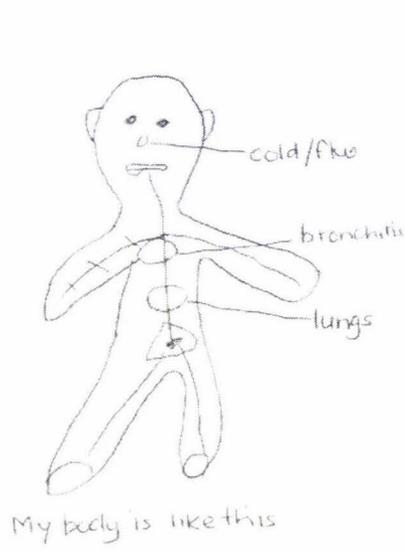
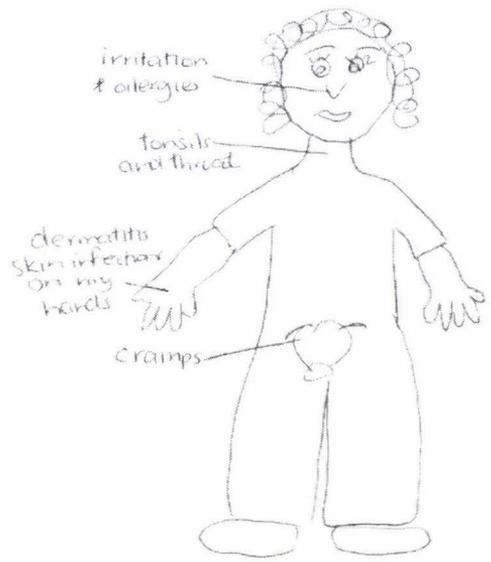


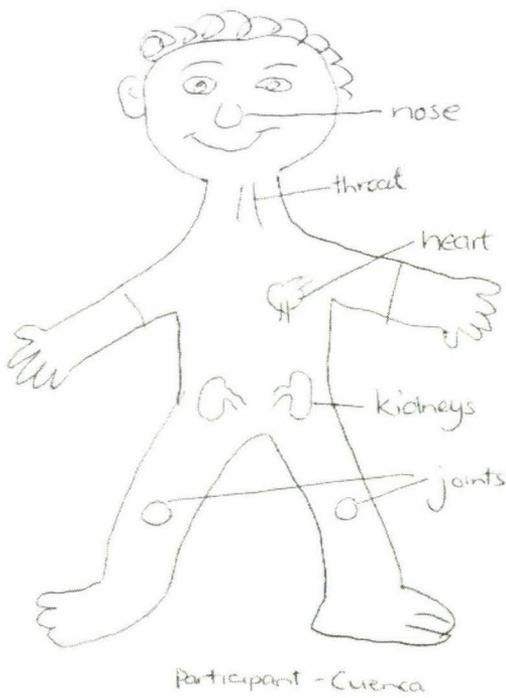
Figure 14: Community Map Drawn by Pindilig Participants.



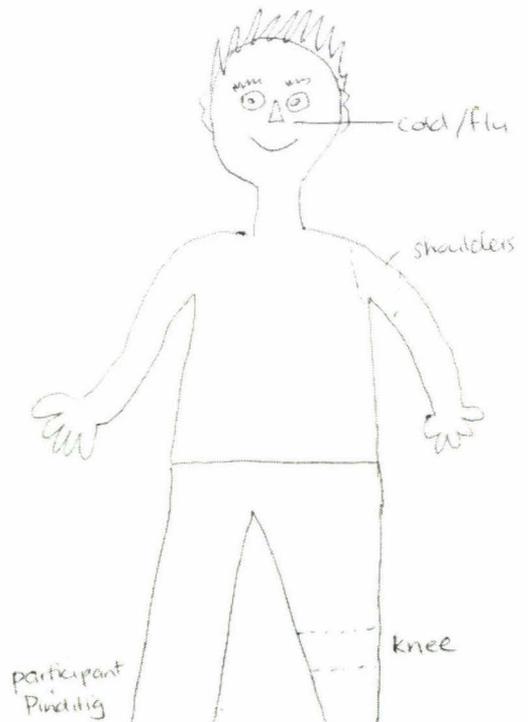
Participant - Pindilig



participant - Cuenca



Participant - Cuenca



participant Pindilig

Figure 15: Examples of Body mapping Ecuador

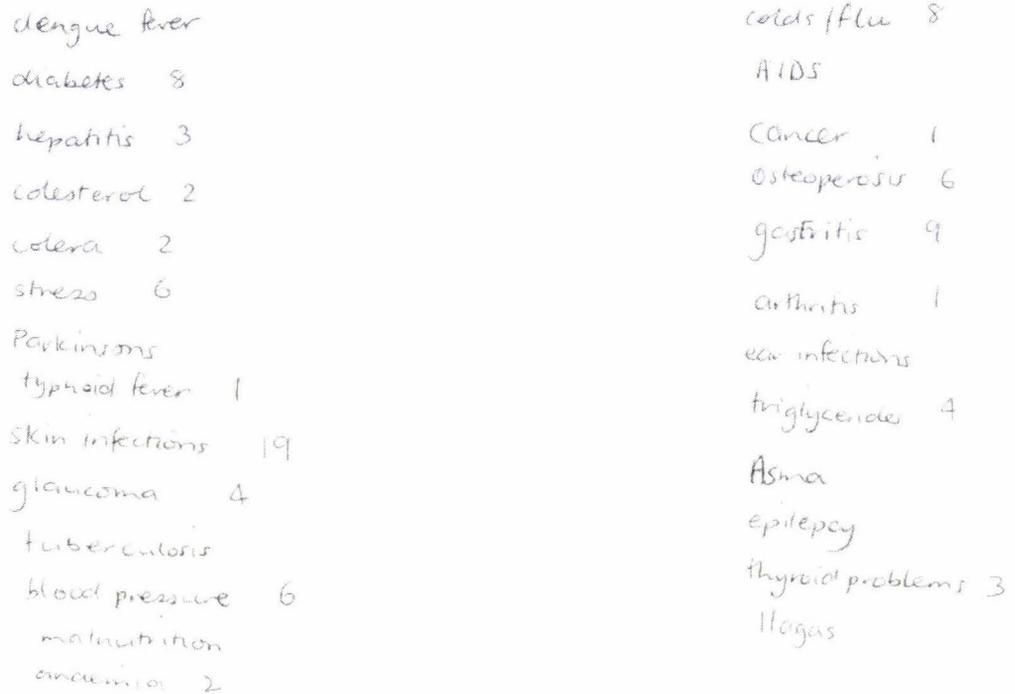


Figure 16: Example (a) of Ranking Exercises of common sicknesses in Ecuador



Figure 16: Ranking exercise (b) common sicknesses in Ecuador

deciding what features would be included, such as the participant's houses, schools, roads, the market, the church and place of work (see figure fourteen). This was followed later by exercises involved drawing a map of the body, and where disease most affected them (see figure fifteen). A further activity involved talking about and discussing symbols that represented health for them. Some participants preferred to do this visually, while other used written or spoken words.

Ranking

In this study, two specific ranking exercises were undertaken. One involved the participants brainstorming a list of all the sicknesses that affected them and their families. Then each participant was given fifteen maize grains that were to be placed by the sickness that affected them in order of importance. At the end of the exercise, the sicknesses with the highest number of maize grains, were noted as being the most common. This gave a clearer picture of what sicknesses really affected each participant, rather than just a list of all the known illnesses. Next we explored dietary patterns by creating a list of all the foods most commonly eaten by the participants. As you might imagine this took quite some time. This was followed by three consecutive ranking exercises. Again the participants were each given fifteen maize grains that were to be placed firstly with the foods eaten most. These were then tallied up. Secondly, the foods they considered 'better' for their health, and thirdly the foods that they enjoyed the most. Finally, time was spent discussing the significance of these exercises. Two examples of the sickness ranking exercise are shown in figure sixteen.

The Participatory health game: The Path of Health

When thinking about the tools to use for this research, I reflected on my experience in Ecuador working with students and those affected by HIV/AIDS. I thought about how people had responded to new information, when they had been most open and comfortable participating in group activities. People seemed to respond well to the two games I had seen used. One was an educational board game produced by UNIFEM used in El Salvador to address the issues of women's rights. The other was aimed at teaching about HIV/AIDS in an interactive way. This led me to develop this board game and try it. The wording of the game questions passed through many checks by a range of people in an attempt to get simple, understandable and non-directed questions.

The purpose of asking a variety of open-ended and often ambiguous questions, was an attempt not to impose my cultural forms and preconception of health on the way the participants responded. This was all in the hope of creating the most appropriate and empowering research environment possible. I was quite open to the possibility that the game would not work, in which case I would have discarded it as a tool. However, it turned out to be very popular. The first question of many participants was, can we play the game today? In addition, a number of people, including the Afro-Ecuadorian group members have asked to have it as a resource to use in their community work. The game consists of a playing board (see figure seventeen) with an entrance, exit and three alternative paths to follow. Each player has a coloured button and chooses a pathway made up of alternating coloured squares (yellow, green, pink or blue). Each player moves along the path by throwing the dice (which has corresponding coloured sides) and answering the card of the same colour. When each participant has responded to the question, the player moves his or her button to the next square of the same colour. This continues until a player reaches the end of the path or time runs out. The aim of the game is not to win, but rather to share experiences and knowledge of health. Each card has a written question, that helps to explore the beliefs and practices of health, including areas such as: causes of unwellness, health seeking practices, food and food uses and concept of body.

Setting the Scene – The Group Protagonists

Let me describe for you one of the group activities, so you can place yourself in the context. It is set in the small Andean village of Pindilig, with a population of about eight hundred people. The nearest town is two hours drive away. (Refer to the following pages of photos) Although it is the rainy season and the paths are muddy, the night is clear and very cold. After being given a written invitation and explanation of the thesis, the ten invited participants had decided the time, date and location to meet in the community hall. Each invite was followed up by a personal visit the day before the meeting. As the participants trickled in over the first half hour we made good use of the time getting to know everyone and sharing the latest gossip. Fourteen people in total including the local politician and nun arrived to participate in the proceedings, ranging in age from fifteen to eighty years.

The second planned meeting time did not occur because everyone had forgotten about the Corpus Christi special mass to be held the same night. However the group decided they

wanted to meet the following night instead. Over two evenings together this group completed a number of activities. Firstly, as a group they drew their village (figure fourteen). I was interested to see what features were important to them and how the group dynamics functioned. This also served to create a greater degree of comfortableness amongst the group. Next, each participant drew a picture of his or her family. This provided an indirect form of gathering demographic information about the population, and a great deal of hilarity when they began to explain all the inter-family connections. Being a small community, most were related! Later, each participant drew a map of their own body and which parts are affected most by unwellness.

Next, the group participated in a number of ranking activities, as explained earlier. Firstly, a list of ALL the sicknesses that affect them was made, and then each person had fifteen grains of maize with which to rank the sicknesses, as to which affect them and their family most. Next we made a list of all the foods eaten, followed by three ranking activities, firstly the foods they eat most commonly, secondly, the foods they think are best for their health, and thirdly the foods they like most. We then talked about the outcomes.

The other main activity was the health game as described above. Especially with the game, I have never seen a group enjoy themselves so much. At times they were nearly falling off their chairs laughing, and discussing with great passion and dignity their knowledge about health and common customs. The participants' response to the game questions revealed a wide range of knowledge both of their own context and the outside world. I returned two months later to visit each of the participants and was able to present a brief summary of the resulting common themes and a letter of thanks.

This particular group were keen to keep meeting together to discuss the health needs of the community. I encouraged them to do so, with the assistance of the local nurse who had participated in one of the group activities. This desire of the participants to keep meeting, indicated to me that one of the main aims of PR had been fulfilled, that the PR group activities were facilitating a process of empowerment amongst the participants. They felt that their knowledge was valued, enjoyed the experience of sharing their knowledge, and therefore wanted to keep meeting to discuss health issues in their community.



Figure 17: The playing board of the Participatory Health Game



Figure 18: Examples of question cards from the health game.

The Voice of the Interviews

To complement the group activities I was able to complete five one to one interviews. Through the use of individual interviews I was hoping to get a more in-depth description of the participants experiences of health. As most people enjoy talking about their own experiences, this was successful. Each interview was open in nature, rather than being a specific list of questions, and lasted between forty-five to sixty minutes each. After the initial 'getting comfortable' conversation that often included a hot drink, I asked each participant for his or her permission to cassette and note take during the conversation (as at times the recordings were not clear). The initial question asked in the information sheet given to each participant was **"tell me about your experience of health"**. It was obvious each participant had given the question some thought, as after an initial prompter question all were comfortable and fluent in sharing their experiences.

The participants ranged in age from twenty-three to fifty-three years, and included three women and two men. Some of their occupations included being a nurse, teacher, mother, homeopath, father, and student. Consistent with the research groups, these participants were from rural, urban and a variety of social classes and ethnic backgrounds. The individual participants were people introduced through mutual friends, who were willing to participate, and who fulfilled the above criteria. They were different to the participants in the PR group activities. As with the research groups, each participant was given a chance to comment on the brief summary of the resulting common themes and a letter of thanks. I felt this opportunity for feedback was important to ensure I had not mis-interpreted their stories, and to check up on some details.

Set in the meeting room of the Afro-Ecuadorian cultural centre, the noise of central Guayaquil's city streets at times submerged our conversation. Buses, the telephone and door buzzer at times interrupted us. The participant is a man age fifty-three from the northern coastal province of Esmeraldas. Of a small almost fragile stature, he began his story by saying:

For me to be alive is a miracle. When I was six months old I began to suffer from mini heart attacks. When I was eighteen years old, I was diagnosed with diabetes. This is what I have lived with until now. Five years ago, I began to suffer from chronic liver failure. Because of this I had to move to the city where I can have dialysis three times a week.

With a serene dignity he gave a detailed and well thought out account of his numerous personal health problems and his difficulties in overcoming them. He described the changes in health he had seen over the years, and how health promotion had formed part of his lifetime work in his home area. Having moved to the city recently, he was quick to share his observations of the differences in health between the rural and urban environment. Toward the end of our conversation a woman joined us, contributing to a discussion of the identity and symbols of health within the Afro-Ecuadorian culture. I felt quietly humbled to have heard something of the personal suffering of this man and his life of sacrifice lived for the sake of helping his community. This is one example of the fascinating knowledge and experiences shared by the participants in these interviews.

Each of the PR tools used for this study proved valuable and worthwhile in their facilitation of the sharing of knowledge by the participants. Tools such as the mapping and ranking were appropriate because they were not dependent on the participants being literate. Each of the PR exercises provided the opportunity for me, as researcher, to be in the position of a learner in a context where the participants were in control of what and how they presented their knowledge. It was interesting to observe the effectiveness of various techniques in the different groups. Most participants were more comfortable and seemed to enjoy the oral participation of the health game rather than the drawing or mapping activities. This reflects Latin American culture, which is strongly oral. Ecuadorians are generally very good storytellers and public speakers.

Strengths of this Study

- Chambers (1997:126) in his discussion of participatory group work, discusses how the visual and interactive style of sharing information allows for the filling of gaps and mutual correction of details when knowledge is being shared. The idea here, is that participatory group exercises can create a synergy, thus generating a wider field of knowledge. I feel that this occurred in the context of this study as participants listened and interacted with each other's stories, adding information and correcting each other.
- As researcher, I did not need to depend on an interpreter to facilitate the activities. This meant there was no middle person in the understanding and interpretation of information shared. However, at times it was necessary to seek clarification with

translation and in understanding of some informal and dialectic vocabulary used by participants.

- I think that the time spent living and working in Ecuador, and the relationships built with participants prior to and during the study enhanced the quality of information gained in this study. I feel that my genuine attitude of wanting to learn and respectfully listen to each participant, resulted in a sharing of experiences that perhaps would not have occurred, if a different methodology had been used.
- While the number of participants in this study was not particularly high (about fifty people in total), the time spent and quality of the communication leaves me feeling satisfied, that valuable knowledge about how a group of Ecuadorians perceive and experience health, has been shared. In addition, it is important to acknowledge the input of all those 'non-official' participants, who through their openness to share their lives with me on a daily level, have significantly contributed to the content of this thesis.

Limitations of this Study

- As in any group dynamic, at times some participants tended to dominate more than others. This often reflected their education, status and personality. This occurred only in one group, where an extroverted and vocal nurse might have influenced some participants to respond according to what they thought was the 'correct' answer, rather than their reality in some of the activities. I was aware of the possibility of this dynamic. There were two ways I tried to avoid this effect: A) by doing a group community mapping activity first. Through this I could observe group dynamics, and see which participants tended to dominate. B) I actively tried to encourage the participation of other group members, and affirm them, that whatever their experience, it was valuable to me.
- The ideal context for PR is exploring an issue defined by the participants as part of an ongoing transformation and empowering process (Cornwall and Jewkes 1995:1669). The initiative for this research came from my experience in Ecuador, rather than being an expressed desire of the participants. However in adopting the attitude of a learner, and attempting to create an empowering environment for

knowledge sharing, I feel this study remains consistent with the basic philosophy of PR.

- The fact that I am white, a foreigner, educated (young and female, in some circumstances) was both a disadvantage and an advantage affecting the responses of the participants.
- Considering that this whole study considers the importance of worldview, I acknowledge that this study is a reflection of how I think, act and write from my own perspective and experience. While using direct quotes is an attempt to minimise this, my filters will always affect how this study is read and interpreted, as do yours as a reader. As researcher I take responsibility for any misunderstanding or errors there may be.
- I was not able to complete the variety and depth of exercises in some research contexts as I had initially hoped. For example a group in the Amazon region. At times too, I wanted to spend a little more time exploring some of the comments and themes of discussion. Due to circumstances, and limited time, this did not always occur.



Photo 2: Part of the Village of Pindilig, Site of One PR Group.



Photo 3: The Plaza of Pindilig on a Typically Foggy Day.



Photo 4: Neighbours and Friends, pPart of the PR Group Meeting in Pindilig.



Photo 5: The road between the health centre and plaza Pindilig.



Photo 6: Cuenca plaza – highland, urban site for one research group.



Photo 7: A Cane Housing Area on the Edge of the River Guayas, Guayaquil



Photo 8: Marginal Area of Guayaquil Where Some of the Participants Live



Photo 9: A typical Scene from the Centre of Guayaquil, Ecuador's Largest City.

- Although I worked hard to make the questions used in the health game easily understandable, it was notable in some cases that the questions needed to be read a few times before being answered. Perhaps questions were not the most appropriate way to find out information in all cases⁸.

Summary

The word "research" derives from the French verb *recherchier* meaning to look again. Research is the process of rediscovering and recreating personal and social realities (Smith et al 1997:7). This chapter has outlined the need for a research methodology that serves the purpose of the study, as well as the philosophy behind PR and what it means in practice. With its clear theoretical and flexible practical guidelines, PR provided a variety of useful tools in my process of discovery and illumination into the participants' worldview of health. In using PR methodology it made me aware of the ever-present tension between completing an academic learning process defined by time and output, with the desire to be a part of an ongoing process of social transformation and empowering in the lives of each participant. Overall however, I believe the utilising of PR in this study facilitated a process of respectful knowledge sharing that was enjoyed by all involved.

⁸ An example of question cards are given in Figure 18, however all the questions are in Spanish so I did not see it as useful to include them in the Appendices. They were written directly into Spanish so as to try and capture the sense of the questions, rather than being translated from English.

Chapter Five: Findings

The Storytellers

You could call it biographical, sharing of a reality, oral history
or simply a story

Everyone has a story to tell of life and its experiences

One that can only be told in your particular way

Wealth in the wisdom brought by sharing commonalities,

Sharing the differences

I like stories - do you?

Some like to make you laugh

Some like to be 'right'

Others just tell it like it is

Some create pictures of words to capture the moment

Others struggle to use words at all

using colour, texture, paint or song

Stories demand time and respect

Like the whakapapa – the rights of the talking stick

The listener gives value to the storyteller

The listener learns from the being of the storyteller

Cycles are repeated,

Cycles are exposed

Cycles are broken

Everyone has a story to tell

Why don't we ask more?

Then STOP

and listen

If I truly believe every persons story is of value

Why don't I take more time to discover and learn from our stories?

(Hicks 2000)

The Stories Speak – Discovering Paradoxes

This chapter shares the experiences of the participants in this study. Participants who are: mothers, sisters, sons, teachers, carers, students, husbands, children, men and women; Ecuadorians: their lives and health, the lives of their families – **their** stories. There are three parts to this chapter. Firstly, I describe the nine themes that were common to all the participants. These are the themes that have been commonly expressed in the sharing of knowledge and experiences of health in Ecuador. The areas of commonality that arise from the ideas, experiences, phrases and practices that were repeated many times throughout the stories of the participants, both individually and in the groups. The colours and patterns created in each of these themes, reflects some of the hues of the Ecuadorian culture traits discussed in the Ecuador chapter, reminding us that a worldview can be revealed in all areas of human existence.

The second part of this chapter, is a case study focusing on the Afro-Ecuadorian group who participated in this study. I would like to describe this group in greater detail for two reasons. Firstly, because within Ecuadorian literature and the socio-political reality, those of African descent have little voice in representing their culture and experiences. I want to give space to this voice. Also, it was very important for the members of this group, that something of their story be represented in this study. Secondly, while the common themes were present in the stories of this participant group, the details of health beliefs and practices reflecting the theme, often showed the distinctiveness of their African heritage. For example, the names and treatments of traditional diseases, and their strong relationship with nature. Perhaps this is because this group were more conscious of, and articulate, in talking about their cultural heritage. I found these differences moving and interesting, in that their cultural roots have remained strong in their current worldview of health.

The third part of the chapter, is a collection of proverbs and common sayings related to health, that were shared with me by the participants. In themselves they are not conclusive evidence of a worldview, but as Samovar and Porter (1997:236) say, they do reflect some underlying assumptions or 'truths' of the people whom they represent. It has been my experience that these sayings are widespread, and really did affect the daily decisions and practices of Ecuadorian people.

The Therapeutic Route

When discussing illness and the process of healing, participants consistently mentioned three elements that provided options within the healing process. Each of these three parts could be utilised simultaneously, or one after the other. The three elements involved in healing are the socio-physical environment, home or herbal remedies and health professionals (this included traditional healers and western trained health professionals). To illustrate, this is the story of one participant who describes her first memory of being very sick:

I had lived in this small community all my life. When I was eighteen I fell in love for the first time. But this relationship was not good and did not work out. When this happened I became sick. I wanted to die, I couldn't eat, and my body was in pain – my head, heart and stomach. My mother was very worried because after weeks and weeks I didn't improve. She gave me herbal teas and plant remedies and took me to see the doctor. Finally she sent me away from the village to stay with my sister in the city. After months in a new environment, with different work and medicine from the doctor at the health centre, I began to eat again. From there my health was better.

In the case of this participant, a combination of the three factors were used to treat her state of unwellness: a change of geographical location, work and social environment, herbal remedies, and treatment by a doctor. The order of these is interesting, in that, first the herbal remedies were tried, later resorting to a change of environment and treatment by a doctor. This therapeutic route was commonly expressed, with the order of preference being first the use of home remedies, followed by visiting a traditional healer and if in severe pain or seriously ill, a doctor or hospital was consulted. Whether a traditional healer or doctor was consulted, depended on the type of sickness suspected. A statement made by a grandmother while visiting the family home, reflects the importance of the person's environment in the state of health:

Each time I change houses to another one of my children and my health improves. The change of environment is what I need.

Another participant talked about what his family does when ill:

When we don't have the means to cure in the house, or if it is a serious sickness, we go to the health centre.

Linked with this pattern, was the commonality of the participants' experiences in describing three distinctive types of unwellness. This is similar to those outlined in the section discussing non-western health systems of healing in the literature review, that which I have called a multi-sectored health system. The different types of sickness described were: illnesses cured by natural remedies, western diseases that need an

'educated' doctor, and those where a traditional healer is necessary. Examples of cures for these distinctly classified types of unwellness shared by participants include:

When someone in my family is affected by gastritis, I will give them cold milk mixed with the juice of grated potatoes, honey and drops of dragon's blood (the red sap taken from a local tree).

When we are sick with bad flu, or severe pain that we do not know how to treat, or things like malaria and dengue fever we go to the doctor.

If the children are affected by evil eye, evil air or fright the mother will take them to the local healer. The old women, they are usually in the square on Tuesdays. They are always there with their herbs, bottles and chants.

As Dentan (1968:94) says, this reflects a degree of eclecticism in how sickness is treated. If a certain treatment works for one type of disease, and not for another, it is obvious the people choose the most effective cure in each case. It was clear however, that visiting the health centre or doctor, was the option chosen, only if the sickness was considered serious. Perhaps this reflects the cost of healthcare, and the disruption of daily routines involved, to travel and wait to be seen by a doctor.

Of Divine Descent but Humanly Frail

Within this theme exist two related paradoxes. Firstly, how the participants explain where health and sickness come from. Secondly, we look at the contrast between the discourse of health in what is said to be 'good and right' and the participants' daily-lived beliefs and practices. In the Ecuadorian context, the origin of health is clearly expressed as being from someone or something outside themselves, it comes from and is affected by the spiritual realm, that was generally described as being God. Each of the following statements came from a different participant:

Without health we cannot live. God gives us health to live and work.

Health is our biggest treasure. It is a divine gift from God.

To be alive for me is a miracle. It is God's will for me to have health.

These statements affirm the divine origin of health and its essential nature for living and quality of life. The placing of health firmly within the spiritual dimension, is in keeping with the theme outlined in the literature review, where the physical and spiritual dimension of health is seen as inseparable. In the context of Ecuador, it also reflects the existence of synchronistic beliefs and behaviours, a mix of the deeply ingrained Catholic religious history and the original animistic beliefs of the aboriginal peoples, as outlined in the

Ecuador chapter. At the same time there, is a sense that because the origin of health is divine, it is not completely controllable in human terms. It is here we see the typical response to unwellness, repeated by many people:

He will get better, if it is the will of God.

Maybe it is the will of God that I am sick for now.

In my experience, this attitude that seems to be a mixture of dependence and fatalism reflects these syncretistic beliefs, but at other times, is simply a way of acknowledging some things are outside human control.

The second paradox is related to the difference between discourse and lifestyle. On the one hand the participants were quick to affirm the importance of health to their lives:

Health is something that needs looking after. It is a gift.

Health is for caring, working and living. We have the responsibility to care for our health, so that we can provide for our families and children.

Caring for our own health is the most important form of prevention.

However, at the same time, participants acknowledged explicitly and implicitly, that their actions and lifestyle do little to care responsibly for their health. The participants said:

In Ecuador people in general don't pay much attention to their health until they feel pain or are seriously sick. Then we look for the quickest and cheapest cure. We don't really think about how we live and how it affects our health.

We know that some remedies are not good but we use them anyway. Some people use things like alcohol when a child has a fever.

Our health is compromised by excessively hard work, where we often abuse our bodies.

Health professionals are the worst examples of health, diet and rest. They are racing around trying to earn money in three jobs. Life is very stressful. I guess we eat what we can, not what we should.

The main inconsistency appears to be between what is 'known' to be right and what is the daily reality. Participants themselves acknowledged this inconsistency and explained some of the reasons why:

Sometimes we don't have enough money. Rice does not have many vitamins but it makes you feel full.

Often I am too lazy to prepare something good for my children. It is easier to cook noodles than to prepare a meal from raw wheat products.

The doctor said I must not eat foods high in cholesterol, but I like them.

Here on the coast we use a lot of oil in our cooking. Everything is fried. It is bad for the heart I know, but it is our way of eating.

Some people have no education. They have not been taught what foods are good or not. That is why their health is not good.

The nature of human frailty seemed apparent here. The sense that they want the best health, but the realities of life often made it un-attainable. Here, we also see clearly how important the whole area of food and food practices are in the area of health. As outlined in the literature review, traditional beliefs about food, and how it is used form an important part of a person's worldview of health. As the above quote indicates, 'our way of eating' with fried foods is a stronger influence in this participants daily eating habits, than what she has been told by a doctor. We see here also, the theme of tradition, and how it dictates strongly in the beliefs and practices of health in the participants.

Nature's Healers

As described in the literature review, the use of plant and herbal remedies is common to non-western belief systems. It is not surprising then, that this was true in the case of Ecuador. Without exception, all participants were familiar with and referred to an extensive list of plants, herbs and treatments easily available in the home, that they used regularly as remedies. While this is not a comprehensive list of all the species and treatments of Ecuador, I have chosen to describe some of the more interesting and commonly used herbal remedies in the words of the participants:

There is an *aguita* (herbal infusion) for almost everything! If there is pain in the stomach or throat, a high fever, leg swelling or bad digestion, there are remedies for all of these. We use plants such as: chamomile, aniseed, valerian, mint, oregano, *torongil*, *llantén*, and *hierba buena*. These are boiled in water creating a herbal tea, that is either drunk at regular intervals or used to bathe the affected area.

If there is stomach ache in our family, I will boil a spring onion in water and the person must drink the infusion. The pain goes away.

If there is bruising or swelling of a knee or joint I place swabs soaked in boiling camomile water on it. This reduces the swelling and pain. If I don't have camomile sometimes we use salt.

Cooled camomile tea is an excellent wash for irritated and inflamed eyes.

When my lactating baby has diarrhoea, I boil the hair of newly harvested corn with aniseed and camomile. I leave it to cool then put it in a bottle and feed it to the baby. This settles the stomach.

A plant called *zorillo* can be made into a bitter infusion and drunk. My mother says that this helps to control diabetes by regulating insulin levels.

My mother always says tomato juice is good when you've lost your voice.

Stress and bad nerves are very common. We always use *torongil* for this, as it is very calming.

Plants like *ortiga* are good to help improve the circulation, or *oreja de burra* for chest pain.

We women use many remedies for menstrual cramps. For example, infusions of plants such as *ruda*, *hinójo*, cumin or figs.

Sometimes we use a mixture of products from 'natural' health stores and our own herbal remedies. Sometimes we buy tablets, powders and creams that are helpful as well.

Learning about, experimenting and valuing the extensive range of herbal remedies has been for me, one of the most encouraging and positive parts of this study. It is an area of health that remains accessible to all Ecuadorians with few knowledge and cost limitations.

An Acute Consciousness of the State of Health

This theme contains three parts. The first revolves around the existence of a high level of consciousness by each participant, regarding their individual state of health. By this I mean, that irrespective of age, gender or education level, each participant appeared to be extremely in touch with the state of their own body, its pain, illnesses currently affecting them, as well as suggested cures and treatments. For example, participants could and would talk at length about their kidney problem, stating symptoms, history and possible cures. However outrageous or inconsistent these symptoms and cures appeared to be, they demonstrated a high level of self-awareness and worry about not being healthy. One of the participants said:

I have a lot of pain in the lower back area. It is my kidneys that are always giving me trouble. There are some things that when I eat the pain is worse. I have tried the new cleanser that I bought at the natural store. It seemed to help for a while, but I think I should probably go the health centre about it.

Compared to my experience in other cultures, there seemed to be a high level of awareness and preoccupation for the state of their health.

The second pattern relates to the participants expressing a clear awareness of historical patterns of health in their own, and the life of their community. They were quick to place

themselves within historical patterns of health and nutrition. For example, recent changes in health, and how their lifestyles and food patterns differed to that of their ancestors, was a well-discussed topic:

Our ancestors ate more natural foods that were grown without treatments, such as barley, wheat, potatoes, quinoa, and unprocessed cereals. These did not have colours or anything artificial added. Now everything is processed or treated, even the animals are pumped with chemicals. The colours and flavours like maggi, food in tins and packets, and artificial preservatives are affecting our health. This is why our health is worse, and now we have diseases like cancer.

In talking with many Ecuadorians, these changes in food consumption patterns appeared to be of great concern. Many explained to me how they choose not to use tinned products or flavourings made with preservatives, because they believe they have a negative impact on their health. The participants (especially those involved in agriculture) frequently expressed a sense of frustration and hopelessness in not being able to reverse these negative trends brought by the global market. They described being forced to produce more from the land, and having to use fertilisers that they do not like. In addition, concern was expressed as to how these changes are affecting the upcoming generations.

Another way this awareness of patterns of health was revealed, was through the consciousness of their life cycles, and how they were responsible for continuing healthy patterns within their families and communities. One father stated:

We must grow good children, healthy, and with not too much discipline and not too little, because a good child will be a responsible adult, a responsible adult will be a good parent, and a good adult, a wise old person. This is our responsibility.

Another participant talked about how her mother's health has in turn affected her:

My mother had great difficulty getting pregnant with me. She had lots of uterine infections and was always taking anti-biotics. That is why my health is so bad. She was taking a lot of medication when she was pregnant. Since birth I have always been weak and sick.

I found it interesting that this sense of family history, and the awareness of the past, pervaded into the area of the participants current state of health. From my experience in non-western cultures, this reflects one of the themes discussed in the literature review. The ancestors and a sense of relationship with them are important. The generations that have gone before, are an important part of the participants' lives, and also in how they think about the forth coming generations.

The third area of this theme, relates to an expressed sense of the collective responsibility for health. When talking about who is responsible for the health of the community, the participants' response was:

Those who have good will, and those who see the needs, are responsible to help.

This appears to be consistent with the theme mentioned in the literature review, the concept of self and community. The participants' understanding reflects a communal approach to life consistently found in non-western cultures. Although acutely conscious of their individual state of health, health was rarely referred to as an individual concern, rather always in the collective or communal. In each part of this theme, I was somewhat surprised that men were equally represented, conscious and expressive, regarding health. This is because in my experience and reading of many cultures, women are often considered to be more involved in the life of the home and family, therefore more responsible for health. This did not appear to be directly so in the case of participants in this study.

Path of Tradition

This theme, shares the participants' comments on where their beliefs and practices of health originate. It was clear from the descriptions of the participants, that their way of understanding health, and their daily practices followed the traditions of what they had seen and experienced in their lives. This is how they describe them:

All of what I have learnt is from my family, my mother and grandmother, their example. Maybe a little bit from high school health classes, but mostly at home.

My father woke us up early every Saturday morning to go to the market. There he would teach us how to buy well. What foods are good and how to choose safe fish. We didn't have to go to this distant market but my father wanted us to learn.

My grandmother always used a wooden stirrer when cooking. She said it made the food better. She always chopped everything by hand. Even now my mother won't use a liquidiser because of what my grandmother always said.

Here we see how important areas such as home remedies, food habits for eating and preparation are transferred from parents to children, through example in the home. Participants explained that each generation then confirms the benefit of the remedy or technique, through their own life experience. While there seems to be little change in the underlying beliefs about remedies and causes of sickness, at times people have adapted

their forms of treatment because the circumstances have changed. An example of this was explained by a parent from an urban centre:

We are quicker to take our children to the doctor than our parents would have been. Living in the city, the doctor is closer.

Another participant said:

I use a lot of tuna when I cook. This is because it is a cheap source of protein, and easy to prepare. My mother would never have used it so much.

This whole area of which practices have been adapted and why, would make a very interesting extension of this study. It was interesting that the influence of the media or society in general, was not mentioned as being an influencing factor in the participants' beliefs and practices of health.

Commonality: Causes of Sickness and Death

Participants were generally agreed in their analysis of the most common causes of death, and re-occurring sicknesses affecting the population of Ecuador. These were described as having clear seasonal patterns in both rural and urban environments. The most common sicknesses during the hot season were respiratory problems from dust and pollution. During the cold and wet time, colds, lung and throat infections were described as being the most common ailment. Other sicknesses frequently affecting the participants included; skin infections, parasites (some 90% of population is normally affected by these), kidney problems, stomach pain, high blood pressure and diabetes. Please refer to the sickness ranking figure sixteen.

The most common causes of death were described as being traffic accidents, heart attacks, high and low blood pressure, alcoholism, cancer of the lungs, uterus, breast, and stomach, and diabetes. Remarkably, little difference was demonstrated between rural-urban, ethnic, gender and class differences. These patterns also agree with 'official' statistical records (INEC & OPS 2000).

No Health Without Money

This theme relates to the idea that the state of a person's health, is dependent on their economic resources. It presented another interesting paradox. On the one hand,

participants stated that generally they did not make frequent visits to health professionals, preferring to rely on herbal and traditional remedies. This would indicate that the necessity of money to cover medical expenses is minimal, as these local cures are low cost and accessible to all. However the participants were also clear in stating that to have good health in Ecuador, money is essential. One of the participants, talking about the health of the general population said:

The World Health Organisation had the slogan of health for all by the year 2000. Where are we now? We are worse off than before. Only those who have money have access to health care, the government doesn't put enough money into the system to meet the needs. The hospitals never have enough medicine, and the queues are so long. Everything costs money, so if you don't have money you are left to die. Even for those who want to pay for medicines, the current economic crisis means there isn't enough work for those who want or need to earn it. Many people want treatment but they don't have money to pay for it.

One of the most frequent comments made to me in regard to health was:

**We can't have health because it costs too much.
To have good health in Ecuador you need money. For us health is a luxury.**

Participants clearly stated that their health depends on the existence of economic resources. The paradox is, that everyone knows and always uses the low cost option of herbal remedies, before consulting western medicine; and yet also say, that those who do not have money in Ecuador, do not have health. To me, it appears that this a reflection of western influenced health trends that have created a system that focuses on greater specialisation, treatment by drugs, complicated surgery and expensive technology. Once created, this level of specialist service is only accessible to those with money. As described in the Ecuador chapter the public health resources available to the majority of the population are minimal, while private health services are expensive. It also seems clear that when using the word health, people are really referring to immediate pain relief, or cure of a serious illness. This is rather than recognising the broader meaning of the word health, which includes areas such as diet, hygiene and exercise, that are not dependent on receiving a high income. As one participant commented:

The medical doctor is seen as immediate pain relief, rather than a long-term cure. Most people do not really want to change unhealthy lifestyle patterns.

Rather than utilising existing natural remedies, and encouraging healthy lifestyle decisions of housing, diet and exercise, the neo-liberal economic system continues to create a health system that encourages dependency. In the long term, the benefits continue to be received by the haves rather than the have-nots.

Traditional Diseases

This theme relates to diseases not commonly recognised or experienced within the bio-medical model. As described in the literature review, the origin is of a psycho-spiritual nature, that translates into physical symptoms in the human body. Rather than re-explain 'traditional' sicknesses such as evil eye, fright and evil air which have been sufficiently defined in the literature review, this section aims to confirm the reality of these sicknesses as forming part of the Ecuadorian worldview. Here some of the participants share their stories of being affected by these sicknesses. It seemed that regardless of age, social class, education level or ethnic background, each participant agreed to the presence of these sicknesses and were happy to share their personal experiences. Evil eye was the most common cause of sickness, as described in the following participants story:

When my daughter was young (about three or four) and very pretty, she was always invited to many birthday parties. On returning home from a party, she would often begin vomiting, be listless, lose her appetite and have diarrhoea. Her grandmother's automatic reaction was she's been 'ojeado' admired or envied; her sickness was the result of someone putting a curse on her. I am a nurse so I treated her with medicines, but there was no improvement. She did not improve, and was beginning to get dehydrated. My mother was very angry, saying that science doesn't have all the answers and that she needed to be sent to a traditional healer. Finally, when the situation was serious, we took her to a local healer and after a short curing ceremony the symptoms disappeared leaving my daughter sleeping peacefully. I don't know if it was the healer, the medicines or her own body that cured her, but that's my experience with that sort of thing. She was never affected by it again.

Another participant shared her own childhood experience:

Since I was a baby I was always weak and sick. One day I had a bad fever, diarrhoea, and vomiting. I was given medicine to take for eight days but didn't improve. Finally, upon the advice of neighbours and friends, my mother took me to a woman who cures. She said I had been affected by evil eye, and the passing of an egg over my body cured me. A locally made alcohol *trago*, was also used.

One of the participants in Pindilig, a rural village shared the following:

My babies have often been affected by fright sickness, so I just keep the plant and eggs for the cure here at home. I pass it over them and they get better. The traditional healers in this area like to charge a lot of money now. We don't trust them any more, so we do it ourselves.

Another young urban participant talked about her childhood:

I must have been an unusual child, always getting into mischief, because my mother says she was always taking me off to the healer for some cleansing or another. My brothers on the other hand, never had one.

It was very interesting that while the symptoms and explained causes for these sicknesses were the same in each case: diarrhoea, loss of appetite and nausea, the forms of treatment, although being similar in nature, showed regional variations. In one area, the participants believed that the curing ceremony had to be undertaken by a healer, while in another, it worked just as well if done by the mother or grandmother of the home. Treatments included: placing objects on the belly button (this being the centre of the body), lighting candles, placing an ash cross on the back, forehead and belly button while reciting. The most common cure recommended was the use of a herbal plant or an egg being passed repeatedly over the body. Another cure suggested was the burning of a particular plant or being rubbed down with an animal. In one area this was a guinea-pig, in another a special species of frog. This was described as sucking out the disease. A participant in one group explained:

Fright sickness can be a dry or wet shock, both of which have different treatments. Dry fright can be cured by anyone, by putting on a red band of cloth, or reciting and making ash crosses on the sick person. To cure wet fright, the child must be moved over a container of water while reciting - first the healer, then the doctor.

Another participant, talked about how her grandmother cured evil air by burning a piece of old material. The smoke was said to cure the headache. Clearly these 'traditional' diseases with their psycho-spiritual explanations, are a common phenomenon. The cures for these traditional sicknesses provide a clear example of syncretism in the area of health. There are elements of the original aboriginal belief systems, such as rubbing a sick person with an animal to suck out the disease, combined with rituals introduced by the RCC, such as the use of the ash cross while chanting. Another example from above, where syncretism is revealed, is the lighting of candles in a healing ceremony or the burning of a cloth. The use of candles is common in Catholic religious ritual, while the burning of cloth has often been recommended by doctors as a safe way of removing disease from an environment. The fact that this mix of practices can be used in a healing ceremony shows the evidence of syncretism in the beliefs and practices of health in Ecuador.

Participants gave various explanations for these traditional sicknesses, often referring to the psychological and spiritual realm, such as curses or envy. Others explained the naming of these sicknesses as a tradition that provides a sense of security in visiting a healer, while others said that people use these sicknesses when there is no other way of explaining or curing symptoms. In this way parents can feel that they had helped their child to be healed. One student said:

My university medicine lecturer explains these diseases as being an imbalance of the body's energies. This professor regularly sends his children to traditional curers to be cured of fright sickness.

Apparently there is no evident conflict between treatment of different sicknesses by modern and traditional methods. The philosophy seems to be, use whatever provides a cure. Helman (1994:63) describes this as pluralism, where different belief systems of health co-exist, although they are often based on entirely different premises. However, he comments, to the sick person relief of their suffering is really the key issue. How this occurs is not so important. A friend who is a paediatrician, made the following observations about these diseases:

There is no doubt that people believe in the power of these traditional beliefs. I often have parents bringing in their children, days after being taken to the traditional healer, when the symptoms have not gone away. Generally they are affected by parasites, or from bad food that the body cures itself of, in a matter of days. I usually make sure they are not dehydrated, give them something to get rid of worms and talk about their eating habits with the parents. I think it is just easier for people to explain sickness in this way.

This area of traditional sicknesses, is perhaps one of the strongest links with the patterns found in other non-western systems of healing, that of syncretism. The belief in the action and involvement of the spirit world on physical health remains strong, remaining consistent with the beliefs and practices of their aboriginal ancestors. However, we have seen above, how this is combined with elements of other belief systems such as the RCC and the bio-medical model of health. A further example of syncretism I observed amongst participants, was the use of industrially produced 'natural' health products. When travelling in any bus in Ecuador, it is a common experience to be approached by vendors selling a new 'natural' health product. As described by Miles (1998) the sale and use of these products depends heavily on the mix of traditional beliefs, such as cleansing, and the advantages of 'modern' scientific medicine, that have created a better product for the clients' health. Many participants said to me that they use these bought 'natural' products along with the herbs and treatments they have used for generations.

You are Well if you Look Happy

My experience in Ecuador has taught me that external appearances are very important in the society there. This is reflected in the importance of a person's physical appearance such as dress and shoes, and in how a person speaks and carries themselves. I guess it is not surprising then that this characteristic also affects the area of health. A comment that

kept reoccurring was in response to the question: can you tell if a person is in good health? The reply was always:

Of course, its obvious from the way a person looks. A person will appear happy and animated if they are in good health, or sad and with a downcast face if they are not well.

You can tell by the energy a person has. For some people it depends on the type of sickness and type of character the person has. Some people are more resistant, while others feel like dieing with a cold.

This seemed to be different to the response I expected. Perhaps I was expecting to more scientific explanations of physical symptoms, such as yellowness of skin, a malnourished pot belly, or sneezing and a running nose, each of which denote the presence of compromised health. In reality, the participants' way of understanding this area, was quite different. The participants' responses indicate the importance of emotional wellbeing and the feelings of people, in judging a state of health. This is an acknowledgement of a more integrated way of understanding health, present in many non-western worldviews of health, as outlined in the literature review. In many non-western contexts health is seen as relating to the holistic wellbeing of a person, including physical, emotional, spiritual and environmental factors.

Those then, are the nine common areas reflected by the participants in their understanding and experience of health. The next section focuses on the particular perspective provided by the Afro-Ecuadorian participants in this study.

An Afro–Ecuadorian Case Study

The context of this group was an Afro-Ecuadorian cultural centre, in the centre of the bustling city of Guayaquil. This centre is facilitated by a group of Catholic Combombian (a catholic order) brothers, to provide training and formation for Afro-Ecuadorian people who are willing to work in their communities. The aim is to empower and facilitate social transformation in these most socially and economically marginalised communities of Guayaquil. Many of the people in the cane housing areas are predominantly of African origin, the majority of whom have migrated from the northern coastal province of Esmeraldas. The aims of this centre include: the group members becoming conscious of their cultural identity and history, social transformation in areas of ethnicity, gender and human rights, and the encouraging and developing of indigenous expressions of faith.

I have participated in numerous group meetings held at this centre. It is the best example of participatory development that I have seen, consistent with the principles outlined in the methodology chapter. They seem to consistently work toward the empowerment of their respective communities, and genuinely work towards the best solutions for all the participants. I have also been privileged to spend time both in the communities where the participants of this group live, and participate in the lives and communities of other Afro-Ecuadorian friends in Guayaquil, on a regular basis.

My experience in the Afro-Ecuadorian group showed that syncretism existed in their expression of faith and in the area of health. For example, while these participants were members of a RCC community, facilitated by the Combombian order, they clearly believed in all of the traditional sicknesses described earlier. The participants did not express any conflict in using traditional healing rituals for diseases such as evil eye, while remaining firm in their belief in prayer to the Christian god. For many people this acceptance of two such different ways of understandings would cause conflict. Within this context this did not seem to be the case. It appears that the existence of the spiritual realm in both these belief systems, is stronger than the particulars of how a person is cured. We see that the traditional beliefs remain significant, but operate in tandem with newer introduced belief systems.

This whole area of syncretism in the Afro-Ecuadorian context would provide a fascinating area to be explored to a much greater depth. However, for me in this study, it was not possible for two reasons; firstly, because literature in the whole area of the Afro-Ecuadorian experience was very scarce in Ecuador, and secondly, my time and energy were limited in focusing on health. However, although I am not able to give an extensive review of this area, as this group are valuable participants in this study, I felt it was important to include the glimpse I had into their worldview of health. The experiences of the participants focused on three areas that formed an integral part of how they understood health: the role of nature and music within their ethnic identity, the influence of history on their current context, and the significance of women and healing within their culture.

The Rhythm of Life and Nature

In this group, we began by talking about the symbols within the Afro-Ecuadorian culture, and how these represented health. There were two main strands described: music and nature. Participants described how traditional African instruments such as the *marimba*, *bombo* and *cununa* were described as being symbols of health and wellbeing. They explained that rhythm and movement are central in this expression of wellbeing both as individuals and as a community:

The bombo gives me a deep joy and makes me rise, it stays in my soul.

It doesn't matter how hard life is, or how bad I feel, when I hear the beat of the *bombo* I rise up. It gives me strength to keep on with life.

Healing songs share the knowledge of how to heal and the plants that can be used to cure. This is how our ancestors have taught us.

I observed that this use of traditional instruments and chants was an important part of group meetings at the centre, and in their communities, as part of religious ceremonies and communal celebrations. It is part of their culture that many participants felt had been lost in the urban environment, and that it was important to teach the upcoming generations. A ceremony that I participated in, revolved around the use of the rhythm given by the *bombo* drum and a traditional chant. The form of worship was African, but the saint that they were revering was Catholic. This whole ceremony was a mixture of the participants African heritage and their Catholic faith.

The other clear area described by the participants was nature. How the forces of nature represent a source of strength and nurture in their daily lives. The plants, animals, land and sea, provide all that is necessary for the physical body and energy to the soul. One participant described this:

We have always found our force for life in nature, and its close relation with spiritual and physical health. The mountains, the river and the Pacific coast are important to us.

We see a visual example of this in the pictures drawn by two of the participants (Figures nineteen and twenty). These symbols, nature and the *bombo* represented for them health and wellbeing. Participants described in detail the importance of the mountains, water, the sun and earth, in providing them with life sustenance. For this reason these symbols were considered essential to health. Another participant described how the remedies that nature provides are used:

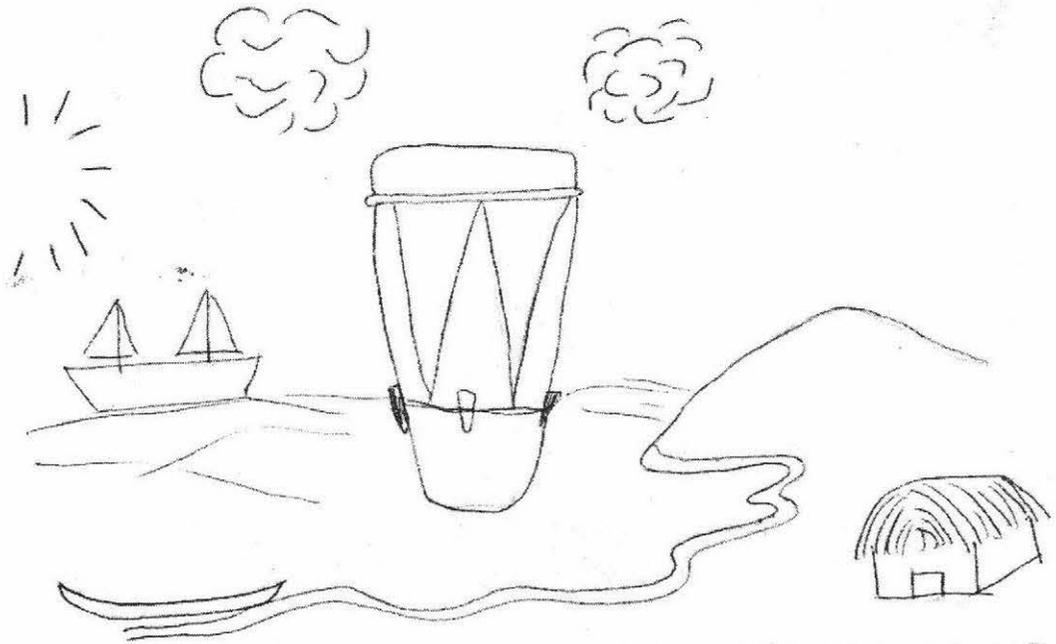


Figure 19a: A Drawing of Symbols that represent health to an Afro-Ecuadorian participant. We see the representation of nature with the mountains and river, music in the *bombo*, and the ship which represented his history of slavery.

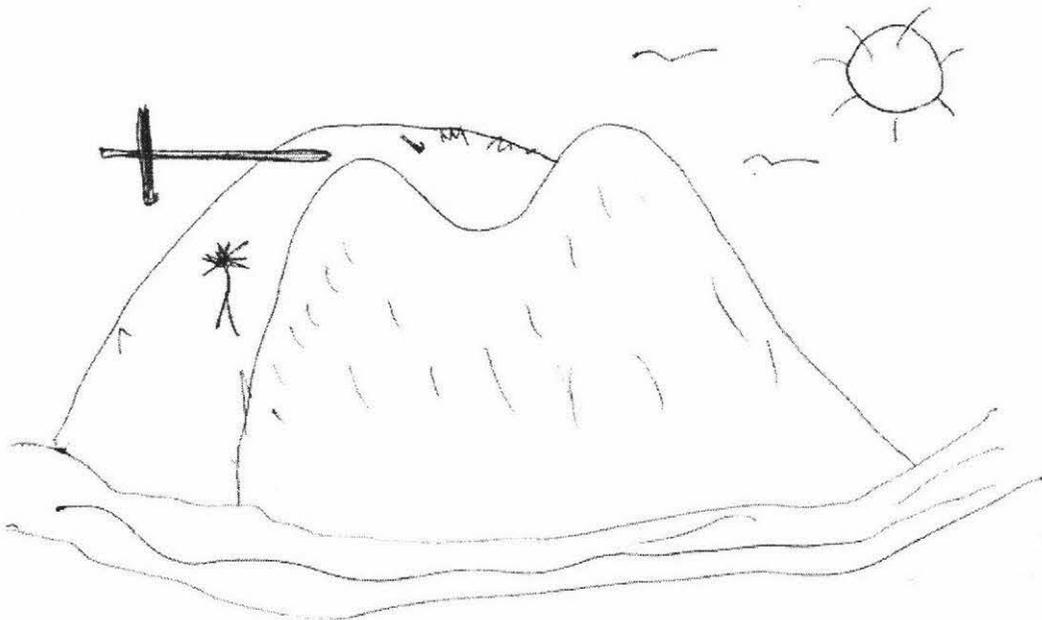


Figure 19b: A Drawing of Symbols that Represents Health for and Afro-Ecuadorian participant. Here we see nature in the river, mountains and bush, also a cross, which represents death as being very common in his experience.

All our life and remedies come from nature, we use only what is necessary. For example, animals like the frog (a particular sort) are used for rubbing on a sick person until it absorbs the sickness or bad energy. The ash of a certain plant can be burnt and used to cleanse the body. Cane liquor and tobacco have also been used as part of healing rituals. Living in the city and being removed from nature is one of the hardest things for our people, as we don't have access to nature's resources.

More than the other participant groups, this Afro-Ecuadorian group expressed their need and dependence on nature in their health beliefs and practices. This included the use of remedies for healing the body, food for strength, but also the spirit and soul for survival and the freedom of their people.

The Spirit of Slavery

The second part of interest in this case study relates to the explanation of the participants, of the role played by history in the current state of health in their communities. Participants spent considerable time relating to me their origins in Ecuador as slaves, the extreme maltreatment and how in many ways at a profound level in society, for them, little has changed. The slave origin of Ecuador's Negro population was explained as being closely related to the current state of the population's health. One participant explained:

Our people were brought here as slaves from Africa. For generations under the Spanish the conditions were extremely inhumane, with filth, starvation, and chains, being treated worse than animals. Then, even when we were freed from our physical slavery, the mentality and lack of empowerment in my people from generations of colonisation still leaves many in chains of poverty, un-employment and violence. I see the conditions of slavery unconsciously repeated in a new form in the poorest areas of our city. People don't know how to break the cycles that are repeated. The government health system doesn't provide for our needs, so we have to take the responsibility for ourselves and use the natural resources we have always had. Our immune systems have become very strong to survive and keep surviving in the conditions in which we live.

This was to me one of the clearest evidences of how within a country, the historical events can shape the current context and worldview in an area such as health. Another participant described how health is more than physical symptoms:

For us the reality of death is always close, our people die of simple diseases. Having a strong spirit helps us to survive and have good health. That is, we need self-esteem, faith, a healthy body, and resistance to bad circumstances.

This idea of survival related strongly to the experience of their ancestors being slaves. It seemed that this conscious awareness of their history, combined with a recognition of

strong existing cultural beliefs, provided a clear understanding of what health was for them.

Women as Life givers

Another distinct feature in this Afro-Ecuadorian community, was the specific and verbalised recognition given to the role of women in communal life and especially in healing. I had noticed in Ecuador that women with African heritage, seemed to display greater assertiveness and control in the life of the family and community. Perhaps an explanation for this is seen in their cultural roots. One participant described it this way:

In our culture, the healers are always women, as the symbol of women is very important. The African god of nature is female, She influences fertility and gives the special healing abilities that are genetically inherited. In our history, matriachal societies were common, this meant that in families, the surname of the mother would go first, until the Spanish outlawed it. Now the mans must go first.

Another participant talked specifically about the role of women in healing:

We have lost many of the healing rituals that our ancestors had, for example, the healing dances. This is because in colonial times it was prohibited to speak other languages. Over time, the words of the healing songs and dances were forgotten or reduced to small phrases and chants now used by the women *rescanderas* (the ones who recite) and *parteras* (the one who helps us to give birth). They are still our healers today.

This was the only participant group that talked specifically about the role of healer being special to women. The participants explained how the women in their communities remain responsible for healing and health. They are the ones called upon when a baby is about to be born, or someone is sick. My experience and observations of Ecuadorian society in general did not indicate that gender relations within the Afro-Ecuadorian community were any better because of this cultural heritage. However, it was certainly an area that this Afro-Ecuadorian centre was developing amongst its female participants. They expressed great interest in exploring more of their African tribal roots, and the gender relations that had existed before. That concludes, what was for me, a very fascinating insight into how the African roots of this participant group, have remained strong in their worldview of health today.

The Common Sayings of the People

In the literature review, it was mentioned that sayings and proverbs within a culture can help to glimpse part of a worldview. The final part of this chapter is a collection of beliefs and practices expressed through sayings from the 'mouth of the people'. The translations of the sayings from Spanish to English have been kept as literal as possible, while trying to communicate adequately the meaning behind the expression. Many of these sayings were shared during discussions in normal life, rather than specifically collected during the formal research time. Having questioned many people, these sayings were found to be common. In addition, I observed that many of these sayings did affect people's daily lives. They are in no particular order, where possible an explanation or example are provided along with the phrase.

What does not kill me will make me fat.

The idea here is that if a food does not hurt me, it will benefit me. This is in a context where people who often don't have much food will eat whatever is available to them, also assuming that to be fat, is also to be healthy and strong.

The sick person who eats will not die.

This was explained as meaning, if a person is not too sick to eat, then whatever they do eat will help them to become strong and well.

Eat chilli because it makes your body strong and resistant. It makes you macho, so you wont be homosexual.

This appears to reflect the idea that chilli is a food that is hard on the body, so if a person eats it, they will become strong. A number of people told me that chilli is very good for cleaning parasites out of the digestive system. The reference to homosexuality, reflects the social stereotype present that gay men are considered weak.

The secret of health is to drink a smoothie of duck eggs and beer regularly.

It is better for the stomach of the poor to explode than to refuse food.

This reflects some of the common expectations about hospitality, in that a person must not refuse food that is offered to you. It is offensive to do so.

The most important thing is to feel healthy.

This is reflected in the theme if you look good, then you are well, as described earlier. The idea, is that a person's state of feelings is the most important thing for them to be healthy. For example, although obviously unwell, an older person will leave the clinic after receiving an iron injection saying, I am healthy and strong because they feel strong.

A good doctor will give me vitamin drips and expensive tablets.

In my experience, one of the most common beliefs that vitamins and tablets will cure everything. The place where I saw most evidence of this was in the hospital where patients literally fading away, were prescribed with expensive vitamin drips that did not appear to have any effect. To me, this reflects messages transmitted through western-based health education, that had been partially understood. It is an example of syncretism, where the teaching that vitamins and minerals are important to be healthy has been understood in part, and taken to an extreme.

In eating, the most important thing is to be full. Quality, taste, and composition is not so important.

Foods of the poor are those like barley flour, cereal smoothies, and potatoes, while foods of status are: pasta, meat, chicken, milk and cheese.

This reflects the theme related to the importance of food and food practices. In this context, appearances and social class are important factors in making a decision about what to eat. This belief clearly affects daily eating patterns. For example, one woman knew and explained to me in detail, the limitations of diet given to her by the doctor for the benefit of her fragile health. These included cutting down cheese and red meat. However, because of her high class status she felt that it was essential to eat meat daily. She continued to eat large quantities, and her health has deteriorated as a result.

In the morning you should always drink something warm to heat the stomach for the day, before consuming other food.

I saw this illustrated when a friend's grandmother was convinced I would become ill, because I had drunk cold water first thing in the morning. This belief affects the order foods can be eaten.

Soup is the essential part of the daily diet because it gives health.

It is explained that by boiling the soup, the goodness such as vitamins are held in the liquid. These are then absorbed by the body when the soup is drunk. Soups are also the main or only source of vegetables in a meal for many families. This is another example of how western health education about nutrients in food have been taken into the Ecuadorian worldview of health.

Underwear must be hung the right way in on the line while they are drying.

This was explained as being important, so germs and bacteria do not enter the underwear, causing illness. This is especially important for women. Again, we see here reflected a

scientific understanding of how disease is caused, by germs and bacteria, but with a slightly different application of this knowledge.

Mothers who are breastfeeding must not eat foods with strong flavours such as pork, chilli or peanuts, because it will affect their milk and cause sickness in the child.

Women should rest for forty days after giving birth.

This is a time to regain lost strength, so you should eat a special diet. On the coast this diet consists of young dove soup, while in other areas it is a guinea pig or chicken broth.

Foods such as fish, potatoes, bananas, beans or grains must not be eaten after surgery or giving birth because they cause inflammation and prevent healing.

This belief, was explained to me by a nurse who worked in the public hospital. She said that it is problematic because often patients won't eat the food served to them, as they believe it will hinder, rather than help healing. This is another example of how beliefs about food affect daily food practices.

During menstruation woman must not bath or eat foods such as banana or avocado.

It is said to stop the cleansing process. The female participants in this study commented that this is a traditional belief still taught by their grandmothers, but that they don't really take any notice of it anymore.

In the older rural population, it is believed that to be fat is to be healthy.

Being fat is a sign of prosperity and strength. This clearly relates to the theme of body image as described in the literature review, where body size is related to being healthy.

When people are sick, 'light' foods such as noodle or bean soup should be eaten. This maintains the body's strength while also giving the stomach time to heal.

The past is forgotten quickly, the future is not considered, and the present moment is what matters.

This was explained to me as a reason why most people are concerned only for immediate pain relief and a fast cure, rather than being concerned about a change of lifestyle. It is easier to see immediate results, rather than focus on long term prevention of sickness through diet and exercise.

Chilli is good for vision, it will help you see well.

Babies' nappies should be steamed (or at least ironed) before using them, so the baby is not affected by the cold.

Shoes must always be worn even in the house so as not to get cold and get a cold.

You must not eat food like fish, beans or peanuts at night as they are considered heavy foods, which will disturb your sleep.

After cooking foods like beans and grains, the water must be drunk.

That is because that is where all the nutritive goodness of the food is found.

You must not eat during a blood transfusion or you might die.

Here the idea is, that the intake of food will stop the process of blood flowing. This relates back to some of the traditional ideas about cleansing of the body, and purifying of the blood being the way to cure illness.

HIV/AIDS is the result of a curse that has been placed on someone.

Here we see the theme of the spiritual realm being involved in health. The cause of HIV/AIDS is seen as similar to that of evil eye or evil air. It is the result of activity in the spirit realm. This is a traditional belief structure being applied to a modern context.

These sayings reflect common beliefs and practices of health in Ecuador. It is clear that many of them have clear links with the common themes described earlier, such as syncretism, the importance of food and food practices, and the interconnected nature of the physical and spiritual realms.

This chapter explores the stories of the participants, both within a group and individual context. These stories reveal nine common themes that together with the case study, contextual information in the methodology chapter, and the collection of sayings relating to health, provide us with an insight into the Ecuadorian worldview of health. These are the beliefs and practices shared by the participants that reflect their underlying way of conceptualising health. The significance of these themes is evaluated further, in the final chapter.

Chapter Six: Reflections and Conclusions

Stories are important to understanding reality, they are the oldest form of building a history and culture. Storytelling is the medium by which knowledge, skill, roles and values are transferred from one generation to the next. Particular stories call us to accountability, stories of conflict, oppression and exclusion, they reveal an expression of marginality at the level of everyday life through oppositional and transformative consciousness (Manley 1995:116).

This final chapter provides a space for reflection, and a point of closure for the stories shared throughout this study. The life of each participant and their cumulative experiences, the story of a country, its history, culture and health, the story of the researcher being immersed and challenged by a new reality, the story of you, the reader, interpreting as you interact with the shared reality of the participants and researcher in Ecuador. The first part of this chapter is a summary of the proceeding chapters' research journey. The second part reviews the evidence presented in answering the question; is there an Ecuadorian worldview of health? The third part looks at some of the future implications of this study.

The Thesis in Revue

This study has utilised four sources of information to fulfil one main purpose: to explore the Ecuadorian beliefs and practices of health. That is, to try and understand the way health is perceived and construed within this unique historical and cultural context. The aim was to see if there were commonalities, patterns of beliefs and practices in the area of health. Even with the limitations of participant numbers, time, energy, and money, and with the biases of researcher and history, I feel this aim has been achieved. The areas of commonality described in the previous chapter, to me, represent part of an Ecuadorian worldview of health.

Chapter One provided an introduction to the concepts of worldview and culture, why they are important, and how they are integrally linked within the area of health and development theory. This first chapter also placed the researcher, voices of the participants, limitations of language and post-modern influences within the study context, setting the stage for their interaction throughout the thesis.

The frame of reference for the research was constructed by reviewing some of the relevant literature for this study. The literature review is divided into chapters two and three, and focused on three main areas. Firstly, the concepts of worldview and culture, and how they affect the human experience. Secondly, I explored two main constructs of health, the western biomedical model, then some of the beliefs and practices of health revealed in non-western cultures. The common areas found in these non-western cultures, provided the structure for this study's exploration of the worldview of health in the Ecuadorian context. These areas of commonality are: the origins of sickness and health seeking practices, food and food use, concept of self and community, the inter-related nature of the physical and spiritual realms, the existence of a multi-tiered health system, the concept of body image, and syncretism. Thirdly, is the topic of Ecuador, its history and health experiences. Chapter two leaves us with a more informed general overview of global health patterns, and a clearer idea of the literature in this area.

Chapter Three creates the link between the researcher, participants and readers, in its placing of the research in the social, historical, political, economic and environmental context of Ecuador. This chapter is all about Ecuador. The intended outcome of this chapter is a better understanding of the origins of present beliefs and practices, and the challenges of health within this reality. This chapter gives a summary of Ecuador's general history, and bring to light the history of health, throughout its generational changes in culture and society.

Chapter Four moves away from literature and development theory, to a discussion of research paradigms, and a justification for the use of PR as a methodology for this thesis. We begin to see the outworking of development theory in practice, and explore the origins and evolution of PR. We look at the synergistic effect gained by the interaction of four information sources, that is in-depth interviews, participatory research groups, participant observation and unstructured information gathering and a literature search. Then the interactional roles and responses of the researcher and participants are noted, and a detailed explanation of the 'menu' of methods used in Participatory Research is described. Finally, we get a glimpse into the lives and context of the participants, hearing their voices, and seeing some of the strengths and weaknesses of this study.

Chapter Five shares through quotes, themes, common sayings and a case study, the stories of the participants in this study. Nine common themes drawn from the stories of the participants, give us a glimpse of how health is perceived in Ecuador. The common themes are: the therapeutic route, nature's healers, you are well if you look happy, of divine descent but humanly frail, no health without money, the path of tradition, an acutely conscious state of health, and traditional diseases. An Afro-Ecuadorian case study shows us that there are simultaneously many stories and one story. While the general themes found in this study are present in this group, this section explores a little further, part of the understanding of health, particular to this group. The final part of this chapter is a collection of common sayings, that affect the daily practices of health of participants in this study. This chapter reveals part of a worldview of how health is conceptualised and lived out in Ecuador. A story that is ancient, surviving, natural, syncretistic and at times confused and dependent. This story is valid, worthy and deserving of our respect and understanding, because it represents the reality of participants, people like you and me.

Is There An Ecuadorian Worldview of Health?

Due to my experience in Ecuador, at the beginning this study I thought there would be areas of commonality in how health was understood in the context of Ecuadorian culture. This was because my observations both in Ecuador and other countries indicated that people have common beliefs and practices, which affect their everyday decisions relating to health. However, I did not assume that there would automatically be cohesive common patterns found in the study. Instead I kept both my observations, and the knowledge gained throughout the literature review, in the back of my mind, while exploring the topic. Now at this concluding stage of the study, the findings demonstrate, that in fact there are areas of commonality in the beliefs and practices of health amongst a group of Ecuadorians. Perhaps then, if the stories of participants in this study reflected these common themes, they could also be true for Ecuadorians in general. Evidence to prove this, would need to be gathered through further, more extensive research.

The next question needing a response is, do these areas of commonality in health constitute a worldview? I believe that these findings are too limited to claim having described a comprehensive and in-depth worldview in its fullest meaning. However, in the sense that areas of commonality were consistently expressed by participants in a variety

of contexts, indicates to me that to some degree an Ecuadorian way of understanding health, do exist. This then is part of their worldview of health.

We also see clear links between the themes found in Ecuador, and the patterns commonly seen in other literature on non-western systems of healing. For example, the area of syncretism, food and food practices, the integral nature of physical and spiritual realms, the concept of self and community and the existence of a multi-tiered system of healing. I believe that these areas of commonality would have been present in Ecuador, even without the knowing about the themes described in non-western health literature. The themes found in the literature review did not dictate what I found in Ecuador, but they did help to give structure and explain them more clearly. The Ecuadorian worldview reflects some commonalities found in other non-western contexts, but also has its own peculiarities. While being neither exhaustive nor limiting, this glimpse into how Ecuadorians perceive and practice health, is for me a valuable understanding into part of their worldview of health.

In addition to answering the above questions, there are a number of other outcomes and benefits that I believe this thesis provides. The first relates to the nature of development. In choosing a participatory methodology and explaining the philosophy behind it, I hope it is clear that I believe development must be a people centred process. A process based on dialogue, empowerment, creating choice and the valuing of existing knowledge. While western experience, academic knowledge and economic models have something to contribute, the uniqueness of needs, experiences and worldviews in each context, mean that a respectful, integrated approach must be taken in all areas of the development process. As health forms an integral part of the overall development process, these values must be implicitly present in health education and care structures. My hope is, that this thesis will facilitate an understanding of this, in those who read it.

It is clear that an acknowledgement and understanding of worldview is vital in a cross-cultural work environment. If two people with a different worldview use the same terms, both could be referring to and understanding completely different things. This can result in either frustrating mis-communication or an ignoring or one person's knowledge, in favour of the other. Specifically in the area of health, dialoguing and communicating in a relevant and appropriate manner with the existing perspectives is crucial. This research will be of

direct assistance to those working in the area of health education and care in Ecuador, because through a reading of it, people should consider their own perspectives and how the presence of differing worldviews affect their daily interactions. I can see an immediate application in the context of the HIV/AIDS group with whom I have been involved. If the health professionals took into account the way their patients understanding health, I believe many of their suggestions regarding diet, medication and forms of treatment would be different. The treatment would be more appropriate and attainable for the patients, and consequently better adhered to. This would result in a more appropriate and efficiently administered way of caring for patients.

This thesis has provided significant personal benefits in a number of areas. Principally it has been a journey of discovery for me: discovery about culture, my own and that of others; of processing my own worldview and how this does and should affect my daily interactions, and of learning about Ecuador. It has provided for me a clearer understanding of Ecuadorian culture: its history, cultural origins, foreign influences, society, religion, politics and economy. I have gained a wealth of understanding about Ecuador that I believe will help me to understand the culture and context better. The poems included throughout the thesis represent part of my reflection and how I felt during this experience.

Another personal goal was to see if participatory methods functioned well in this context. Despite certain limitations, I believe participatory methods provided satisfactory results both for this thesis and for the participants. It created the opportunity for the process of empowering the participants to begin. As they explored their own beliefs and practices, they became conscious of the wealth of knowledge and resources that are available to them. The value of each participant's experience and the cumulative knowledge and worldview expressed, were affirmed through this study.

The Future Implications of this Study

In bringing to an end the process of reflection and critical interaction, what can be taken away from this study?

The Readers

Throughout the reading of this thesis, I hope you as a reader have become aware of, and reflected on, the implications of worldview in your own context. Each person is given the choice to listen to, acknowledge and value a different construct of health as expressed by participants in their unique field of work. This may be with people of a different culture, generation or worldview on a particular topic. This difference in worldview will affect your communication. The challenge for each of us, is to let what we hear and learn in our daily interactions impact our way of being, to facilitate greater acknowledgement and respect of differences within our own life context. Those who are health or development professionals have the choice to respond in a number of ways. Each person has the opportunity to seek out the stories around them, place themselves within the worldview of their work community, practice respectful dialogue, transform professional-client relationships and creatively adapt forms of health education that communicate adequately with the existing worldview.

The Researcher

As a researcher and participant in this study I have learnt so much. It has provided a wealth of insight and understanding into the Ecuadorian culture and existing beliefs about health. Through coming as a learner to this study, opportunities have opened up to knowledge and perspectives, I would never have otherwise heard. I believe these will help to make my work as a professional in this country and region more appropriate. In addition, this knowledge will certainly be spread amongst a range of friends and health professionals in Ecuador, where I hope it will be the basis for serious reflection and a change in attitude and practice for many. The interest generated so far amongst a variety of health professionals has been very positive.

The Participants

The participants have the satisfaction of having their stories heard. A number of participants thanked me for being interested in their beliefs, and for respectfully learning from their culture. Because of this, I am certain that each participant did feel valued and affirmed throughout this study. On my return to Ecuador, with two of the participant groups, there is the ongoing opportunity for discussing and working through some of the

implications of their health beliefs in community education programmes. These participants are keen to have a better understanding of health in their own context, and how they might be involved in bringing this about. These groups are also interested in learning how to use participatory tools to promote community action and change within their own context.

Further Research Options

The second main implication of this study is the further research options it presents. Using the study as a platform, there is great scope for further investigation. A study of greater detail and depth could be done seeking to include a greater number of participants from other geographical areas of Ecuador. This would help us to see if these areas of commonalities are consistently expressed throughout the whole country. Another fascinating study could focus on the area of gender within health practices. A similar study could also be undertaken in other cultural contexts to improve the understanding of the worldview between health participants and patients in that environment. A further whole area of interest could revolve around the study of the distinct elements of the Ecuadorian worldview of health, and making the points of connection with the western bio-medical model. This could be of assistance in providing more appropriate health care and education services in many contexts.

Whether the issue in question is health, education, sexuality or religion, each person has a set of beliefs and practices, representative of their underlying worldview. Every hue, flavour and colour reflected in our worldviews as human beings need to be acknowledged, respected and taken into consideration.

**Perhaps now stepping stones stretch out between us
Pools of commonality now that we have heard
and lived a little of each others reality
Asking to be crossed over, learning to step together
The dance that brings health and life**

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Appendices

Confidentiality Agreement for Research and Language Assistant

As a research and language assistant for this study, I agree to respect the participants in this study, by keeping information shared, confidential. This means I will not discuss or disclose research material outside the context of the study. No other person will have access to information shared with me during the research; neither will I use the information for any other purpose outside of this study.

Signature

Date

Letter of Presentation of the Research

Title of the Research: Exploring the Ecuadorian Worldview of Health

My name is Ruth Hicks. I am a student from Massey University New Zealand, doing research to complete a Masters thesis. The aim of this research is to learn about your knowledge and experience of health as an Ecuadorian.

To do this, I would like to meet with you to talk, at a time and place that are convenient for you. The main question I will be asking is “ ***tell me about your experience of health***” With your permission, the interview will be taped, although your confidentiality will be maintained with any information you share with me. I would like to meet with you again after reviewing your story, to check that the way I have interpreted your story is correct. I am very interested in your knowledge and experience of health. Your story is valuable to me.

If you have any questions about the study you are welcome to contact me ([REDACTED]) Guayaquil. This study is being done under the School of People, Environment and Planning, Massey University, New Zealand. Further enquires can be directed to my supervisors' Dr Barbara Nowak at B.S.Nowak@massey.ac.nz or Dr Francisca da Gama at F.daGama@massey.ac.nz

I trust you will be available to help me.

Yours sincerely

Ruth Hicks

Group Consent Form

Title of the Research Project: Exploring the Ecuadorian Worldview of Health

Researcher: Ruth Hicks

We affirm that:

1. We have received sufficient information about the study to understand its purpose and have had the opportunity to ask any questions or cover areas of doubt we may have.

2. We are participating voluntarily and understand that we can withdraw our participation at any time as individuals or as a group without giving any explanation.

3. We have agreed to share our experiences and knowledge of health.

4. If we choose, we can remain anonymous. We understand that the researcher (Ruth Hicks) will maintain our confidentiality with the information shared. If the information is transcribed, only the research team will view it. The group activities will be recorded and the cassettes kept securely until being destroyed at the end of the study.

5. We have the right to communicate with the researcher (Ruth Hicks) at any time to ask questions or comment on the information shared, before the thesis is published. If we choose we can receive a summary of the study and copies of any photos taken during the study.

6. We agree that the information that we have shared can be used by the researcher (Ruth Hicks) in publishing her thesis, other books, presentations or teaching materials linked with this study.

Date

Signatures

Individual Consent Form

Title of the Research Project: Exploring the Ecuadorian Worldview of Health

Researcher: Ruth Hicks

I agree that:

1. I have received sufficient information to understand the purpose of this study, and had the opportunity to ask any questions or cover areas of doubt that I may have.

2. I am participating voluntarily and am free to withdraw my participation at any time without giving any reason.

3. The interview will take place when and where it is convenient for me, will last between 30-60 minutes, and will be recorded.

4. If I choose, I will remain anonymous, and I understand that the researcher (Ruth Hicks) will maintain the cassettes secure until the end of the study when they will be destroyed. If the interview is transcribed, only the research team will see it.

5. I have the right to communicate at any time with the researcher (Ruth Hicks) with questions or comments regarding the information I have shared, before the thesis is published. If I choose, I can receive a summary of the study and copies of any photos taken during the study.

6. I agree that the information I have shared can be used by the researcher (Ruth Hicks), to publish her thesis, other books, presentations, or teaching materials related to the study.

Signature

Date